meditation: Theoretical considerations and preliminary results. Gene Hospi Psychiatry. 1982;4:33-47.
8. Segal ZV, Williams JMG, Teasdale JD. Mindfulness-based cognitive therapy for depression. New York: Guilford Press; 2002.
9. Marlatt GA, Pagano RR, Rose RM, Marques JK. Effects of meditation and relaxation training upon alcohol use in male social drinkers. In DH Shapiro and R N Walhs. Meditation: Classic and contemporary perspectives. New York: Aldine Press; 1984. p. 105-120.
10. Neff KD and Germer CK. A pilot study and randomized controlled trial of the Mindful Self-compassion program. Journal of Cl Psychology. 2013;69(1):28-44.
11. Worden JW. El tratamiento del duelo: asesoramiento psicológico y terapia. Barcelona: Paidós; 1997.
12. Limonero JT, Lacasta MA, García García JA, Maté J, Prigerson HG. Adaptación al castellano del inventario de duelo complicado. Med. Pal. 2009;16(5):291-7.
13. Freud S. Mourning and melancholia. London: Standard Edition; 1917.
14. Bowlby J. The making and breaking of affectional bonds. Brit Jour of Psychiatry. 1977;130:201-10.
15. Bonanno GA, Keltner D. Facial Expressions of emotion and the course of bereavement. Jour of Abnor Psychology. 1997;106:126-37.
16. Neimeyer R. The lessons of loss: A guide to coping. New York: McGrawHill; 1998.
17. Tedeschi RG, Calhoun LG. Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. Psycho Inquiry. 2004;15(1):1-18.
18. Engel GL. Is grief a disease? A challenge for medical research. Psycho Medicine. 1961;23:18-22.
19. Stroebe M, Schut H, Stroebe W. Attachment in coping with bereavement: A theoretical integration. Rev of Gene Psychology. 2005;9:48-66.
20. Lindemann E. Symptomatology and management of acute grief. Am J Psychiatry. 1944;101:141-8.
21. Engel GL. Is grief a disease? A challenge for medical research. Psycho Medicine. 1961;23:18-22.
22. Kübler-Ross E. On death and Dying. London: Routledge; 1969.
23. Parkes CM. The first year of bereavement: A longitudinal study of the reaction of London widows to death of husbands. Psychiatry. 1970;33.
24. Sanders C. Grief, the mourning after: Dealing with adult bereavement. New York: Wiley, 1999
25. Neimeyer RA. Aprender de la pérdida. Una guía para afrontar el duelo. Barcelona: Paidós; 2002.
26. Rando TA. Grief, dying, and death: Clinical interventions for caregivers. Illinois: Research Press; 1984.
27. Worden JW. Grief counseling and grief therapy. A handbook for the mental health practitioner. London: Routledge; 1982.
28. Wittouck C, Van Autreve S, De Jaegere E, Portzky G, Van Heeringen K. The prevention and treatment of complicated grief: A meta-analysis. Cl Psychol Rev. 2011;31:69-78.
29. Currier JM, Holland JM, Neimeyer RA. Do CBT-based interventions alleviate distress following bereavement? A review of the current evidence. International Jour of Cog Therapy. 2010;3(1):77-93.
30. Edwards M. Being present: experiential connections Between Zen Buddhist practices and the grieving process. Dis Rehabil. 1997;19(10):442-51.
31. Wada K, Park J. Integrating Buddhist Psychology into Grief Counseling. Death Studies. 2009;33(7):657-83.
32. Kumar SM. Grieving Mindfully. Oakland. CA: New Harbinger Publications, Inc.; 2005.
33. Kumar SM. Mindfulness for prolonged grief. Oakland. CA: New Harbinger Publications, Inc.; 2013.
34. Cacciatore J, Flint M. Attend: Toward a Mindfulness-Based Bereavement Care Model. Death Studies. 2012;36:61-82.
35. Cacciatore J, Thieleman K, Osborn J, Orlowski K. Of the Soul and Suffering: Mindfulness-Based Interventions and Bereavement. Cl So Work Journal. 2013. DOI 10.1007/s10615-013-0465-y.
36. Thieleman K, Cacciatore J, Hill PW. Traumatic Bereavement and Mindfulness: A Preliminary Study of Mental Health Outcomes Using the ATTEND Model. Cl So Work Journal. 2014;1:9.
37. Tacon AM. Mindfulness: existential, loss, and grief factors in women with breast cancer. J Psychos Oncol. 2011;29(6):643-56.
38. O'Flanagan S, Bates U, Sarma K, McGuire, B. Treating prolonged grief disorder: testing the efficacy of a mindfulness-based cognitive therapy (MBCT). Psycho and Health. 2011;26(2):271-2.
39. O'Connor M, Piet J, Hougaard E. The Effects of Mindfulness-Based Cognitive Therapy on Depressive Symptoms in Elderly Bereaved People with Loss-Related Distress: a Controlled pilot Study. Mindful. 2014;5:400-9.
40. Stang H. Mindfulness & Grief. London: Cico Books; 2014.

Compassion Focused Therapy for Psychoses

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This paper outlines the theoretical and empirical basis for a treatment of psychosis from an evolutionary model of emotional regulation: Compassion Focused Therapy (CFT) for recovery from psychosis. CFT was originally developed for people with high levels of shame and self-criticism. Along with stigma, these are common features in people who are recovering from psychosis, and who may also develop serious emotional regulation problems. Elements of attachment theory involved in the origin of these difficulties are explored and some empirical facts about the clinical utility and efficacy of this new treatment are presented. A brief description is given of a recent group protocol that has been subjected to randomized trial, obtaining promising results.

Keywords: Compassion, Psychosis, Psychotherapy, Group, Recovery

Terapia Enfocada en la Compasión para las Psicosis

Este trabajo resume las bases teóricas y empíricas del tratamiento de las psicosis desde un modelo evolucionista de la regulación emocional: la Terapia Enfocada en la Compasión (CFT) para la recuperación de la psicosis. La CFT fue desarrollada inicialmente para personas con altos niveles de vergüenza y autocrítica, que junto con el estigma, es una característica frecuente en personas que se recuperan de la

psicosis, que además pueden desarrollar serios problemas de regulación emocional. Se exploran elementos de la teoría del apego que intervienen en la génesis de estas dificultades y se presentan algunos datos empíricos acerca de la utilidad clínica y eficacia de este novedoso tratamiento, junto con la descripción sucinta de un protocolo de intervención grupal reciente que se ha sometido a un ensayo aleatorizado con resultados prometedores.

Palabras clave: Compasión, Psicosis, Psicoterapia, Grupo, Recuperación

The emotional and functional recovery of a person with psychosis is a key dimension of patient treatment[1] which goes beyond merely reducing symptoms [2], and which emphasizes social functioning, the ability to perform gratifying activities, self-care, achieving goals and leading a meaningful life that is worth living.[3]

However, in order to achieve this goal, several obstacles related to the levels of external suffering caused by the psychotic experience must be surmounted, which include depression, despair, suicidal thoughts [4], shame and stigma[5], feelings of being trapped and fear that the psychotic episode will recur[6].

With regard to the effective treatments available, to the numerous limitations of pharmacological treatment[7], we must add the difficulties of psychological therapy in preventing relapses[8], which is the basis of a lasting recovery.

In this paper we outline the theoretical and empirical basis for a novel, promising approach for recovery from psychosis that has received much interest in clinical practice and undergone an intense empirical research effort in recent years, obtaining results that show considerable clinical improvements in a variety of problems and clinical environments: mental health units[9], acute care units[10], penitentiary psychiatric units[11] and outpatient clinics[12].

Concept of compassion and the origin of compassion-based therapies

There has been increasing interest in compassion-based interventions, and there is evidence that their regular use or intensive training in compassion produces beneficial effects in a range of mental health problems13. Additionally, this type of therapy has beneficial effects on the immune system and several areas of the brain[14,15]. There is robust evidence that self-compassion training is effective in reducing anxiety, depression, eating disorders[16], personality disorders[17], and that it is associated with lower psychopathology[18], which suggests that it has transdiagnostic utility of interest to clinical practice.

Compassion Focused Therapy (CFT)[19] includes the concept of Buddhist compassion: "Sensitivity towards one's own suffering and the suffering of others, along with the commitment to try to alleviate it and prevent it"[20].

CFT is considered to be a third-generation therapy within a cognitive-behavioural focus and shares several concepts and perspectives with mindfulness-based therapies and with acceptance and commitment therapy (see also the unifying practical work of Wright et al.[21] for the treatment of psychoses).

CFT is based on the clinical observation that many patients are capable of generating alternative thoughts when faced with distorted cognition, but this is not always helpful for them. This is partly due to the emotional texture of these thoughts and partly due to the high levels of threat and/or despair that they are experiencing. The use of traditional "cognitive restructuring" strategies is useful when the patient has sufficient cognitive flexibility and moderate levels of threat, activation or despair. It is common for a patient to express: "I see it clearly from a logical perspective, but I feel and I know that I'm being watched, I clearly feel like I'm being followed and that terrifies me". This is a difficulty known in cognitive therapy as rational-emotional dissociation[22], which is why the therapist in CFT for psychosis works on combining the rational mentality with the compassionate mentality in a balanced way[23].

At the beginnings of CFT, Paul Gilbert developed the therapy for patients with high levels of shame and self-criticism, which is why the first CFT treatments simply practised introducing a warm, compassionate inner voice, like talking with a friend, and trying to really existentially feel this affectionate inner voice.

According to Gilbert and Choden[20], the concept of compassion can be broken down into two different psychologies:

1. The ability to approach suffering and difficulties in a non-judgemental way, increasing tolerance for discomfort, with an empathetic understanding of the causes of one's suffering and the suffering of others.

2. The development of knowledge and wisdom to try to prevent and alleviate suffering.

We see that this second psychology is aimed at compassionate action. Access to affiliative emotional processes is central to CFT, which in treating psychosis involves the development of courage in order to experience threatening voices, traumatic memories and paranoia. Thus, this therapy is training the ability to approach terrifying experiences from the perspective of validation, understanding, empathising with oneself and moderating the hostile voice and constant self-criticism.

The polar opposites of compassion are self-attacks and self-contempt. Hutton et al.[24] argue that people with persecutory delusions have a higher frequency and intensity of self attacks in the form of hate, feelings of inadequacy, negative self-concept, as well as lower self-correction of errors and self-respect than the general population and control subjects with clinical depression. These data provide support for a compassionate formulation[4] of the recovery from psychosis, which is articulated in a model that helps patients develop a different way of relating to themselves, identifying self-attacks without identifying with their content.

Despite their usefulness and effectiveness, it appears that approaches aimed at modifying self-depreciating thoughts, achieving meta-cognitive insights or doing away with negative ways of thinking may not be enough to help patients face inner experiences that are extremely difficult. Therefore, it may be of use to add strategies that develop greater self-acceptance, understanding and compassion.

Attachment Theory, Recovery Narratives and Compassion in Psychosis

Attachment theory[25] provides a solid conceptual framework for understanding the history of human beings' development, and how life experience influences our ability to embrace ourselves and tune into our own mind and that of others, the empathetic commitment to our pain and that of others, and our expression of forgiveness and compassion in relation to these experiences.

A mental state of secure attachment is characterised by the ability to value the influence of inter-personal relationships with equanimity, with openness to both the positive and negative aspects of life's difficult experiences, distinguishing appearance from reality. In this way, we cultivate emotional regulation, maintaining relative objectivity, along with an attitude of reflection regarding experiences of discomfort without losing meta-cognitive awareness and the expression of compassion and forgiveness. These skills are reflected in coherent narratives of attachment experiences as told by patients. It has been shown that these experiences promote attachment and security, especially in children[26].

This feeling of security is associated with our sensitivity toward suffering in ourselves and others through empathy, awareness (ability to interpret our own behaviour and that of others by assigning a series of mental states, which is developed in the context of early social relationships and attachment) and curiosity, along with the motivation and commitment to prevent and alleviate suffering, which are developed along with the capability for self-reflection that makes it possible to develop meta-cognition and emotional regulation. These mental states are very similar to compassionate social mentality as described by Gilbert[19].

In fact, Bowlby's [25] conceptualization of the affective attachment link is based on (a) providing a *safe refuge* in moments of threat or stress and (b) acting as a *secure base* from which the environment can be explored and new physical and mental abilities can be developed. A compassionate attitude is cultivated for the purpose of being in harmony with one's own needs, the needs of others, and a concern for their growth, development and autonomy. This cultivation makes it possible to see oneself in the mind of the other as a worthy, respected and valued individual, so that a developmental foundation of the person is laid, on which we can base psychological treatment[27].

Developing meaningful, coherent recovery narratives is considered to be an important measure in dealing with psychosis[28]. Formulating a narrative corresponds to several experiential exercises that are performed in CFT which are focused on developing a comprehensive, coherent attitude of self-reflection, along with the articulation of a revised narrative that includes the subject's self-acceptance.[23]

Among the effects of CFT, an increase in compassionate narratives was found in the results of the first randomised study on CFT in psychosis[29]. In another recent study, Gumley and Macbeth[30] have studied the relationship between psychotic symptomatology and compassionate narratives. The results show that as the level of compassionate narratives increases, there is a decrease in negative symptoms, cognitive disorganisation and excitation. This same group[31], in a recent pilot study on attachment and recovery after the first psychotic episode, observes that greater coherence in narratives, measured with the Adult Attachment Interview[27], predicts a greater recovery from negative symptoms in a 12-month period. The authors argue that this way of understanding and conceptualising attachment has significant shared elements with compassion.

We have seen that the first component of compassion is sensitivity, the concern for and harmonising with the pain and suffering experienced by oneself and by others. Secondly, from this harmony arises courage and the motivation to approach, understand and alleviate suffering. In the basis for this understanding of compassion, there is a series of skills that are rooted in the development of a secure attachment.

The experiences of trauma, abuse and neglect, which are common to the development of psychosis, and which directly affect attachment systems, may require cultivating courage and tolerance for discomfort in order to facilitate exploratory behaviour towards this suffering, built on a secure base and a safe refuge. A deeper understanding of these processes may help us to clarify compassion's role in

the development of new approaches to recovery from psychosis.

Formulation of a compassion-based recovery after psychosis

There are solid data that demonstrate the effectiveness of cognitive-behavioural therapy for psychosis (CBTp) in decreasing the severity and frequency of persistent psychotic experiences, including in patients who are resistant to conventional treatment. However, the evidence regarding CBTp in preventing relapses is scarce, according to a recent rigorous review[8]. Garety et al.[32] also did not find that CBTp reduces relapse rates or increases remission rates at 12 and 24 months, although it did improve delirium and social functioning in those people who lived with the support of family members or caretakers.

Patients who suffer relapses, in comparison with those who have not relapsed, experience a growing feeling of guilt and shame related to their psychosis in a period of 12 months. It is understandable that they have difficulty in asking for help, given that they may have experienced problems in earlier relationships or interactions with family members and therapists and may see them as critical, overwhelming, or as causing shame and rejection. Therefore, a therapeutic approach based on the first signs may create the expectation of having to seek help in a context of high levels of anguish, a context that for some people may overwhelm all of their internal and external resources. This may result in defensive avoidance or a delay in seeking help, which could cause more responses to the crisis driven by the threat of relapse, which confirms the person's negative expectations and increases the feeling of being trapped in the disease.

Following Gumley et al.[4] model of recovery, people with long-term psychosis usually experience various cycles of frustration, feelings of failure and episodes in which they call off or postpone seeking help until the relapse occurs. Given the traumatic, upsetting nature of psychosis, feelings of needing help and the perspective of seeking it by yourself can produce expectations of threat. Patients may fear an increase in medication, hospitalisation, or involuntary procedures. They may also experience feelings of shame and guilt related to the idea of disappointing their therapists or family members.

These emotional responses may appear in a context of diminishing psychotic experiences, as perceptive or cognitive anomalies or inter-personal mistrust. Although the majority of relapses are preceded by these experiences, their occurrence, along with emotional distress, does not necessarily lead to a relapse. The way in which a person responds to this threat will determine the intensity of emotional anguish.

Psychosis can also cause feelings of loss (for example, interruption of relationships or friendships) or events that threaten social range, value or acceptance (for example, feeling inferior, ashamed or humiliated by a psychotic episode; subjected to the pity, fear or exclusion of others), experiences that may be depressogenic because of their impact on the perception of self-concept and social status.

All of these processes inform us of the vulnerability and problematic nature of recovering after psychosis and the importance of creating experiences of security and social confidence and of developing a calming, compassionate relationship with oneself that counteracts self-criticism and feelings of exclusion.

Gilbert[33] has described the compassionate attributes and skills needed to alleviate feelings that arise from internal or external threats and their unwanted consequences:

1. Motivation to be affectionate and sensitive with oneself and others that is reflected in the cultivation of a "desire to help and care".
2. Sensitivity towards one's own emotions and needs and those of others, with attention and openness to discomfort instead of avoidance.
3. Sympathy. Being open and capable of getting in touch and emotionally harmonising with our feelings, suffering, needs and those of others.
4. The ability to tolerate (instead of avoid) difficult feelings, memories or painful situations.
5. Empathetic understanding of how our mind works, why we feel what we feel, what our thoughts are like, and extend this understanding to others.
6. Accept, do not judge, do not condemn. Develop a non-judgemental, non-submissive approach to ourselves and others.

These attributes and skills can be included in individual, group and family psychological treatments. They may also serve as a basis for a contextual-compassionate approach to the organisation of health and social services[4,34]. This approach focuses on the importance of those services having the ability to provide a safe base to promote self-compassion and autonomy among service users, while also providing a secure context that facilitates assistance at times of relapse risk. All of this requires a self-reflective and open attitude between clinics and managers in order to analyse the response we provide for these people and how contexts and professionals may inadvertently increase suffering.

Empirical Basis of Compassion-Based Interventions for Psychosis

The application of compassion-based therapies in psychosis is very recent and empirical research is scarce. There are still several issues to be resolved regarding its effectiveness, acceptability, therapist training and difficulties for patients.

Mayhew and Gilbert[35] conducted a series of case studies in which they applied CFT to three people who heard hostile voices. The purpose was to explore the degree to which the patients could access experiences of warmth and happiness with the aim of treating themselves with self-compassion. After 12 individual sessions, they explored the effect of CFT on the experience of hearing hostile voices, anxiety, depression, paranoia and self-criticism. The study found that CFT had a significant effect on the voices, which were perceived as less persecutory and malevolent, and the subjects responded in a less submissive way, achieving a more self-compassionate dialogue. The results showed a significant decrease in depression, inter-personal mistrust, anxiety and paranoia. However, despite significant improvement, one of the patients described serious difficulties with coexisting with compassion, saying that it caused rejection and a deep "pity and sadness" because he claimed "I don't deserve compassion". This is a phenomenon related to fear of positive emotions (and associated with insecure adult attachment styles) that may require an adjustment in treatment in certain patients in order to desensitise them from the fear of compassion.[36]

Laithwaite et al.[11] have developed the pilot programme Recovery After Psychosis (RAP), based on Compassionate Mind Training, which was carried out in a penitentiary psychiatric unit. The sessions were led by a team made up of three therapists (for security reasons). The programme was implemented with 18 inmates with psychosis over the course of 10 weeks (20 group sessions), with 2 sessions per week. The results showed a significant improvement in levels of depression, self-esteem and a moderate decrease in shame and social comparison. The changes were maintained through a 6-week follow-up.

Based on this programme, a group intervention protocol was developed that was used in the first randomised trial of CFT in psychosis, directed by Braehler et al.[29] with 40 patients in a community mental health unit distributed in two groups: 22 patients received 16 group CFT sessions and the usual treatment, and 18 patients received just the usual treatment. The CFT group had a significant increase in levels of compassion which was associated with a decrease in depression and social isolation. They also experienced a superior clinical improvement to the control group in all measurements, including a decrease in fear of relapse and in negative thoughts about psychosis.

Eicher et al.[37], in a correlation study, found a clear negative association between self-compassion and psychopathology in a sample of 88 people with psychosis. From the multiple regression analysis, it can be seen that patients with high hostility and depression may be ideal recipients for compassion-based interventions. From this study, it is interesting to note that patients with greater "disease awareness" tend to show less self-compassion and more self-criticism, overidentification and social isolation.

Heriot-Maitland et al.[10] conducted a qualitative pilot study of CFT application in an open group with 82 patients in an acute care hospital unit. The pretest-posttest measurements showed a significant reduction in discomfort and the qualitative data showed that patients especially valued the compassion in imagery practices that evoke a safe refuge.

Lastly, of interest is the first-person account[38] of a participant in a CFT group who had suffered from schizophrenia for 20 years, in which the patient explains the effects of his group experience, the different experiential exercises and how it helped him maintain a compassionate dialogue with the voices.

CFT group protocol for psychosis

Below we summarise the group CFT process performed by Braehler et al.[39], which was developed to be applied in the community. In addition to the main psycho-educational concepts of CFT, it includes aspects of group mindfulness[40] and of group processes in psychosis[41].

It consists of 16 sessions divided in 3 phases:

- Training Phase (sessions 1-5). In this phase, participants explore the impact of psychosis on their lives, making a recovery formulation in the evolutionary terms of the CFT model. Ideas inherent to the model are developed, as are the objectives of reducing shame, stigma, blame, and activating motivation to construct compassion skills. The group is established as a safe base, promoting shared motivation toward recovery. It is graphically illustrated how over-activation of the threat system obstructs recovery.
- Intermediate Phase (sessions 6-13). Focused on the gradual development of compassion towards oneself and others. The nature of compassion is explored, as are the ways in which it can be expressed in the group and how to internalise it for oneself. The patients experientially practise compassionate skills such as attention, appreciation, imagination, mindfulness, compassionate behaviour and these practised skills are re-framed by applying them to internal and external threats and difficulties related to the education received and life

experiences (for example, shame, vulnerability, stigmatisation, social anxiety, paranoia, self-attacks, hostile voices, lack of motivation, anhedonia). The protocol aims to create a group basis for the practices as a shared experience.

- Final phase (sessions 14-16). In this phase the security acquired is used to express difficult emotions in a compassionate way through expressive writing tasks that help to construct compassion-based narratives that can be shared with the group. Writing a compassionate letter to oneself, for example, may help participants to reflect upon and assimilate the changes towards recovery with a compassionate attitude, in order to integrate the impact of psychosis into their life and to look towards the future with confidence. In this phase, the transition towards the end of the group is facilitated, encouraging the continuance of shared activities.

Throughout all of the sessions, the group process is aimed at encouraging a compassionate care-giving group mentality, reinforcing interactions of support and the ability to relate with colleagues. The practice of compassionate skills between sessions is facilitated, through providing materials and audio files.

Conclusions

There is growing interest[42,43] in cultivating and practising compassion as a component of psychological treatments for psychosis. Approaches such as CFT are new in that they explicitly focus on the evolution of human affiliative behaviour. CFT is a multi-modal, transdiagnostic therapy that includes aspects of other evidence-based therapies based for psychosis. Clinicians can use knowledge and understanding of the biological foundations of emotional regulation systems and how they are affected by early development in order to integrate this perspective into a framework of applying effective treatments.

Current evidence, based on a recent systematic review[44], suggests that CFT is more effective than an absence of treatment or as effective as the usual treatment for various disorders, including psychosis. Specifically, CFT shows encouraging results as a treatment for people with a high self-criticism component. However, the evidence is insufficient to show that CFT is effective in comparison with well-established treatments such as TCC or family interventions.

CFT is a safe intervention accepted by patients with psychosis, which influences the validation of the person, has an evolutionary-functional vision of emotions, and which tries to create a formulation that gives meaning to the psychotic experience[23], working on emotional regulation and reducing the processing of threats. CFT also offers a general framework for promoting the emotional recovery of patients which may be helpful on an individual or group level, as well as in community mental health services.

References

1. Birchwood M. Pathways to emotional dysfunction in first-episode psychosis. British Journal of Psychiatry. 2003;182:373-5.
2. Guía de Práctica Clínica sobre la Esquizofrenia y el Trastorno Psicótico Incipiente. Madrid: Plan de Calidad para el Sistema Nacional de Salud del Ministerio de Sanidad y Consumo. Agència d'Avaluació de Tecnologia i Recerca Mèdiques; 2009. Guía de Práctica Clínica: AATRM. Nº 2006/05-2.
3. Lemos S, Fernández P, Fonseca E, Vallina O, Paino M. Bases Clínicas para un Nuevo Modelo de Atención a las Psicosis. Clínica y Salud. 2010;21(3):299-318.
4. Gumley AI, Braehler C, Laithwaite H, Macbeth A, Gilbert P. A compassion focused model of recovery after psychosis. International Journal of Cognitive Psychotherapy. 2010; 3(2):186-201.
5. Iqbal Z, Birchwood M, Chadwick P, Trower P. Cognitive approach to depression and suicidal thinking in psychosis. 2. Testing the validity of a social ranking model. British Journal of Psychiatry. 2000;177:522-8.
6. White R, Gumley A. Postpsychotic posttraumatic stress disorder: associations with fear of recurrence and intolerance of uncertainty. Journal of nervous and mental disease. 2009;197(11):841-9.
7. Moncrieff J. The bitterest pills: the troubling story of antipsychotic drugs. Palgrave Macmillan; 2013.
8. Wykes T, Steel C, Everitt B, Tarrier N. Cognitive behavior therapy for schizophrenia: Effect sizes, clinical models, and methodological rigor. Schizophrenia Bulletin. 2008;34(3).523-37.
9. Judge L, Cleghorn A, McEwan K, Gilbert P. An exploration of group-based compassion focused therapy for a heterogeneous range of clients presenting to a community mental health team. International Journal of Cognitive Therapy. 2012;5:420-9.
10. Heriot Maitland C, Vidal JB, Ball S, Irons C. A compassionate focused therapy group approach for acute inpatients: Feasibility, initial pilot outcome data, and recommendations. British Journal of Clinical Psychology. 2014;53(1):78-94.
11. Laithwaite H, O'Hanlon M, Collins P, Doyle P, Abraham L, Porter S, et al. Recovery after psychosis (RAP): A compassion focused programme for individuals residing in high security settings. Behavioural and Cognitive Psychotherapy. 2009;37(5):511-26.
12. Gilbert P, Procter S. Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. Clinical Psychology & Psychotherapy. 2006;13(6):353-79.
13. Hoffman SG, Grossman P, Hinton DE. Loving-kindness and compassion meditation:Potential for psychological interventions. Clinical Psychology Review. 2011;31:1126-32.
14. Klimecki OM, Leiberg S, Lamm C, Singer T. Functional neural plasticity and associated changes in positive affect after compassion training. Cerebral Cortex. 2012;23:1552-61.
15. Lutz A, Brefczynski-Lewis J, Johnstone T, Davidson RJ. Regulation of the neural circuitry of emotion by compassion meditation: Effects of meditative expertise. PloS one: 2008;3:e1897.
16. Goss K, Allan S. The development and application of compassion focused therapy for eating disorders (CFTE). British Journal of Clinical Psychology. 2014;53(1):62-77.

17. Lucre K, Corten N. An exploration of group compassion-focused therapy for personality disorder. Psychology and Psychotherapy: Theory, Research and Practice. 2013;86:387-400.
18. MacBeth A, Gumley A. Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. Clinical Psychology Review. 2012;32(6):545-52.
19. Gilbert P. Introducing compassion focused therapy. Advances in Psychiatric Treatment. 2009;15:199-208.
20. Gilbert P, Choden. Mindful Compassion. London: Constable-Robinson; 2013.
21. Wright N, Kelly O, Turkington D, Davies D, Jacobs A, Hopton J. Treating Psychosis: A Clinician's Guide to Integrating Acceptance and Commitment Therapy, Compassion-Focused Therapy, and Mindfulness Approaches within the Cognitive Behavioral Therapy Tradition. New Harbinger Publications; 2014.
22. Stott R. When the head and heart do not agree: A theoretical and clinical analysis of rational-emotional dissociation (RED) in cognitive therapy. Journal of Cognitive Psychotherapy. 2007;21:37-50.
23. Gumley A, Schwannauer M. Volver a la normalidad después de un trastorno psicótico: un modelo cognitivo-relacional para la recuperación y la prevención de recaídas. Bilbao: Editorial Desclée de Brouwer; 2008.
24. Hutton P, Kelly J, Lowens I, Taylor PJ, Tai S. Self-attacking and self-reassurance in persecutory delusions: A comparison of healthy, depressed and paranoid individuals. Psychiatry research. 2013;205(1):127-36.
25. Bowlby J. Secure base. Clinical applications of attachment theory. Tavistock/Routledge; 1988.
26. Fonagy P, Steele M, Steele H, Moran GS, Higgitt AC. The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. Infant Mental Health Journal. 1991;12:201-18.
27. Wallin DJ. El apego en psicoterapia. Bilbao: Desclée de Brouwer; 2012.
28. Lysaker PH, Lancaster RS, Lysaker JT. Narrative transformation as an outcome in the psychotherapy of schizophrenia. Psychology and Psychotherapy: Theory, Research and Practice. 2003;76(3):285-99.
29. Braehler C, Gumley A, Harper J, Wallace S, Norrie J, Gilbert P. Exploring change processes in compassion focused therapy in psychosis: Results of a feasibility randomized controlled trial. British Journal of Clinical Psychology. 2013;52(2):199-214.
30. Gumley A, Macbeth A. A pilot study exploring compassion in narratives of individuals with psychosis: implications for an attachment-based understanding of recovery. Mental Health, Religion & Culture. 2014;17(8):794-811.
31. Gumley AI, Schwannauer M, Macbeth A, Fisher R, Clark S, Rattrie L, et al. Insight, duration of untreated psychosis and attachment in first-episode psychosis: prospective study of psychiatric recovery over 12-month follow-up. British Journal of Psychiatry. 2014;205(1):60-7.
32. Garety PA, Fowler DG, Freeman D, Bebbington P, Dunn G, Kuipers E. Cognitive-behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: randomised controlled trial. British Journal of Psychiatry. 2008;192(6):412-23.
33. Gilbert P. The origins and nature of compassion focused therapy. British Journal of Clinical Psychology. 2014;53(1):6-41.
34. Veale D, Gilbert P, Wheatley J, Naismith I. A New Therapeutic Community: Development of a Compassion Focussed and Contextual Behavioural Environment. Clinical psychology & psychotherapy. 2014.
35. Mayhew SL, Gilbert P. Compassionate mind training for people who hear malevolent voices: A case series report. Clinical Psychology and Psychotherapy. 2008;15:113-38.
36. Gilbert P, McEwan K, Catarino F, Baião R. Fears of compassion in a depressed population. Implications for Psychotherapy. J Depress Anxiety. 2014;S2:003.
37. Eicher AE, Davis LW, Lysaker PH. Self-Compassion: A Novel Link With Symptoms in Schizophrenia? Journal of Nervous and Mental Disease. 2013;201(5):1-5.
38. Ellerby M. How compassion may help me. Psychosis: Psychological, Social and Integrative Approaches. 2014;6(3): 266-70.
39. Braehler C, Harper I, Gilbert P. Compassion focused group therapy for recovery after psychosis. CBT for Schizophrenia: Evidence-Based Interventions and Future Directions. 2012;235-66.
40. Segal ZV, Williams JMG, Teasdale JD. Mindfulness-based cognitive therapy for depression. (2nd Edition). Guilford Press; 2012.
41. Kanas N. Group therapy for schizophrenic patients. American Psychiatric Association; 1996.
42. Barnard LK, Curry JF. Self-compassion: Conceptualizations, correlates, and interventions. Review of General Psychology. 2011;15(4):289-303.
43. Simón V. El reencuentro científico con la compasión. Cebolla A, et al. Mindfulness y Ciencia. Madrid: Alianza; 2014. p. 191-225.
44. Leaviss J, Uttley L. Psychotherapeutic benefits of compassion-focused therapy: an early systematic review. Psychological medicine. 2014;1-19.

Loving-Kindness and Compassion practices in Dialectical Behavioral Therapy for Borderline Personality Disorder

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In recent years many psychotherapeutic approaches have included Loving-kindness and compassion practices in their treatment agenda. Although empirical evidence is still scarce, these practices might lead to an amelioration of shame and self-invalidation, both related to borderline personality disorder (BPD). In the present article, we describe an intervention in loving-kindness and compassion developed for BPD subjects. The principal aim of these sessions is to help participants to develop a greater capacity for self-com-