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ARTICLE *in* INTERNATIONAL JOURNAL OF COGNITIVE THERAPY · JUNE 2010

Impact Factor: 0.98 · DOI: 10.1521/ijct.2010.3.2.186

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International Journal of Cognitive Therapy, 3(2), 186–201, 2010

A Compassion Focused Model of Recovery after Psychosis

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People recovering from psychosis can show of range of problems in their ability to experience certain kinds of emotion and drive. There can also be a lot of shame and stigma around the experience of having suffered a psychosis. CFT is based on a model of affect regulation derived from neuroscience and evolutionary psychology and is particularly suited to exploring the difficulties in recovering from psychosis and offering compassion-focused interventions. In addition it was designed for people with high levels of shame and self-criticism, a common feature in some people recovering from psychosis. This article will explore the application of CFT as a way of conceptualizing some of the difficulties of psychosis and outline some potentially useful interventions.

It has been known since the early years of psychiatry that an "acute curable" psychosis became "chronic" when the affects began to disappear.

—Eugene Bleuler (1950, p. 40)

There is a *"paradox of emotion"* in schizophrenia (Aleman & Kahn, 2005, p. 287). On the one hand we observe an excess of affect associated with the emergence of acute psychosis often characterized by a hypersensitivity to threat. On the other hand we see a diminution of affect characterized by affective flattening and impaired perception and expression of affect. Arguably, therefore, dysregulation of affect defines the core problems of schizophrenia and emotional recovery lies at the heart of functional and symptomatic recovery. Building on the work of Bleuler and others (Jung, 1976; Semrad & Van Buskirk, 1969), Garfield (1995) argued that unbearable affect is at the

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core of psychosis and that recovery involves the processes of acknowledging, bearing, and putting in perspective the intolerable emotions which often have their origins in early development. Therefore, in order to best respond to the needs of individuals experiencing psychosis, it is important to understand the developmental, interpersonal, and cognitive determinants of emotional recovery and affect (dys)regulation.

The five years after the first episode of psychosis is the critical period that determines long-term outcome (Birchwood, Todd, & Jackson, 1998). Relapse is a crucial factor in determining long-term course, occurring in 20-35% at one year, 50-65% at 2 years, and 80% at 5 years (Robinson et al., 1999). Recovery from subsequent episodes of psychosis is less satisfactory than the first with the emergence of persistent and distressing psychotic experiences (Wiersma, Nienhuis, Slooff, & Giel, 1998). Relapse also provides the basis for development of demoralization and entrapment, and has been linked to compromised emotional adaptation following psychosis (Birchwood, Iqbal, Chadwick, & Trower, 2000). People with psychosis, who feel unable to prevent relapse, are more likely to develop depression (Birchwood, Mason, MacMillan, & Healy, 1993) and social anxiety (Gumley, O'Grady, Power, & Schwannauer, 2004). Such negative feelings are grounded in the reality of individuals' experiences of their psychosis. These feelings are associated with persisting psychosis, involuntary admission, heightened awareness of the negative consequences and stigma of psychosis, being out of work, and loss of social status and friendships (Rooke & Birchwood, 1998). People can feel marginalized, stigmatized, and ashamed of their psychosis leading to social withdrawal (Birchwood et al., 2006; Gumley, 2007). Social avoidance, due to fear or shame, has a major impact on abilities to generate positive emotion, because social relationships are a main source of positive affect (Cozolino, 2007, 2008) and affect regulation (Gilbert, 2009).

COGNITIVE BEHAVIORAL THERAPY FOR PSYCHOSIS

Despite evidence for the effectiveness of Cognitive Behavioral Therapy for psychosis (CBTp) in alleviating persistent and distressing psychotic experiences, the evidence concerning the prevention of relapse is disappointing (Wykes, Steel, Everitt, & Tarrier, 2008). Most recently, Garety et al. (2008) did not find that CBTp reduced rates of relapse or improved rates of remission at 12 or 24 months (although for individuals living with the support of a cargiver there was improvement in delusional distress and social functioning—highlighting the importance of helpful relationships). Several reasons for these largely negative findings were proposed. First, in terms of sampling, those randomized were all persons admitted to hospital following an acute relapse or exacerbation. Many of these individuals were responsive but non-adherent to medication and thus showed a rapid response to the reinstitution of antipsychotic treatment. Second, many did not overtly seek out psychological therapy and may have had a tendency to avoid their experiences (Tait, Birchwood, & Trower, 2003). Third, this was a trial of generic CBTp (Fowler, Garety, & Kuipers, 1995) based on a general psychological model of psychotic symptoms (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001) and the trial therapists reported that it was sometimes difficult, in the absence of symptoms or of distress, to maintain a clear focus on the positive psychotic symptoms.

A therapeutic focus on psychotic experiences for the purposes of relapse prevention focusing attention on the "end stage" of the relapse process is usually too late.

Also, when relapse prevention is delivered based on a model where positive symptoms are the main focus there may be systemic and organizational responses that impede successful intervention. Gumley and Park (in press) described the "*relapse dance*" to characterize the cycle of unsuccessful, thwarted, or aborted help seeking and relapse. Given the traumatic and distressing nature of psychosis, feelings of needing help and help seeking itself may produce fearful expectations. Individuals may fear increased medication, re-hospitalization, and involuntary procedures. Individuals might also experience feelings of shame, guilt, and embarrassment in relation to disappointing or letting down their caseworker or their loved ones. Gumley (2007) showed how, in comparison to non-relapsers, individuals who experience relapse reported increasing feelings of self-blame and shame in relation to their psychosis over a period of 12 months. It is understandable that individuals find help seeking a challenge and may have experienced their relationships and previous interactions with others (including clinicians) as critical, shaming, overpowering, or rejecting. Thus, by having a therapeutic focus on early signs alone we create an expectation of individuals to seek help in the context of high levels of distress, a context that for some individuals can outstrip internal and external resources. This may result in a defensive avoidance or delay in seeking help—an observation that is particularly relevant for those individuals already experiencing a more protracted and complex recovery. Delayed help seeking may unintentionally result in clients adopting more crisis-driven responses to the threat of relapse, thus confirming the person's negative expectations and increasing feelings of lack of control and entrapment in illness, potentially creating a toxic cycle. Instead, we suggest that successful relapse prevention requires a therapeutic focus on affect regulation processes, especially those relating to social relating, their developmental origins and interpersonal context rather than a sole focus on psychotic symptoms. Intrinsic to this approach is an appreciation of the implications of social mentality theory.

SOCIAL MENTALITY THEORY

Since psychosis involves intense feelings of threat it is important to link our models of psychosis to current understanding of threat detection and processing. All living organizms need to be able to detect threats and defend themselves. Mammals have a range of evolved defences that include alerting and orientating emotions such as anger and anxiety, and behaviors including fight, flight, freeze, and faint. These are part of innate threat-defence systems that can be quickly triggered and easily conditioned (see Gilbert, 2010, this issue; Welford, 2010, this issue). However, as recent neuroscience makes clear (Depue & Morrone-Strupinsky, 2005) and as is utilized in Gilbert's (2005, 2009) three systems affect regulation model, there are also two types of positive affect. One underpins drive and abilities to pursue rewards and incentives; the other underpins contentment and links to attachment systems of soothing and peaceful well-being (Gilbert, 2005, 2009, 2010, this issue). This "soothing" system, which is linked to endorphin and oxytocin systems can down regulate threat systems (Kirsch, Esslinger, Chen et al., 2005). For example, prototypically when a child is distressed, he or she returns to a caregiver who comforts the child. This sooths the child and enables a return to exploration and play. Thus it is important to make the distinction between the absence of threats and the presence of cues that signal safeness and impact on threat processing systems (Gilbert, 2005, 2009). Furthermore, the loss of contact with the signals of safeness (e.g., loss of contact with the mother)

will activate the threat system (Bowlby, 1988). Crucially, supportive relationships are a major source of well-being; that is the freedom to explore, autonomous states if mind and feelings of safeness emerge in the context of a secure attachment (Bowlby, 1988; Meins, Fernyhough, Russell, & Clark, 1998).

Gilbert (1989, 2005, 2009) has proposed that to act competently within any social role—our motives, emotions, attentional focus, thinking, and behavioral outputs have to be coordinated and integrated appropriately. This organizing principle, of coordinating these different psychobiological processes for the *purpose of creating a particular type of relationship* is labelled a social mentality. Social mentalities track and adjust appropriate psychobiological processes in line with dynamic reciprocal interactions (Gilbert & McGuire 1998). Following from Gilbert's (1989, 2005, 2009) model each social role pursued—be it closeness to a parent, development of a friendship seeking out sexual partners, or pursuing status—will be evaluated in terms of the threat posed, the potential rewards, and the availability of safeness (e.g., as conferred by affiliative support).

The *threat-defence* system is activated in situations of perceived and actual threat. For example, a socially ranked relationship may provide a source of threat, whereby dominant individuals will issue commands and hold power, while subordinates will have to respond to those commands usually with internal inhibition of certain types of positive affect (e.g., those linked to excitement or confidence) and be submissive. Social mentality theory states that the social mentalities that are used for processing social information (e.g., caring or condemning) to pursue specific goals can also be sources of self-evaluation. So role relationships that exist between people can also exist *within* people and arise from internal working models of early relationships. Therefore, human beings can internalize the voice of a critical other and develop submissive/subordinate responses to this. Basically we can be friendly and affiliative to ourselves or hostile and critical of ourselves—and the emotional textures of self-to-self relating impact on neurophysiological systems (Longe et al., 2009).

Developmentally informed theories help us understand the impact of early attachments on adult psychopathology and hence the development of safe(ness) or threat-focused social mentalities. A secure attachment facilitates the development of internal working models of others as "safe, helpful, and supportive" (Sroufe, 1996) and influence the ability to develop safe, and secure adult relationships (Bowlby, 1988). This enables people to turn to others for emotional sharing, pleasure, and self-validation, but also when distressed be able to elicit support and soothing. Crucially, internal working models also help individuals to develop self-soothing and compassionate behaviors toward themselves and others, activating the *safe(ness)* and soothing system. Gilbert (2005) refers to two consequences that result when parents are unable to create (and stimulate) safeness, are threatening or shaming and do not convey warmth: first, the *under-stimulation* of positive affect associated with affiliation caring and warmth systems; and second, the child is more likely to be *threat focused*, seeing others as a source of threat. Subsequently, they are more sensitive to the power of others and thus social rank, especially the power of others to control, hurt, or reject them. Sloman (2000) and Sloman, Gilbert, and Hasey (2003) have shown that those who have not been able to internalize a sense of warmth (were unable to stimulate positive affect in the mind of others for the self—for example, due to parental depression) and who feel unloved by others, can set out on quests to earn their place, becoming excessively competitive and sensitive to rejection (Gilbert, Broomhead, Irons, et al., 2007; Gilbert, McKwen, & Irons et al., 2009).

RECOVERY AFTER PSYCHOSIS: A REFORMULATION

Underpinned by the theoretical perspectives outlined above, we present a reformulation of the barriers and obstacles to emotional recovery and staying well after psychosis (See Figure 1 below). Formulation can be contextual, lies within the three affect regulation systems (Welford, this issue), and also in the more diagrammatic form as shown in Figure 1 (see also Lowens, this issue). In our reformulation we recognze the importance of the interplay between early developmental experiences (and their implications for the organization of attachment, affect regulation, and interpersonal functioning) and the role of subsequent stressful life events (including psychosis) in shaping individuals' vulnerability and resilience.

THE INTERPERSONAL ENVIRONMENT AND BACKGROUND EXPERIENCES

Good premorbid child and adolescent social, academic, and emotional adjustment is a predictor of better outcome after first episode psychosis (Torgalsboen, 1999). This is independent of duration of untreated psychosis (Marshall et al., 2005). Conversely, poor premorbid adjustment predicts poor outcome (see Macbeth & Gumley, 2008). Furthermore, the background experiences of those experiencing psychosis are an important factor in determining vulnerability to psychosis itself and the recovery trajectories emerging after the first episode. Life events such as sexual abuse, homelessness, assault, and being in care (Bebbington et al., 2004) predict risk of developing psychosis, even after controlling for mood, substance use, and interdependence of life events. In addition, it is now well established that rates of trauma including childhood sexual abuse are prevalent in persons diagnosed with schizophrenia (Read, van Os, Morrison, & Ross, 2005).

These risk factors can be viewed as psychologically toxic to the integrity of the safe-soothing affiliative positive affect systems, via the threat posed to attachment security. Attachment organization is unstable over the longer term in high-risk populations. Maintenance of attachment insecurity and transition from attachment security is predicted by stressful life events (Weinfield, Whaley, & Egeland, 2004). In our terms—the soothing system is just not robust enough to regulate threat processing. Therefore it is significant that the AESOP study (Morgan et al., 2007) found that separation from, and death of, a parent before the age of 16 were both strongly associated with a two- to threefold increased risk of psychosis. There is also evidence to suggest that attachment security may be compromised or even disorganized in infants who are later diagnosed with schizophrenia. Mothers of persons who go on to be diagnosed with schizophrenia are more likely to have experienced loss or trauma in the 2 years prior to or after childbirth (Pasquini et al., 2002). In addition, there is evidence that being "an unwanted child" increases risk of becoming psychotic in later life (Myhrman, Rantakallio, Isohanni, Jones, & Partanen, 1996). These life events and risk factors are also known to lead to the collapse and disorganization of attachment, characterized by impaired mentalization, fragmentation, dissociation, and segmentation of episodic memories, and use of competing and inconsistent coping responses (Liotti & Gumley, 2008; Read & Gumley, 2008). These also may stunt development of the "soothing" system (Cozolino, 2007)

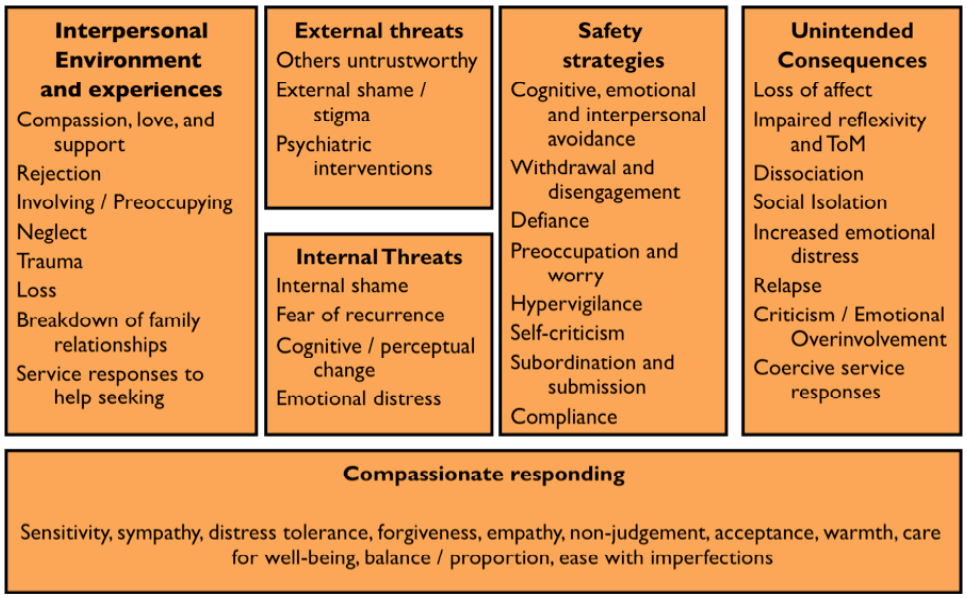

FIGURE 1. A compassion focused formulation.

With regard to the threat system, feelings of paranoia and social anxiety are commonplace among those who later go on to develop psychosis. For example, in a large cohort study Malmberg, Lewis, David, and Allebeck (1998) found that a combination of interpersonal and affiliative problems including difficulty mixing in groups, having few friends, feeling more sensitive than others and not having a girlfriend were associated with an increased risk of developing schizophrenia. Jones, Rodgers, Murray, and Marmot (1994) in a birth cohort study found that sel-reported social anxiety at age 13 and teacher-rated social anxiety at age 15 was associated with an increased risk of developing schizophrenia in adulthood.

The connection between attachment (dis)organization, interpersonal functioning and utilization of social supports is important for understanding the complex interplay of developmental, interpersonal, and life events in the unfolding of psychopathology. Insecure states of mind are associated with more negative representations of supportive behavior (Sarason et al., 1991) lower perceptions of support, and lower utilization of available supports (Ognibene & Collins, 1998). Mikulincer and Florian (1997) found that conversing with a close other about the emotional and instrumental aspects of a stressful and distressing event reduced negative affect among secure individuals whereas avoidant individuals appeared to benefit only from instrumental support in the same condition and anxious/ ambivalent individuals showed increased negative affect in the condition of emotional support being offered. Recent evidence shows that attachment insecurity is associated with the use of avoidant coping strategies, which correlate with problematic service engagement including lack of help seeking (Tait et al., 2003; Tait, Birchwood, & Trower, 2004). Using the Adult Attachment Interview, Dozier and colleagues (1990; Dozier & Lee, 1995; Dozier & Lomax, 1994; Dozier, Lomax, Lee, & Spring 2001) have shown that psychosis is associated with an insecure avoidant attachment organization characterized by a closing off of affect and episodic memories associated with affect. This attachment organization is associated with minimization of symptoms, reduced help seeking, which in turn seems to be associated

with greater caseworker and family anxiety. In addition, most of these interviews were also classified as unresolved with respect to loss or trauma. It is significant that such a sealed off/avoidant style of affect regulation is likely to locate greater anxiety in busy case workers and may produce greater use of more catastrophic or coercive strategies in community-based teams thus maintaining a sense of relational insecurity and entrenched nonengagement. Thus to the clients avoidance the case worker pursues more (out of fear of oncoming relapse) leading to feeling of threat in both pursuer and pursued. The threat systems, rather than the affiliative systems, are thus activated within the relationships and can form the basis for reciprocal interactions.

KEY THREATS AND THEIR IMPORTANCE TO RELAPSE PREVENTION AND EMOTIONAL RECOVERY

As discussed above, feelings of fear, depression, helplessness, hopelessness, embarrassment, loss, humiliation, and shame are common in problematic adaptation to psychosis (Birchwood et al., 2000). These findings also show the importance of internally focused fears where individuals may experience feelings of shame and fear in response to the return of physiological, emotional, or cognitive-perceptual experiences signaling the potential for relapse (Gumley, White, & Power, 1999). These emotional responses often arise in the context of the emergence of low level psychotic-like experiences including threat focused cognitive perceptual anomalies, hearing voices, suspiciousness, and interpersonal sensitivity. These experiences have sensitivity but not specificity for relapse. While most relapses are preceded by these experiences, the occurrence of low-level psychotic experiences in combination with affective distress does not necessarily lead to a relapse. Therefore it is more appropriate to consider early signs of relapse as an *"at risk mental state"* marked by the threat of recurrence. The way in which a person responds to this threat will thus shape the intensity of emotional distress, mediating outcome. For example, maintaining a reflective awareness characterized by a non-catastrophic reaction combined with productive coping and recruitment of instrumental and emotional support from others is likely to decelerate and/or prevent relapse. Key then is whether people turn toward or away from potential supportive others; this may link with previous experiences.

Indeed, for many individuals the threat of relapse can lead to catastrophic expectations and a disorganization of the person's coping responses. It is now established that the experience of psychosis is traumatic and associated with the development of psychosis-related posttraumatic stress disorder—characterized by intrusive memories linked to the experience of psychosis, hypervigilance and fear, and sealing off and avoidance (Shaw, McFarlane, Brookless, & Air, 2002). The threat of recurrence of psychosis is therefore likely to generate contradictory and disorganizing reactions such as catastrophic appraisals of relapse, fear, vigilance, and interpersonal threat sensitivity on the one hand, and cognitive, emotional, and behavioral avoidance and delayed help seeking on the other (Gumley & Macbeth, 2006). Fear of relapse has been previously identified in retrospective studies of the phenomenology of early relapse (e.g., Herz & Melville, 1980).

We investigated the sensitivity and specificity of *fear of recurrence* to relapse in a large 2-centre randomised controlled trial of relapse detection, which compared fortnightly monitoring of fear of recurrence versus fortnightly monitoring of symptoms of relapse. Both approaches were equally sensitive in detecting recurrence in the 2 weeks

prior to relapse (Gumley et al., in press). Crucially optimal detection of relapse was in the 2 weeks prior to recurrence showing that the window of intervention is limited and delayed detection or help seeking is liable to increase likelihood of recurrence.

Although delayed help seeking can be conceptualized as a defensive response to the threat of relapse, there is an accompanying probability that this unintentionally increases the likelihood of increased severity of psychotic experiences, admission to hospital and use of involuntary procedures thus fulfilling catastrophic expectations. So, for those who have experienced psychosis, psychotic experiences and their associations represent a source of threat. Indeed, some studies have suggested that the methods used to treat psychosis may also be partly responsible (Frame & Morrison, 2001; McGorry et al., 1991). Psychosis can also evoke feelings of loss (e.g., loss or disruption in important attachments or friendships) or events that threaten an individual's social rank, value, or acceptance (e.g., feeling subordinated, shamed, or humiliated by an episode of psychosis; subject to pity, fear, or exclusion by others) are depressogenic via their impact on the lowering of perceived self-esteem and social status. Individuals, who develop depression and suicidal thinking following psychosis, appraise this life event as representing a humiliating threat to their future status (a reason why others would want to avoid, reject, or exclude them), leading to the loss of a sense of personal value in various social roles (Birchwood et al., 2006). In addition one may fear one cannot escape this fate due to actual or feared relapse, or indeed persistent symptoms (Birchwood, Iqbal, Chadwick & Trower, 2000; Birchwood, Mason, MacMillan, & Healy, 1993). We have also found that feelings of entrapment and low self-esteem characterize social anxiety in persons diagnosed with schizophrenia (Gumley et al., 2004) and that feelings of entrapment predict a variety of anxiety and affective disorders which are co-occurring with psychosis. Gumley et al. (2006) found that relapse was associated with greater feelings of self-blame and shame.

If we consider this in the social mentalities model we can see that threat activation arises from many sources, but the availability of safeness and soothing cues are few. Threat comes from changes in feelings, sensations and intrusions, fear of their meaning and where these will lead; there many be activation of trauma memories of previous episodes (including recall of how terrorized one felt and the hospitalization). There may be fear of revealing to others and increasing distrust. Others can be seen as powerful-dominant with malevolent intent. In addition self-critical feelings, thoughts, and "voices" can arise and the internal self-attacking thoughts may further stimulate threat processing (Longe et al., 2009). Neither inside nor outside is there any source of safeness or "soothing" to impact on the threat system; rather the threat system is being severely overstimulated.

Outlined this way it becomes clear that we must not just consider how to reduce a sense of threat but also need to activate the safeness system. Relapse detection and prevention relies heavily on the presence of a productive and secure working relationship between people with psychosis and care providers including health professionals. This fact is not lost on clients who value services as a secure base for exploration and proximity seeking. This provides us with an important link to the developmental and interpersonal roots of affect regulation (or dysregulation) based on the organization (or disorganization) of attachment representations, and organization threat-safeness processing, and social mentalities. Once it is clear that the absence of threat is not the same as the presence of safeness, that safeness has it own major complex physiological systems (e.g., Porges, 2003, 2007), then this informs us about the nature and vulnerability to problematic recovery from psychosis and the importance of creating

(experiences of) safe and reliable relationships external to the person, and teaching how to develop a more compassionate soothing relationship with the self to replace self-criticism and persecution.

SAFETY STRATEGIES AND THEIR UNINTENDED CONSEQUENCES

Safety strategies often develop as individuals first efforts to "get safe and defend themselves" when confronted by threat or aversive emotions. The most common safety strategies are escape, avoidance, and aggression. However it is well known that these interfere with learning how to explore and overcome a threat and may actually maintain or exasperate a fear (Thwaites & Freeston, 2005). So ways of responding to threatening experiences and fears by trying to avoid or defend against internal or external sources of threat and attack are important in understanding the persistence of emotional distress and vulnerability to recurrence in psychosis. We can also understand these safety strategies in terms of their developmental origins that shape the organization of attachment relationships, experiences and memories, providing the basis for affect regulation. In particular, insecure (attachment-focused) safety strategies can serve two important functions in the face of internal or external threats. The first is avoidance of and deactivation of threatening experiences by hiding and distancing oneself from others. A second strategy is to become hyper-vigilant, alert and orientated toward threatening experiences— reflected in preoccupied and ruminative states of mind.

In this framework, avoidance and sealing over represent defensive strategies against key fears such as stigma and shame or the catastrophe of rehospitalization by compartmentalizing experiences in a way that minimizes threats to the self. In addition it cuts the person off from any possibility of social help or affiliative support—key inputs for the soothing system. So, such strategies may produce further unintended internal and external threats. For example, affect regulation strategies designed to withdraw from social contact, close down awareness of threatening affects, memories, and thoughts can lead to impairments in mentalization and reflective functioning, greater emotional detachment and blunting, and increased vulnerability to the destabilizing impact of stressful life events. As mentalization and emotional awareness decrease, the core self becomes more impoverished and increasingly alienated and disconnected from others.

In terms of the responses of others, we observe that increased criticism and hostility from family members and loved ones tends to occur in the context of withdrawal and negative symptoms (Hooley, Richters, Weintraub, & Neale, 1987). Moore, Sellwood, and Stirling (2000) noted that in the face of requests from dominant powerful others (e.g., prescribing psychiatrists) to comply with medical advice, reactance-prone individuals may attempt to reassert their freedom and autonomy through opposition and noncompliant behavior. Psychiatric treatment and diagnosis can often be experienced as a threat to freedom and autonomy and thus defiant, reactant, and sealing over defensive strategies may provide a means for individuals to avoid or deactivate threats from powerful others. This may often times be misunderstood as poor insight and failure to acknowledge the defensive nature of such coping can often lead to counterproductive interventions such as psychiatric education or coercion.

In contrast, individuals may employ strategies aimed at avoiding harm through being self-critical, overly submissive, compliant, unassertive, self-blaming, or persis-

tently preoccupied with their own and others' mental states. For example, Morrison and Wells (2007) found that there were no differences observed in levels of worry between those participants with psychotic diagnoses and those with anxiety disorders and that worry was related to hallucinatory distress, but not other dimensions of hallucinatory experiences, for example, conviction. In addition, Startup, Freeman, and Garety (2007) found that higher levels of worry were associated with higher levels of delusion distress but not with higher levels of delusion conviction.

These preoccupied strategies may also be associated with greater awareness of the negative implications of psychosis and increased feelings of stigma, hopelessness, fear and entrapment (Birchwood et al., 2006). Indeed submissive strategies may be associated with others taking control and increased feelings of passivity and helplessness. The individual's own needs and feelings are subjugated to others leaving the person's own feelings unresolved. This might be reflected in greater pining in relation to loss, or greater feelings of anger in relation to perceived rejection or humiliation. Submissive safety strategies in relation to the externally perceived threat of derogatory or command hallucinations might undermine the person's sense of control over both the external world and over their own mental processes. Such a frightening experience might trigger intense feelings of defeat, anxiety, self-attacking, and possibly increase risk of suicide.

Finally, it is important to bear in mind that stressful life events, particularly trauma loss, and conflicts have a disorganizing impact on the attachment system and abilities to think clearly and problem solve. This is often reflected in dissociated, compartmentalized, and disaggregated mental states, characterized by failures in metacognitive monitoring and awareness. In extreme cases this can be associated with contradictory avoidant and preoccupied strategies. In the infant this is reflected in some types of disorganized attachment where the infant may both cling to and lean away from an attachment figure who represents both a source of security and a source of fear simultaneously: fear without solution and in behavior terms approach-avoidance conflicts—which in animals and humans have major disorganizing effects. In adulthood, this can be reflected in highly contradictory strategies such as idealization followed by angry rejection of another (See Liotti & Gumley, 2009 for a review in relation to psychosis).

COMPASSION FOCUSED THERAPY

A key aspect of the Recovery After Psychosis (RAP) approach is the development of self-compassionate soothing responses to internal and external sources of threat. The Dalai Lama defines compassion as "a *sensitivity* to the suffering of self and others, with a deep *commitment* to try to relieve it." Compassion Focused Therapy (CFT; Gilbert, 2009) was developed with and for people who have chronic and complex mental health problems linked to shame, self-criticism, and who often come from difficult backgrounds. The roots of CFT are derived for an evolutionary, neuroscience, and social psychology approach, linked to the psychology and neurophysiology of caring—both giving and receiving (Gilbert, 1989, 2009, 2010, this issue). Feeling cared for, accepted, having a sense of belonging and affiliation with others is linked to a particular type of positive affect regulation system that is associated with feelings of contentment and well-being.

The caring and nurturing social mentality develops most prominently but not solely in the context of attachment security and is evolutionarily crucial to the develop-

ment of collaborative and cooperative social systems (Hrdy, 2009). Attachment security has been associated with narratives characterized by a freedom to explore thoughts and feelings during attachment discourse (Main, Goldwyn, & Hesse, 2002). Secure speakers have a tendency to be moderately or highly aware of the nature of their experiences with parents and the effects of those experiences (both positive and negative) on their own attitudes and behaviors. Indeed security of attachment is associated with openness to reflecting on painful experiences as being formative and influential to current personality and identity. Importantly attachment security is associated with a tendency toward forgiveness of others, an openness and ease with imperfections within the self, and a compassionate attitude to caregivers and to the self.

Summary

In summary, this formulation contains seven key elements summarized below.

1. A key barrier to recovery is a person's (and caregiver's) sensitivity to threat (relapse, stigma, shame, self-criticism).
2. Personal responses to threat are understandable reactions, which function to regulate emotional distress.
3. These coping responses will also be understandable in context of formative life experiences.
4. Developmental and interpersonal factors provide a key basis for understanding responses to threat (and particularly personal resilience).
5. Coping responses may have significant unintended consequences (e.g., increased risk of relapse, increased use of coercive measures, impaired mentalization/metacognition, or increased emotional distress, anger and threat).
6. Not only may the threat system be highly sensitized and vigilant to certain types of threat, the maturation of the soothing system, linked to, and developed via affectionate inputs from caregivers and others seems compromized, greatly interfering with threat regulation.
7. Therefore one of the major therapeutic goals is to help individuals cultivate a compassionate self-reflective stance toward their own experiences, in understanding self-other interactions, and in their approach to solving emotional and interpersonal problems.

THERAPEUTIC IMPLICATIONS

Gilbert (2009) has outlined compassionate attributes and skills, which are required to counteract feelings arising from threat directed social mentalities and their unintended consequences. These include:

1. The motivation to be caring and sensitive to oneself and others reflected in the cultivation of a "desire to be helpful and caring."
2. A sensitivity to the feelings and needs of oneself and others with open attention to distress rather than avoidance.
3. Sympathy, being open and able to be moved and emotionally in tune with our feelings, distress, and needs and those of others.
4. The ability to tolerate rather then avoid difficult feelings, memories, or situations.

5. An empathic understanding of how our mind works, why we feel what we feel, how our thoughts are as they are—and the same for others.
6. An accepting, non-condemning, non-submissive orientation to ourselves and others.

These attributes can be incorporated into psychological therapies provided for individuals, groups, and families and can provide a basis for a "whole systems" approach service organization. The skills of the approach are in the development and use of: compassionate imagery, compassionate attention, compassionate thinking, compassion behavior and compassionate feelings

Gumley and Schwannauer (2006) have outlined a cognitive interpersonal approach to emotional recovery and staying well after psychosis that can incorporate these compassion principles. Cognitive Interpersonal Therapy (CIT) develops reflexivity, adaptive coping, and self-regulation through development of a compassionate mentality and orientation to oneself and others. The approach is highly collaborative and formulation driven. Through the development of a compassionate focus on current and previous experiences, CIT aims to support individuals in (a) responding to feelings of shame, humiliation, and embarrassment, (b) enabling the activation of positive affects to counter problems of affective flattening, alogia and apathy, (c) developing compassionate self-reflectiveness to support making sense of unusual experiences and threatening beliefs, and (d) developing non-catastrophic responses to the threat of recurrence.

Group CMTp aims to develop compassionate responding to others and oneself in order to reduce feelings of shame, humiliation, and embarrassment, activate positive affects and promote adaptive coping and self-organization. Group CMTp explicitly utilizes group processes and peer attachment. Laithwaite and colleagues (2009) have reported preliminary effectiveness of this approach among 19 individuals recovering after psychosis in the context of a high security special hospital facility. This approach is further being developed in the context of a preliminary randomized controlled trial.

Family-based interventions could have an important role in supporting families and loved ones to develop compassionate responses to their family member and their difficulties. In addition, compassion-focused family work would also provide a context for families to understand their own threat-based reactions in a way that is non-blaming, empathic, and accepting. For example, Patterson, Birchwood, and Cochrane (2000) found that feelings of grief and loss preceded the development of criticism and emotional overinvolvement in early psychosis. Compassion focused family therapy could enable families to acknowledge and process their own feelings of loss and grief arising from the impact of psychosis.

Finally, we believe that our model has important implications for how services engage with individuals in the process of recovery. In particular our approach emphasizes the importance of services developing their capacity to provide a secure base to promote exploration and autonomy among service users while providing a safe context for help seeking during times of distress or increased risk. Such an approach requires a self-reflective and open stance among care providers to the way in which they or their service may respond which inadvertently impedes help seeking or indeed implies catastrophic and threat-based responding.

CONCLUSION

This article has outlined the rationale for a compassion-focused approach to psychosis, utilized within the broader base of our current psychological therapies for psychosis. With its roots in evolutionary psychology attachment theory, and the neuroscience of affect regulation, a compassion-focused approach can provide a developmentally and interpersonally sensitive approach to recovery. Indeed, principles derived from a compassion-focused approach can guide the development of service systems and organizations to promote a recovery-orientated focus with compassion at the core of the value base. For example it follows from this model that special attention needs to be paid to the development of reliable and compassionate relationships that are easily accessible—not just at points of symptom development. Second, that in addition to focus on the cognitive processes (for example the meanings people give to their inner feelings and thoughts), therapists must attend to the emotional textures of those thoughts and alternatives. In particular it is important to help clients develop abilities to be mindful, more observant of their inner processes while at the same time developing compassion motives and understanding of this process. CFT offers new ways of engaging with people with psychosis and utilizing many of the interventions that have been currently developed in other therapy approaches. CFT however focuses specifically on stimulating a major affect regulation system that may not be easily accessible in people locked into the threat experiences of psychosis.

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