EDITED BY **PAUL GILBERT**

compassion

Conceptualisations, Research and Use in Psychotherapy

Compassion

Humans are capable of extreme cruelty but also considerable compassion. Often neglected in Western psychology, this book looks at how compassion may have evolved, and is linked to various capacities such as sympathy, empathy, forgiveness and warmth. Exploring the effects of early life experiences with families and peers, this book outlines how developing compassion for self and others can be key to helping people change, recover and develop ways of living that increase well-being.

Focusing on the multi-dimensional nature of compassion, international contributors:

- Explore integrative evolutionary, social constructivist, cognitive and Buddhist approaches to compassion.
- Consider how and why cruelty can flourish when our capacities for compassion are turned off, especially in particular environments.
- Focus on how therapists bring compassion into their therapeutic relationship, and examine its healing effects.
- Describe how to help patients develop inner warmth and compassion to help alleviate psychological problems.

Compassion provides detailed outlines of interventions that are of particular value to psychotherapists and counsellors interested in developing compassion as a therapeutic focus in their work. It is also of value to social scientists interested in prosocial behaviour, and those seeking links between Buddhist and Western psychology.

Paul Gilbert, Professor of Clinical Psychology, University of Derby, has been actively involved in research and treating people with shame-based and mood disorders for over 25 years.

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Acknowledgements

The past few years have seen an increasing interest in the power of compassion to promote social harmony and happiness. My personal inspiration for this book has come from various sources. First, is an ongoing interest in Buddhism and other spiritual traditions. Second is from new research on the evolution and neurophysiology of affiliation, and third has been the insights and sharing with many patients, especially highly shame-prone and self-critical people, of how difficult it can be to feel warmth and compassion for the self. So, some ten years ago we started to see if we could develop interventions to help people feel a greater sense of inner compassion and warmth for the self. When I tentatively approached some colleagues about the idea for the book, it was a delight therefore to receive much support in this work, and in particular, the encouragement from all of the authors in this book. They have been enthusiastic about the project and each has furnished many new insights for me personally.

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interventions. Within the Research Unit, special thanks go to Lesley Legg for her research coordination, enthusiasm and interest. I am grateful to Diane Woollands, my secretary, for her tireless support. There have been numerous reference checking and reading-throughs! In the last year we have had keen research assistants and hence my thanks go to Claire Broomhead, Rakhee Bhundia, Rachel Christie, and more recently, Kirsten McEwan, Alison Mills and Bexs Bellew, who all make a very happy team.

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Chapter 1

Introduction and outline

Paul Gilbert

Introduction

The book explores the psychology of compassion. Although it has been long neglected in Western psychology, Eastern traditions have viewed compassion as central to liberating our minds from the power of destructive emotions such as fear, anger, envy and vengeance (Goleman, 2003). Compassion not only is a process that underpins the building of prosocial relationships with others, but also has great potential to heal our minds and bodies. In Buddhist traditions, compassion is linked to *metta* or loving-kindness. This form of loving is not linked to 'desire' for the other or seeking attachments. Salzberg (1995) says that *metta* comes from two words meaning 'gentle' and 'friend' (p. 24). Compassion (which is an element of loving-kindness) involves being open to the suffering of self and others, in a non-defensive and non-judgemental way. Compassion also involves a desire to relieve suffering, cognitions related to understanding the causes of suffering, and behaviours – acting with compassion. Hence, it is from a *combination* of motives, emotions, thoughts and behaviours that compassion emerges.

The great insights of the Buddha were basic observations on life and are illuminated in the four noble truths (Walpola Sri Rahula, 1959/1997). These are that life is full of threats and suffering (or *dukkha* – sometimes translated as dis-ease). All sentient beings seek to be free of suffering (*dukkha*). However, many of our ways of trying to reduce threats and relieve ourselves of suffering and distress, such as seeking the love/approval of other humans, fame, glory, sex or wealth, may offer only temporary comforts (all things are impermanent). Moreover, they can leave us worse off because we can come to crave these things, fear their loss, and in pursuing them we can distort our sense of self and create envy and suffering for others. The Buddha argued that to 'become enlightened' and create an inner state of 'being at peaceful happiness' was to come to see through these 'illusions or afflictions' by training the mind. Cultivating loving-kindness and compassion for self and others was a path to the release from suffering for all.

It has probably only been over the past century or so that Western

psychology has shown much interest in Eastern psychologies. This is in part due to different 'world views' and the non-availability of good translations (Harvey, 1990). As Western science turns its attention to the power of compassion as a healing process it will do so with a culturally constructed mind-set. For example, Nisbett *et al.* (2001) have explored the impact of different culture styles (individual vs collective) on the way people give meaning to and think about the world around them, their relationships and the nature of their lives. They compared ancient Greek and Chinese societies, and more modern Western and non-Western societies. In societies that focus on relationships, the way of seeing the world is in terms of patterns and the *interconnected* nature of things. This ripples through all facets of life: the type of medical sciences that develop (for example, non-Western medicine tends to focus on yin and yang, bodily energies and the flow of patterns of energies), the nature of the universe (for example, created by sets of balancing and interacting forces/energies; dialectics), the way people are seen as responsible for their actions (for example, personal responsibility is tempered by social circumstances and contexts for actions), and the values on which their self-identities are formed. Harmony is valued over competition and conflict. In contrast, individual-focused cultures create styles of thinking that split things into individual categories and units. Medicine is about discrete disease entities. The cultural focus is on developing logic, rationality, the classification and dissecting of objects, studying smaller and smaller individual units. Individual achievement is valued; individuals are held responsible for themselves and are not (seen as) socially constructed; competition (rather than harmony) is valued whereby the strongest or best (whether an individual or a scientific idea) prove themselves in competition with others.

These contrasting styles pose an essential dialectic to our thinking, which can benefit from their integration and from seeing that both give insights to different types of truth. As the Dalai Lama (2003) says:

> Buddhism and science are not conflicting perspectives on the world, but rather differing approaches to the same end: seeking the truth. In Buddhist training, it is essential to investigate reality, and science offers its own ways to go about this investigation. While the purposes of science may differ from those of Buddhism, both ways of searching for truth expand our knowledge and understanding.
>
> (p. xiii)

The past 30 years or so have seen major efforts to blend Western and Eastern psychological concepts. For example, John Crook, who was both a professor of ethology and a practicing Zen meditator, explored how evolution theory and Buddhism were highly compatible in his wide-ranging book *The Evolution of Human Consciousness* (Crook, 1980). Since the 1950s there have been increasing studies of the physiological and psychological effects of breathing control,

mindfulness, yoga and meditation on states of mind, physical illness and mental illness (a recent example being Davidson *et al.*, 2003). Efforts to integrate Eastern psychologies and mind training practices with Western forms of psychotherapy have also advanced greatly in the past few decades (e.g. Young-Eisendrath & Muramoto, 2002; Watson *et al.*, 1999), with specific integrated therapies for borderline personality difficulties (Linehan, 1993) and depression relapse prevention (Segal *et al.*, 2002). Integration can be difficult, however, due to different language and problems in translating 'meaning and concepts', different focus of interest (Clark, 1994; Young-Eisendrath & Muramoto, 2002), and Eastern approaches requiring that a 'therapist' be an active participant in practices (e.g. mindful meditation) and not just trained to deliver 'technologies'. Western psychotherapies and Eastern psychologies are designed to do different things and work in different ways. Welwood (1999) offers a thoughtful discussion on how some people can seek 'spiritual solutions' for complex psychological problems (for example, spending long periods of time at retreats, seeking gurus or communities) but make little progress. Sadly, these can be strategies of avoidance of one's inner pain, not of healing it. Thus Western psychotherapy has evolved from a particular way of thinking about 'self in the world', within a particular culture to address specific psychological problems. The way Eastern approaches are designed to address or alleviate these difficulties is different in focus and design. Indeed, as Welwood (1999) indicates, some people need to develop/strengthen their sense of self and identity before they engage in a journey to try to transcend it, and in this context the therapist relationship and ability to engage with things the person may try to avoid may be crucial.

Despite this growing interest, and the centrality of loving-kindness and compassion in Buddhist psychology, Western psychology has not (until recently) focused on compassion as a central psychological concept (Davidson & Harrington, 2002). Instead Western psychology has focused on related concepts such as affiliative behaviour, prosocial behaviour, forms of attachment, and different types of love (e.g. sexual/passionate, romantic or friendly, intimate or committed), underpinned by different competencies (such as empathy and sympathy). It is also notable that personal relief from depression, anxiety and anger is more commonly (in the West) rooted in building self-esteem, self-efficacy or self-regulation (on 'doing or achieving'), and is less often focused on the cultivation of loving-kindness to self and others (Neff, 2003). Yet if compassion is a healing process, as Buddhism suggests it is, then we should make this central to our investigations of exactly what it is, and how it works. We need to know how Western science can aid us in understanding the processes involved in compassion and how to cultivate it in our relationships with ourselves, with others and in our political deliberations.

The aim of this book is *not* to compare and contrast Eastern and Western conceptions of compassion, as others have sought to do (Davidson &

Harrington, 2002; Goleman, 2003). Nor is it to reach any agreed definition of compassion; authors were free to use their own definitions. Rather, the issue of compassion is addressed from multiple perspectives, especially in regard to thinking about compassion as a process for healing in a psychotherapy context. All authors took to the challenge enthusiastically.

Outline

The book is organised into two parts. The first part covers themes of conceptualisation and research. Chapter 2 offers a biopsychosocial overview of compassion. It is suggested that compassion is an emergent property of our minds that is dependent on the interaction of complex processes that include genes, psychological systems, early life experiences and social ecologies. Chapter 3, by Sheila Wang, develops an important model of compassion that is able to link Buddhist conceptualisations of mind with neuroscience. She points out that we are all highly interdependent beings who are in a constant process of co-regulation at multiple levels. Compassion is a process that can have multilevel organising properties. Gillath, Shaver and Mikulincer, in Chapter 4, review much of the data on how our early attachment relationships can create the contexts for developing compassion for others. Their landmark research has done much to illuminate the link between early attachment experiences and subsequent prosocial behaviour. This has clear implications for childcare. Chapter 5, by Bierhoff, looks as the links between helping behaviour, prosocial behaviour and altruism and explores the importance of social learning, group process and self-identity to compassion. Chapter 6 addresses the key issue of how relationships can stay supportive and warm even in the context of conflicts. Worthington, O'Connor, Berry, Sharp, Murray and Yi explore the key role of forgiveness and guilt in compassion. They point out how these can be involved in psychological problems and that excessive forgiveness can have a dark side.

Part II is primarily focused on how compassion can be a healing process in psychotherapy. Eastern approaches often seek to help a person obtain deep insights (for example, reach a more subtle level of conscious awareness) that undermine mental anguish. Western psychological therapies, however, focus on: developing a clear formulation derived from some theory of mental processes (e.g. psychodynamic, systemic or cognitive); articulating clear and specific therapeutic aims (e.g. to overcome a phobia or work with traumatic memories); providing *specific* experiences (e.g. within a therapeutic relationship or via exposure to feared situations or feelings); work with 'acknowledged–conscious' and 'less acknowledged or less conscious' material; and (for some) give instruction/psychoeducation in how to regulate one's feelings and thinking (e.g. as in the cognitive-behavioural tradition). Questions of higher (or more subtle) levels of consciousness and the 'ability to awaken' are not a focus here (Watson *et al.*, 1999). Part II therefore explores compassion primarily

within this context of Western, and in particular cognitive-behavioural, therapy.

Leahy in Chapter 7 presents an important exploration of how humans need to learn the meaning of their emotions and how to regulate emotions. Compassion for self and others can be difficult without supportive early relationships offering emotional validation and providing frameworks and guidance for affect understanding, integration and regulation. These learning opportunities can be re-established in therapy by a process of validation of the patient's feelings, especially for those who have lacked parental support and guidance. The use of guided imagery as a therapeutic aid to Western psychotherapies (used especially by Jung in his work on active imagination and amplification) has attracted increased interest over the past 100 years, and especially the past 30 years. In Buddhist psychology compassionate imagery, as a healing process, has been developed over *thousands* of years. In Chapter 8, Ringu Tulku and Mullen offer important insights into the use of compassionate imagery, and the process of focusing on compassionate deities. These deities and images emerge from the cultural history of Buddhism. The authors also reflect on the social construction of 'embodied beings' who have certain qualities, and the process of an imaginary merging with them, becoming them, and internalising their qualities.

Allen and Knight, in Chapter 9, remind us that in the West depression (primarily a disorder of positive affect) is a major health problem and is increasing. They explore how two compassion-based therapies, mindfulness and compassionate mind training, can be used to help depressed people and prevent relapse. Gilbert and Irons, in Chapter 10, address some of the reasons why many psychological difficulties are rooted in people's inner experience of themselves and in particular self-criticism and self-hatred. They give an overview of self-attacking, exploring it from a safety behaviours and functional analysis point of view. They describe various therapeutic techniques that include imagery and types of compassionate focus (called compassionate mind training), which can be used for helping people become compassionate and accepting of themselves. In Chapter 11, Lee uses case studies from her work with people with post-traumatic stress disorder to illustrate her own modifications to this therapeutic approach. In particular she discusses the role of imagery of 'the perfect nurturer' for compassionate mind training. Ann Hackmann, in Chapter 12, also uses illuminating case studies to outline her imagery work with anxiety disorders. She raises the important therapeutic need for empowerment as well as compassion in imagery work. Last, but by no means least, Bates in Chapter 13 provides a fascinating insight into the healing potential of group therapeutic processes. Coming from a cognitive background, he explores how compassion between participants becomes expressed, the role of the therapist in facilitating this intragroup communication, and the healing properties of doing so.

All these chapters seek to use insights and concepts about compassion to

inform their own clinical practice. Each therapist intuits that compassionate relationships have powerful effects and health-regulating properties. Although empathy, positive regard and many other prosocial relational interactions have been recommended as central to psychotherapy for many years, compassion offers a slightly different way of thinking about these processes and opens up new avenues for research and development, one especially exciting possibility being the power of compassionate imagery to stimulate new brain pathways.

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Part I

Conceptualisations and research

Chapter 2

Compassion and cruelty

A biopsychosocial approach

Paul Gilbert

If compassion is rooted in desires to alleviate suffering, prosocial behaviour and loving-kindness (Dalai Lama, 1995, 2001; see Chapter 1), then its antithesis is *cruelty*. My *Concise Oxford Dictionary* (Allen, 1990) defines 'cruel' as: '1. Indifferent to or gratified by another's suffering. 2. Causing pain or suffering, esp. deliberately.' (p. 279). Of these two human potentials, Goodall (1990) argues that:

> although the basic aggressive patterns of the chimpanzee are remarkably similar to some of our own, their comprehension of the suffering they inflict on their victims is very different to ours. Chimpanzees, it is true are able to empathise, to understand at least to some extent the wants and needs of their companions. But only humans, I believe are capable of *deliberate* cruelty – acting with the intention of causing pain and suffering.
>
> (p. 92)

Indeed it is our 'knowing' insight that others suffer, and of what might intensify or stop suffering, that gives meaning to the concepts of compassion and cruelty (Eisenberg, 1986, 2002; Gilbert 1989; Wispe, 1986). We might define some intended, harmful acts as 'evil', but evil is a complex judgement that many find problematic (Baumeister, 1997; Shermer, 2004; Straub, 1999). Here, therefore, we will contrast compassion with cruelty, with a focus on how human compassion and cruelty emerge from a complex, non-reductive interplay of innate, psychosocial and ecological factors (Jantsch, 1980; Johnson, 2002). Figure 2.1 shows a simple diagram of some of the interactions that will be discussed.

Historical background

Any analysis of compassion plays against a historical background of beliefs about human nature. Although Buddhism sees compassion as basic to our nature (Goleman, 2003; Wang, Chapter 3 this volume), in the West, we have

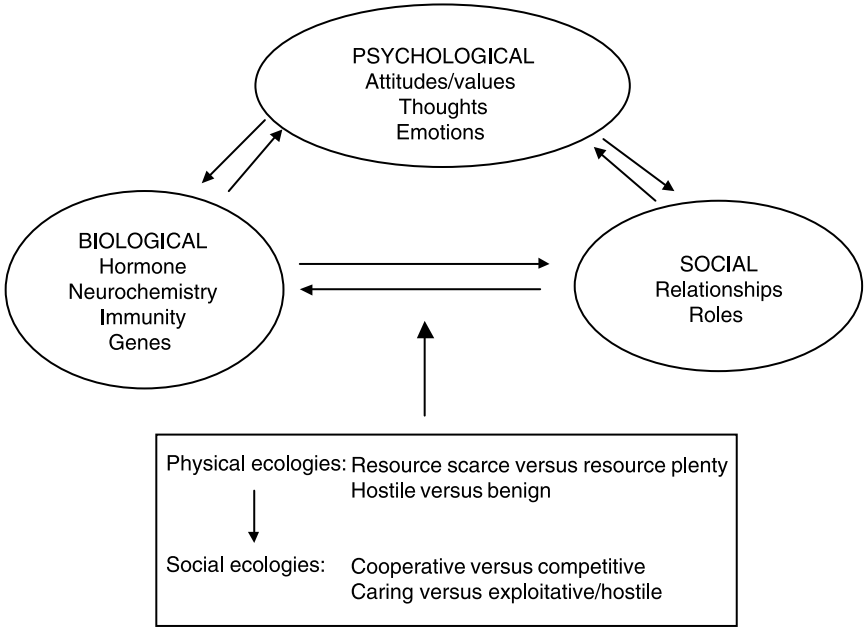

Figure 2.1 Biopsychosocial and ecological interactions.

long held the view that our basic natures (our evolved dispositions) are to be more cruel than kind (de Waal, 1996). We have grown in the shadow of beliefs that anything that is basic to human nature is *bad nature*. It is easy to see why. The past few thousand years have been marked by wars and atrocities: the mass crucifixions of the Romans, the invention of the torture chamber, the Holocaust, Stalin's persecutions and ethnic cleansing are but a few examples of State and religious use of terror (Millett, 1995; Straub, 1999). Violence, abuse, bullying and callousness in schools, at work and in the home stalk the lives of many (Schuster, 1996). Greed has spawned slavery and the exploitation and subjugation of peoples. Even our own (negative) self-evaluations can be rooted in cruel and callous indifference to the pain we cause ourselves (Gilbert *et al.*, 2004; Gilbert & Irons, Chapter 10). Our entertainments too are riddled with a fascination for cruelty. From the gladiatorial games to more modern fantasies in Hollywood, cruelty stalks the imagination. All these of course are textured not by open admission of cruelty, but with various psychological manoeuvres that sanitise our actions and offer justifications for why they are not cruel but are deserved, warranted and acceptable (Bandura, 1999; Beck, 1999; Gay, 1995). Romans claimed a passion for bravery, glory and contempt for death, while today we claim a desire for excitement and thrills.

Western psychological science has not been short of explanations for our

predilections to cruelty and underpinnings for a Hobbesian view of human beings. The birth of psychoanalysis, which was highly influenced by Darwin's theory of natural selection (Ritvo, 1990), came with similar conclusions. For both Nietzsche and Freud, 'the unconscious is the realm of the *wild, brutish instincts* that cannot find permissible outlets, derived from earlier stages of the individual and of mankind, and find expression in passion, dreams, and mental illness' (Ellenberger, 1970: 277; emphasis added). For the early psychoanalysts, compassion was often regarded as a reaction formation to sadism and more brutish instincts (Kriegman, 1990). During the 1960s and 1970s a new twist was added to these views by biologists who had developed models to argue that evolution proceeds via gene selection. Dawkins' 1976 book *The Selfish Gene*, illuminating in many ways, was problematic in others. In using the motivational term *selfish* to describe the processes by which genes come to replicate in populations (genes have no motivations, obviously), and with some book covers conveying humans as puppets to their genes, it was easy to misunderstand his message. Gene replication over long periods of time (as distal and genotypic) and personal self-interest, selfishness or even callous narcissism (as proximate and phenotypic) have been seriously confused. Dawkins based his work on that of Hamilton (1964), who was interested in the origins of altruism. In fact Dawkins argued that capacities for some forms of altruism are also part of our innate heritage.

Evolution, genes and physiological systems

Altruism

In 1859 Darwin published the *Origin of Species* in which he argued that challenges to survival and reproduction acted as selective pressures. Some variations between individuals that gave an advantage in coping with these challenges (over time) spread through that population – were naturally selected. However, Darwin recognised that altruism (helping others at a cost to oneself) was a problem for his theory (Laland & Brown, 2002). It was the focus on genes that gave new insights into various forms of altruism – helping kin (kin altruism) increases the chances of shared genes being passed on (Geary, 2000; Hamilton, 1964; Sober, 2002). This is called *inclusive* fitness. The reason why sterile ants and bees work for the benefit of the hive became clear – they were clones and so were advancing their genes. Altruism became linked to genetic relatedness. Thus if, say, you survive an accident but your ten brothers and sisters are killed, your own individual fitness may be intact but your *inclusive fitness* has seriously suffered. If you die saving them, then your inclusive fitness has still suffered, but not as much as if *they* had all died.

If one helps non-kin (reciprocal altruism), favours may be returned later and cooperative exchanges ensue – which again increases the chances of an individual's genes (including those for helping) being passed on (Sober, 2002;

Trivers, 1971, 1985). The point about this is that kin and reciprocal altruism are believed to have evolved because, although they are helping acts that may cost a donor, they are not at the expense of his/her own inclusive fitness; indeed, they may benefit it. It is simply a statistical fact that any small mutation, resulting in a trait or behaviour that increases the chances of genes being passed on, can get established in the gene pool (Sober, 2002).

There are *many* debates on how one goes from a focus on genes and long-term (generation to generation) replication rates to the evolution of person-centred motivation, emotional and cognitive systems that guide actions on a moment-to-moment basis (Barrett *et al.*, 2002; Knox, 2003; Lickliter & Honeycutt, 2003). This debate has become even more intense with the finding that we have only around 25,000 genes, and not the 100,000 or so once thought. Recent discoveries have suggested that small changes in a few genes can have radical effects on how neurons grow and form complex networks in the brain and how modification occurs via learning (Geary & Huffman, 2002). Attention is now focused on the ways genes interact and are expressed and the multitude of internal and external factors affecting gene expression and their effects – giving rise to phenotypes (Lickliter & Honeycutt, 2003). These and many other such important issues will not concern us (Laland & Brown, 2002; McGuire & Troisi, 1998; Moss, 2003; Smith, 2002). However, one key issue is that no animal is motivated to increase its inclusive fitness, but *it is* motivated to actions (e.g. to seek mates, care for offspring, help friends) that over the long term have impacted on inclusive fitness (replication rates).

Signal-sensitive systems and the gene–physiology interface

One solution to linking altruism to inclusive fitness, and altruism to personal motivation is to posit the evolution of *signal-sensitive systems* that can detect/recognise key stimuli (food and mates), have a reactive/response function (e.g. threat signals activate defences such as fight/flight), and have a 'what to look for' (seeking) function (e.g. food seeking or mate seeking). Signal-sensitive systems build the infrastructure for motivational, emotional and cognitive systems (Buss, 2003; McGuire & Troisi, 1998). The issue of the evolution of signal-sensitive systems (for detection, response and 'seeking out'), that are stimulated and modified into vast neuronal networks via learning, has given rise to many unresolved questions about the types and limits of the 'information' that genes can provide to these systems (Knox, 2003; Lickliter & Honeycutt, 2003). Learning is important because learning does what genes cannot – that is, provide information on local and changing circumstances. One way learning does that is via modification and patterning of (gene-guided) physiological systems that make certain motives, emotions, cognitive competencies and behaviours possible. To put this another way, genes facilitate the formation of physiological systems (e.g. hormone and neurotransmitter systems; Moss, 2003; Panksepp, 1998). These physiological systems are

attuned to various stimuli/signals, linking them with motives and emotions (e.g. for food, for sex and to care), but they are developed and patterned by experiences (Knox, 2003; Li, 2003). Moreover, genes themselves can be turned on and off by factors such as the womb environment and post-birth experiences.

Genes and learning, then, are complex co-constructors of physiological systems, and their internal patterns, from which traits (phenotypes) emerge. The point is that when it comes to qualities of mind such as compassion (and allowing for individual differences in the ease of learning), 'experience' can actually shape the brain to enhance the biopsychological infrastructures that make compassion possible (Gilbert & Irons, Chapter 10; Schwartz & Begley, 2002). New research has shown that even if monkey infants have genetic sensitivities for aggression and anxiety, these can be modified via early experiences (Suomi, 1997, 1999).

Environments and strategies

If compassion is an emergent, phenotypic property of our minds, then attention can be focused on the interaction between gene-guided physiological systems and their shaping in environments – an issue fraught with controversy, as is well delineated by Smith (2000) in his 'three approaches' to an evolutionary analysis (see also Laland & Brown, 2002). Some evolutionary psychologists are interested in how specific (internal) mechanisms for analysing information have evolved and become used when dealing with certain challenges (e.g. of finding and retaining mates, forming cooperative alliances, caring for offspring; Buss, 2003). For them, questions would arise as to the *modules* underpinning compassion. Different environments require different solutions and thus recruit different modules. This approach is hotly debated (Barrett *et al.*, 2002; Malik, 2000). The finding that the human brain is far more plastic (neuroplasticity) than was thought even ten years ago may be a challenge to this approach (Geary & Huffman, 2002; Knox, 2003; Schwartz & Begley, 2002). Human behavioural ecologists, however, are less concerned with 'internal mechanisms' or modules and focus instead on specific *strategies* that are shaped by the environment into flexible phenotypes (Barrett *et al.*, 2002; Buss, 2003). Phenotypes (e.g. styles of caring) can take a variety of forms according to the constraints on flexibility in the species and their maturation in an ecology (McGuire & Troisi, 1998; Smith, 2000). Animals, and especially humans, flexibly adapt their behaviour to their ecology. Others suggest that the kind of learning humans are capable of via *culture* means that culture provides a new way of passing information from one generation to another and thus can be thought of as a new form of information transfer upon which 'human genes' and physiological systems depend. As such, culturally transmitted values and styles can come to vary widely (Laland & Brown, 2002; Smith, 2000).

Caporael (1997) makes the point that it is not just genes that replicate; environments must replicate too. Many gene-built systems 'need' and 'assume' that certain environments and inputs will be there to lock into; that is, they assume and are oriented to seek out and form partnerships, where a major source of information required to function comes from outside the individual. As Buck (2002) puts it, the genes of one individual can cooperate with (partner) the genes in another. For example, the sexual displays of an animal are linked to an internal set of genes/hormones. However, these blindly assume receptors for the signals they emit (i.e. activation of sexual desire) in a partner. Genes for language ability (both comprehension and production) are stymied if there are no others around to speak to the child. Attachment mechanisms are useless if parents do not provide at least some measure of care (Gillath *et al.*, Chapter 4). Although different approaches to the evolved-environment issue can make different predictions about behaviour (Laland & Brown, 2002; Smith, 2000), from a biopsychosocial point of view we simply argue that environments (including the actions of others) *carry information that strategies need in order to learn how to mature, pattern and choreograph themselves into adaptive, ecologically sensitive, functional systems*.

Strategies

Evolved strategies are ways of achieving outcomes conducive to fitness (Trivers, 1985). For example, the breeding strategy of turtles, which lay hundreds of eggs, is different to those of the mammals, which have live birth. Sexual strategies vary greatly between species but are linked by the common theme of attracting and being attracted to. From a psychological point of view, strategies guide their hosts via motives and emotions. Thus we like sweet things rather than bitter things; we are attracted to certain types of sexual partners; we feel good when loved, wanted, accepted, esteemed and when we feel we are a valued, participating member of a relationship or group. We feel bad when rejected, abandoned, devalued or exploited (Nesse & Williams, 1995). Strategies (that have been shaped by learning) can give rise to what is called *intuitive or implicit knowledge* that can operate outside conscious awareness (Haidt, 2001). People can come to decisions about things they like or hate and make moral choices on the basis of emotions and feelings. They may be very unclear or lack conscious insight of why they feel as they do. Conscious thoughts about feelings may be justifications for feelings rather than their creators (Haidt, 2001).

The fact that strategies guide their hosts via motives and emotions (enticing to this and avoiding that) opens up another avenue for complexity in that emotions are highly sensitive to learning. It is well known, of course, that human learning takes place in many ways, from forms of classical conditioning and sensitisation in specific brain pathways through to learning social values and self-identities. Through social interactions we learn to give

meaning to the things that can elicit emotions (Li, 2003), and to the meaning of the 'experience' of emotion itself (Leahy, Chapter 7; Wells, 2000). Human sexuality may well be guided by strategic choices, but sexual *pleasures* can vary greatly from any linkage to reproductive outcomes (e.g. internet sex, anal and oral sex and various perversions). These pleasures in turn depend on cultures making them possible (e.g. inventing the internet). Conscious knowledge about the linkage of sex to reproduction can result in deliberate attempts to *undermine* it (via use of contraception). Religious values in turn can undermine the use of contraception. A person's desire for spiritual enlightenment (created by a cultural systems of meanings) may result in inhibition of sexual behaviour. If this is true for sexuality then there is no reason to assume that it cannot be true for other of our dispositions, such as caring and compassion – these too are highly open to activation and modification via learning in partnerships with others (Bierhoff, 2002; Eisenberg, 2002).

There may be gene-based sex differences in the ease of learning to be caring and compassionate, with women being more disposed to (some forms of) them than men (Gilligan, 1982; MacDonald, 1992; Taylor *et al.*, 2000; Zahn-Waxler, 2000), and it is easier to care for our own children than other people's; it also is easier to care for our friends (familiar and similar allies) than for those we see as (unfamiliar and dissimilar) threats or enemies (Burnstein *et al.*, 1994); it is easier to learn compassion (for self and others) if others around us treat us compassionately and we like and value it (Eisenberg, 2002; Gillath *et al.*, Chapter 4). Liking, however, can quickly turn to disliking (or even hatred) when a person betrays a trust (one's loved spouse has an affair, one's good friend is selling one's secrets to the newspaper). In these contexts forgiveness may play a salient role in relationship repair (Worthington *et al.*, Chapter 6).

Social mentalities

Cruelty and compassion are enacted in relationships and thus to understand their evolution attention must be directed to the social, dynamic, reciprocal relationships that are patterned into roles (e.g. carer–cared for, dominant–subordinate). This is important, as it means that what evolves are ways of analysing social signals, and responding to them in ways that impact on the *mind of the other*. A sexual display is designed to stimulate sexual interest, a threat display to make the other back off, and care to aid the other. It's a good idea not to get these mixed up! Combining evolution theory with Jung's concepts of archetypes and circumplex theory, Gilbert (1989, 1995) suggested that different co-assemblies between motives, emotions, information-processing routines and behaviours give rise to different internal *patterns* of neurophysiological activity that can loosely be called *social mentalities*. Social mentalities aid in the co-creation of social roles (e.g. caring, sexual, cooperative)

that solve particular forms of social challenges. It is the choreography of patterns of activity in the brain that gives rise to social roles. These patterns are themselves choreographed by external signals (how others are behaving and signalling to the self, e.g. with love or hostility), by internal motives, and by internal processing systems that give meaning to signals. Hence, for example, creating an affiliative role with others arises from how others are relating to the self and how a person interprets these signals (e.g. to be trusted and valued or mistrusted and dismissed), and from personal desires to be affiliative. A rough classification, which, while not comprehensive, captures some of the more important *archetypal* social mentalities, can be suggested as follows.

1 *Care eliciting:* Involves relationship forming with another who can provide protection, and needed investment for survival and (in mammals) emotional regulation. It solves the problems of regulating (early) threat to self and having to provide for the self. Competencies include assessing proximity to (an)other, distress calls, seeking the other, and being responsive to their (care) signals.
2 *Care giving:* Involves relationship forming with another for providing investments of time, energy and other resources (e.g. to an infant) that increase the chances of their survival, growth and subsequent reproduction. It solves the problems of threat to young or 'weakened' kin and allies. Competencies include responsiveness to distress and assessing (and providing for) the needs of another and (in humans) empathy and sympathy.
3 *Formation of alliances:* Involves relationship forming for cooperation, with aggression inhibition, sharing–exchange, affiliation, friendships, group living and reciprocal behaviour. Competencies include judging who is similar to self, in-group/out-group, and who is desirable as an ally. In humans this social mentality gives rise to thinking in terms of reciprocation, equity, fairness and rights. It solves problems of constant infighting and allows for cooperative action to confront problems of survival (e.g. team work).
4 *Social ranking:* Involves relationship forming for direct competition for resources, gaining and maintaining rank/status (dominance/leader), accommodation to those of higher rank (submission/follower), and competing in ways that lead to being 'chosen' by others for certain roles (e.g. as an ally, sexual partner or leader). It solves the problems of constant infighting and offers social coherence. In humans, what earns status can be socially constructed to fit an ecology (see below).
5 *Sexual:* Involves relationship forming for sexual behaviour, involving attracting, being attracted to, courting, conception and mate retention. Different strategies and blends of emotions and motives may operate for short-term mating versus forming long-term sexual bonds.

It is the choreography and blending of functionally specific and non-specific sub-systems that enables role forming via reciprocal interactions to emerge. Thus, for example, a social rank mentality will relate to motives to subdue, defeat (be more powerful) or outperform competitors (e.g. be seen as more attractive or desirable), emotions for the desire to succeed and fear of failure, and information-processing routines (such as social comparison) that regulate the forms and vigour of competitive behaviour. Much of my own research in psychopathology has focused on the social ranking mentality because this mentality is about social power and threat: *striving* to be valued by others for social inclusion (or to exert control over others), *seeking* status in the eyes of others to be chosen in the competitions for social place, being highly sensitive to social comparisons with fears of 'not being good enough or inferior', and heightened shame sensitivity. Accentuation of this mentality increases vulnerability to various disorders via feeling defeated, inferior, subordinated, rejected, shamed or persecuted and the activation of defences such as fearful submissiveness and social anxiety, depression and aggression (Gilbert, 2004). Compassion, however, emerges from the *care-giving mentality* that recruits motives for care, emotions (e.g. concern, sympathy), and information-processing (e.g. theory of mind) competencies that are attentive to and analyse the needs of the other (Gilbert, 1989, 1993).

Wang (Chapter 3) points out that specific physiological processes (e.g. action of cortisol) can function differently according to how our minds are organised (i.e. which social mentality is activated). Because a social mentality is *not* reducible to a specific module or modules but is emergent from and organises various dissipated brain systems into patterns, it follows that how engaged, competent or successful an individual is in co-creating a social role with a partner or partners (the other) will depend on a host of factors. For example, psychopaths may not engage care-giving because of a lack of motivation and/or 'distress-in-others' emotionally attuned systems; people with forms of autism may struggle with understanding and reading the feelings in others; a depressed person may be so exhausted that they cannot create this role with another even if they want to (but could and would if they were not depressed); people can develop beliefs about how to care (for example some may believe that children need a lot of physical affection whereas others believe children need to toughen up). Hence, although a social mentality is strategically focused, and orients a person to create a social role (that is, to relate to another in a certain way such as being caring, cooperative, competitive or sexual) and to be sensitive to the roles others are trying to create, it is choreographed by many interacting internal and external factors. Social mentalities, then, can be seen as *gene-learning emergent co-assemblies of motives, emotions, cognitive processing routines and behaviours that are ecologically sensitive, and enable the enactment of strategies via the creation of specific forms of partnerships and social roles*.

Social mentality theory (Gilbert, 1989) also noted that role relationships

vary in terms of closeness. For example, relationships can be classed in terms of *intimate, personal, social, and public* (Weitz, 1979), or as intimate, friendly, acquaintance, group, stranger and intergroup. Each domain of closeness can recruit role-forming mentalities, but in different ways. We may (for example) be highly caring with our intimates but competitive and hostile to outgroups. Some people are rather neglectful of their children but may engage in much charity work and dedicate themselves to a cause. Feeling uncomfortable with caring in one domain need not mean lack of caring–concern in another. It is interesting that whereas Western psychology has focused (mostly) on the regulators of prosocial and caring behaviour in close relationships (infant–mother, romantic partners and friends), Buddhist psychology directs attention to the care and compassion we extend to *all* others, and indeed all living things (Dalai Lama, 2001; Wang, Chapter 3).

Strategic, role-forming competitions

Animals and people use different strategies and textured social mentalities to navigate their social worlds and pursue biosocial goals (for example, some are more passive than others, some are more aggressive than others). These different ways of 'being in the world' will have different rates of success in terms of survival and reproduction. Genes, and their phenotypic strategies, 'compete' in populations (Buss, 2003; Trivers, 1985). This important insight from evolutionary theory suggests that in some environments some strategies and their social mentalities will do better than others. As environments change, different strategies (pursuing different desires or goals with different emotional textures) may be more or less successful.

Making others into strategic partners

When a child seeks care, or a person seeks to be wanted as a friend/ally by others, or to be sexually attractive to another, or to be recognised as dominant, they are seeking to stimulate strategies and social mentalities in others that fit their own. Gilbert & McGuire (1998) called this 'role matching'. Aggressive dominance seeks to create states of mind of fearful submission in others (Gilbert, 2000a, 2000b). Dominant monkeys will sometimes unpredictably threaten subordinates in order to test 'their state of mind' and keep them wary via raising their stress hormones (e.g. cortisol) and lowering their serotonin (Gilbert & McGuire, 1998). Friendly cooperation seeks to create states of mind of non-aggression, low stress and 'liking' for the self, in the mind of the other. There need be nothing conscious about this, but it is in these co-constructed relationships that the strategies for aggression or cooperation interact. In other words, strategies will try to create social environments (influence the minds of others) such that the strategy can work. Suppose Jack has a strategic orientation (or personality) for aggression but Fred for

affiliation, then Jack may be more disposed to try to create wary subordinates around him, while Fred will try to create affiliative allies. As argued later, if we, (say) consciously adopt a value system for compassion then we are also trying to create states of mind in others that allow safe–affiliative strategies to flourish and work well. Ecologies influence which strategies and role enactments (e.g. competitive or affiliative) are going to be most useful (Cohen, 2001; see below).

Human life is about a battle not so much between good and evil as between the playing out of different strategies (e.g. compassionate versus cruel/exploitive). In humans this reaches into different ways of giving archetypal *meanings* to our 'being-in-the-world'. It is interesting to reflect that (old) reptilian strategies use motives for sex, control and power, while the (newer) mammals evolved live birth, caring and co-operation (MacLean, 1990). Archetypal depictions of evil often see 'devils' as reptilian in appearance, concerned with sex and possessive power, totally devoid of mammalian concerns with care of the young, families, friends and others. In our moral dilemmas, old and well-tried and tested strategies for sex and power confront newer ones for care, concern and compassion. Just how far, and to whom, will we extend care and concern?

It follows, therefore, that if different strategies and social mentalities are 'battling' it out in populations, seeking to co-construct states of mind in self and others, and to 'reach into' different meaning-making processes (Gilbert, 1989), then they also battle it out inside the minds of individuals. This, of course, is a basis for *internal* conflicts in our motives and desires. We can experience powerful urges to act in certain ways, for example to be other-focused or self-focused, to try to help others or exploit/cheat them, to be aggressive or forgiving. It is interesting that in many spiritual quests, noted particularly in the stories of Christ and the Buddha, there were key experiences where they had to confront the 'old temptations' for self-advancement, sex and power. Each of us can probably identify with these conflicts but would now see them as sourced by inner desires rather than experienced as 'devil-like' tempters. The externalisation or internalisation of these conflicts is partly related to cultural beliefs and to processes such as projection. I have certainly seen both psychotic and personality disordered people who believe that some of their negative thoughts and desires are sourced by (supernatural) external agents.

Armed with these basic concepts, what follows is an exploration of possible evolutionary origins for some components of care/compassion; how it creates its prosocial and soothing features via the creation of *safeness* in self and others; and how components of care/compassion are blended by our evolved capacities for 'thinking' in social contexts that shape self-identities. Providing care and compassion to self and others can be pleasant and rewarding to do, or very hard.

Threat, safeness and the evolution of care

Even on such a life-conducive planet as ours, the struggle for life is so fierce and risky that the vast majority of species that have ever existed (over 99 per cent of them) are now extinct. A species close to us, the Neanderthals, has long gone, leaving only bones and artefacts as testament to its lives and struggles. Environments present animals with many different specific types of threat, some of which a species cannot do anything about, especially if they are infrequent and major (e.g. meteorites). It is when threats are constant or build up slowly, and give species opportunities to evolve specific ways of coping, that we see adaptation. There is no classification of threat, but threats will include predators, climates, ecologies (food availability), parasites/viruses, and competitors from one's own species. To cope with them animals evolve strategies, for example the ability to detect predators and a body that can run fast or camouflage itself, or ways to keep warm and cope with the cold, such as hibernation or types of fur. Our immune systems evolved to cope with threats (e.g. viruses) that get inside us. Each type of threat requires a detection ability and a solution or coping mechanism(s)/strategies.

In pursuing goals, enacting strategies and co-creating social roles, all organisms must coordinate a range of internal processes and outputs according to whether the environment is threatening or safe (Buss, 2003; Gilbert, 1989, 1993). When environments are threatening, humans have (often rapid) access to an evolved menu or suite of strategic responses (ways of attending, feeling, behaving and thinking) to aid adaptive responding. In contrast, when individuals feel safe there is an evolved menu or suite of strategic responses (ways of attending, feeling, behaving and thinking) for engaging with the environment, pursuing needs and goals, or resting. Table 2.1 offers a simple classification of some of these.

Table 2.1 Domains of threat and safeness (adapted from Gilbert (1989, 1993))

	Non-Social	*Social*
Threat-defence		
Active	Defensive, persecutory and displacement aggression, flight, active avoidance, safety seeking	Ritualised (symbolic) threat, Distress calling Protection (from other) seeking Reassurance seeking
Inhibitory	Freeze, faint, passive avoidance, cut-off, camouflage–conceal	Submission, appeasement
Safe(ness)		
Active	Interest, explorative, creative, openness, freedom	(Socially) explorative, affiliation, play
Passive	Relaxed, calm, quiescent	Tolerant

The threat–defence system

The menu of options for coping with threats and harm has been referred to as a threat–defence system (Marks, 1987). It has two key domains: non-social versus social, and active versus inhibitory (Gilbert, 1989, 1993, 2001). Non-social defences can be used in social situations (e.g. violence and aggression, or running away), although aggression directed at conspecifics is different from (say) hunting aggression, or defensive aggression to predators. However, social defences are rarely if ever used in non-social situations (for example, we don't try to shame or submit to the oncoming lion). Social defences work only if there are others to co-create roles. Many types of threat and harm activate the fast reacting 'limbic brain based' threat–defence system (LeDoux, 1998). Gray (1987) has shown that threats can be of either signals indicating a punishment or direct *injury*, or signals indicating a block to goals – typically called *frustration*. Frustration can lead to displaced aggression. Signals indicating the *unfamiliar* or novelty can also activate the threat system (and turn off safeness modes or organised states). In addition to the behaviours of Table 2.1 there is a menu of emotions for dealing with specific threats such as *anger* (to fight harder or struggle to overcome frustrations, or retaliate), *anxiety* (to escape or avoid threats), *disgust* (to avoid, expel or eradicate the noxious) and *sadness* (to respond to losses). Baumeister *et al.* (2001) suggest that we have more processing systems that are allocated to threat and harm than are focused on more positive things.

Not shown in Table 2.1 is the fact that outputs of the threat–defence system may themselves be threats to the self. For example, distress calling in a high predator environment (and when a parent does not return) can attract predators; or expressing aggression to a more dominant animal can result in getting injured. Thus, the outputs of the threat system may require regulation, for example, inhibiting a behaviour or *demobilisation* and hunkering down – noted particularly for depressed states (Gilbert, 2004). We humans, who have symbolic self-awareness, metacognitions and construct self-identities (see below), can feel threatened by our own being (for example, that we are not attractive or talented enough to get what we want, to be liked/wanted or to avoid rejection; Gilbert, 2001), our own thoughts and feelings (for example, we may be frightened by our own anger, or fear becoming fearful), and by predictions of what can happen to us (for example, that we are going to decay and die (Wells, 2000)).

As discussed below, in regard to cruelty, threat can also generate a range of defensive behaviours that include: *detect, protect, avoid, subjugate, persecute and eradicate*. Although we tend to associate some of these behaviours with specifically human actions, Goodall (1990) observed how a group of chimpanzees split into two groups and then how one group systemically attacked and killed members of the other group. In humans these behaviours are often orchestrated via beliefs that are socially constructed and reinforced in groups.

They can give rise to various rituals (for example, religious, to protect from the influence of evil spirits and sacrifice to appease the gods), witch hunts and persecution of those seen as threats to the social order, and efforts to eradicate and 'stamp out', leading to appalling atrocities. The ease with which hatreds and contempt of others can be inflamed is frightening (Gay, 1995).

Importantly, too, people can adopt these threat defensive orientations to themselves. They can become self-hating and turn their *detect, protect, avoid, subjugate, persecute and eradicate behaviours on themselves* (Gilbert *et al.*, 2004; Gilbert & Irons, Chapter 10).

Safeness vs safety

Gilbert (1989, 1993) suggested that a safety system was a separable processing system to that of the threat–defence and protect system. However, the ethologist Michael Chance pointed out to me that safe*ty* was a confusing term because it did not capture the essence of safe*ness*. People can engage in a variety of defensive behaviours that could be called safety behaviours (e.g. aggression, avoidance or running away) that are aimed at coping and reducing threats. Indeed, many psychologists use the term 'safety behaviours' and 'defensive behaviours' interchangeably. But in psychotherapy there is a difference when people are threatened and trying to get safe (safety seeking, fight/flight, etc.), in contrast to feeling safe and then, from that position, exploring what it is that makes them feel threatened and defensive. Consequently, Gilbert (1995) changed the term safe*ty* to safe*ness* to indicate the way our minds are organised when we feel safe (for example, with relaxed and open attention, explorative and non-defensive; Gilbert, 1993).

Like threat–defence, safeness can be divided into non-social and social (see Table 2.1). The safeness system, however, holds no inhibitory mechanisms, for all these come from the threat system. For safeness there is gradient of arousal associated with degree of 'fulfilment/satisfaction' or basic explorative interest (Gilbert, 1989, 1993). In regard to the non-social and passive domain it is clear that animals can relax because their environments are comfortable and they are 'satisfied' – they are neither defending nor seeking. In humans this may be noted as a state of contentment. As noted below, states of 'contentment' are often associated with compassion and are ones that Buddhism suggests should be practised and developed.

However, in humans in particular (but also in other mammals), safeness is often conferred through social relationships. *Social safeness is co-created in relationships via a host of signals and exchanges that are fundamental to health and well-being*. When children and adults feel safe, they are more creative in their problem-solving, more integrative in their thinking and more prosocial. When threatened, they need to stay vigilant to and track threats and be ready for rapid defending, with decisions about which response(s) to engage (e.g. fight, flight, submission). The next section explores the evolution of the

social safeness (creating) system, via caring for others, which gave rise to the importance of human warmth/affection and certain types of positive affect. This system may underpin compassion.

Strategic solutions to protect kin and allies and caring–giving

It was threat to offspring/kin (carriers of genes) that may have laid down some archetypal roots for care-giving and (later) compassion. Consider that some fish and reptiles lack the ability to recognise their own kin. The poor infants, after hatching, can become just another meal for the parents or other predators and at birth must be mobile enough to *disperse* and escape this fate (Bell, 2001; MacLean, 1985). One solution (strategy) is mass production. The genes of these species (information for building their hosts) survive simply because of the numbers of their hosts, and most hosts die before coming of age to reproduce.

Another solution is kin recognition and inhibition of infant cannibalism (Bell, 2001; MacLean, 1985). However, other forms of predation of the young are endemic in life because predators need food and the young are a good source of food with low risk of injury in getting them. The young are unable to defend themselves; they are small and cannot swim or run fast or for long. So even if your parent doesn't eat you, other predators will. Young can also be at risk from their own kind (for example, males deposing other males can kill infants, and of course in war children can die in high numbers).

Another solution is to produce fewer offspring but offer them some protection in early life. Even a small amount of care provided either pre-birth (for example, making nests out of harm's way) or post-birth (nest guarding) offers big advantages (Geary, 2000). The more a species protects its young from the threats to life, by defending it against predators, the more it creates *safeness*. In this social context, rather than disperse, avoid and put distance between self and a parent at birth, the opposite can evolve such that the infant *seeks closeness* to the parent. The shift from dispersing to seeking security from a parent had major impacts on subsequent evolution, not least because an infant now had to depend on the parent to protect and provision it (e.g. with food).

Parental care (a form of kin altruism) became known as *parental investment* (Geary, 2000). There are many aspects to parental investment, including the types of partner an individual seeks out for reproduction, the quality of the environment in the womb a mother can provide, and the multiple forms of care both parents can offer and/or elicit from others (e.g. kin and allies). Many selective pressures work on different aspects of parental investment (Geary, 2000). Gilbert (1989) argued that care-eliciting and care-giving should be analysed as separate social (role-focused) mentalities (rather than under a

single construct of 'attachment'), each underpinned by different physiologies, motives, emotions and cognitive competencies (see also George & Solomon, 1999; Heard & Lake, 1997).

The evolution of parental care makes the infant's environment safe(r). This made possible delays of maturation and the evolution of flexible learning systems (for a fascinating review see Bjorklund, 1997). Basically, if you don't have to run away, hide from predators or your parents, or fend for yourself as soon as you are born (because others will care and look after you), then genes do not have to build systems that can do these things from the off (Bell, 2001). Some developments (e.g. for locomotion) can evolve to be 'slowed down' rather than accelerated. Evolution can 'allow' the infant to be more helpless, with the pay-off that more resources can be given over to learning about its environment and becoming emotionally attuned to care-givers before locomotion gets going. Many implications flow from this (Bjorklund, 1997; Trevarthen & Aitken, 2001), including the role secure attachment plays in the safe exploration of a child's internal and external world (Elliot & Reiss, 2003; Knox, 2003).

Providing a safe/secure base from external threats, and being responsive to distress calls (MacLean, 1985), was central to Bowlby's attachment theory (1969, 1973), making attachment primarily a threat–protection regulation system (MacDonald, 1992). Bowlby, (1969, 1973, 1980) was one of the first to consider the implications of evolved security-providing for infants and its effects on infant development, emotional regulation and internalisation of 'working models of self and others'. Attachment theory is now the basic approach for conceptualising child development and has generated considerable research (Cassidy & Shaver, 1999). Attachment theory has recently been explored from a kin-altruism perspective (Simpson, 1999).

Multiple domains of caring

Over time, mammalian parenting evolves, becoming increasingly elaborate, with parental *protection*, *provisioning* (for example, milk with antibodies, food, warmth, and other resources necessary for development), *mediating* the infant's exposure to the world, *teaching and socialising* the infant (Gilbert, 1989; Schore, 1994). Over time (and with the mammals) there evolve potentials for other kin (e.g. siblings and aunts) to play a role in infant care. These multiple functions came to have far-reaching and multiple effects on the physiological maturation of the infant (Hofer, 1994) and the infant's maturing brain came to depend on them. For primates, and humans especially, the power of nurturing relationships from a variety of individuals (parents, friends and lovers) to impact on physiologies throughout life has become profound (Cacioppo *et al.*, 2000; Schore 1994).

The physiology of care-giving in close relationships is complex and involves a number of evolved and integrated brain systems such as oxytocin,

vasopressin, opiates and various other systems (Bell, 2001; Nelson & Panksepp, 1998). Oxytocin seems especially important for the mother to orient herself to a caring and affiliative role. Once she is oriented into this role relationship, other systems may switch into sequence a number of different, reciprocally influenced behaviours in ongoing patterns (Carter, 1998; Panksepp, 1998). The way these hormones affect our capacities for caring and compassion is subject to ongoing research, but it is possible that they play a key role in our interests in, and feeling of care/compassion for, others (Wang, Chapter 3).

Caring, safeness and the role of positive affect

MacDonald (1992) pointed out that parental investment (and indeed other forms of caring for others) *requires motivating systems to guide animals to do it*. He suggested that nurturing and investing time and effort in another is mediated through a *positive social reward system*, such that the caring interactions between (say) mother and infant (or between friends) are positively rewarding and motivating. The more an infant (and later adult) requires the investment of another, the more important the social reward system becomes in social interactions. However, the linkage of care-giving to (certain types of) safeness creating and positive affect is complex.

Although compassion has been linked to positive affect (Davidson, 2002) research is highlighting the fact that there are different types of, and functions for, positive affect. For example, some positive affects are linked to a *seeking system* that is oriented to rewards and securing goals, and is mediated by dopaminergic systems. It comes with behavioural activation (Panksepp, 1998). If seeking is blocked (we can't get what we seek/want), then defensive frustration, fear or sadness can be activated. However, this system may actually be turned off when individuals feel safe and are not anticipating rewards or seeking them out. For Bowlby (1969, 1973), attachment systems may be turned off when the child is safe. Seeking attachment figures or other goals implies some sense of deficit and 'wanting' in a way that safeness does not (Allen, personal communication).

Bembridge & Robinson (2003) distinguish a 'wanting' from a 'liking' positive affect system (see also Phillips, 2003) and Buddhists distinguish between feelings of pleasure (often dependent on securing external 'things/accomplishments') and those of happiness as an inner state; pleasures can wax and wane while happiness is rooted in contentment and non-seeking (Goleman, 2003: 85; Wang, Chapter 3). Depue & Morrone-Strupinsky (in press) distinguished between the positive affect system that is involved in 'seeking, anticipating and striving' and 'consummatory feelings of satisfaction'. It is unclear whether, or how, the 'liking' or 'consummatory' system is involved in states of happiness. However, it is clear that Western psychology's view of 'happiness and pleasure' as the same, or to refer only to 'positive affect' as if this were one system, is simplistic. Moreover, happiness and contentment

may have a special link to safeness; happiness/contentment may depend on feeling safe.

A third element of positive affect is the social domain (Gilbert, 1993). There is increasing evidence that warmth–affiliation is related to a different type of positive affect system (e.g. opiate and oxytocin) from that of a seeking system, and may be a key phenotypic variation for temperaments; that is, some individuals are 'warmer' than others (for a major review see Depue & Morrone-Strupinsky, in press). The hormone-like neuropeptides oxytocin and vasopressin may be especially important in attachment and interpersonal warmth (see below). Hence, in the face of evidence of there being different types of positive affect system, and at the risk of oversimplification, we can diagrammatically depict the interaction between the threat-defensive and two different positive affect systems of resource seeking and soothing/contentment–affiliative (see Figure 2.2).

A key issue is the way these systems interact to create *patterns* in neuro-pathway connections, because these systems are *always interacting* and have reciprocal effects on each other. Each system will be responsive to certain types of signal. Genes and experiences will affect the maturation of the *emergent patterns* of their interaction. Thus, for example, a child who is loved and regularly soothed will have their soothing systems (neuro-pathways) stimulated to grow and branch. These in turn will affect the maturation of, and regulation of, 'seeking' and 'threat' systems. Such children are likely to mature brains that are 'calmer' and more emotionally regulated, and (when stressed) they can easily recall feelings and memories of being soothed (Schore, 1994). Hence the soothing system can help regulate the threat system. For children who are often threatened or left feeling uncared for or unsafe, the threat system is more 'vigorously' developed. Moreover (like a muscle perhaps), the soothing system is relatively 'weakly' developed and

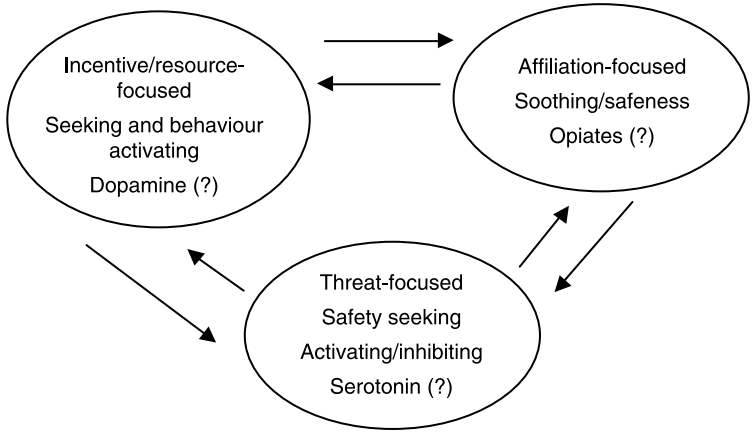

Figure 2.2 Types of affect-regulating system.

thus builds fewer pathways in the brain. This can result in people finding it difficult to feel safe in the world – at peace and/or content. They may be quick to rely on their defensive anger or fear. Others may rarely feel content or safe but feel driven to achieve or own, and to prove themselves.

Given that there are different types of positive affect system (e.g. seeking/activating vs soothing/calming and safeness), a key suggestion is the degree to which, for humans, happiness, contentment and compassion for self and others may be linked to *warmth and safeness (opiate/oxytocin) systems*, which have powerful regulating effects on our brains. To explore this further in relation to compassion, we must separate protection-giving from warmth/affection.

Warmth and affection

Warmth involves a number of qualities such as tenderness, gentleness, kindness and concern. Leary (1957) identified warmth–hostility and dominance–subordination as two orthogonal dimensions of personality and interpersonal relating, and there is now considerable evidence supporting this 'circumplex' model (see e.g. Depue & Morrone-Strupinsky, in press; Wagner *et al.*, 1995). In studies of personality, warmth–agreeableness has emerged as one of the 'Big Five' factors of personality, separable from extraversion and agency (Costa *et al.*, 1991). While Bowlby focused on attachment via accessibility and availability of parental figures, Rohner (1986) directed attention to the warmth dimension of parent–child interactions (Gilbert, 1989). MacDonald (1992) also distinguished a protection-based attachment system from a warmth-based and affectionate one. He suggests that:

> While attachment as a mechanism for protection from danger is virtually a pan-mammalian system, close intimate relationships characterized by warmth are not. The only plausible explanation for the existence of the human affectional system is that it evolved as a mechanism for underlying close family relationships, parental investment and mate choice.
>
> (p. 757)

Distinguishing between these two (protection and warmth) systems allows insight into why one can have attachment in the absence of warmth–affection, and provide affectionate care for others (for example, care of the dying) in the absence of (a desire for) attachment. Dominant animals and humans may be able to protect their infants from dangers and threats in a way that subordinates cannot (Suomi, 1999), but this does not mean they provide more warmth. People may form attachments based on submission/appeasement to 'not very warm others', if they seem the best bet for protection. Some parents are highly protective of their children but may still treat them as 'objects' or 'property' to be moulded and controlled to their parents' will (Gilbert, 2002b). Indeed, anxiously attached people use appeasement as an attachment/security device (Sloman, 2000). So what do we mean by 'warmth'?

We can suggest that warmth has at least three key attributes. First, warmth provides signals of care and investment that are *soothing* and switches on the recipients' 'safeness' *internal organisation*. Second, warmth can involve a sharing of positive affect between individuals that stimulates *liking*, affection and feelings of connectedness. Third, warmth is more likely when individuals feel safe with each other. Individuals who are easily threatened and become defensive may struggle to feel or express warmth. We look at soothing first.

Soothing

In contrast to a 'seeking' positive affect system that directs attention to doing, achieving and acquiring, and is behaviourally activating, is a system that underpins the positive feelings of soothing, calming and *being soothed* – it *deactivates defensive emotions (anger, anxiety, sadness) and behaviours (e.g. aggression and flight)*, and can also turn off seeking, doing, achieving and acquiring. Part of the positive feelings of soothing may come from declines in or regulations of negative affect (e.g. feelings of relief; Gray, 1987) or in the immediate phase of having acquired and consumed (Depue & Morrone-Strupinsky, in press). However, the positive affects of *social*, safeness-creating soothing, via the exchange of *social signals* that impact on the mind of the other, need consideration in their own right because they have far-reaching organising effects on the brain and are associated with specific social (safeness-conferring) signals (not just the removal of threat signals).

Field (2000) has reviewed the growing body of evidence on the beneficial effects of holding, stroking and touching during development – interactions of affectionate care. As Field notes, there is evidence that even laboratory rats can grow up calmer if they are regularly stroked. These signals are soothing in their own right and not because they are linked to some other reinforcers. As Sapolsky (1994) observed:

> Touch is one of the central experiences of an infant, whether rodent, primate, or human. We readily think of stressors as consisting of various unpleasant things that can be done to an organism. Sometimes a stressor can be the *failure* to provide something to an organism, and the absence of touch is seemingly one of the most marked of developmental stressors that we can suffer.
>
> (p. 92)

From the first days of life, safeness-via-warmth (Rohner, 1986) is not simply the absence of threat but is *conferred* and stimulated by others with the soothing, care-giver signals of touching, stroking, holding (Field, 2000), voice tone, the 'musicality' of the way a mother speaks to her child, facial expressions, feeding and mutually rewarding interchanges that form the basis for the attachment *bond* (Simpson, 1999; Trevarthen & Aitken, 2001). These

signals may stimulate endorphins that give rise to feelings of safeness, connectedness and *well-being*, and the infant's physiological systems are attuned to them (Carter, 1998). Thus, from birth, infants are highly sensitive to interpersonal communications and particular signals that regulate arousal, help organise physiological systems and set strategies onto developmental trajectories.

Care-giver signals and communications (emanating from the state of mind of the care-giver) have a major impact on the child's developing brain and mind and thus the choreography of his/her basic strategies – that is, to develop them into phenotypic forms and patterns (Schore, 1994; Trevarthen & Aitken, 2001). Depressed mothers, who may be able to protect a child from external dangers, may be unable to offer signals of warmth–safeness and engagement and this can have a stunting effect on an infant's cognitive–emotional maturation (Trevarthen & Aitken, 2001; Zahn-Waxler, 2000), while outright abuse can seriously damage the brain (Teicher, 2002) and skew it to be overly reliant on more basic (implicit) defenses (e.g. of fight, flight, avoidance; Gilbert, 1995; Perry *et al.*, 1995). When we think about a 'compassionate other' we normally imagine them as having qualities of low negative affect and generating warmth and expressing soothing signals (for example, friendly facial expression and soothing voice with feelings in-them-about-us, of acceptance). A basic co-regulating partnership that involves genes and physiologies in one person communicating with genes and physiologies in another, and minds communicating with other minds, thus emerges. The very sense of self is being sculpted in interaction, and at the root of this are brains that need others to love and care for them. Without this, disease, terror and death can await.

It is possible that when we feel in the compass of (say) the loving-kindness (warmth) of others, we feel safe and it is the opiate system(s) that is giving us the feeling of safeness (see Depue & Morrone-Strupinsky, in press; Wang, Chapter 3). This turns off both seeking and threat-processing; we are, if you like, 'at peace'. The highest state of this system may be a form of bliss, described by meditators, in which the sense of an individual self dissolves and a state of just 'being' and (safe) connectedness 'with all things' dominates the experience (Coxhead, 1985). These states differ phenomenologically and physiologically from other positive affect states such as the excitement of winning the World Cup or making a deal on the Stock Market (Coxhead, 1985). And they differ from the kind of 'safe relaxation' we might get from lying comfortably in the sun on a lazy afternoon, because they can be associated with a new kind of *alertness, awareness and sensory enhancement*. What has always struck me about these experiences in the texts (Coxhead, 1985) and personally is how they come with an experience of 'being safe and *connected*'.

So to 'be socially soothed and feel safe' requires certain social signals, while to be 'soothing' requires providing these signals to others (Gilbert, 1993). As noted by Bowlby (1969, 1973), once soothed individuals may either relax

(passive safeness) or redirect attention to explore the environment (active safeness). It has been this reasoning that has stimulated therapeutic work to try to teach people how to generate *soothing* (compassionate) images, feelings and thoughts (Gilbert & Irons, Chapter 10). Indeed, I have been struck by how many of our depressed patients find warmth and soothing difficult to do – as if this system is toned down and suppressed, with increased threat-safety needs and thwarted seeking.

Clearly, not only must a parent protect a child from external dangers but they must not be a threat to the child themselves. If they are, they will stimulate the threat–defence processing systems (Perry *et al.*, 1995), will have a major effect on the maturing child's brain (Schore 2001; Teicher, 2002), and will influence affect regulation abilities and sense of self (Gilbert, 1989, 2004; Liotti, 2000; Schore, 1994; Wearden *et al.*, 2000). There is now a large literature on the effects of threat, abuse, neglect, and shaming and lack of warmth on children (Schore 1994, 2001).

Sharing positive affect

The second aspect of the warmth system is the sharing (co-stimulation) of positive affect between individuals that stimulates *liking*, affection and feelings of connectedness. Heard & Lake (1997) have developed attachment theory to include a concept of 'affiliative relating' derived from *joys* in safe *interest-sharing*, and in particular the sharing of interest that is *valued and appreciated* by both participants. They regard this as central to care-giving, and link it to theory of mind (see below) and to later development in companionable peer relationships and also play. They also use this system to illuminate processes in psychotherapy.

Trevarthen & Aitken (2001) also outline the co-stimulation and exchange of positive affect in mother and infant as a domain of warmth. Research has shown that if a mother stops reciprocally interacting with her infant and suddenly presents a blank and expressionless face to her infant during an interaction, the infant becomes distressed and threatened (Schore, 1994).

Signals of warmth, especially the sharing of positive affect that indicates liking/affection, provide salient information to the child that they are lovable/likeable. The experience of being liked also signals the probability of *investment* and *non-threat* from the other. This is important because what has evolved in humans is a motive to *stimulate positive affect* in the minds of the other about the self such that others 'desire us' (for example, in later life as friends, colleagues and lovers), and thus form investing/supporting relationships or those conducive to our interests (Barkow, 1989; Gilbert 1989, 2002b). A child who 'sees' affection in the eyes of his/her (m)other is laying down feeling memories of self as lovable that possibly link to the safeness opiate systems, while seeing disgust, anger or rejection (shame) in the face of the (m)other can lay down feeling memories of being undesirable and vulnerable

in some way, coded in threat-defence systems (Gilbert, 2003). To lay down (non-warm) feeling memories of being undesirable or only an object for the other creates considerable (implicit) uncertainty as to the ability to form (subsequent) safe relationships based on liking/being liked (Gilbert, 2003).

There is another element to warmth that is important to humans, discussed more fully by Leahy (Chapter 7) using the concept of validation. In some contexts, to feel warmth from another requires not only some sense that the other cares about our welfare, and signals warmth, but that they have empathic understanding of what we are feeling and why, and are accepting. So there is of course much more that could be said about the effects of safeness and warmth on the way a child comes to learn about *the contents of his/her own mind* and what emotions and impulses are safe, or (due to parental responses) are confusing or threatening (Liotti, 2000). Important is the ability of a parent to be empathic and validating of the child's experience so that his/her internal experiences do not become overwhelming, threatening or confusing but are *safe to explore* and become familiar, allowing development of mature regulation (Schore, 1994). Thus, as Schore (1994) and Hofer (1994) point out, there are many systems at work that are reciprocally orchestrated in relationships. Different signals and interactions (for example, providing safeness from external dangers, answering distress calls, availability and accessibility to a care-giver, physical affection and warmth, provision of resources, stimulating and soothing, sharing interests, socialising–disciplining, valuing, admiring and shaming) may each impact on the maturation of internal models of 'self and other' in different ways and relate to different neurophysiological processes. A question to consider now, however, is how early experiences can shape social mentalities and especially potentials for compassion.

Social rank, warmth and compassion

The third element of the warmth system (directed both inwards to self and to others) is the suggestion that it is more likely to operate (and mature) in conditions of safeness. It is suggested that an orientation to be warm and compassionate to others is an emergent quality of our minds that is related to temperament, and to having *experienced the warmth* and care of others. If warmth is key to our abilities to have concern for others (and threat turns it off) then it may be possible to consider how early experiences of safeness and threat lead to the development of a sense of self and a choreography of social mentalities that can aid or compromise warmth and compassion. Figure 2.3 offers a simple overview of some possible processes.

Derived from the pioneering work of attachment theorists and researchers (see Gillath *et al.*, Chapter 4) and those studying prosocial behaviour (Eisenberg, 2002; Hoffman, 1991), we can suggest that infants experience a social world in which *others create* safeness (stimulate the safeness system), provide warmth and validation, and instil a sense of being a likeable/lovable

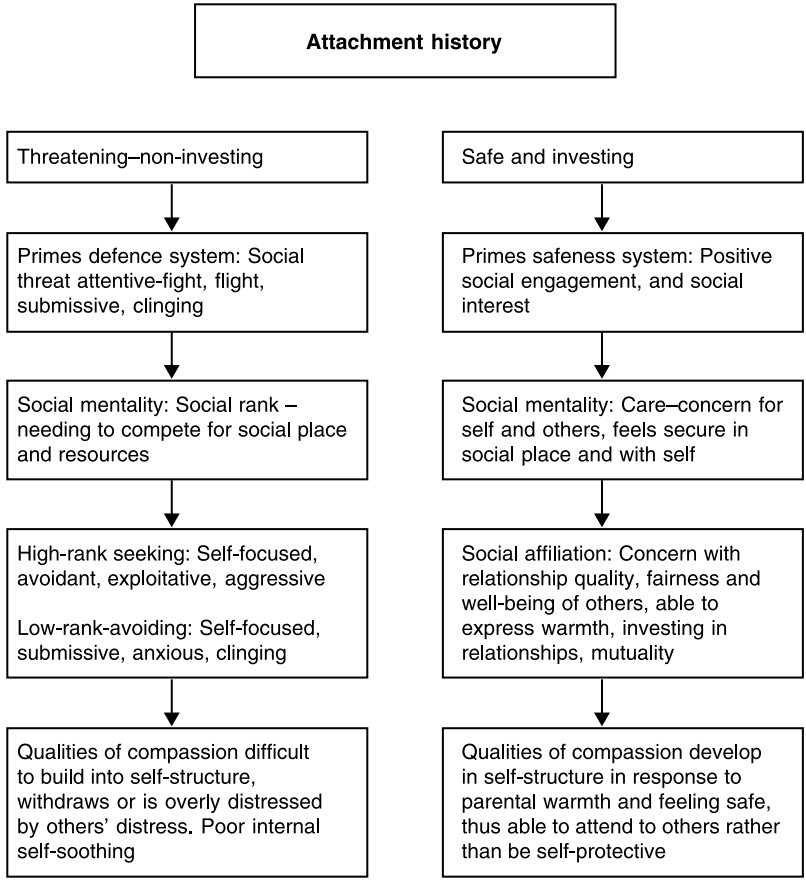

Figure 2.3 Attachment history and maturation of compassion abilities.

person. One may enter the social world, seeking partners to enact cooperative and affiliative strategies, with a range of motives and talents (e.g. for empathy and sympathy) to co-create these roles (Mikulincer *et al.*, 2001, 2003). When parents are unable to create (and stimulate) safeness, are threatening or shaming and do not convey warmth, two consequences may flow. First there is under-stimulation of positive affect and warmth systems; and/or second the child's defences (anger/fight, anxiety/flight, submission/appeasement, and anxious clinging) may be overly activated (Perry *et al.*, 1995). Not only does the world become a dangerous place but, as Perry *et al.* (1995) point out, repeated activation of threat–defences can build into permanent changes in brain pathways via their use and 'training'. The *social* mentality best suited to cope with social threats is often the *social rank mentality*, which will focus the child on attending to the power of others, to their harmfulness or neglect/

abandonment. Sloman has been at the forefront of exploring how attachment systems and social rank systems interact (Sloman, 2000; Sloman *et al.*, 2003). Those who have not been able to internalise a sense of warmth (able to stimulate positive affect in the mind of others) and felt unloved by others can set out on quests to try to earn their place, becoming excessively *seeking*, competitive and sensitive to rejection (Gilbert, 2004).

Another aspect of the competitive dynamic is to become excessively submissive in the face of a threat from a dominant and/or when seeking protection and investment (e.g. help/support) from him/her, and this emerges in many different types of relationship (e.g. leader–follower; Gilbert, 1992). As Jung (1954/1998) pointed out, for example, this archetypal issue is replayed in the problems of how you cope with a God who can love, care and save you but who can also be wrathful, send you to hell, send hardships or set tasks to test your loyalty. Appeasement and submission is one way to cope – and in fact, learning to defend oneself by submitting/appeasing to 'make safe' and elicit care is a way in which these defensive, safety-seeking social strategies become linked into (more) intimate relationships (Gilbert 1992, 2000a, 2000b; Gilbert & Irons, Chapter 10). These, however, are safe*ty* and defensive behaviours, not safe*ness* ones. Bowlby (1980) argued that children may be disposed to *defensive exclusion* whereby the child (or later adult) screens out the idea of parent 'as bad' and self-blames, because it is far more threatening to be aware that one's parent (or God) could be 'bad' or a danger. It is not God's fault we are in the state we are; the shame/blame falls on us as 'sinners'. Safe-making (as safety-seeking) then, within the parent–child (or other dependant) relationship, is complex and at times it is the child (or dependant) who carries the burden for safe-making, but it is threat-based and there is always the fear that one might do something wrong and elicit anger or rejection from the other. *Compassionate care* must therefore involve the ability of the carer to take responsibility for the creation of safeness in a relationship by regulating their own fear and hostile (or exploitative) impulses and creating warmth.

This, however, can only be the crudest of sketches for it does not mean that many people from insecure or harsh backgrounds do not make major, successful efforts to care for their children or others in more affectionate ways than they were cared for. Nor does it mean that all securely attached people turn out as loving, or that genes and temperament are irrelevant to these outcomes. Indeed, we need more research on what it is that enables people from harsh backgrounds to become warm and compassionate, and determined that others should not suffer as they have – for many do, and this motivation ('people should not suffer as I have') has been a source for many types of social change. Moreover, there are many ways (other than early experiences, e.g. with peers) that can activate our rank- and security-seeking mentalities, leading us to be bullying or indifferent to others. The co-construction of self-identities to fit with local ecologies is one such process (see below).

It is speculation, of course, but one aspect of meditative (mindful) practice and some psychotherapies may be the way that they help us to come to terms, and feel safer, with the contents of our own minds. We can learn to reassess our values and the things we feel threatened by, stop acting out, and stimulate a sense of connectedness (that we are all products of the same evolutionary journey) and compassion (that we are seeking a way out of suffering). As our sense of threat reduces, the safeness system may emerge as an organising process in our minds from which warmth for self and others can flourish.

Human cognitive psychology

As noted above, the parental creation of safeness and provisioning for an infant enabled the evolution of a complex array of flexible and integrating cognitive abilities, especially those that are socially focused (Bjorklund, 1997; Byrne, 1995; Trevarthen & Aitken, 2001). Many human cognitive abilities have evolved as *flexible, general* problem-solving competencies that can be used to solve a variety of different role-forming problems (Chiappe, 2000; Mithen, 1996). Moreover, humans can take a basic ability for (say) musicality and produce a Wagner or Rachmaninov, or can use intelligences that evolved for making tools and social communication and put somebody on the moon. The integration of attention and fast decision-making under rapidly changing conditions and learnt rules, as occurs in driving a car, is way beyond what any other animal could learn. Such abilities suggest some fundamental organisational properties in the human brain that synergistically link processing systems into complex neurophysiological patterns and networks with emergent properties. These produce vastly more complex patterns of inter-neuron brain activity than exist in other life forms (Geary & Huffman, 2002). In this type of brain new patterns can emerge that offer new levels of understanding.

Many theorists see the frontal cortex as key to human evolution, for it gives us our capacity for planning and some of our empathic abilities. Hence, the frontal cortex has also been linked to prosocial behaviour (Schore, 1994) and the emergence of civilisation and moral behaviour (Goldberg, 2002). Without a well-functioning frontal cortex, people can be impulsive and not care much for others. Goldberg (2002) has called the frontal cortex *the executive brain* because of its high-level control function on other parts of the brain; for example, the strategy-serving motives and emotions of the sub-cortical limbic system. Interestingly, at birth the frontal cortex is very limited in its wiring to the limbic system but with maturation and under the guiding hand of genes, and stimulation by experience, the connections between the frontal context and limbic brain grow rapidly (Schore, 1994). Clearly, however, people can behave in appalling ways to others (dropping bombs on them, designing anti-personnel mines, or being complicit in a holocaust) but have a

perfectly functioning frontal cortex. Moral and compassionate behaviour need more than a healthy frontal cortex. Also, our limbic brain and higher cognitive process can conflict between what we feel like doing and what we (morally know we) ought to do.

Types of thinking

Our cognitive abilities give the human mind extraordinary creative flexibility in how we think about, search for and enact social roles and give meaning to the world in which we live. There are at least four types of thinking that may be (more or less) specific to human cognition. These are: theory of mind, symbolic self–other representations, metacognition, and belief formation. All these abilities play a crucial role in cruelty and compassion.

Theory of mind

Compassion requires some 'understanding' of suffering in others and identification of the causes. One of the key elements of human evolution (and our capacities for certain types of empathy) was the ability to understand other people and what might be going on in their minds. This is called *theory of mind* (Byrne, 1995; O'Connell, 1997), which may emerge from neonate abilities for intersubjectivity (Trevarthen & Aitken, 2001). With theory of mind abilities one can think about someone else – what motivates *their* behaviour, what they might value, what they know and what they don't know, and we can *think* how to manipulate them to like us or be wary of us, or help them. We can think of linked inferences: 'I believe that you believe, that she believes . . .'. Whitten (1999: 177) argues that 'Reading others' minds makes minds deeply social in that those minds *interpenetrate* each other'.

Self-consciousness may have evolved because of the advantages it gave us in reading other people's minds by having insight into our own. Certainly, we often operate on the assumption that 'if I see this as red others will too', or 'if I feel good or bad about this event others are likely to too'. If we use our own minds to judge what is in the minds of others this is called *projection* – we project our feelings and thoughts about things into the minds of others; that is, we make assumptions that they think and feel as we do. Indeed, as Nickerson (1999) notes, if we cannot assume that other people are more or less like us, they become like aliens. It would be horrendously difficult, if not impossible, for us to work out how to interact with them. Thus our theory of mind, on which we base our knowledge of others, *must start* with the idea that others are much as we are and then we have to change/update our views/models about them as we discover otherwise. This updating skill is crucial to theory of mind and hence recognition that others may not know or feel as we do. This updating (understanding differences between us and other people via use of theory of mind abilities) is not always achieved adequately, and some

people have difficulties in understanding that others do not know what they know, or feel as they feel (Nickerson, 1999).

Theory of mind is not domain-specific and is a reason why compassion need not be overly linked to a particular type of (attachment) bond. In fact, we can project our feelings and conceptions onto various living things and imagine them to be pleasured or suffer as we are. Bering (2002) offers fascinating insights into the idea that religious beliefs and feelings may be emergent properties of our minds, derived from theory of mind competencies and projections. We can create fantasy figures (gods) and then imagine them to have (project) feelings like we have – hence they can feel anger or compassion. For this chapter, however, the key idea is that theory of mind enables a kind of 'knowing' that can underpin caring and nurturance.

Theory of mind also allows us to have a sense of *we-ness* (Plotkin, 2002; Trevarthen & Aitken, 2001). It brings another form of 'connectedness'. One can operate in a team with a joint understanding of what 'we together are trying to achieve' and what one's part/contribution is or needs to be. Animals may be able to work together for specific outcomes (e.g. hunting as a pack) but lack insights at the symbolic and theory-of-mind level into what they are doing. Humans use such insights and can turn many activities into co-constructed activities that only have meaning in the interaction (e.g. sports, playing in an orchestra, landing a person on the moon). These require an enormous capacity for assembling a range of cognitive and motivational abilities, both in self and between self and others (partnership formation). Feeling part of a network with others and having a sense of belonging (Baumeister & Leary, 1995) can make the world feel safe, while feeling an outsider and not wanted or valued in a network can make the world feel threatening (Gilbert, 1989). Some patients have problems in feeling a part of a network (socially (dis)connected) and experience a loss of 'we-ness' feeling (sometimes due to a sense of alienating shame; Gilbert, 2002b). Compassionate care (e.g. in psychotherapy) may intuit this need for 'we-ness' feeling and belonging and seek ways to help people (re)gain it. Group therapy may be a particularly powerful medium for these experiences (Bates, Chapter 13). Safe-making by feelings of belonging, being like others (even in our suffering), is also central to Buddhist psychology, which discusses the notion of *taking refuge* in the 'three jewels' of the Buddha, the teachings, and the spiritual community (Harvey, 1990; Ringu Tulku & Mullen, Chapter 8). Buddhist psychology is not about seeing oneself as an isolated, autonomous individual who must simply train one's mind to find enlightenment, but rather to see oneself as an interconnected being, on the same path as others (seeking to end suffering; Walpola Sri Rahula, 1959/1997). Buddhist compassion seeks to harness this capacity for feelings of 'we-ness' and connectedness (Wang, Chapter 3). Buddhist psychology therefore relies on harnessing 'theory of mind'.

Hence, compassionate understanding of others rests on some sense of 'we-ness' thinking and in particular on how and where we place the boundaries

between 'us' and 'them'. Bailey (2002) outlines how evolved cognitive systems aid us in classifying others in different types of 'we-ness', as biological kin, psychological kin and others. Feelings of sharing psychological kinship grow from ideas of similarity with others, sharing goals and values and the felt ease of forming an alliance (Bailey, 2002). While evolution may guide us to draw the boundaries narrowly, Buddhism and some other spiritual philosophies challenge us to place them widely and to be united in the understanding that all humans are struggling to free themselves from suffering (Dalai Lama, 1995, 2001).

The symbolising self

Care and concern systems (using theory-of-mind competencies) can be built into compassionate *thoughts* via processes that utilise abilities for symbolisation, language and imagination. The emergence of symbolisation and the use of imagination may have evolved first to create objects and tools in a series of stages that can be traced in the archaeological record (Lock, 1999). Lock (1999) makes the point that *social relationships put pressure on humans to recruit competencies they already had and use them in new ways*. Moreover, rather than each individual having to learn how to make (say) a flint spear from scratch, humans can learn from others – culture and civilisation depend on this. Symbolisation and imagination became the sophisticated abilities they are because they took place in a community of people *sharing their symbols and imaginations* – allied with motivations to attend and share knowledge with others. Teaching and guided instruction can be a source of compassionate care when focused on the needs (and abilities) of the other.

The powers of symbolisation and imagination were also sources for self-understanding and the creation of a self-identity. Sedikides and Skowronski (1997) have explored some of the possible origins and earlier precursors of a capacity to symbolise 'a self'. They point to three types of 'self': *subjective, objective and symbolic. Symbolic* self–other awareness is the ability to imagine the self (or other) as *an object* and to judge and give value to the self and other, to have self-esteem, pride or shame, or allocate positive or negative values to others (good and able or worthless and useless). These symbolic representations can influence care and compassion (see below).

Metacognition

Linked to the above abilities are the abilities for metacognition – this is the ability to reflect on and judge one's own thinking and feelings. Like other cognitive abilities, these mature over time (Bjorklund, 1997). Metacognition allows for the important ability to *update* thoughts (inner models) when we recognise discrepancies or that things simply don't make sense; we can understand that our thinking is flawed; we can't rely on our gut feelings, intuitions

or implicit knowledge. Metacognitions allow us to monitor and change our beliefs rationally (Wells, 2000), but also to create new threats. For example, we can become frightened of becoming anxious because we think anxiety (and its increasing heart rate) might kill us; or we might think that having certain types of thoughts and feelings makes us a bad person or we will lose control to them and act them out (Wells, 2000). We can check our thoughts, beliefs and feelings against inner models of what is and is not moral (Haidt, 2001). Meditation relies on metacognitive abilities because it harnesses abilities to reflect, and in this process to become familiar with, and make safe, the 'contents' of our minds.

Allied with these cognitive competencies and those for symbolic imagination, we can run *simulations* of inner working models in our minds (Wells, 2000). Thus I can imagine, think about, and reflect on the likely outcomes of my actions on others and how others will react to me. I can run simulations in my mind that consider the likely future implications of my behaviour and recall the past. As a child one can play out (practise and simulate) roles with toys and engage in 'pretend' (e.g. with a teddy bear; O'Connell, 1997). Hoffman (1991) argues that teaching children to think about and reflect on the effects of their actions on others (in a safe environment) is important for empathy training.

Suddendorf and Whitten (2001) have pointed out that a mind with these types of abilities (e.g. symbolic representation and theory of mind) is a *collating mind*. This is a good term, as it describes well the ability to bring together (to assemble) different time periods to mind (e.g. past, present and future) and run different simulations. It allows us to bring different attributes of mind together more flexibly in the service of social role enactments. Mithen (1996) argued that the human advance into culture arose because we became able to use (these) evolved cognitive abilities in new and flexible ways. For example, the advent of agriculture was possible because humans could understand that 'nurturing' plants and animals (and what they needed) would enhance their development. As he says, this insight is impossible for other species because they lack the flexible cognitive infrastructure for such insights. Such caring, of course, does not focus on the 'interests' of the plants or animals but may be purely self-interest and cognitively driven. When these competencies are harnessed by the care-giving mentality, becoming part of it, this may advance our abilities for compassion and pursuits such as medicine. When these competencies are harnessed by desires to threaten and harm, we end up with torture chambers and weapons of mass destruction. Indeed, it is precisely because these 'intelligent' cognitive systems can be recruited by any of the core mentalities that we can have either the best or the worst of worlds; we can do good or terrible harm (Gilbert, 1989).

The formation of beliefs

With these and other abilities, a menu of thinking processes open up. We are able to think about ourselves, others and the world we live in, *systemically*. That is to say, we can form *inner working models* of things and the connections between things. In so doing we need to, and can, understand *the laws* and processes that link them. Thus thoughts related to attributions (why things happen), expectations (what is likely to happen if . . .) and explanations (this happened because . . .) are part of our model building. Metacognition allows us to reflect then on our models and check out our attributions and explanations. Our whole feeling about something may change when we change an attribution (e.g. Sam pushed me over deliberately or by accident). Attributional style, however, can also be affected by personality, beliefs and values. Caring can be affected by our attributions, for example, whether someone is an unfortunate victim or has brought their hardship on themselves (Skitka, 1999). As noted below, however, beliefs are often socially constructed and these can have a powerful influence on compassion.

Components of compassion

So far it has been suggested that the caring-giving mentality underpins compassion. There are a number of salient competencies to care-giving, such as protecting from threats, not being a threat oneself, helping, soothing, sending signals that indicate acceptance, and positive affect – warmth. We have also explored some cognitive abilities that can be recruited into caring. In this section we explore some specific components of compassion.

Caring

Archaeological finds of Neanderthal and early humans have revealed evidence that people with deformities and badly broken bones survived – which was unlikely unless others cared for them (Mithen, 1996). Caring for others, provided it does not exceed the resources one has, and is voluntary, can have positive effects on mental health. People can feel real joy from working hard and seeing others benefit (Schwartz *et al.*, 2003). Care-giving that is felt to be obligatory in some way, or where the need of the other exceeds the resources one wants to put into caring, can be stressful and detrimental to health (Vitaliano *et al.*, 2003).

Fogel *et al.* (1986: 55) define the core element of care–nurturance as: 'the provision of guidance, protection and care for the purpose of fostering developmental change congruent with the expected potential for change of the object of nurturance'. They discuss how a human care-focused relationship may pertain to four classes of objects: humans, animals, inanimate and insubstantial. This last class represents the domain of nurturing a skill or

spiritual growth, and is primarily self-referent. Indeed, the capacity to recognise one's own needs to be nurtured by the self (to look after and care for oneself), in preference to a neglectful or agonistic internal relationship, is an important characteristic of health (Gilbert & Irons, Chapter 10).

Fogel *et al.* (1986) also demarcate four dimensions of care–nurturance. These are: (1) choice of object (as stated above); (2) expression of nurturant feelings; (3) motivation to nurture; and (4) awareness of nurturance. In this last dimension they suggest that 'awareness of nurturance can be conceptualized as the degree of articulation of an individual's concepts of their own and others' developmental processes' (p. 59). The expression of nurturant feelings can vary greatly. For example, a person may seek to care for others by building emotional closeness and helping a person with feelings of distress. Another person may shun emotional closeness and express their nurturance through trying to provide for others in more practical ways.

Fogel *et al.* (1986) point out that our desires and motivations to nurture can be directed to our pets (or animals in distress) and our gardens. A caring and nurturing mentality can even become the lens by which we approach and construe ecological issues. What often stimulates such concerns is threat. The less attentive we are to the threats that our polluting and exploiting economies are posing, the less we may be motivated to treat our environment with care and nurture it. In fact, the segregation of care and concern (MacDonald, 1992), such that it can be expressed to some people or animals and not others, gives rise to some strange and bizarre anomalies of mind. Hitler was a vegetarian, and at the time he was ordering the gassing of the Jews he gave a dictate that lobsters should be given a painless death!

Caring, and concern with the welfare of another, is obviously an important component of compassion, but is not identical to it. As noted above, farmers may 'care' for their crops or livestock not out of any genuine concern with their welfare but because their well-being benefits the farmers. People may try to be caring of others because they want others to like them, or to develop good reputations or self-identities. Compassion requires other abilities, especially (as discussed above) that of warmth.

Empathy and sympathy

Compassion has long been linked to empathy and sympathy. Many authors have illuminated the chequered history of ideas on the nature of empathy and sympathy (e.g. Duan & Hill, 1996; Eisenberg, 1986, 2002; Preston & de Waal, 2002; Wispe, 1986). Their analysis suggests that confusion reigns in this area because there have been many different definitions of empathy, including empathy as a cognitive skill, a feeling state and a personality disposition. Eisenberg's (1986, 2002) landmark work on the origins of prosocial behaviour drew attention to the fact that research has confounded different

emotional constructs related to empathy, sympathy and personal distress. She articulates these as follows.

1 The situation in which an individual feels the same emotion as another or understands what is in the mind of another: this is neither self-centred nor other-directed, and is *true* empathy or emotional contagion.
2 The responses of one to the distress of the other, which need not match the other but are focused on the *well-being* of the other. This is labelled 'sympathy'. Sympathy is more closely associated with altruism. However, it is unclear whether this is related to both types of altruism (i.e. kin-welfare based and reciprocal-rights cooperation based). In social mentality theory it is a key emotion of the care-giving mentality and key for compassion (Gilbert, 1989).
3 A self-centred response related to anxiety, worry, shame or guilt rather than sympathy: this is labelled 'personal distress'. Personal distress is related to self-focused threat processing.

Empathic resonance

Care and compassion require that we are in some way in tune with the feelings and needs of others. This ability may link to a fundamental evolved property of brains by which the mental states of one individual can trigger similar states in another. Preston and de Waal (2002) and many subsequent commentators on their target paper have recently offered fascinating insights into the evolutionary origins of (some) empathic abilities. They point out that the way (say) an alarm call spreads anxiety (alarm) through a group of animals is due to the way specific signals resonate in recipients as a form of emotional contagion. Animals must be sensitive to certain states of mind of others (for example, if they have spotted a predator or are under attack) and (re)create inside themselves something of the anxiety of the alarm caller and thus take defensive action (for example, escape). In the infant–mother dyad the distress of an infant must stimulate distress arousal in the mother in order for her to take action. A mother's smiling may induce the motor programmes for smiling in her infant. This can be called empathic resonance (Decety & Chaminade, 2003).

Building from such observations, Preston and de Waal (2002) present the *perception-action model* of empathic learning with a review of neurophysiological data that shows that signals expressed by one person can directly stimulate corresponding systems in recipients. For example, when we watch things happening to others, such as in a sad or exciting film, we can feel sad or excited ourselves. The anterior insula is an important area of the brain for processing disgust. Wicker *et al.* (2003) found that observing others experiencing disgust stimulated the anterior insula in observers. Wicker *et al.* (2003) and Decety & Chaminade (2003) suggest that this empathic resonance

enables us to understand others by (automatically) simulating internal models of feelings and actions that others might be feeling or thinking.

These findings and new understandings about empathy clearly have huge implications for understanding social interactions, especially mother–infant developmental interactions and patient–therapist interactions. Therapists may come to be 'in tune' with their patients via empathic resonance of emotions/thoughts that a patient stimulates in the therapist. Patients may come to feel soothed by experiencing warm soothing signals of a therapist that stimulates inner soothing. One can only speculate on the effects of an insecure therapist who signals alarm, threat or disgust, or one who tries to be 'a blank screen' to a patient's inner experiences (Gilbert & Irons, Chapter 10).

Empathy and theory of mind

As noted above, empathic mind-reading (theory of mind and purposeful/reflective metacognition and mental simulations) opened the door to a special kind of understanding and knowing that can be central to 'skilful' care-giving. However, although these can be harnessed for caring, they are not in themselves care-related but are separate abilities/competencies with their own (often multiple) evolutionary shapers (Byrne, 1995; Gilbert, 1989; Wispe, 1986). Some forms of empathic mind-reading can be used to manipulate and exploit people, and need not involve any *caring interest* at all. Psychopaths, advertisers and story-tellers may each be empathic, knowing how to influence others to be frightened, enticed or enthralled, but not be very caring and have little capacity for sympathetic feelings. The empathic torturer/terrorist puts the gun to your child's head, not yours; threatens your family rather than you. Politicians who want to 'dig the dirt on opponent' need to find the Achilles heel and 'need to know' what an audience would find distasteful. Hence, while some cognitive 'empathic' abilities (e.g. theory of mind) can be used by the care-giving mentality they can also operate for other reasons.

Sympathy

Sympathy *is* related to care and concern for the well-being of another, and is commonly elicited automatically by distress signals (Eisenberg, 2002). In sympathy we are emotionally drawn into the suffering of the other with feeling created in the self. The accuracy of *understanding* may be loose, however. The feelings and emotions ignited by sympathy may not match those of the object of sympathy. In extreme cases, the sympathiser may be more upset than the object of sympathy. Sympathy moves by the elicitation of feelings within oneself and can be elicited by projection, whereas projection reduces accurate empathy (Gilbert, 1989). However, sympathy may be a key competency for compassion.

Empathic–sympathetic care

It is the blending of the *motive* to care and have concern for 'the welfare of the other' with empathy that leads to empathic care. This seems the best way to create safeness for the child (or other person), and to tailor nurturance to the child's (or other person's) needs. Mikulincer *et al.* (2001) have shown that our capacity for being empathically concerned with others is linked to our own sense of security (or in this chapter 'safeness') as may be laid down in early attachment relationships. It is as if we are able to reach out to 'the other' because we feel 'safe with and within' ourselves. As Leahy (Chapter 7) notes, this may be partly mediated by the fact that an early secure relationship enables us to understand, tolerate and integrate a range of feelings; we become emotionally competent (Izard, 2002) rather that sensing that other people's feelings or needs are confusing, overwhelmingly distressing or threatening.

To give one example, Koren-Karie *et al.* (2002) explored three types of maternal interaction: positively insightful, one-sided, and disengaged. Positively insightful mothers try to see their child's experiences through the *child's eyes*, and accounting for them being a child. The mother makes an effort to understand the *child's* feeling and motives and explores them; that is, they have concerned empathy (Eisenberg, 2002).

The one-sided mother (whom we might see here as using projection) is keen to care for her child but has preset ideas of what a child needs and a 'unidimensional' view of the child. The researchers think that this could lead to inconsistent care. All is well when the child conforms to expectations but not when the child does not conform and new things need to be understood. These mothers impose care rather than empathically working out feelings with the child.

Disengaged mothers are characterised by lack of emotional involvement. Even thinking about what might be going on in their child's mind was novel to them and not something they found pleasant. The researchers think that these disengaged mothers would have avoidant children. There would be little attunement of emotion (Trevarthen & Aitken, 2001).

As one might expect, the positively insightful mothers had the most secure children. These mothers were more complex in their thinking about their children and ready to update their views (of 'like-self', 'not-like-self' models; Nickerson, 1999) during interaction with their children. Presumably they have theory-of-mind skills that inform them that their children *cannot* think and feel as they do (because they are not adults). Note also that positively insightful mothers appear to *feel safe* and less threatened by their children (i.e. they neither see their children as threatening their authority or sense of competency nor are threatened by feelings in themselves that their children may have stimulated) (Liotti, 2000). Therapists too may vary in these dimensions, with some seeking to understand and others seeking to impose control, feeling their 'authority' to be easily threatened.

The preparedness and ability to update and change our models of the states and abilities of 'the other' by trying to be empathically attuned to the other (not just projecting) is thus a major skill in compassionate caring. It offers an emotional framework for care rather than just trying to do the 'right things' – like out of a recipe book. Similar themes arise in psychotherapy and when (for example) we offer help to communities and try to work with them rather than impose what we think they need. Compassionate care is thus a *collaborative (ad)venture*.

If one thinks about this in a psychotherapy situation, one senses the enormous difference of feeling that someone is *trying* to understand you from *your* point of view and trying to move into your space, in contrast to someone trying to direct you, inform you, impose control or being disinterested in what you feel or why you feel what you feel (Leahy, Chapter 7). Some people with emotional difficulties seek therapy in order to feel understood and experience something that they feel they have never had – that a mind (hopefully more integrated and safe-with-feelings) other than their own is working to understand them in a safe, non-judgemental and non-shaming way. Indeed, throughout life the people we (usually) want to be most intimate with are those who try to understand us, are positively insightful and caring (investing), in whom we are able to stimulate 'liking' for the self, and with whom we feel safe. However, in psychotherapy even this can be threatening. If a person has deep shame of their inner world and can't feel a sense of safeness or care from the therapist, they may turn away from the desire to be understood. As one patient said, 'If you get to know me you'll see the really horrible person I am'. Another said, 'I do want to be understood, but then you will have to get close and I will have to take my barriers down – well, frankly, that scares the shit out of me!'

Empathic care for the future

Animals can prepare for their future (building nests or burrows), but do so from purely innate sources of knowledge. In humans, however, concerns for the future are driven by our cognitive competencies and insights. Because we are capable of simulations that can be future-directed, we can anticipate future needs of self and others. Motives to care, with sympathy for others suffering, mean that we can work for the betterment of others *in the future* (even those not yet born) – to seek to create a better life. We can try to create social contexts that privilege the maturation of compassionate phenotypes. No animal, as far as we know, can consciously and deliberately do this. Of course our ability to simulate and predict the future is not specific to the care-giving mentality and could be used equally well to prepare for war.

Personal distress

Many researchers have found that personal distress at the suffering of another can interfere with empathic care-giving, and presumably compassion (Eisenberg, 2002). People may help others because it turns off their own distress, but personal distress may also interfere with care-giving, in that a person may be more motivated to escape or turn away from the distress of 'the other' because it is too upsetting/threatening. If a person tells me of their lost child, I can feel for, and with, them by imagination; what it may be like to lose a (my) child – I can run a simulation in my mind of 'if that were to happen to me'. This type of empathic understanding may depend on emotional contagion (one feels tearful with their tears) and on 'theory-of-mind' abilities. Such may be vulnerable to distortion due to projection, but it also depends on me being prepared to listen actively and enter that world and seriously consider this possibility. If I find that thought or feeling of grief too overwhelming (for example, unsafe and threatening, feel shame in allowing the patient to see I feel tearful with them, or worry that this sadness cannot be contained unless I stay detached, or that showing tears is unprofessional) I might not be able to 'go there'. I may try to be kind/supportive but not really get close to the feelings. There are many debates as to how one should empathically attune and 'feel with' a patient and how 'detached' one should be, especially in non-verbal communication. For some patients too much detachment is experienced as cold and they feel that that their distress does not emotionally impact or move the therapist. For others, too much emotional contagion is frightening. One form does not fit all. However, what is being suggested here is that inner safeness also gives us abilities to *tolerate* pain in self and others without being hustled into defensive reactions.

Self-focused *threat* emotions can interfere with abilities to 'tolerate' and compassionate caring. For example, shame–threat in a therapist can ignite distress and defences that interfere with caring–empathy. A patient says they are going to kill themselves and the first thoughts of a therapist are of being taken to court for negligence or persecuted by managers. A patient says they have sexual feelings for the therapist and this alarms the therapist such that the therapist subtly (or sometimes not so subtly) shames and rejects the patient. Therapists who have not had an opportunity to learn to cope with their own shame can be problematic for patients, and shame distress in a therapist (for example, fear that they are not good enough, fear that others will criticise them) can lead to unhelpful defensive manoeuvres. The same is true for other types of relationship, such as a parent who feels that their child's behaviour shames them in public or calls into question their adequacy as a parent to 'control' their child. A not uncommon response is anger and a switch to efforts to overpower the child via threats, shaming, or lashing out.

Disgust may also turn off care in that seeing someone injured or having vomited, one turns away and 'can't bear' to touch or help the person. The

failure to control one's own distress and aversive emotions might produce guilt for acting this way (for example, not helping). And anger/disgust (for example, in hearing about a perpetrator's abuse, or cruelties) can turn off empathy because we do not want to create those feelings in ourselves – that is in 'them' and could never be in me. In these types of empathy one can exercise some choice into how far one enters the world of the other (or keeps out). As Carl Jung and many others have pointed out, to enter the inner world of another means we have to have some familiarity and safeness with our own; to know our own shadows. If we are blocked and defended against certain feelings in ourselves, compassionate understanding for the other may become difficult. We may struggle to 'educate' patients on their emotions and meanings if we are not 'educated' ourselves (see Leahy, Chapter 7).

Recent research shows that the more unfamiliar and dissimilar experiences are from those of one's own life, the more difficult empathy and theory of mind might become (Preston & de Waal, 2002). There are also many anecdotal stories of therapists who have worked with depressed people, but it was not until they themselves had suffered a depression that they 'really' understood it. If one has never lost a loved one then the pain and pining from grief might be hard to really understand. Many schools of psychotherapy believe that one should experience therapy, not just to help sort out and become familiar and safe with one's own thoughts and feelings, confront one's own shadows, or learn techniques, but to gain first-hand experience of being in the patient's position. I must say, when I did this I 'saw' therapy rather differently.

Personal distress, guilt and harm avoidance

Preston and de Waal (2002) and Wang (Chapter 3) have noted work on both rats and primates that shows they won't, say, push a lever for food if they connect this with one of their kind being harmed. There are some contexts, then, where animals are clearly not indifferent to doing things that might cause harm to others. O'Connor (2000) has given an important analysis of the evolution of harm avoidance to others, which in humans comes with feelings for *guilt*. When self is seen as a source of harm or hurt to others, by either direct actions or failures to act, guilt can result (Zahn-Waxler *et al.*, 1992; Zahn-Waxler, 2000). Guilt often depends on felt or assumed responsibility, but this is not always so. For example, survivor guilt can arise when one survived a disaster but family or friends died – and there is no sense of being responsible for the harm done. Rather the feelings are on entitlement/deserve (why did I survive when they did not?) or grief. Feeling that one is doing better than others can also link to a feeling of guilt over 'deserve' (O'Connor, 2000). It is concern for others that is key.

Compassion may depend on us being able to tolerate others' distress, and our own guilt (without turning it into shame; Tangney & Dearing, 2002).

Guilt is an affect that warns us if we are close to harming, or stimulates reparation if we have hurt someone. Cognitive defences and self-defences may be key. It can start with a sudden shock. For example, you are driving down the road and a dog runs out and you hit it. Externalising anger would focus on the damage the dog has done to your car (stupid dog); shame would focus on fear of what others might say about your driving or negative self-evaluation; guilt focuses on *sadness and sorrow*. Guilt is linked to empathic and sympathy abilities (Tangney & Dearing, 2002). Unlike shame (which evolved within a rank mentality, is focused on social comparison, social punishment and loss of status/reputations, and does not require cognitive abilities for empathy and sympathy; Gilbert, 2003), guilt is a moral emotion: it requires sympathy and empathy in a way that shame does not (Gilbert, 2003; Tangney & Dearing, 2002). Guilt supports prosocial behaviour, and builds interpersonal bonds (Baumeister *et al.*, 1994). This suggests that the negative affect of guilt or the anticipation of guilt may nudge us towards care and compassion.

There are, however, a number of psychological problems that can arise from harm avoidance and guilt (O'Connor, 2000). For example, in some psychotic depressions people can have delusions of having caused harm. Some obsessional disorders have been related to fears of harming others (for example, by contaminating others, not taking enough care or not checking things) and an inflated sense of responsibility (Wroe & Salkovskis, 2000). Some people can have exaggerated feelings of responsibility for the welfare of others (O'Connor, 2000).

In contrast to too much guilt, some people may show little capacity for guilt, sorrow or remorse and are not physiologically affected by signals of distress in others. The archetypal personality is the psychopath, well known for their lack of guilt or remorse for the harm they can do (Miller & Eisenberg, 1988). For all of us, though, even if we like to think of ourselves as caring and non-psychopathic, it is rather easy to want to do harm and even get pleasure from it (for example, the bomber pilot gets a buzz of pleasure when he sees his bombs hit the target; we watch the movie and hope the 'baddies' get their come-uppance). Here there is a kind of dissociation from guilt, which is adaptive to the extent that to be paralysed by guilt (for example, for harming one's enemies) would inhibit offensive and retaliatory actions. Harming others who are threats to us, or whom we envy, can be a pleasure of sorts (Leach *et al.*, 2003).

Responding to distress

We can respond to others' distress in a host of ways such as with emotional or practical support. Helping others in distress, or those who are incapacitated, is part of our primate evolution. For example, consoling behaviour has been observed in non-human primates (de Waal, 1996). At other times, helping involves *bravery* (Zahn-Waxler, 2000). People will die risking their lives to

save strangers. As the morning of September 11th 2001 unfolded in New York, many people within the doomed buildings, and personnel from the emergency services, were to die in efforts to save others (and knowing they were at risk), giving rise to the many stories of extraordinary heroism from ordinary people on that day (Smith, 2002). This does not mean that people would try to save other people's children before their own, or that they would try to save a trapped stranger on the floor below rather than a trapped friend on a floor above, or that many people weren't more concerned with their own safety than with that of others, or that there aren't non-caring situations that lead people to risk their lives in pursuit of a cause (for example, to be a hero). What it does mean is that in extraordinary conditions our motives and emotions to see others as 'like-self', and rescue and protect even strangers, can power us along and take us over. Even in the terrors of the Holocaust many individuals put themselves and their families at great risk to help those who were being persecuted (Oliner & Oliner, 1988). Why people will act this way is complex, related to: familiarity with those persecuted, personality, self-identities, beliefs and values, and seeing others as 'like-self'; there may be anticipation of guilt if one does not help.

Retaliation

Harm to ourselves, others we love or identify with, or our group may not only stimulate great acts of heroism but also hatred towards perpetrators with desires for retaliation. Retaliations have been observed in many species, and are a basic social strategy (Buss, 2003). A tragedy of September 11th 2001 was not only the loss of life and the messages of love left on thousands of answer phones, and the grief thousands must now live with, but that in the following year retaliating Allied bombs would be collapsing buildings – calling forth more acts of heroism to save others more grief and sorrow, and (for some) desires for revenge. The desire to retaliate against those who harm us can be a powerful source for turning off compassion and can open avenues for cruelty with desires to *persecute and eradicate*. In extreme cases harmful others are seen like a disease, stimulating feelings of disgust and requiring eradication (for example, Hitler's depiction of the Jews as vermin and an infection). For some there is the belief that unless harmful others (or their views and values) are *eradicated* and stamped out, they will simply regroup and come at us again. And then there is the need for social demonstrations of retributions (e.g. crucifixions) to demonstrate power and put others off any idea of trying to challenge the social order. To be gripped by such archetypal defensive solutions to threats in the modern world is tragic, often fails, and can be a source of immense cruelty (Shermer, 2004).

Forgiveness

Forgiveness is one way we can slow the hand of retaliation. Although forgiveness is important in Buddhism, it is probably most noted in Christianity. Like other aspects of our psychology it is complex, with a variety of personality, historical, social and contextual factors influencing it. Forgiveness depends (in part) on theory of mind and the ability to understand why people act as they do, and at times our own part in stimulating their anger. It also requires a conscious decision to turn off one's (strategic) anger – to harm them back or seek revenge. The potential for forgiveness is therefore part of compassion. There is increasing evidence that forgiveness in personal relationships is associated with health (see Worthington *et al.*, Chapter 6 for a full review).

People can grow up in environments where forgiveness is valued or where it is not (for example, the need to maintain vendettas; 'an eye for an eye and tooth for a tooth'). People may have various beliefs about why forgiveness is bad (e.g. for certain crimes). Forgiveness can be shamed; for example, if children do not carry on the vendettas of the parents they are seen as disloyal. Children (and adults) may need to distinguish forgiveness from submission and learn self-assertion, especially in bullying situations. Compassionate forgiveness is *not* an exercise in appeasing, submission, denying hurt or that the other could take you as a mug and simply stamp on you! (Salzberg, 1995; Worthington *et al.*, Chapter 6). This introduces various *moral* dilemmas, consideration of ways to prevent conflicts before they begin, and processes of reconciliation (for example, as Nelson Mandela instigated in South Africa). Further research is needed on the way dominants forgive subordinates and subordinates forgive dominants; and the way in-group members forgive (or ostracise) other in-group members, in contrast to out-group members.

Gratitude

The ability to appreciate others is key to affiliative relationships (Heard & Lake, 1997). If forgiveness is important to developing compassion in the context of others' harming behaviour, then gratitude may be important in the context of others' helpful behaviour. McCullough *et al.* (2001) have recently given a fascinating overview of gratitude as a moral affect. The ability to be open and appreciative of the help that others have given builds social relationships. It motivates prosocial behaviour in the recipient and reinforces the giver to continue to help. Mutual exchanges of gratitude can be related to warmth and affection. McCullough *et al.* (2001: 263) note that 'Gratitude is one of the most typical responses to perceived benevolence from other moral agents'. Fostering gratitude by focusing attention, thinking and writing about it once a week for ten weeks, was found to result in better well-being and fewer physical complaints than writing about neutral things or hassles

(Emmons & Crumpler, 2000). Fostering gratitude is salient to many religions. In Buddhist psychology part of the reason for (monks) becoming dependent on what others give (e.g. food) is to inspire feelings of (and reflections on) gratitude and mutual dependence.

McCullough *et al.* (2001) point out that grateful behaviour does not mean that a person has experienced grateful feelings. You can't order a person to feel gratitude any more that you can order them to feel love or forgive. Gratitude can be used defensively, as in the way a dependent person might be excessively grateful to try to boost the good feelings in the other about the self and thus reduce risk of rejection. They may fear expressing anger to others. One of my patients tried to find women who were in some way 'damaged' so that he could rescue them and they would form a bond from gratitude with him; see him as a rescuing hero. Rescuing heroes often have fantasies of being (gratefully) admired and loved for their deeds – perhaps not so uncommon in small measure. Those who refuse to acknowledge gratitude for the help of others may be trying to slip the obligations that gratitude may entail and be defensively focused on self-ability and self-promotion. Thus, excessive gratitude, lack of gratitude or trying to stimulate gratitude overly in others can direct a therapist to key problems in interpersonal relating. It is an interesting thought experiment to think what compassion might look like in a person who could not feel gratitude. A case could be made that learning to feel appropriate gratitude not only comes with feelings of safeness (recognition that others can and will help the self if needed), learning that it does not undermine or belittle the self, but also promotes well-being and compassion.

Developmental stages of compassion

Our abilities for compassion probably mature with those for empathic sympathy and gratitude – abilities that will develop into strategies for building mutually supportive relationships. Hoffman (1991) suggests a developmental trajectory of moral and caring behaviour that links emotional contagion and sympathy with the maturation of empathic abilities and emotions.

Global empathy

This is via emotional contagion. An infant cries and those around him/her may do so also. What happens to others may produce distress in the self, but without clear separation of self and other. This is close to the view of empathic resonance (Preston & de Waal, 2002).

Egocentric empathy

From about one year old, self and other are becoming distinguished and the child recognises that distress in the other is in the other and not the self,

although there may be no clear idea about what that distress is. For example, Hoffman (1991) offers the example of an 18-month-old who took his own mother to a crying child, rather than the crying child's mother, because, presumably he knew what comforted him, but was not aware of what would comfort the crying child (i.e. the crying child's own mother). He might also have felt safer with 'using' his mother this way than approaching the mother of the crying child.

Empathy for another's feelings

From two to three years, with the advent of role-taking and switching perspectives (theory of mind with its updating abilities), the child becomes able to recognise that feelings in another may not be the same as feelings in the self. Empathic awareness is directed more at what the other may feel rather than what the self feels. Thus, a child may come to recognise that a distressed child may need to be left alone or should not be shamed. Presumably the skill of this depends on the growing ability to differentiate emotions and feelings within oneself. In therapy one often finds that empathic failures by patients in their relationships with others can be traced to the fact that the patient's own affect system is poorly differentiated and they are unable to articulate their own feelings, let alone other people's.

Also at this level children can be distressed by another's suffering even if the other is not physically present. Children can be unhappy by hearing stories of others' pain, or enjoy 'happy endings'. This leads onto the following.

Empathy for another's life condition

This relates to recognition of another person's life conditions and circumstances. It depends on increasing cognitive abilities to form models of the world, and of social groups as separate groups. It requires our abilities to think *systemically*. It involves complex processes of attribution and explanation. From here may arise the ethical basis for political beliefs and greater interest in alleviating suffering for those not in the immediate environment.

So children start to show concern and interest in helping others (even unfamiliar non-intimates) in distress from around two years old (Hoffman, 1991). Zahn-Waxler *et al.*, (1992) taught mothers to be observers of their children's behaviours to study the development of these abilities. As predicted by Hoffman, they found that caring and prosocial behaviour matures in the context of developing cognitive abilities for self-recognition and symbolic self-awareness. As they put it: 'It is probably not coincidental that increases in prosocial behavior development occur at time periods (around 1½ and 2 years) in which there are corresponding increases in the use of symbols and the capacity to imagine and pretend' (p. 133). Such illuminating work may indicate how a care-giving mentality, rooted in motivated concern,

is operating as a choreographer for a variety of competencies and abilities (for example, symbolic self–other representation, theory of mind) which enable increasingly sophisticated and flexible enactments of caring, social roles. Evidence suggests that the way one is cared for impacts on how caring of, and compassionate with, others one might be later in life (see Gillath *et al.*, Chapter 4). For example, Mikulincer *et al.* (2001) showed that internalisation of secure attachment (experiences of safeness and soothing early in life) increases people's ability for sympathetic empathy with others. Security of early attachment also influences potential negative reactions to out-group members (Mikulincer *et al.*, 2003). However, prosocial interests and abilities, even in securely attached people, can be overwhelmed by leaders who stimulate group and tribal identification and violence to outsiders (see below). Few of these writers include discussion of the maturation of gratitude, and how it might build through neonate interactions with caregivers, but this may be another important element of a fully prosocial mind (McCullough *et al.*, 2001).

Compassionate abilities

We have arrived at the position where what started off as a solution to threat – protection and then, later, care of infants *with warmth* – has, with humans, evolved and emerged into an array of complex interacting processes, motives and abilities. These can radiate into many different types of relationship, and are summarised in Figure 2.4.

Compassionate relating emerges from complex interactions between motives to be concerned for and improve the well-being of others, and competencies to be sensitive to others' distress with sympathy for, and understanding of, their position – with a complex array of cognitive competencies. At the same time one must be able to tolerate distress in others and in self to avoid defensive withdrawal or over-control. Empathic abilities that may begin with emotional resonance mature with cognitive abilities (for example,

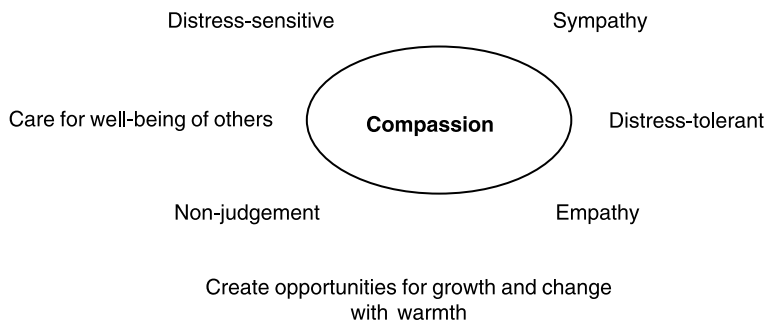

Figure 2.4 Components of compassion.

theory of mind and metacognitions); these abilities, allied with a non-condemning or non-shaming judgement, support motives for care. Other characteristics for compassion may include strength (Emmons & Crumpler, 2000). Certainly, in psychotherapy compassion that is seen as weak is often not helpful (Gilbert & Irons, Chapter 10). Compassion also involves abilities for gratitude, generosity and forgiveness.

Warmth, with its elements of kindness, gentleness, safe-making and soothing signals, interpenetrates these elements of compassion. I suspect that the warmth system is a fundamental affect system whose evolution made some of these elements possible. However, at the moment the link between a warmth system and compassion needs more research before this can be further illuminated. Whatever the case, compassion is a complex, multifaceted process. The potential for cruelty (as indifference to or pleasure from another's suffering) can arise from various kinds of threat, envy or self-promotion that *turn off*, bypass or fail to activate compassionate, especially warmth, subsystems. Moreover, as noted above, people can behave in kind or helpful ways because they want to be liked and to form accepting supportive relationships. It is difficult to know how much compassion is actually involved when kind acts operate from these essentially self-protecting or self-enhancing motives.

Compassion and moralities

How does compassion relate to morality? Groups generate all kinds of social rules/values that can be described in terms of moral behaviour. For example, sexual perversion can be seen as 'immoral', or one may be described as having a moral duty to meet obligations, or exploitation of others can be see as 'immoral'. For the Japanese Samurai, moral behaviour was that which did not bring shame (but brought honour) to self or others.

In this chapter, however, we have touched on different types of altruism – kin and reciprocal (Trivers, 1985). From a different perspective, Gilligan (1982) drew attention to two types of moral thinking: one based on conceptions of fairness and justice and one based on feelings of concern–care for others. Women may be more focused on nurturance because they are more investing in young (MacDonald, 1992), and depend on supportive, kin-based alliances (Taylor *et al.*, 2000). Men may be more focused on problems of competition and needs for its regulation through systems of fairness and rights. Recent data, however, has questioned these gender differences and directed attention to situational factors that require different types of moral thinking (Jaffee & Hyde, 2000). None the less, welfare versus justice/rights can be related to the care-giving mentality and cooperative mentality respectively that consider moral dilemmas in different ways.

Thinking about 'rights', taken and bestowed, and systems of justice, is focused on recognition of autonomy to pursue goals and freedom from exploitation (Lewis, 2003). Rights are important for cooperation and for

prevention of exploitation of the weak by the powerful, and have often been hard won. Social hierarchies also play their part because evidence suggests that dominants can be rather dismissive of the needs of subordinates (Keltner *et al.*, 2003) and see them as manipulable to meet their own ends (see below). Grady & McGuire (1999) have illuminated how systems of rights, agreements about rights, formal constitutions and laws are emergent from the interaction and 'battles' between alliances of subordinates and dominant elites (see also Scott, 1990). Related to 'rights' is the issue of respect and dignity. Cruelty often attacks and undermines people's sense of dignity via shaming and humiliating; compassion, in contrast, is sensitive to, respectful of and boosting of dignity. Cruelty seeks to reduce or devalue people's rights.

However, since cooperation can be a solution to competitive threat, the benefits may flow only between those who are potential participants; others (e.g. women, or the dispossessed), who can be subdued by other means, may not be party to the benefits or process. Thus, in many societies men (and the competitions between them) dominate the landscape with the expectation that women fall in behind. Even in democracies a woman's right to vote is relatively new. In some social systems men are given 'rights' over the control of women and may be allowed to beat or even kill them (honour killing) if they violate these rights. Many social systems bestow 'rights' on parents to educate (and punish) children as they wish, to indoctrinate them with traditional values and religions, and even (in the case of female circumcision and Chinese foot binding) to mutilate them – often to fit cultural norms. This is linked to concepts of ownership and control on the one hand (Gilbert, 2002b), and efforts to pass cultural values from generation to generation on the other. The links between 'rights', socially agreed entitlements and cruelty are therefore complex.

Moralities based on systems of care-providing (may have) evolved from kin altruism and parental investment (care/support/protection of kin), which allow for *emotional* concerns for the *welfare* of others. Social comparison and reciprocation are (mostly) irrelevant but *sympathy* for others is key – in a way it need not be for cooperation. Unlike the legal profession, which focuses on people's rights, the caring professions focus on people's welfare.

Batson *et al.* (1995) demonstrated that justice and care (which they call empathy-altruism) *are* different prosocial motives, which can produce different behaviours. Consider, for example, two people presenting to hospital for care. One has paid their taxes and has a relatively minor problem, while the other has not, but has a more serious problem. You can treat only one person. Using different dilemmas like this, Batson *et al.*, (1995) found that care-based systems for moral thinking could lead to (what they call) immoral behaviour in so far as it may violate a moral justice-based principle (for example, you help the person in greatest need rather than the one that is entitled or 'has a right' to care, having paid into the system). Care-based moral thinking can lead to partiality. Clearly, however, for persons who pay into the system but

are not given preferential treatment, anger and a subsequent refusal to pay may ensue, leading to a breakdown in the infrastructure for a medical care. Skitka (1999) has shown that these systems are linked to different political philosophies and personalities. In providing aid, liberals are more likely to focus on need than on attribution of deserve, whereas conservatives think more in terms of deserve. As Haidt (2001) argues, these kinds of moral dilemmas can be fuelled by different types of 'feelings and emotions' about them (linked to different strategically oriented social mentalities), rather than (only) rationalities.

Using compassion: the role of self-identities and social ecologies

It is well known that even if someone has the 'abilities' needed to act compassionately they may not do so for situational or personal identity reasons (Reynolds & Karraker, 2003). Alternatively, people may choose to train their minds to develop these talents (phenotypes) in extraordinary ways (Goleman, 2003). Western and Buddhist psychologies have somewhat different views on what promotes compassion. In Buddhist psychology compassion grows from mindfulness, compassion training and seeing that our self-identities, and need to maintain and defend them, can get in the way of 'clear insight' into the nature of the self. Meditation does not mean extermination or annihilation of the self or 'being' (a not uncommon misunderstanding; see Walpola Sri Rahula (1959/1997), especially Chapter VI), but rather to experience oneself as 'being-in-the-world' in new ways (Goleman, 2003; Harvey, 1990; Kabat-Zinn, 1994). Western psychology, on the other hand, suggests that how and to whom we use or choose to develop compassion is linked to the construction of a self-identity (Bierhoff, 2002; Reed & Aquino, 2003).

In a symbolising, self-aware mind that has theory of mind and metacognition, and can regulate a multitude of desires and possible roles, not having a self-identity would create *too much flexibility* and too many competing possibilities for thought and actions (McGregor & Marigold, 2003). Many psychologists now see 'the self' and self-identity like this, as an organising system that coordinates memories, emotions, beliefs and other processes for a cohesive securing of goals in specific contexts/social niches (see for example Leary & Tangney (2003) for reviews). Taylor (1989) puts it clearly when he says:

> To know who I am is a species of knowing where I stand. My identity is defined by the commitments and identifications which provide the frame or horizon within which I can try to determine from case to case what is good, or valuable, or what ought to be done, or what I endorse or oppose. In other words, it is the horizon within which I am capable of taking a stand.
>
> (p. 27)

Different social mentalities guide different sub or mini self-identities. One may have a self-identity when in the role of carer (father or psychotherapist), as a sexually attractive person, a friend (e.g. as reliable), or competitor (e.g. as tough and assertive). One needs to coordinate different aspects of one's mind for different roles, and different 'identities' designed to orient self in roles can conflict. What constitutes a specific role is unclear and in some cases may come down to a single dyadic relationship (e.g. between spouses) or membership of a group. Multiple relationships therefore allow for multiple roles and the blending of social mentalities for a specific role. These can be far from integrated and cohesive in any overarching sense of a self. This is why a person can regard himself/herself as a loving parent/person, but then goes to work in a death camp or to the factory that will build bombs that will kill other children. There has, of course, been much work on the cognitive dissonance that this can create, and how we erect justifications to deal with it (Bandura, 1999; Gay, 1995).

However, Reed & Aquino (2003) suggest that caring, kindness and honesty attributes can become important for a self-identity, which they call a moral identity. Having such attributes at the core of 'one's identity' is associated with less hostile behaviour to out-groups, and increased probability of forgiveness in harmful situations. One might question the term *moral*, given that it can mean different things to different people (see above; people can view themselves as highly moral, go on moral crusades but not be very warm or caring). It is unclear how such an identity links with the personality dimension of agreeableness (Costa *et al.*, 1991) and liberal values (Skitka, 1999). None the less, the important finding is that *wanting* to be a kind and compassionate person (i.e. to harness the care-giving mentality for self and social role co-creation) does contribute to more benevolent behaviours and values.

Threats to belonging and self-identity

Self-identities need to be constructed to fit local social conditions, values and rules, and to ensure acceptance by others (Abrams, 1996). Unfortunately, our (safety-seeking) needs for social approval, fear of shame and desire to maintain a self-identity/reputation in relationship with others, can do much *to lower* our abilities to act with compassion. There is little doubt that many of our cruelties and immoralities flow from social threats of exclusion and condemnations from those we seek approval and acceptance from. Indeed, we may go out of our way to harm others if we think this will court favour in our group or from our superiors. Hitler was known to play his generals off against each other to win his favour and prove themselves to him, and failure to do this created a great sense of threat and feeling unsafe with him (M. Gilbert, 1987) – a psychology not unknown in some religions and families. As Kelman & Hamilton (1989) have argued eloquently, many of our 'crimes' are crimes of

obedience – to win over our superiors or show loyalty to and defend our group's values. How often do we find ourselves doing what is expected, or remain silent bystanders, from fear of being laughed at or rejected – the fear of shame (Gilbert, 2002b)? Tice & Baumeister (1985) found that macho self-images in men could inhibit helping if helping was seen to undermine (or shame) this self-image. As they note, people can hold back on helping if they think this will draw attention to themselves or court the criticism of others. As Zimbardo (1995) has shown so well, with his work over many years, there are many ways you can get good people to do bad things. Compassionate actions may at times require a self-identity that is prepared to risk disapproval, being shamed or even being persecuted (Oliner & Oliner, 1988).

The social and ecological domains

Self-identities and choices about what we will train ourselves to enhance (both individually and collectively) are not solely of our own creation but are a means for tracking and operating within specific social niches (Abrams, 1996). There is now considerable work on how gender identities are co-constructed through temperaments, early experiences and social and physical ecologies. For example, David Gilmore, in his 1990 book *Manhood in the Making*, argues that in hostile, threat-filled contexts – from predators, the need for dangerous hunting, or other hostile male groups – male identity tends to shape around 'males as strong and fearless' with various rituals and processes for demonstrating courage and strength. Males not only adopt these values into a self-identity, but train themselves for these roles. Fear and weakness are shamed, with those showing them risking ostracism. The relationship between the sexes is highly segregated, with women more likely to be seen as subordinate to men, subject to their control, and as property. Child-rearing tends to be harsh, preparing children to 'toughen up' for their harsh environments. Gilmore contrasts this style with groups living in benign ecologies, such as the Tahitians. They live in an environment with few dangerous predators, little in the way of warfare or feuding, and where 'the local lagoon supplies plentiful fishing without the need for arduous deep sea expeditions' and masculine identity is less aggressive and more affiliative (Gilmore 1990: 205). In these benign environments there is greater androgyny and child-rearing is more relaxed and playful. Pinker (2002) argues similarly that although there are biological and temperamental differences between men and women, noted from childhood, whether men endorse and enhance aggression or affiliation depends on the way the social context shapes how reputations are made or lost and the relative benefits from each way of behaving (see also Buss, 2000; Cohen, 2001). MacDonald (1992) also points out that styles of care of children can vary widely from culture to culture in the dimension of warmth and affection. There have been many societies (e.g. the Spartans and early Romans) where although attachment clearly took place,

warmth was not accentuated. Compassion was often seen as a weakness, and in Sparta deformed children were thrown off a cliff. Children were often beaten to 'toughen them up'; some died as a consequence.

It would seem, then, that the interconnectedness between evolved potentials and the culturally shaped and trained mind are far-reaching – going right to the core of the types of minds we have, the choreography of neurophysiological patterns and the way we see and give meaning to the world (Knox, 2003; Li, 2003; Lickliter & Honeycutt, 2003). Socially shared values give rise to a group identity, bind a sense of 'we-ness' and belonging, and thus underpin self-identities (Baumeister & Leary, 1995). They also shape the meaning of threats and ways to deal with them. Heath *et al.* (2001) have explored how legends and traditions (including religious beliefs) arise in cultures and become adopted and exchanged in the minds of a group. They point out that to adopt a belief system, such as a belief in witchcraft, God, *or the power of compassion*, the focus must be on something that is relevant to a person, and is transpersonal (affects others); it usually contains messages about types of *threat* and how to deal with them; it must fit with the ecological needs of the group (for example, developing beliefs in gods of the sea is relevant to seafarers but not landlocked peoples); it guides social behaviours and informs rituals; it is emotionally textured; and it provides a sense of group coherence and belonging (believing in the same things). Combinations of these factors can keep belief systems going, especially if there are sanctions/punishments for 'non-believers'. There may also be dominant elites who benefit from maintaining them (for example, those who control rituals; Scott, 1990).

One function of co-constructed, socially shared and reinforced belief systems is that they articulate fears and threats (and sometimes create them), and offer ways of dealing with threats. Whether we are focused on an individual, or threat–defensive beliefs and behaviours in groups, whether we focus on witchcraft, diseases or ethnic cleansing, beliefs can take a form of 'a myth' (Heath *et al.*, 2001) that orchestrates the defensive/protective behaviours of *detect, protect, avoid, subjugate, persecute and eradicate* behaviours. Sometimes these are played out in rituals (e.g. sacrifice). Recently, Eidelson & Eidelson (2003) labelled certain beliefs 'dangerous' because they accentuate *threat* focus and reasons to be exploitative of and aggressive towards others. They are socially reinforced in groups sharing these beliefs. People develop beliefs and styles of thinking that fit and reflect their social worlds and enable them to 'disengage', *dissociate* from, or turn off mentalities that focus on others' welfare (Bandura, 1999; Zimbardo, 1995).

The power of dominant–subordinate relationships

Dominant–subordinate relationships operate in most mammals, and humans are especially sensitive to this social mentality. It is now well known that

leaders (be they threat-based tyrants or high-status figures) can do much to harness attention and texture self-identities (Crook, 1986; Lindholm, 1993). Leaders can inspire us to compassion, reconciliation and peacemaking, or violence and cruelties. Although we often put great emphasis on the importance of personal freedom, we often fail to recognise just how much of our behaviour is directed at seeking approval, fitting in with our social groups and *subordinating* ourselves to various individuals, doctrines, traditions and values (Cohen, 2003). In a fascinating study, Green *et al.* (1998) looked at the historical records for the link between unfavourable economic conditions (e.g. high unemployment) and hate crimes (lynching and beatings) directed at minorities. Current wisdom had it that with increases in relative poverty, envy and frustration build up, leading to increases in hate crime. But this link proved weak. Green *et al.* believe that an important factor in the rise of hate crimes is the emergence of leaders or power elites that direct and orchestrate violence for their own ends or reasons. Although hatred of the outsider is an all too familiar aspect of our behaviour, such feelings are typically mixed in cauldrons of social values that literally cultivate it, as Gay (1995) has so fully described, and Nelson Mandela demonstrated by his refusal to endorse such. Is it possible that the human race has been burdened and scarred in the way it has partly because there are certain types of personality (enacting certain strategies) that seek and get power and then are able to inflame people to violence because of our compliant and submissive tendencies, need for belonging and tribal identity, and fear of shame by 'breaking ranks'? Can leaders inflame violent strategies towards outsiders for political ends to impress others and/or to deflect attention from their failed leadership and internal economies? Many political commentators believe so.

Grabsky (1993) offers many examples of how leaders have manipulated situations for their own ends. Hitler and Stalin are modern examples, but he also notes that Gaius Julius Caesar, born around 100 BC, was a man of extraordinary personal ambition. Grabsky suggests that Caesar's invasion of Gaul and the destruction of its early civilisation (changing European history) was little more than a calculated effort to impress the Senate for political ends. Some leaders may even have little interest in their own 'group', using their armies simply as cannon fodder – well noted in the First World War (Dixon, 1976/1994). Dominants can manipulate subordinates in various ways, with little interest in their needs or 'rights' (Keltner *et al.*, 2003). One form of manipulation is appeals to tribal/gang loyalty. In his powerful book on the war in Bosnia, Ignatieff (1999) explored how people who had once been friends and neighbours could turn on each other with such hatred. He had little doubt that this was because of the way group identities and tribal loyalties (archetypal processes) can be easily inflamed and orchestrated by a small group of leaders whose ruthlessness, playing one off against another, and exploiting economic dissatisfactions, had enabled them to obtain power.

These leaders are followed and one stays loyal to one's group/tribe, at a cost. Ignatieff suggests that people:

> must turn their aggressive drive to conform, against their own individuality. In order to dissolve his identity in Serbdom, for example, the foot soldier must repress his own individuality and his memory of common ties with former Croatian friends. He must do a certain violence to himself to make the mask of hatred fit.
>
> (p. 51)

Key, then, is what leaders direct our attention to, how they create in us a sense of belonging to a tribe, and how we endorse and follow those values.

Leaders get their power only because subordinates are too weak to oppose them (and their henchmen), they offer some kind of solution that has appeal, or they shore up tribal loyalties (Scott, 1990). As Lindholm (1993) and others observe, 'followers' actually create their own state of subordination. In the case of the religious leader Jim Jones, who enticed many of his followers to commit suicide in 1978, their obedience to him was not (only) because he disciplined them or promised them salvation, but because they had accepted him as their leader and the group's life and identity depended on him remaining leader. Even though many close to him knew he was a fake, they actively colluded in maintaining the 'myth of his leader qualities'. Indeed, it is often the immediate subordinates (and not just the leaders themselves) that keep regimes going. Once they defect or rebel, the system may collapse.

A group can take a life of its own; people fear that should it be discredited, the group will fragment and die. With it will go all the privileges of being in that group: the safeness, the sense of belonging, alliances, the hopes and aspirations for a better life, and, of course, the status or sense of specialness (for example, being in a group chosen by God). In extreme circumstances one has no life, no identity, no existence, outside the group (Lindholm, 1993). People can then be subject to paranoid and depressive experiences and even suicide. More than a few have killed themselves when the group on which they had pinned so much fragmented and died. A 'group' can become the organising process through which strategies inside individuals become orchestrated and related between individuals. A full analysis of compassion and cruelty requires insight into these social processes that operate beyond individual psychologies.

The politics of ecology creation

Different political agendas and ideologies emerge from social interactions and create different social ecologies to which humans must then adapt. Different ecologies create contexts that influence not only personal motivations and self-identities but also neurophysiological processes such as the dopaminergic

(Pani, 2000), serotoninergic and stress (James, 1998) processes. Capitalist economies focus on control, ownership and competitions for 'things and possessions'. Their success in creating material comforts and technologies, developing sciences for combating diseases, and building social infrastructures for commerce is undisputed. These advances are not to be cast cynically aside. However, they are not without a cost, for such economic relations form social ecologies that recruit the competitive and rank-forming mentality whereby people are enticed to think in terms of winner–loser, success–failure, to address themselves as objects that must be groomed to fit the race or drop out, and where failures are seen as due to individual failings of effort, talent and deserve (James, 1998; Lasch, 1979). Wealth and pleasure-seeking, not happiness, is the focus: we are led to believe (falsely) that one flows from the other, despite much evidence that (outside obvious poverty) it doesn't (Argyle, 1987; Kasser, 2002).

Although many post-agricultural societies have created social hierarchies of haves, have-nots and have-lots, until recently these have often been maintained by beliefs as to the natural order of the ruling elites or threat of violence (Scott, 1990). People did not feel responsible for their social positions. Modern capitalism is different in two ways. First, although it too has created huge disparities of haves, have-nots and have-lots, it depends on the excitation of wants, desires, striving and possessing (i.e. the seeking system; Pani, 2000). It excites people's aspirations and expectations. At the same time it creates the myth that anyone potentially can acquire and achieve if they work hard enough. Thus, second, failure to acquire is an indicator of *personal* inferiority, is shameful or is the result of some incompetence on the part of others. Advertising, stimulating envy, and rejecting/shaming those 'not up to it' carry it along. This may be good for business and creating comforts (for some) but can wreak havoc on our minds and relationships. Indeed, the over-stimulation of striving to acquire has been given a new label, 'affluenza' (Graaf *et al.* 2001). We are a long way from early egalitarian lifestyles and controls on selfishness and possessiveness (Boehm, 1999; Smith, 2002). Modern life also creates increasing problems with frustration. We do not easily learn to tolerate and cope with (threat-activating) frustrations. Life speeds up as the 'system' seeks efficiencies of 'more and more' from 'less and less'. The stress of 'time pressure' is one reason why people may not be as helpful or compassionate as they could be (Reynolds & Karraker, 2002). Frustration with oneself and with others, because we can't have what we want when we want, is now seen to underpin the increasing 'anger problems' in modern societies.

Ever since the advent of agriculture that enabled surplus and disparities of wealth, there have been serious consequences of poverty (those allocated to the lower ranks) on health and crime (Wilkinson, 1996). Groups that value individualistic materialism increase striving, create segregated communities, and have elevated rates of crime and mental ill-health (Kasser, 2002). The

World Health Organisation estimates that depression is poised to become the second most burdensome disorder in the world, and the first for younger women. There is now increasing evidence that adolescent depression, anxiety, self-harm and antisocial behaviour have been rising steadily since the 1960s. Suicide is increasing in young males, especially those without jobs, who have lost hope and are not integrated into communities. The richest nations have the highest numbers of prisons and locked-up young males (Vila, 1997). The drive for efficiencies and competitive edge may be producing serious disturbance in minds that evolved for small-group, supportive relating. In the face of this, the privileged are forced into more and more defensive manoeuvres and retreat from egalitarianism to protect themselves from the discontent and crimes of the poor, and politicians become eager to focus attention on the threat of crime from those who feel they have no stake in society. We end up believing we need to defend a way of life that has many benefits but is also actually driving us a little crazy (James, 1998). As Galbraith (1992) has noted, wealth allows one to 'buy out' from the obligations of social responsibility, to support the political party that promises to maintain one's privileges, and to seek to segregate oneself from the ecologies of the poor – few would choose to live in a poverty-stricken inner city. Wealth-seeking can be motivated by a desire *to escape* the limitations and perceived degradations of poverty that individualistic competitive wealth-seeking may itself create. Such a motivation would not be advantaged in a sharing, egalitarian group (Boehm, 1999).

It is not machines or computers we should fear taking over, but the social processes and economic systems *that already have* (for example, that entice us to resource accumulation, group self-interest and poor frustration tolerance) and of which we are either unconscious or in deep denial. There is increasing alarm at the way large corporations pursue market share and profit, and exploit resources with ruthless cruelty. Cruising the world for cheap labour and less restrictive laws, closing down people's livelihoods if factories become inefficient, funding political parties to privilege self-interest all suggest that we have lost control over the emergence of economic systems and risk being willing servants in the manufacture of cruelties (Bakan, 2004). Compassion is tricky if we stay in denial of the fact that sociopolitical systems are organising processes in their own right that can influence the most intimate aspects of our lives (our physiologies, values, goal pursuits and self-identities) and the forms of co-constructed relationships we enact with others.

Groups/societies that value caring and the *welfare* of others, and seek equity, have lower rates of crime and various forms of illness (Arrindell *et al.*, 2003). Strategies for care-giving can flourish (although they will still have to cope with basic self-interest and pleasure-seeking) in contexts (ecologies) that promote social relationships (generate partners) for reciprocal care relationships. There are efforts to explore how communities can develop their mutual support systems, called 'social capital'. (Interested readers can enter 'social

capital' into a good web search engine for further reading.) The Buddha too was well aware that compassion was not just about helping others in one's personal life or contemplating enlightenment, but should be an *active* process to help people practically, by (say) addressing poverty and education (Walpola Sri Rahula, 1959/1997). It would be interesting to see what might happen if psychological science put compassion at the centre of its efforts to improve the well-being of humanity, and focused rather less on the need for personal achievement of goals.

Compassionate beliefs and training

No animal, as far as we know, can override its desires by high-level cognitive processes linked to self-directed goals. No animal can understand that if it practises a skill it can improve at it – *develop its phenotypes by consciously chosen, purposeful training*. Humans clearly do understand this. We might feel hungry but, in order to lose weight and be slim or healthy, not act on the desire to eat. The Dalai Lama pointed out that being a Buddhist did not mean that he did not have sexual desires or never felt angry, but rather his belief–value system (and self-identity) was such that he adopted a particular orientation to these feelings and *trained* his mind in a certain way. Indeed, as Ringu Tulku & Mullen (Chapter 8) outline, Buddhism, over very many years, has developed mind-training procedures for enhancing compassion. This brings us to a key question in compassion, of what we learn to value – what we want to be.

Training our children

There are increasing concerns that television, modern diets, stimulating excessive wants, and need to achieve in children, all stimulate the (over) arousal and dopamine (seeking) systems (Pani, 2000). Brains maturing under these conditions may become more 'restless', vulnerable to feelings of anxiety, frustration and anger (Restak, 2003). Much of our education of our children is to ensure they are sensitive to the need to earn their place in the world, to individual status and achievement (Holt, 1969), and is over-focused on personal self-esteem (Crocker & Park, 2004); this produces what Lasch (1979) called the Culture of Narcissism – social-rank- and shame-focused cultures.

In contrast, Izard (2002) has suggested that given the complexity of our emotions, and the importance of learning emotional regulation, more attention should be given to children's emotional education (Leahy, Chapter 7). In her review, Eisenberg (2002) indicates how prosocial behaviour and feelings can be harnessed and developed through parental and teacher behaviours, empathy training and conflict resolution skills, rewards for being caring, developing affiliative rather than competitive peer groups, and social role models that promote caring (see Bierhoff, Chapter 5). As Straub (2002) points out, caring also requires a sense of responsibility for others and feelings

that they deserve care, fairness and justice, that hardship can be bad luck, not poor effort – beliefs that capitalist economics tends to downplay. Thus, the desire to be a caring person and to feel *responsible* for the welfare of others needs to be built into self-awareness and self-identity via social education, compassionate care and attention to ecology creation. Science will continue to illuminate these processes. What we will do with the knowledge, and whether we will put it in the service of creating a more just and compassionate world, remains to be seen.

Conclusion

Cruelty and compassion are the antithesis of each other. It has been argued that compassion is rooted in a care-giving mentality that began with 'making safe' for, and investing in, others (e.g. infants) to nurture their development. As the human mind became progressively more complex a host of competencies, such as theory of mind, became sources for skilful, compassionate engagement in a range of relationships. Compassion therefore emerges from complex interactions – from genes that guide the building of physiologies, and physiologies that are shaped via experience, through to social contexts that shape self-identifies and roles people enact with each other and within themselves. Compassionate caring can be the mentality that we can use to construct forms of relating with all sentient beings. Cruelty, as indifference to, or pleasure in, the suffering of others, is a turning off of this mentality towards a specific group or class of living things. Compassion and cruelty are then strategies, operating through various subsystems in our brains for feeling and reasoning.

The Buddha's great insight was that the mind needs to be trained to understand the power of the threat system, and self-identities forming systems, for they will easily take control of our minds (as they are evolved to do). He did not speak of threat systems as such, but of our effort to escape 'suffering'. Today we are able to understand how we are often caught in the passions of strategies and archetypes (for sex, status, to belong to groups and follow leaders, to pursue the pleasures, anger and fear). He was aware too of the power of political and economic systems to create ecologies that enhance or damp our natural care-giving interests and competencies. As the Dalai Lama has often noted, compassion, no less than any other of our potentials, can be put under a scientific spotlight and when we do this we can bring new insights to the discussion, from a variety of disciplines, on 'its emergence into the world'. In this chapter I have tried to widen our focus beyond the domains of individual psychology, for, as many suggest, ecologies, group processes and leadership–follower psychology all need to be understood if we are work towards greater compassion in the world.

Although our sense of self emerges from complex interactions of genes, evolved strategies, social relationships and social ecologies, we do not need to

be passive actors in these dramas. Our high-level cognitive abilities allow us to step back, reflect, and understand ourselves, and the nature and consequences of our social actions. The more we learn about the nature of our minds and how to enact more compassionate ways of being in the world, the more tools we will have for confronting some of the darker sides of our minds – sides that have also got us to where we are. One thing is sure: that in a highly creative and intelligent mind like ours, when we turn off care and compassion to others, all hell can break loose – quite literally (Millett, 1995; Straub, 1999) – for other than fear of retaliation there is nothing to stop it emerging into the world. It is us, and not external gods or devils, that allow the demonic to stalk the earth. Evolution has given us minds that are capable of understanding this. It is now up to us.

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Chapter 3

A conceptual framework for integrating research related to the physiology of compassion and the wisdom of Buddhist teachings

Sheila Wang

While Western science tends to reduce complex phenomena into smaller and smaller units, Buddhism has focused on specific organizational principles that affect the way the mind works (Gilbert, Chapter 1, this volume). They address two key themes: developing mindfulness and cultivating compassion. Western scientists are beginning to explore some of the specific physiological correlates and consequences of developing mindfulness (Carlson *et al.*, 2003; Davidson *et al.*, 2003) and compassion (Davidson & Harrington, 2002; Goleman, 2003) but little attention has been given to examining how these states emerge from and impact the *organization* of our physiological systems.

This chapter explores the physiological underpinnings of our capacity for compassion and how our experience of compassion may have profound impact on the way our physiology is organized. MacLean (1990) and then Henry & Wang (1998) proposed that there are different physiologic and emotional systems involved when one is operating from a prosocial 'species-preservative' perspective compared to an individualistic 'self-preservative' perspective and evidence will be presented that suggests that the significance of biological measures may be interpreted differently depending on which mode of organization is predominant. The self-preservative system is focused on defending the organism from harm and securing resources necessary for survival such as food and shelter, ownership and possession of territory. It is based on a sense of self vs other and developed early in evolutionary history. The species-preservative system has evolved much more recently, is based on a more inclusive sense of self and promotes awareness of our interconnectedness to others. It is concerned with the welfare and needs of others; initially and most specifically, the welfare and needs of the infant. Full development of this system includes the welfare of all living things, including our planet, therefore it might be more accurate to call it the 'life-preservative system.' I will use the term 'species-preservative' here because the core aspects of this system have been previously described using that term. It is within this self- and species-preservative framework that I will discuss scientific research findings and aspects of Buddhist teachings as well as suggesting future research strategies for studying compassion.

This chapter is organized into five major sections: (1) a description of the self-preservative and species-preservative system model and how it relates to compassion with relevant data from brain imaging, autonomic and hormonal studies; (2) an extension of the model that suggests that the success or failure of early attachment relationships leads to different capacities for emotional and physiological/emotional regulation which in turn may lead to different capacities for compassion; (3) a discussion of affiliation vs compassion; (4) a description of my understanding of the meaning of compassion; and (5) directions for future research and summary.

The physiology of self- and species-preservative systems

There are many more physiologic systems involved in the self- and species-preservative systems than can be described here; however, certain systems will be highlighted that appear to be associated with these two distinct modes of physiological organization. More emphasis will be placed on the species-preservative system because it provides the infrastructure for the emergence of compassion. Several unique aspects of mammalian and human evolutionary development will be discussed, including (1) brain structures, for example the thalamocingulate division of the limbic system and the enlarged neocortex; (2) autonomic nervous system structure, specifically the mammalian ventral vagal complex; and (3) neurotransmitter/hormonal systems, e.g. oxytocin and cortisol.

Central nervous system foundations of self- and species-preservative system

MacLean (1990) proposed that the two phylogenetically older subdivisions of the limbic system, the amygdala and the septum serve as telencephalic internodes relating respective parts of the limbic cortex to the brainstem. The self-preservative system involves amygdala circuits and emotions, such as aggression and fear, whereas the species-preservative system involves septal and thalamocingulate circuits and is related to reproductive behaviors and mammalian maternal behavior. It is the thalamocingulate division of the limbic system (including the cingulate cortex), for which there is no evident counterpart in the reptilian brain, that is implicated in three forms of behavior that characterize the evolutionary transition from reptiles to mammals, namely (1) nursing, in conjunction with maternal care; (2) audiovocal communication for maintaining maternal-offspring contact; and (3) play. This species-preservative mammalian system of care, interaction and awareness of others provides fertile ground for the roots of human compassion.

Destruction of the specifically mammalian cingulate areas by ablation in monkeys resulted in loss of grooming and affiliative behaviors and walking over their cagemates 'as though they were inanimate' (Ward, 1948). Cingulate ablations in hamsters result in the disruption of maternal behavior, disruption of the development of play, and the behavior of repeatedly walking on top of other pups 'as though they did not exist' (MacLean, 1990: 396). MacLean notes that the functions of parental care, play, and social bonding associated with the thalamocingulate division would 'seem to have favored the evolution of the human sense of empathy and altruism' (MacLean, 1990: 520). More recently, Lorberbaum and colleagues (2002) have suggested the importance of thalamocingulate circuitry in human maternal behavior.

Thayer and Lane (2000) have also proposed that 'the cingulate cortex, specifically the anterior cingulate, serves as a point of integration for visceral, attentional, and affective information that is critical for self-regulation and adaptability.' Increases in blood flow to the anterior cingulate in healthy women have been associated with higher levels of emotional awareness and accurate detection of interoceptive and exteroceptive emotional signals (Lane *et al.*, 1998a), and in healthy men have been associated with an internal emotional focus condition (Lane *et al.*, 1998b).

The role of the neocortex in the development of compassion

The greatly expanded human neocortex is cited as being responsible for the uniqueness of human intelligence, including planning, problem solving, and refined differentiation and discrimination of happenings in the external environment, but it also provides important inhibitory control of subcortical systems allowing for modulation of more reflexive and conditioned responses. The neocortex is also thought to be responsible for the uniqueness of human crying and laughter, especially the human propensity to tearing in connection with altruistic acts (MacLean, 1990). The prefrontal cortex (PFC), specifically through its connections with the thalamocingulate division, is believed to link interoreceptive and exteroceptive systems necessary for a feeling of personal identity, because of its strong interoceptive vagal inputs. MacLean (1985) writes:

> Presumably such internally derived experience is necessary for an individual's identification with the feelings of others. And it may be imagined that such an interiorized sense is also necessary for 'insight' requisite for the foresight to feel a concern for the future of others, as well as the self. The possibility is suggested that through the neofrontal connections with the thalamocingulate division, a parental concern for the young generalizes to other members of the species, a psychological development that amounts to an evolution from a sense of responsibility to what we call conscience.

Here it is suggested that increased awareness of internal states is important in the development of conscience and both processes have their roots in the species-preservative caregiving system. Conscience can be seen as promoting a shift in the 'I' to include others' perspectives, but it is also dependent upon awareness of internally derived experience. Both are necessary to recognize the interconnectedness of self and other.

Compassion is a complex social behavior that appears to emerge from the development of an enlarged neocortex and from the critical role of caretaking of the young, especially by the mother.

> There are many groups of mammals that display complex social behavior, but all have in common two important features that are interrelated. These features are, first, the increased size of the executive neocortex compared with the rest of the forebrain and second, the importance of the matriline in maintaining social cohesion and group stability . . . especially in primates.
>
> (Keverne *et al.*, 1999: 263)

The neurologist Damasio (2003) argues that ethical behaviors depend on the proper functioning of certain brain systems and that the essence of ethical behavior does not begin with humans. He states that evidence from birds and mammals indicates that other species can behave in what appears to be an ethical manner; they exhibit sympathy, attachments, embarrassment, dominant pride and humble submission. In one experiment, rhesus monkeys abstained from pulling a chain that would deliver food to them if pulling the chain also caused another monkey to receive an electric shock. Some monkeys would not eat for hours, even days (Miller *et al.*, 1966). The animals most likely to behave in an altruistic manner were those that knew the potential target of the shock, i.e. those who were familiar. Familiarity is a critical feature of compassion and will be discussed in more detail later.

Damasio's observations of patients with PFC damage reveal little or no deficits in intellectual function, but he found that they made decisions that were not advantageous for themselves nor for those close to them. Their spouses reported a lack of empathy. Unsuccessful attempts were made to account for these patients' poor decision making on the basis of cognitive failures. Damasio argued for a social emotion problem, specifically, embarrassment, sympathy and guilt being diminished or absent. The use of cooperative behavior appears to be blocked in patients with damage to brain regions such as the ventromedial frontal lobe. They fail to express social emotions and their behavior no longer reflects mutual engagement in the social environment.

Davidson notes:

> . . . if we look at the frontal lobe of the brain in relation to the rest of the brain size, in humans there is a higher ratio than in any other species.

> This tells us that there is something important about the frontal lobe for qualities that are distinctly human. One of the most important human qualities may be our ability to regulate emotion – and here the frontal lobes appear to play a key role.
>
> (in Goleman, 2003: 188)

Many others have linked the frontal cortex to emotion regulation, prosocial behavior (Schore, 1994) and moral behavior (Goldberg, 2002). Davidson (in Goleman, 2003: 189) points out that one of the most exciting discoveries in neuroscience over the past five years is that many areas of the brain including the frontal lobes change in response to experience. He adds that these brain areas are dramatically affected by the emotional environment in which we are raised and by repeated experience.

Compassion, positive affect and prefrontal cortical activity

Davidson (2002) suggests that individuals who exhibit more frequent and prominent signs of compassion will likely be individuals who also exhibit other traits of positive affect. A pattern of differential activation of the right and left PFC during positive and negative emotion, with greater relative left-sided prefrontal activation observed during the elicitation of certain positive emotions and greater relative right-sided prefrontal activation observed during the elicitation of certain negative emotions, appears to be emerging (see Davidson, 2000 for review). Henriques and Davidson (1991) found that clinically depressed patients exhibited a pattern of left prefrontal hypoactivation compared to controls. Evidence from studies of normal subjects, including adults, infants and rhesus monkeys, indicates that positive affect is associated with increased left prefrontal activation. These studies elicited positive affect using film clips (Davidson *et al.*, 1990) and voluntary smiling (Ekman & Davidson, 1993) among other stimuli (see Davidson (1995) for review). Davidson is currently involved in studying the brain activity of Buddhist monks and other individuals who have undergone intensive mind training. He has found similar leftward shifts in prefrontal activation under baseline conditions and during generation of a state of compassion (Goleman, 2003). Probably due to methodological difficulties, most of these studies do not involve studying the subject during a social interaction that would include rhythmic, prosodic and other nonverbal aspects of communication and might prove to show different patterns of neural activation.

Harrington (2002) notes:

> Compassion is a human emotional and cognitive experience that does not happen to a single individual in isolation, but as a response to another sentient being. It is a process of external and internal reorientation that

> softens our sense of our individuality by bringing it into a felt relationship with the pain and needs of some other. We all know that such intimate experiences are the blood and flesh of rich human life; yet the tradition of Western laboratory behavioral and brain science has been historically so attached to the idea of the autonomous 'self' that it largely lacks effective and conceptually robust ways to study the transactions, the processes that may happen 'inbetween' individual selves.
>
> (p. 21)

Many studies suggest that the right hemisphere may be preferentially involved in receptive emotional prosody, which is the ability to understand the emotional information being conveyed by another person (Bowers *et al.*, 1985; George *et al.*, 1996; Nakamura *et al.*, 1999; Ross, 1981; Vingerhoets *et al.*, 2003). Several researchers also hypothesize that the right cerebral cortex may have a specialized role in human social attachment (Henry, 1993; Horton, 1995; MacLean, 1990; Schore, 2002; Sieratzki & Woll, 1996).

When linking compassion to positive affect, the level of inclusiveness of the 'I' may be quite different, depending on the stimulus conditions. It is true that people who are more compassionate would likely express more positive emotions and experience more happiness, but we must not fall into the trap of associating elicitation of compassion with what have traditionally been thought of as responses to positive (appetitive or pleasurable) stimuli including erotic scenes, receiving money for tasks and pharmacological effects of opiates. Compassion requires us to be sensitive to the suffering of others, which may not be 'pleasurable' in the moment, but enhances our inclusive sense of 'I' and provides respite from our own destructive emotions. Matthieu Ricard, Buddhist monk and French interpreter for His Holiness the Dalai Lama, distinguishes pleasure from happiness:

> Happiness here refers to a deep sense of fulfillment accompanied by a sense of peace and a host of positive qualities such as altruism. Pleasure depends upon the place, the circumstances, and the object of its enjoyment. By contrast, a deep sense of fulfillment does not depend upon time, location, or objects. It is a state of mind that grows the more one experiences it. It is different from pleasure in almost every way. What we seek by disentangling ourselves from the influence of destructive emotions is the kind of inner stability, clarity and fulfillment that we are referring to here as happiness.
>
> (in Goleman, 2003: 85)

The self-preservative system and the amygdala

The self-preservative system, activated by unsafe conditions, threat, fear and anxiety, is associated with negative human emotions and is founded on

motivational circuits in the brain that evolved to facilitate survival in dangerous environments. Animal and human studies have revealed a 'general defense motivational system', including the nuclei of the amygdala and the structures to which it directly projects, that mediates autonomic and somatic reflexes that characterize distress responses in both animals and humans (Davis & Whalen, 2001; Lang *et al.*, 2000). The frontal lobes have inhibitory effects on amygdalar activity, which is an example of the importance of the neocortex in regulating emotion. There is evidence suggesting that 'when people commit violence or some other antisocial act impulsively, without thinking about it, there is underactivation in the frontal lobes' (Davidson, in Goleman, 2003: 213).

Fear activation of the amygdala does not require conscious appraisal and reportable perception of the fear-eliciting stimulus to be effective (Lang *et al.*, 2000), which reveals the automatic processing mechanisms that can become conditioned and may cause unconscious obstructions in perception, especially perception of internal states. Studies of patients with anxiety disorders show low correlations between subjective reports and actual bodily states (Hoehn-Saric & McLeod, 2000; Pennebaker, 1982). Activation of the fear system mediated by the amygdala is a critically important and adaptive biological process; however, chronic activation of the amygdala by anticipation of aversive events or conditioned stimuli in everyday life can be maladaptive and result in obstructive negative states. Signal decreases to the amygdala have been reported during meditation (Lazar *et al.*, 2000). Sensitivity to others and accurate perception can be hindered by chronic negative states.

> If you consider that destructive emotions restrain our inner freedom and impair our judgment, then as we get more free from them, they will not have the same strength. The sage who is completely at peace and free from disturbing emotions has a much greater sensitivity and concern toward others' happiness and suffering.
>
> (Ricard, in Goleman, 2003: 84)

Ricard's observation was confirmed in Paul Ekman's laboratory where two experienced meditators, both of whom had spent at least two years in solitary retreats in the Tibetan tradition, were tested on identifying facial signs of different emotions presented only for a fraction of a second. They both scored two standard deviations above the norm in recognizing these superquick facial signals of emotion (Goleman, 2003: p. 84).

Autonomic correlates of self- and species-preservative systems

Porges (1995) emphasizes the importance of the evolution of the mammalian nervous system, especially the ventral vagal complex (VVC), in providing the

neurophysiological substrates for the emotional experiences and affective processes necessary for social engagement and the species-preservative system. The phylogenetically older sympathetic and primitive vagal, or parasympathetic system, regulates physiology under conditions of significant metabolic demand and/or threat conditions, but Porges proposes that it is the uniquely mammalian VVC, a newly evolved branch of the primitive vagus, that contributes to the regulation of many behaviors that are important in social interaction. These include looking, listening, facial expression, vocalizing, filtering of low-frequency sounds to discriminate human voice from background sounds, head gestures and ingestion. Under conditions of safeness, the visceromotor components of the VVC contribute to rapid modulation of control of the heart and bronchi through inhibition and disinhibition of vagal tone (an active vagal brake). This promotes a fine-tuned and immediate engagement and disengagement with objects and individuals providing moment-to-moment physiological and affect regulation. Under conditions of threat, or when there are difficulties in regulating the vagal brake, phylogenetically older systems, such as the sympathetic (fight or flight) nervous system, are recruited, limiting the influence of the VVC and assessibility to the social engagement system. This pre-emptive action of more primitive self-preservative regulatory systems, which can be elicited by fear, negative affect, unsafe conditions, etc., severely limits access to the more recently developed systems (Porges, 2004) that are necessary to engage in the looking, listening and feeling associated with compassion. The frequent activation of the self-preservative system and the negativity accompanying it becomes an obstruction to the perception (i.e. the looking, listening and feeling) of the present moment. I believe this is why the emphasis in many Buddhist practices is on diffusing negativity (and self-preservative system responding) as a way of removing obstructions to a more accurate perception of the present moment and the arising of compassion.

Control of the heart by the mammalian vagal brake produces a heart rate pattern known as respiratory sinus arrhythmia (RSA), which is observed as a rhythmic increase and decrease in the frequency of spontaneous breathing. Monitoring dynamic changes in RSA and heart rate gives a measure of heart rate variability and provides an efficient and noninvasive method of assessing the status of the inhibitory control of the heart and therefore access to the social engagement system. One advantage of predominantly vagally mediated control of the heart (higher heart rate variability) includes more efficient and flexible use of metabolic resources to meet current demands, which places much less stress on the body and enhances self-regulation (Porges, 1998). Consistent with that observation, lower heart rate variability is associated with less effective physiological regulation in infants (Porges, 1996), several disease states (Kristal-Boneh *et al.*, 1995), anxiety (Thayer *et al.*, 1996), and lack of behavioral flexibility (Porges, 1992), while higher heart rate variability (more inhibitory vagal influence) is associated with the ability to self-regulate

and thus to have greater behavioral flexibility and adaptability in a changing environment (Thayer & Lane, 2000).

Self-regulation is a critical component of attention and mindfulness, two important ingredients in cultivating compassion. It depends on neural inhibitory processes to select meaningful information and disregard irrelevant information from the external and internal environments. Neural inhibition allows maximum flexibility of behavior, and of the dynamic and 'complex set of reverberating circuits or sub-systems working together in a coordinated fashion' (Thayer & Lane, 2000). The Dalai Lama notes that our brains are not irrevocably fixed and that systematic training of the mind is possible because of the very nature and function of the brain (Dalai Lama & Cutler, 1998: 44–45). It is likely that the process of systematic removal of obstructions and negativity from consciousness results in increased self-regulation and behavioral flexibility and would be associated with increased levels of neural inhibition reflected in higher levels of vagal tone and heart rate variability.

Hormonal correlates of the self- and species-preservative systems

The self-preservative system

The self-survival system includes both an active (threat to control) and a passive (loss of control) response to challenging stimuli (Henry, 1991). An active response includes elevated catecholamines, increased testosterone and increased mobilization of metabolic fuel (sympathetic nervous system activation), among other changes. A passive, non-aggressive response is correlated with a 'defeat' reaction including elevated cortisol, steady or lowered catecholamines, decreased testosterone and decreased mobilization of metabolic fuel (primitive parasympathetic system activation). These patterns of response can be activated in sequence or alone depending on the resources of the organism, contextual and social factors, and the extent of the challenge.

The more a person is challenged, the greater the demand for control and the greater the arousal of these systems. Elevations in cortisol have been associated with depression, anxiety, arousal and 'active coping' (J.W. Mason, 1968). It is clear that these high negative arousal states and concern with one's own vulnerability can interfere with attending compassionately to others' needs (Gillath *et al.*, Chapter 4). In general, the greater the loss of control, the greater the distress and the greater the elevations in cortisol; however, extreme loss of control, helplessness and arousal may sometimes actually lead to disengagement from aspects of the current environment (dissociation, emotional numbing, avoidance, denial) and a compensatory suppression of cortisol levels (Mason *et al.*, 2001). There appears to be a primitive defense of shutting down of emotional stimuli, as an anti-arousal coping response to overwhelming arousal, which is very costly to individuals

and to society in terms of social functioning and sensitivity to others. Avoidance symptoms, including emotional numbing and inability to have loving feelings, have been related to lower levels of cortisol in posttraumatic stress disorder (Mason *et al.*, 2001), a condition in which interpersonal and social functioning are significantly impaired. Persons with posttraumatic stress disorder often feel 'unsafe' and may have shifted their threshold to self-survival to include many neutral and everyday situations (Wang, 1996). Low salivary cortisol has been reported in several groups with significant impairments in social competence and sensitivity to others, including boys referred with problems of persistent aggression (McBurnett *et al.*, 2000), children with attention deficit hyperactivity disorder and oppositional defiant disorder (Kariyawasam *et al.*, 2002), and girls with conduct disorder (Pajer *et al.*, 2001). Adult psychopathic criminals who have committed unusually cruel crimes also appear to be in a shutdown mode and have blunted cortisol responses to stressors (Woodman *et al.*, 1978). It is important to consider that cortisol levels reflect much more than a simple measure of stress and that suppression of cortisol levels, associated with avoidance and emotional disengagement strategies, can be as debilitating to sensitivity toward others and the arising of compassion as are the anxiety and negativity associated with elevations of cortisol. Gillath *et al.* (Chapter 4) propose that the use of avoidance behavior and disengagement blocks activation of the caregiving system, because the individual may be overwhelmed by the emotional involvement required by empathic responsiveness, acknowledgement of others' distress, and acceptance of the closeness that an empathic reaction implies.

One can see that the interpretation of cortisol being low is quite different depending upon the challenge, the social environment, the coping responses one has developed, and the physiologic system from which the person is responding. For example, in response to stressful stimuli, it would not be accurate to interpret the lower cortisol levels of the deviant criminal in the same way as you would interpret the lower cortisol response of the nursing mother. Similarly, it would not be accurate to interpret the lower basal cortisol levels in the youths with conduct disorder in the same way you would interpret the lower cortisol levels one might have resting in a hammock on a porch on a balmy Sunday afternoon.

Hormonal correlates of the species-preservative system

Oxytocin (OT) is both a neurotransmitter in the brain and a peripheral hormone secreted from the posterior pituitary. It appears, from animal studies, to be involved in nearly all aspects of mammalian maternal and pair bonding behavior, i.e. the species-preservative system, although in humans OT data are scarce. It is synthesized primarily in two hypothalamic nuclei, the paraventricular (PVN) and supraoptic (SON) nuclei. From there secretory neurons project to the posterior pituitary from which oxytocin is released into

the general circulation as a hormone playing a critical role in parturition and nursing. There are also projections of OT fibers arising from parvocellular neurons in the PVN found in many areas of the limbic system as well as in several autonomic centers in the brain stem where it functions centrally as a neurotransmitter. Levels of centrally active OT and peripheral OT appear to be somewhat independent and it is central oxytocin that accounts for most of the maternal and prosocial species preservative behavior when it is manipulated experimentally (see Carter & Keverne (2002) for review). Oxytocin administered directly into the ventricles of the brain of virgin female rats induces full maternal behavior within minutes (Pedersen & Prange, 1979). In fact in rodents, with adequate levels of ovarian hormones, increasing central OT facilitates, and decreasing central OT (e.g. via antagonists or antibodies) inhibits, the onset of maternal behavior. Peripheral administration does not produce the same results in behavior (Insel *et al.*, 1999). Interestingly, if OT is blocked after several days of mothering experience, maternal behavior is not affected, suggesting that central OT is critical for the initial activation of maternal behavior, but not for the maintenance of established maternal behavior. In female prairie voles, treatment with OT quickly facilitates positive social behaviors, including social bonding (Carter *et al.*, 1999; Carter, 2004), although in males, vasopressin plays a dominant role.

Shift in motivational priorities in maternal behavior

A major factor in establishing maternal behavior in mammals appears to be the shift in motivational priorities toward selective reinforcement of mother–infant interactions, such as nursing, infant grooming, infant retrieval, physical contact, and protection of the infant, which are relevant to the infant's early physiological regulation, well-being, and survival. Research on the enodogneous opioid system, the dopamine system and the OT system, in relation to maternal behavior and the formation of social bonds, indicates that these three systems are likely to be involved in the shift in reinforcement toward selective, intimate interaction. Blocking opioid receptors with naloxone in postpartum rhesus monkeys reduces maternal initiation of caregiving and protective behavior toward the infant, including grooming and infant retrieval (Martel *et al.*, 1993). Blocking OT receptors has been shown to decrease maternal behavior in mammals, including decreasing the percentage of time a nursing mother rat grooms her infant compared to the time she grooms herself (Pedersen & Boccia, 2002). Dopamine–oxytocin interactions have been implicated in the formation of social bonds in some mammals (Aragona *et al.*, 2003) and it has been proposed that the rewarding effects of dopamine could be related to the strong positive emotional feelings associated with the formation of social bonds (Insel, 2003). In primates, there may be less exclusive reliance on these hormonal systems than in smaller brained mammals, and consequently more reliance on experiential and cognitive

influences to initiate a shift to preferential reinforcement of caregiver–infant interactions. This is an important point because it allows non-biological mothers and other individuals to provide high-quality caregiving.

Harlow (1986) and Scott (1968) demonstrated that social motivation and social bonding could arise independently of the reinforcing effects of basic rewards such as food and, by inference, all other conventional regulatory sources of gratification. It was argued that social bonding relied more critically on 'social' stimuli (namely, stimuli that emanate from living beings) such as bodily warmth, the comforts of touch, and various dynamic movements and odors of social interaction (Panksepp *et al.*, 1999). Compassionate behavior often involves responding to social stimuli that emanate from living beings and is likely dependent on systems that mediate reinforcement of cooperative and prosocial behavior. Bowlby (1988) argued that mother–infant attachment bonds, based as they are on a sense of security and emotional trust as well as satisfaction arising from social contact, provide the foundation for all subsequent social relationships. The significant behavioral, psychological and physiological consequences that result from the severance of such bonds are well established and will be discussed below.

The importance of the organization of the species- and self-preservative systems

In describing the components and infrastructure of the self- and species-preservative systems, it is important to remember that the presence of these components does not guarantee the proper functioning of the systems; their organization is key. The organization of the system determines how the components are integrated.

From the discussion thus far, species-preservative behavior appears to be characterized as calm, nurturing and regenerative but it can also be active and mobilizing, such as in rescuing someone from a dangerous situation, maternal aggression and partner protection. These behaviors use pathways normally associated with the self-preservative system, for example, sympathetic nervous system and amygdala activation, yet they occur under the organization of the species-preservative system. The same pathways are used but the organization of the system depends on the inclusiveness of the 'I' using them.

According to Buddhist teachings for bodhisattvas (beings, motivated by compassion, who vow to work for the liberation of all beings), the first option when dealing with cruelty is of course to consider peaceful means, pacifying and calming with words, with comfort, etc. If that doesn't work, the second option is to give the person something, a gift that will calm the waters, which could be something tangible or intangible, like knowledge. If that doesn't work, the third option is to use power to subdue the person, and then, the very last resort is ferocity or wrath . . . even violence. Theoretically speaking, violence can be permissible if it's done out of compassion; however, in practice

it is very difficult because violence often generates more violence (Dalai Lama, in Goleman 2003: 288). An important focus here is that action is taken against the cruelty, not the person, and the goal is subduing, not attacking. The same systems of physiological mobilization are used, but they are organized from the species-preservative perspective.

Similarly, Porges (1998) suggests that because of the presence of OT, behaviors that would normally be associated with defeat or defense, such as immobilization, can be associated with species-preservative behaviors, such as nursing or mating. As an experiential example of the difference between conditions when mobilization and alarm are elicited under the organization of species- and self-preservative systems, compare the difference in feeling and the degree of inclusiveness of the 'I' after you have rushed to rescue a child from being hit by a car, and after you have rushed to overtake someone to secure a place in front of them in line.

Under conditions of safeness and the organization of the species-preservative mode, cortisol responses may be associated with engagement and sensitivity instead of fear and arousal. Mothers who had higher plasma cortisol engaged in more affectionate approach responses with their infants, exhibited higher intensity of maternal behaviors (Fleming *et al.*, 1987) and showed more sympathetic and alertness responses to infant cry stimuli (Fleming *et al.*, 1997). First-time mothers with higher cortisol levels were also better able to recognize their own infant's odors (Fleming *et al.*, 1997). Hart *et al.*, (1995) observed that cortisol was positively related to social competence in school children. Sensitivity and compassion require an openness to engagement which has been associated with a responsive cortisol system. Singer (1974) introduced the concept of an engagement–disengagement axis as the primary underlying dimension that seemed to be directly reflected in the cortisol system. Again, the social context, the inclusiveness of the 'I', the system from which one is responding and the level of engagement all determine the 'meaning' of cortisol responses.

Some studies in humans and in nonhuman primates have shown that lower levels of serotonin or serotonin metabolites are associated with higher levels of aggression and decreased affiliative behavior (Higley *et al.*, 1996). However, Kraemer and Clarke (1996) found that rearing conditions and the neurobiological organization accompanying those conditions changed the relationship between the neurotransmitter and the behavior. They report that correlations between serotonin metabolites and aggression may exist in some brain organizational states, not because variation in psychosocial experience has specific effects on the brain serotonin system, but because correlations between measures of neurobiology and behavior occur when neurobiological systems are organized in the usual way and not otherwise. The organization of a system determines the relationships between component parts and components that are significantly associated under one organizational condition may be dissociated under another. This point suggests that it may not be

successful to merely 'add or subtract' components to achieve a certain outcome; however, it does argue for designing social and physical environments that support physiological organization based on safeness and an inclusive sense of 'I' which can facilitate the emergence of prosocial behavior, including compassion.

Oxytocin and familiarity

Oxytocin has been associated with positive states such as physical proximity, touching, prosocial behavior, and the ingestion of food (Carter *et al.*, 1999; Uvnas-Moberg, 1999) and can reduce stress-induced increases in cortisol in rats (Carter, 1998), as does the presence of a bonded partner in guinea pigs (Sachser *et al.*, 1998). Oxytocin can also facilitate the extinction of an active avoidance response (Ibragimov, 1990; Kovacs & Telegdy, 1985), perhaps reducing the stubbornness of avoidance which is an important aspect of the species-preservative system, i.e. the ability to initiate social behavior and contact even after aversive interactions.

In various animal experimental models, OT was shown to facilitate bonding and attachment or simply to increase the amount of social contact between individuals. A lowered level of suspicion or aggression is an important aspect of increasing social contact (Uvnas-Moberg, 1999). Reduction of 'stranger anxiety' and increased social contact with central administration of OT has been reported in rats (Witt *et al.*, 1992). Oxytocin is critical for processing social information, especially recognition of others as 'familiar,' yet oxytocin does not seem to be critical for responding to the familiarity of non-social stimuli (Ferguson *et al.*, 2002).

The feeling of positive recognition and familiarity toward others inhibits aggressive behavior, and lack of familiarity can make aggressive behavior non-aversive to the perpetrator. 'As long as others are not familiar, i.e., personally relevant, it will not hurt to see them hurt' (Henry, 1993). Oliner and Oliner (1988) reported in a study of Christians in Germany who personally took risks to rescue Jews during the Second World War that the rescuers were not only more attached to their own families but also felt a greater sense of familiarity with all people compared to 'nonrescuers.'

> Just as rescuers' greater proclivity toward attachment to others emerged early in life, so did their inclusive orientation – their feelings of connection to diverse people and groups. While they shared with nonrescuers similar perceptions of their likeness to other Christians, they were significantly more likely to perceive their likeness to Jews and Gypsies. Their sense of shared similarities with Jews is particularly striking. Twice as many rescuers as nonrescuers reported feeling 'very much like Jews'. In fact, their sense of psychological proximity to Jews was no different from what they felt toward other Christians.
>
> (Oliner & Oliner, 1988: 175)

Many meditative and spiritual practices involve the perception and treatment of others as familiar, i.e. like oneself. In the Bible, it is recorded that Jesus said 'Love thy neighbor as thyself' (Matthew 22:39, King James version). The Dalai Lama explains that the process of 'familiarizing' oneself with an inclusive orientation does not occur by simply repeating the word 'compassion' like a mantra every moment:

> That is not the process of familiarization. The process rather involves directing every conscious thought toward the goal of cultivating compassion so that whatever activity the individual engages in, it is always from that orientation.
>
> (Dalai Lama, in Goleman, 2003: 218)

Ricard provides further detail:

> In the sutras, it explains how to do that in every single gesture. When getting up, one thinks, 'May I get up to deliver all sentient beings from suffering.' When tying one's belt one thinks, 'May I cultivate the belt of mindfulness.' When coming down the steps, 'May I go down again to take beings from suffering.' When opening a door, 'May the door of liberation be open for sentient beings.' When closing it, 'May the door of suffering be closed for sentient beings.' In that way, every instant is filled with the thought of compassion.
>
> (in Goleman, 2003: 218)

Wallace describes a common Tibetan meditation on compassion emphasizing familiarity:

> You view all sentient beings as if they were your mother, bearing in mind that in some past life they all must have actually been your mother. This is done to arouse a sense of affection and gratitude by focusing on the person who has shown you the greatest love and compassion.
>
> (in Goleman, 2003: 143)

This can be viewed as a strategy for maintaining a species-preservative system perspective and physiologic organization.

Familiarity with our own thoughts and feelings is also critical for diffusing negativity. Ricard relates the importance of the concept of familiarity in meditation practice:

> When we speak of meditation, the word used in Tibetan really means 'familiarization.' We need to familiarize ourselves with a new way of dealing with the arising thoughts. At the beginning when a thought of anger, desire, or jealousy arises, we are not prepared for it. So within

> seconds, that thought has given rise to a second and a third thought, and soon our mental landscape becomes invaded by thoughts that solidify our anger or jealousy – and then it's too late . . . One may wonder what people do in retreats, sitting for eight hours a day. They do precisely that: They familiarize themselves with a new way of dealing with the arising thoughts. When you start getting used to recognizing thoughts as they arise, it is like rapidly spotting someone you know in a crowd. When a powerful thought of strong attraction or anger arises that you know is bound to lead to a proliferation of thoughts, now you recognize it: 'Oh, that thought is coming.' That's a first step. That helps a lot to avoid being overwhelmed by this thought.
>
> (in Goleman, 2003: 214)

Familiarity is a fundamental component of the species-preservative system and is a critical component in the development of compassion.

> In a sense, all human beings belong to a single family. We need to embrace the oneness of humanity and show concern for everyone – not just my family or my country or my continent. We must show concern for every being, not just the few who resemble us. Differences of religion, ideology, race, economic system, social system and government are all secondary.
>
> (Dalai Lama, 2002a: 80)

Summary

Particular brain structures, autonomic nervous system developments and appropriate hormonal milieux provide the foundation for the self- and species-preservative systems. Compassion likely emerges from the species-preservative, social engagement system that includes bonding, caregiving and familiarity of others. Prefrontal cortex, cingulate cortex, the ventral vagal complex, oxytocin and cortisol all appear to be important in accessing the species-preservative system. These components all play a role in allowing us to participate safely in the immediacy of the moment, to engage fully in looking, listening and feeling in our interactions with others and within ourselves. Our awareness goes beyond ourselves and includes others. The awareness is not just mental but also emotional and physical. We not only 'know' others; we also 'feel' others. This kind of awareness requires openness to engagement and requires appropriately responsive hormone, autonomic and brain systems to mediate that awareness. If our self-regulation is significantly challenged by our own negative affect, then these systems are preempted by the more primitive self-preservative mode of organization which can interfere with our 'feeling' of others.

The important point here is that though many of the pathways,

neurotransmitters and hormones may overlap in the two systems, the organization of the self- and species-preservative systems is distinct. Although there is strong evidence that certain systems, such the OT system, are critical for certain affiliative and maternal behaviors and may mediate the positive benefits of social support, it is in the context of the organization of the species-preservative system (including brain activity, autonomic activity and multiple hormone and neurotransmitter systems) that OT is related to these behaviors. Under a different system of organization, levels of OT may or may not be significantly related to prosocial and affiliative behaviors. Heinrichs *et al.* (2003) reported that intranasal OT administered in the context of social support was more effective at reducing anxiety and cortisol responses to a stressful task than was OT administered in the context of no social support.

Physiological organization based on the recently evolved mammalian species-preservative as opposed to the ancient self-preservative system gives rise to parental care, nursing, social interaction, pair bonding and mutual defense. In some cases, stress during infancy that is severe enough to create insecure attachment facilitates a permanent bias towards self-preservation as an adult (Henry & Wang, 1998). In the next section of the chapter I will argue that an individual whose physiology is biased toward self-preservative organization (and a separate sense of self) will be less likely to experience compassion because of the necessity of committing resources and attention to 'managing' negative affect that consistently arises from the perception of challenge to control, and that a major contributing factor to the bias toward self-preservation is inadequate early caregiving. Negative emotional arousal is associated with focus on the self (Wood *et al.*, 1990) and self-preservation. Physiological organization based on the self-preservative system prevents full access to the species-preservative system and, therefore, the spontaneous emergence of compassion.

Extension of the model

Henry & Wang (1998) argue that the physiological system associated with affiliation, prosocial behavior and compassion, the 'species-preservative' system, is predominant in a safe environment but can be short-circuited under unsafe conditions of threat, isolation or chronic stress and pre-empted by the more primitive self-preservative system. The inclusiveness of an individual's sense of 'I' and the prominence of the self- or species-preservative pattern of physiological organization is likely determined by the profound effects of the individual's experience during development, especially early caregiving experience, on later functioning (Commons & Miller, 1998; Grossman and Grossman 2004; Schore 2001; Spangler & Grossman, 1993).

Importance of synchronicity in caregiver–infant interactions for self-regulation and consequences of disruptions in maternal care

Synchronous affective communication between infant and caregiver provides support for the infant's emerging bioregulatory abilities and this fosters resilience of stress coping capacities and self-regulation throughout life. The experience of the caregiver and child's micro-level matching of affective states and level of arousal provides the basis for children's social development, empathy, and moral internalization (Feldman, 2003). The innate experience of a newborn's sense of interconnectedness either can be supported by continuation of the experience of oneness through consistent physical contact and synchronistic communication with the mother/caregiver, or can be diminished through repeated separation and isolation, chronic distress, and/or consistently non-synchronous interactions.

Pipp and Harmon (1987) suggest that early human bonds serve the function of developing homeostatic regulation. Early relationship features, particularly the history of emotional responding and regulation, get mapped onto the biological structure of the infant and are carried forward across the lifespan. Porter (2003) reported that when mother–infant dyads spent a greater proportion of a laboratory play episode in symmetrical patterns of coregulation, infants showed higher vagal tone and greater heart rate variability. Symmetrical patterns of coregulation occur when there is mutual innovation of the communication sequence that takes place on the part of both partners (e.g. peek-a-boo). When infants experience a greater proportion of their interactions symmetrically with a caregiver, it is speculated that these relationship features aid in the formation of effective self-regulating strategies (Gable & Isabella, 1992; Gunnar 1994), perhaps through greater parasympathetic dominance. Schore (2002) notes:

> If attachment is the regulation of interactive synchrony, stress is defined as an asynchrony in an interactional sequence, and, following this, a period of re-established synchrony allows for stress recovery and coping. The regulatory processes of affect synchrony that creates states of positive arousal and interactive repair that modulates states of negative arousal are the fundamental building blocks of attachment and its associated emotions, and resilience in the face of stress is an ultimate indicator of attachment security.

Cross-cultural observations

Infant rearing practices in different cultures foster various levels of physical closeness and feelings of oneness between mothers and infants. Traditional African and Asian cultures have been described in terms of a high appreciation

of interrelatedness in their conceptions of relationships and competence (Harwood *et al.*, 1995; Kagitcibasi, 1997). The independent value orientation is mainly represented in Western industrialized societies (Markus & Kitayama, 1991). In this regard, it is interesting to note that African mothers watching videotapes of German mothers and their babies express concern about the lack of physical and emotional closeness they see. They wonder whether it might be forbidden in Germany to hold babies on the mother's body. 'They handle them as if they are not their babies, as if it belongs to somebody else or as if they are a babysitter' (Keller *et al.*, in press). Differences in American and Japanese perspectives toward infants are described by Kawakami (1987) in this way: 'An American mother–infant relationship consists of two individuals . . . On the other hand, a Japanese mother–infant relationship consists of only one individual, i.e., mothers and infants are not divided.' Mayan women respond with shock, disapproval and pity upon hearing that American babies are forced to sleep alone. They think of the practice as tantamount to child neglect (Morelli *et al.*, 1992). The capacity of self-regulation in babies raised under conditions of close physical contact and more interdependent values appears to be higher than those raised under conditions of less physical contact and a more independent orientation. Kagan *et al.* (1994) compared physiological reactions of four-month-old infants from Beijing with European American infants of the same age. They showed these infants a number of sensory stimuli, moving objects, and then looked at their behavior and found that the European American infants cried more, vocalized more, and fretted more. In short, they looked more worried and distressed.

Interestingly, it has been reported that some cultures rated as having a high degree of 'affectional and body bonding' are much more likely to be peaceful, i.e. have low rates of adult violence, than those rated with low infant affection (Prescott, 1996). In studies of aggression in primates, Kraemer and Clarke (1996) found that 'exposure to psychosocial risk factors, such as maternal privation, produces biological changes in offspring and increases the probability of violence.'

Animal studies of disruptions in maternal care

Animal studies show dramatic effects of maternal presence or absence on the self-regulating capacity of offspring in both infancy and adulthood. Hofer (1987) has carefully studied the critical function of the components of maternal behavior influencing specific biological regulatory systems in the rat. Meany and colleagues have shown that higher maternal responsiveness in rats in the form of increased licking and grooming is associated with greater self-regulatory capacities in offspring when stressed. Low licking and grooming mothers produced offspring that were more reactive to stress (Meany, 2001). Two independent groups have reported a decrease in oxytocin receptor bind-

ing in the amygdala following repeated mother–infant separations or decreased maternal licking and grooming (Francis *et al.*, 2000; Noonan *et al.*, 1994). Both high and low licking mother rats represent normal variations in rodent maternal behavior, yet these subtle differences appear to significantly affect stress reactivity and therefore self-regulation. Rats subjected to mild 'maternal deprivation,' defined as six hours of maternal separation during postnatal days 2–20 (Ladd *et al.*, 1996) or just three hours per day during postnatal days 2–14 (Husum & Mathe, 2002), showed long-term effects on brain systems that mediate stress. Plotsky and colleagues have also shown that three hours per day of maternal separation for the first two weeks of life has powerful and long-lasting influences on an organism's physiology and behavior (see Sanchez *et al.* (2001) for review). These effects include:

1 changes in stress-induced corticosterone response and increases in anxiety-like behaviors (Kalinichev *et al.*, 2002)
2 changes in the organization of neurocircuits involved in neuroendocrine regulation of arousal and vigilance behavior, regulation of autonomic nervous system tone, and regulation of fear or contextual conditioning (Sanchez *et al.*, 2001)
3 reduction of hippocampal mossy fiber density (Huot *et al.*, 2002)
4 facilitation of adult ethanol preference (Huot *et al.*, 2001).

If these subtle differences in maternal care and brief maternal separations lead to long-term significant differences in systems that mediate stress and organize neural circuitry of fear conditioning and self-regulation in rats, then it is necessary to ask whether cultural differences in human infant care, including frequency of physical contact, length of nursing and co-sleeping, would also lead to significant differences in these systems which could impact the organization toward species- or self-preservative modes and therefore the emergence of compassion.

Co-sleeping in humans

In fact, because humans are born the least neurologically mature of all mammals, develop the most slowly, and are the most dependent for the longest period of time, early disruption of synchronistic contact with the mother might be even more impactful on physiological regulation than in animals born more neurologically mature. Indeed, in the early phases of human infancy, social care, including holding, carrying and co-sleeping, are synonymous with physiological regulation (McKenna, 2000). Physiological data on mother–infant pairs co-sleeping for one night and sleeping separately for one night show that when co-sleeping, the mothers and infants spent more time simultaneously in the same state of sleep or wakefulness (McKenna *et al.*, 1994). In other studies, it has been reported that children who co-slept with

their parents received higher evaluations from their teachers, were underrepresented in psychiatric populations (Forbes *et al.*, 1992), had higher self-esteem (Crawford, 1994), experienced less guilt and anxiety (Lewis & Janda, 1988) and felt more satisfied with life (Mosenkis, 1998). Children who never slept with their parents were harder to handle, dealt less well with stress and were rated as being more dependent on their parents than co-sleepers (Heron, 1994). Selection factors may constitute major confounding variables in these studies, yet the data suggest an interesting trend. When reflecting on this issue, it is interesting to note that Western industrialized human beings are the only mammals that force their young to sleep alone . . . and yet there has been little systematic research on the impact of this accepted practice. McKenna (2000) writes: 'Regardless of where parents want their children to sleep, parents should be reminded that as a beginning point for understanding, infants, children and their parents are biologically and psychologically designed to sleep close.'

In many traditional cultures infants are carried the greater part of the time, some over 90 per cent of daylight hours. In the United States, holding and carrying infants occurs on average only two to three hours a day in the first few months of life and even less for older infants (Field, 2001). Barr (1990) showed that increased holding by mothers tends to result in infants that cry less. The benefits of body contact for all infants, but especially premature infants, including weight gain and clinical improvement, have been documented (Field, 2001).

The mother/caregiver's consistent presence and physical contact is an important factor in the organization and emergent self-regulation of the infant's physiological system.

> The mother initially provides an external regulating mechanism for many of the physiological mechanisms that the infant possesses but does not regulate itself. These effects are mediated by effects of the mother on the infant's neurobiological processes. At some point in development the infant becomes self-regulating through the development of internal regulatory mechanisms entrained to the stimuli that the mother provides.
>
> (Kraemer *et al.*, 1991)

It has been suggested that the stimuli provided by the mother during co-sleeping are so important to regulation of the infant that lack of physiological regulation of the infant during solitary sleep may be a cause of the significantly higher rate of sudden infant death syndrome in Western industrialized countries (Konner & Super, 1987). It is possible that infant care practices affecting development of early self-regulatory abilities in a particular culture may influence how naturally and spontaneously individuals in that culture will experience compassion.

Social deficits in primates due to early maternal separation

Social deficits in rhesus monkeys as a result of disruptions of maternal care and subsequent rearing in standard primate nursery care have been reported by several investigators (Chamove *et al.*, 1973; Erwin *et al.*, 1973). More recently, in a study comparing nursery reared (NR) and mother reared (MR) rhesus monkeys, reciprocal social behaviors and cerebrospinal fluid levels of oxytocin (OT) were significantly reduced in NR animals and agonistic behaviors were increased (Winslow *et al.*, 2003). MR and NR monkeys exhibited profound and persistent differences in social and emotional behavior and a significant relationship between reduced levels of OT and reduced affiliative behavior was observed across rearing conditions.

Consistent with previous studies, 'monkeys removed from their mother shortly after birth and raised in standard nursery conditions developed a syndrome characterized by decreased affiliation, increased aggression, and increased self-directed, repetitive behavior' (Winslow *et al.*, 2003). In the presence of a familiar companion, MR but not NR monkeys showed an increase in social contact, a reduction in abnormal repetitive behaviors, and a reduced cortisol response. These results suggest that rearing conditions have long-term effects on both social behavior and central OT concentrations as well as confirming that deficits in positive social interactions by NR monkeys are particularly evident in reciprocal behaviors such as allogrooming. These data suggest that abnormal rearing influences the normal development of brain OT systems and social competence in rhesus monkeys.

The precise mechanisms by which early social deprivation results in subsequent social deficits are largely unknown; however, the differences in OT between groups and the correlations between OT and positive social interactions suggest that the OT system is involved. Just as early visual experience appears critical for the development of normal visual acuity, one might hypothesize that appropriate social experience early in development modulates the development of neural pathways required for subsequent social behavior (Winslow *et al.*, 2003). Other investigators have suggested that infants that experience early stress, without the opportunity for consistent sensitive regulatory interactions with a caregiver, will show significant differences in brain development and social behavior (Prescott, 1996; Schore, 2001; Teicher *et al.*, 2003).

Prescott (1971, 1976) proposed that somatosensory affectional deprivation (SAD) underlies maternal–social deprivation, and identified somesthetic (body touch) and vestibular–cerebellar processes (body movement) as the two critical emotional senses that define the sensory neuropsychological foundations for maternal–infant affectional bonding. He emphasized the cerebellar regulation of limbic system activity that mediates emotional–social behaviors as a crucial component of regulatory effects of mother–infant bonding demonstrated by W.A. Mason (1968), who found that the isolation rearing of

infant monkeys on a 'swinging mother' surrogate (vestibular–cerebellar stimulation) prevented the development of the many deficits associated with maternal separation.

Reviewing the neurobiological consequences of disruptions of attachment during critical periods of early development, Van der Kolk (1987: 39–40) notes that separation from the mother produces a protest/despair response in all primates and argues that 'social attachment is not only a psychological event; it is related to the development of core neurobiological functions in the primate brain.'

Though the mechanisms are not yet clear, it is clear that lack of consistent physiological regulation by the mother results in significant long-term deficits in developing infants. There appears to be an overlap between the qualities associated with compassion (and the species-preservative system) and the long-term deficits associated with maternal deprivation (see Table 3.1).

The Dalai Lama has said that the mother–infant bond is an origin and a natural expression of compassion (Goleman, 2003: 10). It is also the origin and natural expression of the species-preservative system. It appears that many of the qualities of the species-preservative system that are dependent on adequate and consistent caregiving experiences are also qualities that are important in developing compassion. If the early caregiving experience is disrupted, inconsistent or insensitive to the infant, there is ample evidence to suggest that there will be deficits in these same qualities and, perhaps, less likelihood of the spontaneous emergence of compassion.

Traumatic stress

These same deficits can emerge from traumatic stress after infancy (Herman, 1992), with similar effects of interfering with feelings of affiliation and

Table 3.1 Relation of qualities associated with compassion and deficits associated with maternal deprivation

Qualities of the species-preservative system associated with compassion	*Deficits associated with maternal deprivation*
Self-regulation	Decreased self-regulation
Sensitivity/prosocial behavior toward others	Decreased sensitivity/prosocial behavior toward others
Desire to relieve suffering/decreased agonistic behavior	Increased agonistic behavior
Behavioral flexibility (less stereotypy)	More stereotypy
Capacity for reciprocal social interactions	Reduced capacity for reciprocal social interactions
Affiliation/kindness	Less affiliative behavior

compassion. The impact of extreme stress can be minimized depending on whether a familiar, sensitive, safe caregiver is available, as suggested by Bowlby (1988) in describing the effects of the bombing of London in the Second World War on two groups of children. He and colleagues noticed that children who had been evacuated from war zones (and separated from their parents) were far more disturbed by their wartime experiences than those who had stayed with their mothers during the bombing of London (Palmer, 2001). This would suggest that the profound regulatory effects of being with the mother prevented the children from going into a self-preservative physiologic organization with its separate sense of self. Data strongly suggest that sensitive, responsive, secure caretaking plays an important role in buffering or blocking stress-induced elevations in cortisol for infants and young children (Gunnar *et al.*, 1998) as well as in nonhuman primates (Levine & Wiener, 1988). Interestingly, Liddell (1953) found that he could easily create experimental neurosis with unpredictable mild shocks to the forelimbs of lambs, but only if the mother was not present. If the mother was present, he could not induce experimental neurosis. Whenever the self-preservative system organization dominates with the sense of a separate 'I', whether from early inadequate care, later trauma or both, safeness is threatened, control is paramount, and negative affect increases and must be constantly managed. These conditions interfere with the experience of the more inclusive 'I,' compassion for oneself and therefore compassion for others.

Summary

Healthy attachment between infant and caregiver that includes sensitive and synchronistic physical and emotional interactions leads to more effective physiological regulation in the developing child. Infant care practices in various cultures differentially emphasize physical contact, familiar caretakers, co-sleeping and responsivity to infants' distress. It remains to be seen whether less physically interactive infant care practices represent disruptions in maternal care that could compromise the development of qualities that facilitate the emergence of compassion.

More effective self-regulation leads to less distress from negative arousal, better accuracy in perceiving internal states, but less self-focus, less defensiveness and less need for control. Since there is less internal negative arousal, there is greater willingness and capacity to approach others who are suffering, more capacity for awareness of others, more connection and sense of familiarity with others, and therefore more likelihood of spontaneous expression of compassion.

Inadequate caregiving interactions, or repeated or prolonged maternal/caregiver separation, lead to less effective self-regulation, more obstruction from internal negativity, and less accuracy in perception of internal states. Internal distress leads to exaggerated self-focus, need for control, defensive

behavior and avoidance, therefore less capacity for awareness of others, less feeling of connections with others, less willingness to approach others who are suffering, more feelings of alienation/unfamiliarity, and therefore less likelihood of the spontaneous expression of compassion.

Accurate perception of internal states and exaggerated self-focus may sound similar but are quite distinct. Accurate awareness of oneself with compassion allows us to observe our feelings and perceptions without reactivity and without judgment. It does not short-circuit our capacity to stay engaged in the present moment. Exaggerated self-focus compels us to react reflexively in an attempt to minimize our own distress by defensive and controlling strategies such as avoidance, aggression and withdrawal, all of which obstruct our full engagement in the present moment. Effective self-regulation permits us to stay more in touch with ourselves in the current reality, even when negativity arises. It is through the realization of ourselves and our deeper nature in the here and now that we rediscover our compassionate nature.

> What are we to be in touch with? The answer is reality, the reality of the world and the reality of the mind. To be in touch with the mind means to be aware of the processes of our inner life – feelings, perceptions, mental formations – and also to rediscover our true mind, which is the well-spring of understanding and compassion. Getting in touch with true mind is like digging deep in the soil and reaching a hidden source that fills our well with fresh water. When we discover our true mind, we are filled with understanding and compassion, which nourishes us and those around us as well.
>
> (Thich Nhat Hanh, 1998: 3)

Affiliation vs compassion

Compassion is often experienced in relation to our loved ones and, as we have seen, there is an overlap between the physiology of affiliation and the physiology of compassion. In fact, many mammals exhibit this type of 'compassion' in their affiliative behavior. Yet, when we examine compassion in relation to strangers or in relation to those who have harmed us, we are tapping into a uniquely human dimension of compassion that is not related to affiliation or love. It is in this dimension that we can discriminate compassion and affiliation.

Gilbert (personal communication, July 19, 2003) notes:

> Compassion need not even involve affection as such but rather care and empathic understanding. To have compassion for those who hurt us does not imply we have affection for them. Nor does compassion depend on wanting 'a relationship' but like sympathy it is being moved by the suffering (or ignorance) of another. One can feel compassion for those we

> might never meet (the starving children in Africa). Without empathy compassion would lack the understanding of the other. Without sympathy empathy can be cold, indifferent or even exploitative.

What is it about humans that allows us to experience the oneness, the connectedness to others without the help of the physiology of love and affiliation, even in the face of others harming us? It appears to involve maintaining an inclusive sense of 'I' such that the self-preservative system associated with a separate sense of 'I' doesn't take over exclusively, and therefore rule out the possibility of maintaining the awareness of the other's humanity. It is the awareness of the other's humanity, as well as our own, that allows us to maintain an inclusive sense of 'I,' maintain organization from the species-preservative system perspective and experience compassion. The Dalai Lama (2002a: 76) says: 'Real compassion is based on reason. Ordinary compassion or love is limited by desire or attachment.' However, real compassion also needs the emotional/physiological infrastructure of the species-preservative system and the sense of a more inclusive 'I' to have access to the awareness of the interconnectedness of humanity and compassion. When one is operating from and motivated by that system, then reason can do its work. Without that awareness, reason justifies tremendous cruelty. Deficits in the development of the infrastructure of the species-preservative system hinder the emergence of compassion, but not reason, and allow the perpetration of and justification for extremely inhumane behavior based on reason. The Dalai Lama (2002b), in another text, makes a similar point: 'our intelligence and capacity for reason and calculation also make us potentially the most destructive life form on earth' (p. 79), and explains that reason alone is not sufficient:

> So relying on reason alone is dangerous. Look where our 'reason' and 'intelligence' have brought us! Reason in itself is blind to the considerations of deeper moral questions; we need qualities of the heart to counterbalance the force of our intelligence. It is our basic humanity that must guide our intelligence in the positive direction. The key to genuine peace lies in each of us reconnecting with the power of our mother's love, the affection that nurtured us when we were all children . . . Even as a vision based on proper motivation can lead to wonders, when one's motivation is divorced from basic human feeling, its potential for destruction cannot be overestimated.
>
> (Dalai Lama, 2002b: 76, 79)

Cultivating compassion without affiliation and the importance of enemies

It is difficult, to say the least, to maintain the inclusive sense of 'I' when one is being mistreated. The Dalai Lama reports a story about an extraordinary Tibetan monk who was captured by Chinese soldiers:

> He told me that while he was in a Chinese Communist gulag for almost eighteen years, he faced danger on a few occasions. I thought he was referring to a threat to his own life. But when I asked, 'What danger?' he answered, 'Losing compassion toward the Chinese.' He considered this to be the danger! Most of us would feel proud to tell others about how angry we got, as if we were some kind of hero.
>
> (Dalai Lama, 2002a: 62)

To develop and strengthen this uniquely human dimension of compassion, it is necessary to train oneself in the midst of adversity and conflict. Again the Dalai Lama:

> Enemies provide us some of the best opportunities to practice patience, tolerance, and compassion. Shantideva [an Indian scholar-yogi] gives us many marvelous examples . . . 'For a practitioner of love and compassion, an enemy is one of the most important teachers. Without an enemy you cannot practice tolerance, and without tolerance you cannot build a sound basis of compassion. So in order to practice compassion, you should have an enemy.'
>
> (Dalai Lama, 2002a: 75)

The idea here appears to be to participate voluntarily in situations that would normally arouse negative affect: instead of reacting to the negative arousal, one practices tolerance and maintaining awareness of the other's humanity, which prevents lapsing into a separate sense of self, i.e. one maintains an inclusive sense of 'I.'

Varela and Depraz (2003) describe the Buddhist practice of tonglen as a kind of mind training that when practiced leads to a progressive softening or weakening of the automatic position of 'me first' characteristic of our cognitive ego or self. It involves breathing in the pain, darkness, sorrow and heaviness of the chosen scene and breathing out from one's core openness, warmth and release back into the person or situation. It is based on the existing intersubjective nature of one's experience and the exchange is possible only because humans are already immersed in a network of empathic relations.

> One's cognitive identity is inseparable from this foundation. Tonglen

> seems to exploit explicitly the fact that each person's individual life is like a hologram of human social life, with its bonds and interpersonal circulation. Through this training, which initially goes against the river of our phylogenetic heritage of self preservation, the opposite of a 'private' thing, the true nature of experience comes to the fore.
>
> (Varela & Depraz, 2003: 221)

Compassion, ideology and ethics

Thich Nhat Hanh (1998), a prominent Buddhist teacher, offers the following mindfulness training regarding fanaticism and intolerance:

> Aware of the suffering created by fanaticism and intolerance, we are determined not to be idolatrous about or bound to any doctrine, theory, or ideology, even Buddhist ones. Buddhist teachings are guiding means to help us learn to look deeply and to develop our understanding and compassion. They are not doctrines to fight, kill, or die for.
>
> (Thich Nhat Hanh, 1998: 23)

Groups based on shared humanity may oppose and abhor behavior of others but do not oppose and abhor the people themselves, therefore there is no justification for dehumanizing others. Groups based on separateness allow the hatred of the (real or imagined) behavior of others to extend to hatred and dehumanization of the people themselves. The sense of a separate self expands to a group level with even more destructive power. The Dalai Lama suggests a fascinating way to discriminate between these two perspectives:

> No society can claim to have a healthy value system so long as it cannot adjudicate between Hitler's fascism and Mahatma Gandhi's principle of nonviolence. I, for one, believe that human nature itself provides the criteria by which we can judge the ethical nature of diverse values. If, as a society, we have a healthy understanding of our compassionate nature, we can judge the ethics of a value simply on the basis of whether or not it genuinely resonates with this fundamental nature.
>
> (Dalai Lama, 2002b: 68)

The Dalai Lama's suggestion is that we can judge the ethics of a value by its resonance with our own fundamental nature when we are aware of the deep truth of our oneness, that is, when our physiologic system is organized from the species-preservative perspective. Morrison & Severino (2003) call this fundamental nature 'resonant attuned consciousness' and add:

> Morality, thus, is based on human relationships. To the extent that the way we attune to one another produces biological states that influence

> our being, our morality derives both from our relationships and our biology. What we deem to be right or wrong is relative to our biological state.

A Buddhist perspective on negativity and the luminous mind

A central aim in Buddhism is to eliminate negativity by means of eliminating erroneous ways of viewing reality. Ricard explains that as one's perception of reality (including the sense of 'I') becomes more free from distortion, negative emotions start to disappear, not because they have been kicked out, but because the original apprehension of the negative emotions was based on a distortion of the nature of reality.

> When we speak of freedom from negative emotion, the point is not so much to get rid of something but to dispel a mistake. To be free from an erroneous way of dealing with the arising of thought, free of an erroneous way of perceiving reality, we are not just blanking out our mind. There is not 'something' to get rid of. We are getting rid of unknowing, and of wrong perception . . . If you mistake a rope for a snake, when you recognize that it's a rope and not a snake, there is no snake that has gone somewhere.
>
> (in Goleman, 2003: 96–97)

An emphasis in Buddhist practice is on training the mind to correct the wrong perceptions that create distortions ('afflictions') and lead to becoming exclusively self-focused. What is interesting is that these objectives are not reached by suppression, denial or repression, but by adopting a deeper view – some would say a more accurate view – of the nature of reality. The Dalai Lama explains:

> When Buddhists talk about afflictions of mind not being an inherent part of the mind, certainly they are not claiming that these afflictions are not natural. Just like any other qualities of the mind, these afflictions are also innate aspects of the mind. Rather, the claim is that the afflictions have not penetrated into what is called the luminous nature of mind, which is seen as its most fundamental aspect. This claim is made on several premises. One is that the fundamental nature of the mind is luminous. The second is that all the afflictions we experience are rooted in a fundamentally distorted way of perceiving the world. In some sense they don't have a solid, stable support – they are not based on reality, so that makes them fragile . . . This luminous nature of the mind is not some high state, not something that you accomplish, but something that is primordial, fundamental and essential . . . By closely engaging with reality correctly, you then diametrically oppose and overwhelm

> the mental afflictions that, by nature, falsely apprehend the nature of reality.
>
> (in Goleman, 2003: 94–96)

Henry (1992) points out that correcting false perception can be very difficult because perception itself can be molded depending upon the organization of the physiological system:

> The perceptual process has an active organizing principle, including an element of purpose which tends to select and modify sensory messages. The attachment of value to signals that have been identified presumably comes through activation of the structures in the brain implicit in both positive and negative reinforcement. These structures give the animal an urge to repeat or desist from a repetition of any particular experience. It is this type of qualitative control, molding the very nature of the information, discarding some features and enhancing others, that constitutes a check on those who forget the picture we have of the environment is determined by the nature and set of the nervous system. Systematic as well as irregular distortions may creep in because of universal as well as individually determined prior patterning and censorship.
>
> (Henry, 1992: 24)

Our perception of ourselves, as separate or as being fundamentally connected to others, significantly affects our physiology, our thoughts, our perceptions, our behavior, and our expectations. The Dalai Lama also emphasizes the point that our perception of ourselves is extremely critical:

> Ultimately, how we act and behave in relation to our fellow humans and the world depends on how we perceive ourselves . . . If we think of our nature as essentially compassionate and cooperative rather than violent and competitive, we will tend to behave in certain ways, as well as expecting similar tendencies from others. In contrast, if destructive traits such as aggression and selfishness dominate our fundamental view of human nature, we will incline in the opposite way.
>
> (Dalai Lama, 2002b: 67)

My understanding of the meaning of compassion

Compassion is the feeling that arises from the realization of the deeper reality that we are all connected, we are all one. For most of us, compassion is experienced in response to loved ones, but the experience in its most expanded form arises from an awareness of the fundamental truth that we are all one. From this vantage point, 'me' as distinct from 'you' becomes less relevant. For a moment, we share a reality in which giving and receiving has

lost its directionality. The normal Western economic concepts of interpersonal interaction do not apply when we are in contact with this reality, i.e. when I give to you, I am not adding to you and subtracting from me. In nourishing you, I am nourishing myself because our experience of each other is not separate . . . we are fundamentally and powerfully connected. We are in communion, without the normal boundaries of ego, personality and defense.

Compassion and the mother–infant bond

Why does the Dalai Lama say that an origin of compassion as well as its natural expression is the mother–infant bond? My speculation is that this is because the mother–child relationship embodies most comprehensively, i.e. physically, emotionally and spiritually, the deep truth that we are undeniably and profoundly connected and that we share a reality of oneness. A growing fetus is nourished by the mother nourishing herself. Exactly when do her cells end and the baby's begin? Exactly when does her blood become the baby's blood? When does the 'ownership' of the mother's carbohydrates from the bread she eats change to the baby's? Can the mother 'decide' to keep proteins for herself and not share with the baby? The ancient dance of oneness between mother and baby starts long before birth and continues long after birth, if the natural, spontaneous awareness of this connectedness is allowed to continue without obstructions. This does not imply that the relationship is 'equal'. The focus here is on the experience of oneness. Can we participate in this state of profound truth in our everyday life? Is it possible for us to experience this more ultimate dimension of reality and compassion outside of the mother–child relationship? Buddhism teaches that our natural state is one of compassion and it is our false perceptions and our negativity that obstruct our perception of this reality. Ricard says 'When one sees things as they are, it becomes easier to rid oneself of negative emotion and to develop positive emotions . . . including a much more spontaneous and natural compassion' (Goleman, 2003: 86).

Though the Dalai Lama is under no illusion about the natural human tendencies toward cruelty and evil, he believes that deeper than those tendencies is the fundamental, luminous nature of awareness, which spontaneously expresses itself, when unobscured by mental afflictions, in compassionate, caring responses (B.A. Wallace, personal communication, March 4, 2004). This point of view suggests that our deepest nature includes dominance of the species-preservative system. The prevailing Western point of view squarely supports the idea that our basic nature is to be more cruel than kind and that nearly all behavior is guided by selfish motivation (Gilbert, Chapter 2), suggesting dominance of the self-preservative system. In this regard, it is interesting to note that these two points of view come from traditions in which cultural attitudes and practices regarding infant care are quite distinct. In Tibetan culture, there is close physical contact between mothers and infants,

including infants being carried most of the time, prolonged nursing and co-sleeping. Is it possible that our culturally accepted practices of infant care, including repeated maternal separation, affect our basic way of viewing the world?

Concepts of self

Here I would like to mention a basic difference in the concept of 'self' in Western and Buddhist thought discussed extensively by Galin (2003). In the West, we see a person as an entity and consider terms such as 'self, I, me, myself' as synonyms – which, when analyzed carefully, are not synonyms at all. Consider the statement 'I am not myself today.' Though we do not have difficulty intuitively understanding this statement, we are generally unaware that we consider a person an 'I' with one or more 'selves' (Lakoff & Johnson, 1999). In Buddhism, the self is not seen as an entity 'but as a dynamic process, a shifting web of relations among evanescent aspects of the person such as perceptions, ideas and desires. Ultimately, no separation is to be found between these dynamic processes and the universal frame of reference or ground of being; all is interdependent and changing' (Galin, 2003). This difference in perception of the self is important because when we shift from a self-preservative to a species-preservative mode, we are switching from an experience of 'self' that is a discrete entity to a 'self' that is interdependent and connected to others. The engagement in compassionate service to others promotes a shift in the 'I' to incorporate the other's point of view (Deikman, 1996).

Humans, and all mammals, are conceived and develop within their mothers. We are created and begin our lives in a physiological reality of oneness. We don't need to shift to incorporate our mother's point of view; we are part of her and she is part of us. We (and many mammals) are also born into our mother's community, which significantly affects our social development. From this embedded and inclusive sense of 'I,' not separate from our mothers, we can further develop and expand this inclusive experience of ourselves and others or we can develop a discrete sense of 'I' that is not perceived as connected to others. I have argued that if our early experience is predominantly one of safety and participation in synchronistic, harmonious dyadic interactions (the species-preservative mode), then our brain, autonomic and hormonal systems become organized toward an inclusive sense of 'I.' Conversely, if our early experience is predominantly one of distress, separation, and our interactions are predominantly either with inanimate objects or within non-synchronistic, non-harmonious dyads (the self-preservative mode), then our brain, autonomic and hormonal systems become organized toward a separate sense of 'I' and will show (a) different patterns of response and (b) different correlations between physiology and behavior, under certain conditions. Gilbert (1989) has called these two systems the 'threat–defence

and safeness systems.' It is well known that the effects of early experience are especially significant in subsequent emotional and social development, but the plasticity of the brain, i.e. its ability to change as a result of ongoing experience, is also significant. Figure 3.1 shows the inclusive 'I' state in which we are born and two possibilities for development depending on whether the self- or species-preservative system predominates.

While considering the consequences of the predominant activation of these systems, it is important to keep in mind that *Homo sapiens* has the worst record for violence against infants and children, and no wild monkey or ape mother has ever been observed to deliberately harm her baby (Hrdy, 1999). Most mammals under natural conditions follow species-specific patterns of social organization. In captivity, in general, it is the monkeys that have experienced significant disruptions in their maternal care that become abusive or inadequate mothers. As a group, it appears that we, as humans, have not preserved our innate species-preservative primate instincts as well as our closest genetic relatives. Yet it is we, as humans, that have the unique opportunity to become aware of and experience the interconnectedness of all life through the enhancement and expansion of the species-preservative system, our natural tendency to care, to love and to protect.

Thich Nhat Hanh explains this oneness in terms of 'inter-being':

> Nothing can exist by itself alone. It has to depend on every other thing. That is called inter-being. To be means to inter-be . . . Looking deeply into a flower, we see that the flower is made of non-flower elements. We can describe the flower as being full of everything . . . We see sunshine,

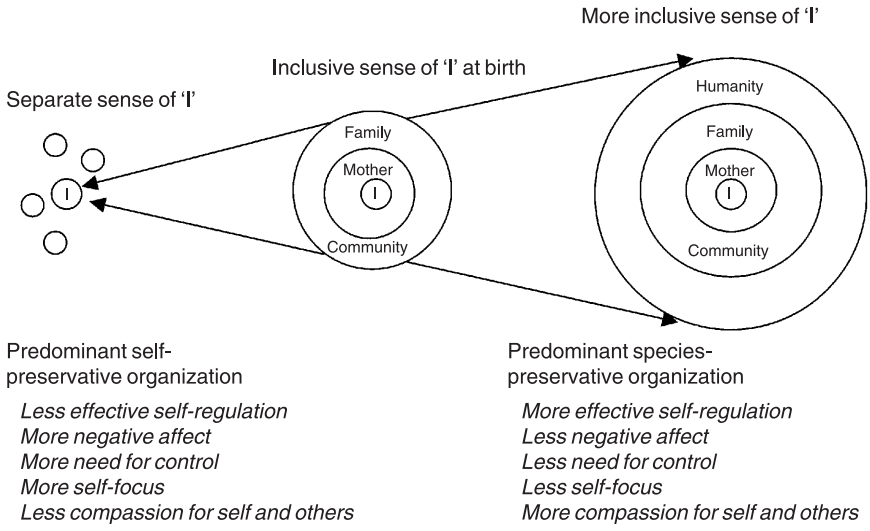

Figure 3.1 Inclusive sense of self at birth and two possible directions for development.

> we see the rain, we see clouds, we see the earth, and we also see time and space in the flower. A flower, like everything else, is made entirely of non-flower elements. The whole cosmos has come together in order to help the flower manifest herself. The flower is full of everything except one thing: a separate self, a separate identity. The flower cannot be herself alone. The flower has to inter-be with the sunshine, the cloud and everything in the cosmos. If we understand being in terms of inter-being, then we are much closer to the truth. Inter-being is not being and it is not non-being. Inter-being means being empty of a separate identity, a separate self.
>
> (Thich Nhat Hanh, 2002: 47–48)

The development toward predominance of the species-preservative system and a more inclusive sense of 'I' does not imply that a person does not individuate, take strong action or become a strong leader. It does imply that a person's sense of self is founded upon a deep realization of the interconnectedness of humanity. I don't think that anyone would argue that Gandhi, Martin Luther King, Mother Theresa, Jesus or Buddha, all of whom resonated with the oneness of humanity, were weak, dependent or non-individuated.

We all have our specific threshold of negative affect, in the form of threat, sadness, anger, fear, etc., at which point we switch temporarily from a species-preservative mode (more inclusive 'I') to a self-preservative mode (more separate sense of 'I'), and then another threshold at which point we feel safe enough to switch back again. Of course, the self-preservative mode is appropriate and necessary in situations where we must avoid or deal with imminent danger or secure basic physical needs, and activation of this system in those cases is adaptive; however, it is the elicitation of this self-preservative system in our everyday life in response to everyday events that becomes problematic. Chronic activation of the system can shift the threshold point such that a person is predominantly in the self-preservative mode with only temporary reprieves in the species-preservative mode. Many Buddhist practices seem to be aimed at training the mind to consistently allow the negative affect related to self-centeredness to diffuse such that the threshold to the activation of the self-preservative system is not reached, and in fact is shifted to a higher level. In this way, the species-preservative system, from which compassion arises, can predominate. For example, the Dalai Lama points out that a meditative practice aimed at enhancing the 'compassionate disposition' encourages one to develop an outlook where one disregards one's own desires and pursues the well-being of others. In terms of the model, the practice is not to exclude one's own interest, but to guard against prematurely switching over to the self-preservative mode:

> the aim is to develop a deep conviction of the negative consequences of excessive self-absorption or self cherishing. You are trying to counter a

> way of thinking where your self-centeredness is so strong that you are totally oblivious to others' well being. You are countering that self-centeredness, not the pursuit of self interest.
>
> (Dalai Lama, 2002b: 98)

Directions for future research

Richard Davidson and colleagues have initiated novel research projects on compassion and meditation at the University of Wisconsin Department of Psychology, with studies of brain activity of Buddhist monks and with studies measuring brain activity and immune outcomes in normal subjects after mindfulness meditation training and practice. In addition to their innovative approaches, one of the most important directions for future research is to measure simultaneously the physiology of two people during compassionate and non-compassionate interactions. Although one can experience compassion alone or during meditation, these are preparations for compassionate responding to a live person. The Dalai Lama says: 'if a person who has attained stability in his or her compassion training continues to stay in seclusion, that person is not really doing anything with compassion. That person should be out, running around like a mad dog, actively engaged in acts of compassion' (2002b: 91).

Focusing on absolute measures of hormones, autonomic activity or brain imaging in single subjects not interacting with anyone limits the results to a certain dimension of compassion. This is a dimension that Western science is familiar and comfortable with, namely a single individual responding to a stimulus with no attention focused on the interpersonal dimension. However, if compassion, as is suggested in this chapter, involves an inclusive sense of 'I' and an awareness of the oneness with the other, then some measure of physiological synchronicity or co-regulation should be detectable during a compassionate interaction with another person. There have been very few studies designed to measure synchronistic physiologic measures, and none I could find involving compassion, but interestingly, one study showed that it was during a married couple's negative interaction that physiological measures were most synchronous (Levenson & Ruef, 1992). Another study showed that cortisol levels of mothers watching a live videotape of their toddlers walking a balance beam for the first time in a separate room were significantly correlated ('physiologically attuned') with their child's cortisol levels if the mother was highly sensitive (Sethre-Hofstad *et al.*, 2002).

Work needs to be done on defining compassion, developing instruments to measure it and developing methods that include the spontaneity of emotional responding that the Dalai Lama considers to be critical to compassion.

> An important support for my thesis that human beings are fundamentally compassionate is our natural ability to connect spontaneously

> and deeply with the suffering of others. Ethnicity, culture, geography, and religion make no difference so far as this inherent capacity for empathy is concerned. An Eskimo from Greenland, a nomad from the vast plateau of Tibet, a broker from Wall Street in NY, all share this basic characteristic. For most of us, when we confront the sight of suffering – for example, a child crying, a man in agony, people dying of starvation – our immediate visceral reaction is sympathy. Often we feel as if we ourselves are undergoing this suffering. There is a certain spontaneity and directness in our natural reaction. It touches us profoundly as human beings. Such a reaction may seem inexplicable from a strictly rational point of view, but it indicates a profound interconnectedness among all living things.
>
> (Dalai Lama, 2002b: 73)

We should not confuse compassion with pleasure research, for example looking at brains of addicts receiving their drug of choice as being related to compassion. Though common reward pathways may be involved, these two responses are based on completely different systems of organization. Compassion occurs when we are open to experiencing others' suffering, which is not a positive emotion in any traditional sense of the term. Perhaps the association between compassion and positive emotion comes from the relief of our constricted and separate sense of 'I,' and the negativity associated with it. When we experience a moment of compassion, we experience a more inclusive sense of 'I' and a glimpse of our luminous nature. Wallace (personal communication, March 4, 2004) points out that this luminous nature of awareness can be experientially accessed through sustained meditative practice, which cognitive scientists have hardly begun to explore. Buddhism bases its theory of human nature on such profound contemplative experience, while cognitive science bases its theory of human nature on the behavior of normal and subnormal humans. Buddhism would say it probes to a deeper nature than that accessed by the cognitive sciences, without refuting what those sciences have discovered using their own methodologies.

Finally, much more work needs to be done to understand the organization and integration of brain, autonomic, neurotransmitter and hormonal systems of the self- and species-preservative systems as well as the integration within these systems. Kraemer & Clarke (1996) found that the specific interrelationships between biogenic amine system activity that developed soon after birth in mother reared monkeys did not materialize in socially isolated rhesus monkeys. They suggest that:

> primate brains are set up so that mechanisms that usually control behavior come into existence as a result of early attachment and later social interactions, and fail to organize otherwise. Thus, brain function, meaning the cohesive patterning of neural activity producing purposeful

behavior, normally depends on social attachment in nonhuman and presumably human primates.

Investigating the organization of the species-preservative system from which compassionate behavior emerges, and the impact of infant care practices, along with other variables, on the development of that system is of primary importance.

Summary

As Gilbert points out (Chapter 2), life evolved in very hostile circumstances with high mortality of young in many egg-laying species, and then with the evolution of mammals came a solution to high infant mortality . . . intensive and extensive parental care and bonding with the infant. This bond of attachment is a psychological and physiological template for all other relationships and supports the capacity for developing highly sophisticated skills of empathy, care, sympathy and compassion. As a result, we have the unique opportunity to think beyond the self, to recognize that we co-create experience in both self and other. Compassion facilitates the ability to co-create states that are safe and allows us to move out of the self-protective and self-preservative systems. When we do this we have the opportunity to discover different realms of our being. It is difficult for us to discover this when we are focused on threat and defense, but when we feel safe, neither vigilant of or defending against threats, nor seeking pleasures or self-enhancing goals, the organization of our neurophysiology can provide emergent experiences that offer new insights into the nature of 'being' and reality.

The components of the species-preservative caregiving system include the expanded neocortex, the thalamocingulate division, the ventral vagal complex, the responsiveness of the cortisol system and the oxytocin system, among others. However, the presence of these components does not guarantee the proper functioning of this newly evolved system; their organization is key. Cortisol levels may represent something quite different in a system that is threat-focused compared to one that is compassion-focused. One cannot therefore assume that 'levels of cortisol' are going to have the same meaning in different states of physiological and psychological organization. In particular, individuals that have been traumatized, or that have psychopathic disorders, and are very self-focused, can have blunted cortisol responses, perhaps signaling the shutting down of feeling, warmth and care associated with the species-preservative system.

Sensitive, consistent and synchronistic early care without major disruptions appears to foster organization toward predominance of species-preservative organization, a more inclusive sense of 'I' and perhaps more spontaneous emergence of compassion. Disruptions in quality early care, trauma and chronic stress appear to foster organization toward dominance of

the self-preservative system, a separate sense of 'I,' and interference with the spontaneous expression of compassion.

We have a challenging road ahead. With the advances in technology that blur the boundaries between countries, with the increased awareness of events in the world, with the increased awareness of the impact of our actions on others and the earth, there is no way to justify a view that favors some and dehumanizes others. The deeper reality of interconnectedness that the Dalai Lama describes is becoming more obvious every day, as demonstrated, for example, by the undisputed dependence of humans and other living things on the same ecosystem. Campbell (1988) describes the old world view:

> Love and compassion are reserved for the in-group, and aggression and abuse are projected outward on others. Compassion is to be reserved for members of your own group . . . Now, today there is no out-group anymore on the planet. And the problem of a modern religion is to have such compassion work for the whole of humanity.
>
> (p. 171)

He also notes that:

> When you see the earth from the moon, you don't see any divisions there of nations or states. This might be the symbol, really, for the new mythology to come. That is the country that we are going to be celebrating. And those are the people that we are one with.
>
> (p. 32)

Compassion invites us to full participation in our humanity, to a full recognition of the oneness of humanity. How will we respond to that invitation?

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Chapter 4

An attachment-theoretical approach to compassion and altruism

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> In Buddhism compassion is defined as the wish that all beings be free of their suffering.
>
> (N. Vreeland, in Dalai Lama, 2001)

For centuries, compassion has been a central virtue in all major religious traditions. It has also appeared – sometimes indirectly – in the literature on social psychology under headings such as empathy, altruism, and prosocial behavior (e.g. Batson *et al.*, 1999). In psychotherapy, compassion has been viewed as crucial, but again, often under different names – empathy, unconditional positive regard, containment or holding, client–therapist rapport, and working alliance. Compassion appears, partially disguised, in the extensive literature on good parenting, under headings such as availability, sensitivity, and responsiveness. In recent years compassion has become visible in its own right, partly because of the growing emphasis in educated circles on Buddhism, which highlights compassion (Dalai Lama, 2001, 2002), and partly because of the tendency for compassion to wear thin in cases of 'compassion fatigue' (e.g. Keidel, 2002), a common problem in the helping professions.

When one considers compassion from the standpoint of attachment theory (Ainsworth & Bowlby, 1991; Bowlby, 1969/1982; Cassidy & Shaver, 1999), the theoretical framework in which our own research is conducted (see Mikulincer & Shaver (2003) for an overview), compassion is associated with what Bowlby called the 'caregiving behavioral system' – an innate behavioral system in parents and other caregivers that responds to the needs of dependent others, especially (but not limited to) children. This behavioral system is thought to have evolved mainly to complement the 'attachment behavioral system,' which governs people's, especially young children's, emotional attachments to their caregivers (Gilbert, Chapter 2).

Much of the research based on extensions of Bowlby's child-oriented theory into adolescence and adulthood focuses on attachment, and individual differences in attachment, in the context of peer relationships, including romantic

relationships. In recent years, however, increasing attention has been given to caregiving, and to individual differences in caregiving, including caregiving that extends well beyond close personal relationships. In particular, we have found that being secure with respect to attachment – either dispositionally secure or momentarily secure because of experimental interventions – is associated with empathy and willingness to help others (Mikulincer & Shaver, in press).

The purpose of the present chapter is to review studies on attachment and caregiving in adulthood in search of answers to the following questions: What causes a person to be compassionate or uncompassionate toward others? What are the effects of compassion on its recipients? Can compassion be enhanced? Can professional caregivers' vulnerability to compassion fatigue be reduced? The chapter is organized as follows: First, we provide an overview of attachment theory. Second, we provide an overview of the caregiving system. Third, we examine the connection between attachment security and compassionate caregiving. Fourth, we consider how attachment and caregiving research has been, and can continue to be, extended to clinical settings. At the end, we offer suggestions for applying our findings concerning links between attachment processes and compassionate care.

Attachment theory: Basic concepts

According to Bowlby (1969/1982), because human infants are relatively premature, helpless, and vulnerable to harm when born, they have been equipped by evolution with a repertoire of behaviors (*attachment behaviors*) that assure proximity to 'stronger, wiser' others (*attachment figures*) who can provide protection, guidance, and assistance in the process of distress regulation. Although attachment behaviors are most important early in life, Bowlby (1988) claimed they are active over the entire lifespan and are manifest in thoughts and behaviors related to proximity seeking in times of need. As explained below, our research shows that extension of the theory to cover the entire human lifespan is both appropriate and scientifically productive.

Bowlby (1969/1982) claimed that proximity-seeking behaviors are organized into a specific behavioral system – the *attachment behavioral system*. A behavioral system is a biologically evolved, inborn program of the central nervous system that governs the choice, activation, and termination of behavioral sequences, and produces a predictable and generally functional change in the person–environment relationship. Behavioral systems can be conceptualized in terms of six features: (a) a specific biological function that increases the likelihood of an individual's survival and reproductive success; (b) a set of contextual activating triggers; (c) a set of interchangeable, functionally equivalent behaviors that constitute the primary strategy of the system for attaining a particular goal state; (d) a specific set-goal – the change in

the person–environment relationship that terminates system activation; (e) a set of cognitive operations that guide the system's functioning; and (f) specific links with other behavioral systems.

According to Bowlby (1969/1982), the attachment behavioral system is activated by perceived threats and dangers, which cause a threatened individual to seek proximity to protective others. The attainment of proximity and protection results in feelings of relief and security as well as positive mental representations of relationship partners and the self. Bowlby (1988) viewed this behavioral system as extremely important for maintaining emotional stability, development of a positive self-image, and formation of positive attitudes toward relationship partners and close relationships in general. Moreover, because optimal functioning of the attachment system facilitates relaxed and confident engagement in non-attachment activities, it supports the operation of other crucial behavioral systems, such as exploration and caregiving, and thereby broadens a person's perspectives and skills and fosters both mental health and self-actualization.

In addition to mapping universal aspects and functions of the attachment behavioral system, Bowlby (1973) described important individual differences in attachment-system functioning. He viewed these differences as largely derived from reactions of significant others (caregivers, attachment figures) to a child's attachment-system activation and from internalization of these reactions in *attachment working models* of self and others (i.e. mental representations, with associated emotional and behavioral tendencies). Interactions with attachment figures who are available and responsive in times of need facilitate optimal development of the attachment system, promote a sense of connectedness and security, and allow people to rely more confidently on support seeking as a distress-regulation strategy. In contrast, when a person's attachment figures are not reliably available and supportive, a sense of security is not attained, and strategies of affect regulation other than proximity seeking (*secondary attachment strategies*, characterized by *avoidance* and *anxiety*) are developed.

In studies of adolescents and adults, tests of these theoretical ideas have generally focused on a person's *attachment style* – a systematic pattern of relational expectations, emotions, and behaviors conceptualized as residues of particular kinds of attachment history (Fraley & Shaver, 2000). Initially, research was based on Ainsworth *et al.*'s (1978) three-category typology of attachment styles in infancy – secure, anxious, and avoidant – and Hazan & Shaver's (1987) conceptualization of similar adult styles in the domain of romantic relationships. Subsequent studies (e.g. Bartholomew & Horowitz, 1991; Brennan *et al.*, 1998) indicated that attachment styles are more appropriately conceptualized as regions in a continuous two-dimensional space, an idea compatible with early dimensional analyses described by Ainsworth and her colleagues (e.g. 1978: 102).

The first dimension, attachment *avoidance*, reflects the extent to which a

person distrusts relationship partners' goodwill and strives to maintain behavioral independence and emotional distance from partners. The second dimension, attachment *anxiety*, reflects the degree to which a person worries that a partner will not be available in times of need. People who score low on both dimensions are said to be secure or to have a secure attachment style. The two dimensions can be measured with reliable and valid self-report scales (e.g. Brennan *et al.*, 1998) and are associated in theoretically predictable ways with relationship quality and affect-regulation strategies (see Mikulincer & Shaver, 2003; Shaver & Clark, 1994; Shaver & Hazan, 1993, for reviews). Throughout this chapter we refer to people with secure, anxious, or avoidant attachment styles, or to people who are relatively anxious or avoidant (based on self-report scales that assess the two dimensions).

Attachment styles are initially formed during early interactions with primary caregivers (as thoroughly documented in an anthology edited by Cassidy & Shaver (1999)), but Bowlby (1988) contended that impactful interactions with significant others throughout life have the effect of updating a person's attachment working models. Moreover, although attachment style is often conceptualized as a global orientation toward close relationships, there are theoretical and empirical reasons for believing that working models are part of a hierarchical network of complex, heterogeneous, and both generalized and context- and relationship-specific attachment representations (Mikulincer & Shaver, 2003). In fact, research indicates that (a) people possess multiple attachment schemas (e.g., Baldwin *et al.*, 1996; Pierce & Lydon, 1998) and that (b) actual or imagined encounters with supportive or non-supportive others can activate particular attachment orientations (e.g. Mikulincer *et al.*, 2001), even if they are incongruent with a person's usual, more general attachment style.

Findings from studies of attachment processes in adulthood have been summarized in a model of the functioning and dynamics of the attachment system in adulthood (Mikulincer & Shaver, 2003). According to this model, the monitoring of experiences and events, whether generated internally or through interactions with the environment, results in activation of the attachment system when a potential or actual threat is encountered. This activation is manifest in efforts to seek and/or maintain actual or symbolic proximity to external or internalized attachment figures. Once the attachment system is activated, a person automatically (either consciously or unconsciously; Mikulincer *et al.*, 2002) asks whether or not an attachment figure is sufficiently available and responsive. An affirmative answer results in normative functioning of the attachment system, characterized by mental representations of attachment security and consolidation of security-based strategies of affect regulation (Shaver & Mikulincer, 2002). These strategies generally alleviate distress, foster supportive intimate relationships, and increase both perceived and actual personal and social adjustment.

Perceptions of attachment figures as unavailable or insensitive result in

attachment insecurity, which compounds the distress already aroused by an appraised threat. This state of insecurity forces a decision about the viability of proximity seeking as a protective strategy. When proximity seeking is appraised as viable or essential – because of attachment history, self-concept, temperament, or contextual cues – people adopt *hyperactivating attachment strategies*, which include intense appeals to attachment figures and continued reliance on them as a source of safety and support. Hyperactivation of the attachment system involves increased vigilance to threat-related cues and a reduction in the threshold for detecting cues of attachment figures' unavailability – the two kinds of cues that activate the attachment system (Bowlby, 1973). As a result, even minimal threat-related cues are easily detected (if not simply imagined), the attachment system is chronically activated, psychological pain related to the unavailability of attachment figures is exacerbated, and doubts about one's ability to attain safety and a sense of security are heightened. These concomitants of attachment-system hyperactivation account for many of the well-documented psychological correlates of attachment anxiety (see Mikulincer & Shaver (2003) for a review).

Appraising proximity seeking as unlikely to alleviate distress results in the adoption of *attachment-deactivating strategies*, manifested in avoidance or denial of stimuli and events that activate the attachment system and determination to handle distress alone (a stance that Bowlby (1969/1982) called 'compulsive self-reliance'). These strategies involve dismissal of threat- and attachment-related cues, suppression of threat- and attachment-related thoughts and emotions, and repression of threat- and attachment-related memories. These tendencies are further reinforced by a self-reliant attitude that decreases dependence on others and discourages acknowledgment of personal faults or weaknesses. These aspects of deactivation account for the well-documented psychological manifestations of avoidant attachment (again, see Mikulincer & Shaver (2003) for a review).

The caregiving system and its interplay with the attachment system

According to Bowlby (1969/1982), the caregiving system is designed to provide protection and support to others who are either chronically dependent or temporarily in need. It is inherently altruistic in nature, being aimed at the alleviation of others' distress, although the system itself presumably evolved because it increased the inclusive fitness of individuals by making it more likely that children and tribe members with whom the individual shares genes would survive and reproduce (Hamilton, 1964). Within attachment theory, the caregiving system provides an entrée to the study of compassion and altruism, and understanding this system provides a foundation for devising ways to increase people's compassion and effective altruism (Gilbert, Chapter 2).

'Caregiving' refers to a broad array of behaviors that complement an interaction or relationship partner's attachment behaviors or signals of need. The set-goal of such behaviors is reduction of the partner's suffering (which Bowlby (1969/1982) called providing a 'safe haven') or fostering the partner's growth and development (which Bowlby called providing a 'secure base' for exploration). In its prototypical form – that is, in the parent–child relationship – the set-goal of the child's attachment system (proximity that fosters protection, reduction of distress, safety, and a secure base) is also the aim of the parent's caregiving system. Signals of increased protection and security on the part of the person who needs help deactivate the helper's caregiving system. If we extend this conceptualization to the broader realm of compassion and altruism, the aim of the caregiving system is to alter the needy person's condition or situation so that signs of increased safety, well-being, and security are evident (Gilbert, Chapter 2).

Beyond explaining this complementarity between the attachment system of the support-seeker and the caregiving system of the support-provider, Bowlby (1969/1982) also delineated the psychodynamic interplay between these two systems *within* the person who assumes the role of caregiver or attachment figure. In his view, because of the urgency of threats to the self (especially during early childhood), activation of the attachment system was thought to inhibit activation of other behavioral systems and thus interfere with certain non-attachment activities. This process was clearly demonstrated in Ainsworth *et al.*'s (1978) research on the inhibition of children's exploration in a laboratory Strange Situation when an attachment figure was asked to leave the room. The same kind of inhibition often occurs in caregiving situations (Kunce & Shaver, 1994) if a potential caregiver's own well-being is threatened. Under conditions of threat, adults generally turn to others for support and comfort rather than thinking first about being support providers. At such times they are likely to be so focused on their own vulnerability that they lack the mental resources necessary to attend compassionately to others' needs for help and care. Only when relief is attained and a sense of attachment security is restored can people easily direct attention and energy to other behavioral systems. A relatively secure person can perceive others not only as sources of security and support, but also as human beings who need and deserve comfort and support.

In short, the aim of the caregiving system is more likely to be achieved when a person is secure enough to allow for a focus on someone else's needs. This ability to help others is a consequence of having witnessed and benefited from good caregiving on the part of one's own attachment figures, which promotes the sense of security as a resource and provides models of good caregiving (Collins & Feeney, 2000; Kunce & Shaver, 1994). Thus, we undertook our research on caregiving by hypothesizing that people who are dispositionally secure, or whose level of security has been contextually increased, would be more motivated and able to provide care for others. That

is, attachment-figure availability and the consequent activation of the sense of attachment security would foster engagement in caregiving activities. In contrast, attachment insecurities and worries can interfere with the activation of other behavioral systems, including caregiving.

Securely attached people's interaction goals and positive models of self and others also foster empathic compassion and the reduction of personal distress. Such people's comfort with closeness and interdependence (Hazan & Shaver, 1987) facilitates approach to others in need, because in order to be comforting and helpful a care provider typically has to accept other people's needs for closeness, sympathy, and temporary dependency (Lehman *et al.*, 1986). A secure person's mental representations of available and caring others may make it easier to construe a distressed partner as deserving of sympathy and compassion, and so may motivate the secure person to provide comfort and support to a needy other. Moreover, the secure person's positive models of self may help to maintain emotional equanimity while addressing a partner's needs, a task that can otherwise generate a great deal of tension and personal distress (e.g. Batson, 1987). Positive models of self also sustain a sense of control and confidence in one's ability to cope with a partner's distress, reduce one's own distress, and free resources to provide effective support.

Insecurely attached people may be less inclined to feel empathy and compassion toward a distressed partner. Whereas an anxious person's egoistic focus on personal threats and unsatisfied attachment needs may draw important resources away from altruistically attending to a partner's needs, an avoidant person's lack of comfort with closeness and negative models of others may interfere with altruistic inclinations and inhibit compassionate responses to a partner's plight. This does not mean, however, that anxious and avoidant people, although both are conceptualized in attachment theory as insecure, will react in the same way to a partner's distress. Whereas the anxious person's hyperactivating strategies may intensify the experience of personal distress without resulting in effective compassion, the avoidant person's deactivating strategies may encourage feelings of disdain or pity and decrease the inclination to provide assistance.

Anxiously attached people may become emotionally overwhelmed in response to a partner's distress. Their hyperactivating strategies may facilitate the associative reactivation of self-focused worries and increase attentional focus on both the partner's suffering and the self's personal distress. Despite their focus on the partner's suffering, anxious people's lack of self–other differentiation (Mikulincer & Horesh, 1999) may prevent them from reacting with compassionate altruistic care. (There is a similar distinction in Buddhist psychology between effective and ineffective empathic compassion (Dalai Lama, 1999).) Batson (1991) claimed that compassion involves self–other distinctiveness and a corresponding ability to distinguish between the other person's welfare and one's own. Anxious people seem to blur this distinction.

Avoidant people's deactivating strategies may encourage emotional detachment from a partner's plight and inhibit the engagement in compassionate, altruistic care. For avoidant persons, a distressed partner can act as a mirror that makes salient the self's own weaknesses and vulnerability to life's adversities. Deactivation may require suppression of the sense of vulnerability and distancing of the self from the source of distress. As a result, avoidant people may defensively attempt to detach themselves from the suffering of others, feel superior to others who are distressed, thereby feeling less weak and vulnerable themselves ('I am immune to such misfortunes') and experiencing disdainful pity for the suffering partner. In some cases, negative models of others and associated hostile attitudes toward them may even transform pity into contemptuous gloating – actual enjoyment of others' bad fate.

Empirical evidence concerning the interplay between the attachment and caregiving systems

Parental caregiving

Before reviewing findings from our own research on adult caregivers and care recipients, we should indicate briefly that our basic hypothesis had already received support in studies of parental responsiveness to children's needs. Belsky *et al.* (1984), for example, found that secure and avoidant mothers did not differ in their level of involvement with their infant under most circumstances, but avoidant mothers responded much less supportively than secure mothers when their infants were distressed and needed maternal support. This and similar studies suggest that avoidant adults find it difficult to respond to another person's vulnerability and urgent calls for help.

In a study of mothers who had maltreated their children – a study that also included each mother's husband or lover – Crittenden *et al.* (1991) found that more than 90 per cent of the adults (both women and men) were insecure according to the Adult Attachment Interview (AAI; George *et al.* (1985); see Hesse (1999) for a recent overview), a measure of memories of childhood attachment experiences with parents. In a non-abusing control group, matched for socioeconomic status (SES), the proportion of insecure parents was dramatically lower, 60 per cent, suggesting that parents' own insecure attachment is a major cause of their poor provision of care to their children.

Crowell & Feldman (1988) administered the AAI to mothers of preschoolers and observed the mothers interacting with their children in a series of semi-structured teaching tasks. The secure mothers were warmer, more supportive, and more helpful toward their child than the insecure mothers. In a subsequent study, the same researchers (Crowell & Feldman, 1991) administered the AAI to 45 mothers of preschoolers and observed their behavior in a laboratory separation–reunion session. The secure mothers were more affectionate with their children and prepared them better for the

separation. They left the room with little anxiety and quickly established closeness upon reunion. Insecure mothers, whether avoidant or anxious, did not prepare their child well for the separation and failed to reestablish closeness upon reunion. The anxious and avoidant mothers differed in their emotional reactions to leaving their child alone: Avoidant mothers showed little distress whereas anxious mothers were very agitated and found it difficult to leave the room. (As shown below, this same kind of personal distress, which interferes with effective compassion, is characteristic of anxious adults that are called upon to help a fellow adult in need.)

In a study of attachment antecedents of maternal sensitivity, Haft & Slade (1989) administered the AAI to mothers of 9-to-23-month-old infants and videotaped interactions between mother and child, later coding the tapes for a mother's noticing of and attunement to her child's affects and needs. Secure mothers were more attuned to their babies than insecure mothers. Moreover, secure mothers attuned to both positive and negative affect and were consistent in reacting to their baby's experiences. Avoidant mothers did not attune to negative affect, seeming to ignore it, whereas anxious mothers attuned inconsistently to both positive and negative affect. Cohn *et al.* (1992) conducted a similar study but included both mothers and fathers of preschool children. Parents that were classified as insecure based on the AAI were less warm and supportive and provided less helpful structure when interacting with their child. Interestingly, insecure mothers who were married to secure husbands interacted more positively with their children than insecure mothers who were married to insecure husbands, suggesting that a mother's parenting behavior is influenced by both her own attachment dynamics and the secure or insecure context provided by her husband. As we explain below, the same kind of dual influence – from both dispositions and contexts – is evident when adults are called upon to provide care to other adults. Similar findings have been reported in other studies of parental sensitivity (see van IJzendoorn (1995) for a review of nine such studies, all based on the AAI as a measure of parental attachment orientation).

In two independent studies, Rholes *et al.* (1997, Study 1) and Rholes *et al.* (1995) showed that the association between attachment security and parental caregiving can also be observed when adult attachment style is measured by self-report scales. In Rholes *et al.*'s (1997) study, college students who were not parents completed scales tapping their desire to have children, their perceived ability to relate to children, their expectations about child rearing (warmth, disciplinary strictness, parental aggravation with the child, and encouragement of independence), and the satisfaction they expected to derive from caring for their own infants. Attachment avoidance was inversely related to desire to have children, perceived ability to relate to children, expected warmth in child rearing, and satisfaction from caring for infants. Attachment anxiety was inversely related to perceived ability to relate to children and expected warmth in child rearing. Both avoidance and anxiety

were positively associated with expected disciplinary strictness and the tendency to be aggravated by children. In a sample of mothers of preschool children, Rholes *et al.* (1995) found that mothers who scored higher on self-report scales of attachment anxiety and avoidance were less supportive toward their preschool child during problem-solving interactions.

In short, both interview and questionnaire measures of adult attachment style relate to a variety of measures of parental caregiving, in line with our general hypothesis that secure attachment is a prerequisite for, or at the very least an important foundation for, the provision of sensitive and responsive care to children.

Caregiving in romantic relationships

To extend the construct of caregiving to romantic and marital relationships, Kunce and Shaver (1994) constructed a self-report questionnaire that assesses caregiving behaviors in such relationships. They found that secure individuals were more sensitive to their partners' needs, reported more cooperative caregiving, and described themselves as more likely to provide emotional support than insecure individuals. Moreover, whereas avoidant people's deactivating strategies led them to maintain distance from a needy partner (restricting accessibility and physical contact), anxious people's hyperactivating strategies led them to report high levels of overinvolvement with partners' problems and a pattern of compulsive, intrusive caregiving. These findings have been replicated using other self-report scales and behavioral measures (e.g. Carnelley *et al.*, 1996; B.C. Feeney & Collins, 2001; J.A. Feeney, 1996; J.A. Feeney & Hohaus, 2001; Fraley & Shaver, 1998). In a recent study, J.A. Feeney & Hohaus (2001) found that high scores on both attachment anxiety and avoidance were associated with less willingness to care for a spouse, and this association was mediated by a person's sensitivity to his or her spouse's signals of need (as measured by Kunce & Shaver's (1994) scales). This pattern of association was replicated for wives and husbands.

The link between attachment security and sensitive caregiving has been further documented in observational studies by B.C. Feeney & Collins (2001), Simpson *et al.* (1992), Rholes *et al.* (1999), and Simpson *et al.* (2002), who videotaped heterosexual dating couples while one partner waited to endure a stressful task. Overall, as compared to insecure participants, those high in attachment security spontaneously offered more comfort and reassurance to their distressed dating partner. Moreover, participants that were relatively secure and whose dating partners sought more support provided more support, whereas secure participants whose partners sought less support provided less. This finding indicates sensitive responsiveness: secure participants recognize their partners' worries and vulnerabilities and try to be especially warm and supportive. In contrast, more avoidant participants provided less support, regardless of how much support their partner actually sought.

The association between attachment security and sensitive caregiving in a romantic relationship was also observed in Collins & B.C. Feeney's (2000) laboratory study, in which dating couples were videotaped while one member of the couple disclosed a personal problem to his or her partner. Findings for participants who were given the role of a caregiver (listening to a partner's disclosure of a personal problem) revealed that higher scores on attachment anxiety were associated with provision of less instrumental support and lower responsiveness, and more negative caregiving behaviors toward the distressed partner. Collins & B.C. Feeney (2000) also found that whereas caregivers that were high on attachment anxiety tended to provide relatively high levels of support only when their partners' needs were clear, more securely attached caregivers tended to provide relatively high levels of support regardless of whether their partner's support-seeking needs were overtly and clearly expressed. Caregivers' attachment insecurities were also found to negatively bias their appraisal of support giving: caregivers that were less secure (higher on attachment anxiety and avoidance) evaluated their support as even less helpful than it actually was.

The findings of the studies summarized above generally corroborate our hypothesis that avoidant people's deactivating strategies block activation of the caregiving system, because empathic responsiveness to others' needs entails emotional involvement, acknowledgment of others' distress, and acceptance of the closeness that an empathic reaction implies. The demands of caregiving work against the goal of deactivating strategies – to distance a person from all sources of suffering and all kinds of closeness to others (Mikulincer & Shaver, 2003). Moreover, anxious people's hyperactivating strategies also interfere with caregiving, because the anxious person is likely to be preoccupied with his or her own vulnerability and emotional arousal. This self-focus and lack of security interferes with full attention to and accurate appraisal of other people's needs.

The discovery of reliable links between adult attachment orientations and caregiving behavior in both parent–child and romantic partner relationships led us to explore the possibility that attachment security, whether assessed as an individual-difference characteristic or enhanced experimentally, would be associated with compassion and empathy beyond the realm of well-established close relationships. This research is discussed in the following section.

Attachment security, compassion, and altruism

Even before we began our series of studies, there were hints in the literature that attachment security would be associated with empathy and altruistic caregiving more broadly. In a study of preschoolers, Kestenbaum *et al.* (1989) reported a positive association between secure attachment to mother and empathic responses to other children's distress, as assessed by both teacher

ratings and direct observations of children's social interactions. In a study of adults, Soerensen *et al.* (2002) found that attachment security, assessed with multiple questionnaires, predicted a person's preparation for caring for older relatives, suggesting that secure adults are care-oriented even before care is explicitly called for. Priel *et al.* (1998) found that securely attached high school students (as identified by a brief attachment scale) were perceived by peers (assessed through a sociometric rating procedure) to be more approachable and supportive than their insecure classmates. In addition, securely attached students were more likely than insecure students to engage in reciprocal supportive relationships.

In a recent laboratory study, Westmaas & Silver (2001) examined the association between attachment style and reactions to a confederate of the experimenter who had been diagnosed with cancer. As expected, participants who scored low on attachment avoidance (and hence were relatively secure on that dimension) behaved more supportively toward the confederate than participants who scored high on this dimension. In addition, participants who scored high on attachment anxiety (and thus were relatively insecure on that dimension) reported greater discomfort while interacting with the confederate than participants who scored low on this dimension.

Although these studies consistently reveal an association between attachment security and empathic, compassionate reactions to others' needs, they are correlational in nature and do not necessarily indicate that a sense of attachment security was active while people were responding to others' needs. Recently, a number of investigators, including ourselves, have adopted an alternative research strategy that is more appropriate for testing causal predictions about the effects of attachment security on compassion and altruism (e.g. Mikulincer & Arad, 1999; Mikulincer & Shaver, 2001; Pierce & Lydon, 2001). Using well-validated priming techniques – for example, subliminally exposing study participants to security-related words (love, hug, close) or leading participants through a guided imagery scenario in which they feel safe and secure, these researchers have contextually activated representations of attachment security and assessed their psychological effects in well-controlled experimental settings.

Overall, these studies indicate that contextual activation of the sense of having a secure base leads people to respond more like people who are dispositionally secure. For example, Mikulincer & Shaver (2001) found that contextual activation of attachment security (for example, via subliminal exposure to proximity-related words or conscious imagination of a security-enhancing experience) led to less negative reactions to out-group members. People whose momentary sense of security was heightened were more willing to interact with a member of a potentially threatening out-group (for example, an Israeli Arab who had written a derogatory essay about the study participants' own secular Jewish Israeli in-group), were less threatened by the social and economic threats of a recent immigrant group (Russian Jews),

and were less discriminatory toward homosexuals. In these studies, security enhancement completely eliminated in-group/out-group differences that were evident in unprimed control groups and groups of participants who received positive-affect (but not attachment-related) primes. This provided dramatic evidence for a potentially useful application of security-enhancement procedures.

Following this line of research, Mikulincer *et al.* (2001) conducted five studies to examine the effects of chronic and contextually activated attachment security on compassionate responses towards others' suffering. In these studies, dispositional attachment anxiety and avoidance were assessed with the Experience in Close Relationships scale (ECR; Brennan *et al.*, 1998), and the sense of attachment security was activated in one of several ways: asking participants to recall personal memories of supportive care, having them read a story about one person's provision of care for another, having them look at a picture of a supportive interaction, or subliminally exposing them to proximity-related words. These conditions were compared with the activation of neutral affect, positive affect, and attachment insecurities. The dependent variables included reports of compassion and personal distress in reaction to others' suffering, and the accessibility of memories in which participants felt compassion or distress in reaction to others' suffering.

Across all five studies, enhancement of attachment security, but not simple enhancement of positive affect, strengthened compassion and inhibited personal distress in reaction to others' distress. Both scores of dispositional attachment anxiety and avoidance were inversely related to compassion, and higher scores of attachment anxiety were positively related to personal distress in response to another's suffering. This is one of several examples of findings that paralleled earlier studies of attachment and parenting, and attachment and caring for a romantic partner: anxiety appears to increase self-preoccupation and a form of distress that, while possibly aroused via empathy, fails to facilitate provision of care to the needy person. In effect, anxious people seem to quickly occupy the role of needy person themselves, thereby disrupting compassion for a needy other.

The enhancement of attachment security affects not only specific cognitive and behavioral reactions but also broader value orientations. In a series of three studies, Mikulincer *et al.* (2003a) examined the effects of chronic and contextually activated security on the endorsement of two self-transcendent values, benevolence (concern for close others) and universalism (concern for all humanity). The values were measured either with standardized scales (Schwartz, 1992) or by asking study participants to spontaneously list their own values. Dispositional attachment anxiety and avoidance were assessed by the ECR scale (Brennan *et al.*, 1998), and the sense of security was enhanced by asking participants to recall personal memories of supportive care or by exposing them unobtrusively to a picture of a supportive interaction. Findings revealed that both lower attachment avoidance scores and contextually

activated attachment security were associated with heightened endorsement of self-transcendent values.

In an attempt to examine more directly the contribution of attachment security to altruistic helping behavior, we (Mikulincer *et al.*, 2003b) recently assessed individual differences in engagement in voluntary altruistic activities, such as caring for the elderly or donating blood, as well as altruistic behavior in a laboratory setting. In the first stage of this project, we conducted a questionnaire-based, correlational study at three different locations (Bar-Ilan University, Israel; University of California, Davis; and the University of Leiden, in the Netherlands) and asked participants to complete (a) the ECR scale, (b) a scale designed specifically for this project, listing different volunteer philanthropic activities (for example, teaching reading, counseling troubled people, providing care to the sick) and tapping the number of philanthropic activities a participant volunteered for and the time he or she devoted to them, and (c) the Volunteer Functions Inventory (VFI; Clary *et al.*, 1998), measuring the extent to which participants volunteered for either selfish, egoistic reasons (self-protection, career promotion, ego-enhancement, achieving a sense of togetherness that benefits the self) or more altruistic reasons (other-focused values, achieving a more mature understanding of the world and the self). In addition, participants completed scales tapping self-esteem, perceived social support, and interpersonal problems in order to explore competing explanations for the results focused on representations of self and others or on the quality of a person's relational functioning.

The results were highly similar in all three countries. Avoidant attachment was consistently and strongly associated with engaging in fewer volunteer activities and being involved for less altruistic reasons. Attachment anxiety was not directly related to engaging in volunteer activities, but it was associated with more egoistic reasons for volunteering, another indication of the anxious individual's focus on self. Because security is defined in terms of low scores on both the avoidance and anxiety dimensions, we can definitely conclude, as predicted by our main hypothesis, that people with a chronic sense of attachment security are more inclined to engage in volunteer activities, devote more time to helping others, and volunteer for more altruistic reasons. They are, in other words, predisposed to be compassionate and altruistic, and not only in terms of states of mind but also in terms of real-world behavior. Our analyses of alternative explanations indicated clearly that the association between attachment styles and volunteering is not explicable in terms of other factors, such as self and other representations or problems in interpersonal functioning. Both attachment style and volunteering were correlated with these alternative explanatory variables, but the independent contributions of these variables were essentially nonexistent when the two attachment dimensions were included in regression analyses. These studies therefore paved the way for experimental studies in which we enhanced attachment security and examined the effects on compassion and altruism.

To examine the actual decision to help or not to help a person in distress, we created a laboratory situation in which study participants (college undergraduates who previously completed the ECR scale as a measure of attachment style in a different setting with a different experimenter) could watch one another via a video intercom while one of them performed some aversive tasks and the other merely observed. Both people were connected to polygraphs so that autonomic arousal could be measured. Actual participants in the study were always placed in the observer role, and the person undergoing the aversive experiences was, unbeknown to the actual participants, a confederate appearing on a videotape. The actual participants thought the purpose of the study was to assess the stress (autonomic arousal) levels of two people, one undergoing aversive experiences and the other observing the suffering.

As the study progressed, the videotaped confederate became increasingly distressed by the aversive tasks, finally becoming quite upset about the prospect of having to pet a large, live tarantula in an open-topped glass tank. After a short break in the procedure, supposedly to allow the confederate to calm down, and after being told that the other person refused to continue performing the aversive tasks but would be willing to exchange roles, the actual participant was given an opportunity to take the distressed person's place, in effect sacrificing self for the welfare of another.

In this study, participants were randomly divided into three conditions according to the type of representations that were primed immediately before the scenario just described: representations of attachment security (the name of a participant's security-providing attachment figure) or attachment-unrelated representations (the name of a close person who does not function as an attachment figure, the name of a mere acquaintance). This priming procedure was conducted at either a subliminal level (rapid presentation of the name of a specific targeted person) or a supraliminal level (asking people to recall an interaction with the targeted person). At the point of making a decision about replacing the distressed person, all participants completed brief measures of compassion, personal distress, and willingness to take the other person's place. Results indicated that security enhancement, by subliminal or supraliminal priming of representations of a security-providing figure, increased participants' compassion toward the distressed other and willingness to actually take her place. Dispositional attachment avoidance was related to lower compassion and lower willingness to help the distressed person, thus corroborating the results of our questionnaire study of volunteering. Dispositional attachment anxiety was related to heightened personal distress, but not to either compassion or willingness to help, which also fits well with the questionnaire study.

Thus, across the questionnaire study of volunteering to help others in everyday life and the experimental study of willingness to reduce another person's distress by taking the person's place in a stressful situation, attachment security was associated with greater compassion, greater willingness to

help, and greater participation in altruistic activities. Avoidant attachment was related to lower levels of compassion, helping, and volunteering. Anxious attachment was associated with heightened personal distress that did not translate into greater willingness to help, and when an anxious person actually volunteered to help others in real life, it was often for self-protective or self-enhancing rather than other-focused reasons. All of these results support the hypothesis that attachment security provides a solid foundation for compassion and altruism, or stated the other way round, that insecurity interferes with compassion and helping. As we were led to expect by attachment theory, motivation for caregiving and the ability to provide sensitive, responsive care are conditional upon a certain degree of attachment security. This security may come from a combination of sources: having been treated supportively as a child, being involved in security-enhancing close relationships in adulthood, being able to call upon mental representations of being cared for, or being influenced by a security-enhancing context. Further research is needed to determine precisely how various experiences, perhaps including psychotherapy, serious meditation training, participation in ethically oriented groups, and various forms of study, enhance a person's sense of security and thereby foster compassion and altruism.

Attachment, compassion, and compassion fatigue in therapeutic settings

Contributions of therapists' and clients' attachment security to the therapeutic process

Bowlby (1988), who worked all his adult life as a psychotherapist in addition to being an influential scholar and theorist, drew parallels between the parent–child relationship and the relationship between a therapist and his or her clients. When therapy goes well, the therapist provides a safe haven and secure base for the client, creating a protective environment that allows the client to explore problems, conflicts, feelings, and memories. As the therapeutic relationship deepens, it becomes possible for the client to reassess and restructure perceptions of this particular relationship, which then becomes a model and testing ground for other close relationships. Bowlby noticed, of course, that a client's feelings and behaviors toward the therapist are affected by attachment working models, which allowed him to reconceptualize transference in attachment-theoretical terms. Less emphasized was the likely possibility that the therapist's own attachment orientation and past attachment experiences and injuries might affect the therapeutic alliance and the problems that sometimes arise within it. This possibility has since been documented by Dozier (e.g. Bernier & Dozier 2002; Dozier & Tyrrell, 1998), Mallinckrodt (2001), and Pistole (1999), among others.

The conditions for establishing attachment and caregiving bonds are

implicit in most therapy situations. Clients usually enter therapy when they are feeling distressed, vulnerable, and needy, and the initial session is likely to be characterized by feelings of extreme susceptibility to harm or humiliation. Anxiety and vulnerability activate the attachment system and cause most clients to wish to receive responsive care from what Bowlby called a 'stronger, wiser other' (Bowlby, 1969/1982). The therapist is likely to seem, and hopefully to be, stronger and wiser because of both professional training and the unilateral focus in this particular setting on the client's concerns (Rogers, 1951). The therapist notes facial and postural expressions, vocal qualities, and verbal comments indicating distress and signaling a need for care, safety, and guidance. As the therapist responds to these signals with interventions that comfort and guide the client, the client may begin to feel more secure and increasingly attached to the therapist. The therapist may feel rewarded by noticing the client's increased sense of comfort and security, a major reward for continued caregiving.

In order for this kind of working alliance, or attachment relationship, to be established, several dispositions and skills must come into play (Mallinckrodt, 2000, 2001). Among the important dispositions are the client's and the therapist's attachment styles. A therapist who is secure is likely to be able to focus on the client's problems, remain open to new information, and maintain compassion and empathy rather than be overwhelmed by personal distress. A therapist who is insecure is less likely to be able to empathize accurately and keep personal distress and problems from interfering with compassion. Being secure allows the therapist to acquire and apply different skills, both simple ones, such as maintaining appropriate eye contact and following the client's personal narrative, and more complex skills such as gradually transforming a professional acquaintanceship into an intimate therapeutic relationship (Mallinckrodt, 2000, 2001).

In recent years, studies have shown that a therapist's sense of attachment security affects therapeutic processes and outcomes. Sauer *et al.* (2003) reported, for example, that although clients of more anxious therapists (as assessed by a self-report attachment measure) felt that they had a better working alliance after the first session, this effect was gradually reversed over time. In a study in which therapists listened to taped client narratives, Rubino *et al.* (2000) found that more anxious therapists (assessed with a two-dimensional, self-report measure of attachment) tended to respond less empathically to clients' narratives. However, Mohr (2002) reported that therapist–client similarity in attachment insecurity seemed to weaken the negative effects of the therapist's attachment anxiety or avoidance. Specifically, therapists who scored relatively high on both anxiety and avoidance were more likely than secure therapists to view positively their sessions with clients who exhibited a similar form of insecurity. Moreover, therapists who scored high on avoidance but low on anxiety exhibited less hostile countertransference in sessions with clients who were also rather avoidant.

In a similar study, Rozov (2002) found that secure therapists created better therapeutic alliances. However, therapists who scored high on avoidance and low on anxiety had better working relationships with clients who held a similarly dismissive attachment style (a finding contradicted by other studies and therefore not yet well understood; see Dozier & Tyrell (1998); Tyrrell *et al.* (1999)). Rozov (2002) also found that therapists who scored high on anxiety and low on avoidance created poorer therapeutic alliances in general, and especially poor ones with secure clients.

A *client's* attachment style also has important effects on the therapeutic process. Sauer *et al.* (2003) found that secure clients established better working alliances with their therapists. In related studies, Satterfield & Lyddon (1995, 1998) found that clients that felt they could depend on others to be available when needed were more likely to establish a secure personal bond (perhaps a secure attachment) with their therapist, and Kivlighan *et al.* (1998) reported that client security (defined as being comfortable with intimacy) moderated the association between counselor expertise and the client–therapist working alliance. Similar benefits of client security have been noted even in studies involving more severely pathological patients (Dozier, 1990). Greater patient attachment security was associated with better treatment compliance, whereas avoidant tendencies were associated with rejection of treatment providers, less self-disclosure, and poorer use of treatment. Korfmacher *et al.* (1997) created an intervention program for low-SES, high-risk mothers of infants and found that mothers who were classified as secure on the AAI were more involved in the intervention and accepted more forms of treatment than those who were less securely attached.

Although most of the studies mentioned so far suggest that a client's attachment security is an asset in the therapy process, greater *improvement* may sometimes occur in insecure clients, who presumably have more to gain than secure clients from therapy (Meyer & Pilkonis, 2002). Rubino *et al.* (2000) reported that therapists were more deeply involved with highly anxiously attached clients and reacted more empathically to them than to less anxious clients. (Whether this ability of the more anxious clients to pull for therapist empathy and involvement actually resulted in better therapeutic outcomes cannot be determined from this study.) Hardy *et al.* (1999) reported that therapists tended to respond to anxiously attached clients by 'reflecting their emotions and concerns,' but to avoidant clients by offering cognitive interpretations.

These early studies, while based on a variety of different methods and not all producing identical conclusions, generally suggest that attachment security is beneficial to both therapists and clients and that one important benefit of successful therapy is the enhancement of a client's sense of attachment security. More research is needed to flesh out these early indications of the importance of attachment processes in therapeutic settings, and to discover how they are related to compassion.

The therapist's need for a safe haven and secure base

Therapists obviously experience a great deal of stress while attempting to help troubled clients. They therefore need a safe haven and secure base outside the therapy situation, in relationships with supervisors, consulting therapists, marital partners, friends, and spiritual advisors (Carifio & Hess, 1987; Hess, 1987; Holloway, 1994). Needless to say, it would be dangerous and destructive for a therapist to reverse roles and attempt to meet attachment needs by relying on clients for comfort, safety, and support – a process that attachment researchers have identified as dysfunctional when it occurs in the context of disturbed parent–child attachment relationships.

Attachment theory is useful for thinking about the ways in which the interpersonal characteristics of therapists and their supervisors affect supervision (Pistole & Watkins, 1995). A secure foundation provides the supervisee with sufficient safety so that he or she feels confident relying on the supervisor in times of need. Neswald-McCalip (2001) discussed the example of supervisees who were working with suicidal clients. When confronted with this kind of crisis, an insecure therapist whose working model of attachment figures is one of unavailability is less likely than a more secure therapist to trust a supervisor or seek support. More secure therapists are likely to view supervisors as available and trustworthy. A good supervisor will provide the needed sense of security that allows the supervisee to explore feelings and possible treatment strategies, and to benefit from this increased security when extending compassion to a suicidal client.

In their work with counseling supervisees, Pistole and Watkins (1995) found that a secure supervisory alliance 'serves to ground or hold the supervisee in a secure fashion' (p. 469). The relationship provides supervisees with security or safety by letting them know (a) 'they are not alone in their counseling efforts, (b) their work will be monitored and reviewed across clients, and (c) they have a ready resource or beacon – the supervisor – who will be available in times of need' (p. 469). At present, attachment-oriented research on therapists' relationships with supervisors is scarce. This would be a fruitful arena in which to test theory-based supervisory strategies and their effects on both supervisees and clients.

Attachment processes and compassion fatigue

Psychotherapists who work with special populations such as victims of terrorism, abused children, disaster survivors, dying clients, and severely disturbed patients sometimes neglect their own needs for care while focusing on the extreme needs of their clients (Figley, 2002). While epitomizing the compassion we would generally like to foster, this kind of work can easily result in emotional depletion and professional burnout (Skovholt *et al.*, 2001), sometimes called compassion fatigue. This unpleasant condition is

marked by withdrawal and isolation from others, inappropriate emotionality, depersonalization, loss of pleasure in work and perhaps life more generally, loss of boundaries with dying patients, and a sense of being overwhelmed (Rainer, 2000).

Research has shown that lack of social support is a major factor in burnout (e.g. Davis *et al.*, 1989; Eastburg *et al.*, 1994). Among the various kinds of social support that a person might experience in the workplace, the kind provided by a supervisor is probably the most important (Constable & Russell, 1986). Meeting one's own needs for relief, empathic understanding, and support is an important prerequisite for continuing to serve as an attachment figure for needy others.

To some extent, however, more secure people can also soothe themselves by relying on mental representations of past experiences of being supported by good attachment figures (Mikulincer & Shaver, in press). They can do this partly by recalling how they felt when they were well taken care of, and partly by viewing themselves as having internalized some of the efficacious and loving qualities of their attachment figures. In a secure individual, these two kinds of mental representation seem to become mentally available as soon as threats or stresses activate the attachment system. Beyond a certain point, however, it may be necessary for almost everyone to have tangible care provided by a compassionate, loving caregiver. For therapists, some of this care can come from good supervisors. Some of it may also have to come from friends and family.

Concluding comments

Attachment theory and research provide good leads for fostering effective compassion in therapists, therapy clients, parents, and human beings more generally. Unlike 'selfish gene' theories (e.g. Dawkins, 1976), which discourage us from imagining that evolution equipped *Homo sapiens* with a capacity for compassion and care, attachment theory suggests that the same caregiving behavioral system that evolved to assure adequate care for vulnerable, dependent children can be extended to include care and concern for other people in need, perhaps even compassion for all suffering creatures – an important Buddhist ideal. Research clearly indicates that the condition of the attachment behavioral system affects the workings of the caregiving system, making it likely that heightening attachment security will yield benefits in the realm of compassionate caregiving.

Research on attachment and caregiving suggests several ways to encourage this move toward attachment security and effective compassion. One is to care for children in ways that enhance their sense of security, which, besides having many benefits for the children themselves, makes it much more likely that they will be good parents and neighbors and generous citizens of the world in later years. Another way to heighten a person's sense of security is to

have him or her regularly recall times when beneficial support was provided, or to imagine similar situations, perhaps even ones depicted in religious stories or other inspiring works of art (Oman & Thoresen, 2003). Once a person has benefited from another's care, or deliberately imagined and emulated the kinds of care and concern for others exhibited by supportive parents, Jesus, the Buddha, or Gandhi, merely calling these exemplars to mind seems to have security-enhancing effects, as does exposure to pictures and drawings of examples of loving kindness. Many of these procedures probably foster compassionate caregiving in two ways, by enhancing a person's sense of security and providing models of good caregiving.

When we consider therapeutic settings in particular, additional considerations arise. A therapist is likely to perform better if he or she is relatively secure, but the task of listening attentively and compassionately, hour after hour, to narratives of pain, abuse, inhumanity, and insecurity is likely both to erode compassion and to increase personal distress and insecurity. From time to time, therefore, therapists should be allowed to occupy the role of the needy, dependent person and seek compassionate support from skilled supervisors as well as other professional and nonprofessional attachment figures. It seems unlikely that anyone can sustain security and vitality in the face of continual pain and suffering without at least occasional reliance on stronger, wiser others.

Our research has demonstrated that key constructs, propositions, and principles of attachment theory apply beyond the realm of close relationships to social life more generally. People who are relatively secure in the dispositional sense or are induced to feel secure in a particular context are less threatened than insecure people by novel information and in-group/out-group differences, and are more willing to tolerate diversity, more likely to maintain broadly humane values, and more likely to offer tangible help to others in need. It seems likely, therefore, that the earth would be a more compassionate place if a larger number of people were helped to become secure, both dispositionally and in the varied contexts of their daily lives.

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Chapter 5

The psychology of compassion and prosocial behaviour

Hans-Werner Bierhoff

In this chapter three different paths that lead to compassion are considered: one path is based on principles of conditioning and reinforcement, the second path has its origin in observational learning and modelling, and the third path starts with the prosocial personality. As will be described below in more detail, I assume that compassion and prosocial behaviour are closely linked with each other. From this the implication follows that individual and social influences that enhance compassion also tend to increase prosocial behaviour.

Working definitions of compassion and prosocial behaviour

In the following I will attempt a brief definition of prosocial behaviour, which is the term I prefer, although related terms such as altruism, helping behaviour, and solidarity are available. I speak of prosocial behaviour if an action is intended to improve the situation of the help-recipient. The overlap between the terms prosocial behaviour, altruism, and helping behaviour is shown in Figure 5.1. Solidarity or solidary behaviour is the term often used by sociologists to denote prosocial behaviour, which is the term preferred by social psychologists (cf. Lindenberg, in press).

Whereas the terms 'helping behaviour', 'prosocial behaviour', 'solidarity', and 'altruism' refer to actions, compassion refers to the motivational framework that leads to such actions. Compassion depicts a concern for the suffering of others making one want to help them. For example, the plight of the victims of a hurricane arouses our compassion. The word 'compassion' and its adjective 'compassionate' have a broad meaning including benevolent, charitable, kindly, soft-hearted, sympathetic, tender, and understanding. Compassion refers to the understanding of another person's thoughts and feelings by putting oneself in the shoes of the other. The observer is 'moved by' the other focusing on his or her well-being. He or she feels 'as if' he or she is concerned as the other person is. An equivalent term is 'sympathy', which is defined as 'concern for another based on the apprehension and comprehension of the

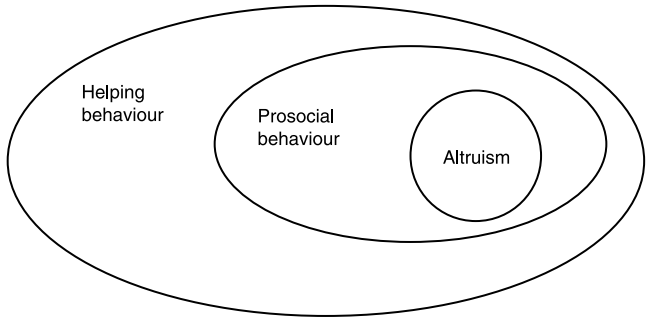

Figure 5.1 Relation of altruism, prosocial behaviour and helping behaviour.

other's emotional state or condition' (Eisenberg *et al.*, 1999: 1360). Such a prosocial orientation may be possible only after successfully learning ego-control which gives the individual the freedom to turn to other persons and allows him or her to apprehend their experiences (cf. Eisenberg *et al.*, 1999). In theories of personality assessment such ego-control is summarized under the heading of 'agreeableness'. Agreeableness is one of the five basic dimensions of personality (McCrae & Costa, 1999; see below).

A better understanding of the meaning of compassion may arise when it is put in perspective by comparing it with the terms 'empathy' and 'personal distress'. Empathy also refers to the experience of shared affective responses. It is related to perspective taking, which does not necessarily require vicarious experiencing of the emotions of the other person. Instead, the emphasis is on the comprehension of the viewpoint of another person, the recognition of the other person's state or condition.

When a person recognizes the pain of a victim of misfortune, he or she may either follow a route that basically is other-oriented, as described by the term 'compassion', or adopt a more egoistically motivated stance by focusing on his or her own feelings of irritation and own suffering elicited by the misfortune of the victim. Personal distress is defined as 'an aversive, self-focused emotional reaction to the apprehension or comprehension of another's emotional state or condition' (Eisenberg *et al.*, 1999: 1360). Whether or not compassion dominates personal distress may depend on the learning history of the observer. During socialization, differential associations are acquired with spontaneous sharing on the one hand and compliance on the other. Personal distress may be understood as a result of pressing exhortations of powerful others to act in a helpful way. These repeated requests may elicit resentment in the target person which feeds the feeling of personal distress when one is faced with another person's bad fate.

Development of compassion and prosocial behaviour in children

An interesting issue is how compassion arises in the first place. The development of compassion occurs in two steps (Hoffman, 2000). In the first step a global, undifferentiated response pattern dominates which is more or less egocentric; the second step is characterized by a more appropriate, differentiated, and less egocentric response pattern. During the first developmental stage, which corresponds with the first step of the model, the young child's cognitive representation of the social world is characterized by self–other fusion. This means that the child does not clearly separate own feelings from those of others. At this developmental stage, if another child cries, the suffering of the other child tends to be confused with own suffering, leading to personal distress that may be expressed by an irritated facial expression of the child observer.

The second stage includes the gradual transition from self–other fusion to self–other differentiation. In the beginning of this change process, attentional focus on the self and on the other may repeatedly alternate. The realization that the other person is an individual of its own makes it possible for the child to recognize the specific needs of other children as well as adults. The motor of this is the cognitive progress the child makes, which includes a separation between self and other. The global emotional response to distress cues is distributed between self and other. The holistic response is broken down into two parts: own suffering is experienced as personal distress; the suffering of another person elicits compassion which focuses attention on the plight of the victim of misfortune. Although both personal distress and compassion stem from the global egoistic response pattern that dominated in Stage 1, the recognition of the independent existence of self and other reorganizes the whole response pattern, leading to the development of compassion as a vicarious emotional experience.

The more advanced response pattern has an important implication: in addition to the egoistic motive system, an altruistic motive system is developed. Whether helping behaviour is egoistically or altruistically motivated is difficult to decide without additional information about the intentions of the actor (Batson, 1991). Therefore, the conclusion as to whether a prosocial response is egoistically or altruistically motivated depends on which goals an actor pursues.

From a theoretical viewpoint, it is not easy to identify the intention behind a prosocial action. In general, two possibilities exist. Experimental conditions may be devised that allow a conclusion as to whether a person responded altruistically or whether the prosocial behaviour was a by-product of an action that primarily served the actor's own well-being. The intention may be derived from conditions that regulate the performance of prosocial behaviour. This is reflected in a statement by Aronfreed (1968: 138): 'Altruistic and

sympathetic behaviour are identified more accurately by the conditions under which they occur than they are by the specific forms which they may assume.' In addition, self-report measures may be devised to figure out whether in a specific situation compassion was more dominant as a subjective experience than personal distress, or vice versa (Batson, 1991).

Hereditary transmission of compassion and prosocial behaviour

Empirical evidence indicates that a prosocial trait may be identified quite early in life that remains stable over long time spans. For example, data on prosocial orientations of 23- and 24-year-old men and women were collected in a longitudinal study that began when respondents were between four and five years old. Spontaneous sharing behaviour of the preschoolers was measured by observation. The results correspond to the assumption that prosocial personality is a viable concept. Specifically, spontaneous sharing at the age of four or five predicted prosocial orientation at the age of 23 or 24 which was assessed by friends. Further results indicate that compassion mediates the longitudinal stability of prosocial orientation. Therefore, spontaneous sharing of preschool children reflects a tendency to respond with compassion to the suffering of others (Eisenberg *et al.*, 1999). The strong consistency across more than 15 years may in part be derived from temperamental factors related to ego-control and compassion.

Even among two-year-olds the association between compassion and prosocial behaviour was observed. At the start of this chapter, the assumption was stated that compassion is associated with prosocial behaviour. Evidence obtained with children tested at 14 and 20 months is especially convincing (Zahn-Waxler *et al.*, 1992). Twin pairs participated in an experimental study which included several incidents that could provoke empathic concern as well as prosocial behaviour: the experimenter or the mother jams her finger, the mother hurts her knee, or the experimenter bumps into a chair. In all these incidents the mother or experimenter expressed signs of pain. The children's responses to these incidents were videotaped. From the videos several variables were coded: prosocial acts, compassion, self-distress, and indifference.

The results are interesting in several respects. Firstly, girls showed more compassion, prosocial acts, and self-distress but less indifference than boys. In the age range studied, compassion increased, whereas indifference decreased. Retest correlations were generally quite low but significant. For example, the six-month stability for compassion was .23. Heritability estimates indicated that compassion of 14-month-olds and 20-month-olds was genetically determined, whereas prosocial acts were characterized by a significant genetic component only in 14-month-olds. Finally, the correlation between prosocial acts and compassion was .38 in 14-month-olds and .20 in 20-month-olds. At the baby-level, self-distress and empathic concern were correlated positively

in both age groups (.14 and .13, respectively). Although the correlation is quite low, it is significant and in accordance with the assumption that personal distress and empathic concern have a common root (cf. Hoffman, 2000).

Socialization

Besides genetic influences, socialization factors play an important role in the development of compassion and prosocial behaviour. By their actions and comments, parents influence the emergence of continuity in prosocial behaviour (Koestner *et al.*, 1990). For example, empirical results show that altruistic behaviour in children is fostered by a supportive family environment as well as by positive peer influences (Ma, 2003). These are based on reinforcement and modelling, which are the core learning principles contributing to the acquisition of prosocial behaviour. The effectiveness of these learning processes depends on the ability to experience vicariously the psychological processes of another person (Aronfreed, 1968). Only if the psychological processes in the other person are inferred and cognitively represented are the preconditions for the occurrence of empathy fulfilled.

The question is how the connection between vicarious experience and own positive or negative consequences for the child is established. One answer is based on the following reasoning. Firstly, the consequences of a prosocial action, which occur in another person, are cognitively represented. Secondly, the cognitive trace is associated with positive feelings. Only in the beginning is this learning process dependent on the actual observation of affective responses of the other person, for example joy after receiving help. With growing ability for cognitive representation of consequences of actions for others, the connection between prosocial behaviour and positive affect of the recipient of help is anticipated without direct observation. The knowledge of positive consequences for the other person acquires a reinforcing value for the donor.

What inferences can be drawn from this learning paradigm, which can be traced back to earlier work by Aronfreed and his co-workers (summarized in Aronfreed, 1968) and which was empirically confirmed in a study with children by Midlarsky and Bryan (1967)? Firstly, the acquisition of altruistic responses is facilitated by the elicitation of positive feelings of the donor. Secondly, the temporal contiguity between the positive feelings of the recipient of help and the donor contributes to the establishment of empathically mediated prosocial behaviour. Finally, affect may also facilitate the positive influence of prosocial models: modelling effects are enhanced if a model of prosocial behaviour shows joy during the performance of altruistic actions (Midlarsky & Bryan, 1972). The emotional experience of joy is relevant in two respects:

- joy of the recipient of help may be associated with positive feelings in the

donor, and as a consequence compassion is elicited which causes altruistic behaviour
- joy of a model that performs altruistic responses facilitates the acquisition of similar response tendencies by the observer.

Therefore, the performance of altruistic responses is facilitated by positive feelings and moods that are associated with prosocial behaviour. A positive feedback loop may be established in which positive feelings and/or their cognitive representations contribute to the performance of prosocial activities, and prosocial activities contribute to the maintenance of positive feelings (Isen *et al.*, 1978).

The learning paradigm described by Aronfreed (1968) is based on the idea that compassion is elicited in the child which makes it possible for the child to share the feelings of other people. The origin of compassion is based on temporal contiguity between joy of another person and positive feelings of the observer. Such a contiguity of positive responses is an everyday experience. For example, shared joy between parents and children is a common occurrence.

The learning paradigm that is based on this temporal contiguity demonstrates that prosocial behaviour is not necessarily to be understood as the result of negative emotions such as guilt and anxiety. Instead, it is perfectly possible that altruistic dispositions are derived from positive experiences which are cognitively represented and associated with other-oriented positive feelings.

Learning processes

This section focuses on the learning of prosocial behaviour. Two major mechanisms are considered: reinforcement learning and modelling. It is assumed that laws of learning explain the acquisition, maintenance, and extinction of prosocial behaviour. Besides conditioning processes, the role of cognitive structuring is emphasized. In addition, in accordance with social learning theory it is assumed that prosocial behaviour is acquired through social modelling where discrepancies between what socialization figures practise and what they preach play an important role.

Social reinforcement

One of the most widely documented principles for the modification of behaviour is reinforcement learning, which was originally described by Thorndike in his 'law of effect' (1906). The idea behind this law may be translated into a 'win–stay lose–change' rule, which is applicable in very different social contexts including social environments in which prosocial behaviour flourishes. The law of effect is compatible with more recent learning theories and with contemporary neural network theory. What the law of

effect is saying is that actors consider the consequences of action alternatives and focus on alternatives that promise higher outcomes. They stay in reinforcement circumstances that are rewarding, whereas they avoid (and actively leave) reinforcement circumstances that are disappointing. The anticipated consequences of action alternatives define what is 'pleasant' and what is 'aversive'. Reinforcement-value theory predicts that people will choose alternatives that have a high probability of leading to satisfactory outcomes (Rotter, 1955). The expected likelihood of an outcome depends on the anticipation of what will happen in the future given a specific course of action, whereas the reinforcement value depends on individual preferences. For example, some people are especially sensitive to social approval and disapproval because they highly value the company of peers, whereas others are especially sensitive to the experience of being successful at a difficult task because they have a strong intrinsic striving for mastery, which is satisfied by being successful in achievement situations regardless of whether or not peers take notice.

A more sophisticated version of reinforcement learning theory takes the comparison level into account (cf. Thibaut & Kelley, 1959), arguing that a given outcome is compared with a standard of judgement that has been acquired through previous experiences in similar environments. The comparison level is a term directly related to the 'aspiration level' (Lewin *et al.*, 1944), which continues to be a cornerstone of motivation theory, especially in achievement contexts (Heckhausen, 1989). People that have a learning history of successes at a given task expect more and are more easily disappointed by a given outcome than people that have a learning history of failures at the same task. As a consequence, it is likely that people 'stay' where they experience satisfactory outcomes. In addition, self-reinforcement may contribute to the development of long-term habits that are more or less independent of extrinsic reinforcement.

The person may learn principles that he or she derives from the learning history. For example, the person that decides to help a needy other may apply the rule: 'If I help a person in need, I will feel good'. During socialization children learn rules and scripts about the appropriate behaviour in specific situations. Frequently, they deduce these rules from reinforcements. Rule learning may be facilitated by verbal statements. For example, teachers may point out: 'If you help a person in need, you will feel good'. Such verbal rules contribute much to the acquisition of what might be termed 'emotional intelligence'. In the same vein, a large number of verbal rules are transmitted during socialization (for example, a teacher comments: 'If you help a friend, your friend will help you when you need it', or a priest instructs: 'If you give to the poor, your guilt feelings will be alleviated'). The consequences of verbal rationales are dependent on their specific content because some are more convincing than others (see below).

That positive reinforcement of prosocial behaviour actually leads to the

internalization of prosocial norms is a conjecture that needs empirical validation. Studies which show that positive reinforcement increases children's generosity merely show that prosocial behaviour is under situational control. Rushton and Teachman (1978) performed a study with 8- to 11-year-olds which indicates that positive reinforcement of prosocial responses may initiate an internalization process. The children participated in a bowling game in which they won tokens that were later exchangeable for a prize. Their attention was called to a child on a poster, who was named 'poor little Bobby'. First, the experimenter played the game and each time she won she gave half of the tokens to Bobby. After modelling prosocial behaviour in this way, the children played the game in the presence of the experimenter. In a positive reinforcement condition children's prosocial responses were reinforced by social approval ('Good for you, you gave to Bobby'), whereas in a second condition prosocial responses were followed by social disapproval ('That's kind of silly for you to give to Bobby. Now you will have less tokens for yourself' (p. 323)). In addition, a control group was included in which the experimenter behaved neutrally during the game, meaning that no reinforcement was given. An important feature of this study is that prosocial behaviour was tested again two weeks later in the absence of the socializing agent. Children won a prize and were left alone to play in the presence of Bobby's poster. The mean number of tokens donated to Bobby was different in the three conditions. Whereas children in the positive reinforcement condition were very generous, those in the punishment condition were not at all generous. In the control group the degree of generosity of the children was between these two conditions. This evidence speaks in favour of internalization of positive reinforcement because the child was in an anonymous situation. However, the limits of this internalization also became visible: if an unrelated opportunity to share with a friend was offered, children from the different conditions did not differ significantly with respect to their generosity. In order to enhance the generalization of the learning process it seems to be necessary that prosocial behaviour that is followed by positive reinforcement occurs in diverse contexts, thus facilitating the broader application of the prosocial self-reinforcement system to different forms of helping.

Gelfand and Hartmann (1982) point out that social approval is an effective procedure for reaching society's goal of internalization of prosocial behaviour. Praise seems to activate an internal frame of reference, facilitating an internal attribution for doing good (e.g. 'I'm a good kid'). In contrast, material rewards are less likely to facilitate internalization of prosocial behaviour. They tend to activate an external frame of reference that includes external attributions of helping (e.g. 'I did it because it pays').

The use of material reward may even hinder the internalization of prosocial behaviour, especially among children whose mothers routinely try to elicit desired behaviour in their children by promising rewards (Fabes *et al.*, 1989). Material rewards activate an external rationale for acting prosocially, which

may interfere with internal interest: once the child has reached a certain level of moral internalization, the elicitation of external attribution for doing good may actually undermine the internalization process. These negative consequences of positive reinforcement may be understood in the context of the overjustification effect. When internal control of behaviour has been acquired, salient and extrinsic consequences for prosocial behaviour may backfire, reducing the autonomous prosocial motivation of the child (Gelfand & Hartmann, 1982). Such overjustification effects of superfluous external rewards are especially likely when rewards are given in an exaggerated manner or on a regular basis.

Prosocial behaviour may be fostered either by positive consequences of helping or by negative consequences after not helping (Grusec, 1982). For example, a child that does not help a needy peer may be criticized by his parents as cold and heartless. Or the parents may point out that the child's behaviour has led to bad consequences for another person. Such reasoning may broaden the cognitive perspective of the child. As a consequence, guilt feelings after misbehaviour may be elicited. After several such incidents the child may develop a preference to actively avoid guilt feelings resulting from not helping. The action alternative 'not helping' turns out to be incompatible with the striving for subjective well-being and happiness. Therefore, the child seeks to avoid the elicitation of guilt feelings in the future by responding prosocially if another child is in need.

If the child fails to act in accordance with his internal moral standards of conduct, negative internal repercussions follow because the failure to correspond to internalized norms is subjectively considered as wrong, eliciting feelings of guilt. Therefore, the conformity with internalized rules of moral conduct is not based only on a system of self-congratulation but also on a system of self-protection against violations of internalized social norms. Guilt may be understood as a motivational system that includes a monitoring function that detects wrongdoing in interpersonal contexts. Such a monitoring system is useful because such wrongdoing would cause interpersonal relationships to break down. Wrongdoers would lose important support in their social network if they did not attempt to compensate for the consequences of transgressions and mistakes that occur in day-to-day relationships. Therefore, guilt feelings that motivate excuses, compensations, and regret minimize the negative interpersonal consequences of wrongdoing (Baumeister *et al.*, 1994). In summary, guilt is to be understood as a prosocial emotion which serves the maintenance of interpersonal relationships that are threatened by harm done to others.

Observational learning

On the one hand, we may intentionally observe behaviour in a specific situation because we want to learn how to behave correctly in such a situation. On

the other hand, we frequently are confronted with novel verbal expressions or new behaviour patterns and adopt them for our own use without actually intending to learn something new. In addition, what is learned by observation will not necessarily be performed. What will be performed is highly dependent on the expected consequences. For example, if a person observes that a specific behaviour pattern of models is associated with positive consequences, the likelihood that it will be performed after acquirement is much higher than if a person sees that a particular behaviour pattern leads to negative consequences for the models. Therefore, it is no surprise that what is learned by observation does not necessarily correspond to what is practised afterwards.

Observational learning occurs in prosocial behaviour as well as in antisocial behaviour. Empirical results show that prosocial and antisocial behaviour is learned quite easily and rapidly by observation. Models frequently function as a releaser that contributes to the performance of prosocial behaviour in children and adults. After learning relevant behaviour patterns, the performance of prosocial behaviour depends on facilitating situational circumstances. Models may also reduce the likelihood of prosocial behaviour. When models show passivity in an emergency situation, they suggest to observers that prosocial behaviour is inappropriate. In both cases – when models facilitate and when they inhibit prosocial behaviour – modelling includes information about what is legitimate, what is appropriate, and what is in accordance with social rules of conduct.

A central assumption of social-learning theory is that observers acquire symbolic representations of perceived behaviour sequences (Bandura, 1986). The information transmitted by models includes the illustration of specific competencies, knowledge, and skills for dealing with tasks and aspirations that may be appropriate in a certain situation (Bandura, 1997). Therefore, models not only have an informational function but also exert a motivational influence. They transmit performance standards of what is possible in face of specific difficulties of environmental tasks.

The occurrence of observational learning presupposes that the attention of the observer is directed towards the model. Once attention is secured, cognitive representation of what has been performed by the model is decisive. For example, the child may be prepared to code the behaviour of a generous model around cognitions of benevolence when such a value is available as an organizing memory principle. In an empirical study it was shown that the activation of values of benevolence fostered generosity in children (Macrae & Johnson, 1998). This priming effect increases the impact of prosocial information that the child derives from a model's generous behaviour.

Production of the modelled response is facilitated if the necessary components of the response are available in the response repertoire of the child. Differences in the ability to produce the response may account for at least some gender differences that were found with respect to prosocial behaviour

(see for a summary Eagly & Crowley, 1986). For example, if help consists of changing a flat tyre of a car standing on the side of the road, the helper must be capable of changing tyres. The skill that is necessary for effective help in this specific situation has been acquired by more males than females. When male and female drivers first observed a model who helped a driver with his broken-down car and then met a second driver whose car had also broken down, much more help was elicited in males than in females (Bryan & Test, 1967). The conclusion is justified that this gender difference does not reflect a deficit in prosocial modelling in women but the possession of a skill that more men than women have acquired.

Bierhoff (2002) has summarized research on the question of which is more influential: models that use verbal instructions or models that show behaviour examples. In general, no differences in effectiveness of modelling of generosity were found, whereas the general effectiveness of verbalization and performance by adult models on 9- to 10-year-olds and older children was confirmed. With the possible exception of younger children, the results support the view that verbalization and performance are equally effective in transmitting generous behaviour during the socialization process.

But the process through which the transmission of generosity occurs may be somewhat different depending on which method of presentation is used. While verbal instructions tend to be more abstract and therefore require some cognitive work (for example, inferences about the meaning of the verbal message, deriving a rule about appropriate behaviour, translation of intention into action), behaviour examples are more concrete and therefore more straightforward in their meaning. However, this advantage of behaviour examples may also be connected with a hidden disadvantage because the derivation of abstract standards of conduct is not encouraged, leaving the lesson on prosocial behaviour highly situation-specific. Therefore, a combination of saying and doing may prove to be most effective in the socialization of prosocial behaviour by models.

The combination of preaching and practising generosity is obviously most effective if both methods of presentation are consistent. In the case of inconsistency, negative side-effects may occur. For example, if a model expresses a generous intention and behaves selfishly, his or her credibility may suffer. But such a credibility loss is only to be expected if the observing child is far enough in cognitive development to figure out that a contradiction has occurred.

Studies with 7- to 11-year-olds indicate that they are not in a position to analyse an inconsistency in terms of repercussions on the credibility of the model and to infer that the model is not being honest if stated intentions turn out to be more prosocial than concrete actions. Children in this age range seem to be quite insensitive about just how truthful or untruthful a model may be. A similar conclusion applies to adults, because research has shown that they also tolerate inconsistencies in the behaviour of others (Cialdini & Insko, 1969).

Still, this low level of sensitivity does not mean that each and every inconsistency in adults' behaviour goes unnoticed by the observing child. If the contradiction is made quite blatant by presenting a model that acts selfishly and afterwards demands good deeds of the child (for example, by remarking 'You really ought to give', 'Remember, this is your chance to make a child very happy'), such prosocial approval may backfire and reduce children's generosity. In this case, social approval is aversive and leads to a boomerang effect that might be explained on the basis of reactance theory (Brehm, 1981): pressuring the child to be generous in a situation marked by a striking inconsistency may elicit opposition in the child. It is well known that children respond with defiance when their freedom is restricted; it is not too far-fetched to assume that the selfish model's approval of children's donation response elicits defiance in the children with the result that they want to do just the opposite of what they are told to do. At this point two strong determinants of the social-influence process come into conflict. On the one hand, adults are very powerful agents of influence for the child. As a consequence, the dominant response to requests of parents or teachers is compliance. On the other hand, children's opposition forces come into play, which usually are not strong enough to block social influence attempts by adults. One consequence may be that children obey in the current situation in which their compliance is demanded but have reservations about the legitimacy of what adults demand. Under these circumstances, children may hesitate to accept moral standards of behaviour that underlie the requests to act generously.

The aversive-approval effect is limited and far-reaching at the same time. It is limited because it might occur only in highly similar situations. It is far-reaching because the negative effect of a selfish model's moral demands on moral behaviour has the implication that parents who display selfish behaviour in everyday interactions should stop telling their children to be generous and refrain from voicing their approval of moral actions. The same may apply in patient-therapist relationships. If a therapist models selfish behaviour (for example, by demanding that the patient pay for a session the patient could not attend because of illness), the therapist may encounter problems if he or she then suggests more generous behaviour on the part of the client.

Prosocial self-reinforcement system

Prosocial behaviour may elicit a positive self-reinforcement if it is in accordance with internalized rules of conduct. Why does prosocial behaviour have self-reinforcing qualities? There are two possible answers to this question (Cialdini *et al.*, 1982). First, prosocial behaviour could acquire the quality of a secondary reinforcer because of frequent co-occurrences with rewarding events. Second, children learn through socialization that prosocial behaviour is socially expected.

Kenrick *et al.* (1979) developed a three-step model of the socialization of prosocial behaviour. They assumed that prosocial behaviour is self-gratifying. Prosocial behaviour may function as a self-reinforcer. The self-reinforcing quality of prosocial behaviour is traced back to the socialization process. It is assumed that socialization is characterized by special emphasis on doing 'good deeds', leading to a regular association between performance of prosocial behaviour and praise (cf. Koestner *et al.*, 1990). An implication of this reasoning is that young children who have not completed the formation of the self-reinforcement system will instead be influenced by external reinforcement. For example, if primary school children expect to be praised for their prosocial behaviour, they are more likely to perform it than if they don't expect social approval.

Kenrick *et al.* (1979) cite evidence consistent with the notion that primary school children are aware of the high social desirability that society attaches to acts of helpfulness, although they may not necessarily act accordingly. The hypothesis suggests itself that they have not yet internalized prosocial norms and that the socialization process needs more time to establish a prosocial self-reinforcement system.

In the three-step model of the socialization of prosocial behaviour, the first step involves low readiness of preschool children to act prosocially. In terms of Kohlberg's (1984) typology, the consequences of an action determine its evaluation as good or bad. For example, sharing means to give up something, which is probably experienced as self-punishment in this age group. The second step is characterized by the acquisition of knowledge of social norms that prescribe prosocial behaviour. Such norms include the norm of social responsibility, which attaches a positive value to prosocial behaviour towards children in need. Primary school children are ready to act prosocially in public, where they expect to receive social approval for their good deeds, but to act egoistically in anonymity, where no social approval is available. The third step is the internalization of these prosocial norms. When children are repeatedly rewarded in public for acting prosocially, prosocial behaviour acquires the quality of a secondary reinforcer because it is associated with rewards via operant conditioning. In this phase the child's prosocial behaviour is accompanied by positive self-reinforcement which is derived from compliance with the internalized social norm. The child accompanies prosocial behaviour with self-congratulation. For example, after sharing candies with another child, the comment may be 'That was nice', substituting the praise by adults with a self-gratifying response. In terms of Kohlberg's levels of moral development, this phase corresponds with his intermediate level, which is characterized by loyalty to the social order. This loyalty to what society expects is the result of the internalization process which brings about internal standards of conduct that the child uses as a frame of reference to evaluate the appropriateness of his or her own behaviour. It was found that the self-reinforcing effect of prosocial behaviour was weak among 5th–7th

graders but strong among 10th–12th graders, indicating that this socialization process is not finished before grade 9, 10, or 11 (Cialdini & Kenrick, 1976).

Attribution training, cognitive structuring, and self-identity

The normative standard of prosocial behaviour that society holds may also be transmitted to the child by verbal rationales and justifications. Such communications may be understood on the basis of a distinction between self-oriented rationales and other-oriented rationales. A self-oriented rationale appeals to personal gains and losses (for example, 'You'll be unhappy if you do X'), whereas an other-oriented rationale refers to other people (peers, parents, etc.) who might suffer (for example, 'Your friend will be unhappy if you do X'). The distinction between these two types of communication maps into the distinction between different mind frames that were proposed by Lindenberg (in press). Specifically, a gain frame is contrasted with a normative frame. The gain frame is characterized by egoistic orientation, whereas the normative frame is characterized by orientation to society's norms. It is assumed that which frame is activated depends on situational demands. In essence, one and the same person may act egoistically in one situation and altruistically in another simply because different frames are applied to the situations.

Verbal rationales by peers and adults may provide a specific cognitive structuring that determines how the child defines the situation, what action the child plans, and what feedback the child expects. The reasoning as to the appropriate interpretation and action in a given situation may be a powerful influence on what is actually done. In accordance with this, a study with 7- to 10-year-olds showed that an other-oriented appeal led to more compliance with a demand than a self-oriented appeal (Kuczynski 1982; see also Kuczynski 1983).

One important process that may contribute to the formation of prosocial intentions in many situations is based on self-attribution. The process is captured under the heading of the development of an altruistic self-identity or the 'role-identity model'.

During socialization children acquire knowledge about the self that might influence their willingness to act prosocially. This process is understood as the development of the self-identity of a donor on the basis of self-perception. Self-perception processes of this kind are likely when the person is searching for an explanation of what happened (Bem, 1972). If a child repeatedly acts prosocially and socialization agents describe the child's actions as 'nice', 'generous', or 'helpful', it is likely that the child identifies facets of self-identity with prosocial behaviour. Socialization agents (e.g. parents and teachers) tell the child to be the kind of person that acts prosocially. As a consequence, an

internalized standard of helpfulness might be established ('I am the kind of child who helps others who need it'). Such a self-perception may develop into an altruistic self-identity that is applied across different situations.

In general, the internalization of a prosocial standard is facilitated by socialization agents' use of trait labels (Grusec & Redler, 1980). From 'You are a generous child' the child infers 'I am a generous child'. This kind of learning process is especially likely before a stable self-concept has been developed. Empirical results indicate that the self-attribution process works best with 7–8-year-olds. Younger children do not yet have available the cognitive competencies needed for making the necessary self-attributions, whereas older children and adolescents do not readily modify their self-identity because it has already been rather firmly established and is changed only very hesitantly in the face of new experiences. After a stable self-identity has been established, many cognitive and social manoeuvres serve the function of defending the existing self-identity against contradictions and challenges – a process called 'self-verification' (Swann, 1987). Self-verification of an existing self-identity is an active resistance against further modification of the self-identity and focuses on confirmation of the given self-identity once it has been established (for example, by selective interaction, by active display of identity cues, and selective encoding and retrieval).

During adolescence, the self-perception process of a generous person may further lead to the acquisition of a role identity that describes the social role the adolescent actively pursues in everyday life. The concept of prosocial role identity expresses the idea that individuals who behave prosocially in a given social setting acquire a corresponding cognitive representation of their role in that setting, which functions as a guideline that promotes the further development of the prosocial habit once it has been acquired. As a consequence of the development of such a generalized role identity, if prosocial behaviour occurs in the present there is a heightened likelihood that it will occur in the future.

The role-identity model is an important contribution to our understanding of the socialization of prosocial behaviour in social settings. By our inferring what we are from what we do, self-identities are initially formed in a specific social or organizational context; after formation the process contributes to their preservation and consolidation. Existing evidence is congruent with this view. For example, the development of a role-identity as an AIDS volunteer played a central role in the maintenance of long-lasting prosocial commitments in an AIDS service organization (Penner & Finkelstein, 1998).

In correspondence with the role-identity model, results on blood donations show that stable intentions to donate blood are linked to commitment to the role of a blood donor and the development of a corresponding self-identity (Piliavin & Callero, 1991). As a result of increasing self-commitment, attitudes and traits that correspond to prosocial behaviour become part of the self-identity as a blood donor. The model explicitly focuses on the emergence of an 'altruistic career'. As a consequence of ongoing self-perception, consistency in

prosocial behaviour develops over time. In this process self-definition as a prosocial person is strengthened, especially if the role identity of prosocial behaviour is made salient to the person.

Prosocial personality

The prosocial personality is rooted in social responsibility, which is based on moral obligations to act in accordance with normative standards and expectations (Bierhoff & Rohmann, 2004). Another core variable of the prosocial personality is compassion, which was positively correlated with social responsibility in several studies (e.g. Penner & Finkelstein 1998). The empirical studies show that the altruistic disposition plays an important role in prosocial behaviour. This result was confirmed in experimental and field studies (cf. Bierhoff, 2002).

From the viewpoint of evolutionary biology, the emergence of the prosocial personality may be explained by the tendency to prefer cooperative interaction partners over competitive partners (Frank, 1988). In many circumstances people can freely choose with whom they want to interact. They are in the position to favour one interaction partner over another (Swann, 1987). In these cases, their choice is based on the quite rational goal of finding interaction partners who are cooperative, fair, and prosocial. Furthermore, it is likely that an interaction will flourish better if the other person is cooperative instead of competitive. Therefore, it turns out to be an individual advantage to find interaction partners who are cooperative and fair. This goal is served best by the selection of partners on the basis of relatively valid indicators or identity cues. Although people are motivated to present themselves positively, some identity cues are easily manipulated, whereas others are not. In reference to prosocial personality, it is quite difficult to feign being prosocial in everyday life. It is very likely that a person displaying prosocial behaviour truly has a prosocial personality.

Several lines of evidence are available that speak to the relevance of prosocial personality. One line of evidence is based on twin studies which show that a genetic component of prosocial behaviour has to be taken into account. Such evidence was found on the basis of a questionnaire study of social responsibility in a twin study with adults (Rushton, 1980) but also on the basis of an observational study with two-year-olds (Zahn-Waxler *et al.*, 1992). Another indication of a genetic component in prosocial behaviour is that it is related to the personality dimension of agreeableness, which is one of the big five dimensions that have a strong genetic background (McCrae & Costa, 1999).

Another line of evidence is based on personality studies. For example, Bierhoff *et al.* (1991) showed that first aiders who intervened after traffic accidents expressed a stronger self-concept of compassion, more social responsibility, less aggressiveness, more internal locus of control, and a

stronger belief in a just world than a control group. Similar results were obtained in a retrospective study of rescuers of Jews in the Third Reich (Oliner & Oliner, 1988).

Conclusions

The psychology of compassion focuses on implicit attitudes of actors that guide their behaviour in situations in which others are suffering. In contrast, the psychology of prosocial behaviour pays attention to the factors – situated either in the situation or in the actors themselves – that mould helpfulness in situations in which the suffering of others occurs. Therefore, compassion and prosocial behaviour refer to the same type of situations with emphasis on different levels of organization of human action: feelings vs action. As we all know, feelings and actions may not always correspond. We may feel sympathetic, tender, and understanding towards a person who struggles with an emergency situation, yet not help.

The possible inconsistency between feelings and actions may be the result of specific constraints that guide behaviour; for example, necessary knowledge and skills that are needed for competent intervention. Besides that and beyond the influence of constraints, compassion and prosocial behaviour are closely linked because compassion is a main motivator of helpfulness and because it combines with normative beliefs forming the centre of the prosocial personality. In addition, learning processes that affect compassion are also likely to influence prosocial behaviour. For example, observational learning that focuses on the observer of an emergency may indicate what kind of feelings are appropriate in a situation characterized by another person in need and may include cues as to how to act in such a situation. Again, the problem of inconsistency emerges if a model seems to feel compassion but acts indifferently. But in many situations, modelling of feelings and of actions do correspond.

In addition, operant conditioning may contribute to the development of a link between helpfulness and positive feelings. These considerations imply that in many circumstances compassion tends to enhance prosocial behaviour and – in addition – that prosocial behaviour intensifies compassion. It is possible that compassion and prosocial behaviour form a reciprocal system, with a positive influence of compassion on prosocial behaviour and a reciprocal influence of prosocial behaviour on compassion. Such a reciprocal system would be congruent with models of the development and maintenance of prosocial behaviour that emphasize the development of a prosocial self-scheme which may function as an internalized standard of helpfulness that is strengthened by acting prosocially. This self-scheme was originally learned through processes of cognitive structuring in childhood and is based on prosocial personality. As a result, children and adolescents may build up a personal identity that includes facets of compassion and prosocial behaviour.

But if socialization processes go in the other direction, the resulting personal identity may include selfishness and interpersonal indifference.

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Chapter 6

Compassion and forgiveness

Implications for psychotherapy

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Forgiveness and compassion are intimately connected. While people may sometimes forgive without feeling compassion for a transgressor, forgiveness comes far more readily when the transgressor feels compassion, guilt and remorse, or when there is something in the situation that allows the victim to identify with the transgressor. Forgiveness and compassion are prosocial variables related to concerns about the well-being of others (Gilbert, Chapter 2; Wang, Chapter 3). When, in the wake of being harmed, people sense that the person who harmed them feels remorseful or guilty, they are likely to feel compassion and thus to forgive them. In the past decade forgiveness has become a topic of study by theoreticians, theologians and researchers from many perspectives (Berry *et al.*, 2001; Enright & Fitzgibbons, 2000; McCullough *et al.*, 2000; Worthington, 1998).

The interaction of compassion and forgiveness is a two-person mechanism to help bring about reconciliation in close relationships following an altercation or disruption in connection, and at least a reasonable resolution in more distant relationships. In the interaction of compassion and forgiveness, the feelings in one person resonate in the other and an implicit emotional process transpires, which regulates both parties and makes the reconciliation more likely. This chapter explores relationships between forgiveness, altruism, compassion and guilt, in regard to theory, research, development, and, finally, implications for psychopathology and psychotherapy.

Interpersonal transgressions are ubiquitous. There is no way to conduct life in our highly developed, relatively large social groups, without sometimes being harmed and sometimes harming others. Many ways in which people ordinarily respond to being harmed have been suggested (Worthington *et al.*, 1999). Responses such as seeking revenge or being chronically vengeful (McCullough *et al.*, 2001) are likely to have negative physical, mental, and relational consequences (Witvliet *et al.*, 2001). Other more prosocial responses – such as forgiving the person who has caused the harm, injury or insult – usually have positive physical (Worthington & Scherer, 2004), mental (Karremans *et al.*, 2003), and relational (Fincham, 2000) consequences.

Compassion has been hypothesized to affect forgiveness (Worthington &

Wade, 1999). Berry and O'Connor (2000, unpublished data) demonstrated that empathy-based altruism and interpersonal guilt are associated with forgiveness, and Worthington *et al.*, (1999) and Berry *et al.* (2004a) have demonstrated that when a victim perceives that a transgressor feels sorry for what he or she has done, the victim is more likely to forgive. Positive, other-oriented emotions, based on primary altruism, such as compassion, empathy, and sympathy (Eisenberg, 1987; Gilbert 2000; Hoffman, 1982; O'Connor, 1996; Sober & Wilson, 1998; Weiss; 1993; Worthington & Wade, 1999), when experienced in the context of recalling a transgression, can lead people to feel less negatively towards a transgressor.

Forgiveness and compassion

Evolutionary psychology suggests that people evolved capacities for altruism, empathy, commitment, and compassion (Berry *et al.*, 2003a; Gilbert, 2000; Nesse, 2001; O'Connor, 1996, 2000; O'Connor *et al.*, 2002a), and the need to reconnect with one another when altercations disrupted their relationships creates strong desire to forgive one another. This enables beneficial/supportive relationships to be repaired. This has served people (and other primates) well as a means to hold families and groups together. When altercations are followed by disrupted relationships and no efforts are made towards reconciliation, people often feel a sense of emotional dysregulation, affecting them adversely. Unresolved conflict in families may be linked to depression and anxiety. Sometimes, if there is also a genetic predisposition, the history of family conflict may lead to drug use or other dysfunctional behaviors (Lewis *et al.*, 2000; McGuire, 1987; O'Connor, 2000). Despite the central importance of forgiveness in interpersonal contexts and reconciliation and the effect of forgiveness on regulation, until the past five years there was little empirical research related to forgiveness and social emotions, including compassion, empathy, sympathy, and interpersonal guilt. This now is changing. The area of study has become noteworthy, in conjunction with the growing field of positive psychology (Seligman & Csikszentmihalyi, 2001).

Forgiveness is often connected to reconciliation, the capacity to aid in the process of reconnection after one has harmed another. Reconciliation may operate in higher apes (Brosnan & de Waal, 2003) and other social animals. Social animals live in groups, depend on a degree of harmony and cooperation, experience a wide variation of social structures, and exhibit wide variation in temperament, culture, amount of group activity, collaboration, and independence. Because of these attributes of social life across different groups, a fundamental aspect of social life is the need to reconcile after altercations. Most lasting *reconciliations* occur in connection with some form of forgiving after harm has been inflicted on an individual or group.

McCullough (2000) argues that forgiveness involves a change of motivation. Enright and Fitzgibbons (2000) see forgiveness as a complex of affect, behavior,

and cognition. Hargrave and Sells (1997) view forgiving as fundamentally interpersonal. All agree that forgiveness is complex and multidimensional. We understand forgiveness to be based on altruism as a fundamental human motivation; it is one of a number of mechanisms derived from primary altruism and as such it ultimately serves to hold social groups together through facilitating reconciliation. More immediately, forgiveness involves a complex set of prosocial emotions, many of which may be implicit, and that shape and are shaped by interpersonal processes. They have, as an end, reconciliation and reconnection following the disruption of interpersonal relationships (Berry *et al.*, 2003c; Worthington & Wade, 1999). Altercations and disruptions of relationships cause dysregulation because we are always in need of others for maintaining our physiological comfort (Lewis *et al.*, 2000; McGuire & Troisi, 1987; O'Connor, 2000). The complex emotional transformations involved in forgiveness tend to regulate both the transgressor and the person who is forgiving (Berry & Worthington, 2001; Witvliet *et al.*, 2001). It is noteworthy that a study described below provided evidence of the fundamental altruism underlying forgiveness. It demonstrated that people wanted to forgive, even in the absence of any personal relationship or direct reason to forgive, and the explanation given was that they identified with the transgressor, or they expressed some other form of compassion (O'Connor *et al.*, 2003).

Forgiveness as an intrapsychic phenomenon usually in interpersonal context

Forgiveness and 'unforgiveness' (negative emotion associated with an inability or refusal to forgive) have been viewed by some from an intrapsychic perspective, i.e. as a state that occurs within an individual (Exline *et al.*, 2003; Worthington & Wade, 1999). In the wake of being harmed, injured or insulted, there is often a difference between what the victim wants to happen as the outcome, and what actually happens; this difference is sometimes referred to as the 'injustice gap.' As time goes by, many events – interpersonal or within the individual – can reduce the injustice gap, making forgiveness easier. Or the opposite may occur and the victim, even in the absence of any interaction with the transgressor, as the result of rumination, may desire more 'repayment' for the transgression, 'to make things right.' Such rumination usually makes forgiving more difficult.

However, if the person who committed the act that harmed the victim begins to feel remorse and guilt, and signals this to the victim, that perception can elicit in the victim a sense of compassion and forgiveness. Forgiveness is thus experienced intrapersonally but usually is engendered within an interpersonal context. The transgressor who remains indifferent to the harm he or she has done is harder to forgive. Interpersonal acts are highly tied up with forgiveness or its absence.

While research described below suggests that there is a tendency for people to attempt to identify with the transgressor in order to enable the process of forgiveness, even in the absence of overt expression of guilt or remorse, nevertheless it remains far easier to forgive when the transgressor expresses feelings of guilt and remorse for the insult or injury he or she has inflicted on the victim. Thus, while the desire to forgive has a strong intrapsychic component, and even interpersonal acts that invite forgiveness do not always lead to successful reconciliation, which has an adaptive function, forgiveness usually occurs within a two-person context leading to reconciliation.

In the absence of remorse and guilt on the part of the transgressor, the person who was harmed or insulted may remain angry and continue to feel victimized. He or she may experience multiple situational, intrapersonal, and interpersonal stressors, with the urge to act in a retaliatory or vengeful manner. Indeed, it may require self-control to avoid acting out these destructive and often self-damaging emotions, and even with self-control the person who has been harmed may still feel resentment, bitterness, and anger.

In unforgiveness, a concept many might identify with Christian theology, there is a focus on bitterness, resentment, hostility, hatred, anger, and fear. Unforgiveness is theorized to be overcome through various means including: seeing or seeking justice, engaging in narrative reframing, employing psychological defenses, forgetting, accepting, and forgiving (Worthington & Wade, 1999).

People who have been harmed may be able to overcome the feelings of anger or sadness they feel if they are experiencing strong feelings of positive social emotions such as empathy, sympathy, compassion, or altruistic or romantic love. It has been suggested that these social emotions may neutralize or at least divert one from feelings of anger, in the wake of being harmed or insulted (Exline *et al.*, 2003; Worthington & Wade, 1999).

Compassion and the interpersonal context of forgiveness

If transgressors become aware of the harm they caused, they often feel empathy, guilt, and remorse and signal this to the victim. This in turn has the effect of creating in the victim feelings of compassion for the transgressor, who is then forgiven. Thus compassion and forgiveness are tightly linked attributes, related to the other evolved capacities that function to hold families and social groups together. Altercations within families are so common in daily life they are almost like the air we breathe; as therapists we can hardly think of a session in which we do not hear of some 'family fight' that has occurred, either that very day or in the recent past. Children and their parents, couples, adolescents, siblings, cousins, and even more extended family members, all engage in fights of varying intensity; for the most part, these are

resolved by the mechanism described, involving the complex interaction of compassion, remorse, guilt and forgiveness.

Empirical studies on forgiveness and compassion – positive social emotions

Forgiveness is facilitated by empathy, compassion, and other prosocial emotions. Studies linking forgiveness to social emotions demonstrate that both empathy and closeness of relationship increase or decrease the likelihood of forgiveness of specific interpersonal transgressions (Fincham *et al.*, 2002; McCullough *et al.*, 1997, 1998).

The disposition to forgive transgressions over time and across situations, often referred to as 'forgivingness' (Berry *et al.*, 2001; Mullet *et al.*, 1998; Roberts, 1995), has been linked to trait empathy (Berry *et al.*, 2004b; Brose *et al.*, 2002; Macaskill *et al.*, 2002; Tangney *et al.*, 1999). Forgivingness has also been associated with cooperativeness (Berry & O'Connor, unpublished data) and with the personality factor of agreeableness (Ashton *et al.*, 1998; Berry *et al.*, 2003a; Brose *et al.*, 2002; McCoullough & Hoyt, 2002; Mauger *et al.*, 1992; Symington *et al.*, 2002), which is related to empathy and the maintenance of positive relationships. People who are dispositionally forgiving are also more likely to behave altruistically toward others who are in need (Berry *et al.*, 2003b), and there is substantial evidence that altruism is often motivated by empathy, compassion, and feelings of responsibility for the well-being of others (Batson *et al.*, 2001; Hoffman, 2000; O'Connor *et al.*, 2003; Tolk *et al.*, 2003). Potentially any variable that increases empathy, compassion, and other prosocial emotions might facilitate the development of forgiveness. For example, Gillath *et al.* (Chapter 4) have shown that a secure attachment style is related to compassionate capacity. Not surprisingly, then, several laboratories have found that insecure attachment is associated with reductions in forgiveness (Burnett *et al.*, 2003; Tangney *et al.*, 1999).

Apology, restitution, and emotional signaling

Forgiveness involves an emotional transformation in the victim, and this transformation, especially in close relationships, is usually the outcome of a complex interpersonal process involving the experience and communication of empathy, compassion, and other prosocial emotions on the part of both the victim and the transgressor. After committing a transgression, people often feel guilty and remorseful about what they have done. Much of this distress is based on immediate empathy and compassion for the victim, who has been caused to suffer. The transgressor can also be fearful and sad at the prospect of losing his or her relationship with the person he or she has injured or insulted. People are highly attuned to one another's emotional states, and emotional states in one person can elicit similar states in others (Lewis *et al.*, 2000;

McGuire & Troisi, 1987; O'Connor, 2000; Pole, 2000). Sandage *et al.* (2000) found that highly empathic people are more likely to *seek* forgiveness when they have hurt or offended another. Apologies and expressions of remorse by hypothetical transgressors produced improved judgments of the transgressors (Darby & Schlenker, 1982; Ohbuchi, Kameda, & Agarie, 1989). Apology has been consistently related to a victim's subsequent forgiveness of a transgressor (McCullough *et al.*, 1997, 1998).

In a recent experimental study (Berry *et al.*, 2004a), participants were presented with one of two scenarios involving a traffic accident in which the transgressor was clearly negligent. When the scenario included an apology and clear expression of remorse from the transgressor, 100 per cent of participants believed the victim would forgive the transgression, and 79.2 per cent made reference to the apology and remorse in their explanations of the willingness to forgive. When the same scenario was presented with no reference to an apology or remorse, then 71.4 per cent of participants believed that the victim would forgive the transgression, while 17.9 per cent believed the victim would not forgive, and 10.7 per cent suggested that forgiveness was not applicable to the situation. In this scenario condition, 39.3 per cent of respondents still made reference to the transgressor's likely remorse, even though remorse was not explicitly described in the scenario. Across the two scenarios, 30 of 52 respondents (58 per cent) made some reference to the apology or remorse on the part of the transgressor, or made some expression of sympathy with the transgressor. Of these 30, 29 believed the victim would be forgiving. In contrast, of the 22 participants that made no suggestions of compassion, two said forgiveness was not required, and five still believed the victim would forgive. Even when compassion was not mentioned, some participants still wanted to forgive.

Worthington *et al.* (1999) asked people to recall two recent interpersonal transgressions in which someone did something to greatly hurt or offend them. In one, the research participants had completely forgiven the transgressor; in the other, they were still unable to forgive completely. For the transgressions that had been forgiven, the victims believed that the transgressors had clearly 'felt sorry' for what they had done, and the victims said they could 'put themselves in the shoes' of the transgressors. Thus, empathy and compassion appeared to distinguish the transgressions that were forgiven from those that were not forgiven. These results were maintained even when statistically controlling for a variety of other factors associated with the transgressions.

The effects of an apology will likely depend on the victim's receptivity to the apology. That receptivity is based in part on empathy. The relationship between apology and forgiveness has been shown to be partially (McCullough *et al.*, 1997) or completely (McCullough *et al.*, 1998) mediated by empathy. Takaku (2001) used multiple perspective-taking conditions in a scenario-based experiment to determine the effects of an apology on forgiveness. When

participants recalled a time when they had themselves been a transgressor, their forgiveness following an apology was higher than that of participants who took other perspectives (e.g. victim perspective, external perspective).

Although compassion for a transgressor can be elicited by apologies, expressions of remorse and guilt, and requests for forgiveness, a victim might also be led to compassion by events that befall the transgressor, such as injuries, illnesses, or other tragic or harmful occurrences (Worthington & Wade, 1999).

In a recent study, Berry, Worthington, and O'Connor (2004a) categorized positive attributes into warmth-based and conscientiousness-based social norms and found that compassion and forgiveness were firmly located among the warmth-based traits and were associated significantly with altruistic acts and with prosocial affective traits such as empathy, proneness to survivor guilt, and agreeableness. In another study, it was found that valuing the warmth-based social norms was significantly associated with the disposition to forgive transgressions (Berry *et al.*, 2003c).

Factors that inhibit forgiveness

We have presented research on many factors that appear to facilitate the development of forgiveness. Whether these factors are dispositional (trait empathy, agreeableness, placing high value on warmth-based traits) or a complex interpersonal process (apologies, restitution, or expressions of guilt and remorse from the transgressor), they all promote emotional forgiveness by increasing compassion, sympathy, love, or other prosocial emotions.

It is expected, therefore, that forgiveness would be made more difficult by factors related to the inhibition, incapacity, or unwillingness to experience compassion. There is substantial evidence that negative affective traits, such as hostility, trait anger, neuroticism, fearfulness, and depression, are related to lower levels of trait forgivingness and to reduced likelihood of forgiving specific transgressions (Ashton *et al.*, 1998; Berry *et al.*, 2001, 2003b; McCullough & Hoyt, 2002; Seybold *et al.*, 2001; Symington *et al.*, 2002; Tangney *et al.*, 1999; Thompson *et al.*, 2003; Walker & Gorsuch, 2002).

Another factor that can interfere with forgiveness is rumination. Rumination has been associated with mental health difficulties such as depression (Nolen-Hoeksema, 1991; Spasojevic & Alloy, 2001), anger (Caprara, 1986; Caprara *et al.*, 1992; Collins & Bell, 1987), anxiety (Segerstrom *et al.*, 2000), obsessive-compulsive disorder (Hodgson & Rashman, 1977), and post-traumatic stress disorder (Horowitz & Solomon, 1975; Horowitz *et al.*, 1980). It is likely that there are individual differences and contextual factors affecting how people cognitively process transgressions. The kinds of rumination that a person utilizes in coping with insults and offenses, i.e. vengeful, depressive, or fearful, will shape the course of affective experiences and motivations around a transgression, thereby shaping the likelihood of forgiveness.

The tendency to ruminate vengefully following transgressions predicts less forgiveness for specific transgressions (Berry *et al.*, 2004b; McCullough *et al.*, 2001) and lower dispositional forgiveness (Berry *et al.*, 2001; Brooks & Toussaint, 2003). Depressive rumination also seems to inhibit forgiveness (Berry *et al.*, 2004b; Brooks & Toussaint, 2003).

The perceived characteristics of a transgression or transgressor can affect a victim's emotional reactions and shape the subsequent likelihood of forgiveness. Some interpersonal events are simply viewed as unforgivable (Flanigan, 1992). In comparing forgiven and unforgiven transgressions, Worthington *et al.* (1999) found that higher levels of the initial severity of a hurt or offense, its unexpectedness, and its perceived injustice or unfairness all work against forgiveness. People appear to be less forgiving when they fear that the person who hurt or offended them is likely to do so again in the future (Worthington *et al.*, 1999). Ongoing contentious relationships are the breeding ground of multiple hurts that build increasing conflicts and negative emotions, potentially inhibiting compassion, and making forgiveness difficult.

Gilbert (Chapter 2) has argued that social rank plays a complex role in attachments and the development of compassion. There is little research, however, on forgiveness across social rank and power differentials. In a recent study of transgressions in the workplace (Berry *et al.*, 2003a), employees were significantly less likely to forgive transgressions by superiors than by coworkers. When a transgression occurred 'down-rank,' the victim perceived the transgression as more severe, and the impact of the transgression on work productivity and psychological well-being was more pronounced. In addition, transgressions that involved a global devaluation of the victim (e.g. sexism and racism) were much more difficult to forgive. It is possible that higher ranking persons were less likely to apologize or express remorse after their transgressions, believing that this would be perceived as a weakness or in some other way incompatible with an ongoing power differential. It is also possible that the power differential implies a real vulnerability or threat to the subordinate, and fear and related negative affects conflict with the kinds of positive, compassion-based affects that facilitate forgiveness.

A model of the development of compassion and forgiveness

There is not yet a definitive body of research on the development of forgiveness in children, enabling us to understand the mechanisms by which we learn to overcome altercations and engage in reconciliations, thereby remaining close to our families and later to our broader social groups. In our definition, forgiveness must be preceded by the ability to empathize with or feel compassion for another, and since we have some understanding of the development of empathy and compassion, we suggest that forgiveness may follow a similar course (see Gilbert, Chapter 2). Social learning theorists might suggest that children learn to be compassionate, and thus forgiving, through

imitation (Bandura & Walters, 1963, as cited in Mulherin, 1998). Imitation of a nurturing, forgiving parent leads to social success, which in turn serves to reinforce forgiving behavior. Eventually, this ritual of apology becomes an internalized value, and children learn not only to receive forgiveness in return for their own remorse, but also to dole out forgiveness to reward the remorse of others. Martin Hoffman's review of research (1963, as cited in Mulherin, 1998) on parental discipline techniques demonstrated links between parental use of 'non-power assertive' techniques, such as scolding or inducing remorse, and children's moral development. While social learning theorists might have posited that the withdrawal of parental love served as a behavioral punishment, Hoffman (1963, as cited in Mulherin, 1998) argued a slightly different twist on how children might learn to forgive. He believed that parents who drew attention to the pain or harm children's actions cause were teaching those children to be sensitive towards others' feelings. This sensitivity, once internalized, would allow the child not only to feel remorse for harm he or she had caused, but also to recognize signs of remorse in others, thereby teaching children the cycle of harm, remorse and forgiveness in which we all engage.

More recent research has continued to support Hoffman's insight that our ability to empathize begins to emerge in infancy – much earlier than social learning theory might propose. Empirical evidence for infantile sensitivity to others' emotions was gathered in a longitudinal, naturalistic observational study by Radke-Yarrow, Zahn-Waxler and collaborators (Radke-Yarrow *et al.*, 1973; Zahn-Waxler & Radke-Yarrow, 1982; Zahn-Waxler *et al.*, 1979, 1983, 1992). These researchers trained mothers to observe and audio-record their children in the home, documenting children's reactions to witnessing someone expressing pain, fear, anger, sadness and fatigue. They also made regular visits to the home to observe and rate childrearing methods on various dimensions of empathic caregiving. They saw evidence for a developmental sequence that began in infancy with distress reactions to the distress of others, followed in the second year of life (15–18 months) by efforts to intervene, mediated often by the seeking out of caregivers, perhaps to involve them in interventions, and producing, by age two, significant increases in prosocial actions. The authors saw this transition as 'a landmark in social development' (p. 251), possibly, reflecting 'universal potentials for concern for others and possible biological maturational mechanisms' (p. 251). In the six months before their second birthday, the children in the study exhibited, in different frequencies, various forms of altruistic behavior ranging from sharing, helping, comforting, to defending, advice giving, and mediation in fights. The investigators also noted in the second year signs of guilt and conscious remorse, evidenced in attempts to make reparations when the children caused someone distress.

Analysis of the data revealed a distinct pattern among some of the slightly older children (20 months old), in particular those children disciplined by

affectively-charged means, who were highly likely to make reparations for distress caused, as well as high in altruism for distress witnessed. The researchers noted: 'These disciplinary practices may be laying down the bases not only for the child's responsibility for his own acts but for the general responsiveness to feelings of others' (Zahn-Waxler *et al.*, 1979, p. 327). These results were corroborated by later studies (see review in Zahn-Waxler & Kochanska, 1988). They support Hoffman's earlier assertions that discipline by means of induction (giving reasons or explanations for the requested change in behavior) or love withdrawal (turning away, ignoring the child) is instrumental in the development of concern and compassion for others' emotions.

Thus, our ability to forgive appears to be rooted in our early maturing abilities to empathize with the distress of others that are continuously developed through parent-child relationships, and later social experiences with peers. The research described above noted that there were clear individual differences in proneness to forgive (Berry *et al.*, 2001). While there is always some question about genetic variability in any personality trait, in the case of a social value we do not know how great a role genetic variation plays, or whether distinctively learned social norms, reflecting both the culture in which a child grows up and the parents, are more relevant to individual differences in adulthood. We cannot know whether those who appear to be more likely to forgive are genetically different or whether they have imitated one or two parents or other caregivers who are more likely to forgive, or some combination of the two factors. This then leads us to the role of the interaction of compassion and forgiveness in psychotherapy, how this interaction functions in terms of dealing with the immediate symptoms clients bring to treatment, how it relates to resolving issues relating to the past, including the family of origin, and how it pertains to whatever might come up in the process of psychotherapy itself, which always to some extent reflects the past, present and future in a client's life.

Forgiveness and psychotherapy

Most clinicians, regardless of their theoretical perspective, training or background, agree that clients are affected by past injuries, emotional difficulties, and disappointments. Psychodynamic therapists find disturbing childhood experiences (including memories and perceptions of them) at the root of clients' problems. Cognitive therapists help people deal with ruminations about negative interpersonal relationships and maladaptive underlying schemas developed in the family of origin. Behavioral therapists likewise help people examine the source of maladaptive responses while focusing on new behaviors. Interpersonal therapists find current patterns of interaction that recapitulate past patterns and that are a source of dysfunction. Family and marital therapists frequently observe how family-of-origin patterns of

interaction influence current interactions. In their own theory-consistent ways, therapists across schools of therapy help clients deal with and repair the fallout from the past.

Sometimes clients overcome prior insults or harm done to them by simple acts of forgiving. DiBlasio and Proctor (1993) found that most social workers (regardless of theoretical orientation) and most marital and family therapists (again regardless of school of therapy, or of their own presence or absence of religion), supported forgiveness in their clients. However, therapists are wise to be aware of their clients' attitudes towards forgiveness, and to take these into account in their own approach to forgiveness in therapy. Clients who value forgiveness as a virtue will be more attuned to therapists who demonstrate an appreciation of this value. Clients who don't think of forgiveness as a particularly admirable virtue will be offended should therapists take the stance of locating forgiveness as a central value. Such a client may feel that the therapist is moralistic and fear that the therapist might be judgmental. Thus, therapists need to follow their clients closely and match their clients' perspective if they are to be maximally effective. In addition, as will be noted below, even when a client may himself or herself deeply value forgiveness as a virtue, it may not be helpful to focus on forgiveness in therapy if the client suffers from a mental disorder in which the moral system is essentially on overdrive, and thus any moral focus becomes something the client turns upon himself or herself in a self-destructive manner. As with most attitudes, values, techniques and methods in psychotherapy, forgiveness as a value or focus or technique calls for case-specificity on the part of the psychotherapist.

The down-side to forgiveness: Clients who forgive too much

While forgiving those who have caused harm is often helpful, it is not always desirable, beneficial, or even positive. The woman who remains in a relationship with a husband who beats her, allowing him to return, feeling compassion for him when he expresses remorse, and forgiving him in the wake of his guilt and remorse, is not being self-protective and, more often than not, ends up again being harmed. Forgiveness, if it leads to such unwise and dangerous reconciliation, as in this all-too-common scenario, is not positive.

There are numerous other less dramatic but potentially self-destructive problems associated with clients who tend to forgive too easily or unwisely. Many clients without significant mental health problems who come to therapy for marital or occupational counseling may as a side problem demonstrate a high proneness to interpersonal guilt, and particularly to feeling omnipotently responsible for the well-being of others. These clients are quick to feel guilt on the part of a transgressor, and equally fast to react with compassion and forgiveness. Not to forgive quickly makes them feel guilty, and they feel like the transgressors. The roles get reversed unfairly. Clients who tend to forgive too quickly, who are so sensitive to others' distress and who are in turn

so distressed themselves, are at risk of poor judgment and may be victimized more than they should be. This is not a down-side to forgiveness *per se*, but to unwise forgiveness, incautious forgiveness, forgiveness driven by overly active empathy and guilt and worry about others, unmediated by careful cognition. While there may be little to be said for holding a grudge, unending love and thoughtless altruism may end up as problem for the altruist.

Forgiveness could be considered as an evolved capacity for holding the family and social group together. It is also an in-group phenomenon. In our global society and culture, it is difficult to see where the 'out-group' and 'in-group' distinction retains any positive adaptive value; but this is from our narrow perspective, what we only can see here, in the present. The failure to forgive the 'out-group' enemies historically created tightly bonded social groups and societies that fought fiercely, defending their territory, their husbands and wives, and their children, against encroachment by those who would harm them. The prosocial emotions and mechanisms evolved for social group living were designed for the in-group. The out-group was another matter. Unforgiveness is likely the emotional and motivational state more appropriate for out-group relations, though it is difficult to see the relevance given our world today.

But often forgiveness is a positive and in fact a necessary factor in human relations. It is part of the fabric of our social life, holding our groups and families together, creating the background for reconciliation when infractions have occurred as they will. Thus, it is often the case that clients are seeking help with overcoming disruptions in relationships, and being able to forgive is something they want to gain from their time in therapy.

Clients often begin therapy reporting on interpersonal conflict. Having difficulty forgiving someone in their lives may be a problem, or forgiving 'too much' may be troublesome. Therapists listen closely as their clients describe their relationships with partners, friends, and family, and often detect themes related to this topic. Therapists may also at times find themselves feeling unforgiving of their clients, particularly if therapists are confused about what is happening in therapy. If a client is testing his or her therapist by imitating a difficult parent who was particularly traumatizing in childhood, the therapist may momentarily feel angry and unforgiving, at least until he or she understands why the client is doing what he or she is doing. If, for example, a client begins to refuse to pay his bills, to miss his appointments, to act provocatively, or to threaten to quit therapy when it is obvious that he is still in need of therapy, the therapist may, without thinking, feel unforgiving until on reflection she is able to understand who in childhood the patient is likely to be imitating and why the patient is repeating this in therapy. When a patient is unable to clearly remember and work on a traumatic experience in words, he or she may work through actions, by imitation, hoping the therapist will be able to remain friendly, despite the patient's difficult behavior. In this manner, the patient is testing his or her therapist, in order to learn a new

way of reacting and to then feel less traumatized by the memory of his or her parent. When first faced with this difficult behavior the therapist may feel lost, attacked, and thus unforgiving. However, when the therapist understands the client's testing, the therapist is able to feel empathy, to identify with the client, to feel compassion and to forgive.

When and how to approach forgiveness: What brings clients to treatment

The most common set of symptoms and problems that bring clients to psychotherapy fall into several broad categories of Axis I diagnoses: mood disorders and particularly depression, substance abuse disorders, and anxiety disorders and particularly generalized anxiety disorders. The other major category of problems that bring clients to treatment includes relationship problems, marital and other family problems such as dealing with adolescents and/or children, and adult children dealing with parents, who are often aging. These sets of problems may be better categorized as related to life circumstances that become problematic. The interaction between forgiveness and compassion comes into play in all of these problems, and while, as noted above, the extent to which a therapist focuses overtly on forgiveness and compassion as a social norm is necessarily case-specific (i.e. in line with the values of the client), in all cases the therapist is implicitly dealing with these issues as they are so much a part of both the social life of the family of origin and the day-to-day life of the client.

Forgiveness and depression

In our modern world, we seem to be suffering from an epidemic of depression (O'Connor *et al.*, 2002a), the etiology of which remains somewhat mysterious although many theories abound. Our own research suggests that many depressed people suffer from an exaggerated sense of responsibility for others, an excessive amount of interpersonal guilt, and self-blame for others' misery and despair (O'Connor *et al.*, 2000, 2002b). The client who comes into therapy suffering from depression can be full of despair about the pain he or she believes he or she is causing others. This is usually greatly exaggerated and unrealistic. The patient is therefore desperate for forgiveness, for what can only be regarded as 'imaginary crimes' (Engel & Ferguson, 1990) that the patient believes he or she has committed against others, often against loved ones. These 'crimes' may include being more successful than someone in his or her family, or not taking 'good enough' care of someone, or in some way feeling 'a disappointment to others' or that one has let others down. The most extreme form of this type of guilt and need for forgiveness may be seen in patients who are hospitalized for depression and suicidality and feeling a burden to others, who make remarks such as, 'As long as I am alive, my

mother is going to suffer terribly' or a similar comment about another member of the family. Beliefs that commonly accompany suicidal patients may be related to imaginary crimes that the depressed person considers beyond forgiveness and compassion. In fact, depressed patients may lack the ability to feel compassion for themselves or to forgive themselves for the ways they believe they have harmed others, and can suffer from an exaggerated sense of empathy for others and severe empathic distress (O'Connor *et al.*, 2000, 2002a). Therefore, as therapy begins, instead of encouraging a depressed patient to become more empathic, compassionate and forgiving, it is often important to focus on turning things in the other direction and help the patient worry less about others' problems, take less responsibility for others, feel less empathic concern, and make *self*-compassion and *self*-forgiveness a primary focus (Gilbert & Irons, Chapter 10). Learning to externalize blame and tolerate anger towards others (and not feel guilty/unlovable for having angry feelings) has been key to many psychotherapies for depression since Freud (Gilbert, 1992), and can be especially important with severely depressed patients in deep despair with unrealistic self-blame.

Such a focus of course does not exclude helping (for instance) a depressed mother learn to be more responsive to her child, for there is now much evidence that depression in a mother can have a negative impact on her child's development (Gilbert, Chapter 2). Indeed, the loss of 'feeling for her child' can be another source of guilt-based depressive rumination. Although depressed people may ruminate on guilty themes and on concerns for others, depression itself reduces the flow of affectionate behaviours.

If a patient establishes a trusting and accepting relationship with a therapist, the therapist may have enough 'authority' to offer the experience of a relationship in which the patient can *feel* forgiveness, understanding and acceptance. From this may grow a more compassionate and forgiving approach to the self, which allows healing to begin (Gilbert & Irons, Chapter 10).

Forgiveness and substance abuse problems

Patients who come to therapy with substance abuse disorders are, like depressed people, often suffering from an exaggerated sense of responsibility for the well-being of others and are particularly high in proneness to interpersonal guilt and shame (Meehan *et al.*, 1996; O'Connor *et al.*, 1994; O'Connor *et al.*, 2002b). Many people with substance abuse problems may have difficulty getting into recovery because they believe that to stop using drugs will constitute an act of *disloyalty* to someone in their family, for example an alcoholic father, a prescription drug-dependent mother, or a drug-dependent sibling. Many clients with substance abuse diagnoses grew up in families in which life revolves around drinking. Alcohol or drugs is the organizing principle of the family culture. Rejecting alcohol is perceived by the family as a rejection of the family culture (O'Connor & Weiss, 1993;

O'Connor *et al.*, 2002b). This then is a difficult hurdle for addicts that desperately want to stop drinking because they know their drinking is destroying their relationships and career. They already feel overly responsible for their family, and they live with the anxiety typical of someone with a high proneness to an exaggerated sense of responsibility and guilt. Alcohol may temporarily reduce their feelings of guilt, excessive responsibility and anxiety. However, inebriation is often accompanied by behaviors for which they feel guilty and ashamed, and is inevitably followed by great remorse and guilt. They feel guilty not only for drinking, but for the damage they have caused as the result of their drinking. They want to stop drinking but believe they will be betraying their mother and father and whole family culture. It may be only after they have tested the therapist, often repeatedly, to be sure that being in recovery and abstinent from drugs and/or alcohol will not hurt this new authority, that they are able to allow themselves to become abstinent and stop the process of active addiction.

Many people with substance abuse problems, after getting comfortable with their therapist and convinced that stopping drugs will not harm those they love despite the culture of the family, the drug or alcohol use of their parents or siblings or friends, will then be able to make use of therapy in conjunction with self-help programs. Here forgiveness and compassion are formalized into working on the 'steps.' In the 'fourth step' of the 12-step programs for addicts in recovery, they are asked to write 'a fearless inventory' of themselves in which they list everyone they believe they may have harmed, and in the 'eighth step' they 'make amends' to those they believe they have harmed, i.e. they ask for forgiveness, signaling both remorse and guilt to the victim of their transgression.

While these steps were developed by non-clinicians based on their own experience and not by practicing clinicians, this is often a highly effective intervention in that it offers to recovering addicts the opportunity to relieve themselves of some of their guilt, which is considerable and a primary source of relapse. The only potential danger in the 12-step process is the focus on harm caused by the addicts in recovery. While this provides the opportunity to seek forgiveness for the real harm they may have caused while they were using drugs and/or alcohol, and to make amends for this harm, in some cases this may reinforce addicts' already exaggerated sense of responsibility rather than relieving them of it. However, for the most part, the spiritual aspect of the 12-step self-help programs contributes to relieving addicts of their exaggerated sense of responsibility for others, while providing them with a concrete way to face the real harm they may have done while using drugs and alcohol, and to make amends to those they have harmed. The 'third step' in the self-help programs suggests that recovering addicts 'turn it over' to a power greater than themselves, and this serves as a daily reminder that they are very limited in their personal power and a higher power is where their problems and worries belong; thus seeking forgiveness while at the same time

learning to 'turn it over' works to reduce recovering addicts' remorse, guilt and shame, both for the past in which they were often out of control when they were inebriated, and for the present when they are somewhat estranged from their family of origin, or old friendship circles, in which life may revolve around the consumption of alcohol.

The role of the therapist in the treatment of recovering addicts is to support their recovery with unwavering clarity in terms of abstinence as an ultimate goal of treatment, and to pass clients' tests, many of which revolve around whether or not the *therapist believes the clients deserve* to be clean, sober and successful. While the therapist doesn't want to discourage the clients' natural inclination to compassion and forgiveness, there is a fine line to be walked in terms of lowering their irrational sense of responsibility for others, their exaggerated proneness to interpersonal guilt and their shame. Clients in recovery have a remarkable opportunity to formally ask forgiveness from those they have harmed, and therapists may also have the opportunity to help clients recognize when some of those whom the clients think they have harmed were in fact victims of imaginary crimes and there was no harm to be forgiven. Forgiveness and compassion are woven into treatment for addiction, and even clients who are not attending self-help programs implicitly seek out a way to factor out the real injuries from the imaginary ones that they may have caused to people while they were using. They find ways to coach their therapists to help them in this endeavor. They deeply wish to offer an apology to these people, and hope for forgiveness in the wake of their authentic guilt and remorse. As we have seen in our pilot study (Berry *et al.*, 2004a), people wish for forgiveness and wish to forgive others, as ultimately this is a mechanism that holds our social groups together.

Forgiveness and anxiety disorders

People who suffer from anxiety disorders, similarly those with substance abuse problems and depression, tend to believe that they are responsible for others, far beyond what is realistic, and in fact many of their worries are focused on the harm they think they have done or could do to others. Thus, the issues of 'imaginary crimes,' compassion, and forgiveness are implicitly central themes in treatment. For example, obsessive-compulsive disorder (OCD) is frequently accompanied by sets of irrational beliefs about harming others (Wroe & Salkovskis, 2000). The woman who washes her hands all day not infrequently reports doing so because she believes that if she doesn't she will contaminate her daughter's food and her daughter will become ill and die. Her hand-washing is therefore a symptom that aims to protect her daughter from harm, inflicted by her. Children with OCD who have numerous verbal or physical rituals often believe that should they stop engaging in them, one of their parents or siblings will fall ill or die. People with this illness live on the edge of disaster that they believe they might create, and most often, the

harm is predicted to happen to those they love most and the painful rituals they engage in are designed to protect their loved ones (Esherick & O'Connor, 1999). While we know that OCD is a biological disorder and involves brain dysfunction, often occurring in children in the wake of a strep infection, the pattern of thinking is remarkably similar in terms of repetitive warnings about the sufferer harming loved ones. Given this common pattern of beliefs, the empirically supported treatment for anxiety disorders is based on a graded list of fears, and exposure with response prevention, in addition to medication such as selective serotonin reuptake inhibitors. A symptom commonly found to a greater or lesser extent in anxiety disorders is hyperscrupulosity. In fact, priests were the first to note and treat OCD when they dealt with parishioners who prayed excessively and who came to confession far beyond what was justified by reality. The priests developed a policy of ordering these parishioners to refrain from praying, and from coming to confession so often. This was the first trial of 'exposure with response prevention.'

While generalized anxiety disorder shows a lesser degree of scrupulosity and hypermorality, these are still present and therefore a focus on morality of any kind is likely to increase clients' anxiety and worsen the condition. A focus on moral values is necessarily counterproductive in the treatment of even the milder anxiety disorders, because one of the primary symptoms is overdrive of the morality system. When clients with an anxiety disorder start worrying about forgiveness, they quickly become overly anxious about their imaginary crimes, whom they might not have apologized to, whom they failed to apologize enough to, or whom they apologized to incorrectly. They have no problem in feeling compassion and forgiving others, because their overly active sense of morality leads them to take responsibility for almost everything, and if someone seems in the slightest bit disturbed or upset, they bend over backwards with compassion and forgivingness, and suffer despite their efforts at reconciliation.

Relationship problems, compassion, and forgiveness

The problems that therapists deal most routinely with are those that involve relationships – families, couples, parents and young children, adolescents, roommates, and ordinary work relationships with peers, supervisors and bosses, and subordinates. Compassion and forgiveness are among the most important two-person events that allow for the resolution of relationship problems. Therefore they are always implicitly and sometimes explicitly a focus when people come to therapy in order to get help with their relationships. Sometimes couples want help breaking up, but more often they want help staying together; they want to get along, they want better relationships with their children, they want their children to stop fighting, they want to get along with their elderly parents more comfortably, they want to get along with their office mates. People want to stay connected. As mammals we are

not able to maintain our physiological – including our neurochemical – regulation by ourselves, without almost continuous contact with others. People who are isolated suffer detrimental effects including depression and suicidality (Lewis *et al.*, 2000; McGuire, 1987), and become dysregulated. Lewis and his collaborators describe an open-loop limbic system, echoing Bowlby (1969), who suggested that we are dependent on one another throughout life, not just in infancy and childhood, and that Freud and followers gave 'dependency' a bad name, misguiding generations of psychologists and psychiatrists. It is safe to say that most people who bring relationship problems to therapy are eager to correct the situation and reconnect with the person or people from whom they have become disconnected. Often all that is needed is permission to use compassion and forgiveness within these important social relationships in order for them to be dramatically altered in a positive direction.

Compassion and forgiveness may not be 'new skills' that need to be taught; they are already there, as we learn them as small children. However, in the midst of fighting, career building, and the hassles of daily life, many people simply forget these skills. All that may be needed is a safe place to be encouraged, to be reminded of and to 'contact' these capacities within them, and use them to (re)build their relationships and re-establish the connections that are part of being human. We are social animals, in search of connections; being reminded of this in therapy is a beginning.

When couples or parents and adolescents or roommates or friends are fighting, a cycle of blame, guilt, shame, and blame is usually established, which it is difficult to escape from. For example, Peter and Amanda are both in their mid-30s, and have been married for seven years. They've been preoccupied with their careers for the past few years, Amanda becoming a successful immigration attorney and Peter a research psychologist in a prestigious university, now up for promotion and tenure. They have two young children who are three and five, one in nursery school and one in kindergarten and both at home after school with a woman who lives with the family. Recently they have found themselves fighting over small things – who is driving the children to school, who is picking up the laundry. They work long hours. Both of them bring work home in the evening and work well past midnight. On the weekends, they often argue over seemingly nothing, with escalating blame. It might begin with Amanda, one Saturday at noon, blaming Peter when she was late for a meeting she had to attend in her office, because he was meeting with his department chair for an early breakfast. Peter, feeling guilty for going out for breakfast on a Saturday morning, grew angry and blamed Amanda: 'If you weren't always thinking about your career first, if you ever thought about your family, you wouldn't be so worked up about a meeting on Saturday. But you never think about your family at all.' Amanda, feeling by then even more guilty and blaming than she had to begin with, shoots back: 'You have it easy, you have no idea what its like to be a woman in a firm.

You're in the boy's club. You can sit there and tell me I just think about my career, but you have no idea of how much time I have to spend worrying about details that you pay no attention to.' And off they go – escalating guilt and shame induction cycles that are disrupting their relationship.

Compassion and forgiveness that they already have as an implicit skill – a form of procedural knowledge, rather like riding a bike – is what therapy can bring to the foreground and cause to be remembered. Amanda can feel compassion for Peter, who is feeling guilty because he went out to an early Saturday morning breakfast with his department chair. However, she can also feel angry. When Peter sees 'just a bit of softness' on her face, he may apologize for being late, and this will then help Amanda to forgive him. Peter may then be more sensitive and try to take care of things for the rest of the day, and try to be more understanding of Amanda's position and life experiences (for example, as a woman working in a competitive world).

While we present this as if it is easy in principle, in practice it is complex and requires case-specific technique. If one member of a couple is somewhere on the anxiety spectrum, it becomes important to veer away from any use of moral value language, including something so simple as 'forgiveness' or 'compassion' because, as was seen above, an anxious person will turn these on themselves and ruminate about how they have failed to live up to expectations, and before the therapist knows it, their anxiety has worsened. Likewise, if one member of a pair is prone to depression, they are likely to turn any moral language on themselves, to blame themselves, and become overly compassionate and worried about the other. So the therapist becomes savvy at finding other words and tactics to interrupt the process and reintroduce compassion and forgiveness without moral language. There is no way for the guilt–blame–guilt–rage–guilt–blame–guilt–rage cycle to continue when it is broken by compassion and forgiveness. This principle is basically the same for all relationship problems, between family members, roommates, office partners, business partners.

Sometimes there are serious conflicts of interests, and couples will separate, or business partners will break up. But most often people are looking for reconciliation, which provides a sense of comfort, relief from distress, and physiological regulation. Reconciliation is the proximate purpose and cohesive social groups are the ultimate adaptive purpose of compassion and forgiveness. As social animals that live in rather large and relatively permanent social groups, we can depend on our capacity to form bonds with one another and to want to maintain these bonds. When the normal disruptions and altercations of daily life temporarily break these bonds and connections that are so important to our sense of well-being, the two-person mechanisms designed to bring about reconciliation are deep in our implicit knowledge base.

Conclusion

Sharing, caring and supportive relationships, based on altruism, are fundamental to many mammals but in particular the higher primates and especially humans. Given the advantages of these relationships, various psychological processes have developed to facilitate the maintenance of supportive non-aggressive and non-injurious styles of relating. In this context forgiveness can be seen to play a key role in the expression of compassion and is fundamental to the maintenance of important relationships in which conflicts may also exist. Forgiveness is thus a trait that is commonly given high moral value, especially in certain religions, although as noted here it is not without its down-side.

This chapter has explored some of the regulating processes of forgiveness that operate in and through interactions, among which learning to regulate anger/retaliation for feelings of being harmed is key. Compassionate empathy can allow us to make connections to perpetrators and in this way forgive them. This chapter also explored the linkage between feeling responsible and difficulties in forgiveness of both self and others in emotional disorders. Further research on facilitating compassionate forgiveness both of self and of others will advance our understanding of how to promote positive relationships and mental health.

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Part II

Compassion and use in psychotherapy

Chapter 7

A social-cognitive model of validation

Robert L. Leahy

Why do we find ourselves drawn toward dramatic productions that portray painful emotions and tragic outcomes? Why is Othello's jealousy and tragic self-destruction an experience that we want to hear about? Why do we find ourselves fascinated and moved by Lear's pride and betrayal by his daughters? What moves us to want to hear the romantic tragedy of *La Traviata* played out again and again? I believe that these tragedies – and the human predicaments of suffering that they reflect – appeal to us because they validate our own mistakes, misfortunes and suffering. They give *nobility* to our emotions, and make us feel we are not alone. As an audience we are the chorus to universal feelings of pain. The suffering on stage points to higher values, language that gives greater meaning to our pain, and a shared vicarious recognition that we are mutual witnesses to the inevitable misfortunes of being human.

Validation – finding the truth in what we feel and think – stands as the fulcrum between *empathy* (where we recognize the feeling that another person has) and *compassion* (whereby we feel *with* and *for* another person and care about the suffering of that person). Finding the 'truth' – even if the truth is in a 'distorted' thought or a biased set of rules; even if the 'rationale' for the other person's suffering has resulted from their own pride or jealousy – allows us to bear 'witness' to the fact that the other person's suffering means something to us. We are the witness who sees their 'truth' and we are affected by their suffering.

I shall attempt to explore the importance of validation as a central component in human experience that begins with attachment processes during infancy and early childhood, is nurtured or deflected through emotional socialization, and contributes to the success or failure of emotional processing. My view is that mechanical therapies differ from validating therapies, and that, for some, the failure of the therapist to successfully validate the patient's feelings, values, and thoughts may become a significant impairment to both the therapeutic alliance and the resolution of emotional difficulties.

The role of the therapeutic alliance has received strong empirical support (Horvath & Symonds, 1991), but the specific components and processes that

contribute to this alliance have not always been clearly delineated. Although perceived empathy is often correlated with better outcome, the directionality of this relationship has been disputed – that is, whether improvement in therapy precedes or follows from perceived empathy (Feeley *et al.*, 1999). It is not my purpose to settle the question of directionality of cause, but rather to examine how validation 'works' for the patient and how the patient's earlier experiences – and emotional schemas – may interfere with obtaining validation.

In this chapter I attempt to develop a social-cognitive model of validation and suggest therapeutic strategies to enhance validation in therapy. I place the issue of validation in the context of general attachment theory, emotional socialization and emotional schemas, and I outline pathological strategies of eliciting validation and examples of self-invalidation. Finally, I will suggest therapeutic interventions that can improve the nature of validation – especially within a cognitive-behavioral model.

Attachment theory and validation

Bowlby (1968, 1973) and Ainsworth *et al.* (1978) have proposed that infants are innately predisposed to form and maintain attachment to a single figure and interruptions in the attachment bond will activate behavioral systems that seek completion until attachment is secured. Bowlby's ethological model of attachment stressed the evolutionary implications of attachment in establishing proximity to adults who could protect, feed and socialize the infant in appropriate behaviors. Attachment theorists further elaborated this model to emphasize the importance for the infant or child in establishing a sense of *security* in attachment – not simply proximity (Sroufe & Waters, 1977). This security entails the predictability of the responsiveness of the caregiver for the child.

Bowlby proposed that security in attachment is enhanced through the development of *internal working models* or cognitive representations of the attachment figure. Specifically, an internal working model for a securely attached infant would imply that the caregiver will respond to cries of distress, will be responsive in soothing the infant through reciprocal interactions and will be predictable in providing positive (rather than punitive) interactions. The assumption guiding attachment theory is that these internal working models – established in earlier childhood – will affect subsequent attachment experiences with other individuals in the person's life. It is this responsiveness, as described by Bowlby and others, that marks the early foundation of validation schemas.

Ainsworth and others have differentiated various forms of attachment styles, including secure, anxious, avoidant and disorganized. Other classification systems that have been employed differentiate three types – secure, avoidant and ambivalent (Troy & Sroufe, 1987; Urban *et al.*, 1991). Research

on attachment styles suggests that early childhood attachment is predictive of social functioning in middle childhood and early adulthood – specifically, peer relationships, depression, aggression, dependency, and social competence (Cassidy, 1995; Urban *et al.*, 1991).

It is argued here that validation in meaningful relationships is reflective of attachment issues. First, during the process of forming and maintaining attachment during early childhood, the rudiments of validation include the caregiver's responsiveness to the child's distress, which reinforces the child's mental representation – 'My feelings make sense to others.' Second, responsive soothing of the child's feelings by the caregiver encourages the child to believe, 'My distressed feelings can be soothed.' Initially, it is proposed here, this 'soothing' occurs through the caregiver's attention and reassurance, but later it is 'internalized' by the child in self-calming and optimistic self-statements – similar to Bowlby's idea of internal working models – in this case, the internal representation that one's feelings make sense and can be calmed. Third, the child's communication of feelings to the caregiver becomes an opportunity not only for expressing feelings, but for the caregiver to link emotional states to external events that 'cause' the feeling – 'You're upset because your brother hit you.' This attempt to comprehend the cause of feelings, and to share them with the caregiver, can also assist in differentiating these feelings – 'It sounds like you are angry and hurt' – and in constructing a theory of mind that can be applied to both self and others. Indeed, without an adequate theory of mind, the child will be impaired in showing empathy, validation and compassion toward others, and will be unable to soothe the feelings of other people.

Patients in therapy enter the therapeutic relationship with different adult attachment styles: secure, anxious, avoidant or disorganized. The anxious attachment style – characterized by clinging behaviors and need for reassurance – may both result from and cause fears that validation will not be obtained. Individuals with anxious attachment styles may have idiosyncratic beliefs about validation (for example, 'You have to feel what I feel to understand me'), and may fear that the therapist will become critical or withdrawn. Nevertheless, these anxious individuals still will seek out validation and eventual attachment to the therapist. In contrast, the avoidant attachment style will be reflected in wariness and distance, avoiding closer contact and openness in the therapeutic relationship – as it does in other relationships. The individual here may avoid disappointment by hoping for less and avoid rejection by sharing less. The disorganized attachment style may have difficulty identifying needs – or may escalate the expression of these needs for fear that they will not be heard and, therefore, will never be met. Conflicts in earlier attachment experiences may result in vacillation between seeking validation (often through escalation of demands, complaining or emotional expression) and wariness of validation (since the attachment figure is seen as unpredictable).

Meta-emotion and validation

Gottman and his colleagues have proposed that an important component of socialization involves the parent's 'philosophical' view of emotion, or what Gottman refers to as 'meta-emotional philosophy' (Gottman *et al.*, 1996). Specifically, some parents view the child's experience and expression of emotions – such as anger, sadness or anxiety – as a negative event that must be avoided. These 'negative emotional' views are communicated in parental interactions, such that the parent will be dismissive, critical or overwhelmed by the child's emotions. In contrast to these problematic emotional socialization styles, Gottman *et al.* (1996) identified an *emotion-coaching style* that entailed the ability to recognize even low levels of emotional intensity, saw these 'unpleasant emotions' as an opportunity for intimacy and support, assisted the child in labeling and differentiating emotions, and engaged in problem-solving with the child. Parents who adapt the emotional coaching style are more likely to have children who will be able to self-soothe their own emotions – that is, *emotional coaching* assists in emotional self-regulation. Furthermore, children of parents using emotional coaching are more effective in interactions with their peers, even when appropriate behavior with peers involves the inhibition of emotional expression. Thus, children of parents utilizing emotional coaching are more advanced in 'emotional intelligence' – knowing when to express and when to inhibit expression and knowing how to process and regulate their own emotions (see Mayer & Salovey, 1997). Emotional coaching does not simply 'reinforce' a cathartic style in children, but rather allows them to identify, differentiate, validate, self-soothe, and problem-solve. The emotional coaching style, as described by Gottman and colleagues, is an extension of the active listening skills and problem-solving strategies advocated by communication-based models of relationship interaction (e.g. Jacobson & Margolin, 1979; Stuart, 1980).

The hypothesized relationships between parenting styles, quality of attachment, beliefs about validation and interpersonal strategies are depicted in Figure 7.1. The developmental pathway for secure attachment begins with parenting that is responsive, warm and predictable, and that involves emotional coaching. This 'ideal' style of secure attachment would result in positive views of validation – that others will understand, support and elaborate emotions and that one can openly share and learn through validation. In contrast, parents who provide unpredictable or even punitive styles of parenting would be expected to have children who display avoidant, anxious or ambivalent attachment styles. These children would be likely to be distrustful of validation – either not expecting to receive validation or viewing validation as a 'cover' for further punishment. Further, children whose parents view emotions in a dismissive or critical manner would be more likely to view their own needs as a burden or annoyance to others. These individuals would be expected to have greater difficulty recognizing their own emotions, to be

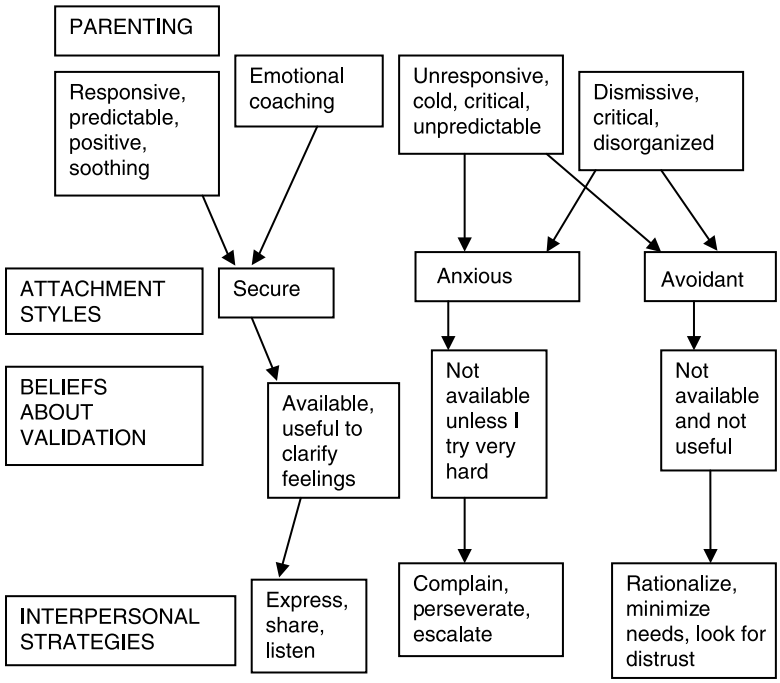

Figure 7.1 Relation of parenting, attachment styles, beliefs about validation and interpersonal strategies.

more likely to be alexithymic, and to be more likely to engage in self-invalidation – for example, to think that their needs are excessive or shameful.

Emotional schemas and validation

Let us imagine the following: a child grows up and never experiences any validation of any thoughts or feelings. He is an *emotionally feral child*, but lives within a community of other people who ignore validation. His parents have adapted a radical behaviorist approach, believing in the 'black box' and adhering to the strictly behavioral position that emotions and cognitions are meaningless constructs because they cannot be directly observed. They read Ayn Rand and hope to raise a child who will think on his own, without the help of others.

When he cries, no one comforts him or asks him what is bothering him. When he feels confused and expresses this to others, no one attempts to clarify the situation – and no one shows an interest in his confusion. Although he receives no validation and no comforting comments, he is not punished and he is rewarded for appropriate behavior.

What do you think the outcome will be?

If we view attachment as involving emotional responsivity, mirroring, and soothing, then we will expect him to become detached, avoidant, distant or even schizoid. He will have no opportunity to learn about *other* minds – that is, how others view events that he feels strongly about. He will not learn about the emotions that others have, since his parents believe that emotions are meaningless constructs. As a consequence of his lack of 'theory of mind' about others, he will be unable to respond appropriately to the feelings and behavior of others. This will lead to rejection and exclusion from the company of his peers.

He will become a 'peripheral man,' living on the outside of an interpersonal world he will never understand and that will never understand him. His internal life – emotions, perceptions, even sensations – will be difficult to label, resulting in his alexithymia. He will not learn how others differentially soothe their own feelings of sadness, anger or anxiety, since people will not share these feelings or allow him to share feelings with them. When he sees the Fosse musical, *Chicago*, he will identify with the number 'Cellophane Man' – people will 'look right through him and pretend he isn't there' – but he will still be unable to say why this moves him. And he will not be able to identify the feelings and perceptions that are encapsulated in his transparent cellophane self.

The question that this existential twilight zone raises is, 'What does validation teach us?' To answer this, we will first review my model of emotional schemas and then examine how these schemas are elaborated precisely through the process of validation. Let us begin with a *model of emotional intelligence* – specifically, emotional schemas. I have proposed that individuals differ as to their conceptualization of and strategies for emotion (Leahy, 2002). 'Unpleasant' emotions, such as sadness, anxiety, or confusion, are universal phenomena. However, not everyone becomes depressed that feels sad, and anxiety does not always lead to generalized anxiety disorder. According to the emotional schemas model, problematic outcomes for emotions occur when the individual views his or her emotion as an experience that is incomprehensible, is not similar to the emotions that others would have, will lead to loss of control, will last a long duration, or is shameful. Emotions are experiences that have implications for us, i.e. they imply that we are similar to or different from others.

Moreover, our emotions also carry implications for our availability for social support. Thus, if we believe that we can express our emotions and receive validation, and that others share these feelings, and that we need not be ashamed, then we are less likely to fear that our emotional experience will marginalize us among others.

Consider a man who has recently separated from his wife and who now lives apart from his five-year-old daughter. He describes himself as both sad and relieved, anxious about the future but hopeful that he will have new

possibilities in a relationship, and forlorn because he misses his daughter. He claims to feel confused about what is currently going on, but certain that he examined this decision in great detail. We can view this man as possibly aimed in two very different directions – one in which he views his emotional experience as pathological and another in which he views his experience as a reflection of the emotional complexity of his decision.

In the first instance – viewing his emotion as pathological – he may believe that he should have only one emotion (happy or sad). He may believe that these sad and confusing feelings will last forever, will overwhelm him, unless he can clarify exactly how he should feel. Thus, he currently views his emotions as somewhat incomprehensible, since he yearns for clarity and simplicity. He also may believe that he should be rational all the time, and that these emotions make him feel 'neurotic.' Because of his negative view of emotion he believes that others would be judgmental of him, thereby leading him to feel ashamed, which results in his hesitancy in sharing these emotions with others. He now ruminates about this emotional confusion, searching for a final answer that will forever clarify for him that his actions were perfectly reasonable and, thus, will eliminate these emotional swings.

In contrast to the rational and ruminating individual, an alternative is available – to view confusion, ambivalence, sadness and relief as understandable manifestations of the human condition. In this case, the separated man recognizes that a marital and family separation is fraught with internal and necessary conflict, leading him to feel pulled in opposite directions simultaneously. Rather than view conflict as 'undesirable' he will view these feelings as reflecting the depth, reality and richness of real life. It makes sense to him that he is relieved to be out of a relationship that is no longer satisfying, but it also makes sense that he feels sad while he misses his daughter. He recognizes that the attachment to his wife and the positives that they experienced are as real as the negatives that motivated him to separate. He views his negative emotions as a stage in a process of transition – one that will begin with confusion and sadness but will, hopefully, result in the ability to balance these experiences. He is less likely to seek 'closure' and 'clarification' and more likely to recognize that ambivalence is a reflection of his authenticity. If he cries now, he recognizes that he will be capable of laughter later, if only because he allows himself to have all the feelings that will come with his truly living his life.

These differing emotional schemas are depicted in a schematic that is presented in Figure 7.2. As we can see in examining this schematic, there are three possible pathways for responding to negative emotion. The first – which reflects the belief that conflicting and negative emotions make sense – will lead to expression, validation and learning. The second – which views negative emotions as experiences to avoid – will lead to substance abuse, avoidance, and dissociation. The third – which also views negative emotion as problematic – leads to worry, rumination, blame, and continued negative feelings.

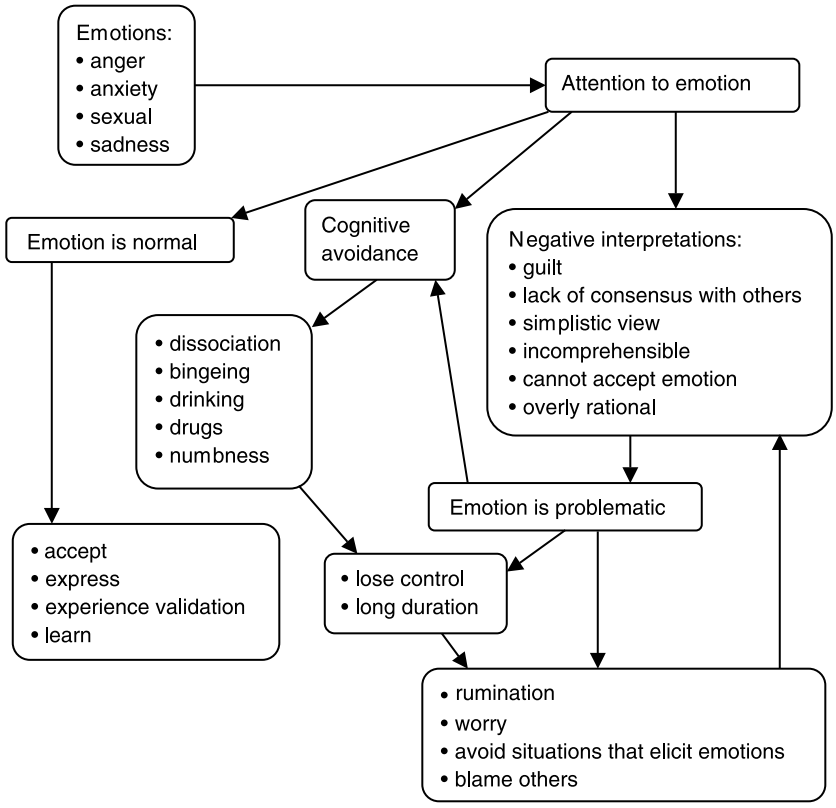

Figure 7.2 Metacognitive schematic of emotions.

The catharsis model, which argues that simply expressing emotions will facilitate emotional processing, was not supported in research on emotional schemas (Leahy, 2002). Specifically, individuals who claimed that they could express their emotions were not less depressed or less anxious – that is, simply expressing emotions may not be enough. However, validation was related to many of the emotional schema dimensions. Thus individuals who believed that their emotions were validated believed that their emotions were more comprehensible, felt less guilty or ashamed, had a less simplistic view of emotion, believed they had greater control, were less emotionally numb, believed that their emotions would not last a long time, believed that others would accept their feelings and had similar feelings, and were more likely to accept their feelings. Interestingly, validation was not significantly related to depression or anxiety in this study, but validation *mediated* the relationship between other emotional schemas and depression or anxiety.

What is the role of validation in regard to worry? Wells (1997, 2003) has

proposed a metacognitive model of worry, whereby individuals who are more prone to worry have the following beliefs: worry prepares and protects, worry is dangerous and out of control, one cannot rely on one's memory, one must constantly monitor one's thoughts, and worry is an obligation (or other superstitious beliefs). In an attempt to investigate the relationship between worry and emotional schemas, I found that validation was related to all five factors of worry in Wells's model. Thus, individuals who believed that they could not get validation for their feelings were more likely to have a positive view of worry (as protecting and preparing), and more likely to view their worry as out of control or dangerous, not trust their thinking, view worry as a responsibility, and self-monitor their thoughts (Leahy, 2003).

Borkovec and colleagues have found that many of the worries characteristic of generalized anxiety disorder (GAD) are focused on interpersonal concerns (Borkovec *et al.*, 1983). Recently Borkovec and his colleagues have proposed that there is a non-specific *interpersonal* component to generalized anxiety (Borkovec *et al.*, 2002). Similarly, interpersonal and psychodynamic approaches to understanding GAD have suggested that individuals with this disorder may be marked by an intrusive and domineering interpersonal style and that this style creates greater conflict and anxiety (Crits-Christoph *et al.*, 1996; Durham *et al.*, 1997; Horowitz *et al.*, 1993). The importance of interpersonal conflict in GAD is addressed by an interpersonal–psychodynamic model of anxiety and treatment proposed by Crits-Christoph and colleagues. According to the Supportive–Expressive (SE) model the focus is on cyclical maladaptive relationship patterns in terms of the core conflictual relationship theme (CCRT) – that is, the patient's wishes (for support), the response of others (e.g. rejection) and the patient's response (e.g. anxiety) (Crits-Christoph *et al.*, 2004), which draws on the earlier work of Luborsky and DeRubeis (1984). The core conflictual response may differ for patients, but anxiety is viewed in this interpersonal context of wishes that are thwarted in the interpersonal domain. The emphasis in Crits-Christoph's model is the positive and empathic aspect of the therapeutic relationship and exploration of interpersonal conflicts and problems within the patient's life.

Finally, our research indicates that the perception of validation differs across the various personality disorders (Leahy, 2003). Individuals higher on dependent, avoidant, and borderline personality disorder traits believed that they were less likely to be validated, whereas individuals higher on histrionic and narcissistic traits believed that they were more likely to be validated. Indeed, overall, narcissistic and histrionic individuals had more positive views of their emotions, whereas the avoidant, dependent and borderline had more negative views of their emotions. The apparent externalization of emotion – characteristic of the histrionic and narcissistic patients – may represent a misperception that their emotions are valued by other people, thereby leading them to underestimate the negative consequences of their emotional displays.

Pathological styles of validation

Although it may be true that attachment systems from early childhood seek out proximity, protection and emotional validation, individuals differ as adults in their *interpersonal styles* in seeking validation. Some of these interpersonal styles in seeking validation may result in increased depression, overfocus on negatives, and even rejection from the very people that one seeks validation from.

Rumination

The patient who believes that he is not heard may perseverate about his complaints, continually dwelling on the same problems. The countertransference sign of this is that the therapist feels like she is wasting time listening to boring and repetitive 'whining.' Ironically, the patient is seeking validation that these problems are troublesome and that the therapist sympathizes, but the therapist may be inclined to lose interest and complain about the patient. Directly addressing this issue can be helpful – 'It seems like we are going over the same material each time. Do you feel like you are not being heard?' or 'Is there something that you would like to hear from me so that you will feel heard?'

Catastrophizing

One style of eliciting validation is to escalate complaints to the point of 'catastrophe': 'You just don't understand – I can't do anything!' The patient may have learned – either in the family of origin or in his marital relationship – that the only way to be heard is to create a crisis. This is not unlike the style that borderline individuals utilize, but here it is viewed as a communication style that is not distinctive for any particular personality disorder. The individual that catastrophizes seeks to make his emotions even more salient and dramatic so that their impact will be felt by others. Indeed, catastrophizing may also be a form of self-validation – 'I feel it is terrible that this has happened. If I didn't think it was terrible, it would be like saying it was "OK" .'

Eliciting feelings in therapist

Another problematic style of seeking validation is to elicit feelings in the therapist – such as feelings of powerlessness, anger, or resentment. Although psychoanalytic writers may view this as 'projection' on the part of the patient, we can view this as an interpersonal strategy to elicit 'understanding.' For example, in marital relationships, the wife may say, 'I want him to understand how much it hurts me – that's why I attacked him. Maybe if he understands how much it hurts him, he will stop hurting me.' This is similar

to the ambivalent attachment styles that infants show – protesting when the parent withdraws and oscillating between clinging and attacking the attachment figure when she returns. This ambivalent attachment response may precede withdrawal, indifference and depression. Ironically, as a style that is used to seek validation, this will almost always lead to counterattacks or withdrawal on the part of the other person, thereby provoking more attempts to elicit painful feelings in the therapist or marital partner. Indeed, the withdrawal or counterattack will be used by the patient to justify the initial failed attempts to elicit validation.

Distancing

This style of eliciting validation is not unlike the wariness shown by the infant who is so anxious and sad over separation that he responds with caution to re-engaging the attachment figure. By distancing, and remaining apart from the other, the patient will be seen as 'passive-aggressive.' However, this passive-aggressiveness is more a form of a 'test' – 'If you really cared about me you would come to me to find out what is wrong with me.' Although we may view 'pouting' as a childish and unnecessary behavior, it can often elicit caring and concerned attention within adult relationships. The difficulty that this presents, however, is that the individual may rely on this distancing and pouting style as a means whereby he can gain attachment security. Eventually, the partners or friends of people who distance will find it unrewarding and distance themselves – perhaps confirming for the individual who initiated the distancing that he was correct to distance in the first place.

Splitting the transference

A common style of validation-seeking is for the patient to claim that another person – perhaps a psychopharmacologist or a friend – disagrees with the therapist and provides better understanding and more help. The patient thereby enlists the caregivers to fight over her attention – each dedicated to proving that he is a better caregiver than the other. This also serves as an investment strategy for the patient as the patient straddles the two relationships, enjoying the power of watching two professionals fight for loyalty. As a form of ambivalent attachment, the patient may enjoy a sense of power in eliciting feelings of helplessness and resentment in the caregivers that he personally feels in his own life. Having these 'surrogate parental or caregiving figures' compete for attention allows the patient to enjoy 'reattachment' experiences with different caregivers while at the same time punishing them for their 'failures' to adequately protect or validate. Unfortunately, as this process unfolds caregivers may retaliate or withdraw from the patient – or retaliate against their 'competitor' – thereby reinforcing the patient's beliefs that caregivers cannot be trusted in the first place.

Pathological rules for validation

As indicated above, some patients will perseverate, ruminate, escalate or provoke the therapist in search of validation. Exploring the patient's idiosyncratic rules for validation can be a helpful first step in breaking the impasses that arise. For example, the therapist can ask, 'Are there certain expectations that you have as to how you would like me to respond? Are there certain things that I can say – or certain feelings that you would like me to have – so that you will feel understood and cared for?' I have found that this direct inquiry leads to core schematic issues, such as the following.

- If you cared about me, you would understand what I am feeling without my having to tell you over and over.
- If you cared, you would agree with everything I say.
- If you cared, you would not try to change the way I feel.
- If you cared, you would make me feel better.
- If you cared, you would protect me.
- If you cared, I would feel better after I tell you about what is bothering me.

These idiosyncratic rules for validation lead directly to the continual failures in validation in the patient's interpersonal world. For example, beliefs that significant people in your life should understand what you are feeling without you communicating your feelings inevitably lead to frustration and anger. The rule that one should agree in order to show he cares represents a fantasy of alliances against a hostile world – one that may further alienate others from the patient's life and reinforce the patient's victim role. Finally, the belief that the therapist should rescue or protect – as a sign of caring and validation – represents the patient's belief that she is helpless and is being attacked by a hostile environment: the therapist's failure to rescue may then be seen as another 'betrayal.'

Self-invalidation

Many of our patients have been taught that their needs are either unimportant or a sign of their character flaws. Consequently, the patient may attempt to lower their expectations about their needs or view their needs as something to eliminate. Patients with eating disorders (anorectic or bulimic patients) may be particularly likely to vacillate between eliminating having needs and clinging and demanding styles of validation-seeking. Common self-invalidation styles include the following.

Unwillingness to talk about needs

In this case, the patient may have difficulty talking about what they need emotionally and will focus on 'practical issues' or anything other than emotional needs. By avoiding talking about needs, the pain of feeling frustrated and left out is avoided.

Viewing needs as weakness

Patients whose parents utilized dismissive or critical styles of emotional socialization learned that their needs were a burden to others, a sign of self-indulgence, or a reason to be ashamed.

Apologizing for needs

Similarly to the patient that views their needs as a weakness, some patients apologize for having needs, anticipating that the therapist will be critical or bored with the patient's feelings. The therapist can open the discussion about this by directly reflecting to the patient that he is apologizing for having needs, and ask, 'What could be a reason why you would apologize for your feelings?'

Using cognitive-behavior therapy as a defense against needs

We have found that some patients will choose cognitive therapy because they view this form of treatment as trivial, shallow and not inquisitive about 'deeper emotional issues.' Unfortunately, there are technique tacticians that will confirm this belief, by over-emphasizing a rational and reductionistic approach. Some patients are quite direct about this – 'I thought I could learn some simple techniques in a few sessions and be completed,' – or 'I understand that we don't have to deal with all of these emotional or traumatic issues.' Thorough history-taking – often including the patient's significant others or family members – may reflect the degree to which this trivializing approach is being pursued.

Attempts to lower expectations

Related to using therapy as a defense against needs and emotions are the self-invalidating internalized parental messages, 'My needs are selfish' and 'I am just a complainer.' The patient may say, 'I shouldn't expect to be happy all the time' or 'Why should I expect to have sex in marriage – people who are married have to be more grown up.' Other concerns about having 'too many needs' are to attempt to lower the therapist's expectations – 'I know that you are a good therapist, but I probably won't work out as a patient.' Again, this

interpersonal strategy not only reflects the dismissive or critical styles of their parents toward the patient's needs during childhood, but also protects the patient currently by avoiding 'getting your hopes up.' Self-invalidation strategies attempt to conserve disappointment within the boundaries of 'no surprises.'

Differentiated validation

As indicated by our empirical findings, validation is associated with viewing emotions as comprehensible, with less guilt and shame and with a variety of other factors (see Leahy, 2002). It is suggested here that the clinician can enhance validation in therapy by focusing on these dimensions. Specifically, validation of the patient's sadness can focus on how these emotions make sense, given the events experienced and the patient's interpretation of these events. For example, the woman who feels sad now that she is separated can find that her feelings of sadness make sense in that the end of a relationship is the end of something quite meaningful. Furthermore, her thoughts that she will never meet another man that she can love would imply that she would feel sad, even if this prediction is *only* a prediction. Her sense of guilt about the separation can also be addressed by helping her examine her husband's role in the marital problems, while at the same time indicating that many people feel that someone needs to be blamed when a relationship ends. Her tendency to be simplistic about her emotions ('I should *either* be sad or happy I am not with him') can be addressed by elaborating the variety of emotions that make sense during separation, and that 'conflicting emotions' carry more of the 'truth,' just as many colors in a painting give the painting richness. Indeed, validation can help her label and differentiate these various emotions, further linking the emotions to specific thoughts ('I am better off without him' (relieved) or 'I will miss him' (sad and lonely)).

Her sense of control over her emotions can be enhanced through her experience of expressing emotions in a validating relationship and experiencing the diminishing intensity of these feelings as she talks about them. Moreover, recognizing how her emotions are linked to her thoughts and the situations she finds herself in may also give her a greater sense of control and the expectation that these feelings will not last forever. She will express these emotions – fearing them less as they are validated – thereby reducing her tendency to rely on emotional avoidance and numbness. As she realizes that others accept and understand these feelings she will accept them as well, reducing her need to suppress them.

All of these processes enhance emotional processing, in the sense that less effort is required to control or suppress emotion and emotions begin to make more sense (Pennebaker & Beall, 1986; Pennebaker & Francis, 1996; Pennebaker *et al.*, 1997). It is suggested here that validation can be enhanced by assisting the patient in exploring these emotional schemas through

viewing current suffering in terms of higher values and needs that are reflected in the current experience, the consensus with others in these emotions, the possibility of having conflicting emotions simultaneously or in sequence, and the possibility that painful experiences may be 'accepted' and experienced, without overwhelming the person.

Therapeutic strategies of validation: value emotion

Examine your meta-emotional philosophy

If validation is viewed as an essential component of the therapeutic process, then how can this validation be enhanced? Clinicians can examine their own meta-emotional philosophies, in a manner similar to Gottman's analysis of parental philosophies of emotions. Are the patient's painful emotional experiences viewed as a waste of time, as an opportunity to access deeper and more fundamental issues, or as a possibility of developing a closer relationship? How does the therapist respond to intense crying by the patient? Does the therapist feel eager to intervene and change the feeling? Or can the therapist share the silence in a manner that is comfortable and paced with the patient's ability to process the intensity? Does the therapist believe that the patient's intensity will 'get out of hand' and overwhelm the patient? If so, does this communicate a negative emotional schema – 'intense emotions will go out of control'? Does the therapist insist on following a specific agenda, with techniques and forms, even when the patient's emotions are not consistent with this procedural fixation on the part of the therapist?

Emphasize the importance of all emotions – not just 'feeling good'

Many patients enter cognitive therapy hoping that they can acquire some 'tricks' that will help them avoid negative feelings. They may label some emotions as 'bad' and others as 'good' and, in some cases, reflect their fear of negative affect. As a consequence of fear of negative affect, the patient may attempt to avoid situations (including therapy) where unpleasant emotions are evoked. Validation that all emotions are important – including sadness, anger, rage, shame and envy – allows the patient 'permission' and 'safety' to experience these feelings and examine the thoughts behind them. The therapist can say:

> We are here to talk about all the things that you feel and see – not just the feelings that you think are 'good' feelings, but all feelings. In fact, your feelings – or emotions – are the most important thing for us to know about. Sometimes we feel sad or angry because our experiences are painful for us. It is important to know what these feelings are in order to

help you cope with the reality that you have. This is not only about feeling 'good' all the time – I am sure you realize how unrealistic that would be. It is more about coming to terms with your feelings and your reality so that you can clarify what you need and how to get those needs met.

Describe how emotions contain meaning of one's needs and one's perspective

Similarly to Greenberg's emotional focused therapy, the patient's emotions may reflect needs that are denied and values that are frustrated. One technique that is useful is the 'laddering technique,' whereby the therapist points to the higher values and needs implied by frustration and sadness (Hinkle, 1963; Neimeyer & Bridges, 2003). For example, the patient complains that he is lonely now that his relationship has ended. The therapist helps the patient climb the ladder to higher needs: 'And the reason that it is upsetting to be alone is that if I did have a relationship it would mean . . .?' The patient responds, 'I have someone to love.' 'And if I have someone to love, this would make me happy because it means . . . that I can feel more complete in giving love.' The therapist can identify this higher need of being connected and having love to give. The laddering technique validates the current pain in the context of the higher value – which is never lost.

The therapist can say:

> Just as our hunger tells us about our need for food, so also our painful emotions may tell us about what we need in life. Sometimes this is not entirely clear, though, since we may have one emotion – such as anger – that tells us we need to win, but hidden behind the anger is another emotion – sadness – that tells us that we need to feel loved and respected. Other emotions may tell you that you think you need to be in control of everything – something that is impossible. We can examine different emotions and different meanings rather than try to eliminate your emotions.

These different levels of meaning were apparent in a married couple contemplating divorce. Both sat in my office, arms folded, angry and defensive – fearful of making the first move. I commented that they were both experiencing tremendous pain at the moment, but neither would comfort the other. The wife indicated, 'I want to comfort him, but I am afraid he will reject me. And he never comforts me.' This led to a discussion of how their mutual anger was a more 'comfortable' emotion that carried the meaning of being an innocent injured martyr who could feel self-righteous. However, hidden by this anger was a sense of sadness that what they hoped would be a loving family life was now close to dissolution. Fearing the experience of sadness –

and fearing sharing the sadness – left them in a reciprocal angry and withholding pattern. As they realized that they shared the sadness about the same set of events, and that sharing their fears and sadness did not 'excuse' the other, they drew closer. Similar ideas are reflected in acceptance and commitment strategies (Hayes *et al.*, 1994).

Encourage expression

- Encourage awareness and expression of emotion.
- Use evocative imagery and memory.
- Give time and space for reflection.

Many of us who practice cognitive-behavioral therapy are too eager to jump in and ask questions and challenge thoughts. When the patient experiences an intense emotion it is important to give her time to reflect and space to live with the emotion in the moment. I have found that silence is often the best policy – calm, reflective, and trusting silence. Indeed, many times the patient's problem is that she has used emotional avoidance techniques to handle these emotions – such as binge-eating, dissociating, or rationalization. Experiencing the impact of the emotion within a calm and reflective space in which the emotion can come and go provides an opportunity for the patient to recognize that emotions do not have to be suppressed. Moreover, giving more time for emotion can help the patient experience several emotions – for example, the emotional experience may begin with anger, drift to anxiety and end up with sadness. These primary and secondary emotions, as Greenberg (2002) labels them, may contain a great deal more meaning that needs to be heard, validated and processed.

Make sense of emotion

Examine shame, guilt, and confusion over emotions

Many people believe that their emotions and their needs are shameful – that they are the 'only one' that experiences envy or depression or the only one that desires someone other than their partner. This shame and guilt is a central component of how obsessive-compulsive individuals evaluate their thoughts and feelings – 'dirty little thoughts' – and this leads them to want to suppress them and fear sharing them with the therapist (Rachman, 2003). Patients may view their emotions as a sign of a character flaw, weakness, perversion, or bizarre insanity. Other patients express confusion over why they would have such 'sick feelings,' since they believe they are basically good people. For example, a highly intelligent and apparently confident physician could not understand why he would have public speaking anxiety, since this was inconsistent with his view of himself. Another man could not understand why he

was so self-critical and depressed, since he knew he had never done anything reprehensible. The underlying question that the patient asks himself is, 'What is wrong with me that I have these feelings?' Emotions and fantasies become parts of the self that need to be hidden from others. The patient says, 'You are the only person who knows this about me.' These feelings of shame become self-perpetuating, since the 'uniqueness' of one's inner life cannot be disconfirmed if it is not shared with others (Gilbert, 1998).

This circular self-criticism – 'I hate myself because I am depressed and I am depressed because I hate myself' – becomes an impediment to therapy. Therapy is another experience of shame and humiliation. The therapist can assist the patient in addressing this shame by examining the genetic or biological basis of depression and anxiety, evaluate how child-rearing experiences contributed to these self-critical beliefs, and view depression or anxiety as a *specific limited vulnerability* – not something that characterizes the entire person. The patient can examine his attitudes toward other people whom he cares about who may have difficulties – is there a double-standard of criticizing the self while supporting others? The moral evaluation of emotions and fantasies can be addressed by contrasting the difference between a desire (e.g. an emotion) and a willful action to cause harm.

Evaluate how emotions are related to specific thoughts, assumptions and schemas

This involves 'making emotions comprehensible.' Traditional cognitive therapy emphasizes the link between automatic thought distortions and depression, implying that these negative thoughts contribute to depression. Viewing these automatic thoughts as hypotheses that are tentative and open to evaluation allows the patient to understand that he feels sad because he has the belief that he will always be alone. This belief can be evaluated utilizing typical cognitive therapy techniques (for example, 'What is the cost and benefit of this thought?,' 'What thought distortions are being used (e.g. mind-reading, fortune-telling, labeling)?,' 'What is the evidence for and against this thought?'). Specific maladaptive assumptions can be explored, such as 'I need everyone's approval to be OK' or 'I need to be perfect in order to be acceptable.' Linking specific emotions to these thought patterns – as well as eliciting situations – can assist validation in that the therapist can indicate that 'It makes sense that you would feel upset if you have these thoughts about yourself and other people.'

View emotions within a transferential and developmental perspective

Emotions can become comprehensible by virtue of understanding how one's emotional schemas and strategies were developed. For example, a woman

recalled how her parents acted as if emotions were a burden and that these emotions overwhelmed the parents, who utilized the daughter for reverse-parenting for their own emotional distress. This resulted in the patient's belief that her needs were either excessive or 'unknown,' and that she should always focus on soothing the needs of other people. Recognizing the developmental origins, and how her view that she did not deserve to have these needs kept her in self-defeating relationships with men and at work, helped her modify her views of how she could get what her emotions needed. This was dramatically expressed by her when she began to cry in session and the therapist asked her to reach out and say what her crying was saying she needed: 'I need someone who will love me and who I can have a family with.' This 'emotional clarification' – using her emotional intensity to clarify her needs and values – marked a turning point in her life.

Transferential interpretations of emotions can also improve validation. For example, a woman with a history of a suicide attempt, depression, intense anxiety and substance abuse presented in a placid, shallow interpersonal manner. The therapist noted this by saying, 'I am puzzled by the "disconnect" between how you talk about your experiences and the emotional issues here. I notice that you present in a *superficial* manner – as if we are not talking about anything very important to you. I wonder why you would do this?' This led to a revealing discussion of how emotions were not allowed in her family, that she learned always to be pleasing to others, and that she feared that she would decompensate in therapy if she allowed herself to feel. This transferential exploration of her 'shallow defense' enhanced the meaning of the therapeutic relationship and validated her tendency to self-invalidate as a strategy to avoid criticism and potential abandonment. It is of interest that in the next session she indicated that she had a dream that the therapist now was going to abandon her – something that she deeply feared and had hoped to avoid by quitting therapy prematurely. She indicated that when socializing with men, she always would present as an 'air-head' – as someone who was shallow; just a 'party girl.' Thus, she reasoned, if she were rejected, it would be on her terms as an intentionally shallow person, and the rejection would not reflect anything deeper about her. As she discarded her shallow defense in therapy, she became more worried about being abandoned by the therapist, since she believed that showing needs was shameful. This led to a discussion of how needs were viewed as weaknesses in her family and that emotions were generally dealt with by minimizing, ridiculing or, in many cases, relying on alcohol.

Develop emotional tolerance

In order to experience validation one has to 'have' an emotion that is experienced and expressed. However, fears of emotional intensity may inhibit this ability to express emotions. The clinician can assist the patient by the following.

Examine fears that emotions will overwhelm and last indefinitely

Some individuals believe that if they have an intense emotion, this emotion will become so overwhelming that they will be unable to tolerate the experience. The therapist can inquire as to whether the patient finds herself continually trying to 'catch and suppress' feelings and what this then makes her feel (Kennedy-Moore & Watson, 1999; Labott & Teleha, 1996). For example, a patient continually tried to catch herself from 'welling-up' with emotion because she feared that she would become so overwhelmed that she would 'lose control' and 'fall apart' in front of the therapist, thereby humiliating herself. The therapist encouraged her to watch for emotions that came up in session, talk about the way she felt, and allow herself to have a feeling. This 'allowance' of having a feeling resulted in less emphasis on inhibiting crying, which resulted in less emotional frustration and confusion. The cognitive approach to the emotional schema about 'uncontrollable' emotion is to have the patient make specific predictions about what will happen if a specific emotion gets 'too intense' and to set up experiments to test these predictions. Another technique that is useful is to have the patient try to lose control of an emotion, to test the belief that one always has to control strong feelings.

Use mindful observation of emotion

Mindfulness allows the individual to experience, observe and be non-judgmental of emotions and sensations that occur 'in the moment' (see Kabat-Zinn, 1990; Linehan, 1993; Segal *et al.* 2002). By *observing* the emotion when it arises, and not attempting to control it or get 'carried by it,' the patient can become aware and acquire distance, simultaneously. For example, noticing ('I am seeing a feeling of anger that I am having') and observing the sensations that go with this feeling, watching the sensations and emotions rise and decline in intensity, can allow the patient to live with the emotion in the present without being controlled by it. This mindfulness can enhance validation insofar as the patient is able to notice and describe experiences that are then shared openly, without the fear of being overwhelmed by the experience.

Experiment with limited expressions of emotion

A fear of being overwhelmed by emotions leads some patients to attempt to eliminate feelings with binge-eating, drinking or reliance on drugs. Similar to panic disorder, these patients fear that once an emotion is aroused, it will spin out of control. These patients can be encouraged to experiment with having a feeling and then learning how to modify this feeling. Examples of this modification include techniques utilized by dialectical behavior therapists – for example, improving the moment, distraction, replacing the emotion with other emotions – as well as techniques that provide for distraction, identifying automatic thoughts, and alternative behaviors. Having an effective program of action or experience that can be utilized for emotional intensity can allow patients to experience emotions that can later be validated.

Conclusions

I have attempted to examine how needs for validation are reflective of earlier attachment styles and the effects of parental bonding and emotional socialization. Although a general process factor in psychotherapy includes the experience of validation, the specific consequences of validation have not been clearly delineated in other models. The model of emotional schemas provides a framework for how validation can effect change in emotional processing and how these changes can affect shame, guilt and self-criticism. Helping the patient identify both personal needs and the need to be validated can often activate problematic attachment styles and emotional schemas that may lead some patients to trivialize therapy, avoid emotionally evocative topics, or even to terminate therapy prematurely. The model of emotional schemas – grounded in both attachment theory and models of emotional socialization – may provide a valuable therapeutic heuristic for developing both conceptualizations of problematic 'strategies' for seeking validation and useful interventions for providing patients in psychotherapy with the opportunity to learn that their emotions not only 'make sense,' but are a valuable part of the narrative with others.

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Chapter 8

The Buddhist use of compassionate imagery in mind healing

Ringu Tulku Rinpoche and Kenneth Mullen

Compassion, and its development, is a major theme of Buddhism. In the Metta Sutta, an early teaching of the Buddha, it is expressed as follows:

> Even as a mother protects with her life.
> Her child, her only child.
> So with a boundless heart.
> Should one cherish all living beings.
> Radiating kindness over the entire world:
> Spreading upwards to the skies,
> And downwards to the depths.
>
> Metta Sutta (1990: 90)

This orientation runs through all schools of Buddhism. The Dalai Lama has said: 'I consider that compassion is the base, the sovereign support of humanity' (Dalai Lama, 1996: 117). Compassion is wishing that all suffering without exception might be utterly extinguished. And here we are not just talking about all the sufferings of one person, or a few people, but all the sufferings of all sentient beings. It is also positive in that our wish is that all may attain unlimited well-being and peace (Ringu Tulku, 2001: 3).

Within the Tibetan Buddhist schools, meditation on, and the generation of, compassion is usually awakened via imagery and the contemplation of bodily representations. These bodily images are then imbibed with positive qualities of warmth, care, concern and loving kindness (Leighton, 2003; Moacanin, 1986). Meditations are intensely relational in nature, the idea being to capture the key qualities of embodied compassion through the (imagined) social relationship. Gilbert (Chapter 2) has considered the question of whether our brains are 'hard-wired' for relating socially; in this chapter we will take a different perspective.

Of course there is now a wealth of literature on meditation practice, and most of the interest has come from psychologists (Fasko *et al.*, 1992; Kwee, 1990; Ornstein, 1977; Shapiro & Giber, 1978). In terms of general health, researchers have found that meditation produces decreases in respiration,

heart rate, blood pressure and muscle tension (Benson, 1977; Shapiro & Giber, 1978; Wallace & Benson, 1972). There is also evidence to suggest that meditation can help patients with bronchial asthma (Honsberger & Wilson, 1973). If we turn to meditation's possible effects on mental health, studies have shown that it may reduce insomnia (Woolfolk *et al.*, 1976) and some symptoms of psychiatric syndromes (Glueck & Stroebel, 1975). More recent work has corroborated such findings (Benson *et al.*, 1990) and produced further research in this area. Studies have shown: reduced levels of psychological symptomatology (Astin, 1997), enhanced coping (Edwards, 1997; Emavardhana & Tori, 1997; Leifer 1999), statistically significant improvements in both subjective and objective symptoms of anxiety and panic (Miller *et al.*, Fletcher & Kabat-Zinn, 1995) and reduction in pulse rate (Suduang *et al.*, 1991). Work has also been done on psoriasis (Kabat-Zinn *et al.*, 1998).

Note that all of this work is written within a particular psychological and empirical paradigm. The distinction we would wish to draw is between positivist and interpretative frameworks (Benson & Hughes, 1983; Schwartz & Jacobs, 1979). The current chapter attempts to use the interpretative sociological approach to move forward on these issues. This approach takes seriously the philosophical and religious ideas underpinning meditation practice and aims not to be reductionist, as psychological approaches have often been (Silverman, 1985). Further than this, we also wish to suggest a practical use for compassionate action.

This chapter considers one Tibetan Buddhist meditation, approaching it from both the Eastern philosophical and the Western sociological viewpoints. This meditation is considered to have healing effects for both physical and mental problems. We will first describe the Tibetan Buddhist meditation practice in its shortest and simplest form. This practice involves the creative visualisation of the Bodhisattva of Compassion, Avalokiteshvara in Sanskrit, Chenrezig in Tibetan. As Buddhism developed and spread beyond its birthplace in India, increased emphasis was placed on its devotional side and focus shifted from a concern with the details of the life of the historical Buddha towards the cosmic expression of the Buddha-nature. Within the schools of Mahayana and later Vajrayana Buddhism there developed a pantheon of celestial Buddhas and Bodhisattvas (enlightened beings) who were believed to reside in various universal pure realms (Conze, 1988). These represent various aspects of the absolute Buddha-nature. Practices often centred round numerous cults, and petitionary forms of worship took place. Some monasteries encouraged these 'cults', and were well known for petitionary practices directed to a particular deity. Various Buddhas and Bodhisattvas were seen to have the power to relieve both physical and mental suffering in its various forms (Bokar, 1991; Clifford, 1992; Zopa, 1994). One of the most popular and prevalent of these cults within devotional Buddhism is that addressed to Avalokiteshvara,

the Bodhisattva of Compassion. Praying to Chenrezig and reciting his mantra is believed to have health-giving effects.

This chapter is jointly written by a Tibetan Rinpoche and a medical sociologist. The method used is a combination of textual analysis of the root text and the elucidation of the text, from both books and oral instruction, amplified by reflection on personal experience of taking part in similar meditation practices over a number of years. Social scientists have analysed texts in numerous ways and trace slightly different theoretical lineages. The medical sociologist works within the field of discourse analysis, and the stance adopted in this paper has close similarities to what Manning & Cullum-Swan (1998) have termed 'semiotic discourse analysis'. Here the aim is not just to focus on the meaning, structure and content of the documents, but also to show how these features relate to our conceptions of self and other in the social world.

The chapter begins by describing the visualisation of the Bodhisattva of Compassion. This is followed by two accounts of the meaning of this practice: first as elucidated within Buddhist teaching, and second from a sociological standpoint. We highlight similarities between the two approaches. We then offer suggestions as to how such a practice may be legitimately adapted to suit a Western non-Buddhist context where religious imagery might prove problematic or where Christian religious imagery might seem more appropriate. The chapter concludes by describing such a short meditation.

Structure of a simple puja

We now briefly describe a simple meditation on Chenrezig, the Bodhisattva of Compassion, in order to give the reader an understanding of the structure of a meditation puja.

The practice

The practice can be divided into *four sections*. The *first*, which is described as preparatory, is common to most Buddhist practices, and involves the chanting of prayers covering the going for refuge in the Buddha, the Dharma (the Buddhist teaching), and the Sangha (the community of Buddhist monks and nuns). Johnston has pointed out that this triple invocation can be paralleled in the Christian devotional life by the prayer, 'I put my faith in Jesus, I put my faith in the Bible, I put my faith in the Church' (Johnston, 1979: 125). This section also includes the wish to engender the enlightened compassionate mind (bodhi).

The *second section* consists of the main practice, which is the meditation on the Bodhisattva of Compassion. In its simplest form this involves the two aspects of visualising the deity and the recitation of his protective name or mantra. At the commencement of this stage the visualisation is generated in

either a sudden or an elaborate fashion, depending on the version of the practice. The practitioner visualises the deity appearing seated on a lotus flower and a moon disk about four inches above his head. He is iconographically depicted as sitting cross-legged having four arms; the two middle ones are joined holding a blue jewel, and the other two are to the side and hold respectively a crystal rosary and a white lotus. It is always insisted that the visualisation should not be solid but translucent, filled with light and similar in appearance to a rainbow. Again depending on which version of the practice is described, the practitioner would chant either a short or an elaborate set of devotional and petitionary prayers to the Bodhisattva. At the end of these prayers multi-coloured light is visualised as emanating from the body of the Bodhisattva; this light radiates in all directions and is imagined as purifying all beings in all realms of the universe. As this is being visualised the practitioner will commence to chant the mantra: Om Mani Padme Hum (see Bokar, 1991; Ringu Tulku, 1998b). As this section progresses everything in the practitioner's surroundings, and indeed in the universe, is imagined to be in the process of change and being transformed into the realm of Dewachen or great bliss. Indeed, the practitioner may also visualise that their own body and that of others is transformed into the appearance of the Bodhisattva. As the meditation progresses a transformation is imagined to take place:

> The radiance from the form of the guru on your head has now transformed all existence into deities and Buddha realms.
>
> (The Fifteenth Karmapa, 1984: 21)

This section will continue for some time with the practitioner attempting to stabilise the visualisation while continuing to recite the mantra.

Once this has been accomplished, a very important *third section* follows. Just as the visualisation has been gradually built up, so now it is dissolved:

> all these dissolve into light and melt into the Guru, the All-Seeing One; he too, dissolves into light and merges with you. And as you yourself dissolve into light, rest evenly in your own essence, exactly as it is, the great, encompassing, and pervasive Sphere of Phenomena, the Mind of the Supreme One, free from viewing and viewed with appearance, sound, knowledge and emptiness all inseparable.
>
> (The Fifteenth Karmapa, 1984: 21)

It is recommended that the practitioner rest in this awareness (the essence of mahamudra) for a short period of time.

The *final section* involves the dedication of any merits gained by the practice to all sentient beings; again this is common to all Buddhist practices. As the practitioner rises from meditation, s/he is exhorted, at all times, to:

> abandon your discursive concern for the mundane, and hold to the complete whole of samadhi of these three points: Appearance as deity, sound as mantra, and mental activity as awareness.
>
> (The Fifteenth Karmapa, 1984: 21)

Buddhist meaning

How can we relate the major points of this description to Buddhist religious philosophy? First, it is clear that the Buddha taught by skilful means. This is an important philosophical idea central to both Mahayana and Vajrayana Buddhism. The concept of skilful means (upayakausalya) is:

> the ability to bring out the spiritual potentialities of different people, by statements or actions which are adjusted to their needs and adapted to their capacity.
>
> (Conze, 1988: 50)

The presentations of celestial Buddhas and Bodhisattvas within the Mahayana are often seen as expedients that, though ultimately untrue, from the relative standpoint provide a focus for devotion and are given to help practitioners, ultimately leading them towards salvation and enlightened understanding.

The meditation practice under discussion can thus be described within the context of skilful means. It is a skilful means for harnessing the mind's general business by letting it become preoccupied with the details of the visualisation. This draws it from the outside world and its concerns, so that it can calm down of its own accord. The colours and content of the visualisation provide interest but at the same time lead to stability. Often one is told to focus on the lower parts of the Buddha's form or on the lotus or throne if the mind is excited. If one then becomes mentally dull, one is encouraged to focus on the upper parts of the Buddha's body, for example on the face or between the eyebrows.

A second point to note is that the bodily form of the Buddha is extremely important, particularly as it relates to the central Buddhist religious doctrine of the three bodies or kayas of the Buddha. In Mahayana Buddhist religious philosophy (which encompasses elements not just of Tibetan, but also of Chinese, Korean and in particular Japanese schools) the distinctions are between the Nirmanakaya, the historical Buddha; the Sambhogakaya, which encompasses the whole range of celestial Buddhas and Bodhisattvas; and finally the Dharmakaya, which, because of its absolute and formless nature, cannot be conceptualised or indeed visualised (Dalai Lama, 1975). The Dharmakaya is often called the enlightenment body, the state of Buddhahood itself: it is the nature of Mind, or emptiness (Jamgon Kongtrul, 1992: 126; Khyentse, 1988). These distinctions are often presented in terms of temporal duration: the Dharmakaya is beginningless and endless, the Sambhogakaya

has a beginning but is endless, while the Nirmanakaya is temporary (Inagaki, 1994). The Buddha Sakyamuni is seen to have possessed all three bodies.

These philosophical distinctions also have their individual personal bodily correlates. These are the three centres or 'gates', each correlating with one of the three bodies of the Buddha. The first is the head centre (between the eyebrows), this corresponds to the Nirmanakaya or physical body. The second is the throat centre, which corresponds to the Sambhogakaya and subtle energy flows and speech. And the third is the heart centre which corresponds to the mind or the Dharmakaya. Towards the end of the practice different coloured lights emanating from the three different sources and aspects of the Buddha's body are visualised as merging with the same three aspects of the practitioner's body. The focus is on the purification of the bodily elements, and this may be accomplished by means of sound and visualised light (see Govinda, 1969; Singh, 1976).

A key issue is the idea that everything can be viewed as a form of energy: not only reduced to forms of energy, but also transformed from one type or modality of energy to another. Notions of solidity are thus counterbalanced with ideas of change and mutability. The attempt is always to move away from the fixity of the normal mind and its attitude towards the world.

This is also reflected in the description of the composition of the body. The Buddha is seen to be physically present but not solid; to be of light and similar to a rainbow, to be luminous but not solid. Tibetans use the term 'Rainbow Body' to symbolise enlightenment. This concern with the body of light is of course present in other religious traditions (Johnston, 1995).

The purpose of this practice is an attempt to undermine our notions of a fixed and rigid self-identity, to show rather that it is changeable, mutable and constantly shifting. The concepts of projection and transformation are central to this discussion:

> All phenomena are projections of mind.
> Mind itself does not exist
> And is empty in its being.
> Although empty, it manifests everything without obstruction.
> (Jamgon Kongtrul, 1992: 22).

A third, philosophical, concern approached experientially in the meditation is the relationship between Samsara, the imperfect world in which we find ourselves with all its suffering, and Nirvana, the perfect state where suffering has ceased to exist. In Buddhist religious thinking this discussion revolves around the relationship between the relative and the absolute worlds. It is often expressed in the clear religious belief which states that Samsara and Nirvana are one. The problem arises from our view of the situation, not from the situation itself. These ideas relate closely to a central feature of Buddhism: that it incorporates a monist religious/philosophical structure. As Conze has

stated: 'If all is one and the same, then also the Absolute will be identical with the Relative, the Unconditioned with the Conditioned, Nirvana with Samsara' (Conze, 1988: 51). Writers involved in Buddhist–Christian dialogue have been deeply aware of this feature of Buddhist religion, and commentators from both sides of the dialogue have discussed the similarity between certain ideas in Buddhism and the occluded, monist side of Christian theology and mystical experience, particularly as expressed in the ideas of Meister Eckhart (Johnston, 1979; Mullen, 1994).

In the form of meditation under discussion, all elements of the individual's lived experienced field (i.e. Samsara) are visualised as being temporally replaced by elements of a pure land, i.e. Nirvana. Generally it is recommended that the visualisation is carried out with the eyes open:

> The dharma is a method that enables us to go from the state of ordinary being to the state of awakened being.
>
> (Bokar, 1991)

Closely connected to the idea of the inseparability of the relative and the absolute worlds is the central philosophical tenet within Mahayana Buddhism of the empty or void nature of all phenomena. This is reinforced in the final stage of the meditation practice:

> Vajrayana meditations are divided into two phases . . . The phase of creation . . . during which one mentally creates the appearance of the deity. The phase of completion . . . during which one dissolves the appearance into emptiness.
>
> (Bokar, 1991)

The meditation practice is a skilful means by which one may recognise, or get a taste of, the empty or conditioned nature of all phenomena; that each is nothing in and by itself. As stated above, phenomena include such conditions as physical and mental sickness.

Sociological account

From the above discussion we can identify various elements of this practice that would be of interest to sociologists, in particular those concerned with the interpretation and definition of the present reality, and the focus on the body. One sociological approach to this material is via the theoretical ideas of Goffman (1963, 1974), which help us to understand the concern with the body and also the importance of the stages of the meditation practice.

Turner (1995) has pointed out that all approaches to the sociology of the body are anti-Cartesian in nature. Crossley (1995) sees Goffman as providing the key to such a non-dualistic sociology where practical embodied action is

interwoven with the perceptual field of the agent. He believes that Merleau-Ponty (philosophically) and Goffman (sociologically) mount a challenge to the central assumption that the mind is an inner and separate world. Merleau-Ponty (1964, 1968) posits three claims: first, he rejects the proposition that mind and matter exist as different 'substances'; second, he claims that we should understand mental predicates as referring not to inner (and therefore incorporeal) mental states but rather to publicly verifiable aspects of embodied conduct; third, he claims that perception does not involve the internal representation of an outer world, but rather an 'openness onto Being' and intertwining or 'chiasm'. As Crossley presents it, 'I must be simultaneously the perceiver and the perceived'. Crossley believes that Goffman's work allows us to develop this ontology into an intercorporeal and non-dualistic sociology.

Kelly & Field, also using the work of Goffman, maintain that both social identity and self-conception are central to human conduct and that both are related to the body: 'The body is central both to the experience and feelings associated with illness (self) and the social processes involved in its management (identity)' (Kelly & Field, 1996: 251). Goffman (1963) writes of 'virtual identities', which are those imputed by others, while individuals' self-conceptions are 'actual identities'.

In the meditation situation one is dealing with a relationship between the self and an imagined or projected other, and the labelling and imputation of self-identity is being carried out by the practitioner himself or herself. Kelly & Field (1996) have indicated a general movement in the construction of identity starting from the physical body via the self to identity. In the meditation practice the movement is from change in self-identity via change in projected bodies. We should also note that in the meditation puja we are dealing with the visualisation of perfect bodies. In such visualisations, all practitioners are viewed as equal, having the form of a perfect Buddha or Bodhisattva. The description of the visualised body stresses its freedom from any illness or blemish, indeed its beauty; as the title of the Buddha's pure land states, everything about the visualisation is 'of great bliss'.

We can see that the 'other' becomes complex and problematic in this situation. The other, from the point of view of the practitioner throughout the practice, is the 'actual deity' visualised in its sambhogakaya form, in the form of light. During the practice there is also an imputed transformation in the physical body of the practitioner; this is imagined as being effected by the deity himself. Eventually this culminates when the identity of the practitioner imputed by the other is imagined to be transformed into the body, speech and mind of the deity. Parallels may be found for a Christian believer; the 'not I, but Christ in me' of St Paul, for example. Indeed, practitioners of all religions relate via prayer to the supernatural, however defined, although this has rarely been the focus of much of the sociology of religion (an exception being the work of Flanagan (1986, 1988)). Of course within the context

of Buddhist philosophy this compassionate relationship is not just between believer and divine but also, as in some way Samsara is Nirvana, a relationship between devotee and all sentient beings. Again this is intensely social and relational in context, often emphasising the primary compassionate relationship between a mother or father and their child. In Japanese Pure Land Schools the Buddha is often referred to as Oya-sama, honourable parent, 'both fatherly and motherly qualities united in one personality' (Suzuki, 1998: 25). In Tibetan Buddhism, students are encouraged to consider that all sentient beings have been our mothers and fathers.

Turner (1995), Bury (1995) and Williams (1996) have shown how recent theorising within the sociology of the body views the self as being charged with emotions, discusses body image, and aims to deconstruct our notions of materiality. All of these have their experiential correlates within the meditation under discussion. We may view the meditation as a deliberate attempt to 'deconstruct' any notion of a constant or fixed perception of the body. We can also see that within the meditation, perfect body images are first projected by the practitioner, but are then dissolved back into the person. This may produce a general sense of well-being, with the person being more likely to identify favourably with the experience of their lived body.

As Nettleton (1995: 103) has pointed out, the major concerns of society are becoming less to do with increasing production, as was the case in industrialised capitalism, and more to do with the regulation of bodies. We are rapidly moving towards a 'somatic society' (Turner, 1995) where the body constitutes the central field of political and cultural activity. Theorists of the sociology of the body have spoken about modern culture being a 'corporeal culture'.

The focus is on control and resistance to such control. In the 1990s, writers on disability spoke out against psychologists who often stressed body-image theory's view of the perfect bodied. From the point of view of this meditation practice it is somewhat in reverse; perfect body-images are invoked but are then dissolved back into the person's real body image. The projected self runs counter to the everyday self of the person. What happens in the space of meditation can be seen as offering a resistance to such all-pervasive forces that attempt to control the body. Indeed, there is also an exhortation to move from one to the other and to take the insights gained in the meditation through into the lived experience of the outside world.

The practice progresses through various stages and in each one there is a particular orientation towards the imaginary body. These can be understood more clearly if we use another of Goffman's (1974) theoretical constructs: frame.

The meditation takes place within the overarching frame of everyday life (Berger and Luckmann, 1967; Schutz, 1971), but the frame and sub-frames of the meditation have distinguishing characteristics. First, these are reflected in the chanted text. Some sections are in a form of prayer and are therefore petitionary in content. Others are descriptive of the deity.

Second, the type of focus and the training in the shifting of focus are important attributes of the meditation frame. One characteristic of these would be the concept of one-pointedness. This has already been highlighted by Johnston (1979) as a general characteristic of the meditation experience in whatever form. Another important characteristic of the meditational frame is the restriction of the focusing of attention to the body. Certain passages can thus be thought of as indexical in that they direct the mental focus towards particular aspects of the visualised mental field.

Just as there are various sub-frames, there are transitional sections when we move from one to another. There are also major sections where there is a gradual build-up of elements both visual and sensual, where the frame is constructed; later, when the visualisation is dissolved, the frame is finally 'deconstructed'. Another important issue is that of the comparison of the meditational frame with the frame of everyday life; at the end of the practice a change has hopefully occurred in the mind of the person and s/he is asked to reflect on this change and take the experience forward into his or her daily life.

Goffman's (1974) discussions of a 'play within a play', the theatrical framing of reality, and the distinction between the natural and social perspectives all throw light on the experience of meditation. Goffman also directs our attention to the importance of keying for ushering in a change of frame. In the more elaborate forms of the described practice the lighting of incense before the ritual commences, the ringing of bells, the clash of cymbals and the beating of the shrine drum when the deity first is visualised all serve to mark important shifts of frame.

Buddhalogical reasoning for adaptation of the meditation

We can now go through the structure of the puja to see if at each section the ideas in it can be interpreted in a wider sense, in a more universalistic sense, or in a sense that is somehow in a trans-religionist context. Attempts to ground religious practices in an inter-spiritual or trans-religionist context are now becoming prevalent (Teasdale, 1999, 2003). Of course we may soon discover that the context of this meditation practice is universal at the outset.

First section

Wider interpretation of the three refuges

The meditation begins with going for refuge in the Buddha, the Dharma and the Sangha. We have already seen how Johnston produced a Christian version of this. However, from both the Christian and the Buddhist side a wider, more encompassing statement can be made. Buddha can be seen in the Mahayana context as the ultimate ground of existence or the Dharmakaya.

The Dharma is the law universal; it is often expressed as whatever will hold up or support an individual. The Sangha can mean those who try to tread the way in conformity with the universal law.

Johnston, in his book *Christian Zen* (1979), interprets the three refuges in the following manner. He points out that this triple invocation can be paralleled in the Christian devotional life by the prayer, 'I put my faith in Jesus, I put my faith in the Bible, I put my faith in the Church' (Johnston, 1979: 125). His interpretation, however, is quite narrow, and this can definitely be widened on the Christian theological side. For example, the Church could be widened to the Church Invisible of the Protestant theologians.

We are therefore justified in widening the meaning given to the three refuges. The Buddha can be seen as complete realisation, the complete eradication of all confusion and ignorance, a state of being corresponding to the complete transformation of all the negative emotions. The Dharma encompasses all the different means, practices and trainings that would lead to this state. Refuge in the Sangha is our readiness to open ourselves to the people who have the understanding and experience of the teachings. We open ourselves to receive the positive influence, the instructions and teachings of the Dharma so that we can work on ourselves (Ringu Tulku, 2000, 1998b: 9). In this first section of the practice the practitioner also aims to engender bodhichitta, the enlightened mind. 'The Bodhichitta is very much inspired by compassion, a limitless compassion' (Ringu Tulku, 1998b: 9).

Second section

In the second section the meditator focuses on the form of 'the deity'. The 'deity' has both a visual and a sound form.

The visualised form

Within the meditation systems of Tibetan Buddhism, different visual forms of meditational support are chosen. This central idea of the yidam or chosen deity is paramount (a similar concept is important in Hinduism, and expressed as ista devata). The yidam is traditionally given by the lama or guru.

For Westerners it may be more appropriate to focus on the image of Christ. This has already been suggested in some quarters (see Akong, 1987). An in-between stage has also been suggested: trying to perceive a ball of light instead of visualising an image of the Buddha. The Dalai Lama in his books has often mentioned that it may be inappropriate for Westerners to change their religion. He is well aware of the dangers for an individual if they cut themselves off from their cultural roots (Dalai Lama, 1996, 1997). In such cases utilising imagery from within one's own religion and cultural traditions would be acceptable.

What should be remembered is that in this instance Chenrezig is one,

and only one, form of Avalokiteshvara, the Bodhisattva of Compassion (see Bokar, 1991). In China and Japan the Bodhisattva of Compassion is often represented in the female form of Kwan-Shi Yin (Blofeld, 1988). As there are countless other forms, perhaps Christ may be seen as yet another form: a form of compassion that is more suited in some way for the West.

In most vajrayana pujas, deities are mainly depicted and visualised as sitting in the lotus position. This is true not just of Buddhas and Bodhisattvas but also of lineage holders and various spiritual masters. In the East today there are an increasing number of representations of Christ depicted in the same seated lotus posture. It is true that most of these have occurred within Indian Christianity as part of the inculturation movement (see Du Boulay, 1998; Teasdale, 2003). The depiction of Christ seated in the lotus position has also occurred in the West at the height of the popularity of the vedanta movement in the mid-twentieth century, for example in California. So within Indian Christianity and vedanta philosophy these depictions now have a certain currency and acceptability. There is an interesting depiction of the Nativity painted in the Tibetan style and presented as a thanka to Fr Laurence Freeman, the spiritual director of the World Community for Christian Meditation, by the Dalai Lama at their joint pilgrimage for peace at Bodhgaya. This thanka is now installed in the Benedictine priory at Cockfosters, London. Again in Lama Yeshe's book (Thubten Yeshe, 1978) Christ is depicted in a line illustration in the usual seated-in-glory posture. Of course this posture is similar to the depictions of Maitreya Buddha (the Buddha to come), who is always depicted seated on a chair (see Govinda, 1969). Increasingly, then, a merging of Eastern and Western representational styles is likely to become common.

The argument of speaking of Christ as a Bodhisattva has also been rehearsed in numerous articles and conferences (see Schmidt-Leukel and Gotz, 2001). Within certain currents of Tibetan Buddhist tradition there is now recognition that Christ was a Boddhisattva, and perhaps even a Buddha (Dalai Lama, 1997).

In various Tibetan Buddhist sadhanas the meditational deity is often conceived of as being apprehended as the 'union of all the precious ones' – although we are visualising one particular form of deity, all the Buddhas and Bodhisattvas are somehow present in the form. Thus if Christ is a Bodhisattva or Buddha, Christ will also be present here. There is also a teaching whereby deities are visualised, as part of a vast cloud of all the precious ones. Thus, even though we may be visualising the Bodhisattva of Compassion in the central place, he is to be envisaged as surrounded by a vast cloud in the sky or ocean of the Buddhas and Bodhisattvas of numerous other lineages and teachings. Again, as Christ may be seen as a Buddha or Bodhisattva, he could presumably be visualised as being present in this vast array or in the centre.

The ultimate focus and grounding is in universal compassion. Another

approach is to see Avalokiteshvara not as a human being, but as compassion embodied in the form of a deity. Avalokiteshvara is a symbolic form representing the compassion of all sentient beings, of all the Buddhas and Bodhisattvas (Ringu Tulku, 1998b: 2). His compassion is of the strongest kind, the kind that inspires one to exchange one's own well-being and happiness for the well-being and happiness of others', to always consider the others' interests before one's own (Ringu Tulku, 1998b: 3). It doesn't really matter whether you visualise his form in one way or another. The form of Chenrezig doesn't really matter because, in a way, it is our own true loving kindness, the root of our basic capacity to love and be compassionate that we project and that is radiating towards us (Ringu Tulku, 1998b: 4). Our purpose is to get in touch with the presence of Chenrezig, an enlightened being that concentrates in himself the energy of all enlightened beings, of all the buddhas (Ringu Tulku, 1998b: 11). We shouldn't categorise him in any particular racial type. He's simply whatever you can imagine as 'perfection'. Maybe the images of the deities are created a little different from usual human beings precisely to avoid them being categorised into a particular racial type (Ringu Tulku, 1998b: 12).

Again, if you're not very good at visualising, you can just feel his presence, a presence of complete unconditional kindness, love and compassion (Ringu Tulku, 1998b: 12). To get in touch with, and engender, compassion is the most fundamental practice. It has to be clearly understood that when 'all the enlightened beings' are mentioned, these are not only the Buddhist enlightened beings. From a Buddhist point of view, there is no difference between Buddhist and non-Buddhist enlightened beings. Any being who has reached a high stage of realisation in whatever way and through whatever tradition is considered an enlightened being. You can therefore include everybody, all the great beings you know about or haven't yet heard about. You invoke, embodied and concentrated in your visualisation of Chenrezig, the totality of everything that is good, positive, powerful, beneficial, compassionate and wise (Ringu Tulku, 1998b: 15).

The sound form

In Tibetan Buddhist sadhanas, each Buddha/Bodhisattva or deity has his/her own seed syllable and mantra. Setting aside for the moment the complex philosophy of what we mean by a mantra, what would be the possibilities for a mantra in a Western or Christian context?

Within the mainstream Christian tradition we already have the use of the repetition of prayer words, for example 'Kyrie Eleison', 'Abba' or 'Maranatha'. Justification for their use can be seen in the writings of the Christian Meditation and Centering Prayer Movements (Freeman 1995, 1998; Keating 1995; Main 1977, 1980, 1995; Pennington 1980). From the time of the Second Vatican Council, the Catholic tradition has been accepting

elements of other religious traditions that do not contradict the teachings of the Catholic Church. This has led to dialogue between the major world faiths and most notably between Catholicism and Hinduism.

One of the major pioneers in this field was Abhishiktananda, a Benedictine monk who also became a sannyasi. In his writings he often mentions the use of mantra, or short prayer phrases and how these relate to, and might be incorporated into, Christian devotion. In his short work *Prayer* (Abhishiktananda, 1972) he discusses the correspondences between the Indian 'Om' and 'Saccidananda', and the Christian phrase 'Abba', the prayer of Jesus. He also mentions the case of Hindu converts to Christianity who had spontaneously used the name of Jesus in the form of a mantra sandwich (see below). Such a process is closely related to the increased acceptance of inculturation by the Catholic Church, where it is possible to use practices found within different cultures and seek to incorporate them within ritual devotions rather than rejecting them. Abhishiktananda was French by birth. Fr Bede Griffiths consolidated this work (see Teasdale, 2003).

There are now many Indian-born Christians who write on these topics. Foremost among them is Vandana Mataji: her key books are *Nama Japa: The Prayer of the Name in the Hindu and Christian Traditions* (Mataji, 1997) and the now classic *Gurus, Ashrams and Christians* (Mataji, 1978). *Nama Japa* is a full exposition of the prayer of the Name within the Hindu and Christian traditions. By 'prayer of the Name' she means the constant repetition of a Name of God, either vocally or mentally. This is a form of bhakti yoga found in most of the world's faiths. Her range of reading and quotation on this spiritual practice is vast, from the Desert Fathers and straying outside the Hindu tradition, to the Buddhist Shin Nembutsu sages.

Of particular interest is the attempted synthesis between East and West at the level of the Name. Of relevance is her inclusion of Eastern-style Christian mantras: 'Yesu Om', 'Om Namah Christaya', and 'Aum Sri Yesu Bhagavate Namah'. She also presents a description of a Christian meditation that is in the puja form familiar within the Hindu and Buddhist traditions, where both visualisation (in this case of Christ) and recitation of mantra (Yesu Om) are advocated.

But what could be suggested within the Tibetan Buddhist framework? The structure of Buddhist mantras often takes the form, to use Abhishiktananda's phrase, of 'a mantra sandwich', with the name of the deity appearing between Om and Hung. Mantras are also mainly expressed in Sanskrit, the sacred language. Mantras already exist for great historical Tibetan Buddhist teachers, for example: 'Om Karma Pakshi Hung'. So perhaps as an adaptation to a Christian context 'Om Yesu Christa Hung' would be the obvious possibility. A strong connection between 'Om Mani Padme Hung', as a universal expression of bringing compassion into the human heart, and the spirit of Jesus has already been made in Buddhist circles (see Pym, 2001).

The question of mantras, what they are, and how they may be related to sound or the breath is a contentious issue. As noted above, within the Christian tradition we have such mantras as 'Maranatha' and 'Abba'. With both of these the long 'Ah' sound is often stressed, as in 'Ma-Ra-Na-Tha' (see Freeman, 1998; Main, 1952, 1995). From the Buddhist tradition such phrases as 'Namo Amitabha' (Hail to the Buddha of immeasurable Light) also stress the long 'Ah' sound. Indeed, in the Dzogchen school of Tibetan Buddhism one of the highest mantras, which symbolises the perfection of wisdom (prajna-paramita), is 'Ah'. In the Tibetan language the sound 'Ah' is always present, underlying any other sound of the syllabary. Of course mantras with no overtly religious connotation may indeed be more suitable in the current Western spiritual landscape: for example, the word 'Peace' or, in its Sanskrit variant, Om Shanti Shanti Shanti, which is common to Buddhism and Hinduism.

Third section

In the third section of the meditation the specific visualized form of the deity is dissolved; we are encouraged to move from the form realm to the formless realm. In Tibetan Buddhism the realms of form (nama rupa: name and form) are to some extent envisaged as lower than the formless realms. The meditation puja is a vehicle that somehow takes you through towards these formless realms. The form and formless realms are both represented within the Chenrezig puja and in the section where the visualisation is dissolved we are trying to get a sense of moving from the form to the formless realms. This is termed the mahamudra section of the puja; after the dissolution of the visualisation, we rest in silence. Of course resting in silence has Christian equivalents, for example in Quakerism (Pym, 1999), or the prayer of peaceful regard (see Johnston, 1995). The most important thing that is stressed is the feeling, and what is that feeling? It is a feeling of warmth, protection, trust and comfort. Such feelings are believed to be able to be nurtured during a person's daily life (Ringu Tulku, 1998b: 15).

So, how could the above points be incorporated into a simple meditation designed to get a person into contact with the heart of compassion?

Text for a simple meditation on compassion

1 Set up your meditation space. This should be pleasant for you. You might wish to incorporate flowers, or a picture of a pleasant place you like to visit, or photographs of inspirational teachers. If you have a focus, you might like to make offerings (e.g. candle, incense, flowers).
2 With palms of your hands joined, bow. It is important that you have a feeling of surrender to universal compassion and that you are in some way invoking protection. As you do this, you may wish to say either a short prayer or a positive verse.

3 Sit down. You may wish to read a religious verse or an uplifting passage of literature.
4 Spend some time getting comfortable. You may either sit cross-legged or, as is often more comfortable for Westerners, just sit in a chair. The main thing is to keep your spine perfectly upright, but comfortable, and in alignment with your head. Your eyes can either be open or gently closed.
5 In the space in front, and slightly above you, visualise a ball of light radiating numerous rays of light that come towards you and envelop you. Think of this light as being the very embodiment of compassion. As it washes over you it sweeps away any negativity. If you feel a connection with Christianity or Jesus you may wish to visualise the ball of light taking the luminescent form of Jesus, or your teacher. You may wish to depict Jesus as described in scripture, as painted down through the ages, or as represented in religious icons. The main thing is to remember that there should be nothing solid about the visualisation. Imagine rays of compassion emanating from the form of Jesus and enveloping you. Alternatively, rather than envisaging lights you can imagine yourself to be enveloped and surrounded by compassion. Feel this as a warm presence.
6 As you are engaged in the process of visualising, you may start to say your chosen 'mantra' for the session. These can be traditional Christian prayer words such as 'Abba', 'Jesus' or 'Kyrie Eleison', or more general words such as 'Peace'. These can be recited either externally or internally. The most important aspect is that the recitation should remain natural and should not be strained in any way.
7 You should continue this practice for a maximum of twenty minutes. At the end of this time you should stop repeating your chosen 'mantra'. You should then imagine that the lights dissolve into the central figure or central ball of light, and imagine that all the light dissolves into your heart centre.
8 Rest as tranquilly as possible for a few minutes.
9 Rise from your seat, join palms and again say a short prayer or poem, this time with a general feeling of thanksgiving. Bow slightly.
10 Make sure you have a few minutes rest before taking part in any other activities.

Conclusion

There are various concepts within Buddhist religious philosophy that correlate with ideas within sociological theory. By the use of this description of a Tibetan Buddhist meditation practice focused on universal compassion, we can go some way towards indicating these interesting similarities. One is the notion of skilful means; the whole meditation and the visualisations should be recognised as a skilful means. Other concepts are indexicality, the

provisional nature of reality, interdependence, and even the core concept of the mutability of the self.

A key theme is resistance. Just as Foucault (1979, 1981) demonstrates how the self is produced through the production of the body, and Turner (1995) shows how we are moving towards a somatic society where the body constitutes the central field of political and cultural activity, we can detect strong elements of resistance in this meditation. The movement is on redefinition of the self via visualisation and is in the opposite direction to that normally hypothesised where self and identity are merely seen as the result of external social forces.

Social theory outlines two polarised perspectives on the body, the naturalistic and the social constructionist positions, with phenomenology often constituting a third perspective, acting as a bridge between the two extremes (Shilling, 1996; Turner, 1995). The weak version of the social constructionist view posits that the body has a material base that is shaped and altered by social practices and its social context. The phenomenological approach tends to focus on the relationship between the self, identity and the body.

The Tibetan Buddhist ideas as presented in this practice have close parallels with the social constructionist perspective, and indeed follow through this way of thinking into a form of action. In the meditation under consideration we are dealing with experiential reality and discursive practices. The aim is to produce a change of view – a change in knowledge and also of feeling – towards the generation of compassion. The meditation is also discursive, with the meditation text being the discourse. The liturgical text is what guides the practitioner to define the reality of the meditational space in the first instance (see Barthes, 1977: 41; Laderman & Roseman, 1996). The question we could ask of the meditation puja is: is the fundamental nature of the body and mind changed by the social interaction within the meditational puja; are feelings of compassion strengthened? This would indeed be adopting a strong version of the social constructivist stance.

Shilling (1996) develops the notion of the body as project. That is, the body is 'seen as an entity which is in the process of becoming; a project which should be worked at and accomplished as part of an individual's self identity' (Shilling, 1996: 5). Creating and maintaining a healthy and fit body and mind is an example of an increasingly common type of body project. We may wish to view meditation as a mental project, which may have not only beneficial mental but also positive physical affects on health.

Laderman and Roseman have described healing as performance: 'as purposive, contextually-situated interaction . . . or "framed" enactment' (1996: 2). Text and context need to be seen as mutually constitutive in ritual performance. This chapter's analysis of one textual description of a meditation ritual may thus yield the following benefits. It is important first as an illustration of the benefits of taking seriously the injunctions to study such practices from within their own philosophical framework. Second, this investigation offers

one illustration of the way in which sociological analysis of meditation practices in relation to mental health may proceed. Third, it gives an insight into the way in which such practices may lead towards a positive redefinition of self, potentially contributing to an improvement in mental health. Finally we offer an adaptation of the practice that is suitable for use by individuals of any religion or none. It is hoped that use of such a meditation will lead to people getting in touch with the compassionate nature of their mind: specifically, to realise that compassion is the most important thing not just for their own well-being, but also for the good of society and the welfare of all sentient beings.

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Chapter 9

Mindfulness, compassion for self, and compassion for others

Implications for understanding the psychopathology and treatment of depression

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The interpersonal nature of depression

The World Heath Organisation has noted that depression constitutes one of the most common health problems in the Western world, is a major personal, social and economic burden, and is increasing (Fombonne, 1999; Murray & Lopex, 1996). One in 4–5 women and 1 in 7–10 men will have an episode at some time in their lives (Bebbington, 1998), while the rates of sub-clinical episodes are much higher and relapse is common. Clearly, understanding the causes of depression and ways to prevent and alleviate it require our urgent attention. This chapter will explore a recently formulated model of depression (Allen & Badcock, 2003), and then consider how two psychological interventions, derived from Eastern psychologies of *mindfulness and compassionate mind training*, can be useful additions to more traditional Western psychological therapies.

Many theorists have argued that depressed states are most essentially related to reductions of positive affect (anhedonia being a key defining feature), and that the regulators of positive affect (i.e. depression) are embedded in *social* cognition and behaviour (e.g. Allen & Badcock, 2003; Gilbert, 1989, 1992; Gotlib & Hammen, 1992; Joiner & Coyne, 1999; Watson, 2000). Changes in both positive affect and the regulators of moods can be understood in the light of their functions in the social ecology (Allen & Badcock, 2003). Critical to a functional or evolutionary view of depression is the proposition that there are various brain (often subcortical) processes that guide individuals to enact certain social or interpersonal roles. As noted below, defeats and losses have specific effects that involve suppressing positive affect systems and increasing attention to social threats. Understanding these processes, especially how they can be 'ratcheted up or down' via human capacities for metacognition and rumination, as well as interpersonal processes, is key to understanding how and why mindfulness and compassion, two concepts strongly emphasised in Buddhist psychology, have much to offer our understanding and treatment of depression. Hence, this chapter will explore the cognitive and interpersonal basis of depressed states in order to highlight the

potential importance of these interventions. Put simply, interventions that emphasise enhancement of the depressed individual's capacity for mindfulness and compassion can turn off the inner processes that 'ratchet up' the inputs (rumination on defeat and the self as unworthy) that suppress positive affect in the face of a defeat or major loss. In order to explore this in more detail we will first examine the social cognitive bases of depression and then return to a consideration of mindfulness and compassionate mind training in the light of these mechanisms.

Depression and the social risk model of depression

There are many clues in the research literature that suggest that social processes (in terms of both social cognition and interpersonal behaviour) play a critical role in the aetiology and maintenance of depressed states. Critical empirical observations here include findings demonstrating that depression is often precipitated by interpersonal events, and that interpersonal processes often mediate the exacerbation or resolution of depressive episodes (Joiner *et al.*, 1999). Stressful interpersonal contexts are among the most reliable antecedents of depressed states (e.g. Kendler *et al.*, 2003; Monroe *et al.*, 1999), suggesting possible etiological significance. Also, certain interpersonal behaviours, such as excessive reassurance seeking, are strong and specific predictors of risk for depression (Joiner & Metalsky, 2001). The prognostic significance of interpersonal processes is suggested by the finding that those recently treated for clinical depression are at greater risk of relapse if their family environment is characterised by high levels of negative affect expression (Coiro & Gottesman, 1996). Depressed individuals tend to attend to signs of social threat preferentially (Mathews *et al.*, 1996), and inhibit the interpersonal expression of positive affect, while increasing interpersonal expressions of negative affect (e.g. Biglan *et al.*, 1985; Hokanson *et al.*, 1980). Social reasoning is more strongly affected by depressed states than is reasoning in non-social domains (Badcock & Allen, 2003).

Recently we have proposed a model of the function of depressed states that seeks to explain why there is such a close link between social cognition, social behaviour, and depressive phenomena. The *social risk* hypothesis of depression (Allen & Badcock, 2003) suggests that depressed mood states, and clinical states of depression, are based on adaptive mechanisms rooted in brain design (Panksepp, 1998). This is not to say that depression is always adaptive in current human contexts, only that the mechanisms that form the substratum for depressed states have been preserved and shaped by natural selection because they solved adaptive problems. While some depressions may be adaptive, as discussed below, depressive disorders can also be understood as 'pathologies' based on poor regulation of adaptive mechanisms (Gilbert, 2001).

The social risk hypothesis of depression suggests that depressed states

(downregulation of positive affect and confident engagement in the world) evolved to facilitate an extremely risk-averse approach to social interaction in situations where individuals perceive their social resources (e.g. status, affection, friendship, power) to be at critically low levels. Thus, whereas positive affect encourages engagement in a range of activities, most especially social ones, reduced positive affect discourages such engagement. In this sense depressed mood was (in the evolutionary past) a defensive–protective strategy to reduce activities, especially those with uncertain pay-offs (see Allen & Badcock, 2003; Gilbert, 2001 for reviews of other theories that focus on this aspect of mood).

There are in fact a wide range of social activities and social roles where people have to make decisions about how costly or risky it is to develop or maintain the relationships, and further the risk that result from the possibility that others might not want to develop or maintain such a relationship with you. For example, Buss (1991) outlined the following social–reproductive tasks faced by humans over our evolutionary history: (1) intrasexual competition to attract desirable mates, (2) choice of the mate with the greatest reproductive value, (3) successful conception, (4) mate retention, (5) reciprocal dyadic alliance formation, (6) coalition-building and participation in cooperative groups, (7) ensuring survival and reproductive success of one's offspring, and (8) investing in kin other than one's offspring. Gilbert (1989, 1995; Chapter 2) derived similar classes of biosocial goals, including care seeking, caregiving, cooperation in dyads and groups, and status acquisition (social ranking). He suggested that the way we are motivated to engage and think about social roles is related to evolved social mentalities; that in (say) seeking status in ranked relationships or competing for one's social place, we think about ourselves and others in very different ways than if we were engaged in caring for others. Clearly roles are co-constructed between self and other(s), and attempts to develop or maintain a role relationship are not without risks and potential costs. For example, cooperating in a group of exploiters might mean they benefit at one's expense, and competing for status and access to resources with others who are more powerful might elicit attacks or rejections. Thus it is important that individuals evaluate risks against benefits in whatever goal or role they are pursuing.

The social risk hypothesis suggests that depressed mood evolved as a *salient mediator* between estimates of social risk and social behaviour. In other words, positive moods will go down when people evaluate that they have suffered a defeat or rejection and this forces a reappraisal of their roles and pursuits. We argue that the 'depression mechanism' controls aspects of both social perception and social behaviours to reduce the likelihood of further, critical reductions in one's social resources; that is to say, when one evaluates that one's resources are low one has to be extremely careful about how one uses them and thus perception and behaviour will be adjusted so as to inhibit risk-taking. This risk-assessing/mood-regulating mechanism affects

social–perceptual processes such that the individual becomes hypersensitive to indications of social risk. In the area of social behaviour, the mechanism affects both communicative behaviour (signalling in order to reduce threats and to elicit safe forms of support) and resource acquisition behaviours (a general reduction in behavioural propensities towards high-risk social investments that may result in interpersonal conflict or competition).

While non-humans may experience the impact of these mechanisms as automatic regulators of behaviour, humans have high-level cognitive competencies that can reflect on and form metacognitions about their moods and current situations. Whereas animals can experience the world as threatening or lacking in resources (e.g. food), humans can consider the causes and implications of such evaluations and derive conclusions about themselves and their futures. These can then act to dampen or amplify affective disturbance. This of course is the basis of the cognitive model of mood disorder (Beck *et al.*, 1979) – that is, our thoughts and the meanings we give to events and feelings can cause escalating spirals of emotions and mood shifts. In the social risk model, depressive rumination can be understood in terms of its social function; that is, to focus attention on the actual, implied, or potential negative social consequences of one's actions. This focus may, in the evolutionary past, have helped prevent social behaviours that might be risky or further damage social resources. In constructing a role with 'another', one clearly needs to consider not only how self will engage but how others will engage with self. Indeed, the recent evolution of social cognitive abilities such as theory of mind and metacognitive abilities may have evolved precisely because they help people work out these concerns (Gilbert, Chapter 2). Certainly the content of depressive rumination is usually focused on social themes such as recent losses, rejections or setbacks, concerns with one's own abilities or talents, the probability of future success or acceptability, lovability, success, and power, *in the eyes of others* (Gilbert, 1992). The more negative these are, the more they are likely to 'ratchet down' positive affect in a downward spiral.

The social risk model of depression suggests that the critical variable to control in order to prevent the loss of beneficial relationships or avoid placing oneself at risk of further losses is the ratio between the resources that are provided to others as a result of one's participation, *as perceived by others* (which we call social value; *Sv*), and the costs to others (i.e. loss of current or potential resources) of one's participation in the relationship, *as perceived by others* (which we call social burden; *Sb*).

When *Sv* and *Sb* are approximately equivalent in a current relationship, danger of demotion, rejection or ostracism or simply being ignored and not chosen for roles (social exclusion) is high, and a protective/defensive strategy in social interactions would be most adaptive. Part of this protective strategy might be to reduce self-esteem in order to reduce the likelihood of risky interpersonal behaviour associated with highly unpredictable interpersonal outcomes (Allen & Badcock, 2003). It is interesting to note that recent work

on self-esteem has conceptualised a similar process called a 'sociometer', which monitors others' reactions and alerts individuals to the possibility of social exclusion (Leary *et al.*, 1995).

Avoiding demotions and/or social exclusion

A critical adaptive problem for the individual is to detect when the danger of demotion or exclusion from currently beneficial social groups or dyadic relationships is high. Hirshleifer and Rasmusen (1989) have pointed out that in economic terms, exclusion or ostracism is an action that has costs for both the individuals who are ostracised and the group or individual that shuns them, because the group loses the resources brought to collective tasks by the ostracised individual. If an individual is high in such resources, the group will be loath to ostracise him/her, even when he/she is burdensome in other ways, because such ostracism will be too costly. However, if individuals are considered to be low in resources, it will cost the group little to exclude them, and may even be advantageous (i.e. reduce the number of competitors making claims on resources). This suggests that individuals would want to track the costs and benefits, to others, of their participation in relationships in order to ensure that such relationships were not at risk of critical damage. Demotions should also be avoided, even though a person may not be specifically ostracised. If their rank falls too low they will have little access to resources (for example, high-quality mates and allies won't bother with them).

Indeed, a considerable amount of theory and research has shown that humans are strongly motivated to avoid social demotions and exclusions (e.g. Baumeister & Leary, 1995; Baumeister & Tice, 1990; Leary & Downs, 1995), and that social exclusion is associated with aversive emotional reactions (Leary, 1990, 2001; Williams & Zadro, 2001). Given that human groups contain concentrations of particular reproductive resources, including potential mates, kin to whom altruism can be directed, and non-kin with whom to exchange resources, the effect of social exclusion on various proximal adaptive tasks can be considerable (Buss, 1990). In the Pleistocene period, social exclusion may have threatened one's survival by excluding the individual from the benefits of group-based forms of protection from predators or foraging for food. Under *threat* of social demotion–exclusion, scorn or shunning, it would be very important to reduce the likelihood of further reductions in the *Sv*/*Sb* ratio, however minor or temporary. Such situations would require a qualitatively different strategy from that employed when such affiliations are not under threat. We propose that this situation provided a fundamental selective pressure for the evolution of new mechanisms to regulate interpersonal behaviour and social outcomes.

In the case of depressive disorders, where depressed states become entrenched and dysfunctional, it is possible to identify a set of escalating interpersonal processes. Although some research has suggested that low levels

of depressive behaviour elicit support and defuse aggression in the context of close or communal relationships (see Allen *et al.* (2004) for a review), perhaps reflecting the initial evolved function of depressive behaviour, in other contexts such behaviour results in the opposite outcome: the depressed person being rejected or avoided (Coyne, 1976; Segrin & Abramson, 1994). This rejection then further elicits depressive behaviours, which in turn make the likelihood of rejection more salient. As such, a vicious cycle is set up whereby depressive responses, which may have evolved as a transitory response to changes in social circumstances, become entrenched and self-defeating.

Individual differences, such as differences in the tendency to be excessively reassurance-seeking, may mediate the switch between adaptive and non-adaptive trajectory of a depressive reaction (Joiner & Metalsky, 2001).

Treatment implications: Integrating mindfulness into cognitive behavioural treatment of depression

We have indicated that human depression can operate via at least two distinct types of process. One is related to a cognitive–ruminative process, where thoughts, emotions and evolved regulators of moods feed off of one another, creating downward spirals. The other relates to how depressed behaviour can increase the chances of rejection and depression. In this section we outline how mindfulness can be a useful antidote to cognitive ruminative spirals. In the next section we explore how developing compassion for self and others may affect depressive thinking and social behaviour.

Throughout its development, the cognitive behavioural approach to psychotherapy has always been prepared to absorb ideas and influences from other approaches to human behaviour and clinical treatment provided they can be accommodated within a cognitive framework. This is partially due to a type of shameless technical eclecticism in cognitive behaviour therapy; whatever works is seen as good and is integrated. It is also partly due to the nature of the cognitive behavioural model, its concepts and philosophy, which enables it to assimilate, or accommodate to, new ideas readily.

The cognitive behavioural model emphasises cognitive change as being the most important ingredient in effective psychotherapy (Beck, 1991). Emotional and behavioural change can follow such change. What is key to cognitive therapy is to target consciously available thoughts with a variety of psycho-educational techniques to help people *train* themselves to be able to identify and alter dysfunctional automatic thoughts and feeling processes. As noted by Gilbert & Irons (Chapter 10), these techniques relate to re-attending, re-focusing, re-attributing, re-evaluating and behavioural practice. Taken at its broadest, therefore, this model can accommodate any approach that attempts to change these aspects of functioning of the individual. What has to be determined is the exact nature of the psychological dysfunction that needs to be changed. Here, too, the cognitive behavioural

tradition remains extremely flexible, largely due to its alliance with the empirical traditions of experimental psychology and (more recently) cognitive and affective science. As the empirical sciences of human behaviour find themselves increasingly able to address issues that have traditionally been thought to be inaccessible to scientific enquiry, such as emotion (Davidson *et al.*, 2000), consciousness (Frith *et al.*, 1999), personality (Canli *et al.*, 2001) and the biological bases of social behaviour (Cacioppo *et al.*, 2000), cognitive behaviour therapy, which has always prided itself on its strong empirical grounding, has likewise been able to assimilate this new information and venture into more complex and profound aspects of human functioning. This has in turn facilitated the applications of cognitive behavioural techniques to a broader range of psychological disorders.

Mindfulness

One particularly striking example of this phenomenon has been the integration of ideas and practices from traditional psychologies, such as Buddhism, into cognitive behavioural practice (Kumar, 2002). Buddhism and cognitive therapy share a view that 'with our thoughts we create the world'. Moreover, both Buddhism and cognitive theory have sought ways to help people understand how their thoughts emerge, the consequences of certain types of thoughts and desires, and how to *train* the mind to cope with these thoughts and desires. As Linehan (1993a) notes, this also illuminates a key issue, which is the dialectic between change and accepting things as they are. The concept of 'mindfulness' is very much concerned with the latter issue, and suggests that the emotional power and distress that sometimes accompany our thoughts can be reduced when we learn to de-centre from these thoughts and allow thoughts and feelings to emerge in the mind without (metacognitively) judging or reacting to them. A series of mindfulness practices associated with Eastern (particularly Buddhist) psychological and spiritual traditions which have been integrated into cognitive behavioural practice have been especially important in this regard (Baer, 2003). Mindfulness means paying attention in a particular way: 'on purpose, in the present moment and non-judgmentally' (Kabat-Zinn, 1990: 4). The practice of mindfulness allows a person to be aware of what is happening at the present moment, rather than being caught up with thoughts that are often projections of the future or analyses of the past. The key element of mindfulness is to be attentive without responding. If a thought like 'I am a failure and nobody will love me' pops into the mind, the person is taught to 'observe' this thought without trying to rationalise it away or overly engage with it. By mindful watching of the thought (for example, 'I note I am having the thought that . . .'), attention is reallocated 'to the watching' and away from further processing of the implications. A person may be invited to 'notice the thought' but also to focus on their breathing. Although this is speculative, one process that mindfulness may

seek to undermine is the cortical–reflective (thinking) and limbic (fast and spontaneous) linkages. Cortical thinking functions are not 'dragged into' amplifying spirals of emotion and thinking.

The practice of mindfulness therefore offers an individual a chance to experience living in the present, and to observe how certain states of mind lead to certain reactions, both physical and mental. It is used to identify the pattern of thoughts, feelings and bodily sensations that characterise a particular state of mind, and with identification of these patterns one is able to identify the consequences and utility of these responses (Segal *et al.*, 2002).

Instruction in mindfulness typically involves the development of a personal meditation practice – although not always, as attention control and 'nonjudgement' are its key elements. As part of this practice a person learns to focus their attention away from their thoughts and back on to an object of meditation (e.g. the breath), often facilitating the insight that thoughts are projections coming from the mind and largely derive their impact from the amount of attention they are given. As one slowly watches the mind it can be observed that one thought can provoke a flow of thoughts, which in turn creates a narrative to which the mind and body further react. Yet, when attention is switched to the breath (for example), this 'story' in a sense no longer exists (Segal *et al.*, 2002).

Mindfulness requires a non-judgemental state of mind, which is different to the state of mind through which most of life is experienced. Segal *et al.* (2002) have characterised this by referring to two different mental modes, the 'doing mode' and the 'being mode'. The doing mode is goal-driven. When a person is in the doing mode they are aware of the difference between how things are and how they wish them to be. This triggers negative emotions such as dissatisfaction, which subsequently sets in motion certain habitual patterns. One aspect of these patterns involves continuous monitoring and evaluation of progress towards reducing the gap between the desired state and the actual state. Therefore, the mind becomes preoccupied with analysing the past and fantasising about the future, while the present moment is given low priority. The being mode, by contrast, is not motivated towards achieving any goal, therefore the person has no need of constant monitoring or 'discrepancy based' processing. Instead the focus of the being mode is 'allowing' and 'accepting' whatever occurs (e.g. thoughts). The mind can be dedicated to the processing of the current experience, allowing the individual to be fully present and aware. In the being mode thoughts and feelings simply pass through the mind; there is no need to react to the thoughts and feelings. This is in contrast to the 'doing mode', where feelings/thoughts normally trigger a series of actions in the mind or body that ostensibly serve to preserve pleasant feelings and remove unpleasant feelings, but in many cases do the exact opposite (Segal *et al.*, 2002).

Mindfulness practices are designed to provide a means to change these mental modes, by choosing what one is going to attend to, and how (i.e. in

which mode) it will be attended. Initially the aim is to recognise the doing mode and its many forms and begin the cultivation of the being mode by intensive formal mindfulness (meditation) practice. The practice provides many opportunities to recognise the doing mode, and to disengage repeatedly from this prevailing mental state to return to the being or 'mindful' mode. As mindfulness skill develops, training then becomes more specifically focused on recognising when negative emotions and reactions trigger the 'doing mode' (e.g. obsessing/ruminating) in everyday life, and learning how to disengage from this mode in 'real time' and to observe mindfully, rather than respond to, difficult and uncomfortable thoughts and emotions.

Mindfulness and cognitive behaviour therapy

One of the early examples of the integration of mindfulness principles in an explicitly cognitive behavioural treatment was in Marsha Linehan's development of Dialectical Behaviour Therapy (Linehan, 1993a, 1993b), a cognitive behavioural approach to the treatment of borderline personality disorder. This multifaceted treatment approach draws its name from its emphasis on the dialectic of *acceptance* versus *change*. This dialectic, which according to Linehan represents a critical paradox for the borderline patient, is addressed through a series of techniques that are designed to simultaneously promote acceptance by the client of themselves and their current situation, while also encouraging active change. According to Linehan the synthesis of these apparently contradictory forces leads to a resolution of the resistance to change that arises from the client's non-acceptance of themselves and their situation. Among the skills that are taught, mindfulness skills, such as non-judgemental observation of thoughts, emotions, sensations and stimuli in the environment, are understood to be critical to this resolution of the acceptance and change dialectic. Although Linehan (1994) notes that severely disturbed borderline patients are unlikely to be willing or able to instigate a formal meditation practice, a wide range of more rudimentary mindfulness exercises are selected by the therapist and client in order to establish some degree of mindfulness skill. In the case of Dialectical Behaviour Therapy, therefore, the integration of mindfulness practices has facilitated the development of an effective application of cognitive behavioural therapy to a diagnostic group about whom there has traditionally been considerable therapeutic pessimism (Linehan, 1993a).

A second notable integration of mindfulness principles into cognitive therapy has been the recent work on mindfulness-based cognitive therapy as a relapse prevention intervention for previously depressed individuals (Segal *et al.*, 2002). Research suggests that in many individuals, depressive episodes show a worsening pattern over the course of repeated episodes, characterised by increasing severity, frequency, and autonomy (i.e. episodes are less clearly precipitated by psychosocial stress), and lack of responsiveness to initially

effective treatments (Kendler *et al.*, 2000; Post, 1996). Teasdale (1988) suggests that there is a critical difference in the role of cognitive processes between first onset depression and relapse of depression. During the onset phase of the first episode the link between dysphoric affect and negative cognitive biases may be weak, but in subsequent episodes this link strengthens. Consistent with this, Post (1992) claims that the first depressive episode is more strongly activated by major life stressors, but subsequent depressive episodes become more autonomous, presumably as the negative patterns of thinking become engrained in the neurobiological processes. The patterns of negative thinking will involve globally negative self-representations, dysfunctional relations between self-worth and approval from others, and ruminative thought patterns that prevailed in previous episodes of depression and are likely to enhance and sustain depressed states (Teasdale, 1999). The ruminative thought patterns are often centred on deficiencies of the self, self-blame, a perceived dependence of self-worth on the approval of others, and hopelessness. As noted by Gilbert & Irons (Chapter 10), one reason for this is that they were part of an early pattern of self-evaluations, and once reactivated they become more difficult to cope with because they come with feelings and memories of being powerless, hurt or abused, and moreover a lack of memories of receiving care and affection (see Gillath *et al.*, Chapter 4).

It has therefore been suggested that vulnerability to relapse in those who have previously experienced episodes of depression is related to the patterns of negative thinking that become activated by states of dysphoria (Teasdale *et al.*, 1995). When a dypshoric mood occurs in the recovered depressed individual, this perpetuates escalating cycles of cognitive-affective processing that can transform the dysphoria into the more intense and persistent state of major depression that defines relapse (Teasdale, 1999). While for an individual that has never been depressed, dysphoria can still activate negative patterns of thinking, these patterns are often not sufficiently depressogenic to intensify the dysphoric mood, which therefore remains mild and transient (Teasdale, 1999).

It is conjectured that the risk of relapse in individuals that have recovered from depression depends on the ease with which such depressogenic, ruminative processing can be reinstated by characteristics related to basic elements of core beliefs about the self, such as being unlovable or unworthy. Such evaluative self-related information can increase dysphoric mood (Teasdale, 1999). Lewinsohn *et al.*, (1999) supported these theories, in a prospective study, finding that adolescents with prior depression exhibited a stronger association between dysphoric mood and dysfunctional thinking, and that this association was a predictor of subsequent depressive episodes, while first episodes of depression were more strongly predicted by stressful life experiences.

Breaking the link between dysphoric mood and dysfunctional thinking may be the key to alleviating emerging depressive symptoms and preventing this link from gaining strength and becoming an autonomous cause of

depressive relapse. Cognitive behavioural treatment (CBT) of depression does specifically target dysfunctional thinking, and the techniques of CBT aim to break the link between dysphoric mood and this dysfunctional thinking. It is therefore not surprising that one of the notable features of cognitive behaviour therapy is its superiority over other interventions with respect to the prevention of relapse (e.g. Evans *et al.*, 1992; Hollon *et al.*, 1992), an effect that does appear to be mediated by the impact of CBTs on the link between dysphoric affect and negative dysfunctional thinking styles (Segal *et al.*, 1999).

Despite these important findings, there are also some limitations to the use of CBT for relapse prevention in depression. One of the most salient is that cognitive behaviour therapy is an approach designed for the treatment of acute episodes of depression, and thus many of its techniques and procedures have not yet been tailored for working with currently well but previously depressed individuals, among whom many of the cognitive phenomena of depression have remitted along with their symptoms (Lewinsohn *et al.*, 1981). Mindfulness based cognitive therapy (MBCT; Segal *et al.*, 2002) was developed as an approach *specifically* for relapse. It may be easier to learn techniques for mindfulness when one is not struggling with the pain of a depression. The idea is that once learnt these techniques can be used on a regular basis to improve mood, and also when people find their thoughts spiralling downwards towards relapse.

Initial evaluations of MBCT have been encouraging. Teasdale *et al.* (2000) evaluated the effect of an eight-week MBCT programme on recurrently, but currently recovered, depressed individuals. Participants were coached in the development of a personal mindfulness meditation practice, and were shown specific applications of these practices to understanding depressive thoughts and their role in relapse. MBCT significantly reduced relapse rates for patients that had three or more previous episodes of depression, although interestingly it did less well for those with two or fewer previous episodes. Recently these findings have been replicated in a second trial of MBCT based at Cambridge (Ma and Teasdale, 2004). A subset of the Teasdale *et al.* (2000) study was followed up to investigate the effect of MBCT on autobiographical memory. It was found that those who completed MBCT training reduced the level of overgeneral memory, which is believed to be a trait characteristic of depression-prone individuals that may play a role in vulnerability to relapse (Williams *et al.*, 2000).

The role of mindfulness in the interpersonal domain

Given the importance of the social domain to depressive states, one question that arises is the role of mindfulness in the interpersonal domain. As discussed above, mindfulness has typically been adopted within cognitive behavioural methodologies because of its putative impact on cognitive processes such as

rumination. There has been little exploration of the impact of mindfulness on interpersonal behaviour, or whether other aspects of the Buddhist tradition, particularly Buddhist approaches to the self and the role of compassion, might also have something unique and valuable to offer the cognitive behavioural approach to depression (see Kumar (2002) for a recent exception).

Mindfulness practice is likely to have a number of benefits in the interpersonal domain. These will mainly result from the more general effects of mindfulness, which are the insights that it affords into the nature of thought and judgement, allowing a more non-judgemental and present-focused engagement with experience. This will have a number of potential effects in the interpersonal domain. Firstly, a perception of safeness will promote a very different repertoire of social behaviours than will a perception of threat. This is consistent with recent work on the functions of positive affect, including Fredrickson's 'broaden and build' model of positive affects (Fredrickson, 1998). Because positive emotions, unlike negative emotions, are not linked to threats requiring quick action, Fredrickson proposes that positive emotions broaden (rather than narrow) a person's momentary thought–action repertoire. In the interpersonal domain this will, among other things, allow the development of less self-focus and greater empathy towards others (Fredrickson, 2000). To the extent that mindfulness assists with distress tolerance, facilitating a sense of being able to cope with distressing emotions and situations, and allowing positive affective states to predominate, it should have a beneficial effect on social functioning. Indeed, mindfulness is strongly associated with high levels of well-being and positive affect (Brown and Ryan, 2003). More specifically in the social domain, mindfulness skills should facilitate disengagement from particular thoughts based on interpretation of the putative meaning of social events (for example, 'she didn't speak to me because she hates me; I am a failure, nothing I do will work'), which should further reduce the likelihood of the kinds of interpersonal behaviours (i.e. excessive reassurance-seeking and dependency in some relationships, excessive withdrawal from others) that will exacerbate rather than reduce depressive concerns.

Despite these potential benefits of mindfulness practice for the interpersonal domain, a question that is raised is whether a set of practices that extend mindfulness more specifically into the domain of social cognition and interpersonal relationships might be able to impact even more directly on the underlying psychology of depression. It is here that compassion work might step in to make exactly this kind of connection.

Depression as a compassion deficit

Mindfulness may help us to detach attention from the urgencies of our risk-assessment strategies that focus on how our plans are working out, or whether we have failed or have been rejected. However, as noted above, positive affects are also regulated by positive social relationships, especially those in which

we obtain a sense of safeness and warmth (Gilbert, Chapter 2). One element of depressive rumination is that it constantly bombards the mind with negative signals that undermine positive affects and focus on personal deficits and losses. A key question is therefore whether training people to focus on pro-social signals such as warmth and compassion for self and others can have the effect of stimulating different brain pathways that will turn off the risk-focused processing systems that engender depression. Moreover, developing this style of thinking may increase the generation of prosocial social behaviours that others are more likely to engage with and reward.

As noted by Gilbert & Irons (Chapter 10), one reason that people become self-critical and depressed is that they have an under-elaborated care–compassion mentality. This may be the result of life history (for example, neglect or early abuse), or of a chronic history of depression itself suppressing these abilities. A number of features of depression militate against the development and maintenance of a compassionate perspective, towards self or others. For instance, self-focused attention (which can be compared to the Buddhist concept of 'self-cherishing') has been conceptualised as playing a significant role in the aetiology of depressive disorders (Pyszczynski and Greenberg, 1986). More specifically, research has suggested that after failure, humiliation, or other stressful events, individuals that are depressed or at risk of depression engage in a self-focused rumination that appears to perpetuate the depressive mood (Tomarken and Keener, 1998). Furthermore, Pyszczynski and Greenberg (1986) found that social threats directed towards the self (such as negative social appraisals from others, and social incidents resulting in reduced self-esteem) were especially in accordance with the greater self-focusing style implicated in depression. Additionally, in depressed moods people have been found to be more introspective and self-absorbed than people who are happy (Wood *et al.*, 1990).

Thus, in addition to the proposed social functions of mild and common depressed states, the associated increase in self-focus may serve a more personal function (Power, 1999). In particular, self-focus may allow a useful period of self-reflection in the light of an experienced loss or social failure, enabling individuals to reassess themselves relative to their social world, re-evaluate past priorities given to important social goals, roles, relationships and strategies, and foster the creation of new approaches. Consistent with this idea, Eisenberg *et al.* (1994) propose that in humans, fear and personal distress lead to self-directed efforts and, thus, are prohibitive of empathy, perspective-taking, and helping behaviours; this has been found empirically with children, college undergraduates and the elderly (Eisenberg *et al.*, 1994, 1996). Consistent with this, Brown (2003) recently demonstrated that the tendency to forgive was inversely related to depression (see also Worthington *et al.*, Chapter 6).

Together, the above research suggests that depressed moods engender a self-focus that would seem conducive to an increased sensitivity and

reactivity to social threats, while simultaneously reducing empathy and social perspective-taking in general. During the increased self-focus of depressed moods, the other's distress may be experienced as reflective of one's own socially vulnerable state. Consequently, we suggest that depressed states may result in increased arousal and reactivity towards people in similarly sad and distressed situations, not due to a true feeling of compassion, but rather based on an increased personalisation of the perceived distress (see Gilbert, Chapter 2). This is consistent with the conceptualisation of depression as a socially defensive state (Allen & Badcock, 2003), in which defending one's own social well-being becomes more critical than responding to needs of others.

Typically, however, this defensive self-focus does not engender *self-compassion* (Gilbert & Irons, Chapter 10). In fact, low self-esteem is a definitive aspect of depression (Robson, 1988), and is evident both in descriptions of self-devaluation among depressed people (Beck, 1967) and in the finding that diminished self-esteem is related to low levels of positive affect, and is specifically associated with depression as opposed to anxiety (Tarlow & Haaga, 1996). It has also been suggested by Gilbert and others that an individual's internal judgements of social rank and position are reflected in self-esteem, and that social comparisons that lead to evaluations of personal inferiority or inadequate social rank are associated with the onset of depressive phenomena (Gilbert, 1992; Price *et al.*, 1994); there is increasing evidence for this view (Gilbert & Allan, 1998) and the finding that feeling defeat has specific effects on positive affect (Gilbert *et al.*, 2002).

The link between lack of compassion for the self and a diminished capacity for compassion towards others is therefore amply demonstrated in depression. This is consistent with the notion that self-esteem is fundamentally based on the social environment, and fluctuates according to feedback from interpersonal contexts. Although self-esteem, as operationalised in psychological research, is clearly not identical to the concept of self-compassion, it is likely to be correlated in the sense that both require a feeling of acceptance towards the self. As such, we feel that the voluminous research on self-esteem can inform our understanding of self-compassion to some degree, although clearly caution is required. As noted above, Leary *et al.* (1995) have found that self-esteem operates as a 'sociometer', an internal subjective gauge of an individual's level of social inclusion that monitors others' reactions and alerts the individual to the likelihood of exclusion or ostracism. As noted by Leary (1990: 226), 'virtually all events that raise self-esteem maintain or improve the individual's chances of being included, whereas events that lower self-esteem decrease inclusion likelihood'. The argument that self-esteem is predicted by positive and negative social experiences has also attracted empirical support (e.g. Harter, 1993; Joiner & Metalsky, 1995; Leary *et al.*, 1995; Maccoby & Martin, 1983). A particularly pertinent example was provided by Baumeister *et al.* (1998), who collected first-person accounts of events that raised and lowered self-esteem. They found that events that raised self-esteem

tended to relate to the achievement of social belongingness, whereas those that lowered self-esteem featured failures to connect with others.

Compassionate practices

The cultivation of a compassionate attitude towards other sentient beings has been a central pillar of Buddhist practice and morality (Dalai Lama, 1984). This is referred to as Bodhicitta, which is the aspiration to bring about the elimination of suffering, and the attainment of a state of peace and well-being for all beings. In Buddhism this compassionate attitude is usually cultivated by the use of particular imagery and meditation practices. One of the most important of these, the meditation on Chenrezig, the Bodhisattva of Compassion, is described by Ringu Tulku & Mullen (Chapter 8). This meditation involves many steps, which include using imagery of sending light out to all beings, and the dissolving of the boundaries between the self and other beings. This latter aspect is understood to be a critical element in the development of compassion, as it results in perceiving the interdependence of the interests of the self and the interests of all other living beings. In this respect, part of the cultivation of compassion is to live with a 'vast mind' that embraces (or identifies with) all living beings. Other meditation techniques involve progressive identification with the desire of all beings to be happy, starting with the self, and then extending to one's most cherished loved ones, and then on to other friends, family members and progressively outwards to all the living beings. In this way, understanding of one's own desire and attempts to be happy is used to identify progressively with others until one achieves an empathy for the way in which all beings struggle to find happiness. A critical step in this type of meditation is the initial validation of one's own desire to be happy by freeing oneself and others of suffering, often by explicit recognition that the most enlightened beings are also the happiest (see Feusi (2003) for a description of this practice). Various ways to train the mind for compassion have been developed over thousands of years (Chodron, 1994; Ringu Tulku & Mullen, Chapter 8). Gilbert & Irons (Chapter 10) suggest that training in self-compassion stimulates brain processes for feeling loved, supported, wanted and included – exactly the pathways that may get turned off as people become depressed, focus on threat and become self-critical. These practices thus raise an important question when considered in the context of depression. Buddhist practice asserts that the development of compassion for all beings also has palpable benefits for the self. His Holiness the Dalai Lama has stated that 'the more we cultivate altruisms and a sense of caring for others, the greater the immediate benefits we ourselves receive' (2003: 18). This raises the issue of what role, if any, compassion for *others* might have in the repair of compassion for the self, an issue that is especially interesting in the context of treatment for depression: a condition that is essentially defined by self-punitive attitudes and self-loathing.

Compassion in treatment of depression

As this literature demonstrates, there is a close link between the experience of personal threat and loss and the development of defensive states that simultaneously result in low levels of abilities to access caring mental states and express compassion for self and others. This apparent link between self-compassion and compassion for others therefore appears to be mediated by a perception of threat towards the self, particularly threats to social well-being such as rejection, humiliation and defeat (Gilbert, Chapter 2). Much of the psychological treatment of depression is based on reducing self-punitive attitudes that are associated with low self-esteem. For instance, in cognitive behaviour therapy much of the focus of cognitive restructuring work is aimed at disputing and changing the negative conclusions regarding the self that are engendered by dysfunctional attitudes. Recent developments in the integration of compassion work into psychological treatment have likewise emphasised the use of compassionate attitudes towards the self in order to overcome feelings of shame and humiliation (Gilbert and Irons, Chapter 10; Lee, Chapter 11).

One important extension of this integration of compassion work into the treatment of depression, therefore, might be the explicit therapeutic use of compassionate attitudes and actions towards others in the treatment of depressive states. This is consistent with the Buddhist practice of compassion, and given the analysis above, which suggests that compassion toward others and compassion towards the self may be intrinsically linked, such a focus may provide an important complement to techniques designed to address lack of compassion to the self.

Some use of compassionate attitudes towards others has long been a part of the cognitive behavioural treatment of depression. For instance, often when a client feels they cannot generate alternative interpretations of their experience during a cognitive restructuring exercise, a form of role play is formally or informally employed whereby the client is asked to give advice to a friend regarding alternative ways of looking at a situation identical to their own. This technique is often a powerful elicitor of alternative ways of viewing the situation that were not accessible to the client when they were 'advising' themselves. One way to understand this type of technique is that it leverages the person's capacity to be compassionate towards others (i.e. to adopt a more tolerant and forgiving view of their circumstances) in order to facilitate a more compassionate interpretation of their own experiences.

Another example is the emotion-regulation skill of 'opposite action' that has been utilised in Marsha Linehan's dialectical behaviour therapy for borderline personality disorder (Linehan, 1993a). Opposite action is an emotion regulation skill whereby a client is directed to act opposite to the prevailing dysfunctional or self-defeating emotion. Typical examples include fear (where the opposite action is to stay in or approach the fearful situation) and anger

(where the opposite action is to withdraw *gently* from the anger-provoking situation). Opposite action is also often used to encourage self-reward in response to self-punishing feelings, and the expression of affection when someone irritates one. As such, opposite action is often used to prescribe compassionate action in response to low levels of compassion for the self or others.

Integrating compassion work into cognitive behavioural treatment

As mentioned above, and as is pointed out elsewhere in this volume (Gilbert & Irons, Chapter 10; Lee, Chapter 11; Ringu Tulku & Mullen, Chapter 8), compassion can play a role in healing the mind, and perhaps nowhere more so than in the case of clinical depression, which, as we have described, is characterised by deficits in the capacity for compassion for self and others. Likewise, an emphasis on developing compassion for others may, ironically, provide an innovative means to increase compassion for the self and defeat depressive rumination and self-focused attention. This aspect has been explored in the use of group therapy by Bates (Chapter 13).

The Buddhist tradition, with its emphasis on developing a compassionate attitude towards others, may have much to offer here, as it has done in the case of mindfulness (Baer, 2003). Potential areas of integration of compassion-based work into cognitive behavioural treatment can be thought of as either cognitive or behavioural. On the cognitive side, the use of simple imagery exercises, such as one of identification with the desire of all other sentient beings to be happy (see above), or that recognises the interdependence of the well-being of one person (or of the self) with the well-being of all others, could easily be integrated into treatment. Such techniques would be especially easy to integrate with clients that are already developing a personal meditation practice as part of a mindfulness intervention. Perspective-taking exercises, perhaps utilising 'empty chair' and other role-play techniques, in order to develop compassion for the perspectives of others may also be useful. On the behavioural side, compassionate action could be a focus, perhaps prescribed as part of an opposite action technique, or even utilised more broadly as part of 'compassionate activity scheduling', where the person schedules activities designed to help others.

There are a number of mechanisms by which such interventions might help ameliorate depression. First, it is difficult to retain a view of the social environment as hostile simultaneously with a compassionate view of others. If a compassionate identification with others results in a perception of the social environment as safer, this will eliminate one of the key precipitants of depressed states. Secondly, a compassionate attitude is likely to result in different social behaviour on the part of the depressed person, thereby reducing the likelihood that cycles of behavioural withdrawal or excessive

dependency will elicit hostile or rejecting responses from others (Segrin & Abramson, 1994). Again, this should serve to defuse depressive states.

Another mechanism by which compassion work might overcome depression is by increasing the sense of mastery and self-esteem that the depressed person experiences. Helping actions are highly valued by social partners, and it has been demonstrated that helping actions improve affect (Williamson & Clark, 1989), while conversely, refusing to help others is associated with declines in positive affect, especially if the refusal occurs in the context of communal relationships (i.e. relationships where benefits are provided according to need, as opposed to 'exchange' relationships where benefits are provided with an expectation of comparable benefits in return; Clark & Mills, 1979; Fiske, 1991; Williamson *et al.*, 1996).

Finally, a compassionate focus on the needs and desires of others is likely to reduce the intense ruminatory self-focus that is characteristic of depression. As reviewed above, this self-focus is probably incompatible with empathic concern for others, and plays a role in the aetiology and maintenance of depressed states. Indeed, much Buddhist practice using compassion imagery aims to dissolve the self, not in the sense that the person has a reduced perception of who they are, but in the sense that the self is no longer seen as separate, but rather is seen as connected with the interests of all sentient beings.

Dangers and caveats

The use of compassion work in the cognitive behavioural treatment of depression, although promising, is subject to a number of potential caveats and pitfalls. The most obvious concerns the difference between compassion and subordination. Subordination, the view that the self is less powerful than others and therefore is trapped in current circumstances with few avenues of escape, is an experience that is strongly associated with depression, and may even be fundamental to it (Sloman & Gilbert, 2000). There is a risk that a depressed person will therefore view a task where they are asked to identify with or provide care for others as a requirement to subordinate their own interests to more powerful or deserving others, and thus will experience the task as reducing rather than increasing the capacity for self-compassion. Indeed, at times people need to feel empowered before they can feel compassionate (Hackmann, Chapter 12). This is based on a misunderstanding of the nature of compassion, which needs to be carefully articulated to clients. The first step in the compassion mediations described above is to identify and validate one's own desire for happiness, before then identifying and validating the desire of others for happiness. Thus the dissolution of the sense of the self as separate and having interests different from those of others is critical to a compassionate stance. Of course, when in hostile environments, the defensive state of mind, with its emphasis on protection of the self, is highly adaptive.

But when the environment is not hostile, experiencing the self as interdependent with others (i.e. that the needs and interests of others and the self are interdependent) will facilitate the benefits of a compassionate mind.

Misunderstanding compassion can mean that people could find it difficult to voice anger or could be prone to guilt (Worthington *et al.*, Chapter 6). Compassion should never be used as a process to invalidate a person's feelings or need to work with their hostile feelings – rather it is the opposite (Linehan, 1993a). Compassion, like other psychological interventions, should not be seen (by the patient) as something the therapist thinks the patient 'should do', for this can lead to feeling that there is something wrong with oneself if one can't bring these feelings to mind. As Gilbert & Irons (Chapter 10) make clear, compassion is offered as an 'experiment to try', and in a highly collaborative way.

Finally, compassion work should be integrated with other therapeutic skills, as it is not a 'technique' that can simply be used independent of other concerns (for example, the therapeutic alliance, basic formulation and other therapeutic interventions).

Conclusions

Humans are in some ways burdened with minds that have evolved over long periods of time. Some of our basic dispositions for forming roles with others and our (new) capacities for self-reflective thought and metacognitions can together, when focused on risk and threat, increase our misery. This chapter has outlined how Buddhist ideas and practices regarding mindfulness and compassion can be integrated into the cognitive behavioural treatment of depression. These ideas may result in new approaches that will facilitate more effective interventions. Like the integration of mindfulness practices, which is more advanced, it can be demonstrated that compassion work directly addresses some of the fundamental features of depression. Furthermore, based on an evolutionary understanding of depression, self-esteem, and socially defensive states of mind, we have pointed out that far from being unrelated or reciprocal, in fact the capacity for compassion for the self and compassion for others is likely to be intrinsically linked. This leads to a series of innovative suggestions for intervention techniques designed to improve compassion for others, along with compassion for the self (see Gilbert and Irons, Chapter 10), with the understanding that this is likely to result in positive psychological changes.

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Chapter 10

Focused therapies and compassionate mind training for shame and self-attacking

Paul Gilbert and Chris Irons

It has been known for a long time that people can have hostile thoughts and feelings about themselves. Religious texts, and early writings on depression, are full of descriptions of people tormented by a sense of being unworthy, unlovable, inadequate or bad, and who are self-condemning or self-loathing (Radden, 2000). Self-critical people can feel alienated from others, cut-off and alone, and (for some) abandoned by their gods. Self-criticism and self-condemnation develop in childhood (Blatt *et al.*, 1982; Blatt & Zuroff, 1992) and are highly associated with a sense of *shame*; being flawed and undesirable to others (Andrews, 1998; Gilbert 1998a; Gilbert & Miles, 2000; Tangney & Dearing, 2002). Self-criticism and inner shame play a major role in many forms of psychological difficulty, including: mood disorder (Blatt & Zuroff, 1992; Gilbert, 1998a, 2002a), social anxiety (Cox *et al.*, 2000), anger and aggression (Gilbert & Miles, 2000; Tangney & Dearing 2002), suicide (Blatt, 1995), self-harm (Babiker & Arnold, 1997), alcoholism (Potter-Efron, 2002), post-traumatic stress disorder (Brewin, 2003; Lee, Chapter 11), psychotic voice hearing (Gilbert *et al.*, 2001), affect regulation and personality disorders (Linehan, 1993), and interpersonal difficulties (Zuroff *et al.*, 1999). Dunkley *et al.* (2003) distinguished between two different types of perfectionism, one related to striving to meet personal standards, the other related to self-criticism. It is the self-critical aspect of perfectionism that is particularly associated with psychological problems. Early onset of self-criticism predicts later psychological problems (Zuroff *et al.*, 1994).

Many approaches to psychotherapy have addressed the pervasive problems of self-criticism and self-condemnation, and the difficulties in helping people develop a warmer and more accepting orientation to the self. There are also self-help books that focus specifically on self-criticism (Stone & Stone, 1993). Freud discussed self-condemnation in terms of superego attacks on the ego (Freud, 1917). More recent psychodynamic formulations stress the internalisation of hostile feelings for the self and the way the self can be persecuted by its own self-focused (conscious and unconscious) thoughts and feelings (Scharff & Tsigounis, 2003). Behavioural therapists see self-criticism as a form of self-punishment (Rehm, 1977), while cognitive therapists focus on

negative self-evaluation (Beck *et al.*, 1979). Gestalt therapists discuss the issue as a 'top-dog, underdog' inner relationship (Greenberg, 1979), and in a similar vein evolution-based cognitive-behavioural therapists focus on an inner relationship of hostile–dominant triggering fearful–subordinate defences (Gilbert, 1989, 2000a, 2000b).

Many types of intervention that offer people skills in solving problems and in how to re-evaluate their thoughts, or that provide opportunities to explore feelings in a supportive environment, can be helpful (Roth & Fonagy, 1996). However, there is also evidence that those who are highly self-critical may do less well with these standard therapies (Rector *et al.*, 2000). This chapter outlines ways of helping people with these difficulties. We first link self-criticism to a form of internal self-to-self relationship that is rooted in evolved systems for social relating (called social mentality theory; Gilbert 1989, 1995, Chapter 2 this volume). We then focus on the processes involved in self-criticism and self-attacking and the way it is often a form of defensive/safety behaviour, requiring insight into its specific *functions* for a person (Driscoll, 1988). We outline specific interventions that combine cognitive behavioural interventions with what we call *compassionate mind training*; these interventions were developed from social mentality theory to help people with internal shame, self-criticism and self-condemnation.

Social mentality theory and the internal hostile self-to-self relationship

Briefly stated, and as noted in Chapter 2 (Gilbert), social mentality theory notes that evolved processing systems are responsive to (partner) *signal-sensitive* processing systems in others. Hence, a sexual display can activate processing systems for sexual interest in another, an aggressive display can activate processing systems for fear and submission in another, a distress call can activate processing systems for seeking and help-giving in a parent, and parental affectionate care with warmth can soothe and activate processing systems for attachment and safeness in an infant. Baldwin (1992) suggests that these systems form the basis for interpersonal schemata from which regulation of self can occur. If people are asked to rate their abilities on a task, and are primed with approving or disapproving faces (are flashed pictures below conscious awareness), they rate *themselves* less positively when they have been flashed a disapproving face (see Baldwin and Fergusson (2001) for a review).

Our focus here, however, is on the fact that the brain can both send and receive signals that are social and reciprocally role-forming. Behaviourists have long argued that internal signals (e.g. thoughts, feelings or images) are like any other stimulus that can produce (conditioned or unconditioned) responses. Social mentality theory adopts this view and suggests that these social processing systems can generate *internal* signal–response systems that

play off against each other, especially in humans, who are capable of symbolic self–other representations, metacognition, imagination and fantasy (Gilbert, 2000a; Chapter 2 this volume). Thus, through fantasy/imagination (with no external signal) we can activate our own sexual arousal or stress arousal, or be soothing. We can generate an internal stimulus signal (e.g. a sexual image) and then respond to it with responses appropriate to that signal. The response to the internal signal can vary: for example, a person might be able to generate a sexual image but be too tired to generate much arousal; or an internal signal (e.g. a sexual image) may, as a result of previous learning, generate anxiety and/or metacognitions of, 'how could I have thought that?' (Wells, 2000). It follows therefore that if we are hostile to ourselves, these internal signals can stimulate a defence to hostility. If we are caring of ourselves, these signals can stimulate calming. There is increasing evidence that this is the case.

Greenberg *et al.* (1990) suggested that depression was more likely when individuals could not defend themselves against their own attacks and felt beaten down and defeated by them. In a fascinating study, Whelton (2000) and Whelton and Greenberg (in press) measured students' level of self-criticism with the Depressive Experiences Questionnaire. He then asked each student to sit in one chair and spend five minutes imagining themselves sitting in the other chair, and to criticise themselves. They were invited to switch chairs and respond to the self-criticism. Those high in self-criticism often submitted to (agreed with) their own self-criticisms, expressed shame and submissive postures (slumbered with head down, eyes averted) and sad faces, and felt weak and unable to counteract their own self-criticisms – in other words, submissive and defeat-like profiles were activated to their own attacks. Low self-critics found it easy to dismiss their criticisms.

Self-criticism is a form of self-to-self *relationship* where one part of self finds fault with, accuses, condemns or even hates the self. The idea that our inner relationships with ourselves are routed in different processing systems that function like *inner social relationships* is not new (Gilbert, 1989, 2000a). Jung (1963) referred to them as inner archetypes *that interact* to pattern a sense of self. Watkins (1986) and Rowan (1990) suggested the formation of interacting sub-personalities that are linked to archetypes. Object relations theorists suggest that it is the inner relationship between internalised experiences of 'self with others' (called self-objects) that patterns the sense of self and regulates emotion (Greenberg & Mitchell, 1983). Cognitive analytic therapists, who seek to integrate object relations theory and cognitive theory (Ryle & Kerr, 2002), develop formulation and intervention on the idea that a sense of self can emerge from different, interacting, internal relationships. Gestalt therapists also suggest similar internal processes that give rise to inner conflicts (Greenberg, 1979; Greenberg *et al.*, 1990, 1993). Cognitive therapists have recently suggested the existence of multiple (often labelled maladaptive) schemata that organise information about the self and others (e.g. Young *et al.*, 2001), although they do not focus on the internal *relating* aspects of schemata.

Brewin (2003) has indicated how people can form different (and multiple) self-identities that may conflict (see Gilbert, Chapter 2). Evaluations of self in implicit (non-conscious) versus explicit (conscious) processing systems can also produce different self-evaluations. For example, some people who appear to have high self-esteem but depend on a continuing flow of successes can have implicit low self-esteem, and become anxious, aggressive and self-critical with failure. Their high self-esteem seems defensive to implicit feelings of inferiority (Jordan *et al.*, 2003).

Stated simply, *many* theorists posit the existence of different self-processing systems (not just a single self-processing system) that can come up with different (and at times contradictory) evaluations of the self. Multiple processing systems for self-regulation that are socially role-focused are key to social mentality theory. Social mentality theory has been used to study mood disorders (Gilbert, 1992, 2004), psychosis (Birchwood *et al.*, 2000, Gilbert *et al.*, 2001), borderline personality disorder (Liotti & Intreccialagli, 1998), eating disorders (Goss & Gilbert, 2002) and post-traumatic stress disorders (Lee, Chapter 11).

Acquisition of hostile–dominant and fearful–subordinate self-to-self relationships

Just as our relationships with others are co-constructed from innate strategies matured in lived relationships, so too is our self-to-self relationship. In part this is because self-to-self relationships are designed to help us navigate the social world and how to act within it, i.e. provide self-identities for roles (Gilbert, Chapter 2). Thus, for each social encounter we come to we co-construct the encounter on the basis of previous learning and core beliefs about the self and others and the role enactments that will ensue. A key question is how a person comes to develop a style of being hostile to themselves and then feeling beaten down and depressed. One possible answer is that children need to learn to enact their strategies and roles and develop self–other core beliefs that are appropriate to the social context (Baldwin, 1992). Strategies for approach, trust and openness to others may be highly maladaptive in contexts of hostility. Rather, attentiveness to the power and threat of others could be more adaptive. Strategies not only guide feelings and behaviours but also influence self-organisation (Gilbert, 2002b). This is because a sense of self and self-identity is also a means of tracking and coordinating thoughts, feelings and behaviours to fit the local ecology, and matures, and is thus shaped, in that ecology (Gilbert, Chapter 2). This has far-reaching implications that an example may illustrate. The example will also indicate how the social rank mentality (rooted in concerns with the power of others, striving, social comparison, fear of rejection and attacks, and shame) becomes the dominant organising mentality for self-to-self and self-to-other(s) processing (Gilbert, Chapter 2). As we shall argue later, the social

mentality for love, affection, care and compassion may be weakly elaborated in self-to-self and (at times) self-to-other processing.

Case example

Sally was physically abused by her father from a young age. Often, when in his presence, her implicit 'inhibited and submissive defence' was automatically activated. She was anxious, and would be quiet and try to keep out of his way. When threatened she (recalled she) would freeze or crouch (cower) down in defensive postures. For Sally, then, her submissive defences were the best she could do to protect herself. Processes of sensitisation and kindling of key neural, defensive circuitry may be a salient issue in such cases (Perry *et al.*, 1995; Rosen & Schulkin, 1998) and would be laid down as implicit knowledge. With the maturation of self-identity formation, Sally became aware of her automatic tendencies to become submissive and inhibited with low self-confidence, and had memories of being labelled as 'bad' by her father. Her cognitively elaborated sense of self was therefore rooted in implicit and conditioned affect/defences of being in a low power/rank position and of being a fearful and submissive person. Moreover, she concluded that she was an inferior and weak person (a metacognition).

Sally was also self-critical (seeing herself as a weak and unlovable failure) and self-condemning. In essence she had (1) integrated into her self-evaluative system the negative emotionally textured labels of her parents towards her; (2) learnt that others are powerful and threatening; and (3) incorporated a defensive (damage-limitation) strategy as a threat-regulation strategy. There are many theories of how and why this happens (Baldwin, 1992; Ryle & Kerr, 2002). However, from a social mentalities point of view, we note a number of *functional* processes that can help in the understanding of self-critical and self-attacking behaviour when people are forced to adopt submissive defences in their early relationships.

Submissive defences and self-attacking

Sally's self-evaluative system matures in line with her (early) social environment, requiring her to keep her 'head down' and adopt a submissive profile to defend herself. Her *conditioned* defence system (probably located in the fast threat-processing pathways; LeDoux, 1998) will act *as a rapid warning system* for when to be fearfully submissive. In threatening environments, defence system processing is oriented to 'better safe than sorry' processing; that is, it is better to assume a threat and take defensive action (even if one did not need to) than to miss a threat (Gilbert, 1998b). Attention will then become narrowed and focused on threat (Chajut & Algom, 2003). Missing a threat could be highly costly, and this is why, as Baumeister *et al.* (2001) point out, we have far more processing systems for handling threats than for positives.

Threats from powerful others (in distinction to hungry lions, cold, lack of food, diseases) produce multiple socially-related defences and self-perceptions. Fournier *et al.* (2002) recently demonstrated the effect of social rank on conflict and defensive behaviour, with subordinates being attentive to the power of others and suppressing anger upwards. In an unequal power (and potentially hostile/rejecting) relationship, it is adaptive for subordinates to be self-focused in their attention. For example, in monkeys eye-gaze can provoke attacks and it is the subordinate that must monitor their behaviour and avert their gaze – even though this means they can no longer look at the dominant. As Scott (1990) points out, dominant individuals direct their attention outwards as they don't have to worry about what *they are* doing, but attend to what subordinates might be doing. Although this has never been clearly tested, we would suggest that self-monitoring is heightened in contexts when others have more power and/or can inflict harm for behaviours that a dominant sees as inappropriate or challenging their power.

Self-attacking as a defensive/safety (appeasement) behaviour, which is linked to efforts to calm the self and *the other* in conflict situations, was found by Forrest and Hokanson (1975). They investigated the propensity for depressed and non-depressed people to use self-punishing behaviours in response to interpersonal conflict (confederate aggression). They measured physiological arousal to conflicts, and how arousal changed depending on how a person responded to the challenge on them. One of their measures was rates of self-administered electric shock in response to aggressive behaviours from others. They found that baseline rates of self-punishing responses were much higher for a depressed compared to a non-depressed group. They suggested that this indicates a previously established repertoire (self-attacking) for dealing with aggression *from others*. They also found evidence that self-punishment, or the emission of a friendly (appeasement) response, in the face of aggression from another, had significant arousal-reducing properties for depressed but not for non-depressed people. In other words, self-attacking and appeasement could reduce the arousal associated with confrontation in the depressed, but not the non-depressed, group. Forrest and Hokanson (1975) state:

> The experimental findings indicate that the greatest plethysmographic arousal reduction takes place in the depressed group when a self-punitive (or friendly) counterresponse is made to the aggressive confederate. The nondepressed group exhibited comparably rapid reductions only following an aggressive counterresponse.
>
> (p. 355)

This leads them to suggest that:

> depressed patients have learned to cope with environmental and interpersonal stresses with self-punitive and/or non-assertive behaviors and

> these behaviors have been successful in dealing with normal day-to-day existence. At times when situational stresses become great this limited behavioral repertoire may be invoked to a degree that may seriously impair adequate functioning and these people may manifest a clinical depressive or *masochistic* episode.
>
> (p. 356; emphasis added)

It is also known that subordinates will often return and approach dominant animals that have threatened or harmed them, expressing submissive behaviours as they do so, until the dominant pats or strokes them and indicates reconciliation (called reverted escape). Further discussion of submissive defences as ways to calm both self and dominants can be found in Gilbert (2000b).

Using a behavioural approach, Ferster (1973) suggested that if children express anger and this generates anger or withdrawal of love from the parent, a child's anger can become conditioned to anxiety. Over time the child may become unaware of their anger and aware only of the anxiety. To this we can add that conditioning of submissive and self-punitive behaviour may also become built into that repertoire. Gilbert *et al.* (2003) found that recalling oneself as subordinate (and having to act as a subordinate) in the family was more strongly related to depression than other parental recall factors such as warmth and overprotection. Conditioning models have much to tell us about the emotional basis of some of these defences, and can be seen as alternative explanations to those of object-relations theory (Gilbert, 1992).

Self-blaming and submissive defences

Rapidly activated submissive defence(s) can arise from implicit, non-conscious (defensive) strategies that bias towards self-blame rather than objective judgements. Although there may be many reasons for self-blame, *one element* is that it fits with a subordinate, self-monitoring and control strategy. For example, Bowlby (1980) pointed out that it can be too threatening to blame a parent for the parent's harsh behaviour (and see the parent as bad). It is *safer* to blame self, and self-monitor behaviour so as not to stir up a parent's anger. As noted in Chapter 2 (Gilbert), this dynamic may be seen in religious contexts when people blame themselves (as sinners), but not God, for (what are seen to be) possible punishments. There is a long history of people trying to appease their gods and thinking that disasters and misfortunes have occurred because they have angered their gods and have been bad in some way. This can lead to various religious rituals for 'making safe' between self and God and protecting from his/her anger/rejection. The point about this is to place self-blame in a socially meaningful context of social power, *as a defensive/safety process*. One function of this safety process is to direct attention to the self because there is not much you can do to alter the (potentially harmful) dominant (especially if

you are trapped with him/her – for example, a child in the home), but you can monitor your own behaviour and check for its 'threat-safeness'. Self-blame then can be automatic, elicited via rapid implicit systems, related to feeling vulnerable to harm from a dominant (either by attack or by their withdrawing love and protection, and/or rejecting the self). Attention then switches to the self and how to reduce the harm of a dominant acting this way. Submissive responses may include hiding, self-blame, appeasing and/or hunkering down, and toning down positive affect (Gilbert, 2004).

Evidence that self-blame is associated with feeling inferior was found by Gilbert and Miles (2000). In their study, blaming self for criticisms and put-downs by others was highly associated with shame and seeing the self as inferior, whereas blaming others was associated with seeing self as (relatively) superior and low in shame. Thus, there is a strong link between self-blame, seeing self as inferior and submissive behaviour. This is sometimes called internalising (in contrast to externalising), which shapes the presentation of a disorder (for example, internalising, bad-self is linked to depression/anxiety, in contrast to 'bad-other' which is linked to externalising disorders such as aggression). Thus, Sally's negative *self-blaming* evaluations/attributions act in tune with submissive (self-monitoring and needing to know what she might have done) defensive strategies.

However, in both animals and humans automatic defences to being threatened by a more powerful other can be ambivalent, such that (in rats, for example) a social threat can elicit the motor expression for initiating fight *and* flight (Dixon, 1998). Thus, even though those enacting subordinate-defence behaviours are frightened and submissive, this does *not* mean that they are not angry. Indeed, self-critics can score high on anger with others (Gilbert & Miles, 2000) and ambivalence is common. Zuroff, Moskowitz and Cote (1999) found that self-criticism can also be associated with poor interpersonal relationships, partly because self-critics can also be critical of others.

Up-rank but self-critical

It is also possible that people who have a fear of others (e.g. rejection/criticism) can adopt *up-rank* strategies. They may adopt perfectionistic striving (Blatt, 1995), or seek high rank to try to put themselves beyond rebuke, have social control, and defend against fears of inferiority (Gilbert, 1992). However, this is not secure but *insecure dominance* and another possible example of safety-seeking. They may mirror those with high explicit but low implicit self-esteem (Jordan *et al.*, 2003). Failures can be felt as disasters because they threaten with (the return of) feelings of powerlessness, inferiority and vulnerability at deep implicit levels (Brewin, 2003). In extreme cases a person may be driven to suicide, linked to ruminations about the self as rejectable, vulnerable to others shaming/rejecting them, and self-attacks/condemnations (Blatt, 1995). Whether people adopt up-rank or down-rank strategies to cope

in the world, self-critics may not feel safe and 'connected' (see Gilbert, Chapter 2, Figure 2.2). The care/concern and compassionate mentality that focuses on warmth, care, investment and affection to self and others, and that lays the foundations for a sense of self as loved and lovable, may not be so well elaborated (Gillath *et al.*, Chapter 4).

Rehearsal of self-attacking

Self-criticism can act as a type *of inner rehearsal* of attack–submit interaction that reinforces feelings of inferiority (low rank) and submissiveness. This is simply to say that if each time one fails or experiences a loss, one automatically self-blames or condemns self (for whatever reason), then over time these become over-learnt and easily triggered coping styles that reinforce negative self-schemata. Using measures of self-esteem, Heimpel *et al.* (2002) found that low self-esteem people appeared less motivated to improve their moods following a setback than high self-esteem people. They suggest that two key processes may be involved. First, low self-esteem people experience a greater loss of energy to a mood-lowering setback than do those with high self-esteem. This is predicted by social mentality theory because (a) low self-esteem is highly related to seeing self as inferior to others (Gilbert, 1992), and (b) part of the function of reductions of energy in ranked relationships (for example, seeing self as having low self-esteem/inferior) is to inhibit a 'come back' or re-challenge, to give up and take a low(er) profile (Gilbert, 1992; Gilbert *et al.*, 2002). Second, they found that low self-esteem people had to struggle with far more self-criticism than high self-esteem people, setting up a vicious circle of a dip in mood triggering self-criticisms that triggers a further dip in mood. This vicious circle was also demonstrated by Teasdale and Cox (2001) who found that with a lowering of mood, recovered depressed people become more self-critical than never-depressed people. Basically, then, self-critics are usually well rehearsed in self-criticism – it comes automatically – but they may be *less rehearsed* in soothing and reassuring the self.

Self-attacking as inner harassment

Self-criticism can act as an internal *hostile signal*. It is like having a self-monitoring system that is constantly looking for weaknesses and condemning the self. If this is repeated over time a person can feel persecuted by their own self-attacks (Greenberg *et al.*, 1990). This forms the basis of what we may call *internal harassment*, the constant, repetitive experience of being (internally) attacked/condemned and feeling shamed (Gilbert, 2004). Its impact may be similar to the impact on subordinated animals being harassed by dominants (for example, it activates stress). Indeed, people with negative self-attacking thoughts and those who hear hostile voices often feel harassed by them, feel

trapped with them and seek to escape (Gilbert *et al.*, 2001). This flight motivation (from one's own self-attacking thoughts or voices/signals) is associated with depression (Gilbert *et al.*, 2001). It follows, therefore, that inner rehearsal and harassment may strengthen threat–defence (rather than warmth, love and acceptance) pathways in the brain (Gilbert, 2000a).

Birchwood and his colleagues (e.g. Birchwood & Chadwick, 1997) have shown that in (psychotic) voice-hearers, the voice could be experienced as powerful and omnipotent. One of us (PG) was so struck by the similarities of their depictions in malevolent voice-hearers with those noted above in severely depressed people that we investigated the similarities and differences in the dominance/power of hostile thoughts in depressed people and of malevolent voices in psychosis. There were no differences in the power of thoughts and voices. Whereas depressed people knew their attacks were from within themselves, people who heard malevolent voices heard the attacks as external and more insulting (Gilbert *et al.*, 2001). Birchwood *et al.* (2000) have also shown that the more powerful a voice, and the more subordinate a person feels to their voice, the more submissive and subordinate to (real) others the patient feels. So the person can be harassed and severely stressed by hostile voices or hostile thoughts.

Defensive/safety behaviour-based self-attacking can be resistant to change

Many therapies have noted that a person can be resistant to change for many reasons (Mahoney, 1991). In humans, 'better safe than sorry' dominates the cognitive strategy (Gilbert, 1998b). People may continue to engage in their defensive/safety behaviours because they will, at times, bring relief, and the person attributes the fact that something bad or even worse has not happened to their defensive and safety behaviours (Salkovskis, 1996). If the safety behaviour does not work, they then assume that it was because it was not done well enough (for example, I was not good enough, not perfect enough, did the wrong things). Again, you can see this in religions where people may ascribe misfortunes to their not having obeyed God's laws well enough; i.e. there is an invigoration of self-blame, which, in this context, seeks to make the misfortune understandable, (potentially) controllable, and not threatening to the dominant.

It is known that people with low self-esteem may not change their negative views of themselves even when they are successful. This was explored in the fear of failure literature by Birney *et al.* (1969). They found evidence that low self-esteem people were anxious about self-improvement because this made them more vulnerable to other people's attacks, they thought they might not be able to sustain improvement in the future, and others (and themselves) might have higher expectations of them. It is at times safer to dismiss positives and remind oneself that one 'is inferior and not try to take risks'

(Gilbert, 1998b). If people are faced with the possibility of giving up self-attacking there can be a fear that they will lose a self-regulating process they have relied on. How to act or 'be' becomes much more uncertain, and they may fear loss of a sense of self-identity (see below). A somewhat similar view has been articulated by Swann, Rentfrow and Guinn (2003), who suggest that people seek coherence in their self-identities, not just self-enhancement.

So submissive behaviour may be a natural, basic defence that comes with self-monitoring. It can be conditioned in many ways (for example, in environments that are hostile and where one cannot get away from a powerful other who is able to withdraw love/support or is actively condemning or abusive; where a child experiences contingent withdrawal of love for acting in a dominate, assertive manner, or where a child is told they are bad or unlovable). These prime implicit self-referent systems for later self-beliefs. For these and other reasons we suggest that self-criticism can be contextualised in an evolutionary and social process model that emphasises safety and defensive behaviours/strategies in social interactions (Gilbert, 1989, 1993, 2000b). Hence, it is suggested that what is being internally acted out (and strengthened by repeated activation via one's own self-attacks) is hostile-dominance and threatened subordination in the self-to-self relationships; that is, the processing systems for generating hostile signals and adopting submissive defences are being repeatedly played out internally in self-to-self relating (Gilbert, 2000a). In the case example above, it would be unreasonable to assume that Sally can develop care, compassion or liking for herself in the absence of this being stimulated in her by another. In a hostile environment that requires rapidly activated defences, having a 'relaxed', caring and calm self may not be adaptive (Gilbert, 1989; Ryle & Kerr, 2002).

Identifying the self-critical process

Having discussed self-attacking from a social mentalities point of view, and linked it closely to the social rank mentality and defensive/safety behaviours, we now explore the therapeutic processes of engaging with self-attacking. We can start by noting that Beck *et al.* (1979) argued that people are in a constant process of self-monitoring, and they automatically ascribe reasons for things happening to them. These automatic thoughts are sourced by core beliefs, which in social mentality theory are themselves rooted in basic (in the case of self-criticism) role-forming mentalities and defensive strategies. Social mentality theory differs from schema theory (Young *et al.*, 2001) in that it focuses on the (internal) generation of a (hostile) signal that then generates a defensive response – i.e. internal interactions and their neurophysiological mediators. It also differs from schema theory in that the processing systems involved were evolved for *social relating* and thus can create inner dialogues within the self (Watkins, 1986). This aspect will become clearer as we proceed.

Writing down

Standard cognitive therapy interventions might unfold by taking a history, sharing a formulation (often using diagrams), and establishing a therapeutic relationship (Beck & Freeman, 1990; Blackburn & Twaddle, 1996; Leahy, 2003). The therapist explains the nature and purpose of the therapy and collaboratively they work out which problems need to be addressed first. When the time comes to address self-criticism, the therapist would invite the patient to engage in guided discovery of the link between her moods, behaviour and self-critical thoughts. The therapist explains in detail the reasons for this and may introduce some thought forms. These will usually have a column for recording the eliciting situations, the feelings aroused, the thoughts that accompanied the feelings, and a column for writing down re-evaluations.

To illustrate this process, and for later discussion of compassionate mind training, we offer an example that may allow readers to have some empathy for the issues; one can try out the various elements on oneself as we go through it. Our example is based on a number of people from therapy, training and supervision sessions, so it does not represent any one person in particular. However, for ease of exposition we will personalise this as *Anne* and pretend she is a real therapist, having therapy herself. The process can be followed using the thought form outlined in Table 10.1.

The situation that triggers Anne's self-attacking is: not doing well with some patients, feeling a desire to avoid them and becoming anxious and depressed. *Guided discovery* is facilitated by the therapist using Socratic questions of 'What went though your mind; what flows from that, or what does that imply?' Questions for self-critics that are directed at locating *external* shame and self-critical material are 'What were you thinking others were (might be) thinking about you?' Questions that are directed at locating *internal* shame and self-critical material are 'What were you thinking/feeling/sensing about yourself?' These thoughts are written in column 2 of our thought form example (Table 10.1). The therapist invites the patient to reflect on the emotions and behaviours that emerge either in the situation described or as a result of the self-criticism. Commonly these are feelings of depression, despair and anxiety (which might be written down in the feelings column, column 3).

Via guided discovery and Socratic questions, we elicit self-criticism around *external shame*, relating to thoughts about the attacks and put-downs from others if they knew about the situation, and also *internal shame*, relating to self-to-self thoughts. It can be useful to explore predicted consequences. Thus for Anne the fear is that *others will be rejecting*. Therapists working with self-attacking patients are at an advantage if they have a good understanding of different types of shame and its distinction from other self-conscious emotions such as guilt and humiliation (Tangney & Dearing, 2002; Gilbert,

Table 10.1 Thought monitoring with compassionate mind training: example 1

Triggering events, feelings or images	*Beliefs and key thoughts*	*Feelings*	*Compassion-focused alternatives to negative thoughts*	*Understanding and change in feelings*
Key questions to help you identify your thoughts. What actually happened? What was the trigger?	*What went through your mind? What are you thinking about others, and their thoughts about you? What are you thinking about yourself, and your future?*	*What are your main feelings and emotions?*	*What would you say to a friend? What alternatives might there be? What is the evidence for new view? (How) is this an example of compassion, care and support?*	*Write down any change in your feelings.*
Not moving on with patients; they are getting stuck and dependent. I don't want to see them.	**External shame** Others will wonder what I am doing. Others will be critical and see me as incompetent or unable. As a result they will be rejecting.	Depressed.	*Empathy to one's own distress:* Understandable to feel disappointed and thwarted – this is hard work. *Like others:* Many experienced therapists often have these problems. When I talk to colleagues they admit to having similar difficulties with some people. *Help seeking:* Can be open and share my difficulties and seek supervision–help. If I don't blame myself I can be open about how to move forward. Previous supervisors have thought I was OK as a therapist.	Warmer to self, less depressed, more encouraged and accepting of the problem.

Table 10.1 continued

Triggering events, feelings or images	*Beliefs and key thoughts*	*Feelings*	*Compassion-focused alternatives to negative thoughts*	*Understanding and change in feelings*
	Internal shame *Should:* I should be getting better results – something wrong. *Negative social comparisons:* My patients would do better with somebody else. *Negative self:* I don't know enough. Not up to this job. Incompetent. Selfish to want not to see them. —— *Image:* Callous, demanding woman with angry and disappointed feelings directed at the self. *Function:* Warn me and stop me relaxing.		Supervision is there to share difficulties and it's through difficulties we learn most. *Refocus attention/memory:* I can remember patients who have done well with me. Patients and I can learn 'together'. *Defocus the shoulds:* All therapists would like to see patients change quickly, but that's not real life. 'Shoulding' myself is understandable but not helpful. I can only do my best. *What is helpful?* The ability to be with patients, listen and bear feelings of stuckness with them may itself be helpful. There is nothing shameful here, but a painful reality of life. —— *Image:* Oldish, tall lady in white, very wise, caring. Linked to caring for nature.	

1998a, 2003). Guilt is about harming others and requires empathy and sympathy to feel it; shame does not.

Gaining clarity regarding the damage of self-critical attacking

Although some self-criticism (noting mistakes and need for improvement) and the ability to tolerate it are important for self-regulation, an early task is to help a person gain deeper insight and understand the link between self-criticism as a *personal judgement and label, associated with anger or contempt*, and feeling bad – that is, the real harm their type of self-criticism can do. It may seem strange, but patients may believe that self-criticism is good for them because it *pushes them on*. Few see it as a defensive/safety behaviour, but this insight can be crucial to helping people change. Greater insight into the damage self-criticism can do can be developed in various ways. For example, one might ask the patient to read aloud his/her self-attacking thoughts but to imagine that he/she was speaking them to a friend who was in the same position. Mild self-critics may quickly see the power and at times sadistic and undermining nature of their attacks. Sometimes a patient might 'think' these critical things about a friend, even if they would not speak them out – to which the therapist can note consistency with regard to self and others. Ken Goss (personal communication, May 2002) has suggested using a mirror so that the patient has to 'see' himself/herself when reading the self-criticisms.

Imagery

The use of *imagery* can illuminate the process (internal signals–responses) between the hostile dominant–fearful subordinate inner relationship. The therapist might suggest: 'Can you try to imagine this critical part of you as if it were a person. Try to connect with those negative thoughts and feelings you have for yourself and then imagine that part of you as if they were a person. What do they look like, what is their voice tone, what is their essence?' Self-critics have few problems in doing this. Typically the inner self-attacking part is described as big, powerful, and *demanding compliance* and is *vigilant* regarding failures (just like a hostile dominant). Facial expression can be imagined to match the affect. At times the emotions are of frustration/anger for failing or can be dismissive disappointment, contempt, or even hatred. Sometimes it can be identified as another (for example, the essence of a father or an abuser), but not always. The essence of these can be written down at the bottom of the thought form (in column 2). For Anne, her image of her self-attacking part was of a *powerful, callous, demanding woman with angry and disappointed feelings directed at the self*. It was related to a mother figure, but not completely. This part of her was experienced as powerful and omnipotent.

Naming the internal critical process

A number of therapists have suggested that it is useful to name self-criticism, either as an 'inner critic' or as an 'inner bully' – to personify it in some way (Gilbert, 2000c; Greenberg, 1979; Stone & Stone, 1993). Patients can be invited to find their own names for it. Others suggest discussing self-criticisms in terms of 'a schema' (Young *et al.*, 2001). In social mentality theory we use relational imagery of 'if this part of you were a person'. This is because the brain evolved processing systems for social information, and clinical practice suggests that: (a) patients find it easier to engage with affect if it is in a social relational format; (b) it highlights the relating and power aspects (dominant–subordinate); (c) the qualities that are part of the critic, such as anger and contempt, are more easily experienced and identified by an imagery focus (for example, of voice tone, facial expression); (d) the patient can link this more easily to memories of others that may have been abusive or rejecting; (e) it also helps to provide insight into why confronting this part of the self can at times feel overwhelming (see below). Clearly, however, these clinical observations require further research.

Two chairs and inner dialogues with the hostile dominant self

Because it is the relational aspect that is focused on, one often wants to indicate the *relationship-like and dialogical* nature of these thoughts and the anger/contempt in them. Hence, people will have 'inner conversations' with different parts of themselves; processes outlined by those interested in narrative approaches (Gilbert, 2000a; Watkins, 1986). To help this dialogue one might use two chairs – techniques pioneered by Gestalt and affect therapists such as Greenberg (1979; Greenberg *et al.*, 1993). One explains the purpose of the exercise of 'getting to know one's self-attacking part better' and how it relates to the self and how to deal with it. In inviting this work the patient needs to feel in control and work collaboratively at all times. The therapist may invite the person to deliver their attack to an empty chair, and imagine that in the empty chair is himself or herself, who is receiving the attack. Hence, the person delivers the attack as they (may) have previously written down on their thought form (and with whatever elaborations come to mind as they do the exercise) – to the empty chair. It is notable that when in the attacking chair, the posture of the patient can be alert, upright and staring – that is, they are acting in the hostile dominant role. The therapist then invites the patient to sit in the empty chair and reflect on their feelings of attack. As noted above, typically in this chair/role the patient submits/agrees with the attacks (for example, 'it's true, I am incompetent/weak/stupid') and switches to submissive, shamed and defeated postures with slumped body and eyes averted (Whelton, 2000; Whelton and Greenberg, in press). Importantly, if you then ask the patient to switch back to the attacking chair and reflect on

the fact that their attacks have generated depression, anxiety and despair, they often show little *compassion* for the hurt they have elicited. For example, for one patient her attacking self said 'Well yes, I know these attacks upset "her" but that is because she is so weak and pathetic – she does not deserve anything else.' If this occurred in a self-to-another person role one would have to say that the failure to be moved or have sympathy for feelings of hurt and distress one has caused is somewhat psychopathic. Indeed, at times the feelings of despair generated in the non-attacking chair by the attack can make the attacking part of self even more angry! Hence, rather than compassion or remorse for causing distress, the attacking part of self is condemning of this emotional reaction to its attack.

Functional analysis

Self-criticism can address different aspects of self. The inner critic (just like a dominant other) can *warn* and point to a threat ('If you don't lose weight nobody will love you'); it can attend and *monitor* weakness or errors ('You did that wrong again, really messed up there'); it can *command* ('You must stop eating; you should not show your feelings, you must get control'); it can lay down *conditional* rules ('You are only lovable if you lose weight, are nice to people, if you are a success'); and, of course, it can *label, name and shame* ('You are pathetic, worthless and useless'). As cognitive therapists have noted, these 'thoughts' are often extreme and distressing. Clearly, what is giving rise to these experiences is not a 'real inner critic' sitting in the brain somewhere, but complex brain processes, with neurophysiological mediators, that run implicit strategies for engaging the world, self-regulation and linking to memories. In social mentality theory these brain processes give rise to emergent experiences of self and internal self-relationships. However, you can't talk to an amygdala, frontal cortex, or hippocampal memory system, but you can communicate with them through their signal-sensitive systems and emergent role-forming properties; that is, they can show themselves through inner images and dialogues. The key is to understand the functions of these inner guiding systems.

It is not uncommon to find that many patients struggle to give up self-attacking or seem to hang on to this style. This is why it is useful to consider it as related to defensive/safety behaviours (as noted above), which can be clarified. Thus, once one has a few samples of self-attacking thoughts (for example, as in Table 10.1) and some insight into their 'power' (for example, via imagery or two-chair work), one may use a functional analysis that focuses guided discovery on the functions of emotion, cognitions and behaviour (Ferster, 1973; Goss & Gilbert, 2002; Hayes *et al.*, 1996; Suyemoto, 1998). This can be explored by simple questions such as 'What is the worse fear of the critical part of you?' Or a therapist can ask the patient sitting in the attacking chair, or when they form an image of the attacking part of the self,

'What do you hope to achieve from your attacks?' For some patients, anger at self is related to poorly regulated emotions (Leahy, Chapter 7), and provided the person is not frustrated, they are not self-critical (Gilbert, 2000c). For many others, however, self-criticalness, associated with feelings of shame and inferiority, 'lives with them' more or less constantly. Various functions have been suggested by Driscoll (1988), such as attacking the self first before others do, trying to elicit sympathy, and self-correction.

Our research has focused on two key functions of self-attacking. One we have called self-improving/correcting self-attacking, and the other self-persecuting self-attacking (Gilbert et al., 2004). Improving self-attacking has the function of trying to make the self try harder or put more effort into things, or stop the person from making mistakes. Improvement self-attackers may believe they have to attack and goad themselves, otherwise they will fail and be rejected. Patients can in fact be rather resistant to giving this up, in part because it is *hoped* they can do the right things and succeed.

To return to the example of Anne (Table 10.1), functional analysis tells us that Anne's *external shame* attacks act *as a warning* about what will happen if she fails to get good results (others will condemn and reject her), and indicate that help is not available. She is able to link this to memories of others telling her that if she is not up to the mark she will be criticised and rejected (and having experiences of being so). 'Better safe than sorry' thinking means she focuses on threat and closes out, or does not attend to, other possibilities. She is aware that these are highly *rehearsed* cognitions and are easily triggered. Her *internal* shaming attacks function (in part) to stop her being angry and rejecting of her patients. She believes she would be an *even worse* therapist if she started blaming patients and rejected them; she would be letting them down, and would herself be cold-hearted. Blaming herself is 'safer' than blaming others, and her thinking is rather dichotomous. Our discussions have revealed that these are linked to safety/defensive behaviours and cognitions, picked up in childhood with a critical mother whom she was often trying to please and was frightened of. Anne acknowledges that in therapy with her patients she is sometimes anxious with them, and tries to please them or retreats into 'techniques', often worried as to whether she is doing 'them' right.

The key here is that rather than condemning the self-attacking part or trying to stand up to it, or attack it back, the therapist can consider the protective or safety functions of these cognitions *positively*. For those who self-attack to try to improve themselves this can be positively connoted by saying, 'Your self-attacking seeks to push you on, keep you going. In days past, it might have been a source for strength, hope or warning. It gets frustrated because it desperately wants to succeed and is frightened of failing.' Time is spent discussing this form of self-attacking from a functional (advantages and disadvantages) point of view and de-shaming the process. One patient was able to see that she wanted to 'achieve' to make her parents love her and be proud of her and was anxious of giving up self-attacking and not 'pushing herself on'.

Sometimes people cannot see any other way to win a valued place in the world, and want the therapist to strengthen, not weaken, their drive for success because they have not changed their conditional beliefs (for example, I am lovable if slim, bad/rejectable if fat). With one patient who talked about trying to work out the right way to do things, PG used a well-known analogy: 'You know it may be like finding yourself in a cave and you want to get out, into the sunlight. As you do, the entrance collapses around you and you feel trapped. In a desperate effort to get out you start clawing at the rocks, putting every effort to escape, getting exhausted and wounding your hands. In your understandable fear and desperation to get out, you are not able to stop and consider if there is another way out of here. Maybe if you go into the cave further you will find another way.' The patient was silent for a while and then tearfully said, 'Yes I guess that is how I have felt all these years, just so desperate to find the way.' So that a person will not feel shame for self-attacking ('I know this is silly and I should not attack myself like this'), the therapist highlights the person's real struggle to do their best, with the gradual understanding of course that this is misguided and unkind because it can simply beat one down. Therefore, how can we develop compassionate ways to achieve our goals?

Contemptuous and self-hating self-attacking recruits different emotions (especially those of disgust) to those of self-improving, and is more complex to work with (Gilbert *et al.*, 2004). One patient, who had been abused and felt inner disgust with the self, said 'At times I want to rip my body open and let the badness out. If I cut myself I think my blood will be black and all the badness can flow out – it calms me.' Once again functional analysis can help here, in that one explores this as a possible desire for self-cleansing and healing: 'It seems as if there is a part of you that is trying, in the best way it can, to cleanse you and become pure and good again. Just like we vomit if we have taken in bad food, this part of you wants to find a way to cut out or vomit or let out the bad.' One patient said of this intervention: 'I'd always thought of my cutting as something bad about me, that I should not tell others about. Seeing it like this makes it feel different.' The point of this intervention is to try to form a compassionate empathic link to the self-destructive urges/emotions in the patient, as a *desire to be cleansed* and 'get rid of', thus especially to de-shame these behaviours and urges (Babiker & Arnold, 1997). There can be so much shame around these feelings that if a therapist tries too hard, too soon to change them, these patients easily turn their efforts into a 'should' and another attack (for example, 'I should not want to hurt myself, I must think logically and get control'). They may also fear (early in the therapy) that there is no other way to self-cleanse, get rid of the bad or calm themselves. Once this is articulated there is empathy for this feeling and collaborative exploration of how to help these feelings using alternative, compassionate behaviours, images and thoughts (see below).

If the self-attacking part is identified as a past abuser, then a very different

function may be operating – to force the self to submit and keep quiet about the abuse. The person has copied this into their self-system and experiences it as an intrusion. One can suggest that: 'As in the past you still go along with this "intrusion" because it was (and still feels) just too dangerous to do otherwise.'

Rebellion and disloyalty

Beginning to acknowledge that parents (or others) may have been harmful, and their rejections, shaming comments, attacks or abuse were not one's own fault, can start a rebellion process that is difficult. Rebellion as a psychological process is rarely discussed in the psychotherapy literature, and self-assertion is the more common focus. However, rebellion may be a preferable notion for the kind of difficulties discussed here (Goss & Gilbert, 2002) because such actions can feel intensely alienating and threatening, with even greater feelings of aloneness. To stand up against a powerful other or group and say 'This is wrong, I am not going to go along with this', knowing that there may well be a counter-attack and rejection for such a show of disloyalty, can feel immensely threatening.

Many years ago, Stanley Milgram (1974), in his now famous experiments on subordination to authority, asked participants to give electric shocks to other participants. He pointed out just how emotionally costly rebelling against (refusing) an authority figure can be. He suggested that the process of rebellion goes through stages of: *inner doubt, externalisation of doubt, dissent, threat, and disobedience*. Milgram's own words testify to the struggle rebellion can entail and explain, perhaps, why many find it difficult to rebel against the subordinate role they have adopted despite all the suffering it causes and contradictory evidence.

> The act of disobedience requires a mobilization of inner resources, and the transformation beyond inner preoccupation, beyond merely polite verbal exchange, into the domain of action. But the psychic cost is considerable . . .
>
> The price of disobedience is a gnawing sense that *one has been faithless*. Even though he has chosen the morally correct action, the subject remains troubled by the disruption of the social order he brought about, and cannot fully dispel the feeling that he has deserted a cause to which he had pledged support. It is he, and not the obedient subject, who experiences the burden of his action.
>
> (Milgram, 1974: 163–164; emphasis added)

If one adds to this the fear of shame, and actual serious consequences that families, bullies and abusers can bring down on one's head for disobedience and defection, then resistance to rebellion is perhaps not surprising. Helping

people change and give up the subordinate roles and self-blame can go through these stages. First, there is the beginning of doubt that the parent was (not) right in their judgements. Next, these doubts become increasingly articulated in the therapy and the patient begins to see other (non-self-blaming) reasons for the parent's harsh treatment of them. Next, the patient begins to actively rebel, in the sense of acting against their negative self-beliefs and refusing to always take the blame. Hence, they learn to disobey. For example, a patient who believed that sex was dirty (because her mother had insisted it was), and who felt dirty if she enjoyed sex, went through these stages. She began to think about why her mother may have hated sex. Active disobedience to her mother's view came when she started inviting her husband for sex. Understanding these processes of rebellion can be useful in aiding the process of letting go of certain types of self-condemnation and actively choosing how one wants to be, rather than subordinate and obedient to the values of a powerful other(s). Social mentality theory suggests that whether it is a set of values one should adopt (e.g. religious values), ways to conduct oneself, aspects of oneself one can enjoy or should disown (e.g. sexual pleasures) or how to think about and judge oneself, rebellion is no easy matter, and can be frightening. Cognitive techniques that may overly focus on 'cognitive distortions' may not acknowledge the *courage* in some people's struggles to change, and may miss the maintaining factors of certain beliefs. They may also miss an important opportunity for empathic engagement.

Disloyalty and breaking attachment bonds

There is another aspect that bears on the issue of loyalty and attachment bonds. If a child is to be loved and accepted then they must be loyal and keep the faith – blend into the narratives of the family or social group. In helping people to challenge their negative self-attacking thoughts (and give up adopted submissive roles), they may have a sense that they are *betraying family secrets and narratives* – being in some way *disloyal*. This creates more feelings of unlovability and bad self-experience. Freud (1917) argued that some self-attacks were to protect others on whom the person felt dependent. Some patients, however, believe that if they stick with the rules and values of the family they will find love someday. To rebel is to break that link and feel disconnected from one's family and early attachment figures.

One patient whom we will call Jane, with whom PG discussed this and who had intense self-hatred, reflected with: 'I had not thought of that before, but in a way I feel that by hating myself I keep my link to my mother – I think about myself as she thought about me and in that way I remain the daughter she created.' To change was to break the link and to be disloyal and maybe condemning of her mother. Her mother was at times mentally ill, and Jane felt sorry for her and wanted to love and heal her. Giving up self-hatred was like making a statement about the damage her mother had done

her (inner doubt and externalising doubt) and *betraying* her. Although her mother had at times been cruel to Jane, Jane also felt she could have done more to help her mother and care for her. To change felt like leaving mother behind (guilt) *and* facing the world alone. It felt like marking herself as 'not one of the family' anymore. And in any case, she reasoned, 'Was it not true that at times she *had* hated her mother despite knowing she was ill – so did that not prove she was herself hateful?' In such cases, normalising emotions (Leahy, Chapter 7), and understanding that hating others comes from being hurt and threatened by them – a natural defence – and is not evidence of badness, can be helpful. One would then empathise with the felt inner dilemma (reject and rebel against my mother's script for self and feel a betrayer and detached from her *versus* stay loyal and linked but subordinate). Careful clarification of the disadvantages and threats of letting go of self-hatred can be helpful. One might note that 'in a way it is an act of love (and/or safety-seeking) to stay loyal, not to attack her in your mind, accept her judgment and carry the "badness."' However, love may still be there (or not) even if we learn to face the truth; one can't engage in forgiveness (if that is required) unless one acknowledges the hurtful behaviors of others (Worthington *et al.*, Chapter 6).

Guilt and the fear of change

O'Connor (2000) has discussed the way guilt (fear of hurting others, leaving them behind, or doing better than others) can underpin various psychological problems (Worthington *et al.*, Chapter 6). Jane was very helpful to the therapist, PG, in helping him understand this with her. Our efforts to counter her self-attacking had helped only a little, but Jane hung on in therapy and came back again and again to images of leaving her mother behind. If she were free to be herself and started to be compassionate to herself it felt like saying goodbye to mother, 'leaving her to rot'. We had of course talked of difficulties in dealing with anger/hatred for her mother. Via guided discovery we got an image of it being like 'someone is dying in a cave' and although you are free to leave, you cannot. So you must stay in the darkness with her. Eventually, Jane came to the view that, in a way, if she could learn to let go of her self-hatred then she could bring a kind of healing to both of them. Mother was too damaged to do it for herself and now she needed Jane to find another way. Jane wanted to (now) take the responsibility for finding a new kind of relationship based on compassion to self and mother. The moment Jane construed her movement to self-independence like this, it was like a light coming on. She said she suddenly felt as if a burden had been lifted from her shoulders and she was free to be the person she wanted to be. Freeing herself from her mother and becoming different from how her mother had 'painted her' was not an act of betrayal or abandonment. It took time, of course. Guilt-based self-attacking, in an effort to stay

loyal and not hurt another, can thus be an important issue for some people (O'Connor, 2000).

When one hears the issue of 'deserve' in self-criticism, or there seems unclear resistance to change, it is worth exploring for patterns of guilt: 'How can I enjoy myself when mother never did; how can I make myself so different from my parents?' Unacknowledged guilt can be a block to change and can trap a person (Gilbert, 2000b). In the film *Good Will Hunting*, there is a scene where Will, who has superior mathematical abilities, is telling a friend that he will never leave their small working-class group that has been together since childhood. He does not want to take advantage of his abilities and leave them. His friend is angry at this, and encourages Will to use his talents, saying that it would not be act of betrayal to leave and go out into the world. The fear of betrayals can haunt some people in complex ways. Socratic questions such as 'How would you changing affect your feelings and images about your relationship with (for example) your mother?' or 'If you changed so that you did not follow your family values, how would that feel for you?' can sometimes start an exploration into these issues. Sometimes people can get trapped in abusive relationships because they feel too guilty about leaving.

Those who work with people who have been abused will be very familiar with the fear of discussing the abuse, revealing family secrets and betraying the family. Some may feel guilt for the pain this will cause others (e.g. their mothers) who had not protected them, or there can be a fear of shame in these things being revealed. Hence, there can be a major dilemma in staying quiet, accepting the blame, carrying the bad and protecting others from having to face *their* blame, versus being open about it. Also, of course, when abused children do turn to others for help, the inability of protectors to cope with their own shame may result in denial and blaming the child. It may take an act of courage, and support and validation by a therapist, to help people resolve these difficulties.

Fear of anger and hatred

Many therapists working with intensely self-critical and self-condemning people have noted that they can have particular problems in processing destructive feelings (rage and hatred) – especially to those close to them. This is true for psychodynamic therapists (Scharff & Tsigounis, 2003) but, as noted above, is also true for behavioural therapists when anger becomes *conditioned* to anxiety (Ferster, 1973). It might take time for people who feel frightened of being criticised by others to recognise and think about anger. We might ask, 'Can you think of any "first flush" feelings that might have been very fleeting when you were criticised?'

In cognitive therapy terms, a common problem is conflicting beliefs of: 'If I express my anger then I am bad and rejectable; if I don't express my anger

then I am weak and contemptible.' Another conflict produces a circular process. For example, for one patient it was 'Mother criticises me and I feel angry but then frightened and feel bad and unlovable – that turns off my anger; but then I think her criticism is unfair and I should say something which turns anger back on again, but . . .' There is a kind of 'grid lock' that ends with self-condemnation and feeling powerless. Envy can also be a source of hatred (Gilbert, 1992).

Most of their lives, self-critical people have been trying to find love and acceptance; acknowledging anger or hatred only seems to confirm for them that they are indeed deeply unlovable. This requires sensitivity on the part of the therapist. Our own procedure is to approach the issue *slowly* and somewhat matter-of-factly, with a lot of exploration and discussion of hatred as a *normal defensive response to feeling hurt*. Time and again we may say, 'It is our human desire to love and be loved that makes hatred so understandably difficult. In your heart you want to find your own goodness.' In the beginning this often produces strong counter-claims: 'But hatred is evil and I am evil to feel or fantasise about it.' The therapist can then write down with the patient all their thoughts about hatred, and slowly engage in discussing it. Talking about it in this (somewhat detached) way can be an important precursor to beginning to talk about actual feelings to specific people. In essence we help people learn to be *compassionate with their hatred* and process feelings of vulnerability and injury that underpin hatred, without self-condemning. Unlike some therapies that may seek to interpret hatred, cognitive therapists seek to create the conditions that allow guided discovery of hatred (including at times for the therapist) with compassionate validation. In cognitive approaches it is the interpretation of hatred that is the key issue. Clearly, however, the idea is to acknowledge, process and heal hatred, and not to act it out in destructive ways. Helping people process feelings of hatred can take many months.

Fear of aloneness

When a person 'hears voices', even though the voices may be critical and controlling, the person can come to form a relationship with them and can fear the emptiness or aloneness that may follow their departure. The same can be true with self-critics. They have been so used to experiencing themselves in these types of relationships with self and others that they can worry about what they will feel, or even what or who they may become, without them; there is a challenge to one's self-identities (Swann *et al.*, 2003). As discussed in Chapter 2, people will keep leaders in place even though they know them to be bad, for to get rid of them threatens a loss of the relationship and of self-identity. The same can be true of internal 'leaders'.

Summary

Compassionate functional analysis allows for a *de-shaming* and *de-guilting* exploration of the real struggle the person is putting in to heal themselves or be loved – their self-attacking can make sense in functional terms. People need validation of their efforts (Linehan, 1993). As Mahoney (1991) has discussed, many of the processes that we see as pathological are actually efforts at self-protection and to maintain cohesion. Once a patient knows that you will not condemn (or label) them for their ways of trying to cope with emotions, or to find love (and accept that even their self-attacking parts are understandable and have a function, although undesirable and damaging to the self), and that you will empathise with their efforts, the therapy relationship can move to a de-shaming, compassionate, and accepting form of open, guided discovery. Functional analysis can sound like a rather detached technique, but it is not. It can be rich in shared meanings of the beliefs and memories that guide the way we treat ourselves.

All these steps help to illuminate three things: the power of the self-attacks, the emotional textures of the self-attacks, and the safety and defensive behaviours of submissive defeat and appeasement to being attacked by the self. Focusing on guilt can illuminate fears of betrayal and abandoning another.

Re-evaluating and changing self-criticism

As noted above, many different therapies have recognised the importance of shame and self-attacking as underpinning psychological distress. Hence, there are a vast range of interventions for it. Key to many of them is the process of acknowledging shame and then 'de-shaming' it. This is also true in Buddhist-oriented psychotherapy, for, as Brazier (1997) makes clear, Buddhist psychotherapy is highly focused on shame. Western psychological therapies are becoming increasingly eclectic in interventions. One reason for this is greater understanding of how many different types of intervention can be helpful. Many years ago Arnold Lazarus coined the term 'multimodal therapy'. Recently he summarised this:

> The multimodal orientation (Lazarus, 1997) is predicated on the assumption that most psychological problems are multifaceted, multidetermined, and multilayered, and that comprehensive therapy calls for a careful assessment of seven parameters or 'modalities': behavior, affect, sensation, imagery, cognition, interpersonal relationships, and biological processes. The most common biological intervention is the use of psychotropic drugs. The first letters from the seven modalities yield the convenient acronym BASIC I.D., although it must be remembered that the 'D' modality represents the entire panoply of medical and biological factors.
>
> (Lazarus 2000: 93)

The therapeutic interventions for self-attacking outlined below can be seen in multimodal terms, or at least as interventions that address these different modalities.

Many traditional cognitive therapies try to help self-critics by re-evaluating the evidence for (and against) their self-attacks, helping them to learn assertiveness or acknowledging and working with anger. Recent work has also focused on metacognitions, the meanings we give to our own thoughts and feelings (Wells, 2000). Cognitive therapies help people reflect on the consequences of their styles of thinking and provide opportunities to stand back from them and bring in new ideas and ways of thinking (Beck *et al.*, 1979). In particular, it invites a person to attend to new information, re-focus, re-evaluate, re-attribute, think of alternatives and consider evidence for and against their negative view of themselves. The therapist and patient will also plan homeworks to act against their beliefs, supporting, encouraging and helping people discover they can do things they thought they might not be able to. These techniques are well described in the literature (Barlow, 2001; Blackburn & Twaddle, 1996; Leahy, 2003; Wells, 2000; Young *et al.*, 2001) and have been outlined for self-help approaches (Gilbert, 2000c); we will touch on them only briefly here. Alternative thoughts can be written down on a thought form (see Table 10.1).

In work with psychotic intrusions (voices), cognitive and metacognitive techniques can be used to explore the fear of resistance to a malevolent voice (for example, the power of the voice; Byrne *et al.*, 2003). These may include: looking at the origins of the voice (for example, as sourced within rather than outside a person); looking at the ability to control the intrusive thought/voice; exploring evidence that the voice cannot hurt the self – but the patient has not been able to 'update' this belief because it has been too frightening to try to do so on their own, or they needed external validation; exploring why it would be in the voice's interests to have the patient be affected by insults or obey commands; reducing appeasement in role-play or by challenging the voice in imagery.

For people who have been sexually abused and feel their self-criticism is the 'voice' of the abuser or that their inner self-critic is the result of feeling degraded, the same interventions as used for psychosis can be helpful. Bergner (1987) has also outlined a number of interventions for helping people who have been abused to re-evaluate their feelings of self-degradation. Lee (Chapter 11) has developed various thought forms for helping people think through the 'credentials' of previous, hostile attacking others. She uses both imagery and sensory modalities. For our work, however, we think about not only the credentials or the (bestowed) legitimacy of another to judge, label and criticise the self (important though they are), but also the defensive–safety behaviours involved (for example, the fear of not obeying/agreeing).

Now and then

A basic premise of cognitive and other therapies is that people remain unduly influenced by beliefs and emotional dispositions that they have picked up early in life and have not be able to update or change. Thus, a therapist helps a patient to see how in early life their beliefs and defensive styles tried to protect them (i.e. safety behaviours) in some way but have not been updated for current life: 'That was then – this is now'. One may describe such beliefs as 'like mini-programs in the mind', or a smoke detector, that blindly issues the same instructions or thoughts over and over again. One can note how the inner critic is (boringly) repetitive in what it says. Careful consideration is given to what might be needed to update these mini-programs into new, more useful models. Helping people recognise the need to, and aiding their ability to, process emotions in new ways can be especially important (Leahy, Chapter 7). The compassionate and safe environment that the therapist provides can be crucial to this process.

To help people think through problems of not updating the mini-defensive or self-attacking programs, one might ask (in a gentle way): 'Although you learnt to think like this as (say) a five-year-old, I wonder what your more adult mind might think now? Can you think of times that your inner critic has got it wrong and what happened? Has your inner critic ever worried about *you* or really put your *welfare and happiness* first? If you were to help a child with this self-critic, what would you say or do? What is the worst fear of the self-critic, and how might you teach it to be less afraid?'

Frustration

As noted above, some people are spurred into self-criticism out of frustration. This requires work on frustration tolerance and envy, and also on beliefs that link (perceived) major threats (catastrophes) to not being able to achieve or have certain things. Gilbert (2000c) noted that it is possible to write down aspects of an 'actual self' and aspects of an 'ideal self' and explore how people feel if the (disappointment) gap grows too large. Enabling people to recognise how some of their self-criticism is linked to frustration can be helpful. Various cognitive and mindfulness interventions can be used to help people learn to be more self-accepting and forgiving, make ideals more realistic, tolerate frustration and reduce rage directed at both self and others.

Dialogic and relational approaches

Dialogic and social mentality approaches use elements of the cognitive interventions such as: attend to new information, re-focus, re-evaluate, re-attribute, think of alternatives. However, it is *acting in a role* of being more assertive with these thoughts that can be particularly powerful; one does not

just say or think them, one has to act them out. For example, the person may imagine delivering their 'alternative thoughts' to the chair from where they enacted their self-attacking bullying part of self. Or they may confront the bully in imagery, reading aloud their re-evaluations that they have written down. Hackmann (Chapter 12) outlines how, when one is using imagery to help people with anxiety, they may want to have experiences of being empowered, dominant and assertive. Switching to a dominant role can be very helpful.

Practice

It is believed that the more a person practises these alternatives, the more the person will change. Central though these interventions are, it is very important to see self-attacking in functional terms and not just as 'a maladaptive belief'. This allows the therapist to avoid potentially sterile engagements about 'evidence' and focus more on issues of safeness, fear of change, habits, and social roles. Indeed, at times the therapist may say that 'It is not the degree to which you can see and believe alternative things about yourself but the degree to which you believe *it is safer to believe them*. So it is not that you cannot generate alternatives to your self-criticisms, it is that it feels a lot safer not to attend to or believe them.' Most patients can see this, and it allows the therapist to move away from trying to 'convince' the patient about evidence and focus instead on safeness and the felt disadvantages of giving up self-criticism.

Compassionate mind training

So far we have outlined ways to work with self-attacking fairly head-on via re-attending, re-evaluating, re-attributing, updating and so forth. In recent years we have been interested in another issue – the degree to which self-critics can access a self-caring and compassionate mentality that is soothing to self and limits the aggression/anger in self-attacking (Gilbert, 2000a). One source of access to self-soothing and reassuring is access to emotionally textured feeling memories of others who have been soothing and reassuring, e.g. loving attachment figures (Bowlby, 1969, 1973; Gillath *et al.*, Chapter 4; Kohut, 1977). In terms of social mentality theory, the care, reassurance and mirroring behaviours of a parent(s) stimulate specific pathways in the child's brain (Schore, 1994). Not only does such stimulation, over time, elaborate pathways in the brain for feeling safe, loved and lovable, and build emotional memories of self in relationships with others, but these pathways can be copied into, or utilised, by self-to-self evaluation processes. It is highly adaptive to do this in investing/loving environments, for it means that the self-system will choreograph strategies for building cooperative-sharing and investing relationships – thus linking to others whose strategies are seeking the same things.

A key problem for some self-critical people may therefore be that they do not have access to feeling memories of being affectionally cared for (soothed), and their self-care and self-compassion mentality has been understimulated, underdeveloped and under-elaborated. Gillath *et al.* (Chapter 4), and Mikulincer and Shaver (in press) have reviewed extensive evidence for this, showing that those with secure attachment refer to these memories (and internal models of others as helpful) when threatened, as a source of help and soothing. Those with insecure attachments do not, and have to defend themselves by anxious help-seeking and appeasement (especially for soothing) or becoming excessively self-reliant, which at times may mean using flight or aggressive defences.

Further evidence that the self-care and self-compassion mentality has been understimulated, underdeveloped and under-elaborated was found in a study by Gilbert *et al.* (submitted), who used an imagery task with students to explore how easy or difficult it was to imagine a self-critical/attacking part of the self and how easy or difficult it was to imagine a soothing, compassionate and accepting part of the self. Those high in self-criticism found it relatively easy to imagine a self-critical part of self that was experienced as hostile, powerful and controlling, while low self-critics found this imagery task more difficult. Self-critics found compassionate imagery more difficult, while low self-critics found this relatively easy to do. In a recent study of volunteers from a depression self-help group, Gilbert and Irons (2004) have found that some people could easily imagine and elaborate on a hostile condemning part to themselves but found it hard(er) to elicit images of a caring part of the self. When one person tried to imagine a caring part of herself, she became distressed because the image quickly turned into one of her (ex) husband who was abusive and she could not distract herself from it. When we asked if she could *recall* others being kind and loving towards her, she could not. Memories of rejection and criticisms, however, were easy to recall – they were more available.

We take these data as preliminary evidence that self-critics have an overdeveloped internal, hostile dominant–subordinate self-to-self relationship, linked to memories of others being neglectful, hostile and condemning. They are oriented to the world as basically hostile, needing to pick up on threats quickly, and defend the self from them. Submissive safety and defensive strategies go with self-monitoring and self-blame ('What did *I* do that was *bad* and provoked/caused this bad outcome?'). In self-criticism related to *shame*, the explanations for things going wrong are commonly some basic flaw in the self (Tangney & Dearing, 2002). Self-critics have less elaborate brain pathways that trigger feelings of reassurance, soothing and safeness, and/or are less able to stimulate these pathways. For some people, then, reduced access to self-soothing systems may be the result of the physiological state of depression, or key beliefs of self-compassion as weak and not helpful, but for many it could be a result of underdevelopment and under-elaboration of this

mentality due to early experiences (Gillath *et al.*, Chapter 4) and well-entrenched safety behaviours for self-blame/condemnation. Irons *et al.* (submitted) found that students who reported unfavourable early parenting, and who also found it difficult to be self-reassuring, had increased levels of depression symptomology. In comparison, those at the same levels of recall of unfavourable early parenting but who had the ability to self-reassure had lower levels of depression symptomology. Hence, even in the context of recall of negative parenting, capacities to self-soothe *may* reduce depression vulnerability.

Compassion versus self-esteem

Clearly, for this approach, the key work is to undermine shame, self-blaming and self-condemnation safety behaviours, and to instigate a new, *warm*, self-to-self relationship. Some may argue that, in so far as we set ourselves the task of trying to stimulate and develop a caring mentality into self-to-self relating, we are just developing positive self-esteem. We caution against this idea for a number of reasons. First, developing self-esteem can imply developing beliefs about abilities to achieve goals. Although this can be laudable and valuable, it may not address the issue of acceptance for failures, self-soothing and the *physiological* task of calming the self when stressed. Moreover, self-esteem seeking does not necessarily lead to positive affect (Crocker & Park, 2004). Second, it is now known that there are different positive affect systems (see Gilbert, Chapter 2). MacDonald (1992) has distinguished (the evolution of) a warmth system from an attachment one. The warmth system is especially attuned to signals of affectionate care and investment from others. These are conveyed in the early interactions, especially via facial displays (affection), voice tone and holding, and later by signals of support, warmth and friendly affection. The self-esteem literature makes no distinction between different positive affect systems. However, compassionate mind training is (probably) more closely linked to an opiate system that calms and soothes, giving feelings of safeness, being 'at peace' and/or perhaps a system underpinning self-acceptance (Gilbert, Chapter 2).

Third, to develop a compassionate mentality towards the self requires activation of various components of care–compassion (Gilbert, Chapter 2), or what Buddhists call loving-kindness (Salzberg, 1995). These include: increased awareness of the harm and suffering caused by self-attacking and thus increased sensitivity to the distress one causes oneself; sympathy and empathy for one's own life situation and experiences; the ability to feel 'warmth' for the self; the ability to adopt a forgiving attitude to the self, the ability to tolerate and 'make safe' memories and experiences that may haunt and terrorise the self, and the ability to access images that are self-soothing and reassuring (Hackmann, Chapter 12).

Neff (2003a, 2003b) has also clearly distinguished self-compassion from

self-esteem. She points out that self-compassion involves: (1) extending kindness and understanding to oneself rather than harsh self-criticism and judgement; (2) seeing one's experiences as part of the larger human experience rather than separating and isolating; (3) holding one's painful thoughts and feelings in balanced awareness rather than over-identifying with them (Neff, 2003b: 224). The last of these elements can be achieved with mindfulness training (e.g. Kabat-Zinn, 1990; Teasdale *et al.*, 2000). Mindfulness training involves a form of focused attention, and sometimes meditation, where thoughts and feelings are seen to arise in the mind but the person does not engage with them; they become like leaves drifting on the river (Thich Nhat Hanh, 1991). The new cognitive therapy view of this is that one tries to change one's *relationship* to one's thoughts and feelings rather than their contents, as one might by challenging the evidence for them (Teasdale, 1999; Teasdale *et al.*, 2000). Although this is an important element of compassionate mind training, it is not one we will discuss here (see Allen & Knight, Chapter 9). Rather, our focus is on how we might use 'natural signals' and processes that the neuropathways for the care–compassion systems in our brains are attuned to and can respond to. In this sense compassionate mind training is not just about recovery or challenging negative beliefs; it is also about discovery – finding new resources within the self and creating new patterns in our minds that have organisational properties (Wang, Chapter 3).

Why training?

We call our approach *compassionate mind training* for a number of reasons. First, the idea that people can benefit from developing *compassion* to, and for, the self, via the practice of certain tasks and exercises, is not new. It is a cornerstone of Buddhist therapies (Ringu Tulku & Mullen, Chapter 8; Salzberg, 1995). Mindfulness training, adopted from Eastern meditation techniques for use in psychotherapy (Kabat-Zinn 1990; Teasdale *et al.*, 2000), teaches people to be attentive to the contents of their thoughts and feelings 'in an attitude of acceptance and loving-kindness' (Marlatt & Kristeller, 1999: 70). A compassionate attitude, rather than a detached or cold, rational neutrality, is often part of the practice (Kabat-Zinn, personal communication, 2003). Dialectical behaviour therapists seek to develop a patient's 'Wise Mind', which is linked to compassion and is an integration of Zen and behavioural practices (Linehan, 1993). Ego-based therapies have developed a range of imagery techniques to develop loving-support for the self (Frederick & McNeal, 1999). Rubin (1975) recommended self-compassion as an antidote for self-hate, and McKay and Fanning (1992) made self-compassion central to their cognitive behavioural approach for building self-esteem. Connors *et al.* (1999) have outlined an approach to psychotherapy based on developing *serenity*. Serenity involves a number of components such as

developing a sense of inner safeness (finding an inner haven), learning self-forgiveness, acceptance and trust.

Second, many psychotherapeutic approaches are based on the idea that insight is rarely enough to help people change. Some therapists believe that it is the repeated experience of a warm compassionate therapist in an interaction that (through empathic resonance) stimulates new insights and internal self-to-self relationships. Many cognitive therapists agree, although they have not written in detail on this aspect. However, cognitive therapists also suggest that more is needed by way of directed training in thinking and behaviour change (sometimes called psychoeducation). Moreover, they suggest that although people can learn to identify, monitor and change their thoughts, feelings and behaviours that are linked to distress, it is through *training* the mind to think in a different way (for example, that counteracts negative self-attacking thoughts and ruminations) that real change occurs. Such training may focus on new ways of thinking, learning new skills and/or facing up to feared and challenging situations (for example, change via exposure and desensitisation). Learning when to tolerate negative feelings and develop acceptance of feelings and situations, and when to change, is the central dialectic of dialectical behaviour therapy (Linehan, 1993) and for working with what Hayes *et al.* (1996) call experiential avoidance. However, as the Dalai Lama has pointed out, compassion does not grow without attention, thinking and *practice* (Goleman, 2003).

Third, although the concept of training can be seen in terms of learning new thoughts, attitudes and behaviours, it can also be seen as a physiological process. It is now known, for example, that when we create memories, or learn new ideas or behaviours, pathways in our brain change; new connections between neurons are made, and at the level of the neuron, receptors change their sensitivities (LeDoux, 2002). There is increasing evidence that learning and training, including that occurring in psychotherapy, have neurophysiological effects (Cozolino 2002; Schwartz & Begley, 2002). Thinking and imagery stimulate physiological pathways (George *et al.*, 1995; Hackmann, 1998). For example, dwelling on sexual imagery can result in a cascade of hormones released from the pituitary that generate sexual feelings, ready the body for sexual behaviour and focus attention on sexual cues. Dwelling on frightening or stressful events results in a cascade of brain changes including changes in the amygdala and the hypothalamic pituitary–adrenal stress system. As stress systems become activated they focus attention and thinking on threats (Gilbert, 1989; Toates, 1995). In neurophysiological terms, threat brings the amygdala on line; it choreographs information-searching of the environment (and from memory systems) and primes defensive responses (Le Doux, 1998, 2002). Cortical and more controlled thought processes may then calm the threat-processing systems or amplify them. Hence, negative thoughts may both cause and reflect activity in stress-regulating (and other)

pathways (Weissenburger & Rush, 1996). The more often certain pathways are stimulated, the more sensitive, elaborate and easily triggered they can become – as a kind of kindling (Rosen & Schulkin, 1998), or what Perry *et al.* (1995) call 'use-dependent development'.

The question of which pathways are stimulated by which types of thoughts and images is increasingly a focus of neuroscience (Schwartz & Begley, 2002). Researchers are beginning to explore how psychotherapies stimulate specific pathways in the brain and change key processing systems, especially those that are threat-focused (Cozolino, 2002; Schwartz & Begley, 2002). Mindfulness training, for example, has recently been found to alter immune system functioning and brain lateralisation (Davidson *et al.*, 2003). Indeed, there is much research showing a link between thinking and coping styles, with immune functions and susceptibility to disease (Martin, 1998). When we refer to the notion of *training* we are therefore concerned with not only changing thoughts and feelings (at both explicit and implicit levels; Haidt (2001)) but also producing brain changes and new patterns of neuronal pathways. Compassionate mind training is close to (neuro)*physiotherapy* where exercises are chosen to stimulate and strengthen various systems and desensitise others (Schwartz & Begley, 2002). Indeed, one might even coin the term *neuropsychophysiotherapy* for this approach.

In summary, we see one aspect of compassionate mind *training* as a way to stimulate new pathways in the brain that enable development of a new self-to-self relationship, based on a 'care and concern' social mentality. This mentality conceptualises, thinks and feels about relationships in very different ways to that of the social rank (dominant–subordinate) mentality (Gilbert 1989, 1992; Chapter 2 this volume). The aim is to tone down dominant–subordinate self-to-self relating, reduce shame, replace unhelpful defensive–safety behaviours and stimulate self-reassuring and self-caring/soothing relationships. This training needs to operate at both implicit and explicit levels of self-relating.

Therapy relationships

In individual therapy, the therapy relationship acts as the first source for compassionate relating and activation of soothing systems in the patient (Leahy, Chapter 7). We are innately set up to monitor and respond to certain signals as safe or threatening (e.g. facial expression, voice tone; Trevarthen & Aitken (2001)). The well-known therapist signals of empathy, positive regard and non-judgemental stance (Rogers, 1961) send clear signals that a person's safeness-monitoring system may be attentive to (Gilbert, 1993; Chapter 2 this volume). There may of course be a host of reasons why this does not happen, such as non-attentiveness. One patient was too frightened to look at the therapist and more attentive to threat than safeness signals. Another patient felt safe only if she could be angry and have control. Any feelings

of dependency or need for care were immensely threatening to her. Basic mistrust may lead the patient to start from a position that the therapist is likely to be harmful despite external appearances.

Open and clear discussion of therapy, as potentially 'threatening', and the fear of being shamed, can be helpful with self-critics. In essence the therapist explores what might feel threatening and what might feel safe in the first stages of the therapy but keeps an eye on the fact that a patient may not be able to articulate this clearly or may have 'secret' fears that they cannot reveal because of shame. A therapist may openly note these as understandable and not uncommon possibilities. Establishing a therapeutic relationship in which the person can at least start to feel some sense of safeness and in control can take time.

Although there are many ways that empathy can be used (Duan & Hill, 1996; Kahn, 1985), perhaps the most basic form is that of empathic resonance or emotional contagion (Preston & de Waal, 2002; see Gilbert, Chapter 2), where the empathic and soothing behaviours of the therapist get empathically created in the patient. For these patients the facial expressions and voice tone of the therapist may be critical; this is a key reason why the psychoanalytically trained therapist, Kohut (1977), abandoned the therapist as a 'blank screen' and use of the couch of earlier analytic techniques (Eagle, 1987). He promoted instead therapist mirroring and (like Rogers) therapist empathy (Kahn, 1985). Although there is little research on non-verbal behaviour in therapy, there is increasing evidence that facial displays can affect the implicit (non-conscious) sense of self and affect processing via subliminal routes (see Baldwin & Fergusson, 2001).

Access to the therapist

People will try to soothe their distress in a host of ways. This may be internal, such as recalling the care of others. Many anecdotal stories tell how when men are at war, for example, they use letters to loved ones and pictures of their loved ones and family to self-soothe. For some very distressed patients an internal source of self-soothing is not available, thus they turn outside. They may use drugs, self-harm, try harder to achieve and possess things, or turn to others in clinging ways. For some it is the rapid availability of the therapist that provides a source for self-soothing. This may require the therapist to negotiate access to them with the patient (for example, via telephone or emergency consultations) outside the therapy session (Linehan, 1993). In effect the therapist is operating as an early attachment object that provides needed external signals of a caring–safe–soothing other, which is where self-soothing starts its normal development (Schore, 1994). Recall that safeness is (in early life) created in a relationship, it is not an evolutionary 'given' state and without these signals the infant moves to a state of threat-linked (dis)stress (Gilbert, Chapter 2).

Subsequent interactions between the therapist and patient can take the shape of a caring parent who encourages and supports the child as he/she engages in the world. Just as a child may use the parent for social referencing, taking his/her cues from the parent's signals of what is safe and what is dangerous (for things both outside the self and inside the self), so too the patient may socially reference to the therapist. Thus, for example, in telling of a history of abuse, or inner hatred for others, or revealing sexual feelings, the patient may monitor the therapist for signals of alarm, disgust, condemnation, disinterest or compassionate understanding and acceptance.

There is of course a large literature on the importance of the role of the therapist as a safe base (Holmes, 2001), the soothing qualities of a therapeutic relationship and the handling of therapeutic ruptures (Safran & Muran, 2000) that shift developmental trajectories. Bailey (2002) has argued that for some people the therapist needs to gain access to an evolved relational processing system that is related to a sense of *kinship*. If a therapist and patient can't do this, then the patient may struggle to develop a sense of collaboration. Thus, our brief discussion here serves only as a context in which to note the role of compassionate care as a type of relationship that creates safeness to work therapeutically (and this may include boundary setting) and is physiologically active.

Working with self-attacking using compassion

To illustrate the process of change using compassionate mind techniques, we return to the example of Anne and thought form 1. As noted above, there are many ways to help Anne change her self-attacking processes, such as helping her re-evaluate the origins of, and current evidence for, her beliefs (Beck *et al.*, 1979), or helping to illuminate functional reasons for self-attacking. Compassionate mind training, however, varies in four major ways. First, it is based on the idea that internal self-to-self relating is often routed in *social* mentalities. These are role-focused, and generate internal signals (e.g. hostile) that another system responds to (e.g. submits). This pattern has salient organising properties on neurophysiological systems. Second, these systems can be engaged via functional analysis and setting up imagery scenes and imaginary dialogues. Third, whereas traditional therapists focus on the consequences of the patient's negative self-evaluative thoughts (e.g. depression, despair and anxiety), compassionate mind training focuses on *the emotion and power of the attack itself*. We described this above in using imagery of the attacking part of self and two-chair techniques. Fourth, we suggest that warmth and compassion systems (for example, the ability to generate internally a warm and supportive signal) are toned down (Allen & Knight, Chapter 9). Thus the therapy aims to stimulate this system *directly*. The way compassion can be used to aid the process of re-attending, re-focusing, re-evaluating and re-attributing, and to stimulate

inner warmth, unfolds in a series of steps but can be shortened with less-distressed patients.

Setting up compassionate mind work

Let's assume that Anne tries to re-evaluate her thoughts, and we have previously written down some alternatives that seem acceptable and helpful (for example, that she passed her training exams, and has helped other patients). However, although she can see the logic of these alternatives, this does not really change what she feels – it has not reached into her implicit self-system. As noted above, we have seen the functions of her self-attacks and through imagery work she experienced an image of her 'self-attacking' self as a rather callous and demanding woman who is always angry and disappointed in her. We might then invite Anne to consider how this part deals with 'alternative' evidence. Anne then sees that this part of her is not very interested in evidence but is more intent on attacking, good at spotting flaws and good at coming up with 'yes but' reasons why she should not believe her rational alternatives. It is a classic bully, but it is also an entrenched defensive (good at spotting flaws and threats) warning system. This helps Anne make sense of her struggle in using alternatives, and de-shames and undermines thoughts such as 'I should be making this therapy work for me. I must try harder!' Her therapist gently points out that the therapy may struggle until she faces this hostile part of herself and tries to work with and/or around it. The therapist might note that warning systems are useful but not if they keep going off when you don't need them to. To work with her hostile warning system she may try to stimulate a different self-to-self relationship, one that is based on compassionate understanding and generating alternative feelings. The therapist explains how this may work, by noting that:

> When we attack ourselves we stimulate certain pathways in our brain, but when we learn to be compassionate and supportive of our efforts we stimulate different pathways. Sometimes we are so well practised in stimulating inner attacks that our ability to stimulate inner support and warmth is rather underdeveloped. 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.

The therapist may explore the value of developing inner warmth and compassion so that it becomes a collaboratively engaged exercise and journey, and not imposed. It would be important to investigate beliefs such as 'Compassion is weak, it doesn't really solve problems, it is letting the self off the hook, I don't deserve it', and so forth. One might point out that Anne knows and listens to her self-attacking part quite often, but she is less familiar with her self-to-self compassionate part. One might note that Gandhi,

Jesus and the Buddha were known for their compassion but could hardly be seen as weak – compassion has its own strengths. Assuming that Anne agrees that developing more compassion and support for herself is a useful experiment to try, we could first *explore her ideas about compassion* – the key qualities that one is trying to develop. When the therapist and the patient have generated some key qualities of compassion (see Gilbert, 2000a, Chapter 2 this volume) – which would include capacity for concern with her well-being; greater distress sensitivity and tolerance; empathy; sympathy; strength; and warmth – ways to develop these qualities and bring them into the inner experience of self are then sought. Bates (Chapter 13) discusses how in group therapy, group members often interact by offering compassionate support. Recall that the therapist relationship is also an aid to this endeavour.

Empathic understanding

The first point of re-evaluation is *becoming empathic to one's own distress and concern with one's well-being* – especially the part that feels subordinated, beaten down or depressed. This can involve acknowledging the upset or difficulties in a situation. In other words, there is nothing bad or shameful about Anne for feeling despondent or struggling with her patients. Empathic understanding helps a process of acceptance (Hayes *et al.*, 1996), and helps the patient not to think they have to battle with their thoughts or 'force' themselves not to think or feel like this – it is OK to feel disheartened at times. As Hayes *et al.* (1996) noted, it is important that a patient does not use cognitive techniques in order to try to *avoid* painful feelings that they need to come to terms with. However, while even self-attacking is understandable and acceptable (there is nothing shameful in being a self-critic), it is also a form of shaming-non-acceptance. Indeed, shame is a common reason for avoiding feelings. Moreover, self-attacking in this context and form is not desirable, being too focused on threat: it will make things far worse than they need be, and it may be over-reliant on early emotional memories and other people's biased judgements.

Compassionate alternatives

This involves widening attention (beyond a threat focus) not only to gain evidence against a view but towards *compassionate* attention, re-evaluating and re-attributing. To help patients generate alternative thoughts, cognitive therapists sometimes invite patients to switch perspectives by asking: 'What would you say to a friend or someone you cared about in this situation?' Such an exercise is designed to elicit reasoning from a caring/encouraging/supporting part of self, and cannot be seen as logic-based practice because one uses different processing systems of the mind to find 'logical evidence' as compared to those of thinking about support/care. Moreover, the kinds of

re-evaluations that one might focus on will be different if one is going for rational reasoning versus self-supporting. For example, when people have extensive shame, their feelings both of themselves and of others are harsh and induce feelings of *being alone*; one sees attacks coming from both outside the self (others will . . .) and inside the self (I am . . .). Alternative thoughts will therefore include the possibility of reducing this feeling of *alienation* by helping the person to feel more 'like others' and able to reach out for help. This is related to trying to activate a feeling of 'we-ness' (see Gilbert, Chapter 2). As noted above, Neff (2003b) points out that being able to see that self shares problems with others, and that one is not 'the only one', can facilitate self-compassion. This is one value of groups (Bates, Chapter 13). The alternatives in Table 10.1, column 4, such as help-seeking, being like others and focusing on what is helpful are examples of this. Additionally, one might try to elicit memories of others who have been supportive (e.g. past supervisors) and spend time 'feeling' that memory. We are not just trying to help a person to see they are better than they think they are, maybe confusing a behavioural evaluation with a self-evaluation, or to accept failings as part of life that one can tolerate (though these are important too), but to activate different forms of reasoning and feeling using a different social mentality. When a series of alternative thoughts are generated and written down, patient and therapist might reflect on 'In what way are these reasonable alternatives *and* compassionate and supportive?' (as noted in Table 10.1).

Compassionate focusing

Once it is agreed to develop the compassionate mentality to self, a useful approach to bring this out and develop it is with the use of imagery. Lee (Chapter 11) has given detailed discussion of the different ways imagery can be used as an aid to compassionate development for self and others. Arbuthnott *et al.* (2001) have reviewed the many uses of imagery work in psychotherapies. They point out the need for caution in using imagery to elicit memories or work on re-scripting actual memories; for example, that patients may become confused about what really happened and how they felt in the past. Our approach to compassionate imagery is very much rooted in the 'here and now' and using metaphoric imagery – in developing ways of thinking and feeling about the self.

Safeness

In Buddhist meditation there are various ways to prepare for a meditation on compassion (Dagsay Tulku, 2002). One way is to take the patient through a short relaxation (of a few minutes) focusing on breathing and full body relaxation. The focus on breathing can help clear the mind and relax the self, although not all patients can do this as it generates anxiety. One may ask the

person to create, in their mind, *a safe place* and verbalise where that is and how it feels. Creating the inner safe place is a well-known approach used in much imagery-focused work in different types of therapy (Connors *et al.*, 1999). The therapist can suggest that this is a place they can create whenever they wish to. 'Safe places' can change over time. Different people find it helpful to spend greater or lesser time in constructing this inner safe place and reflect on what it feels like to be there. It is their own place, where shame has no meaning and they are just themselves. For some patients the feelings of safeness can feel strange, even threatening (see the example of Kerry below).

Compassionate imagery

As noted above, imagery is a powerful means of generating emotions, new insights and physiological effects (Hackmann, 1998). Imagery is often used in functional magnetic resonance imaging (fMRI) research to stimulate different brain areas (George *et al.*, 1995; Schwartz and Begley, 2002). Rein *et al.* (1995) explored the impact of anger imagery and compassion imagery on a measure of immune functioning called S-IgA. Anger imagery had a negative effect on S-IgA, while compassion imagery improved it. Compassionate imagery, then, may do many things, including altering neurophysiological systems.

Compassionate feeling – warmth

To help stimulate *warmth* in an image and meditation, Thich Nhat Hanh (1991) recommends that (compassionate) images should be generated with the production of a *half-smile*. This may well aid neurophysiological processes that affect emotions due to the feedback between facial muscles and more central processing systems. The half-smile should feel comfortable and not forced. In Tibetan imagery work, meditations and images are often accompanied by *mantras* (sayings and words that may be spoken or sung) and *mudras* (hand and body movement and postures) that are believed to accentuate attention, concentration and invocation of feelings with certain exercises. Dagsay Tulku (2002) gives an excellent introduction to these. As pointed out by Ringu Tulku and Mullen (Chapter 8) and Dagsay Tulku (2002), Buddhist compassionate work often involves imagining compassion as personified by deities.

There is a sequence to this practice. First, one imagines 'the compassion Buddha' as harnessing the compassion of the universe, and focuses (meditates) on the essence of compassion. Special attention is given to qualities of the compassion (e.g. postures, translucence and colour). Next the image is imagined to send a flow of compassion into the self. Here one focuses (meditates) on the experience of receiving compassion, compassion flowing into oneself with complete acceptance of the self. Subsequently, the person may

imagine the deity merging with the self so that the self gradually takes on the qualities of the compassionate Buddha. Finally one imagines one's compassion flowing out from oneself to all living things. Elements of this will be noted below. These images and mantras will be embedded in cultural language, meanings, familiarity and relationships, and it is unclear how far they will work for those who have not encountered Buddhism previously. However, as noted below, they can be adapted to use in new forms.

To date we have not used mantras or mudras in our work, and have only recently started to think about the possible value of a half-smile or other postures as aids for compassionate imagery. Ours has been more a 'guided discovery approach', where we do not provide any pre-set images but invite people to explore their own abilities for generating compassionate images. Thus compassionate imagery starts by inviting the patient to do a short relaxation and then (either in their safe place or by just going into the image) to focus on *compassionate qualities*, and allow an image of these to come to mind. In our research (Gilbert & Irons, 2004) and in a number of single cases, we have found that some patients will generate quite different images. Some are of people (e.g. Christ, a loving aunt); others will focus on other aspects. For example, one patient had an image of a tree that was long living, wise, powerful and able to resist all weathers, and was always there, with deep understanding and compassion. Another patient imagined a bright light that shimmered and contained the essence of great warmth and love. Another patient had an image of a bush in bloom that had arms that held her. Yet another patient felt he was floating in a warm sea that supported him and was totally accepting and understanding of him. Our own work and that of Lee (Chapter 11) has found that compassionate images often come with feelings of being *held* or of warmth going 'through' them. Lee also suggests that the more sensory information that is used in imagery, the easier it may be to trigger a recall when needed. Different images come with different visualisations, feeling tones and sensory feelings. Thus, it is useful to explore this from a multimodal point of view. We would, however, now suggest avoidance of religious imagery or of actual known people. The image should be unique and special for them.

We have no data on whether individuals that personify their image do better in this exercise than those that have a non-personified image; more research is needed in this area. Nor do we have any data on *the gender* of the image. In Buddhism most images are male (perhaps reflecting monastery life, where young males are cared for by older monks), but in Western and pagan societies nurturance is more closely associated with the female. We suspect that male and female compassionate images may work differently (again, the reader can try this using *both* male and female images of compassion). The preparedness to generate or work with a gendered image may relate to early experiences with parents. Lee (Chapter 11) suggests that people can be encouraged to imagine 'their perfect nurturer' uncontaminated by human

failings, which can be personified and given qualities of compassion directed at the self. People can be encouraged to spend time developing and writing about this image. This may be close to Jung's concept of 'active imagination' on an archetype, where one tries to contact the numinous qualities of an archetype. In our own work we have focused more on the idea of generating *feelings* of warmth and other compassionate qualities. For the compassionate part of self to have empathic understanding requires that whatever image is created, it has to have a form of consciousness that is *capable* of empathic understanding. It is as if we have to experience our minds as being soothed by other minds that know our minds – a basis of intersubjectivity (Trevarthen & Aitken, 2001).

As this work progresses we focus increasingly on generating images of a compassionate *part of oneself*, highlighting that these qualities are there in the self, perhaps dormant, but can be discovered. However, some people prefer to experience the image 'as if' another is comforting and encouraging them. They are using a theory of mind to 'pretend' and at one level know that this is part of them but also (wish to) experience it as an external other. Lee's concept of the 'perfect nurturer' may be important in that it becomes easier to imbue this image with social signals of warmth and have an ongoing social-like relationship. Again, more research is needed on this aspect. One wants to help the person take their compassionate image with them into their everyday life, so one might say that, 'This image of self-compassion can be there when you need it. You may call it whenever you wish to because you have now created it to be there for you.'

We have found that images can change with practice, and working with a patient's first images may not always be helpful, especially if they feel they *ought* to have that image. For example, the lady who saw the bush in bloom had started with a religious image because this was the image she thought *she should* use, but it didn't work for her – she couldn't generate the compassionate essence/qualities through this image, and eventually came up with the bush image herself. So keep an eye on the 'should feels' or the 'I can't think of anything else'. It may take some practice before patients can begin to generate and imbue their images with the feelings and qualities of compassion.

Compassionate feelings are those that are part of the warmth system (Gilbert, Chapter 2; MacDonald, 1992). Helping people generate warmth as an affect with their image is important for a number of reasons. First, behavioural therapists have suggested that negative emotions can be altered by reciprocal inhibition, i.e. by generating alternative emotions. For example, the well-known work with desensitisation to anxiety may use relaxation as an alternative to anxiety because one can't feel both at the same time. Similarly here, one can't feel anger with self if one is processing warmth. Second, Greenberg *et al.* (1993) have argued that changing emotional processing systems often requires new emotions to be generated and 'worked into' the way negative emotions and thoughts are dealt with. Third, in social mentalities

theory, emotions such as warmth are linked to a care but not social rank (dominant–subordinate) mentality (although they can be recruited into this processing system such as when one loves, and feels loved by, a dominant leader or parent). A social mentality has the ability to create a new organisation or pattern of physiological processes (Wang, Chapter 3) and is thus not the same as creating a new schema. Central, however, is the fact that the warmth system may be underdeveloped and under-elaborated, and thus by focusing on warmth and *practising* generating it for the self, one is trying to stimulate and strengthen this potential for a new organisation of processing systems.

Compassionate re-evaluating

Sometimes self-compassionate imagery can be created quite quickly without having to generate a safe place. One simply asks the patient to do a brief relaxation of a few breaths and body focus, and then close their eyes and imagine a caring compassionate part of the self that comes with warmth. It is useful to clarify what this image is like, focusing on its sensory qualities (for example, facial expression of an imagined person) and feelings (Gilbert, 2000a). When this has been achieved the therapist goes back to the self-attacking thoughts and the alternatives (see Table 10.1). The patient is then invited to read through their (column 4) alternative thoughts again, but this time focusing on the generation of compassionate feeling. The words and evidence are *in the background*, and it is the essence of warmth that comes through the alternatives that is key (again you can try this for yourself – reading through the alternatives given in Table 10.1, focusing on a purely rational-evidence base, and then in a warm-affect focused way, imagining the words spoken with as much warmth and compassion as you can muster – maybe use your own compassionate image). One can then reflect on the differences in the experience for re-evaluating. Patients often find that going through their alternatives with compassionate imagery and generating as much warmth as they can makes them more believable and soothing. It also ensures that re-evaluating is not done in a cold, logical or detached way – or even with hostile affect (which is common when you check for it – 'come on, stop this negative thinking, look at the evidence – dummy!').

Therapists may choose to use specialised thought forms, as does Lee (Chapter 11), or make them easier, or even reduce them to two columns of self-critical and rational–compassionate. Much depends on what patients find easiest to use and what has the most powerful impact.

Third-chair practising

Greenberg *et al.* (1993) suggest that if the self-critical part is guided to be more specific in its criticisms it can 'soften'. Patients can gain greater

insight into the process by enacting it in the two chairs (as noted above). Chadwick (2003) has also developed two-chair work for people with psychosis. He suggests a different way of using the two chairs to that of Greenberg *et al.* (1993) that is based on a more cognitive schema approach and aimed to aid acceptance of negative schemata and build up positive schemata. In compassionate mind training with self-critics, the two chairs are aids to understanding the dominant–subordinate inner relationship. If a softening of self-criticism occurs through this dialogue as Greenberg *et al.* (1993) suggest, all is well and good, but although it might help resolve inner conflicts it does not address the need to *develop* compassion for the self. Hence, we suggest use of a third chair to do compassionate enactment work.

Sometimes people can find it easier to generate styles of feeling and reasoning when they are asked to play a specific role or argue from a certain point of view. People are more likely to adopt or change a view when they have to argue for it. This can be utilised by asking people to sit in a (third) 'compassion chair' and to become (say) a compassionate therapist that has listened to the attacked–attacking two-chair dialogue. From the compassion chair the patient may be asked to reflect on the conflicts between different parts of the self (and reasons) and what they might want to say to different parts of the self (the attacker and attacked). Some patients struggle to do this and are quick to take a *dominant* position, simply issuing orders or 'shoulds' to each part of self. For example, one patient spoke to the attacking chair and said 'You are a bully and must stop bullying' and then to the attacked chair said, 'You must learn to stand up to the bully and not be so beaten down'. It took time for the patient to learn to empathise with both parts and also to experience being more powerful and 'wise' than the attacked or attacker. We might suggest that they try again, this time focusing on one key compassion quality at a time. For example, 'As the compassionate part, how would you show empathy for each part of you (attacking and attacker); or how might you help the attacked part?' or ask 'How does your compassionate self express warmth?'

If the attack is an intrusion (for example, it seems like the voice of an abuser) compassion for the attacking part can be far more difficult, and a person may prefer to develop the strength to fight back (see also Hackmann, Chapter 12). Or one might use techniques that have been developed for people with malevolent voices, as noted above (Byrne *et al.*, 2003). However, given the chance to work this way, people can find solutions that work for them. One patient had identified her self-critic as the voice of an abuser. She said: 'Maybe you were abused or unloved yourself and were terrified for being found out because you knew it was wrong. Your damaged mind made you into a bully and an abuser, but now she [the attacked part of self] is taking responsibility for healing the awful harm you have done her and is no longer frightened of you or contaminated by you.' Saying such things felt like a release, and on her thought forms she wrote down, 'I no longer have to be

dominated by someone else's damaged mind and can turn to my inner compassionate self for guidance'. It does not always work easily, but this patient's courage and insight were both moving and illuminating once she had been given *a context* to find them. It is in the collaborative and guided discovery form of working that these themes can emerge.

Compassionate letter-writing

Pennebaker (1997) has shown that writing about events can help people process difficult experiences, aid self-expression and work through emotions. Sometimes patients find it helpful to write themselves a compassionate letter (for example, imagine a good, caring friend or their compassionate self writing to them, which can then be discussed with the therapist). For example, a letter might start: 'Dear X, I hear you have been feeling very down [or have been cutting yourself] recently. I was sad to hear that and would like you to know . . .' The letter should be written from the point of view of empathic understanding of difficulties and with warmth. This may be done in therapy or set as a homework to be tried each day. For these exercises the aim is to help the patient start to think about himself/herself from a different and *caring* point of view and *practise* doing this. This and other exercises are not about self-pity but compassionate understanding and support-giving, helping the patient generate alternative thoughts and directing attention to different aspects of themselves.

Cueing warmth

Making flash cards is a well-known cognitive technique (Gilbert, 2000d). Here the patient has a postcard that they can carry with them. On this card are some key alternative thoughts that patient and therapist have written down together. These may be reminders (cues to memory) to use compassionate imagery and recall discussion with the therapist. A variant of this is for them to make themselves an audiotape expressing their compassionate thoughts that they can use when distressed. Or the therapist can make a tape with them that includes a short relaxation, compassionate mind imagery and self-soothing statements. These will have been agreed beforehand and used as an 'experiment' to see how they work. One can explore what was helpful and what was difficult. All these are aids to memory and help switch to compassionate thinking and feeling when one is feeling self-critical.

Compassionate homeworks

Homeworks (things they can try to do outside the therapy) might be considered to help the person act on new thoughts or ideas. However, some patients will try to bully themselves into action with thoughts like, 'I must

try to do this because I agreed to or to please my therapist', or 'If I don't I'll be even more of a failure and shamed', or 'I won't get better unless I force myself to do this', or 'I must do this homework and stop being so lazy'. They may do the homeworks by using their old 'criticising to improve the self' style. The affect is not of warm encouragement but of bullying. We try to focus on the *warmth* and encouragement needed for trying new things, and to warn patients to watch out for bullying themselves into homeworks. Bullying may work temporarily, but will not work in the long term. Passive–aggressive types can feel they must resist anything like 'homeworks', which would entail giving in and subordinating themselves to the therapist (Gilbert, 2000d; Goss & Gilbert, 2002). Some people do not do homeworks because their inner self-attacking part has got at them (for example, 'I bet you won't do this well; you'll probably fail as you usually do, and in any case it won't work for you'). So one checks with the patient: (1) on what the self-attacking part (or, in the case of passive–aggressive people, 'the resistant part') of them says about the homework; and (2) on how to generate warmth and encouragement. We may encourage the person to be mindful of their 'inner bully' as well-rehearsed and used to getting its own way, but they can practise trying to put this to one side and use compassionate imagery when preparing for and engaging with homework. Planning homeworks can also be done with compassion. We might ask, 'What kind of homework would a compassionate part of you suggest to help you gain (say) confidence or test out your beliefs? How would that be helpful? How would that part encourage you if the going gets tough, or your bullying thoughts switch in?'

Compassionate practice

Compassionate practice can be used to focus on compassionate *attention* ('What would your compassionate part focus on/attend to in this situation?'), compassionate *behaviour* ('What would your compassionate part help you do?'), compassionate *thoughts* ('What would your compassionate part think and value?') and compassionate *feelings* ('What would you feel if you attended to your compassionate part?'). Thus, compassionate imagery and focus can be used as an aid to thought re-evaluation, engaging in homeworks, letter-writing and third-chair practising. A thought–feeling form that can sometimes be helpful is given in Table 10.2.

Compassionate meditations

As noted above, Buddhist meditations can be focused on mindfulness, which is a process for learning how to relate to our thoughts and images in different ways. Specific imagery is less often part of this work. However, Buddhist meditations can also use various focused images (Dagsay Tulku, 2002; Ringu Tulku & Mullen, Chapter 8). In compassionate mind training many processes

Table 10.2 Thought monitoring with compassionate mind training: example 2

Triggering events, feelings or images	*Beliefs and key thoughts*	*Feelings*	*Compassion-focused alternatives to negative thoughts*	*Understanding and change in feelings*
Key questions to help you identify your thoughts. *What actually happened?* *What was the trigger?*	*What went through your mind?* *What are you thinking about others, and their thoughts about you?* *What are you thinking about yourself, and your future?*	*What are your main feelings and emotions?*	*What would you say to a friend?* *What alternatives might there be?* *What is the evidence for new view?* *(How) are these examples of compassion, care and support?* *Can you think these through with warmth?*	*Write down any change in your feelings.*
	External shame (others will think)		**Empathy for own distress**	
	Internal shame (I think)		**Evidence plus compassionate attention, thinking, behaving and feeling. Openness, support seeking, acceptance, warmth.**	
	Emotion-image **Function**		**Emotion-image** **Function**	

are used including guided imagery because the aim is to *stimulate* specific neurophysiological pathways and build soothing–calming into the self-referent systems whenever possible. This may be helped by practising generating compassionate images and working/meditating on them. When Anne is on her own, she agrees the following homeworks. First, to spend as much time as she can working with her compassionate imagery, focusing on the specific qualities that we have agreed are part of compassion, allowing them to develop and elaborate as the case may be. She might be asked to keep a diary on how these images work, whether she can hold on to them, whether they are easily fragmented, how they change (Gilbert & Irons, 2004). Anne may use these images in therapy with her patients and imagine this part of her helping her and her patient.

As in mindfulness training, emphasis is put on inviting the images rather than forcing or 'shoulding' them to appear. If the mind wanders, just gently bring it back to the compassionate image and try as best you can to allow the feelings of warmth to emerge. It can be suggested that these types of exercise may help to develop brain pathways for compassion, and that practice will help. However, as the person is not used to doing this, it can take time. Even sitting on the bus one can engage in a brief relaxation exercise and then engage the compassionate imagery. Sometimes patients have reported that the minute or so of a short relaxation exercise that focuses on breathing can disrupt the flow of self-critical thoughts, and then the compassionate imagery can be initiated and then the alternative 'thoughts can flow' (see Lee, Chapter 11 for discussion of the compassionate reframe). If patients can build up the time they spend in compassionate mind imagery work this can be helpful, and sometimes people may create a special place to do their meditations or imagery work. However, it is also useful if they can practise it throughout the day – monitoring their thoughts and feelings as they arise and gently considering whether these are shaming or compassionate thoughts.

Special exercises

As noted in Chapter 2, compassion has many elements, so it is sometimes helpful to focus on the feelings and thoughts generated by *different* elements of compassion. For example, you can invite a specific focus on a compassionate image and then ask, 'How does it feel when you focus on: *warmth* for you; on [empathic] *understanding* for you; on *care and concern* for you; on *strength and wisdom* for you; on *acceptance* for you?' You may spend time with each element. We have found that different patients have different blends of these. For example, one patient felt her compassionate part to be wise, understanding and warm, but weak and easily overwhelmed by sadness for her. Another patient could feel warmth but could not (and, interestingly, did not want to) feel total acceptance. He believed that this would mean accepting his inner hatred and that 'would not be a warm or loving thing to do'. He had a belief,

like that of Groucho Marx, that 'I don't want to belong to any club that will accept me as a member.' As noted by Gilbert (1992: 111), people can have the good–bad self-paradox. For another patient the image was warm and loving, but became sexualised in a not-helpful way.

Connectedness, warmth and acceptance

To help people have an *experience* of connectedness and acceptance, one can use an imagery task as follows. Ask the patient if they have any negative associations with the sea, sky or a mountain, and which image they feel comfortable with. Let's assume it is the sea. Conduct a short relaxation exercise and then suggest:

> I would like you to imagine a sea in front of you that is a beautiful blue, is warm and calm, lapping on a sandy shore. Imagine that you are standing just in the water with the water lapping gently at your feet. Now as you look out over the sea to the horizon imagine that this sea has been here for millions of years, was a source of life. It has seen many things in the history of life and knows many things. Now imagine the sea has complete acceptance for you, that it knows of your struggles and pain. Allow yourself to feel connected to the sea, its power and wisdom in complete acceptance of you.

You can modify this for the sky or mountain if that is the preferred image. Sky images can be useful and a person may choose to do the exercise as they sit in their garden or while walking, and actually look at the sky as they do it. The point of the experience is to elicit key feelings of warmth, acceptance and connectedness. Some patients may put their own spiritual meanings to the image, but we discuss the exercise as a way of creating feelings to stimulate new pathways in our brains. This is sometimes a soothing image to close a session with, if a patient has been very upset.

Compassionate perspective-taking

The ability to take another person's perspective is a key skill of empathy and matures with cognitive abilities (Gilbert, Chapter 2). A re-evaluation that can help self-critics is to look at those who have harmed or shamed them through the eyes of the shamer. For example, as discussed by Hackmann (Chapter 12), a patient may come to see that a parent's harsh treatment of them was because the parent was suffering (for example, with depression, poverty or some other life crisis). Developing appropriate forgiveness can be helpful (Worthington *et al.*, Chapter 6). The ability to take a compassionate perspective through the eyes of the other is common in Buddhist therapy and is also a part of cognitive therapy. For example, Liotti (1992) discussed how

to help patients with personality disorders to move out of an egocentric (threat- or need-focused) perspective to an 'other-oriented' perspective. Learning to focus on and think about what may be in the mind of the other can be painful but also helpful to patients. Sometimes people may also discover that they do have happy memories of their parents as well as bad ones, or that a parent could only care for them as he/she was able to, within his/her limitations. When working this way, however, it is important to be aware whether or not the patient can do this rather than feeling that they 'should do this'. Sometimes people struggle with perspective-taking. For example, Hackmann (Chapter 12) offers cases where individuals needed to feel empowered (dominant) before they could take the perspective of another. Sometimes patients can feel that if they are too forgiving too quickly, they will feel disempowered and 'lose their right to feel angry'. One patient felt that she had two distinct parts of her. One was rageful for how her mother had treated her, but when she allowed herself to think on this she felt guilty, bad and unlovable. When she focused on becoming compassionate she felt disempowered and weak. She felt these two parts of her were in a 'constant battle'. Conflicts like this can produce serious disorganisation of the self. Hence, some caution is needed in using these techniques.

An incapacity or reduced capacity to feel compassion for others can also arise from unresolved issues such as blocked grief or anger. If a person is normally caring, but depression has knocked out this ability (see Allen & Knight, Chapter 9), then we may suggest trying to act in a caring way even if they don't feel like it, and see what happens – feelings can change as behaviours change (Gilbert, 2000c). It usually becomes clear if there is unresolved resentment or a person's warm feelings are simply knocked out by a depressed episode. A new mother may find that she does not have warm feelings for her baby, or a man who has loved his wife for years loses feeling when he has a depression. These inner experiences can lead to feeling personally bad to this loss of feeling. Careful analysis is necessary to find out why a person might be unable to feel warmth or care for others.

Problems in compassionate mind work

Many patients like the focus on compassionate re-evaluating and change process (what Gilbert (2000a, 2000c), called compassionate-rationality). Some enjoy going on their own journey to find and develop inner compassion (see Lee, Chapter 11). Moreover, for some patients change can be quick. This may be because when one brings on line a new mentality it can have a major reorganising effect on a variety of systems (Wang, Chapter 3). Models of non-linear change, such as chaos theory, that illuminate how small changes in crucial systems or processes can have radical effects on system organisation may be useful ways of thinking about some change processes (Gilbert, 1984; Mahoney, 1991). Indeed, Hayes and Strauss (1998) have outlined a major

approach based on the organising and reorganising of mental functions during psychotherapy, which they call dynamic systems theory. Developing the caregiving mentality within the self via compassionate mind training may produce systemic change. Patients also put their own meanings on compassion work. For example, one patient said, 'You gave me permission to be compassionate with myself and see it as a strength, not a weakness'.

However, compassion work does not always work out so smoothly. As noted above, strong anger can make it difficult. In recent years, cognitive therapists have started to explore resistance and 'roadblocks' (Leahy, 2001; Mahoney, 1991). Freeman and McCloskey (2003) point out that therapy may run into difficulties because of patient factors, therapist factors, therapeutic relationships factors and environmental factors. We cannot address all of these here, but we do wish to illustrate some factors that may be operative when some people have enormous problems in engaging with this work, even if they want to – and not all want to. Some of these difficulties are outlined below.

No friendly thoughts

Some quite disabled patients find it enormously difficult to generate images or compassionate feelings. Even the straightforward idea of 'imagining what a friend may say to you' can be hard for some people. One patient said, 'I really can't imagine that, and even if a friend says nice things I bet they are thinking something else'. We took that as an interesting observation typical of 'better safe than sorry' thinking (Gilbert, 1998b), and then thought through how we might get around that. Her solution was to think of an 'ideal of kindness', a fantasy creation. It is close to Lee's (Chapter 11) approach of the perfect nurturer.

A patient may say they can't use imagery because they don't imagine things. The therapist may start with imagery training such as looking at something and then closing the eyes and imagining it (Dagsay Tulku, 2002), or for example imagining a liked meal or a desired holiday.

The need for punishment?

Some people feel that they can only be atoned, saved or loved if they are punished. This may be related to conditioning of relief. For example, Kerry's mother, who had a mental illness, was often emotionally distant from her. If Kerry did something 'wrong', there would be a blow-up and she would be beaten. However, this seemed to 'clear the air' and afterwards her mother seemed guilty and was more loving. Her mother would sometimes cuddle her saying, 'Why do you have to make me so angry? Why are you such a bad child?' (a classic double bind). Kerry wondered if at times she had stirred her mother up to produce an attack that 'cleared the air' and get a cuddle. For

Kerry, warmth and compassion, without punishment, actually felt rather frightening. Even trying to help Kerry relax was difficult because she said that, 'As a child if you relaxed, you let your guard down and then bad things just hit you out of the blue'. Not only was Kerry full of self-loathing and a sense of self-disgust, she also had psychotic-like experiences of supernatural forces out to get her. Kerry noted that when she started to try compassionate mind work she also had a growing feeling that 'something bad was going to happen'. Indeed, when we first tried it she had a panic attack and at other times would dissociate, feeling her compassionate side was like 'a totally different personality' in her. Hackmann (Chapter 12) has discussed the possibility of working with specific memories. It is possible that this might have been easier for Kerry. Compassionate mind training did help her, but very slowly, and probably relied at first on the therapist being supportive and non-punitive of some acting out.

Some sexually abused people can be frightened of warmth or closeness because it is conditioned to or associated with sexual memories; as a therapist gets 'close' to them, they can feel (sexually) intimidated or confused. Functional analysis helps to clarify these concerns, enquires what would feel safe for the patient, and enquires how best to separate what happened *then* from what is happening *now*.

Self-harming

When Sally felt rejected or failed at a task she became *ragefully* self-critical, with a desire to cut and harm herself. This was associated with thoughts of being 'no good, a waste of space and may as well kill myself'. For some patients, strong emotions (e.g. rageful frustration) can make them feel as if they are going to fragment 'as a person' and emotions will take a life of their own. Sally had had little opportunity to learn to cope with her rage (Leahy, Chapter 7). Self-harming can be used to bring some temporary calming, which may act via the release of endorphins or other physiological response to injury (Haines *et al.*, 1995). Over time these self-harming consequences may be conditioned to feelings of emotional release or relief. Although there are many reasons for self-mutilation (Suyemoto, 1998), it seems a quirk of our physiological system that both signals of care and self-mutilation may stimulate opiate and calming systems.

There are many ways to help people with self-harming behaviour (Babiker & Arnold, 1997; Linehan, 1993), and compassionate mind training can be a useful addition. If a patient has been cutting you might ask them to look at their wound and feel into it. Then ask, 'How could you let compassion to your wound flow from you?' Spending time focusing on feeling compassion to a wound can generate powerful feelings including sadness (see below). Doing imagery work can involve: 'Imagine those feelings of cutting – now imagine your compassionate image coming to you and spend a moment or

two allowing the feeling of understanding and warmth to come through. What does that feel like? If you could really let the warmth come through to you, how would that affect your desire to cut?' You might also suggest: 'Imagine yourself putting down the razor, and think to yourself "not this time, my wounds need my care". How does that feel? What would stop you?' It is important that self-wounding *is not* used as a way to be caring (see Lee, Chapter 11), but compassion for the self is a way to *stop* wounding the self.

Many years ago PG was working with a lady who cut her face with scissors because she had bad acne. She had seen many therapists. At the time I was guided by the idea of response substitution and we agreed that she should rub a cleansing agent on her face, rather than cut. The agent she chose stung a bit, and this helped her feel she was 'doing something'. We then discussed the idea that as she rubbed she was trying to help and care about her face. I was trying to change the feeling from one of disgust to one of care. Today I would have done far more compassionate mind work, but this intervention significantly reduced her cutting. Helping people find alternatives to cutting *and* using healing ointments on wounds, speaking to them with warmth, can be helpful and at times can elicit strong (sad) affect (see below).

Grief and sadness

As noted above, intense anger and fear can block work with compassion. However, there is yet another key affective process that blocks it, and this is the ability to tolerate grief and *genuine sympathy* for the self. When some patients start to imagine a warm compassionate part of themselves and contact those feelings, rather than feeling soothed they can feel overwhelmed by sadness and grief. They can feel ashamed and become highly self-conscious, trying to hold back tears, covering their face and fearful of losing control. They can at times quickly change the subject or even dissociate or panic. For some patients warmth can be conditioned with abuse and confusion. As in working with any strong affect such as anxiety or panic, the therapist clearly needs to feel confident that they can *contain it*. No therapist would (say) leave a patient in a state of panic if they have induced it in order to do cognitive behavioural work. The same is true of working with grief, although sadness is often a longer-acting affect than panic. Enabling a patient to tolerate and accept their sadness and tears (in a non-shaming way) is thus important.

As a therapist, one does not want to break into and disrupt a flow of feeling that may be important 'to be with' and learn to tolerate, yet it is not very compassionate, in our view, to leave a patient stuck in shame, silence or detachment to their tears. The therapist uses a 'gentle voice' to acknowledge pain and acceptance. You might say, 'Try to allow yourself to cry if that is what your body wants to do. Listen to your tears, for this may be the first time they have really had a chance to speak with you. What do your tears want us to know and to be heard?' If a patient is becoming too distraught, then in a

calm voice one might direct them to focus on their breathing and relax and let go. Ask them to talk to you about their breathing, how it feels as each breath enters and leaves. As patients learn they can come out of their tears and have some control, they may be more able to allow themselves to experience it, going step by step, a little further each time.

Loss of warmth

For some patients the ability to grieve in the therapeutic context can be *a major* step to becoming empathic and sympathetic to one's inner distress. Being unable to work through past injuries and hurt in the context of supportive relationships can result in what we consider to be *a long-term freezing of positive and warm affects*. Bowlby (1980) discussed this in relation to despair and detachment. MacDonald (1992) has distinguished (the evolution of) a warmth system from an attachment one. The warmth system is especially attuned to signals of affectionate care and investment from others. For some patients this system seems turned off, frozen or toned down for self-feelings – and sometimes for others too. Wang (Chapter 3) has discussed the concept of affective blunting that seems to go with reduced cortisol response to emotional signals and stress. This seems a particular problem for people who have been traumatised/abused in early life. It may be an automatic defence/safety strategy for shutting down a warmth and emotionally loving system, for this may be the best (non-conscious) strategy in contexts of abuse or neglect.

A recent patient had *pride* in the fact that she never let anything upset her to the point that she would cry. Her mother had hit her for crying, and she also was rather contemptuous of others who cried. When we did compassionate imagery she could generate images of warmth and compassion, but she thought of film stars whom she described as loners who were strong and caring but would never cry themselves. Pride in one's ability to resist 'giving in' to feelings can arise in a number of disorders. Feeling compassionate sympathy for the self to the point that one feels tearful can be experienced as deeply shaming and undermining of a positive, 'in control' self-image.

Some people can act in caring ways but may say they don't really feel love/warmth for others or self. Indeed, this loss of feeling can be another reason for self-attacking. For someone in whom the warmth system is toned down, you can imagine what happens when we start to try to generate signals that it may be responsive to, for example sympathy, care and warmth for self. One runs into what some therapists call unprocessed affect (Greenberg *et al.*, 1993). There can be fear of signalling distress and becoming vulnerable or shamed, but it can also start a grief *process*. Grieving often activates cortisol and other hormonal (e.g. oxytocin) responses. As Wang (Chapter 3) makes clear, however, the way hormones such as cortisol or oxytocin (that are also part of the warmth system) work is dependent on the state and organisation of the system. Grieving when alone may not help, because grieving is partly a social

signal that indicates a need for care – feeling cared for when grieving is rather different to being alone and ashamed to share one's feelings. Toning down of the warmth system, whether for reasons of genes, classical conditioning or metacognitive beliefs, may be one source of certain types of *affective blunting*, especially for prosocial feelings (Wang, Chapter 3).

Much has been written on grief for external losses, including that people can 'put off' the feeling of loss or act in unhelpful ways to avoid the feelings (Nolen-Hoeksema & Larson, 1999). Neimeyer *et al.* (2002) have indicated how coping with loss is a social process that can be facilitated or inhibited by previous experiences of attachment relationships and current social supporting environments. Intimate supportive environments are situated in cultural practices for coping with grief. For some people, grief can feel a threat with a sense of vulnerability and loss of self-coherence. In social contexts that expect one to get over loses quickly, it can ignite shame and invalidation of feeling: 'Surely you can't still be so upset by your loss; shouldn't you start to put that behind you and get on with your life?' Neimeyer (2004) illuminated a number of narrative approaches (such as writing about losses and exploring meaning) that can help to elevate grief to a normal process that is also a journey for self-reorganisation. Fear and shame for the painful feelings, and need for care that can accompany losses, can be reasons why the warmth system closes down.

When some patients begin to feel warmth, this can set off a grief process: for actual losses, ideals and dashed hopes; for the parent one so wanted but never had; for the feeling of always being 'not good enough and unlovable'; for the feeling that no matter how hard one tried, one couldn't reach one's ideal and 'make it all right'; for the long-lived inner feeling of aloneness, the tragedies and traumas one has had to face, the real courage and struggle it has taken to keep going, the inability to feel warmth for oneself. As people recover from psychological difficulties there can be grief for the lost years, and not wanting to work on this can also block progress. Patients may have beliefs that if they start grieving they are weak, might never stop, will fall apart, or will be shamed for it (for example, lots of self-attacks). At times therapists (or what Leahy (Chapter 7) calls 'mechanical therapists') can feel they have to help a patient self-regulate, interpret, and interfere with a grief process. This is not helpful because grief is part of coming to accept things as they were and are, and needs to be worked with and tolerated. As for all emotions, however, there are helpful and unhelpful ways of experiencing and thinking about grief.

We suggest that grieving *can be* a process that unfreezes the warmth emotional systems. Therapists working at this level will have to be able to tolerate and contain intense sadness as it emerges in their patients. There is a scene from the film *Good Will Hunting* (which is a story of shame and coping with shame) where the therapist pushes Will to recognise that his problems with his father were not his fault. Finally, his recognising this results in a tearful

collapse and acknowledgement of how painful that was. This allows Will to feel and see things differently. It is, of course, given the Hollywood treatment, but it is useful to watch none the less. The kind of sadness one touches when working with compassionate feelings can be very moving and quite different to the type of tearfulness one sometimes sees when people feel angry or have a sense of unfairness. It is also important to distinguish grief from a tearful response that may be a fear-related submissive behaviour. Many very self-attacking patients have not been given space or opportunity to grieve. So, grieving is initially a way of becoming genuinely empathic and compassionate to one's own distress rather than compensating for it, shaming it out of feelings, hiding it or rationalising it. We learn that, painful as it is, we can tolerate it and move through it. In a therapy context, we can find another that can tolerate it and send signals of acceptance and empathic care that the warmth system can respond to. The impact of grieving on reawakening a 'warmth system', however, has been poorly researched and so our thoughts here must be tentative.

Conclusion

We started this chapter by suggesting that self-criticism and a hostile self-to-self relationship are common and underwrite many forms of psychological difficulties. They have many sources and many functions. Cognitive therapy that involves compassionate mind training is *one way* to help people move away from this dominant–subordinate inner relationship and develop a more self-compassionate one. Helping people understand the link between self–other beliefs, inner self-experiences and feelings is central to this approach, as are ways for helping people re-evaluate their thoughts and beliefs. With self-critical people in particular, shame is often close to the surface and the therapist can be mindful of the potential to shame a patient easily with their language and style of interacting (Leahy, Chapter 7). Indeed, it was work on inner shame that partly stimulated this approach (Gilbert, 1989, 1992, 2002a).

While cognitive therapies typically focus on the thoughts that cause distress, compassionate mind training adds a focus on the emotions of the *attacks themselves*, their functions and their origins (Greenberg *et al.*, 1990). Rather than rely on an evidence-based approach, or resolving inner conflicts, to help people change, compassionate mind training suggests (in addition) the generation of new self-care and compassionate inner processes that can be conceptualised as a kind of neuropsychophysiotherapy. Processes involve (via the therapeutic relationship) imagery, affect tolerance, grieving, meditation and a focus on compassion training. These are borrowed from various Western and non-Western traditions. It is not helpful to get too caught up in therapeutic tribalism, but one should try to link interventions to basic psychological science as we have tried to outline. Ultimately, of course, it is a better

science of mind that will help us understand our patients and how to help them. However one chooses to engage compassionate mind training and development, it is important at all times not to impose but to work collaboratively, setting it up as an experiment, something that might be worth exploring, and gaining the evidence as one goes of how it fits with and for the person. For many patients, it is useful to clarify the principles of the work and then gradually work out a step-by-step process that is agreed as one proceeds. The principles are in many ways similar to behavioural work of developing a hierarchy of steps that one works through. The more the patient understands and collaborates in designing the steps, the more involved (and less threatened) they are likely to be. It will be recalled that for many people it has been the issue of the power of the other (with self as subordinate) that has created many of their problems.

We are moving forward steadily in understanding internal processing systems and those that underpin both explicit and implicit self-regulation (Haidt, 2001). Compassionate mind training seeks to operate on both levels. However, it is careful research that will tell whether these interventions stand up and do what we hope they do, and, if so, how to improve on them.

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Chapter 11

The perfect nurturer

A model to develop a compassionate mind within the context of cognitive therapy

Deborah A. Lee

As discussed in Chapter 10, many people with emotional difficulties can be burdened with self-critical and self-condemnatory thoughts and feelings. While traditional cognitive therapies help people focus on the evidence against their negative self-evaluative thoughts (and the possible distortions in thinking that underpin them), this chapter explores the impact of a way to help people who are self-condemning, by developing compassion and inner warmth for the self. Two case studies are presented to illustrate the therapeutic process in developing self-compassion. Both cases are characterised by presentations of chronic posttraumatic stress disorder (PTSD), a thinking style characterised by highly self-critical thoughts and a lack of ability to self-soothe.

The therapy described in these cases aims to facilitate an *emotional* shift towards a more caring and supportive approach to the self that undermines self-attack, facilitates self-acceptance and reduces emotional disturbances, thus enabling a person to become more self-soothing and self-regulating. A key component of this approach, outlined here in detail, is the use of an imagery intervention called 'the perfect nurturer'. This imagery is used to harness the experience of a nurturing relationship that becomes internalised and is used to evoke feelings of self-soothing and safeness (Gilbert, Chapter 2). It is also used to bring about a *compassionate reframe* of dysfunctional thinking within a traditional cognitive therapy framework (Beck, 1976), whereby self-attacking thoughts are challenged/reframed by the nurturing image, so that self-soothing feelings predominate.

Follow your heart, not your head?

For nearly 20 years, cognitive therapy has enjoyed a key position as an effective treatment for a variety of Axis I disorders (Beck, 1976; Beck & Emery, 1985; Clark & Steer, 1986; Salkovskis *et al.*, 1998) and, more recently, Axis II disorders (Beck *et al.*, 1990; Layden *et al.*, 1993). Traditional cognitive therapy seeks to introduce emotional change in clients by altering thought processes. There is now substantial evidence that helping people (i) focus on

and re-evaluate their thinking styles, and (ii) alter their behaviours, is beneficial in fostering a shift in emotional state, such as in depression and anxiety (Clark & Steer, 1996).

Yet for some people, particularly those with longstanding difficulties, this process fails to engage them on an emotional or implicit level. They report that they understand how to challenge and reframe dysfunctional thoughts (they know it 'in their head') but they do not experience any substantial or sustained emotional shift (hence they do not feel it 'in their hearts'). They may say, 'I understand what the alternative view is, in my head, but I just don't feel it' or 'Now I can see that I am not a bad person but I still *feel* bad'. There seems to be a mismatch between implicit self-processing, which operates through automatic, affective and unconscious processing, and explicit self-processing, which operates through controlled and conscious self-processing (Baldwin & Fergusson, 2001; Haidt, 2001). Hence there appears to be a discrepancy or 'lag' between what the person understands from a cognitive perspective and what they feel emotionally. Indeed, many theorists draw the distinction between intellectual reasoning and emotional reasoning, or propositional and implicational cognitive systems (Power & Dalgleish, 1997; Teasdale & Barnard, 1993).

This is an issue that, to date, cognitive *therapy* has not fully mastered. This is partly because the therapy suggests that emotions are linked to schemata or beliefs that can, without too much difficulty, be brought into consciousness, and it is because these beliefs do not change sufficiently that affect disturbance remains. Ways to influence affect have been suggested, such as the following.

1 'Relentless but gentle' and consistent cognitive challenges will eventually facilitate a shift in emotion.
2 A discussion highlighting the drawbacks of 'emotional reasoning' may suffice to promote the desired change.
3 Lack of emotional change in the face of intellectual understanding may indicate the need to revisit the formulation and/or further explore safety behaviours and maintenance factors that may be blocking the pathway to the desired emotional change.
4 A large enough body of evidence has not been collected to promote the new/alternative core belief.
5 Cognitive change needs to occur in the context of aroused emotions or 'hot' cognitions.

In many cases these are powerful and useful avenues to explore in order to facilitate a desired emotional change.

The heart–head lag

Even using such interventions, the 'heart–head lag' in therapeutic change is observed in a number of people, and particularly in those who present with longstanding difficulties relating to self-worth. Moreover, in a clinical setting, one observes that a common theme in these patients is their *lack of emotional warmth to the self*; that is, their efforts to re-evaluate negative information about the self are in a coldly rational or even hostile form (Gilbert & Irons, Chapter 10). They appear to have a reduced capacity to be empathic to the distress their self-attacking causes them or to *emotionally nurture* themselves via self-soothing and reassurance. An ability to feel warmth for the self may be underdeveloped and under-elaborated for a variety of reasons, which will be discussed briefly, with reference to social mentality theory.

Self-attack and compassion

Social mentality theory (Gilbert, 1989; Chapter 2 this volume) proposes that self-relevant information is often processed through systems (social mentalities) that were originally evolved for social relating. In essence, self-focused thinking and feelings are forms of internal self-to-self relating. Thus, a part of the self can enact a hostile, attacking, condemnatory, dominant role. Another part of the self responds and feels beaten down by being attacked. Similarly, part of the self can recognise the need for nurturance and be soothing, which enables the beaten-down self then to feel regulated and soothed. It is understanding the nature of this internal relationship with the self that is important in the emergence of some forms of psychopathology. Gilbert & Irons (Chapter 10) have emphasised the value of focusing on self-compassion and generating new feelings in the self-evaluative process as a important task of psychotherapy.

Why use the compassionate approach in cognitive therapy?

Gilbert & Irons (Chapter 10) have highlighted the need *to train* patients to develop inner compassion and warmth as this will aid the formation of and/or strengthen existing neuronal networks in a way that makes them sensitised and readily triggered. They also suggest that this is a prerequisite to cognitive challenging of critical thoughts (in people that lack the ability to self-soothe), as a cognitive focus alone may not create or stimulate the emotional experience and neurophysiological networks that are necessary for self-acceptance, self-soothing and abilities to tolerate distress. Distress is easier to tolerate and work with in the context of self-soothing abilities.

Self-attack and PTSD

As mentioned above, both the cases presented below are characterised by chronic PTSD and high levels of self-attacking thoughts. There is an interesting similarity between ongoing threat/current threat in PTSD sufferers and ongoing threat in self-critical people. In people who self-attack, via a continual internal dialogue of hostile and critical comments, a sense of ongoing threat to their sense of self is manifest (Gilbert & Irons, Chapter 10). The observation of manifest *current threat* (to physical or psychological sense of the self) has also been identified in contemporary models of PTSD (Brewin *et al.*, 1996; Ehlers & Clark, 2000). In PTSD the original threat is typically external (traumatic event), but the way the event is processed and stored in memory leads to a sense of current threat. When people experience flashbacks, the memories of the event are experienced with the full force of the peri-traumatic emotion (fear, anxiety, shame) – a sensory-based memory. It is as if it is happening again, with poor discrimination between 'now' and 'then'.

Brewin *et al.* (1996) explain this phenomenon in dual representation theory, by suggesting that trauma memories are stored in two parallel forms. First, they refer to situationally accessed memories (SAMs). These are *sensory-based* memories that contain information processed about the traumatic event (for example, 'I am being attacked'), including all peripheral stimuli (for example, darkness, alley, noise, smell of rubbish), sensory information (for example, fear responses) and its meaning (for example, 'I am going to die'). Information about meaning is derived from previous conditioning and innate, non-conscious appraisal mechanisms concerned with achievement of goals such as care receiving and establishment of safety (Gilbert, 1989). The creation of these memories can be characterised by data processing and hence they tend to be primitive, sensory based, and lacking in conceptual detail and integration into autobiographical memory.

Most importantly, they have no temporal context and, when triggered, they are experienced by the individual 'in the here and now', with the full force of the peri-traumatic emotion (fear), i.e. a sense of *current threat* is manifest and it feels as if the event is happening again. Situationally accessible memories are thought to be stored in the amygdala and cannot be consciously accessed. They are referred to as 'situational accessible' as they are triggered by internal or external cues without conscious awareness.

Second, Brewin *et al.* (1996) refer to another type of trauma memory, which they call verbally accessible memories (VAMs). These are characterised by autobiographical memories and can be deliberately accessed and edited. These memories contain conceptual meaning and are stored in a historical and meaningful way. Thus they have temporal context and carry meaning conceptualised on the basis of the person's pre-existing experience of the self, their world and other people. These are thought to be stored in the hippocampus (Williams, 1992).

In the treatment of PTSD, a task of therapy is to achieve a full verbally accessed account of the traumatic event, which contains all the information in the situationally accessed memory, but with a change of meaning. This is achieved by activating situationally accessed memories (using a reliving paradigm) and changing/updating their meaning, via cognitive restructuring, to the present context. For instance, in the example above, the update of the memory may be 'I don't die, I am safe'. An extensive discussion on the treatment of PTSD is beyond the scope of this chapter: suffice it to say that this can be achieved by pairing the sensory memory (SAM) with new, explicit information about meaning, such as with the cognition 'You are safe now' (a cognitive update) (Grey *et al.*, 2001) and, more implicitly, 'And how does that make you feel, now you know that you are safe?' (an emotional experience update (Lee, 2004)). Brewin (2001) argues that in PTSD the new memory has a retrieval advantage due to its 'distinctiveness' (Eysenk, 1979; Lockhart *et al.*, 1976). Thus this process creates a new, updated memory (with updated meaning) that blocks access to the original one (Brewin, 1989).

As with the treatment of PTSD, with people that self-attack and manifest a sense of current threat to the self it may be possible to access sensory-based memories associated with threat to the self (hostility) and 'update' them with new information about safeness (self-soothing), as seen in the PTSD treatment paradigm.

The premise in this approach is of course that people can access feelings of safeness. Yet people who self-attack to the level observed in clinical cases often do not have the ability to make themselves 'safe' from their own attack. Once this is learned (through training in developing compassion and the ability to self-soothe), the task of therapy is to update the sensory-based memories of attack with a new experience of self-soothing. One could hypothesise that eventually, via a process of conditioning, self-soothing comes to inhibit reciprocally the anger/hostility of the self-attack. Furthermore, this process may be greatly enhanced by creating a new sensory-based memory that has a distinct retrieval advantage, perhaps with a novel characteristic. Effectively, the process of threat arousal (associated with the amygdala) may be suppressed by the emotions produced by self-soothing in an individual, in the presence of threat perception (internal attack).

Therapeutic implications of these observations

The 'head–heart lag' presents a sizeable challenge to the cognitive therapist, as within this context, it is rare to see notable psychological recovery and symptom reduction that is sustained over time. This is because without the congruent emotional shift, the changes in thinking style seldom retain their ability to change behaviours. Indeed, from a clinical perspective, it is as if a congruent shift in emotion is the *glue* that makes the alternative thinking

patterns *stick*. Thus therapy needs to address, more explicitly, the issue of emotion-based meaning as well as cognition-based meaning, as they may be quite different (Teasdale, 1993, 1997).

Furthermore, emotion-based reasoning requires a different type of therapeutic intervention from cognitive work to promote change, as it does not speak the language of cognition. At the risk of oversimplification, therapy needs to use 'language' the amygdala understands – the sensory experience of attack – to change meaning at an emotional level and create congruence between the cognitive and affective states.

Patients who have (i) self-loathing, feelings of shame and inadequacy, *characterised by high levels of self-critical thoughts*, and (ii) a reduced capacity to *nurture themselves emotionally and to self-soothe*, are less likely to experience an emotional shift, in the context of traditional cognitive therapy. This process may be enhanced by training in the practice of how to emotionally nurture and self-soothe and access to sensory-based, self-soothing memories associated with a novel stimulus, to promote a retrieval advantage in the presence of internal threat (or self-attack). Once self-soothing processes have been established and brought to predominance, the patient may be better able to reframe effectively, and *with sustained improvement*, the highly self-critical negative thoughts that are hypothesised to maintain mood states (Beck, 1976). Thus, in these cases, emotion-based reasoning, rather than being challenged on a cognitive level (as in traditional methods of cognitive therapy), creates the milieu for the therapeutic intervention. Exploring the patient's ability to nurture themselves emotionally can be viewed as opening a window to their inner conflicts as well as providing a forum to foster feelings of compassion and warmth, so influencing their reasoning during the task of reframing highly negative thoughts about the self.

One way to elicit feelings of warmth and acceptance is via helping patients generate an image of a perfect nurturer. This image is then used to generate and direct warmth, acceptance and new meanings for the self. The use of an image of a *perfect nurturer* to facilitate this process in cognitive therapy conveys that the image is whatever the person wants it to represent (angel, fairy, Mother Nature, God); thus it is not prescriptive. It has the qualities (individually worked out) to nurture the person's emotional needs in an unquestioning way – meeting their needs perfectly. In this sense, the image always gives the answer that is in the person's best interest (because it has been designed to do so) – it does not suffer from human failings.

For some time now the use of imagery in therapy has become increasingly widespread. This is because its power to evoke change of meaning for troubling memories and emotions has been noted (Hackmann, 1998; Chapter 12 this volume). Also, imagery work involving the development of a compassionate figure has been used to good effect for people with personality disorder (Layden, 1998). Imagery can activate brain systems and produce physiological change (Gilbert & Irons, Chapter 10; Hackmann, 1998), compassionate

imagery may produce physiological changes associated with self-soothing. Repeated use of the perfect nurturer imagery to activate self-soothing emotions will increase the laying down of sensory-based memories in the neural networks, and will also increase the likelihood that this sensory memory will be triggered again.

Although one might argue that self-soothing emotions can be generated without imagery, the advantage of using the perfect nurturer image is that it can create a new and *distinctive* memory that may be more readily triggered and accessible (Brewin, 2001; Eysenk, 1979; Lockhart *et al.*, 1976). It also allows for social and relational processing. As noted previously (see Chapter 2), people who self-attack may have strengthened neuronal pathways associated with hostile emotional experiences (readily triggered when they perceive threat). The amygdala is the most likely site for these attack-based sensory memories (Christianson & Loftus, 1990; LeDoux, 1992; Wessel & Merckelbach, 1994). We cannot change the output from the amygdala (as it is akin to a read-only memory system), but we are able to introduce new learning and memory. This may become more readily triggered (by introducing a retrieval advantage) and thus have the effect of suppressing the output from the amygdala. In this case the aim is to develop new conditioned emotional responses (self-soothing) that will be triggered in situations where threat is perceived (internal self-criticism), as opposed to hostility.

The use of a distinctive image, the perfect nurturer, thus may be used not only to generate the feelings of warmth and compassion, but also to make that memory distinctive from others as suggested in the PTSD treatment approach. This in turn may increase the likelihood that neuronal pathways associated with self-soothing emotions will be activated under the conditions of perceived threat.

Case examples of using the perfect nurturer to develop a compassionate mind within the context of cognitive therapy

Having outlined in brief something of the theory underpinning compassionate mind training and introduced the concept of the perfect nurturer, the rest of the chapter will focus on two clinical examples of how it has been used with complex cases. These cases demonstrate techniques that have been developed to:

1 identify the source and extent of the self-critical dialogue
2 train people in how to self-soothe, in order to strengthen neuronal pathways and associated physiological reactions
3 use an image of the perfect nurturer to generate feelings of self-soothing and to introduce novelty in order to create a distinctive sensory-based memory that has a retrieval advantage over old memories of self-attack

4 bring congruence to the cognitive meaning and emotional meaning, by using the new sensory experience associated with the perfect nurturer to reframe self-critical thoughts (*compassionate reframe*).

First case example

The first example concerns a woman with internalised body shame, depression and PTSD. The therapy initially followed a traditional model of working with feelings of internalised shame and self-loathing at a cognitive level to promote an emotional shift. After this proved to have little success, training in compassion and self-soothing was introduced to the work, which produced some remarkable reductions in symptomatology.

Background to the case

Amy's entry into therapy at the age of 25 years was precipitated by an emotional collapse two months prior to the referral. When Amy was 10 years old her nightdress caught fire on an open gas fire and she suffered horrific burns from her neck to her ankles, was admitted to hospital for several months thereafter and nearly died from her injuries and associated complications.

Amy remembers the fire clearly. On the morning of the accident, she got up and was having breakfast with her younger sisters. Her mother was asleep upstairs. Amy recalls 'twirling' around the hearth and then her dress caught fire. She ran screaming for her mother who put her in the shower and Amy recalls an image of her skin dripping from her body.

Interestingly, in the months and years after the event, Amy did not recall any specific symptoms of PTSD, which is not uncommon in those who suffer horrific injury after a life-threatening event. She spent nine months in hospital before embarking on a series on painful skin-grafting operations, which are still needed to this day. Amy recalled that she never discussed her thoughts and emotions about the fire; she was not given the opportunity to do so.

Her mother plays a key part in understanding Amy's presenting psychological difficulties; this will become more apparent later. For now, suffice it to say that Amy recalled her mother as an emotionally abusive and neglectful woman, who was self-obsessed, obsessive, perfectionistic, psychologically damaging and (Amy thought) cared little for her children. Of note was the fact that Amy's mother could never accept the permanence of her daughter's scars and spent many years visiting specialists to try to repair the damage to Amy's skin. Amy attributed her mother's efforts for a 'cure' not to a sense of care for her, but to her mother's own need not to have a scarred child.

In spite of this, Amy functioned well at school and went on to university. She enjoyed her work and had a supportive group of friends. Fifteen years

after the fire, Amy was invited to her mother's house for a family celebration. There she encountered a room full of lit candles and her mother wearing a 'floaty' dress. Amy almost immediately suffered a powerful flashback with dissociation to her own accident.

The problems

Thereafter Amy suffered what she described as an emotional collapse: she developed fear-based PTSD (Lee *et al.*, 2001), depression with suicidal ideation and intent, severe anxiety and panic, and an intensification of other premorbid problems. These related to intense self-loathing, disgust and shame, hatred of her scarred body and eating problems characterised by restrictive eating.

For the purpose of this chapter, I will focus on working with her depression, body shame and internalised shame. In order to convey the depths of Amy's self-loathing and despair, some of her internalised shame cognitions are listed below.

- I feel bad, invalid, redundant, purposeless, pointless.
- I feel so deeply ashamed I have nothing to say.
- If people see my scars they will know how disgusting I am inside and out.
- The knowledge that I will always look like this makes me very unhappy.
- My scars contribute to my feelings of inadequacy to the point where I cannot bear to look at them myself.
- I am absolutely disgusted with my body.
- I loathe myself.
- I want to curl up and die.
- People stare at me like I am a freak.

Amy also engaged in self-harm, triggered by thoughts and feelings of self-loathing. At times of great despair she would cut her arms and cross-hatch on top of the scar tissues on her stomach. She described a sense of purging and relief when she saw her blood. Marked weight loss was associated with pleasure and satisfaction. Amy dreamt of unzipping her body and stepping out of it. She also had dreams of infected wounds, of her body splitting open and plants sprouting out of her wounds. These dreams repulsed her.

At the core of Amy's psychological difficulties was a theme of internal shame. Her depression was maintained by high levels of critical thinking (you're disgusting, you're fat, you're repulsive, no one will ever love you). Her desire to die was a desperate attempt to escape the shame and self-loathing she lived with every day.

The course of therapy

In total Amy had 60 sessions of cognitive behavioural therapy (CBT). Her fear-based PTSD was treated with reliving at around session 12. The last eight sessions will be the focus of this remaining section, but some information about the previous 52 sessions may be of use.

- *Sessions 1–33:* From an in-depth formulation of Amy's difficulties, CBT was indicated to begin work on her severe depression, self-harm and suicidal ideation. These sessions were characterised by: daily activity monitoring, identification/challenge of negative automatic thoughts, identification of core beliefs, written and verbal accounts of the fire and aftermath. Amy was admitted to hospital in week 8 of therapy with marked suicidal ideas and intent. After five weeks she resumed therapy. At the end of 33 sessions Amy was well versed in the language and techniques of cognitive therapy. There was, however, no change in her symptoms of depression, feelings of shame and self-loathing. Her Beck Depression Inventory score averaged 45, indicating severe depressive symptomatology. However, there was hope for change and Amy was desperate for help and committed to therapy.
- *Sessions 34–50 (17 sessions):* This next phase of treatment was characterised by schema-focused techniques, core belief work, positive data logs and behavioural experiments (Padesky, 1994). The purpose of this was to rebuild positive core beliefs and reduce the power of Amy's core beliefs of unacceptability and disgust. At the end of this phase of therapy Amy's symptoms of depression remained unchanged (objectively and subjectively). Her Beck Depression Inventory score, after each session, averaged 45. However, she said that she did not feel exclusively defined by her mental state. Nevertheless, she reported that she loathed and detested her body. She believed her self-identity had merged with her body and while her body remained unacceptable and disgusting, so did she. She reported in reference to the cognitive therapy and the work we had done on her core beliefs: *It all makes sense to me but I don't feel it in my heart.*
- *Sessions 51–57 (7 sessions):* After a four-month gap we embarked on our final stage of therapy. What became ever more apparent was that cognitive therapy was not 'touching' the shame and disgust that fuelled Amy's self-critical attacks. Although able to identify her thoughts, challenge them, identify core beliefs and collect data to support new beliefs (in fact Amy was an ideal patient for cognitive therapy, as she religiously did her homework), she remained full of self-loathing and shame. The intellectual shift had not precipitated the desired emotional shift.

  What also became apparent was the extent to which Amy's inner dialogues were punishing and abusive. She seemed unable to feel any degree of warmth or compassion for herself. Her negative thoughts were punitive,

scathing and mocking and her attempts to reframe her thoughts, although apt, *were devoid of warmth and compassion and delivered in a neutral way*.

We began to discuss a way forward that would facilitate self-acceptance and Amy's ability to nurture herself on an emotional level. Amy had little experience of emotional nurturance as a child, and at first she found it difficult to discuss. She was able to say that she experienced her relationship with her mother as having been damaging and lacking in love and warmth. We discussed the impact of this environment on Amy's psychological make-up and introduced the notion that perhaps we could learn to soothe and emotionally nurture ourselves in the absence of such a learning experience in childhood.

Self-acceptance

A starting point for Amy had to be that should she choose to live, she would need to find a way to accept her scarred body, appreciate that she could not change her body but also understand that she could change the way she felt about her body and herself. We embarked on discussions about the difference between Amy and her body. We worked on creating distinctions between these by finding examples of other disabled, burnt people and discussing Amy's thoughts about them. We were able to move to Amy's acceptance that her body did not define who she was as a person. Amy found it perplexing that she judged herself by different rules to others. She was adamant that she would never speak or think about another person the way she spoke and thought about herself. Amy would not be as critical or judgemental of others.

Given this observation, we hypothesised that Amy's critical thoughts might stem not from her own authentic beliefs about herself and her body but from another source (perhaps she had internalised her mother's critical voice during her childhood and developed a self-bullying role).

In order to test this hypothesis we generated a diary of Amy's critical thoughts. Using Worksheet 11.1, Amy filled in what she was doing at the time of the thought (column 1), what the thought was (column 2), the emotion she felt when she had the thought (column 3), how much she endorsed the thought (column 4), and whose voice she heard in her head (column 5). Worksheet 11.1 contains some examples of her critical thoughts (which she was able to identify with her mother).

These findings were a revelation to Amy, as she had not appreciated quite how much her mother influenced the way she now thought about herself. We then proceeded to place a historical perspective on these voices by linking them to key themes of her childhood. The purpose of this was to enable Amy to make links back to her childhood experiences in order to understand what made her so critical of herself. Using Worksheet 11.2, Amy wrote down prominent memories, rules and events and experiences of her childhood.

Worksheet 11.1 Identifying critical voices (Amy)

Date and setting	*Critical/self-attacking thoughts*	*Emotions*	*Endorsement of critical thoughts*	*Source of self-critical thoughts*
What day is it? *What time of day is it?* *What are you doing?*	*Write down any self-attacking thoughts that you can identify at this moment, e.g. I am useless, nobody likes me, other people are better than me*	*Write down what you feel now when you have these thoughts, e.g. sad, anxious, ashamed, guilty, frightened*	*Write down how much you believe these thoughts (out of 100%)* *0 ..... 100* *Disbelieve Believe*	*Think about whether this is something you think about yourself or whether someone else said these things about you, e.g. You, mother, father, sister, friend, teacher, etc.*
Tuesday 10.00 a.m. Getting dressed	You're too fat You're an embarrassment because of the way you dress and speak	Shame Shame, humiliated	75% 100%	Mother Mother
11.00 a.m. Walking to shop	You're a jinx, you've put a curse on the house	Worried	100%	Mother
11.30 a.m. In house, tidying up	You're a liar	Angry	10%	Mother
11.45 a.m. Talking on phone	You're malicious and devious	Sad	25%	Mother
2.00 p.m. Trying to do some work	You're narrow-minded, lazy and bad	Shame, worry	75%	Mother

Worksheet 11.2 Putting a historical perspective on the critical voices and drawing conclusions (Amy)

Examples of experiences/memories, thoughts, standards/rules for living that help you understand the critical voices

For example: *My mother was anorexic and hated seeing me eat (critical thought: 'you're fat')*
- Mother thought physical perfection was paramount
- Disappointment to mother
- My mother made me feel my body was disgusting
- Put on diet by mother at 11 years
- Bought clothes that covered my scars
- Would not accept permanence of scars
- Teased at school and made to feel like a freak
- First boyfriend was abusive and cruel about my scars

The conclusions I came to about myself

I WAS MADE TO BELIEVE THAT I WAS UNACCEPTABLE PHYSICALLY

These were then used to discuss what sort of beliefs or conclusions Amy may have come to about herself, given these experiences.

Crucially at this stage Amy came to the realisation that she was made to believe she was unacceptable physically, rather than being inherently unacceptable. Given this we discussed how much credence Amy had given to her mother's opinions and judgements throughout her life. Did her mother warrant such credence? Did she value her mother's opinions? Were they balanced and informed? Using Worksheet 11.3, we discussed what Amy thought of her mother and to a lesser extent her father (who was somewhat absent throughout Amy's childhood).

This exercise allowed Amy to (i) view her mother from a different perspective, (ii) begin to question why she held her mother's beliefs so strongly, and (iii) begin to question the lack of love she had as a child. Interestingly, it also allowed Amy to see that her father had been loving and affectionate and that although it was buried somewhere in her mind, Amy had been loved. This experience was very important, as it allowed us to foster in Amy memories of being loved and given physical affection by her father (to strengthen Amy's ability to self-soothe).

The next phase of work became key in facilitating a shift in Amy's emotional state. Having identified the punitive, emotionally abusive environment of her childhood and the lack of love she perceived from her mother, we embarked on the task of creating an internal image of the perfect nurturer. Amy brainstormed around the qualities of her ideal mother (unconditionally loving; wants me; accepts me for who I am; warm, peaceful and tranquil; nurturing; uncritical). Crucially, we focused on fostering the

Worksheet 11.3 Credentials of my critics (Amy)

Name: mother		*Name: father*	
Positive aspects	*Negative aspects*	*Positive aspects*	*Negative aspects*
	Blond, skinny, underfed, highly strung, highly critical, disorganised, perfectionist, cruel, devious, manipulative, careless, self-centred, dangerous driver, domestic fascist, rude, opportunist, selfish, incapable of love, humourless, indescribable, incapable of self-doubt	Loving and physically affectionate. Unlike my self-obsessed, vain mother he is capable of loving but only on his own terms A good man but a bad father	Disinterested, reluctant to take on any responsibility that isn't immediately self-serving

feelings of warmth, compassion and acceptance. It is useful to help people focus on different domains such as physical characteristics, sensory features (facial expression, voice tone, smell), touch/closeness, and the acceptance, emotions and knowledge (wisdom) 'in' the imaged other.

We spent a session generating Amy's image and the feelings that image generated in her. She practised generating the image and feelings every day for several weeks. Worksheet 11.4 contains what Amy wrote about her perfect nurturer.

The final stage of treatment came with the introduction of the *compassionate reframe*. Amy was asked to fill in a critical thought diary (as before), but with a difference. Using Worksheet 11.5, every time she had a negative and critical thought she was asked to imagine her perfect nurturer and, when the feelings of warmth and compassion were aroused, she then asked the image to reframe the critical thought. As can be seen in Worksheet 11.5, Amy wrote down her critical thoughts in column 1. She identified the source of the criticism and identity of the critic in column 2. Then Amy imagined her perfect nurturer and, when she felt the soothing emotions, she asked the image to reframe her critical thoughts, which she wrote down in column 3. Column 4 was used to measure the extent to which Amy endorsed the reframe, and column 5 recorded the mood rating.

This technique proved remarkably powerful in changing her mood. As she became practised at imagining her perfect nurturer, she also developed a short-cut image. After time, this short-cut image had the effect of producing the same feelings of emotional warmth.

Worksheet 11.4 Description of my perfect nurturer (Amy)

Compassionate image: Perfect nurturer. Description of attributes, physical appearance, qualities

I imagine my perfect nurturer to look like one of Blake's angels. Radiant and ephemeral, hovering between earth and sky, physically human but purely spiritual all at once. My perfect nurturer would be my guardian angel. Neither male nor female but both at once. Always there but never visible. Perfectly beautiful but perfectly understanding of human flaws. It is made of love and forgiveness the way I am made of flesh and bone. What hurts me also hurts it, but it can never be fatally wounded or permanently damaged. Because it is made of love and forgiveness it can permanently renew and regenerate. It shows me how to renew and regenerate in the same way.

My angel is my guide, nurturer and protector. It shows me that I am lovable. Its presence shows me that I am worth protecting. It supports me when I do not have the strength to support myself. It keeps me safe when I cannot. It decides I should live when I have wanted to die. It is infinite joy, love, peace, compassion, help, and guidance.

And who am I to refuse that?

Description of emotional responses associated with image
When I imagine my angel I feel a sense of calm and peace. I feel soothed, loved and accepted.

Outcome

Amy's use of her perfect nurturer image as a means to reframe her critical thoughts with compassion proved to be the turning point in therapy. Harnessed with the ability to self-soothe, her progress was staggering and after only six sessions (spread over six months) and two follow-up sessions (over another 1.5 years), her score on the Beck Depression Inventory was 1; this gain was maintained at 1.5 years' follow-up. At discharge Amy was working again (after 2.5 years' sick leave), planning a new career, accepting of her body and accepting of herself.

There are a number of issues to highlight from Amy. The first is that working only with cognitions in 'the here and now' and on the fear aspects of the trauma was of limited help. Second, clearly identifying the self-critical part as the voice of another who Amy had simply internalised was important. Many psychotherapies have indicated that separating what comes from self and what comes from others, and is internalised, is important in letting go of self-criticism. It begins the process of separating 'what I think about me from what others think (or thought); or how I can relate to myself versus how others have related to me'. Cognitive therapy too can address this crucial issue. Understanding that how one evaluates others (who may be suffering the same as self) is different from how one evaluates oneself is common to many cognitive and other therapies. However, these can get stuck at an intellectual, cognitive or explicit level. Moreover, as Gilbert has argued (Gilbert, 2000; Gilbert & Irons, Chapter 10 this volume) in such situations it is feeling

Worksheet 11.5 Using the perfect nurturer to reframe critical thoughts with compassion (Amy)

Self-attacking thought	*Source of critical thought and identity of critic*	*Compassionate reframe (image)*	*Extent to which I endorse reframe (0–100)*	*Mood rating (1–100)*
Write down any self-attacking thoughts that you can identify at this moment, e.g. I am useless, nobody likes me, other people are better than me	*Where does this thought come from? Can you identify a critic?*	*Imagine your perfect nurturer and when you feel soothed, ask the image to reframe your critical thought*		*What do you feel now you have reframed your criticism?*
Went out not wearing my neck scarf. My scars are repulsive to others and should be hidden from sight.	My mother, who was obsessed with physical perfection. SHE could not accept my scars. SHE thought they were disgusting and tried to hide my body with ridiculous clothes.	True beauty is everywhere: just let yourself see it. Your scars are a sign of your strength and courage in a battle fought and won. Let people stare at you and know that it does not matter. What matters is that you live your life for you, not for others.	100%	Peaceful and calm 100%

genuine compassion for the self that may be crucial for change, as it fosters change at an implicit level of meaning – the emotional meaning.

Hence, a crucial component was not to rely (only) on a therapist giving experiences of warm acceptance, but to provide an opportunity for Amy to start to create internal signals that would stimulate her *own self-soothing system*. Deliberately generating images of a perfect nurturer, and thinking that this can also be like an internalised other, offered Amy the opportunity to start a new self-to-self inner dialogue and relating style that was infused with feelings of warmth. The perfect nurturer also introduced a novel characteristic to new learning, thus creating a retrieval advantage over old sensory-based memories. In many ways it appeared that stimulating the inner experience of warmth for her, via imagery, produced the marked change. While all the

elements of the therapy played a part, it was the activation of inner warmth and compassion that Amy found most healing.

Second case example

The second example again outlines the use of compassionate imagery to foster self-acceptance in a young woman with PTSD, poor self-worth, shame and depression. In this case, training in self-soothing was introduced early in therapy.

Background

Sylvie, a woman in her late twenties, nearly died after an emergency Caesarean. The medical staff told Sylvie that she had been 10 minutes from death. In the aftermath of this event, Sylvie became symptomatic with PTSD. She constantly replayed images of the events surrounding the birth of her son and ruminated about the care she received in hospital. When she thought back to this event she was overwhelmed with sadness and grief. She was particularly troubled with the thought 'I don't count'. She believed the hospital staff did not care about her enough to want to save her life. She experienced feelings of being alone and disconnected from people around her.

Sylvie also reported suffering from daily symptoms of anxiety, building up at times to feelings of panic (particularly triggered by thoughts of the event). She had moderate to severe levels of depression (her Beck Depression Inventory score was 29). She was able to articulate that she felt sad and ineffectual in her life. She was plagued by self-critical thoughts that made her feel bad about herself. Sylvie reported that she felt stigmatised and that somehow she had 'fallen from grace'. She described feeling deeply ashamed and humiliated about what happened to her. Prior to the birth of her son, Sylvie was involved in an unsatisfactory relationship with the father of her son. This relationship was characterised by emotional abuse.

As a child she went to several different schools and had painful memories of 'always being the new girl who had to fit in'. She developed a strategy of working hard in order to get people to like her, and indeed she recalled being a popular child. During her adolescence (between the ages of 14 and 18 years) she developed an eating disorder characterised by binge/vomiting. At this time she believed herself to be 'fat and disgusting'. Of note was the fact that her mother had a history of anorexia. As in the first case, it will become apparent that Sylvie's mother plays an important role in understanding her self-criticism. Sylvie felt very ashamed of her 'puking days'; she thought it was a dirty habit and should be kept secret.

Interestingly, this behaviour stopped when she went to university. During her early twenties Sylvie had a termination of pregnancy. After this she recalled sinking into a deep depression. She felt guilty and full of self-loathing.

At around this time she began to cut herself. She described how she wanted to 'give my pain a face as the throbbing pain in my leg would distract me from my emotional pain'. Sylvie described aptly the function of her self-harm – 'I could tend to my physical wound by caring for it, bathing it, cleansing it, putting some cream on it to soothe the pain and then put a plaster on it to make it better'. This task was something she was unable to do with her emotional pain.

Sylvie's last incident of self-harm was just before the birth of her son. She was made homeless and had split up from her partner. In desperation she smashed a glass on her forehead.

We were able to link the traumatic birth of Sylvie's son (and the way she responded to it) to her profound sense that she was unlovable and that nobody cared about her. She believed on one level that the medical staff did not want to save her life. We were also able to link Sylvie's heightened feelings of shame and self-loathing to her premorbid psychological make-up. In essence her near-death experience intensified underlying beliefs of feeling neglected – as if she did not count, and was not good enough even to save from death. At this time, although tempted, she did not engage in self-cutting as she felt she needed to be a responsible mother.

The course of therapy

In total Sylvie had 16 sessions of cognitive therapy. The first four sessions focused on the traumatic birth of her son and PTSD. The final 12 sessions focused on developing inner compassion and warmth, as Sylvie's problems were characterised by (i) self-critical thoughts fostering feelings of self-loathing and shame, (ii) patterns of self-harm and (iii) evidence of a reduced ability to self-soothe her emotional pain (poignantly captured in her description of self-harm).

We used the same techniques as with Amy to develop acceptance and compassion. Thus we began with a discussion about self-acceptance. This included a discussion about how Sylvie viewed and judged her friends. We discussed whether she would speak to friends the same way she spoke to herself – would she have similar thoughts about her friends' appearance and behaviour? Sylvie was able to identify that she was harsher on herself than on others. She already knew that she heard 'the voice of my mother in her head', and would joke about it. She recalled that her mother was a perfectionist with unrelenting standards and rigid beliefs, and was highly critical of Sylvie. Using Worksheet 11.6, Sylvie was asked to focus on her critical thoughts, note the associated feelings, rate her endorsement of the thought and, finally, note the source of the self-critical thoughts.

This exercise proved fruitful for Sylvie, as she was able to tease out her own evaluations from those of her mother. As with Amy, we continued to elaborate on this information by exploring, in more detail, Sylvie's memories of her

Worksheet 11.6 Identifying critical voices (Sylvie)

Date and setting	*Critical/self-attacking thoughts*	*Emotions*	*Endorsement of critical thoughts*	*Source of self-critical thoughts*
What day is it? *What time of day is it?* *What are you doing?*	*Write down any self-attacking thoughts that you can identify at this moment, e.g. I am useless, nobody likes me, other people are better than me*	*Write down what you feel now when you have these thoughts, e.g. sad, anxious, ashamed, guilty, frightened*	*Write down how much you believe these thoughts (out of 100%)* *0 .....100* *Disbelieve Believe*	*Think about whether this is something you think about yourself or whether someone else said these things about you, e.g. You, mother, father, sister, friend, teacher, etc.*
Saturday 7.00 a.m. Getting dressed	You look unkempt You dress thoughtlessly Your arse looks enormous	Shame Embarrassment Anxiety Irritation	90% 100% 80%	Mother Mother Mother
10.30 a.m. Buying clothes	You spend too much money	Anxious Worried	80% 100%	Mother Mother
7.00 p.m. Having a beer in home	You drink too much (80%)	Sad, shame	100%	Me
8.00 p.m. Talking on phone to mum	I am always a disappointment to my mother (100%)	Shame, worry	80%	Me
	I never do things perfectly I don't care enough for other people (75%) I am thoughtless (80%)	Shame, worry	75%	Me

Worksheet 11.7 Putting a historical perspective on the critical voices and drawing conclusions (Sylvie)

Examples of experience/memories, thoughts, standards/rules for living that help you understand the critical voices

For example: *My mother was anorexic and hated seeing me eat (critical thought: 'you're fat')*
- My mother was obsessed with physical perfection
- My mother was always pristine
- Academic achievement was highly prized
- I never had any praise
- I was never good enough
- My mother called me insulting names
- My mother could be mean and tyrannical
- She threw my stuff away if I didn't tidy up
- Re vomiting: 'If you think you are going to manipulate me with this you are wrong'
- She would often completely ignore me for weeks on end
- She would lay the table but not for me

The conclusions I came to about myself

I WAS MADE TO FEEL UNLOVED AND A DISAPPOINTMENT

childhood experiences and the feelings she associated with them, in order to make links with how Sylvie thought about herself as an adult. Worksheet 11.7 contains examples of some of more prominent thoughts/memories.

It is worth mentioning that at this stage in Sylvie's life she had a positive relationship with her mother. As in the first case, the purpose of this exercise is not to foster blame but to 'seek to understand' the development of her critical thoughts. At the end of the task she was able to appreciate why she found it difficult to soothe her emotional pain. She realised that her emotional pain was never soothed as a child; instead, her attempts to seek comfort were usually met with punitive criticism. Perhaps as a consequence, she had been unable to internalise mechanisms to self-soothe in an adaptive way. She had rarely experienced this as a child. However, she had ample experience of critical attacks. This strategy of attack had been internalised and became the prominent feature of her inner self–self dialogues.

To continue with the task of reducing the extent of Sylvie's self-critical dialogues, we explored the credentials of her main critic – her mother – by using Worksheet 11.8. The exploration of the positive and negative aspects of her mother's beliefs and behaviour enabled Sylvie to crystallise the difference between her beliefs and thoughts (the evidence for which was found mainly through her views of her friends' appearance and behaviour) and those of her mother.

As with Amy, we then spent a session developing a comprehensive image of Sylvie's perfect nurturer, which is described in Worksheet 11.9.

Worksheet 11.8 Credentials of my critics (Sylvie)

Name: mother		*Name: father*	
Positive aspects	*Negative aspects*	*Positive aspects*	*Negative aspects*
Warrior	Stubborn	(only a small part)	A nonentity
Rebel	Sharp tongue	Physically affectionate	Absent
Stands up to people	Insecure	Proud of family	Expects success
Dry sense of humour	Dominant	Successful self-made man	Too ambitious
Attractive	Highly strung		Moody
Pristine	Nervous wreck		Stubborn
Classy	Worrier		Ignorant
Tries to overcome her fear	Insomniac		
	Scary		
	Not affectionate		
	Distant		
	Overbearing		
	Cruel		
	Coward		

After *repeated practice* of conjuring her image and the feelings of warmth and compassion, Sylvie developed a short-cut to her image. She imagined just a pair of arms outstretched. She combined this with smelling the skin on her arm (which she described as comforting and 'mummy-ish'). Later in therapy, the smell alone triggered her feelings of warmth and acceptance.

Worksheet 11.9 Description of my perfect nurturer (Sylvie)

Compassionate image: Perfect nurturer. Description of attributes, physical appearance, qualities

My perfect nurturer rises still and tranquil, high from the ground, her arms open in an anticipation of an embrace. Her garments are loose and linen. Her overall texture is warm, breathable, sandstoney skin, matt, warm, soft, alive. Her face is relaxed, her eyes closed in the moment of tasting that impending hug. Her smile is slight, calm and almost otherworldly spiritual and content.

Her embrace comes at times when I feel like a failure. She strengthens me. Her embrace comes at times of discomfort and disappointment when she tells me how special I am. How much she loves me and what she thinks might be right for me. She tells me to listen to me.

She trusts me and my opinion counts with her and that I am worthy. She whispers in a warm soothing voice 'Hey, it's OK, everything is going to be fine'.

But she is not a person, she is a moment of affection and acceptance. She marvels at me as I marvel at my child. Life isn't always going to be good and fun but she will always be waiting for me with her arms open, encouraging, soothing, trusting, holding me . . . just holding me.

Description of emotional responses associated with image
When I imagine my image I feel accepted, safe and loved, warm and comforted.

The final stage of the therapy focused on developing skills to reframe critical thoughts with compassion. As before, Sylvie used a worksheet to keep a diary of her critical thoughts, but this time she reframed them by conjuring up her feelings of warmth and compassion (smelling her arm) and asking her perfect nurturer to respond to the critical thought. Worksheet 11.10 is an example of Sylvie's work. As Sylvie continued to use the compassionate reframe diaries, she expanded the identities of her critics to include the perfectionist, the unforgiving self and the bully as well as her mum. This was interesting, as it appeared that Sylvie began to identify many aspects of herself that played out different roles in different situations.

Outcome

At the end of therapy, Sylvie said she felt strong and positive. At a three-month follow up, her Beck Depression Inventory score was 8. Sylvie's progress pleased her greatly, and she was delighted with what she called the 'new me'. Crucially, she identified her compassionate reframes as central to her continued well-being. She had already observed that when she forgot to use this technique for a period of time her mood would drop.

Worksheet 11.10 Using the perfect nurturer to reframe critical thoughts with compassion (Sylvie)

Self-attacking thought	*Source of critical thought and identity of critic*	*Compassionate reframe (image)*	*Extent to which I endorse reframe (0–100)*	*Mood rating (1–100)*
Write down any self-attacking thoughts that you can identify at this moment, e.g. I am useless, nobody likes me, other people are better than me	*Where does this thought come from? Can you identify a critic?*	*Imagine your perfect nurturer and when you feel soothed, ask the image to reframe your critical thoughts*		*What do you feel now you have reframed your criticism?*
Went out looking unkempt, oily hair, no make-up. This is not acceptable: I am completely unattractive, off-putting, not worthy of positive attention.	My mother. She's obsessed with perfection and always unhappy with herself. She thinks I should wear make-up to make me attractive.	I am attractive and I don't need make-up. I have my own style, of which looking pristine is not part. I can accept this is me and I like it.	100%	Good, strong (100%)

Summary of stages

This section summarises the stages discussed in the casework and discusses how they might work in cognitive therapy. It is always worth reiterating the importance of the therapeutic relationship and timing when working with individuals who experience chronic and deep-seated problems with self-worth. Leahy (Chapter 7) and Gilbert & Irons (Chapter 10) both indicate that the therapy context may be the first time an individual has experienced a compassionate relationship. It may take many months before some of the concepts can be introduced or worked with.

The ability to self-soothe is not necessarily something that comes naturally to some people, and training is an essential component of the approach, especially when people cannot access any feelings of warmth or compassion. A key process in therapy involves recalling experiences/memories that were associated with love and affection. However, this is not always the case, and Gilbert & Irons (Chapter 10) have illustrated techniques that may be used to try to develop compassion.

- *Identifying critical voices:* This is often the starting point of traditional cognitive therapy – the practice of 'catching' thoughts and noting how they make you feel. In individuals where these thoughts are characterised by self-criticism, delivered in a punitive and harsh manner, highlighting the identity of their internal critic can be useful in the first steps to self-acceptance. Rating the extent to which the person endorses their critical thoughts allows them to see the variance between thoughts, and to focus on particularly compelling or 'hot' cognitions. By identifying the source of the self-critical thoughts (whether a person or an early experience), the person may begin to separate out their own thoughts from others' opinions that have become part of their attacking self-dialogue. Two further exercises, the historical perspective and the credentials of the critic, can strengthen this process.
- *The historical perspective:* An examination of prominent memories and experiences of childhood can offer an important insight – we are not born useless, unworthy, disgusting, etc. Rather in early life we are made to *feel* that way by the treatment of others because we may not have any other experiences or resources by which to refute their condemnations. Thus, as in cognitive therapy, our core beliefs can be viewed as the conclusions we have come to about ourselves based on our experiences.
- *Credentials of critic:* Individuals that self-attack give enormous credence to their internal bully – it is literally unquestioning. For individuals who can identify the source of their attack (their mother, father, step-parents, etc.), a discussion about what sorts of people they admire, respect and listen to, and what kind of qualities those people have, is a useful preamble to an examination of their critic's credentials. In many of my cases

this exercise has proved very helpful in beginning to end the internal critic's 'hold' over the person, as the negatives usually far outweigh the positives. This is not an exercise in seeking blame; rather it seeks to help people understand themselves. Given the sensitivity of this and the level of emotional pain these individuals have suffered, it is vital that they understand the purpose of the exercise and that it is conducted in the context of a compassionate and warm therapeutic relationship.

- *Using the perfect nurturer to facilitate a compassionate reframe:* Using the perfect nurturer (as opposed to the person) to make the compassionate reframe of self-critical thoughts appears to have several advantages. It is difficult to undermine the perfect nurturer and make 'exceptions to the rules' to cognitive reframes. This approach also deals with the problem that arises in individuals with a reduced ability to self-soothe – rarely are they able to choose emotionally nurturing friends and partners. Hence the cognitive therapy technique of using 'And what would you say to a friend, or what would a friend say to you?' can become unstuck. It also appears to work faster at dealing with negative thoughts and undermining negative affect. Perhaps this is because it provides the emotional experience at the time of the reframing, thereby facilitating a 'feeling in the heart' as well as 'in the head'.

  Developing the perfect nurturer is both an experiential and a cognitive exercise. Hence the self-soothing emotions associated with the image directly undermine the affect of self-attack, while the compassionate reframe directly challenges the cognition by using emotion-based reasoning – a two-pronged approach.

Concluding comments

Compassionate mind work is focused on developing new self-to-self relating out of which can flow new insights and thoughts about, and experiences of, the self. The key to working this way is to provide opportunities for people to *feel warmth* for the self. For some people this system may be seriously underdeveloped and under-elaborated. People may have few feeling memories of being cared for, or those they do have can be submerged under others relating to shame. Imagery and practising imagery can be one way to start to activate this system and bring it into the experience of self.

Compassionate warmth has special soothing qualities for the self that may be linked to a number of neurophysiological systems. Change for some people, then, is not only about redirecting attention, re-attributing, re-evaluating or re-framing, powerful as these may be – it is also about recognising that we have evolved systems for social and self-processing, for being soothed by others and for becoming capable of self-soothing and self-accepting. For some people these systems will come (back) on line as they change their thoughts and behaviours, but for others, for whom they have

never been well developed, they do not. Blending compassionate mind training into more standard cognitive (and other) therapies offers a possible avenue to help people who have become stuck in self-loathing and contempt.

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Although I have disguised their identities, Amy and Sylvie are real people and this chapter contains the work they did in therapy. They kindly agreed to let me write about their experiences and I want to extend my heartfelt thanks to them.

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Chapter 12

Compassionate imagery in the treatment of early memories in Axis I anxiety disorders

Ann Hackmann

Introduction: Why work with early memories in Axis I disorders?

It may seem odd in view of current cognitive behavioural therapy practice to consider working on early memories using compassionate imagery in Axis I disorders. However, in this chapter an attempt is made to indicate how very effective this can be where treatment is not proceeding at the pace that one might normally expect.

Cognitive therapy for anxiety disorders has made dramatic advances in the past 20 years, with the development of cognitive models for a number of disorders. These models have mainly emphasised the processes that maintain the problem, while acknowledging more distal factors originating from the time of onset. Examples of models would include those for panic disorder (Clark, 1986), health anxiety (Warwick & Salkovskis, 1990), social phobia (Clark & Wells, 1995), generalised anxiety disorder (Wells & Carter, 1999), and obsessive-compulsive disorder (Salkovskis *et al.*, 1998). Health anxiety is included here, as although it is categorised as a somatisation disorder (hypochondriasis) in DSM-IV-TR (APA, 2000), it has a significant overlap with other anxiety disorders such as panic disorder.

Typical maintenance factors in anxiety disorders might include: selective attention, safety seeking behaviours (covert and overt), worry or rumination, and avoidance. Images have also been included in this list, though without much elaboration of how one might work with them (Clark, 1999). The results of trials and case series in these disorders have been very good, with high effect sizes and low drop-out rates. Within a matter of weeks some progress is noted, and sometimes recovery is swift.

In parallel with these developments, a new cognitive model of posttraumatic stress disorder (PTSD) has been proposed (Ehlers & Clark, 2000). This also incorporates the role of the typical maintenance processes listed above. However, more emphasis is placed on intrusive memories, which may occur in the form of images and flashbacks, and on methods of processing the original trauma as a single event without implications for the future. The

patient is encouraged to make discriminations between 'then' and 'now', and in the process must revisit the trauma memories themselves, and reflect on the distorted appraisals made at the time, as well as the current distorted appraisals of the significance of the intrusions in the present. Thus origins are considered in addition to processes maintaining the disorder. It is important, however, that in this process the patient does not view their distortions as in some way shameful or irrelevant (Gilbert, 2002), but rather the therapist validates their experience (Leahy, Chapter 7), while at the same time using guided discovery to explore alternative interpretations. For example, images may be replayed from alternative points of view, or with a different attentional focus.

Over recent years evidence has been accumulating that imagery in the other anxiety disorders has some similarities with the more obvious trauma memory imagery in PTSD. Spontaneous, recurrent images in a variety of modalities have been observed, and found in a majority of cases to have apparent links with memories of upsetting experiences earlier in the individual's life. Such imagery has been observed and measured in health anxiety (Wells & Hackmann, 1993), social phobia (Hackmann *et al.*, 2000), agoraphobia (Day *et al.*, 2004), and obsessive-compulsive disorder (de Silva, 1986; de Silva & Marks, 1999). In the study on agoraphobia, imagery reported by the clinical group in the target situations was significantly different from that in a matched control group, suggesting that the imagery may be of some relevance in the disorder. In social phobia and agoraphobia the memories patients consider may be linked to current imagery are often from many years ago, and in the case of social phobia appear to cluster around the time of onset (in the early teens). In social phobia early memories are often of bullying, harsh criticism or teasing, while in agoraphobia they often centre around sexual or physical abuse, negligence or separation. Further, experiences laid down in childhood, especially those bearing on (the lack of) compassionate care and the security of attachment relationships, can prime threat-processing systems (Gillath *et al.*, Chapter 4).

Different memory systems

It has been proposed by a number of theorists that memories can be laid down in different systems, and accessed in different ways (for a review see Brewin & Holmes (2003). It has been suggested that intrusive memories in PTSD may involve different memory processes during encoding and retrieval to those seen in other types of autobiographical memory (Ehlers *et al.*, 2004). Trauma memories are mainly sensory fragments, stored with their original meanings, and not connected to other autobiographical memories. When they are activated there is a sense of current danger, and the person experiences the intrusion to a greater or lesser extent as something that is happening now. It is also apparent that in some cases people have lost sight of the connection

between the compelling imagery and the traumatic event itself: there is a lack of awareness that there is input from memory at that moment. Triggering can be quite automatic, with sensory cues rapidly triggering intrusions, sometimes without conscious awareness of the triggers. In the Ehlers & Clark (2000) approach it is considered that an important facet of treatment is the exploration of intrusive imagery, by bringing it fully into awareness, followed by conscious reflection on what triggered it, and what has been accessed. Following this, distorted peri-traumatic appraisals can be challenged, and the image can be updated, and compared with present-day reality.

What has not yet been considered in cognitive therapy is whether there is a place for working with upsetting memories in the other anxiety disorders, with a similar treatment rationale. In this chapter the results of two such case studies are presented. In each, progress was negligible until work was done on childhood memories, which appeared to underpin the Axis I disorder.

Background

As outlined by Bowlby (1969, 1973) and discussed by Gilbert (Chapter 2), a common, evolved threat-regulating system is access to supportive others, especially but not only attachment figures. Such figures have certain qualities, such as being more powerful than the child, able to protect against external threats, while at the same time being soothing and non-threatening themselves. There is increasing evidence (reviewed by Gillath *et al.*, Chapter 4) that when people are threatened there is an automatic priming of the attachment memory systems. Those from secure backgrounds have access to soothing or supportive memories while those from insecure backgrounds do not, and further threat may prime the recall of neglect or abusive memories. As noted by Gilbert & Irons (Chapter 10), one of the reasons why people can feel overwhelmed by a threat is that they have underdeveloped and under-elaborated memories and schemata for feeling cared for and able to self-soothe.

One intriguing question is whether guided imagery can be used to provide these experiences that a patient from (say) an insecure background may not be able to call on. In essence, can a person create an image from their own caregiving system, infuse it with certain compassionate care and rescuing qualities, and thereby reprocess the traumatic memories? This approach adds to the repertoire of evidence-based approaches, as it seeks to use one relational processing system (social mentality) to change another. For example, if an image is of being in a subordinated and abused position, can the affective meaning and impact of these memories be changed by introducing an experience (via guided imagery) of being rescued or helped (cared for), or of assertive dominance? Gilbert & Irons (Chapter 10) suggest that this involves connecting different role-processing systems.

In what follows I will present two cases that suggest that not only is this

possible but it can significantly help a person who is struggling using more conventional cognitive therapy techniques. After the description of the two cases an attempt will be made to describe the stages of such an intervention, and place them in a theoretical context.

Case 1: Panic disorder with severe agoraphobia, encapsulating meaning from a childhood trauma

Jill was in her mid-forties, and had suffered from panic disorder and agoraphobia for over 20 years. She was virtually house-bound and worked from home, helping her husband with accounts for his business. She managed to look after her children, but could rarely accompany them outside the home. During her panic attacks she was afraid of a wide range of physical and mental catastrophes. The therapist repeatedly struggled to help her re-evaluate her many distorted beliefs about the likely causes and consequences of her panic symptoms. Trying to change her implicit threat-processing systems by explicit reflection and considering alternatives did not help much. Even if one belief was challenged successfully it would soon reappear, or be replaced by another, equally hard to dispel. She quickly reverted to being highly threat-focused, despite contradictory evidence.

Jill was also exceedingly afraid of doing behavioural experiments, including dropping her multitude of safety behaviours. She had all the hallmarks of a well entrenched threat–safety system that leads to thinking and behaving in 'better safe than sorry' terms. Such a focus can lead to a highly risk-avoidant and 'damage limitation' style (Gilbert, 1998). The therapist allocated extra sessions for the treatment, which was not going according to plan. None of the symptoms of panic, agoraphobia, anxiety and depression showed any sign of improvement.

One day the therapist happened to enquire about images while discussing a recent panic attack. The patient explained that the image was usually the same, whatever the feared physical or mental catastrophe. In it she saw herself collapse, a crowd gather, an ambulance arrive, and herself carried kicking and screaming off to hospital. When asked to evoke the image and let it run on, the patient described getting to hospital, being put into bed, protesting loudly, and not being able to explain to the staff that she needed to go home. Worse still, she was kept there for ever, against her will, and none of her family bothered to visit, or to rescue her. In the end the staff gave up on her, and she remained alone until she died.

The therapist attempted to help the patient challenge this distorted view of what would happen if she did panic or become ill in a public place. After the verbal discussion, involving guided discovery and Socratic questioning, the patient conceded that perhaps there was another way of picturing what might happen, which could incorporate more realistic coping and rescue factors. Since this was still only an intellectual rather than an emotional shift,

it was decided that imagery should be used, and the patient attempted to visualise a more realistic scenario concerning what might really happen if she was taken to hospital. It was at this point that Jill suddenly exclaimed that she now realised where her big fears came from. She recalled a childhood incident where she had indeed been protestingly taken to hospital, and left there against her will. She had been certain at the time that her parents had found a way to abandon her.

It is unlikely that such scenarios are created without some input from memory (sometimes operating out of awareness) that acts as a reference point for such meanings. A key question for the therapist is whether to stay focused on the here and now, or whether to look actively for such memories. In some cases important meanings are located in memories of specific events, while in others they arise from a more general and repetitive pattern of relating (e.g. of feeling unwanted). In Jill's case it was both.

The focus then shifted to childhood. Following the procedure that would be followed in PTSD, Jill was asked to relive the childhood memory, describing it in the first person, present tense, and recounting sensory detail, emotions and thoughts (Ehlers & Clark, 2000; Foa *et al.*, 1999; Foa & Kozak, 1986). Jill explained that she became ill one day when she was four years old. She lived in a remote part of the country, her father was unemployed, and her mother was chronically ill. She had two sisters, and was always told that she had been an unwanted child, and was more trouble than the other two girls. She had never spent time away from home without her parents. When she developed a severe gastric virus that lasted for several days the parents called the general practitioner, and requested a home visit. The doctor came, and conferred with the parents in the kitchen. Jill was then told that she had to go to hospital. This scared her a lot, but her parents insisted, and they drove there with the doctor. On arrival Jill became very tearful, but was persuaded after a struggle to get into bed. Then her parents left, saying they would be back in a minute. When they did not return Jill concluded that she might be lost, and tried to tell the nurses her name and address. The nurses ignored this, even when she cried and shouted. Finally she fell asleep, exhausted, only to wake up in the morning and realise that her parents had still not returned. With a horrible shock she decided that after all they had never wanted her, and that they had found a way to get rid of her. For three days she believed this, until she was finally discharged and taken home again.

In the context of her insecure relationship with her parents, Jill had given the hospitalisation a layer of meaning that it might not have been given by another child. After reliving the memory with some distress, Jill said that from that experience she had concluded that her parents did not love her and had tried to get rid of her, and also that she was intrinsically unlovable, and ineffectual in getting help when she needed it. This had set the scene for an avoidant and dependent interpersonal style. She did not develop panic attacks until she had back trouble as an adult, and was told that she would have to go

to hospital if it did not clear up. This worried her a great deal, as she pictured hospital scenes in which she would never get home or be visited. This in turn gave rise to anxiety, followed by ever more extensive catastrophic misinterpretations of her bodily sensations. Each of these catastrophic mental or physical scenarios included the element of fear of the implications of ending up in hospital.

This seemed to present an elegant opportunity to try restructuring the content of the imagery surrounding the original traumatic memory, in order to convey a more realistic appraisal of the situation, in the light of other autobiographical knowledge. This must be skilfully done. Arbuthnott *et al.* (2001) have outlined potential problems with trying to restructure early memories. Once again using the Ehlers & Clark (2000) principles, an attempt was made to reflect on the appraisals made at the time, and the general conclusions Jill had drawn. This verbal work took several sessions to complete. First the therapist encouraged the patient to examine the evidence that her parents never loved her. On reflection Jill realised that she had many happy and loving childhood memories. After her father finally found a job, and her mother's health improved, their family functioned quite well, and Jill felt more secure. The point of this work was not to invalidate Jill's experience, or persuade her that she was 'wrong', but rather to offer an opportunity to look again with new eyes, and obtain a more balanced view: to consider things that she, with her understandable fear of not being wanted, had not been able to process at the time. In addition to acknowledging that she did not feel loved at that time, she could also begin to accept that this was not because she was unlovable. Her own parents had amply disconfirmed this later in her childhood.

Another element in treatment involved trying to understand why the parents had behaved the way that they did during Jill's hospitalisation. Jill was encouraged to switch perspectives, and see things through her parents' eyes. Again the focus was on compassionate understanding (this time for the parents' position as well as for herself) – not to produce guilt in Jill for having negative thoughts about her parents.

An attempt was made to understand the parents' behaviour in leaving her at the hospital without explaining what would be happening and why. This was accomplished by considering that these events took place at a time before Bowlby's seminal research on the damage done to little children by this type of hospital experience (Bowlby, 1973). The patient then understood that parents and hospital staff at that time believed that separation at an early age was not a problem, and that if you ignored the child's distress it would settle down more quickly than if you made a fuss.

Thus an alternative explanation for the original events was generated: Jill's parents did love her (at least within the limits of their ability). That is precisely why they insisted on taking her to hospital to get well. Their 'leaving her behaviour' could have been a manifestation of doing what they

thought best at the time (considering the then current ignorance of children's needs in that situation) rather than lack of love for Jill. They did not (and thus clearly did not intend to) abandon her, and her attempts to get help in hospital were ignored not because she was ineffectual, but because staff were trying to help her to settle down more quickly. The staff may have been acting on the belief that if you attend to distress you make it worse. Jill was invited to extend compassionate understanding (by taking a wider view) to her parents and the staff. This appeared to relieve part of the fear of abandonment 'locked into' the memory, which had been a vehicle for her beliefs.

This verbal work produced the classic response from the patient: she could grasp it intellectually, but it did not change the way she felt. There may be various functional explanations for this. First, it is understandable because while she might be able to reprocess the intentions of others, this may not address the fear and sense of isolation of the inner memory. This can be explained to the patient, so they are not left with the feeling that it 'should' change their feelings and they are at fault if it does not. This can be compared to another situation: whether or not someone pushes one down the stairs deliberately does not change the pain of a broken leg. A second possible explanation is that the verbal work has not addressed the other major issue, which was not about the intentions of others, but about having the felt experience of being alone and helpless. Ehlers & Clark (2000) have suggested that a method of inserting corrective new information into the memory structure needs to be found. One method of achieving this is to relive the original scenario in the sensory modalities in which it was originally stored, but incorporating the new perspective into the image.

This was discussed with Jill, who suggested that she would like to do this by going in imagery into the memory as her adult self, to deliver a vital message to her parents. As noted by Gilbert and Irons (Chapter 10), it is important to stay collaborative and use guided discovery to see which types of image and what kind of role a patient wishes to incorporate. Finding what 'fits' for the person and experiencing the therapist as a supportive collaborator rather than an imposer is key to the patient owning and working with the images. Her choice of material to transform the meaning of the image directs attention to the fact that for Jill the powerless subordinate issue was important. She relived the original episode, describing it aloud, inserting her adult self arriving in a blaze of light in the kitchen. Her adult self warned her parents and the doctor that it would be dangerous to send her to hospital without preparing her properly, and that she would develop agoraphobia when she grew up if this were to be handled badly. She then spontaneously imagined that they took careful note of her message. The parents looked shocked and sorry in the kitchen, and said that of course they loved her, and would do all they could to support her in hospital. The imagery ended with her visualising her mother visiting her in the ward, and sitting by her bed as

she fell asleep. Note that the completed image combines two relational roles. In the first part of the images she takes a dominant role over her parents, and tells them what to do, perhaps addressing the helpless subordinate aspect of the experience. Only after this does she move on to create the compassionate caring role of feeling supported and rescued, accessing the sense of her mother as more compassionately caring, as she was later in Jill's life. In the completed image she feels soothed and safe, and falls asleep.

The shift in the image was accompanied by a big shift in affect. Jill left the session feeling relaxed and peaceful, having changed her appraisals of the original event. As noted by Gilbert & Irons (Chapter 10), compassionate care imagery (such as Jill's mother sitting by her bed) can tap into a safeness and soothing (or attachment) system. The relaxed-calm response is a good indicator of success. This seemed to allow Jill to subsequently be more explorative, with greater willingness to do behavioural experiments. This imagery experience was also associated with a big drop in anxiety, depression and panic attacks. Creating a new role-relational script appeared to move her on from reliance on old ways of processing experience, allowing her to try new things.

Case 2: PTSD after a car accident, where the meaning was coloured by childhood trauma

Pat was a married woman in her early fifties. She had suffered a car accident, which was completely unavoidable. Her son and her grandson were in the car with her when the accident occurred. Having relived the car crash in the second session, the patient insisted that she had caused the accident. She had also had a strong feeling at the time that she had killed someone. The therapist could see that neither of these beliefs reflected reality. An attempt was made to construct an accurate narrative of what had happened, and to draw everything out on the white-board, so that Pat could see for herself that there had been no way to avoid the impact. The other driver had driven fast towards her, on the wrong side of a narrow road, past quite a long line of parked cars. In addition there were no were no side turnings into which she might have escaped. Any alternative action on Pat's part would have resulted in a worse outcome, or the same result. At the end of this therapy session Pat remained unconvinced, and she returned the following week having listened to the therapy tape, but with her belief that she had caused the crash quite untouched.

The therapist made the decision to explore further the 'felt sense' (Gendlin, 1981), to get a handle on what the patient really meant. She was asked how she experienced this feeling in her body, and what it meant about her. She was also asked for the evidence she might have to support her belief. She replied that she felt as if she had done something really terrible. Also, she thought that the accident was a punishment from God, which she deserved because she was evil. Her evidence for these beliefs was that she had always believed she was evil, because her mother said so. She had done something as a small

girl, which she could not remember, and so she could not repent. Her mother had told her that God would punish her for this. In addition she thought she might have caused her mother's death because shortly before her mother died she had told her friend that she thought she might be dead by a certain date, and indeed she was. Her final proof of badness was that after her mother's death she had been sexually abused by her father, and had not dared to tell anyone in case the children were taken into care. The net result of all this was that for years if anything bad happened to her, she had assumed it was a punishment. Hence she feared that the accident had occurred to punish her. She was not blaming her driving – rather she believed that God had made it happen. Any intrusions from the crash were interpreted as premonitions that there could be another (worse) accident in the future, and this time someone might die.

The therapist began the process of Socratic questioning and guided discovery. Initially Pat resisted the idea that her view of God may have been coloured by the abusive behaviour of her mother. God was a parent, and her own had been very punitive, and led her to believe that God was also like that. Invoking New Testament stories of acceptance and forgiveness was again not helpful, as she could not remember her original 'crime' for which she believed she needed to repent. However, it did transpire that an aunt had recently told her that her mother was mentally ill, and the same aunt had always acted in a very loving way towards Pat and her brother and sister.

Pat was therefore willing to consider an alternative explanation for her mother's behaviour: maybe her condemnation of Pat had more to do with her own mental state than with Pat's sinfulness. Again, compassionate perspective-taking helped her address the issue of the intentions of others. In order to see whether Pat could remember more of the early traumatic memory that had haunted her since the car crash, the therapist asked her to relive the scenario that had made her mother so furious. Pat described being in the dining room with her sister, playing on the floor. Her mother came into the room, tripped over a teddy bear and spilled the food. She went into a total rage, and backed Pat into a corner, where she screamed at her that she had done something unforgivable, and God would punish her. Pat was visibly terrified as she relived the part where her mother's screaming face was in front of her. This was the only part she had been able to recall before doing the reliving. Now she suddenly realised that this had been her 'crime': she had simply left a toy in the way, and this had caused her mother to trip over! This came as a huge relief: with her adult perspective, having had children herself, she could see that it was a normal rather than an evil thing for a child to do, and that her mother's thinking had been distorted. She also now felt that this did not in itself constitute evidence of badness, nor would it be at all difficult for God to forgive.

However, for various reasons (possibly including those outlined above for Jill) her childhood feelings of desolation and terror remained. She felt small,

alone and helpless. It seemed as if she would never feel safe or comforted. The therapist felt that this was not a good place to leave the imagery, since only a partial change in the affect had been made. While Pat no longer believed she was evil, she still felt vulnerable and over-responsible for the other children, and what else might go wrong. There needed to be some acknowledgement that the way she was being treated was not an acceptable way to bring up a child, and that she needed to be nurtured herself.

To achieve this Pat felt it would be necessary for her mother to apologise to her, to explain why she had reacted so harshly, and to say that she did not want to keep hurting the children, but could not help it because of her own mental state. Pat tried to imagine this happening, but it did not ring true – it did not 'fit' for Pat. She was upset when she realised that her mother had never acted that way, and could not now, as she was dead, and only a memory. Some people are able to have an imaginary dialogue with a dead person, visualising what they might say if they could speak from the after-life, when they might have a different and more compassionate view of events than they had when they were alive. However, this did not work for Pat. The therapist wondered if it might be possible to introduce her aunt into the scene from childhood, and observe how she would react. This worked well: Pat imagined her aunt arriving, and telling Pat's mother that the way she was behaving was appalling. However, Pat continued to feel very nervous about the idea of calling the doctor or Social Services. This was because as her child self she feared that if the authorities were involved it might lead to the children being taken into care. Indeed, Pat feared that she might end up where her mother had always said she belonged – in the home for 'bad girls' just down the street.

The therapist asked Pat (as her child self) what she needed at that point. Pat said she needed to feel her mother hug her, but was sad because she knew this would never happen. However, she was able to restructure the image so that her aunt comforted and hugged her, and said she was really sorry that her mother was not capable of looking after her, because she was mentally ill. She would think seriously about what she could do to help the children, and perhaps they might be able to stay with her for a while. Again we see the key theme of the power-subordinated role, but in this case Pat (unlike Jill) wanted someone else (her aunt) to enact the dominant 'telling her mother off' behaviour. The therapist could have collaboratively helped her explore the advantages and disadvantages of imagining her aunt playing that role rather than taking it on herself.

Pat left the session feeling quite shaken, but no longer guilty or sad. She returned a week later, to report that she had done a tremendous amount of thinking. She had made a complete shift, and no longer thought she was evil. As noted by Gilbert & Irons (Chapter 10), self-blame can often be a safety belief that may be illuminated by a functional analysis. She had rethought all the incidents she had assumed were punishments from God, and now

considered that she had simply had an ordinary share of bad luck. On the first two nights after the imagery session she had nightmares in which her angry mother and the car crash had appeared somewhat mixed up together, and following that she had slept well and had not had any of her typical nightmares about the car crash. Her scores on the PTSD, anxiety and depression questionnaires had all dropped by half, and from that point onwards she made steady progress, and did very well. She was notably more self-reassuring, valuing and kinder to herself, and more optimistic about being viewed compassionately by others.

Compassion

Why might these two examples be seen as compassionate imagery work? Firstly, the therapist, although validating the patient's experience, invites a shift of perspective-taking with an invitation to re-evaluate others' intentions. If a person can come to a new compassionate understanding on these matters it can soften their felt sense of threat. Second, although this can be helpful, in both cases described the effects were limited. The collaborative therapist invites the person to go further and generate images of what they need, instead of remaining focused on evidence. In Jill's case she felt empowered to confront her parents' lack of judgement and make them feel sorry and care for her, and then went on to create her own soothing image. Pat needed to imagine having someone to protect her from her mother's fearful, shaming attacks, and then comfort her. The therapist is non-judgemental about these choices (of imagery role enactments), offers compassionate support, and by accepting them does not shame them (for example, implicitly signalling that 'It is OK to want your aunt to say those things'). As noted by Gilbert & Irons (Chapter 10), compassion can be empowering as well as soothing, and should not be seen as 'soft', 'weak', or 'fuzzy'.

Summary of stages in accessing and transforming a key early memory

- Explore the 'felt sense' in a recent, specific episode of the presenting problem, looking at thoughts, emotions, body sensations, images and impressions, and then (having summarised) asking 'What is the worst thing about that? What does that mean about you, other people and the world?'
- Enquire whether this type of imagery/felt sense is a recurrent experience, and if so enquire, 'When in your life do you first remember having the sort of experience you have just described, with similar thoughts, feelings and sensory experiences?'
- Ask if there is a particular memory from this time that seems to be associated with the present image or impression.

- Evoke a description of the early memory (reliving it in the first person, present tense). Unpack sensory detail, emotions and meanings given at the time, and now.
- Does the patient think that this experience may be colouring their experience in the present? Had they previously considered that there might be a connection?
- If the memory seems to have provided a significant input to recent experience, consider where the meanings given to it may have been distorted, using guided discovery and Socratic questioning.
- Attempt to help the patient arrive at a new perspective.
- If there is an intellectual shift but no emotional shift, consider methods of inserting the corrective information.
- If an imagery transformation is chosen, use the patient's creativity to plan a transformation incorporating realistic, compassionate appraisals of the situation.
- Try it out, by reliving the image from the new perspective.
- Be prepared to make several attempts.
- When the affect shifts, check belief ratings: there may need to be a further step in the imagery, to make certain that the child feels worthy of love and affection.
- Reflect with the patient on what they have learned from the imagery exercise, and what they now believe about themselves, the world and other people.
- Check if shift is maintained subsequently, and what the effects have been on the Axis I symptoms.
- Plan behavioural experiments to test the new perspective.

Discussion: How and why does this work?

In both the cases described above it appeared that a particular memory carried important, overgeneralised meanings, and coloured the experience of the present in a range of situations. The identified incident had occurred in each case more than four decades previously. Both patients were responding sub-optimally to treatment aimed at decreasing maintenance factors in a current Axis I problem.

A single intervention aimed at altering the higher order schematic meaning of the identified memory had large effects not only on thematically linked current beliefs, but also on symptoms, affect and behaviour in the present. In each case the material used to challenge the toxic meanings was (mostly) already in the autobiographical memory base of the patient. However, no attempts had previously been made to reflect on the extent to which the original meanings given to the event were realistic, fitted well with other significant information, or were distorted overgeneralisations.

Examples of this type of intervention are common in Axis II work (Arntz &

Weertman, 1999; Edwards, 1990; Layden *et al.*, 1993; Smucker *et al.*, 1995; Young, 1990). Descriptions of case examples prevail, associated with a variety of techniques and theoretical rationales, but research is very limited. However, Arntz and Weertman (2004) are currently running a controlled treatment trial comparing imagery interventions in key early memories with more typical schema-type interventions, in cognitive therapy for personality disorder.

Another parallel is with the treatment of single-event trauma. There appears to be a degree of consensus that following trauma intrusive memories may be sensory, fragmented, and stored with their original meanings, even if these were later contradicted by events. However, a multiplicity of theoretical frameworks and explanations involving findings from cognitive psychology exists, with three main current contenders. For an excellent review see Brewin & Holmes (2003). It is usually agreed that reliving serves a number of purposes, allowing for habituation, and providing opportunities for reflection on peri-traumatic appraisals, the development of a coherent narrative, and formation of new memories incorporating corrective and safety information.

If psychological interventions like this have a substantial impact, the effectiveness of the various components needs to be examined separately. Foa & Rothbaum (1998) have suggested that for fear-based intrusive memories in PTSD, merely activating the fear structure in a safe environment provides an opportunity not only for habituation, but also for reflection on detail, and the possible conclusion that the original negative evaluations were not consistent with all the available evidence. Brewin *et al.* (1996) suggest that repeated rehearsal in a new context, with some verbal restructuring of meaning, allows for the formation of distinctive verbally accessible memories (VAMs), which then compete with the original situationally accessible memories (SAMs) in the presence of situational cues. These new VAMs locate the danger in the past, while SAMs do not incorporate information about past versus present.

Ehlers & Clark (2000) suggest that deliberately prompting for change, so that the traumatic event is clearly seen as an exception rather than the basis for a rule, is of key importance. They suggest that while changes in meaning sometimes occur with reliving alone, the intervention may be more effective if deliberate efforts are made to insert corrective information, and update the memory, if this does not happen spontaneously. Imagery techniques are often very useful in this respect. Another effective procedure is to relive the memory and prompt for change by frequently enquiring what the patient knows now that would contradict the original meaning. The Ehlers & Clark model most closely fits the clinical case examples described above. There are empirical questions about the differential effects of reliving alone, reliving plus discussion, reliving plus restructuring meanings that are fed back into the memory by verbally prompting for a fresh perspective, or achieving this by using an imagery intervention.

There is a further question that concerns the extent to which the affect

needs to be shifted, and which appraisals need to be altered. When a child has been subjected to neglect or abuse, is it sufficient to arrive at a new perspective where alternative explanations for the inappropriate behaviour of significant others is sought? Or is it essential for the person to experience nurturing and compassion directed at the child self? Clinical experience suggests that the individual experiences a tremendous sense of relief if they experience this in an imagery exercise or role-play, as suggested by Arntz and Weertman (1999). This may be because it is possible to believe that adults treated one badly because they were disturbed themselves, or did not understand the child's needs, while still believing that the self was unlovable or not deserving of care and respect. To have these beliefs challenged in an imaginary scenario can have a powerful effect, particularly if it draws on memories of other loving or nurturing relationships that the child (or adult) experienced, so that the original traumatic experience can be seen as an exception rather than the basis for a rule.

There are many different theories about the power of compassionate imagery concerning being loved and cared for. One is that it changes meanings at both implicit and explicit levels and sets up new schematic representations of the self. Another (not incompatible view) is that of social mentality theory (Gilbert & Irons, Chapter 10). This suggests that stimulating images of being cared for recruits specific brain pathways. If one has never (or rarely) felt cared for, then experiencing this through imagery, and bringing on line the care system, could be powerful. This type of imagery may be tapping into innate processing systems that will respond to compassionate care signals.

A final question concerns the degree of repetition required to make the emotional shift. In both of these cases all the work was done in two or three sessions, and only one attempt was made to actually relive the transformed early memory. This shift was, however, followed by behavioural experiments, in which the two individuals went about testing how well they could be cared for in the present, and practised being assertive about their needs. Such experiments were more willingly undertaken once the imagery work had been completed. Imagery often does provide people with something akin to concrete experience, to which the 'experiential mind' is more receptive (Epstein, 1994). In some cases this type of work can be more difficult and might need more rehearsal in imagery and reality, if the person has few good memories to draw upon, or few good relationships in which to practise the new skills.

Implications for clinical practice

As mentioned in the introduction, a number of studies on recurrent imagery in Axis I disorders have provided information about associated upsetting childhood memories that still seem to be providing input into the 'felt sense' in the present. Many of these memories involve interpersonal interactions, which set the scene for the formation or consolidation of schemata about the

self in relationship to other people. Beliefs about unlovability, rejection and likely abuse or abandonment span the full range of disorders. As described above, in social phobia (Hackmann *et al.*, 2000) the sense of self-worth has been attacked through severe bullying or criticism. In agoraphobia the memories are often about separation, or emotional or physical abuse or neglect (Day *et al.*, 2004). In hypochondriasis people may have had experiences that make them doubt how well they would be cared for if they were ill, what it would be like to die, or how they would fare in an after-life (Wells & Hackmann, 1993). It has also been shown that in depression intrusive memories are very common, and are thematically linked to current issues of loss, illness, death and interpersonal disputes (Kuyken & Brewin, 1994; Reynolds & Brewin, 1999).

It would be interesting to research the effectiveness of targeting key early memories in Axis I disorders, using imagery techniques to explore new perspectives on old toxic meanings that have never been updated. It would be of special interest to study the healing effects of compassionate imagery as part of the package. It may well be that revisiting childhood memories in order to impart a sense of secure attachment, love and acceptance is a crucial ingredient in therapy, and that using compassionate imagery is a powerful vehicle for change.

Conclusion

Compassion involves a number of different qualities (Gilbert, Chapter 2). Many of the anxiety disorders are increasingly being linked to specific (traumatic) events, embedded in an insecure attachment relationship, where protection was absent, the parent was neglectful of the child's needs, or the parent was shaming, frightening or harming (Gillath *et al.*, Chapter 4). Imagery work allows the patient to revisit certain scenes from memory, which might act as schematic foci for meanings about the self and others. Through compassionate engagement with these scenes, some people can experience certain things they did not have at the time, such as a sense of being lovable, or being in control and able to be dominant in a relationship, rather than being subordinated and out of control. Using imagery with early memories, change may occur more swiftly than if one had relied exclusively on approaches focused on the 'here and now'. This type of imagery is also highly relational.

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Chapter 13

The expression of compassion in group cognitive therapy

Tony Bates

> Compassion is a human emotional and cognitive experience that does not happen to a single individual in isolation, but as a response to another sentient being. It is a process of external and internal reorientation that softens our sense of individuality bringing us into a felt relationship with the pain and needs of some other.
>
> (Harrington, 2002)

> From my own experience, coming from 20 years of self-loathing and hatred for the fact that I could not trust to tell anyone of the intense feelings of terror I felt while in the company of other people, my first experience of compassion had a profound effect on me, how I viewed myself and, more importantly, how I viewed others.
>
> (Group member)

Successful therapy acts by helping individuals to develop new and alternative strategies for relating to their inner world of meaning, emotion and bodily experience and to their social context. Change is evident when individuals encounter familiar predicaments in themselves and in their relations with others and transcend previously relied-upon patterns and strategies (Aveline, 1992). Many elements may contribute towards moving individuals beyond outworn and inflexible coping strategies; these are well documented throughout the literature on psychotherapy. This book proposes that directing the energy of compassion towards our given experience at any particular time is critical to transformation. For most individuals entering therapy, the only response available towards their unwanted thoughts, emotions and conflicts is one characterized by aversion, rumination and self-criticism. This self-rejection stance serves to lock people into cycles of self-defeating behaviours that perpetuate the very problems they are trying to resolve. Compassion denotes a particular response to pain that encourages an individual to disengage automatic responses to their inner mental states and be present to their pain in a different way. In this way it allows access to a wealth of personal resources for creatively resolving their difficulties.

Since compassion is a learned skill developed through observing and being treated with compassion in the context of relating with others, and through experiencing its power when we ourselves extend this to others, the process of group therapy is an ideal setting to observe its role in change. This chapter will describe the author's observations of compassion within the context of group cognitive therapy, drawing on a Dublin-based programme for people with social anxiety disorder and an inpatient group in an adult acute admission ward.

In terms of the social anxiety programme, we have, over the past five years, adapted the cognitive model of social phobia (Clark & Wells, 1995) to treating outpatients in a city centre mental health service (Cormack, 2000; Rohan, 1997). The precise steps involved in this treatment approach with individual patients are described in an earlier publication (Bates & Clark, 1998). The adaptation of this model to a group format presented unique challenges to integrating a specific cognitive therapy protocol with the therapeutic processes that operate within groups. Simply to present the cognitive protocol in a didactic way would have risked bypassing unique opportunities for change presented by the presence of other individuals, who individually and collectively constituted a tremendous resource for countering social anxiety. To incorporate and maximize the therapeutic benefits of the group context required flexibility in applying the model, with the attendant risk of allowing it to become lost in the complexities of group dynamics. Working with inpatients on the acute admissions ward has required a different kind of flexibility, since the constitution of the group varies weekly and the goals are more modest. Drawing on Yalom's (1995) model of therapy for acute inpatients, we have worked towards encouraging patients to address their 'here and now' experience of being hospitalized and to open up communication between them so as to ease the pain of isolation and allow them to discover the benefit of sharing their distress and of being heard and understood by others.

Our social anxiety groups run for two hours over 12 weeks, with follow-up contact at open monthly meetings for all recent and older graduates. Yalom (1995) has informed our understanding of how to create and sustain a therapeutic climate within our groups, and the model of intervention developed uniquely for social anxiety disorder by Clark & Wells (1995) and Butler (1999) has shaped the structure and content of our meetings. Also, we have recently incorporated elements of the mindfulness work of John Kabat-Zinn (Kabat-Zinn, 1994; Kabat-Zinn *et al.*, 1992) to foster a compassionate response to anxiety symptoms that serves to contain and calm anxiety reactions. Recent work of Wells (2000) and Teasdale *et al.* (2000) has encouraged our belief that mindfulness practice has unique relevance in the treatment of emotional disorders and can help to offset relapse beyond the life of the group.

The role of compassion in shaping the ethos of group therapy

To enter a group and explore one's personal vulnerabilities requires courage and a willingness to invest trust in others with whom one has, at least initially, no sense of safety. The threat posed in such an ambiguous and unpredictable situation naturally provokes key safety strategies to protect oneself and deflect any potentially hurtful reactions from others. For people with social phobia, there is the additional burden of threat due to the activation of traumatic memories of rejection and humiliation. These may be remembered bodily, or may intrude in the form of highly distressing images of being exposed publicly and found 'wanting' in some fundamental way. One cannot but respect the participant who resorts to whatever strategies he or she believes will safeguard against the recurrence of such experiences: silence, avoidance of eye contact, deflecting attention onto others, being critical of others for their non-participation, being superficial or comical to lighten anxieties and avoid closer exploration of one's difficulties, etc. Shame and denial form a callus around one's pain, and interactions with others are defensive rather than open. People come to groups with well-rehearsed scripts that reflect a compromise between their longing for proximity and acceptance and their abiding fear of exposure and rejection.

Safety and trust are emergent properties that develop through skilful leadership and guided interactions in the group, where risk on the part of one member begets the recognition and respect of others, and serves to reduce mistrust and fear of rejection. Compassion is one feature of group interaction that helps create this ethos of openness and honesty. Throughout the group process, it is modelled in the responses of the group leaders. Through empathy and gentle probing, followed by acknowledgement of the courage displayed in risking such openness, group leaders encourage risk-taking within the group. The modelling of acceptance and encouragement displayed by the leader sets the tone for how members relate to each other. Gradually, this style of interpersonal relating can become internalised as each member begins to relate compassionately to his or her personal struggles.

A common group response to someone who has expressed a series of self-attacking thoughts is that there is only one person in the room feeling this way. Feedback from others offers a very different perspective and models a different response. Alternatively, a leader might enquire whether the particular member is feeling as critical of others who have exposed similar shortcomings in the course of the session as they are of themselves. This gentle subverting of their aversion to their own vulnerabilities opens up new opportunities for practising self-acceptance. The capacity for self-empathy is critical to recovery and compassion for oneself, which requires practice and encouragement, and acts as an antidote to debilitating self-criticism and self-contempt (see Gilbert, Chapter 2).

In our experience of working with groups we have been struck by how participants are instinctively able to sense the texture of each other's distress and to respond with a sensitivity that can engage an individual to attend to their inner experience with a greater emotional depth. Often their responses to someone in distress greatly exceeded the quality of the group leader's comments. What was most striking was the accuracy of their intuition in terms of when to extend acceptance and solidarity and when to challenge that individual to move beyond constricting ways of relating to themselves and others.

Aideen was a 30-year-old woman who had emerged from a verbally aggressive and demanding family system with many residual doubts about her capacity to relate to others. Her presenting social anxiety symptoms included a disabling fear of 'freezing' when she made presentations at work. After her first group session, she completed a homework assignment where she had to write a brief account of what it had been like for her to attend the meeting. At the second session, she read out the following words and described how difficult it had been for her:

> I found it extremely difficult to come here. Everyone else looked at ease, I was on the verge of panic. I did my usual thing of trying to control my nervousness. When you're used to hiding your anxiety, it's pretty daunting to confront the problem head on. There was one other thing . . . *(hesitates)* I wondered would I have to become friendly with these people. Because for me, people mean nothing but hassle *(pauses, gets upset)* . . . they upset me, intimidate me and scare me *(becomes more upset but tenses noticeably to control it)*. I don't know why I'm feeling so upset, I wasn't upset coming in here. I am afraid of getting upset because I'm sick of getting upset.

She read the above quite quickly and silence followed. One of the group leaders sensed the intensity of her barely acknowledged affect and gently encouraged her to attend to her feelings and articulate her experience. This intervention met with resistance and the leader decided to draw on the group to connect with Aideen and not allow her retreat into a painful sense of isolation. Linda, another member of the group, spoke directly to Aideen and it was her warmth and compassion rather than the therapist's probing that opened out Aideen's deeper feelings and concerns.

Therapist: And how do you feel now?
Aideen: Slightly relieved but I'm still quite tense . . . *(Becomes silent and tightens up, avoiding eye contact with others)*
Therapist: *(To group)* I'm wondering what other people are feeling about what Aideen has shared?
Linda: *(leaning forward towards Aideen in a warm, gentle voice)* Thanks, Aideen . . .

Aideen: *(genuinely surprised and moved)* Oh thanks, that's really good to hear.

Linda: I have a daughter and she reminds me of you. And I think it's so great to be so young and to learn there is different way.

Aideen: *(her demeanour softening, becoming openly tearful)* That's so nice . . . All I ever hear is people, like my mother, telling me, 'I thought you were over that thing, is there something else wrong with you now?'

Linda: I would say your mother doesn't know any better, because I have a mother just like yours, and I still have a bad relationship with her. I'm at a point now where I just know she doesn't know any better. And it's hard, and you will cry many tears, because I have *(becoming slightly tearful)*, but I know I have to accept what is. It's hard, but *(looking at Aideen, smiling)* . . . you're here.

Aideen attempted to acknowledge Linda's feedback gratefully while maintaining her rather tense demeanour, but quite suddenly she lost composure and began to weep. She was moved by Linda's comment because it was such a different message to what she had grown up with at home. There, she was always expected to be more than she felt she could be, and now someone was extending a warmth and acceptance to her for being exactly who she was. Without saying a lot, Linda's feedback had sensitively curbed Aideen's anger at herself and allowed her to access a range of underlying vulnerable feelings that she was denying. Aideen's tension visibly melted and she became open and present to the group for the first time since our programme had begun.

Compassion is closely related to self-understanding through the course of therapy. One facilitates the other, as in the case of Aideen, who felt 'stupid' for being repeatedly distressed and upset, yet who discovered, through being accepted and listened to, that her distress was maintained by an unreasonable pressure to be 'perfect' emanating from both her internal and her external world. Understanding the mechanisms of one's distress produces a perceptual change in how the experience is evaluated. Gradually one makes sense to oneself and one learns to trust the validity of one's reactions. The client may also experience a compassion for what they have endured and a respect for their capacity to carry this pain for such a long time.

Compassion is communicated in the attitude the leaders bring to each encounter, and in the manner in which they use the inherent potential of the group to connect with each other's struggles and develop a confidence in their ability to use their own experience of suffering to extend care to another. This leadership function is critical to building a climate of trust and in turn a sense of cohesiveness within the group. Attention to practical and emotional issues acts in parallel to establish trust. Promptness, preparation of the meeting room and handouts, and checking in with members at each stage of the group process paralleled the criteria of secure attachment (reliability, consistency and warmth) and contributed to their feelings of

security and safety within the group. In addition, attention to these boundary details conveys a message to each of them that their distress is important and their recovery is worth fighting for. One member commented at the close of one of our programmes:

> I remember after the first day of group therapy being struck by the fact that T and F [group leaders] seemed to be genuinely interested in what it was like for me to live with extreme anxiety on a daily basis. For me to know that they cared was powerful. Here were 'other people' who didn't ridicule me for my fears or my behaviour. They wanted to listen to my story and it felt strangely safe for me to share it.

Compassion is expressed in the commitment of the leaders to each member and their willingness to proceed collaboratively rather than to impose a protocol rigidly. One therapist (FF) in our programme wrote:

> I see compassion as the foundation of our work with the group. Without it, our words are empty. It brings us to a level of contact with those who are vulnerable in a way that can transform deeply their beliefs about them being unworthy. It challenges, contradicts and confuses them at a level where they find it hard to refute the experience of their own importance. When compassion is picked up by others members of the group it carries even more power to release the grip of these core beliefs.

Expressions of compassion between group members

A group setting offers multiple opportunities for the leaders to encourage expressions of compassion between members and foster cohesion within the group. Allowing and asking for feedback; appreciating and acknowledging the significance of specific behavioural risks for particular individuals and marking such moments; reframing and promoting understandings of behaviour that can be irritating and challenging to members; and mobilizing the concern of members who want others to take full advantage of opportunities for trying new behaviours that create possibilities of self and others in a different way; each contributes to the goal of fostering a compassionate mind.

Feedback

Feedback between members can be offered quite spontaneously or specifically requested by the group leaders. Constructive feedback between group members generally carries more weight than anything the group leaders might say. It's all too easy for members to write off the latter, since their perception may be that leaders are obviously biased in terms of group members. At a mid-point in a social anxiety programme, David described his lifelong belief

that he was incompetent as one of his main reasons for wanting to be in our group. This had resulted from years of being criticized by a very aggressive father. Fearing criticism in the group, he had held back for a number of sessions before speaking openly about his fears. On one occasion he spontaneously broke silence to comfort another member in distress. Observing this, Lisa, a woman with a long-standing fear of blushing, remarked to David that he had an amazing gift for imparting strength to others and how important a 'leader' he was in the group. She added that watching him over the past number of weeks had been like 'watching a butterfly come out of his cocoon'. At the close of the group David identified her feedback as one of the highlights of the experience for him.

Within the group, leaders can encourage feedback between members through asking questions such as 'Does this story resonate with any of you?' or 'Who in this room do you feel could most readily (or least readily) understand what you have just shared with us?' Feedback is the life-force within group therapy, and even when poorly articulated can have a lasting and positive impact on the recipient. It has the potential to communicate compassion and transfer negative perceptions of self which are pivotal to shame and self-loathing.

Liam, in his early thirties, was crippled by a fear that he sweated and smelled under his arms. He wore only dark tee-shirts and always covered these with a further layer of clothing. Having listened to his tragic story of shame and personal isolation, we invited him to take off his heavy sweater one warm evening and see if he could allow himself to be more comfortable. He was extremely reluctant to take this step, but agreed to do so. His face revealed his profound embarrassment, and yet to all of us there were no sweat marks visible, and certainly no odour. This feedback from the leaders did little to reassure him, however, and he grew steadily more uncomfortable sitting in the room surrounded by others. He refuted all warm feedback he was given by the group in a manner that was hostile and defensive. Without drawing him out any further, I let the silence hang for a while and then I asked Helen, a lady in her forties who had remained quiet during this experiment, what she thought about Liam taking the risk to expose himself as he did. She spoke very movingly about how courageous she perceived him to be and how helpful and respectful he'd always been in his interactions with others in the group. Knowing that Helen's presence was prompted by her great fear of writing in a public situation, I invited her to go to the flip chart and write down the words with which she had described Liam. (In a previous session we had discussed her writing fear but she had declined an invitation to write on the flip chart, finding it too painful.) She hesitated, but only briefly, and walked silently to the top of the room, where she wrote in tiny script what she had already shared. When she had finished I thanked her and invited her to write her words once more, but this time in large 'oversize' script so that we could all clearly understand them. As she rewrote her feedback in this

way, Liam's gaze was locked on to her every gesture. It was clear that he felt for her, and that he was perhaps a little angry at my putting her through such an ordeal. After she finished I allowed the silence to hang once more in the room. Liam was the first to speak, this time in a gentle appreciative tone. He told her how very moved he was by what she had done. Turning to the leader, he said, 'Talk is cheap, but I know what that cost her and I can't deny she meant every word of it.' For both of them this was a transforming experience, where compassion for each other transcended their uneasiness and shame and freed them to be present in a new way to the group.

We have observed in both our inpatient and outpatient groups that feedback, like mercy, is twice blessed. It is as much a gift for the giver as for the recipient. The experience of group members having something to give to another member counters their pervasive sense of being of no value to others.

Marking moments of risk-taking behaviour

Deirdre, in her self-appointed role of group 'cheerleader', behaved in a classically avoidant way. She dressed immaculately and projected a confident and pleasant persona, but was remarkable for what she didn't say rather than for what she actually disclosed. She talked more than any of the others and deflected attention from herself by noting the behaviour of others and expressing concerns for what might be going on for them. In a very superficial way she reassured others that they were fine and that their problems could easily be resolved with a more 'positive attitude'. Her behaviour provoked a quiet annoyance in the other members and yet they relied on her to fill awkward silences and maintain a non-threatening superficiality in the room. As she grew more secure in the group, she arrived on one occasion in an obviously distressed but non-communicative state. The group didn't quite know how to respond and were themselves quieter than usual. When their attention was drawn to this tension of non-communication, one member, Maura, spoke about how they were all 'missing' Deirdre. They were unused to her being quiet and were conscious that she was upset. Gradually, they spoke directly and very gently to her, inviting her to open herself to the concern of others rather than feel she had to be always giving to them. Deirdre opened up for the first time about her fear of not being accepted and how lonely she felt living in a small town where she had established no real relationships. She kept repeating, 'There are so few people you can be honest with and you never really know when people are being honest with you.' The leaders marked the significance for Deirdre of countering her usual way of relating to others and risking such an honest disclosure of her vulnerabilities. Feedback from the group was generous and forthright, praising her for taking the risks she had taken and noting how much easier it was to relate to her when she was being real with them.

Compassionate reframing of self-defeating behaviours

Many studies have identified cohesiveness as a key predictor of successful outcome. Cartwright & Zander (1962) define cohesiveness as 'the resultant of all the forces acting on all the members to stay in the group' (p. 74). This amounts to the extent to which a group shares a sense of being bound together in some significant way and extending to each of its members a sense of belonging. This sense of cohesiveness within a group is widely believed to have a positive impact on voluntary attendance, participation, mutual help, and loyalty to the norms and values of the group (Hurley & Brooks, 1987; Wright & Duncan, 1986). Yalom (1995), in his review of research attempting to establish key therapeutic factors in group therapy, identifies 'cohesiveness' as the most recurrent predictive factor of successful outcome cited.

> Cohesiveness, the sheer experience of being a valued member of a group, may for some patients be the major vehicle for change; for others, cohesiveness provides the safety and support that allows one to explore oneself, to request interpersonal feedback, and to experiment with new behaviour.
>
> (Yalom, 1995: 71)

A cohesive group, Yalom believes, is largely shaped by the example of the leader in offering compassionate acceptance of individual difficulties as well as an appreciation of the strengths and courage that are evident in those same individuals. Yalom (1995) gives a very good illustration of this in his account of a woman who withheld personal information from the group for a long time before finally 'confessing' that she had spent some months in a psychiatric institution. On that occasion, Yalom observed a novice therapist responding in a reflexive and somewhat critical way with the comment 'Why haven't you told us this before?' The patient found this response quite punitive and shaming. It served to reinforce her fears and she did not disclose further regarding her experiences. A more compassionate response suggested by Yalom would have been to acknowledge the degree of trust in the group that the woman had finally achieved to enable her to disclose this information and also to acknowledge the strain that she must have experienced previously sitting with this in the group but feeling too frightened to share it. This latter style of response is not only effective in reinforcing disclosure behaviour, but may be critical to transforming core assumptions regarding what is acceptable to others.

Compassion alerts us to, and helps formulate, the deeper meaning of challenging behaviours exhibited by patients. Viewing behaviour in terms of its adaptive or protective functions is a core feature of cognitive therapy that promotes a more compassionate understanding of apparently dysfunctional behaviour. Susan, a lady in her late forties, exhibited a constant series of

dependent behaviours, much to the irritation of some others in the group. We invited the group to consider what might cause someone to persist with behaviours that were clearly self-defeating in terms of achieving acceptance and belonging in a group. This allowed the group to 'reframe' her behaviour in terms of her attempt to honour a very frustrated part of herself that had long desired a closeness with others but which she hadn't ever found in her relationships with family or friends. In cognitive terms, her behaviour was an expression of her assumption that she would never find what she needed from others unless she constantly demanded it. This changed the view of the group towards her: they now saw in her more compassionate terms, viewing her essential 'neediness' as an expression of a fear of rejection they each shared with her. Their understanding and acceptance of Susan had a calming effect on Susan, who could then be encouraged to try other less off-putting ways of accessing support.

Gentle persuasion

Compassion should not be viewed as merely an act of gentleness and kindness to others. It can confront another who is persisting with some self-defeating or self-harmful behaviours. While accepting the other in the reality of their here-and-now distress, it also communicates a strong faith in their ability to change. It seeks to bring understanding and clarity to the client's confusion and to encourage them to forgo self-defeating behaviours that serve to perpetuate their distress needlessly. Many members reach a point in our groups where they need a 'push' to tackle something they know they need to do, but are too frightened to try. Lucy, a woman in her mid-forties with a long-standing morbid fear of blushing, spoke repeatedly of wanting to take off her make-up even once in the group. She strenuously resisted this experiment when her opportunity to do so came, but the group cajoled her and refused to let her off the hook. They recognized instinctively that she would very likely write off the whole experience of the group afterwards if she backed off from this critical challenge. With 'gentle persuasion', motivated by a concern for her and not by any other agenda, she completed this video experiment and was quite elated by the sight of herself on video looking perfectly normal, in spite of a mildly elevated facial colour.

The impact of compassion in group therapy

Resolving painful emotional states involves a sequence of therapeutic tasks from *approaching* the pain through *allowing, experiencing* and *accepting* the pain as part of oneself (Greenberg & Paivio, 1997). The achievement of each of these tasks transforms how these feelings are evaluated by connecting the individual more deeply with themselves and others. There is both a release from feelings of alienation and demoralization and an emergent sense of one's

ability to 'go on', in spite of, and because of, this pain. The assumption that facing one's pain inevitably destroys the self modulates into a renewed appreciation of one's inherent resilience. What was avoided as unbearable has been faced, leaving the self strengthened rather than shattered. This releases the individual from the burden of constantly monitoring and inhibiting trauma-related cognitions and emotions (Pennebaker, 1990).

Compassion creates a context of safety 'where pain can unfold in a different way' (Chodron, 1997). It slows down the pace of confronting painful feelings, rather than pushing it with the risk of re-traumatizing the client. It conveys respect to the client that such working through of painful emotion is possible and important and imparts strength to undertake it. One man spoke the following words in one of our groups at the close of the programme:

> It was only when I came here and met up with other people who felt as I did, that I could see how distorted the image they had of themselves was. I could see it in you, but you couldn't see it in yourselves. And I realized no one should have to live one day of their life feeling this way, never mind 20 years or 25 years. When I think of the years of loneliness . . . No one ever asked me if I was doing OK. I was a child in an adult's world. I worked in a huge garage when I left school and found it terrifying. I often got upset in those years but I never let myself think about it until I got here. There were parts of my mind I could not go for years. Here I was able to lay it all bare and say to myself, you're great, you survived! I think everybody here is remarkable. The compassion you find here from people who know how you feel, it's amazing.

Awareness alone of inner mental states is not enough; people also need kindness to recruit resources in themselves that are imaginative, nurturing and empowering. Compassion engages the capacity to hold distress in awareness and allow it to unfold in a natural way. As Greenberg and Paivio (1997) described, it creates 'a place to stand from which to view the painful experience and how it was created' (p. 97). Compassion activates an adaptive schema that views those unwanted parts of oneself, all the parts that represent 'imperfection', as important aspects of personal identity. It allows the client to assemble in awareness the elements of both their difficulties and their strengths and creates the possibility for a transformation to occur in their regard for their suffering. In her work with borderline-personality related difficulties, Marsha Linehan describes this perspective as 'wise mind' (Linehan, 1994).

In our groups we use video feedback of clients in *in vivo* behavioural experiments to counter distorted constructions of themselves in performance situations (Bates & Clark, 1998). While we have always been impressed at the power of video feedback to offset these destructive images of self, we have also noticed an equally powerful impact of feedback that includes the group

member becoming upset in the course of their experiment. Initially we were reluctant to play back images that we feared would compound rather than correct their catastrophic predictions. To our surprise, we observed that the opposite more often occurred. Lucy, whose fears of being seen to blush drove her to engage in a daily ritual of layering on make-up for a minimum of two hours, caught herself on a video clip (featuring a role-play between two other members) with and without this safety behaviour. She was later impressed by how normal she looked without make-up, but on this occasion what struck her even more deeply was how sad and fearful she looked in the group with her make-up on. She talked about how inadequate she had been made to feel growing up and how miserable she had become over the years, expending enormous energy in focusing on one aspect of her personality that she believed she could control. Contrary to what we might have predicted, she was moved by these images of her discomfort to talk about her lifelong pain in trying to hide from others. It was a surprise to her that she felt both hurt and angry on her own behalf, and she realized how her terror of blushing had prevented a strong and capable woman from claiming the life that rightfully belonged to her.

In the experience of cognitive development and cognitive transformation, there are transitional experiences where an individual needs to consider and come to terms with aspects of their inner experience that are felt to be contradictory and poorly integrated with their self-concept. Winnicott (1965) describes these states of mind as states of being 'unintegrated', in contrast to states of integration or disintegration. Compassion provides containment through which the client can engage with elements of their experience that don't obviously fit together, for example their contradictory experiences of believing they must appear confident, yet feeling terrified of routine social encounters; experiences of believing one should have 'gotten over' a trauma, while being unexpectedly overwhelmed by situations that recall bodily memories of the event. Perhaps analogous to Winnicott's good mother, whose presence allows the child to play 'uninterrupted in the room', compassion facilitates the client exploring (processing) unintegrated elements of their inner experience until they can be assembled and related to one another in an integrated manner that bestows a more coherent sense of self.

Recovery, according to Teasdale's proposal, requires change at the level of felt experience for the client. 'It is not sufficient simply to gather data about experience, and evaluate beliefs against the evidence . . . it is necessary to arrange for actual experiences in which new or modified models are created' (Teasdale, 1997). Compassion generates an alternative way for clients to be with their distress. Teasdale affirms the potential of compassion to change the mind-in-place: 'It might be important to help clients, at times when they feel like total failures, to relate to themselves more gently and kindly, in that way creating a store of alternative models related to failure' (Teasdale, 1997: 90).

Viewing one's suffering through the lens of compassion can transform the meaning of that experience. In the language of the interacting cognitive subsystems model (Teasdale & Barnard, 1993), compassion works at the level of generic rather than specific meanings; changing the intuitive, holistic, felt sense of the total experience. It can affect an individual's relationship with self-as-subject, in contrast to challenging specific propositional meanings, which contain more objective information relating to the self-as-object. Change, in Teasdale's (1997) model, comes from a process of 'dis-identification', whereby an individual ceases to see their identity as enmeshed with their particular problems, and manages to achieve some internal stability that allows them to view their internal experiences from the vantage point of a witness. One member of our group described how compassion had given him a 'viewing tower' from which he could look safely at things when he became upset.

Another process that Teasdale and colleagues identify as tapping into the implicational affective–cognitive meaning involves the arousal of affect that serves to break the set of rigid depressogenic beliefs and to allow an individual access to a much richer way of understanding and creating new meanings for their recurrent difficulties. Lucy's reaction to seeing her intense discomfort caught unintentionally on a video clip, and Helen's 'written' feedback to Liam, are examples of how compassionate feedback can provoke strong feelings that alter perceptions. Table 13.1 summarizes some of the ways in which we have observed compassion to impact on group members.

Yalom (1995) has identified 11 curative factors in group therapy. While they are listed as separate entities, they are 'intricately interdependent'. The relative importance of different factors depends to a great extent on the type of group, the specific objectives it sets for itself, the particular stage of development it has achieved, and the needs and intellectual and social skills of the members. In earlier research on these therapeutic factors predictive of successful outcome, Yalom *et al.* (1968), employing a Q-sort methodology with 60 items, found that the item rated most highly by patients was one they called 'discovering and accepting previously unknown or unacceptable parts of myself'. Patients reported feeling a greater sense of vitality when they were able to integrate and express previously dissociated aspects of their experience. When Yalom investigated more specifically with participants in the study what this item reflected for them, he found to his surprise that more often than not participants had discovered positive strengths in their personalities that had never been previously acknowledged: 'the ability to care for another, to relate closely to others, to experience compassion' (Yalom, 1995).

Table 13.1 How compassion can transform experiences of distress

Reduces felt sense of being alone
The warmth and acceptance that are extended to another in compassion counter feelings of isolation, bringing the sufferer back into relationship with another.

Softening of aversive reactions to pain
Our reaction to suffering is typically characterized by fear, tension and aversion/avoidance. Fear compounds the client's overall experience of distress and makes exploration of their inner world difficult. Compassion softens an individual's reaction to their own troubled experience and allows them to move towards it without resentment.

Dis-identification with symptoms
The sufferer begins to separate their sense of identity from being enmeshed with specific symptoms or problems, and to see themselves as someone worthy of concern with difficulties that others can appreciate and relate to, as well as resilience that they have failed to acknowledge in themselves.

Arousal of alternative affect
Compassion arouses alternative affect (e.g. sadness, hurt) that disengages locked-in beliefs that hold the individual in a state of shame, fear, and demoralization and creates potential for new meaning.

Creates a spaciousness around problems
Shifts attention from specific focused concern with some particular aspect of a problem towards a broader appreciation of both the individual's suffering and their resources. Facilitates a more panoramic perspective rather than the constricted attentional focus that anxiety and depression generate.

Opposes the essence of social anxiety
Compassion reduces shame, frees the sufferer from the internal compulsion to conceal their vulnerability, and creates the conditions whereby they can own and reveal their experience as it unfolds.

Compassion and the group leader

> Successful therapists generally possess an especial capacity for identifying with the insulted and the injured . . . psychotherapists often have some personal knowledge of what it is to be insulted and injured, a kind of knowledge they would rather be without, but which actually extends the range of their compassion.
>
> (Storr, 1979)

In his valuable collection of papers on the theory and practice of group therapy established within the Nottingham Psychotherapy Unit, Mark Aveline (1992) includes a particularly sensitive account of his work with healthcare professionals to whom he offered a 12-week programme. His account reveals the extent of personal tragedy that lay close beneath the

surface of their competence. In line with the findings of McCarley (1975), he identified three dominant themes reported by individuals at the coal-face of psychiatry: an oppressive feeling of being overwhelmed by the responsibilities of caring; a realization of how they were so burdened by their own self-worth's stipulation that they should constantly give to others, and an inner sense of deprivation. Aveline's account highlighted the vulnerability of all professionals struggling long-term 'with the blunt instruments of therapy against the unyielding clay of illness, inhibited personality and social systems' (p. 130). For therapists, this work holds the potential for personal development as well as for the wearing down of morale and self-esteem. To function continuously in the role of compassionate witness to the suffering of others requires that therapists consider their personal need of resources and practices that can sustain them. At the very least, therapists need to equip themselves with a philosophy that embraces both the inevitability of suffering and the inherent resilience of human beings to overcome life's obstacles and challenges. Group work confronts the leader with infinite examples of both. To be present in a compassionate way to members suggests that they are opening themselves to the impact of these stories and consequently to being personally affected by them. In our groups there are always at least two conductors, and time is taken before and after each meeting to prepare and debrief from the impact of the session. The openness between conductors sets up an important protective factor for all our programmes. Negative feelings of competitiveness and mild 'resentments' at being excluded from a particular interaction or not having one's suggestions picked up by a co-leader arise in the course of group work, and success is significantly dependent on attaining the degree of honesty that allows for all feelings provoked in the course of any given session.

Among the many opportunities these pre- and post-session discussions provide in which a particular observation made by one of the leaders can affirm an important moment that may have gone unnoticed by the others. Typically one of the conductors might note the impact of some comment made by a member for the particular significance it held for the group. Compassion attunes us more precisely to the significance of the personal struggle it can be for people to attend therapy, to disclose their inner experience and to risk new behaviours both in and outside the session. It attunes the therapist to the courage such disclosures can require, even if the content objectively seems neither startling nor unexpected. Good practice recognizes disclosures that mark a deepening trust and merit comment. Acknowledgement of risk-taking on the part of a member conveys respect and encouragement, which strengthens the alliance and enhances the likelihood of continued engagement and self-exploration.

Group therapy interventions cover myriad techniques designed to encourage commitment, self-disclosure, risk-taking and openness to learning from interaction and feedback. Interpretation, formulation and customized

behavioural experiments all feature throughout the group programme and require careful planning to maximize what can be achieved within the time-limits of a 12-week course. Compassion informs this complex undertaking and is critical for the creation of a safe, cohesive working group that can embrace difficulties with a certain curiosity and playfulness. Another vital resource for leaders (and members) is a capacity to see humour in the midst of struggle. This is not to advocate a type of humour that minimizes or avoids distress, but rather a sense of humour that allows and encourages a playful relationship with one's symptoms. Part of the spaciousness that compassion brings to group process is its utter acceptance as normal and human that people become entrenched in behaviours that maintain and bring about the very nightmares they seek to avoid.

Our groups are characterized by laughter as much as by the silent acknowledgement of tragedy and psycho-education. To analyse and contemplate coldly the components of an emotional disorder can be a rather grim and depressing exercise. Therapists and clients can unravel the intricacies of problems in developmental and functional terms, but become easily daunted by the prospect of change. The danger with cold, critical analysis is that it can leave an individual with new ammunition to use against themselves: 'Look at the way I think, (feel, behave), it's so stupid.' Compassion complements insight in important ways, at times through silence and deep empathy and at times through encouraging an appreciation of the ironies revealed in our formulations. The capacity to 'lighten up' when faced over and over with the same painful dilemmas is a wonderful resource for leaders and members in a group. The message becomes one of hope: 'I may be crazy but I see clearly what I'm doing and I see the funny side of it.' Humour bonds a group as members see their own human frailty played out in the idiosyncrasies of the others and come to accept that this is indeed the nature of being human, not some aberration of which they alone are guilty. Humour counters inflexibility and opens individuals up to a compassionate acceptance of all that's right and not so right in themselves, others and the world in which they live.

Pema Chodron (1997) describes the emphasis in Buddhism on balancing 'clear seeing' with 'loving-kindness' (which includes humour) towards the self:

> There's an interesting transition that occurs naturally and spontaneously. We begin to find that, to the degree that there is bravery in ourselves – the willingness to look, to point directly at our own hearts – and the degree that there is kindness towards ourselves, there is confidence that we can actually forget ourselves and open to the world . . . to the degree that we can look clearly and compassionately at ourselves, we feel confident and fearless about looking into someone else's eyes,
>
> (Chodron, 1997)

Compassion encourages a kindness towards the self that will inevitably succumb to long-standing habits that lead to becoming distressed when confronted with threat. It softens individuals their reaction to themselves and encourages a tolerance for imperfection and failure, which, like suffering, are unavoidable. Growth and maturity are facilitated through the development of this different way of relating to the self and others. This carries the individual forward as the group comes to a close and the loss of companionship is deeply felt, but where new possibilities of engagement with the world open up on the horizon.

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