COMPASSION-FOCUSED THERAPY WITH CHILDREN AND ADOLESCENTS

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Abstract

Compassion focused therapy (CFT) is embedded in an evolutionary, functional analysis of psychopathology. It focuses on the affiliative, caring and compassion processes relating to feeling cared for by others, having a caring interest in others, and having a caring orientation to oneself. This therapeutic model distinguishes between CFT and compassionate mind training (CMT). CFT relates to case formulation, therapeutic relationship and task of the therapy, whereas CMT encompass the particular practices designed to develop compassion processing systems that help regulate threat-focused affect.

Although this model has been applied in a number of adult settings, , its clinical applications for child and adolescent psychopathology and psychotherapy have not. This paper describes the applications of CFT in paediatric populations through the presentation of its rationale for case formulation, the illustration of compassion-focused therapeutic strategies, and the discussion of developmental specificities for its use with children and adolescents. Specifically, the following developmental considerations are discussed: the unique importance of parent-child and attachment relationships for the development of self-compassion, being open to compassion from other and being compassionate to others; the potential impact of compassion training on the child's/adolescent's maturing brain (affective regulation systems); and the therapeutic targeting of shame and self-criticism as a means of alleviating psychological distress and enhancing the effectiveness of cognitive-behaviour interventions.

Over the last 20 years there has been increasing research interest in the beneficial effects of cultivating compassion and prosocial behaviour. Effects have been demonstrated on a range of psychological processes (e.g., Keltner *et al*, 2014), social relationships (e.g., Cozolino, 2007; Crocker & Canevello, 2012), physiological processes (e.g., Brown & Brown, 2015; Klimecki *et al*, 2014), and genetic expression (e.g., Fredrickson *et al*, 2013). Cultivating compassion for the self and others has also become a central focus for the development of psychotherapies (Gilbert, 2010; Hoffmann *et al*, 2011; Neff & Dahm, 2015). In this context, CFT has emerged as one of the leading approaches with an expanding evidence base (Kirby, 2016; Leaviss & Uttley, 2015).

Compassion can be defined as sensitivity to suffering/distress in self and others with a commitment to try to alleviate and prevent it (Gilbert, 2013). Compassion sits within a family of prosocial motivations that includes caring and altruism. In interpersonal relationships compassion can be viewed as a flow such that there is the compassion we feel for others, the compassion we are open to receive from others, and self-compassion. Each of these has a range of facilitators and inhibitors. For example, it is easier to be compassionate toward people we like than to people we do not and to receive compassion from people we like than from people we do not, and to be self compassionate to the things we like about ourselves rather than to things we do not like about ourselves. Psychotherapeutic focus therefore is on understanding the facilitators and inhibitors of compassion in these different domains and working on their improvement.

Attachment and interpersonal neurobiology

Our understanding of prosocial motives and emotions, including compassion, has advanced through recent discoveries in several independent research fields (e.g., developmental psychology and cognitive neuroscience). Particularly important is the understanding of neuroplasticity and neurogenesis whereby social context plays a major role in choreographing and sculpting brain processes (Fredrickson *et al*, 2013; Puglia *et al*, 2015). Several studies in child development and neuroscience have helped therapists understand what happens to the brain and to people´s subsequent psychological development when under various forms of early rearing difficulties (Gilbert, 2014; Siegel, 2001). Interactions with attachment figures are essential to creating contingent, attuned collaborative communication to establish patterns by which the caregiver can regulate the child's positive and negative emotional states. These emotion-regulating interactions are required for the experientially influenced maturation of the infant's developing emotional and social brain (the mind's ability to create a representation of the self and of the minds of others) (Schore, 1994; Siegel, 2001; Mikulincer & Shaver, 2007). Moreover, the quality of early relationships affects the development of internal working models of the self (e.g., as worthy or unworthy of care and support) and others (e.g., as caring and available or threatening and unavailable) (Bowlby, 1980; Baldwin, 1997; Mikulincer & Shaver, 2007). Thus, these self-other scripts form the basis for subsequent self-to-self evaluations and determine one's predictions of others' and of one's behaviour in social interactions (Baldwin, 1997).

Early experiences and affect regulation systems

Children who come from abusive, hostile, neglectful, and/or threatening backgrounds are vulnerable to deficits in their affect regulation systems (Schore, 1994).

These early experiences overstimulate the threat-defence system, a system designed to respond quickly and automatically to threat signals, whileunder-stimulating the soothing and social connectedness affect system (Gilbert, 2014). The activation of the threat system is easy and can generate enduring negative affect and defensive behaviours (Perry *et al,* 1995) Therefore, feeling rejected, uncared for, and unvalued is one of the most powerful elicitors of the stress response, being related to physical and mental health problems (Cozolino, 2007). On the other hand, feeling cared for, supported, and valued by others significantly influences physiological and emotional regulation, generating feelings of safeness and soothing (Depue & Morrone-Strupinsky, 2005). Social interactions and underlying emotion-regulation processes are associated with specific neurohormones as well as with a set of evolved central and peripheral physiological systems. These mechanisms can be conceptualized as integrating different affect regulation systems, namely the threat-defence, the resource-seeking, and the contentment-affiliation and soothing systems (Depue & Moronne-Strupinsky, 2005; Gilbert, 2010). These three affect regulation systems work interactively and mutually affect each other.

The threat system is focused on the detection of threats and on the automatic activation of defensive emotions (e.g., anxiety, anger, and disgust) and behaviours (e.g., fight, flight, submission, and freezing). This system is linked to the secretion of the hormones serotonin and cortisol and operates through specific brain structures, such as the amygdala and the hypothalamic–pituitary–adrenal axis (LeDoux, 2003; Depue & Moronne-Strupinsky, 2005). The synaptic regulation of serotonin plays a role in the threat-defence system - partly because of the defensive rule ‘better safe than sorry’ - which is an easily conditioned system and a source of psychopathology (LeDoux, 2003). A second affect regulation system is the drive-resource acquisition system,

mediated by the dopamine reward circuitry. This system is crucial to survival and prosperity as it is responsible for positive feelings (e.g., activation, pleasure, excitement, and satisfaction) that guide and motivate us to seek out resources (e.g., food). Lastly, the contentment-affiliative and soothing system, characterized by positive feelings of warmth, soothing, and well-being is linked to endorphins/opiates and oxytocin, involving a state of quiescence, non-seeking and happiness/contentment (Depue & Moronne-Strupinsky, 2005). Maturation and activation of this system co-occurs with the development of the attachment system, in which attachment figures are expected to act as reassuring and soothing agents (Gerhardt, 2004). Thus, early attachment relationships will stimulate this system (e.g., throughout warmth and love signals), providing memories that will be available and recruited in the future, both in interpersonal contexts (e.g., forming affiliative bonds) and in self-regulation when facing stressful situations (Gilbert et al, 2008). Acting in a soothing and affiliative way with the self and others makes the world safer (decreasing stress and cortisol levels, shame feelings and behaviours, and negative evaluations about the self and others), promotes feelings of safeness and connectedness, and deactivates the threat-defence system, providing tools and strategies to cope with adversity (Gilbert, 2010).

Activation of the threat-defense system, shame and self-criticism

Human beings are highly motivated to create positive images and positive affect in the minds of others and to be viewed as an attractive social agent. Shame, as a self-conscious emotion, emerges from our evolved abilities to be aware of 'how we exist in the eyes of others', as a response to the social threat of being socially unattractive (Gilbert, 2007). This emotion has been defined as the experience of the self as

unattractive, undesirable, worthless, inferior, or defective in some way, linked to having flaws, failures, and deficits exposed (Gilbert, 2014).

Gilbert´s biopsychosocial approach posits two types of shame: external shame and internal shame (Gilbert, 2007). External shame, in which the world is experienced as unsafe (e.g., others will be harsh and rejecting rather than supportive and forgiving), leads to the engagement in defensive manoeuvers, eliciting behavioural efforts trying to achieve a positive image in the mind of others (e.g., by submitting, appeasing, obeying). However, the internalization of these experiences can result in devaluating the self in line with those same negative experiences: the individual considers himself as flawed, inferior, defective, and globally a failure (Gilbert, 2010; Castilho *et al*, 2012). These negative self-evaluations and feelings, known as self-criticism, can be seen as a form of self-to-self relationship, an internal process that triggers the same subordinated-defeat strategies normally used to respond to external threat signals, which, when activated, result in negative emotions and psychopathology (Castilho *et al*, 2015). Shame-proneness has been associated with increased vulnerabilities to psychopathology, both internalized (e.g., Matos *et al*, 2013; Tangney & Tracy, 2012) and externalized (e.g., Gold *et al*, 2011; Ribeiro da Siva *et al*, 2015).

Activation of the soothing system and self-compassion

Feeling cared for, supported, and understood helps to understand our own minds and emotions and shapes our motives (Gilbert, 2009). Several authors argue that feelings of safeness are central to the development of secure attachment bonds (Gerhardt, 2004). In fact, securely attached individuals seem to be more self-reassuring and warm toward themselves, as well as more pro-social and more prone to trust in others (Gilbert & Irons, 2008). Signals of compassion from others or from the self

activate the warmth/contentment system, which is related to the care-giving mentality and associated with feelings of care, affiliation, soothing, and safeness. Therefore, compassion involves several emotional, cognitive, and motivational elements, including care for the welfare of others, sympathy, distress tolerance, empathy, nonjudgment, distress sensitivity, and the ability to create opportunities for growth and change with a warm attitude (Gilbert, 2010).

An increasing number of studies have demonstrated an association between self-compassion (though measured in a different way to the model discussed here) and adaptive psychological functioning. Some studies have found self-compassion to be negatively associated with depression and anxiety in adolescents and young adults, while other studies have suggested that, among college students, self-compassion is associated with adaptive coping and wellbeing in response to academic failure (see Neff & Dahm, 2015 for a review). In regard to CFT again there is good evidence for its effectiveness in reducing many mental health problems (Kirby, 2016).

Case Formulation in CFT with Children and Adolescents

Developing motivating rationales

The importance of a treatment rationale is well established in cognitive-behavioural therapies: the "rationale" represents a common understanding between the therapist and the client on the possible aetiologies of the difficulties experienced ("Why/How is this person having this problem?") and on the proposed intervention program ("What can we do to change it?"). Moreover, the acceptance of a treatment rationale is associated with positive intervention outcomes (Addis & Carpenter, 2000). The rationale can be viewed as a shared case formulation, and in CFT this formulation

is regarded as a co-constructed process aimed at enabling people to gain insight into how some of our basic defensive systems (e.g., anxiety, anger) may be quite automatic and trigger behavioural safety strategies (e.g., withdrawal, submission) (Gilbert, 2013). As in the case of adults, there are four essential domains to look for when developing a case formulation in CFT with children and adolescents:

- *Background experiences* that bring about emotional memories and the (de)activation of affect regulation systems (e.g., harsh criticism or other forms of abuse by parents or other attachment figures; indifference or discrepant responses to emotional needs; school bullying; negative social comparison and social put-down; emotional deprivation; lack of warmth and safeness experiences; dysfunctional modelling of expectations, beliefs, and behaviours);
- *Core fears* developed within the context of the aforementioned backgrounds (e.g., fear of expressing needs, disagreement or emotions; fear of being left out or alone; fear of being mocked or ridiculed; fear of failing or underachieving; fear that others will take advantage on us);
- *Safety strategies* developed as means of avoiding, containing, or mitigating the core fears (e.g., acting tough to hide what is perceived as weaknesses; using self-criticism as an attempt of self-correction or improvement; self-harming as an affect regulator; displaying submissive behaviour to turn off aggression in others; threatening, to elicit fear and compliance in others; ruminating for problem-solving; suspiciousness to anticipate threat; substance abuse to block memories and emotions; procrastinating to postpone evaluation; isolating to keep conflicts away);

▪ *Unintended consequences* (e.g., greater external control and pressure; inability to make decisions; being easily manipulated by others; disengaging from valued goals; entrapment; lethargy, fatigue; overeating and overweight; increased shame and self-criticism; alienation, depersonalization, derealization).

These case formulations pattern people's emotional dispositions and motives. For example, children who have grown up with a lot of criticism may be overly motivated to please others in effort to avoid criticism, lack self-assertion and a sense of independence; they are vulnerable to feelings of anxiety, aloneness and depression. Other children may develop more aggressive defences, quick to anger and threaten others if they are criticised.

A focus on de-shaming

Children and adolescents are often involuntary clients, brought to therapy by the hand of their parents who state that there is something "wrong" with the child, thus from the start locating the child in an external shame position. Typically, paediatric clients do not fully grasp the idea of "therapy", why they are being brought to therapy or what is expected from them in a therapeutic context (Berg & Steiner, 2003; Turns & Kimmes, 2014). Given that psychotherapeutic settings involve exposure of the self to other, they are likely to elicit feelings of shame, self-contempt, and personal inadequacy, and therefore, these clients are in particular need for a compassionate therapeutic engagement. The development of a "de-shaming" rationale requires two aspects: one is to be genuinely validating of the client's emotional experience (e.g., traumatic, adverse events are not "cognitive distortions"); and the other is to explore safety strategies and symptoms as people's best efforts to cope with very

difficult situations (Gilbert, 2014). If the rationale conveys a warmth understanding of the problem (key messages: "we all do our best to avoid or cope with suffering", "this [the problem] is not your fault – it is your body's best efforts to cope and avoid being hurt in one way or another"), then children and adolescents are likely to lessen their internal shame and self-criticism, and thus will likely feel safer and encouraged to express emotions, and collaboratively explore more adaptive ways of coping with difficulties. Box 1 describes two examples of developmentally appropriate de-shaming therapeutic rationales, while summarizing the aforementioned points in case formulation.

Box 1. Case Vignettes

Jack, 8 years old, ADHD

We all have different, unique bodies. The point is that we all have a body to take care of. If you look around you will find that some of your colleagues have pretty quiet, sometimes even floppy bodies. Others may look solid as a rock and rather stiff. Others still –and perhaps these will sound more familiar to you – have a hyperactive body. Well, there are lots of cool things in having a "hyperactive body": we really enjoy excitement in games and plays, and there is lots of energy to be spent – for instance, you told me that no one can beat you in "running contests" on the playground during recess. However, this same body is sometimes so excited and energetic that it makes it difficult to calm it down – especially when it gets bored. A hyperactive body needs a good "chum" – one who is able of fully enjoying it and of calming it down when necessary. It is just like in Formula One: you need one type of speed to run the straights and you need a different one to pass the curves and corners. My invitation is for us to

meet here once a week and train our “chumship” inside, so that you can overcome any type of circuit you’ll have to race in your life. Then you can choose whether to be excited or calmer…

Rose, 15 years old

Moving from one town to another and from one school to another is very challenging: we have to make new friends and get acquainted with what is absolutely familiar to the others. This takes courage to face new situations and get to know new people. You told me that there were times when you were bullied in your last school: a group of girls would tease you, call you names, and mock at you. That must have been so hurtful for you. Fortunately, you overcame that problem and the bullying stopped. However, we don’t forget those kinds of things and it is actually very easy to remember them and to be afraid that they might happen again. As you described pretty clearly: even when others stop bullying us, we can keep on bullying ourselves. This can withdraw us from living our lives the way we want to live them. For instance, you have been declining invitations to go out with some of your new colleagues who would like to know you better, or you feel it is too difficult to attend the cafeteria or the main playground during school breaks. That is completely understandable given what’s happened to you before. The problem is if a particular situation has changed. It’s a good idea to keep your umbrella up if it’s raining but maybe not when the rain stops; so sometimes it’s how we step-by-step plan to trust a bit. Certainly you wished this would make your life easier, but you realize that you are feeling more lonely and insecure. This is because you still want to build new

friendships and have good moments of fun at school (and out of school!). What do you think if we could find ways of calming the "bully inside" and in the meantime letting you find the courage that has been blocked, but that you already proved you have?

a. The cases vignettes are based on our collective clinical experience and do not describe any specific patients.

CFT with Children and Adolescents: General Features

CFT is best described as an integrated, multi-modal therapy. Rather than outlining a single "school" or "model", CFT is primarily based on the research and contributions drawn from psychological sciences and is ultimately committed to enhancing the science of psychotherapy and improving the understanding and outcomes of the psychotherapeutic processes (Gilbert, 2009). Therefore, CFT uses an array of established cognitive-behavioural techniques, such as Socratic questioning, exposure, functional analysis, reframing, mindfulness, and chaining analysis. Nevertheless, Compassionate Mind Training (CMT) is the key therapeutic process in CFT. CMT is aimed at rebalancing the sensitivity, overactivity, and conflictuality of the threat protection and/or drive systems through the stimulation of the soothing/contentment system, which in turn provides a sense of calming, reassurance, and relief that is likely to improve the patient's engagement in the development of emotional tolerance, generate authentic alternative thoughts, and take on caring behaviours and helpful actions towards others and towards him/herself (Gilbert, 2010; Leaviss & Uttley, 2014).

In this sense, CMT exercises (e.g., compassionate other imagery, compassionate chair work, soothing rhythm breathing, compassionate behaviour) may be regarded within a "neurophysiotherapy approach" (Gilbert & Irons, 2005) because patients will

be training their minds in different ways, namely in terms of experiencing safety in their interactions, tolerating distress when exploring certain themes in therapy, and replacing self-criticism with self-compassion. The ultimate goal of CFT is to develop the following compassionate attributes (Gilbert, 2010):

- Care for well-being: motivation to self-care and to prosocial behaviour, facilitating distress alleviation and flourishing;
- Sensitivity: ability to be attentive to feelings, needs, suffering, and distress;
- Sympathy: being emotionally connected, moved, engaged, and attuned (as opposed to being cold, distant or dissociated);
- Empathy: taking the perspective of somebody else or even the perspective of different part of ourselves (e.g., why we feel what we feel; critical self versus compassionate self);
- Distress tolerance: ability to contain, to stay with difficult, complex, and highly negative emotional states, instead of avoiding, denying, or invalidating them;
- Non-judgment: taking an accepting, non-critical, non-condemning, and de-shaming approach to emotional experiences.

Those competencies help us to engage with our difficulties rather than deny them, avoid or dissociate. In addition, there are a set of competencies that help us to try to alleviate and prevent suffering or try to heal it. These include: how to pay attention to what is helpful; imagining what is helpful; using our reasoning to think through things and focus on what is helpful; behaving in ways that address the problem even if that requires courage; using our bodies to calm our minds, and working with our feelings. So in CFT model there are six competencies underpinning our abilities to engage suffering and six for working with it.

Children who face highly adverse and stressful situations during their development are prone to experience impairments in the maturation of their affect regulation systems (Gerhardt, 2004). As a general therapeutic framework, the main goal of CFT is the activation of the soothing affiliative system, which will ultimately improve the effectiveness of a variety of psychological interventions (Gilbert, 2009). Because the activation of the soothing affiliative system and the regulation of difficult emotions depend on care providing relationships, the therapeutic relationship and parent-child relationships will be at the heart of CFT with children and adolescents. CBT has long acknowledged that the therapeutic relationship is an interpersonal context in which previous attachment problems as well as failure in emotional validation and compassion may be reflected, thus providing a crucial opportunity for modifying related psychological difficulties (Leahy, 2008). Aligned with these claims, CFT offers a milieu of the intended therapist's qualities and behaviours and a refined view of the therapeutic relationship as an active ingredient of the change process itself. The therapist is expected to master the skills and convey the attributes of compassion, leading the client to experience the therapeutic relationship as safe, warm, de-shaming, and supportive and helping him/her develop a compassionate approach directed at him/herself and his/her difficulties.

People who come to therapy often display a cold, intimidating, and aggressive inner tone in trying to change their thoughts and behaviours (Gilbert, 2009). Children and adolescents with psychological disorders are likely to experience additional criticism within their care-providing relationships, namely from their parents (Barish, 2009). Therefore, in CFT with paediatric patients, when replacing criticism, avoidance, harm, and incapacitation with kindness, understanding, and encouragement, a distinctively simultaneous emphasis is placed in both the child/adolescent and in his/her

interpersonal contexts (e.g., parents, teachers, peers) as possible sources of criticism and heightened psychological distress. The experience of safety, reassurance, and encouragement within the therapeutic relationship is key to this process (Gilbert, 2013); if this is not attained, the child/adolescent will find it difficult to generate alternative thoughts or to believe in them, to engage in new behaviours, or to validate his/her emotions. In CFT, logic and rational evidence are secondary to warmth. Therefore, the therapeutic qualities of motivated interest in caring, encouragement, gentleness, kindness, patience, and a sense of wisdom are to be experienced through the corresponding therapist's behaviours, such as building on positives, forward-looking, focusing on compassionate self-correction, and increasing the opportunity for engagement as well as for reparation.

Compassionate Mind Training with Children and Adolescents

CFT argues that many psychological disorders are rooted in interpersonal problems, such as difficulties in feeling cared for by others, having a caring interest in others, and having a caring orientation toward oneself. Accordingly, compassion can be experienced and developed in three directions: the compassion one can feel for others (e.g., prosocial behaviour); the compassion one can feel from others toward oneself (e.g., parent-child relationship); and the compassion we can direct toward ourselves (i.e., self-compassion) (Gilbert, 2010). CFT proposes that the aforementioned compassion attributes (sometimes called "engagement attributes") imply specific skills need to be trained and developed. These "transformative skills" include compassionate attention, compassionate reasoning, compassionate behaviour, compassionate imagery, compassionate feeling, and compassionate sensation (Gilbert, 2014). Although many exercises used in CMT are most certainly linked to more than a single compassionate

skill, the clinical techniques and exercises presented in the next sections were grouped according to the specific skill they most clearly target. Likewise, the exercises described below were selected or adapted from a wide array of techniques available in the clinical literature, in order to plainly describe the practice of CMT with children and adolescents.

Building the compassionate self and image

One of the most crucial aspects of CFT is to help people realise that they can, on purpose, create a different sense of self. For example, we can imagine the core qualities we would have if we were at our most compassionate, wisest and confident. We can imagine being that – just like an actor taking on role. Then we bring to mind a life event and imagine how we might cope with that event if we were in say the anxious mind position – what would that feel and do. Then we can move into soothing breathing and create the compassion body postures and imagine ourselves at our compassionate best – bringing wisdom, courage and commitment to that situation. How would we cope with the situation in this compassionate self position? This is shifting one mental position to another, one sense of self to another – we help our clients realise that they can, on purpose, refocushow they approach difficulties. Overtime, the practice of becoming the compassionate self and looking at oneself with compassion becomes part the core therapy.

We could also imagine what it would be like to create an image of an ideal compassion other (human or even an animal) that would always listen and be understanding of us, committed to be helpful. Having a client feel that sense of compassion can itself be therapeutic, particularly if there is high distrust. Again when troubled the client can imagine hearing that calm soothing voice of the compassionate

image. The use of imagery in this way can be very helpful and may foster the effectiveness of a variety of techniques.

Techniques and exercises

1. Compassionate Attention

The ability to pay attention to what is helpful, in a supportive way, is developed in therapy through attention training (e.g., refocusing) (Gilbert, 2014). Recently, practical guidelines and exercises have been reviewed for the clinical application of mindfulness with children and adolescents (e.g., Carona *et al*, 2016). Mindfulness is defined as "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn 1994, p. 4). The awareness that emerges from this manner of paying attention inherently encompasses a warm, kindhearted tone within the attending (Kabat-Zinn, 2003). Therefore, developing mindful attention skills is particularly important in CFT because it enables the exposure of the individual to their painful thoughts and feelings, while embracing themselves with compassion (Neff & Dahm, 2015). Moreover, learning to pay attention to positive qualities and the savouring of experiences may assist the development of the client's appreciation and gratitude (Gilbert, 2009). Given the considerable variety of exercises that are currently available in the literature of paediatric mindfulness, the following exercises were selected as clear illustrations of the intended attention training.

Counting breaths

Counting breaths is a very simple exercise that may be particularly helpful in mindful attention training with younger children, who may find it difficult or boring to keep their eyes shut for longer than a moment (Ozawa-de-Silva & Dodson-Lavelle, 2011).

The practice involves counting the breaths as a means of (re)directing attention and gaining increased awareness of the present moment. Silverton's (2012) detailed description is reproduced here with a slight adaptation to the clinical context: first, ask the child/adolescent to choose a number of his/her preference between 3 and 10; second, with a hand placed on the belly, the child/adolescent counts on each out-breath up to the chosen number, directing his/her attention to breath and belly as a way of keeping the mind occupied (alternatively, or preferably the first few times, the therapist can count the breaths); third, each time the child/adolescent notices that attention has wandered, he/she simply returns to counting (once the desired number is achieved, he/she may want to start again). While performing this exercise, children/adolescents may be reminded, in a friendly and warm tone, that their breathing is always there with them, keeping them alive, helping them "anchor" in the present moment, and taking care of themselves.

2. Compassionate Reasoning

Compassionate reasoning relates to the ability of thinking about oneself, others, and the world in ways that are helpful and supportive. In cognitive therapy, a number of techniques are implemented to achieve more balanced reasoning, such as those of reappraisal and reattribution. However, logic and rationality are largely insufficient for modifying one's thoughts, emotional states, or behaviours; in CFT, it is crucial to ensure that the client experiences alternative thoughts as kind, genuine, and helpful (Gilbert, 2009). Therefore, understanding the protective value of certain negative emotions and thoughts and activating the affiliative, soothing system through the therapeutic relationship are necessary conditions for effectively developing compassionate reasoning skills.

Compassionate chair work

In compassionate chair work, the client is encouraged to change between seats: on the one side, the client is invited to replicate his/her "critical self"; on the other side, the client the client response to criticism. We only do that briefly so that the client can see the impact of the criticism. We then move into their chair, which becomes the compassion itself that can bring the wisdom, courage and commitment. It is not a good idea to encourage the compassionate self to have complex dialogues with the critical self because they are commending debate. The main focus is to help the person locate themselves in the compassion self.

Later, the person can begin to think that the critical self lies behind a number of difficulties, as an expression of fear of rejection, thus rehearsing and training his/her compassionate skills and attributes (Gilbert, 2010). Although this exercise may assume different levels of complexity (e.g., more than two aspects of the self), it is suggested that the exercise be kept as simple as possible when delivering it to preadolescents and adolescents.

The image of "the bully inside our heads" may be useful in explaining the rationale for this exercise. Compassionate chair work may be particularly useful in assisting clients in the development of a "compassionate inner voice" and a foremost strategy for training balanced reasoning in responding to threat-focused and self-critical thoughts. Flashcards with "critical thoughts" and "compassionate responses" may sometimes be useful in facilitating the generalization of the in-session work to the child/adolescent's real-life contexts. With younger children, the chair work may be adapted to funny role-reversal exercises in which the therapist models compassionate skills and attributes (e.g., "Casper the Friendly Ghost", "Shrek's Donkey"), in

responding to negative remarks from the "shy ghost" or the "sleepy dwarf", for instance.

Socratic questioning for compassionate guided discovery

Using Socratic questioning as a means of guided discovery implies that the client has the knowledge to answer questions that draw his/her attention to broader or different issues than those under the client's current focus, as a process of facilitating the construction of a new idea or a different appraisal (Padesky, 1993). Depending on its level of complexity, this technique is generally suitable for older adolescents, who have evolved cognitive abilities for abstract thinking, with the aim of leading them to gain insight into the importance and the possibility of introducing a generous quality into coping with difficulties. The following questions may assist in achieving that purpose:

- If, by magic, you would stop criticizing yourself, what would be your biggest fear? What would be so bad about that? (Usually, a self-corrective aim comes out as an answer. For example the child/adolescent may say "if I wasn't self-critical, I wouldn't work so hard, I would not reach my potential; maybe I would make mistakes or maybe not bother to be harmful to others". So here the therapist acknowledges these good goals, but wonders if maybe self-criticism is the way to achieve it. The child/adolescent may then be invited to do a behavioural experiment – to meet the "critical self"
- Can you give me an example of something you don't like about yourself and for what you criticize yourself? Can you give me an example related to the reason why you're here?

▪ Would you be willing to let go of this internal bully that keeps kicking you when you are already on the floor?

The therapist then invites the client to begin to explore the critical self. First spending a few moments imagining the critical self; what would it look like if you could take it out of your head and look at it. Next we pay attention to what is it is actually saying, allowing ourselves to really hear its words; then we pay attention to the feelings it has for us. Finally we note how we feel when we do this. We can then explore with the client their experience. Typically the "critic self" will look hostile in someway, it will say unpleasant things, it would direct unpleasant emotions (anger contempt) to the self, and then one ends feeling bad. We can then explore "does this help you meet your goals?" (these are the goals that came from fears of giving up critic).

Clients quickly see that actually their self-criticism is a lot more damaging than they realised and a lot more unpleasant. In CFT we very rarely try to argue with the critical self, but rather help them refocus on the compassionate self. So keeping the same goals, we go into the breathing and focus of the compassionate self – allowing it to settle into the body – then asking "what does your compassionate self or image look like?"; then spend some time: "what is it saying to you?"; then "what does it feel for you?"; and then "how are you feeling now?"

The idea is that the client themselves begins to have an experience of contrasting hostile self-criticism with compassionate self correction and encouragement. Ultimately, they will see the value in the compassion focus.

3. Compassionate behaviour

Compassionate behaviour may involve doing things that are helpful for oneself (e.g., exposing oneself to feared stimuli, painful experiences, avoided situations) or others (e.g., offering help if someone is hurt or upset). The core aspect of compassionate behaviour training is the validation and development of the client's courage, particularly through modelling the acknowledgement of any constructive effort in confronting the difficulties (Gilbert, 2009, 2013). Classically, (graded) behavioural task assignment is the major therapeutic method in training compassionate behaviour, which invariably involves exposure to both negative and positive emotions. Nevertheless, a number of other strategies may be valuable in facilitating the development of compassionate behavioural patterns. In this section, prosocial behaviour is directly targeted as a way of translating compassionate behaviour derived from self to others (Gilbert, 2010), which should not be overlooked in CFT.

Fostering prosocial behaviour

Prosocial behaviour refers to "voluntary actions that are intended to help or benefit another individual or group of individuals" (Eisenberg & Mussen, 1989: p. 3) and includes positive interactions such as helping, sharing, cooperating, and comforting (Hay, 1994). Current research suggests that goals for happiness, popularity and prosociality are not only compatible, but also reciprocal (Layous *et al*, 2012); in fact, there is increasing evidence for the assertion that "it's good to be good", i.e., for the role of prosocial behaviour as a determinant of positive health outcomes (Post, 2014). Additionally, it has been noted that prosocial behaviour often leads to the experience of a "warm glow" and that its emotional benefits may be observable in very young children (Aknin *et al,* 2012). In CFT with children and adolescents, behaviours such as care-giving, teaching, assisting, protecting, and soothing are to be carefully monitored

and positively reinforced across all life contexts (e.g., home, school, leisure activities). The assignment of tasks demonstrating empathy, kindness, and concern for the needs of others (e.g., allowing sibling to take first turn in a videogame, standing up for someone who is being bullied, helping with a school fundraiser) often integrate the psychological intervention protocols for children with behavioural disorders (Jongsma *et al*, 2006). Nevertheless, it is worth highlighting that in the context of a compassionate therapeutic relationship and process, prosocial behaviours should be shaped and modeled rather than merely taught or assigned.

4. Compassionate feeling

Compassionate feeling encompasses the experience of kindness and affiliation (compassion for others and from others), as well as the ability to understand and turn negative emotional states (e.g., anger, anxiety, shame) into self-compassionate behaviour (e.g., assertiveness). Validating the child's or adolescent's emotional experiences is a continuous (rather than a discrete) therapeutic strategy aimed at de-shaming and therefore is at the heart of CFT. Therapeutic validation may be defined as the radical acceptance and acknowledgement that all behaviour has validity and understandability and is particularly crucial when working with youths that come from invalidating environments (Salsman & Arthur, 2012).

Developing the child's or adolescent's emotional philosophy

Validation implies finding truth in what one feels and thinks and is therefore an intermediate between empathy and compassion (Leahy, 2005). When working with children and adolescents, the therapist should be mindful of the client's pathological

styles of validation (e.g., “if you cared about me, you would agree with everything I say”; “if you cared about me you would not try to change the way I feel”) and self-invalidating strategies (e.g., “needing others means I am weak”; “there’s no point in talking about things one cannot change”). Within this social-cognitive model of validation (Leahy, 2005), two strategies may assist the client in developing his/her “emotional philosophy” (i.e., compassionate understanding of one’s emotional states and experiences): one is to emphasize the importance of all emotions (not just “feeling good”, as illustrated in the movie “Inside Out”); the other one is to teach how emotions contain one’s meanings and needs. In this context, unrealistic expectations and beliefs about emotional well-being and regulation (e.g., “to be happy is to be always cool”, “it is ridiculous to get nervous in such situations”, “losing my temper means I am a bad person”) are to be challenged and readily addressed as emotional or mind “traps”, given their counterproductive consequences. When exploring the nature and diversity of human emotional experience, the therapist may facilitate the client’s insight into how negative emotional states were or may be linked to positive outcomes through one’s helpful behaviour (e.g., regret makes us apologize and/or correct the consequences of our unintended actions; anxiety reminds us about our goals and gives us a boost to act on them; anger is perfectly understandable and greatly useful when standing up for injustices). Regarding younger children or youths with severely impaired emotional development, it will likely be necessary to work on their emotional vocabulary and on the recognition of feelings in themselves and in others. Currently, a number of clinical resources (including activities, books and games) are easily accessible for this purpose (e.g., Center on the Social and Emotional Foundations for Early Learning - http://csefel.vanderbilt.edu/; http://csefel.vanderbilt.edu/modules/module2/handout6.pdf).

5. Compassionate imagery

Given their physiological power, imagery exercises (along with meditation-like practices) are greatly valued in CFT as a means for stimulating the affiliative emotion system (Gilbert, 2014). Examples of exercises that directly target imagery in CMT include (Gilbert, 2010) safe place imagery (generating an image of a place where the person feels safe and soothed); compassionate colour imagery (imagining a colour that the child/adolescent associates with warmth and kindness and imagining it having a motivation to help him/her); ideal compassionate other imagery (creating an ideal compassionate image, which has three key qualities: wisdom, strength, and commitment to care); and compassionate self imagery (imagining the self who has the same three qualities: wisdom, strength, and commitment to care).

Loving-kindness meditation for children

There are different techniques for loving-kindness mediation (Hoffmann *et al*, 2011), but a suitable age-appropriate adaptation has been developed by Saltzman and Goldin (2008). The procedure for this loving-kindness practice is as follows: (1) Ask the client to remember a time they felt loved by someone (it can be a very simple moment with a parent, grandparent, teacher, friend, or pet).(2) Invite the child to really feel this loving moment, and have the child fee the love flowing between themselves and the person or animal who loves them (e.g., younger children may enjoy blowing kisses, whereas older children can simply imagine receiving and sending love in and from their hearts). This sequence can be repeated for a loved one. Additionally, (3) children can experiment sending love to someone they do not know very well (e.g., server in the school cafeteria, bus driver); (4) children might then think about someone

they are having troubles with, such as their "ex-best friend"; and (5) the exercise can be finished with the children's thoughts of sending love to themselves and to feel their love returning to them, and then to send love to the whole world and feel the whole world's love returning to them.

6. Compassionate sensation

In CFT, sensory work includes breathing exercises, voices tones and facial/body postures to generate physical sensations (e.g., activation of the parasympathetic system), which result in affect regulation and compassion – which ultimately implies exposure to difficult internal and external stimuli. In addition to mindfulness, in CMT, soothing rhythm breathing is a preferred technique for achieving this type of compassionate sensation (Gilbert, 2010).

Soothing rhythm breathing

The easiest way to familiarize children and adolescents familiar with the soothing rhythm breathing is to teach them to pause for nearly three seconds between the in-breath and the out-breath – this moment of pause has been labelled "the still quiet place" in a mindfulness program for children and adolescents (Saltzman, 2014). If repeated at least three times, the pauses between breaths allow for the activation of the parasympathetic system, resulting in the experience of one feeling more relaxed and grounded. Another way of teaching soothing rhythm breathing to children and youths is "Counting from One to Ten on the Exhale" (Greenland, 2010): this technique simply involves relaxing as one inhales and counting from one to ten as one exhales (usually, one has to count pretty quickly). Another possibility is to teach gradual soothing breathing, beginning with counting 1-2-3 in the in-breath, and then again (following a

brief 1 to 3-second pause) 1-2-3 in the out-breath; then, the number is gradually increased (between 5 and 7 would be a reasonable goal for most children and adolescents).

Developmental considerations: The importance of a parent-child approach

Generally, parents are the primary attachment figures for a child. Healthy attachment relationships ensure that children seek proximity to attachment figures, have a sense of protection and soothing, and develop a model of security to explore the world. During early life, the development of basic circuits of the brain such as those responsible for the mental processes of emotion generation and regulation; the capacity to adopt flexible, mindful, and reflective behaviour; the autobiographical sense of self; and the ability to engage in interpersonal communication and to experience empathy – is largely shaped by the quality of the child's interpersonal experiences. There are five core elements to foster in caregiving attachment relationships (Siegel, 2001):

- *Collaboration and non-verbal communication* (e.g., eye contact, facial expression, synchrony of responses; soothing/encouraging tone of voice; the experience of "feel felt" by others);
- *Reflective dialogue* (e.g., creating meaning for experiences; creating the representations of the mind of others and of the self);
- *Repair* (e.g., allowing to make sense of periods of painful disconnection and psychological distress);
- *Coherent narratives* (e.g., creating an autobiographical narrative and self-awareness);

▪ *Emotional communication* (e.g., attachment relationships can amplify the positive affect experienced in joyful moments of living, as well as reduce negative emotional states through sharing, validation, and soothing).

Therefore, targeting parent-child relationships and interactions becomes of paramount importance in CFT with children and adolescents The idea of engaging parents as "proto-therapists" in their child's treatment process is emphasized by the fact that parents provide the most healthy context for the development of their child's maturing brains. In fact, psychotherapy may be defined as the encounter of (at least) two minds with the shared aim of lessening psychological suffering (Gilbert, 2014). To this end, the idea of "mind" can be put in terms of patterns in the flow of energy and information, which can occur within one brain or between brains (Siegel, 2001). Accordingly, psychotherapy is concerned with the repair of impediments to flexible self-regulation and coherent self-knowledge, which often result from blockage or other impairments in the flow of energy and information within the mind and between minds (Siegel, 2001). In other words, CFT with children and adolescents should be primarily aimed at fostering compassionate parenting behaviours, as briefly illustrated by the following therapeutic exercises and techniques.

Replacing (self-)criticism with compassionate (self-)correction: the "two schools" metaphor (Gilbert, 2009)

Parents often "mis-take" criticism for correction, either towards themselves or towards their child. This perception is largely due to what has been coined in developmental psychology as "fundamental educational error", i.e., the belief that one's

"bad behaviour" (e.g., failures, mistakes) demands punishment, and one's "good behaviour" calls for no particular consequence, because it was the expected, adequate, or desirable behaviour (Lourenço, 1992). Such belief impedes parents from noticing and encouraging their child's or their own efforts to manage difficulties and eventually foster critical, non-helpful behaviours. This phenomenon can be illustrated by the clinical observation that parents often bring their child to therapy and present their difficulties with a critical tone, while blaming themselves and becoming easily self-critical in their parenting efforts. Through Socratic questioning, parents may be invited to reflect on the perceived advantages of criticism and its actual outcomes, its links to their own attachment experiences as a child, and its association with mindless parenting behaviours. Within this "guided discovery", parents may be asked to imagine that they were asked to choose one of two schools for their child (or for themselves): in the first school, children are under constant pressure to "do it right", and therefore their slight mistakes are immediately pointed out and criticized by their teachers, who want them to attain their best academic performance; in the second school, there is also a strong commitment to positive outcomes, but every time the child fails, he/she is reassured by his/her teachers and given the opportunity to face and manage difficulties, and to correct his/her work or behaviour. Thus, bearing your child's best interests in mind, which school would you chose?". This simple metaphor may well serve as a starting point for parents to question the nature, value, and outcomes of their critical approach to difficulties.

Loving-kindness meditation (Shapiro & Carlson, 2009; Shapiro & White, 2014)

Mindful parenting involves the ability to experience compassion for the self and the child (Duncan *et al*, 2009). As in the typical CMT, parents are encouraged to practice exercises that are likely to foster the acknowledgment of a common humanity and the development of compassionate skills and attributes towards themselves and their children. This practice may be recommended for parents of typically developing children, or parents of children presenting internalizing or externalizing problems, but it may be distinctively important for parents who have children with developmental disabilities. In these cases, CMT in general, and lovingkindness meditation in particular, may assist to counteract the maladaptive cycle of shame (internalized stigma), guilt and self-blame, in which these parents frequently find themselves trapped (Neff & Faso, 2014).

The following example (Box 2) is an adapted version of the "Loving-kindness (Metta) Meditation" proposed by Shapiro and White (2014) for the context of parenting.

Box 2. Loving-kindness meditation for parents

- Parents are invited to sit in a comfortable position and to allow themselves to connect with their bodies and breathing (e.g., by placing a hand over the heart centre and feeling the warmth sensations).
- Parents are encouraged to invite an intention to this practice (e.g., "to open my heart", "to invite compassion into my life", "to give kindness a moment").

▪ Parents recite to themselves "*May I be safe. May I be happy. May I be healthy. May I live with ease. May I be free from suffering.*", or alternatively "May I find the courage, the strength, and the wisdom to help me out in this situation(s)".

▪ When becoming aware of any resistance to accepting these wishes for yourself (e.g., intrusive images, evaluative thoughts), simply notice those thoughts and/or feelings and gently return to the practice of reciting the phrases.

▪ For the next part of the practice, parents are asked to call their child to mind (e.g., bringing different images of the child to mind or just recalling a specific moment). They repeat the same loving-kindness phrases directed to the child, while noticing and feeling the compassionate sensations: "*May you be safe. May you be happy. May you be healthy. May you live with ease. May you be free from suffering*".

Conclusion

CFT provides a multimodal therapy framework that can enhance the effectiveness of other psychological interventions. There is now consistent evidence for the negative association between self-compassion and psychopathology (MacBeth & Gumley, 2012), as well as preliminary evidence for the clinical effectiveness of CFT, particularly for people with high self-criticism (Leaviss & Uttley, 2014). The practice of compassionate loving-kindness meditation has been proved effective in activating the neural circuitries linked to empathy (Lutz *et al*, 2008), as well as in reducing symptoms and increasing feelings of social connection, positive emotions and mindfulness (Hutcherson *et al*, 2008). Likewise, self-compassion was found to be linked to the emotional well-being of preadolescents and adolescents (Bluth & Blanton, 2014; Bluth

& Blanton, 2015) and the effectiveness of a cognitively based compassion training for the reduction of inflammatory markers (that are believed to predict the risk for medical or psychiatric illnesses) has been reported in a study conducted with adolescents living in foster care (Pace *et al*, 2013). Nevertheless, given the relative nascence of CFT as a formal psychotherapeutic model and the considerable complexity of its conceptual and clinical framework, in-depth clinical training is required to ensure the clinician's mastery and effectiveness in delivering CFT, namely with younger populations.

New developments concerning the applications of CFT with children and adolescents are likely to arise in the upcoming years. These developments will hopefully expand the current evidence base for what now appears a solid and most promising model of psychotherapy.

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Learning objectives:

- To understand and differentiate the three affective regulation systems and their links to different forms of child and adolescent psychopathology;

- To recognize the main components of the compassionate mind training with children and adolescents and related specific therapeutic strategies/exercises;

- To acknowledge the importance of adopting a parent-child approach in CFT, to include such a component in the intervention.

MCQs

Select the single best option for each question stem

1. In compassion-focused therapy (CFT), the regulation of the threat protection and/or drive systems is best achieved through:

a. The suppression of the over-activated system(s)

b. The stimulation of the soothing/contentment system

c. The rational dispute of maladaptive beliefs

d. The facilitation of a corrective self-criticism

e. The logical analysis of pros and cons of maladaptive behaviors

2. The development of case-formulation in CFT is best described as the articulation between:

a. Early maladaptive schemas, precipitating factors and avoidance patterns

b. Past and current object relations

c. Background experiences, core fears, safety strategies and unintended consequences

d. Childhood traumas, dysfunctional self-regulation and self-criticism

e. Lack of compassion, fear of compassion and compassion avoidance

3. In compassionate mind training (CMT), which of the following is not listed as a transformative skill?

a. Compassionate reasoning

b. Compassionate behavior

c. Compassionate attention

d. Compassionate imagery

e. Compassionate self-attack

4. In CFT with children and adolescents, CMT exercises:

a. Can only be performed with older adolescents

b. Are exclusively focused on parent-child relationships

c. Can be tailored to the patient's age

d. Are indicated for internalizing problems only

e. Are all based on meditation practices

5. A parent-child perspective to CFT assumes that is vital to:

a. Keep coercive parents away from therapy

b. Reinforce parent's self-criticism to modify inadequate parenting

c. Always have parents and their children together in therapy sessions

d. Help parents distance themselves from their child's problems

e. Assist the development of compassionate parenting behavior