

Beaumont, E., Hollins Martin, C.J. (2015). A narrative review exploring the effectiveness of Compassion-Focused Therapy. *Counselling Psychology Review*. (The British Psychological Society). 30(1): 21-32. ISSN 0269-6975

A narrative review exploring the effectiveness of Compassion Focused Therapy

Content and Focus: This narrative review summarises findings of research that has shown use of Compassion-Focused Therapy (CFT) to improve psychological outcomes in clinical populations. This article reviews the research studies that have utilised CFT to treat clients experiencing a variety of mental health issues. The paper begins offering an overview of CFT theory and compassionate mind interventions. A literature search was conducted which included book chapters and articles that discussed compassion focused therapy. Twelve studies were identified which showed significant psychological improvements in clients with diagnosed trauma symptoms, brain injury, eating disorders, personality disorders, schizophrenia-spectrum disorder, chronic mental health problems and psychosis, both within groups and during one-to-one therapy. Within the context of the reviewed studies, CFT has shown itself to be an effective therapeutic intervention when combined with approaches such as Cognitive Behavioural Therapy (CBT).

Conclusion: The research design of the majority of the studies examined precluded determining the extent of individual contributions that CFT made towards client recovery. Further research that uses more rigorous approaches are required to evaluate more effectively the role CFT plays in clients' therapeutic recovery.

Keywords: Compassion-Focused Therapy (CFT), Compassionate Mind Training (CMT), Self-compassion, clinical outcome measure, narrative review

A narrative review exploring the effectiveness of Compassion Focused Therapy

Compassion Focused Therapy

Over the last decade there has been an increase in the amount of research that has explored the benefits of cultivating compassion (Germer & Siegel, 2012; Gilbert, 2010, 2009, 2000; Neff & Vonk, 2009; Lutz et al, 2008; Hutcherson, Seppala & Gross 2008; Leary et al, 2007; Neff, Hsieh & Dejitterat, 2005; Rein, Atkinson & McCraty 1995). With the evidence-base in mind, this paper intends to look at what the literature says about Compassion Focused Therapy (CFT) and its ability as a therapeutic intervention to enhance psychological outcomes in clinical populations.

Compassion Focused Therapy was initially developed to help people with chronic and complex mental health problems linked to high levels of shame and self-criticism (Gilbert, 2009). According to Gilbert (2009), CFT has been designed to increase awareness and understanding of human innate automatic reactions to threats within the environment, with the underpinning principle to motivate the client to care for their own well-being, increase sensitivity to their personal needs, and develop warmth and understanding for self. Over recent years there has been an increase in the use of third-wave CBT approaches, such as mindfulness (Segal et al., 2001), compassion focused therapy (Gilbert, 2005) and acceptance and commitment therapy (Pierson and Hayes, 2007).

At present there is a growing body of evidence within the healthcare community that suggests that developing feelings of compassion for self and others can have a profound impact on physiology, mental health and well-being (Harman & Lee, 2010; Gilbert & Irons, 2004; Gilbert et al., 2006). For example, CFT has been shown to increase immune system effectiveness (Lutz et al., 2008; Klimecki et al., 2012), lower blood-pressure and cortisol release (Cosley et al., 2010), reduce

paranoid ideation (Lincoln et al., 2012), moderate negative emotions associated with Cluster C personality disorders (Schanche et al., 2011), and improve general psychological well-being (Neff & Germer, 2012).

In contrast to other therapeutic approaches, CFT employs self-soothing techniques, and individuals benefit from these' which are designed to develop empathy, compassion and loving kindness (Harman & Lee, 2010; Gilbert & Irons, 2004; Neff et al., 2007) towards themselves. CFT processes are informed by the evolutionary model and psycho-education and seek to depersonalise and de-shame by helping the client understand how their brain regulates emotion. The theoretical background of this approach draws on evidence from neuropsychology, attachment theory, evolutionary psychology, social psychology and Buddhism, and aims to help the individual self-sooth and develop acceptance and empathy for their suffering (Gilbert, 2009). Once the client stops condemning and blaming themselves for their symptoms, thinking and feelings, they are freer to progress towards taking responsibility and learning to cope.

Cognitive Behavioural principles are incorporated into therapy, for example, at commencement of therapy the therapist conducts an assessment and develops a case formulation and treatment plan in collaboration with the client. Psycho-education is essential and the role behaviour, physiology, cognitions and emotions play are examined and the basic evolutionary model that underpins CFT is explored to help the client understand how their body is responding to perceived threat. Socratic dialogue, guided discovery, exploration of goals and homework activities are incorporated into CFT sessions, and are designed to help the client become their 'own therapist'. In addition, setback plans are formulated that involve asking questions such as:

- What kind of situation could 'set you back'?
- How could your compassionate-self deal with a set back?

Individuals are encouraged to employ self-soothing techniques, with the therapist focused on identifying strengths, positive attributes and good coping strategies (Gilbert et al., 2006; Gilbert & Irons, 2004). The CFT process involves the therapist listening warmly and acknowledging and validating clients' emotions and personal meanings (Gilbert, 2009; Gilbert & Irons, 2004; Lee, 2009b). Whereas CFT describes the process and theory of applying the model to therapy, compassionate mind training (CMT) is an element of CFT which focuses on activating the self-soothing system by using a variety of interventions.

Therapeutic interventions may include compassionate letter writing, building a compassionate image, examining compassionate behaviour and exploring compassionate ways of thinking. In addition, mindfulness techniques may be incorporated to help the client focus on what the brain is sensing 'in the now', instead of ruminating on past events (Segal et al., 2001).

Purpose of the review

CFT is a new and flourishing style of therapy, which is currently not widely available in the UK or the extended international market. To increase awareness of the worth of CFT, the objective of this paper was to present a synopsis of studies to assist therapists' understandings of how CFT has been successfully used and where developments in the body of research are required. The research questions asked included: (1) Is CFT an effective therapeutic intervention, and (2) What are the benefits of using CFT as an adjunct to psychotherapy and CBT?

Method

A review of the literature was undertaken to identify and summarise relevant research observations of the effectiveness of CFT either standalone or as an adjunct to other therapies. Narrative reviews are an essential part of scientific enquiry because they combine results from a variety of studies, therefore giving them a value that no single study can have (Baumeister & Leary, 1997). This method of review was considered suitable because it provides a historical account of the development of a theory, offers an overview of research in a particular area, and as such is a valuable method of pulling together what is known about a particular phenomenon in the broader sense, such as for a grant proposal or as a resource to therapists (Baumeister & Leary, 1997). Narrative reviews therefore, can be a valuable building technique and can tell a trustworthy story, aiming to identify and critically analyse research (Popay et al 2006).

Our purpose was to simply inform the field about what is already known about CFT and its ability to treat clinical populations. Having justified the choice of method, the ultimate aim of this review was to produce a paper to educate therapists about the state of knowledge on the topic of CFT and its ability to improve clients' situation.

Ethical Considerations

Published data were used in preparation of this manuscript, hence no ethical approval was required (Hollins-Martin & Martin, 2013).

Results/Findings

The review was conducted between January and May 2014. All titles, abstracts and full-text of studies identified were screened for potential inclusion. Primary research directly related to CFT therapy and its outcomes were examined. Papers required to be published in English and as CFT is a relatively new concept any studies that had been published before 2014 were included. Studies which focused on non-clinical

samples and/or student populations were excluded, because the objective was to explore the effectiveness of CFT as a therapy to treat clinical populations.

Search strategy

Data bases explored included MEDLINE, PsychINFO, CINAHL, Cochrane Database and Google scholar. Key words and search terms included were:

- Compassionate Mind Training
- Compassion-Focused Therapy
- Self-Compassion

The authors wanted to include both qualitative and quantitative methods and so a strict hierarchy of evidence was not applied.

The initial review identified 885 papers, but after closer examination was reduced to 13. Studies were excluded because they did not focus on examining CFT therapy outcomes with a clinical population. Studies that did not incorporate compassionate mind interventions as per Gilbert's model were also excluded. For example, research papers which focused on non-clinical samples, compassion fatigue or student populations were excluded from this review. Finally a further study was excluded (Gilbert & Irons 2004) as this was a pilot study which aimed to explore how individuals experience self-criticism on a daily basis, as opposed to examining CFT as a treatment intervention.

To view a summary of the 12 studies reviewed (see *Table 1*).

Table 1: Summary of the findings from studies using CFT as a therapeutic intervention

TABLE 1

Participants in the studies presented with (a) mental health problems (2 studies), (b) psychosis (3 studies), (c) trauma symptoms (4 studies), (d) eating disorders (1 study), and (e) personality disorders (1 study), and (f) CFT-group approach for acute inpatients (1 study). A summary of the literature that addressed use of CFT with participants experiencing mental health problems follows.

(a) CFT and its effectiveness at treating individuals with mental health problems

Two of the 12 studies support the effectiveness of CFT at treating clients with chronic mental health problems (Gilbert & Proctor, 2006; Judge et al., 2012).

(1) Gilbert and Proctor (2006) used a group-therapy approach to help individuals experiencing high-shame and self-criticism. Participants' received 12 two-hour CFT sessions supported within a CBT programme. A weekly diary was also completed to assess participants' self-attacking and self-soothing behaviours. Post-therapy, a significant reduction in depression ($p < 0.03$), anxiety ($p < 0.03$), self-criticism ($p < 0.03$), shame ($p < 0.03$), inferiority and submissive behaviour ($p < 0.05$) were found. Also recorded in the diaries was discourse that relates to an increase in feelings of self-warmth, reassurance for self and self-care. There was no significant change in self-correcting and self-attacking scores. One limitation of the Gilbert and Proctor (2006) study was the small participant group ($n=6$). However, this study presents as a pilot, with room for repetition and validation in similar contexts.

(2) Judge et al. (2012) found significant reductions post CFT therapy in symptoms of depression, anxiety, stress, self-criticism, shame, submissive behaviour and social comparison in individuals ($n=27$) attending group therapy (seven groups with an average of ($n=5$) per group). The analyses revealed significant improvements in

scores for all of the study variables with the exception of the self-correction subscale. The authors propose that self-correction could possibly be seen as a positive, preventing people from becoming too arrogant or as a way of helping maintain their standards. CFT had a significant impact at reducing depression, anxiety, and internal and external shame in clients' experiencing chronic mental health problems. Additional qualitative data supported that CFT was easily understood, helpful and well-tolerated by clients.

(b) CFT and its effectiveness at treating people with psychosis

Three of the 12 studies support the effectiveness of CFT at treating clients with psychosis (Mayhew & Gilbert, 2008; Laithwaite et al., 2009; Braehler et al., 2012).

(3) Mayhew and Gilbert (2008) present individual case-studies that explore three clients' with auditory hallucinations and their acceptance of CFT. Between sessions clients recorded auditory hallucinations, and their critical and compassionate thoughts towards self. CFT focused on helping them develop empathy for fear and distress felt, and also to develop tolerance and compassion for their fears through generating warmth and self-acceptance in response to their self-critical thoughts. Results recorded a decrease in depression, psychoticism, anxiety, paranoia, Obsessive–Compulsive Disorder (OCD) and interpersonal sensitivity. In response to CFT therapy, all three participants' auditory hallucinations became less malevolent, less persecuting and more reassuring. A surprising finding from this study was that two participants' self-compassion and self-criticism scores as measured by the Self-Compassion Scale (Neff 2003) did not reflect their diary sheet scores. All participants rated themselves as highly self-compassionate at commencement of therapy but

later reported that they had not understood 'self-compassion' until they started to engage in CMT.

(4) Braehler et al. (2012) conducted a Randomised Clinical Trial (RCT) that compared outcomes of a CFT group (N=22) and a Treatment As Usual (TAU) group (n=18) in clients diagnosed with schizophrenia-spectrum disorder. Therapy focused on reducing symptoms of shame and self-criticism and developing self-compassion. Post 16-weekly sessions, the CFT group showed greater observed clinical improvements ($p < 0.001$). A significant increase in compassion ($p=0.015$) was associated with significant reductions in depression ($p=0.001$), and a decrease in perceived social marginalization ($p=0.002$). When treatment scores were compared at the end of therapy there was a significant increase in compassion ($p = 0.02$) compared to non-significant small effects in TAU. Although further studies are required to validate these findings, using CFT as a therapeutic intervention with individuals with schizophrenia-spectrum disorder has shown to be an effective and safe form of therapy.

(5) Laithwaite et al. (2009) evaluated a 10-week CFT program that included (N=19) clients diagnosed with psychosis who were residing in a high security setting. By the end of the program significant improvements in social comparison ($p<0.05$), self-esteem ($p<0.01$), shame ($p<0.05$), and depression ($p<0.05$) were achieved. Significant differences in self-compassion and self-concept were not found, leading the authors to conclude that the self-report of compassion could be different for individuals who have lacked the experience of compassion from others during critical periods of their development. Further replication of this study could involve a waiting list control group and a larger sample size.

(c) CFT and its effectiveness at treating symptoms of trauma

Four of the 12 studies supported effectiveness of CFT at treating clients with symptoms of trauma (Ashworth et al., 2012; Beaumont et al., 2012; Bowyer et al., 2014; Beaumont & Hollins Martin, 2013).

(6) Ashworth et al. (2011) reported that CBT had limited effect on Jenny who had experienced traumatic brain injury. In contrast to CBT, CFT helped reduce depression and anxiety, improve validation of 'self', increase acceptance of difficulties, raise self-esteem, and reduce anger. Ratings of beliefs relating to key cognitions also improved. The cognition 'I am worthless' fell to 10% from 100% by the end of therapy. It is important to note that Jenny was treated in the context of a holistic rehabilitation program. Therefore, it cannot be assumed that the clinical changes observed are due only to CFT interventions. However, developing a portfolio of case studies would work towards validating the findings of this single-case report (Fishman, 2005).

(7) Beaumont et al. (2012) compared outcomes of clients with trauma-related symptoms between a group that received CMT and CBT (N=16), and a CBT only group (N=16). Participants in both treatment groups experienced statistically significant reductions post-therapy in symptoms of anxiety ($p < 0.001$), depression ($p < 0.001$), avoidance ($p < 0.001$), hyper-arousal ($p < 0.001$) and intrusive thoughts ($p < 0.001$). However, there was no significant difference between treatment groups. Participants in the CBT/CMT condition developed statistically significant higher self-compassion scores post-therapy than the CBT-only group. The main effect comparing the two types of treatment was significant [$F(1,30)=4.657, p \leq .05$] suggesting higher levels of self-compassion post-therapy in the CBT/CMT group.

(8) Bowyer et al. (2014) used CMT to enhance trauma-focused CBT with a 17-year-old girl who was sexually assaulted at the age of thirteen. Post therapy, there was an increase in self-reassurance, with reduced PTSD, depression, self-attacking behaviours and shame. Again, assembling an anthology of case-reports with similar findings will help validate use of CMT adjacent to trauma-focused CBT.

(9) Beaumont and Hollins Martin (2013) propose that CMT can be used as a resource in Eye Movement Desensitization and Reprocessing (EMDR). In the Beaumont and Hollins Martin (2013) single-case report, EMDR was used to treat a 58-year-old man who presented with psychological distress and somatic symptoms post-trauma. EMDR combined with CMT facilitated recall of forgotten memories about the client's sister's traumatic death, with emotions of shame and grief creating insight into how past events linked to a current signature-signing phobia. The combined EMDR/CMT approach was implemented to reduce threat of rejection, self-criticism, and self-attack (Wheatley et al., 2007). This client responded well to strategies used to increase self-compassion and tackle the 'critic within.' Eight sessions of compassion-focused EMDR eliminated the client's signature signing phobia, reduced his anxiety and trauma related symptoms, and elevated his mood and self-compassion. These effects maintained at 9-month follow-up. A multiple baseline case study could be used in future research to examine the individual contributions of CMT and EMDR.

(d) CFT and its effectiveness at treating individuals with eating disorders

One of the 12 studies supported effectiveness of CFT for treating clients with eating disorders (Gale et al., 2012).

(10) Gale et al. (2012) measured outcomes between 2002-2009 from integrating CFT into a standard CBT programme for clients with eating disorders (N=139). In total, 73% of clients with bulimia nervosa, 21% with anorexia nervosa, and 30% with atypical eating disorders reported significant improvements in their eating disorders by end of treatment. The results of the study suggest that individuals with eating disorders can benefit from a compassion-focused approach. However, due to issues surrounding missing data only 99 people who completed the programme had pre and post scores at the end of treatment.

(e) CFT and its effectiveness at treating individuals with personality disorders

One of the 12 studies supported effectiveness of CFT for treating clients with personality disorders (Lucre & Corten, 2012).

(11) Lucre and Corten (2012) measured the responses of clients with diagnosed personality disorders (N=8) who had completed a 16-week course of CFT informed by CBT. A significant reduction in depression ($p<0.05$), stress ($p<0.05$), shame ($p<0.05$), social comparison ($p<0.01$), self-hatred ($p<0.01$), and an increase in self-reassurance, well-being and social functioning ($p<0.01$) were reported. Qualitative feedback informed that participants found CFT helpful, with benefits upheld at one-year follow-up. A limitation of this study is that it is difficult to identify the specific aspects of the CFT programme that accounted for the significant changes in the self-report measures. However, improvements were maintained at 1-year follow-up.

CFT and its effectiveness at treating individuals in acute in-patient settings

One of the 12 studies supported effectiveness of CFT for treating clients in acute in-patient settings (Heriot-Maitland et al., 2014).

(12) Heriot-Maitland et al. (2014) assessed the impact of 22 CFT group sessions delivered over a 6-month period to patients (N=82) in an acute unit. Participants rated their pre and post-session levels of distress and calmness on a 6-point Likert scale, which produced 57 data-sets. Results found a significant reduction in levels of distress ($p=0.005$) and a significant increase in overall calmness post-session ($p=0.05$) particularly within a session which focused on imagery ($p=0.019$). Qualitative data themes produced were labelled 'understanding compassion', 'experience of positive affect' and feelings of a 'common humanity'. A limitation of this pilot study is that it did not use standardised outcome measures. However, comments from the individuals in the group offered rich data regarding client experience of therapy.

Discussion

Strengths and limitations of the studies examined and identified areas for future research follow. First, the research questions were supported by the findings of this narrative review. CFT has shown itself in the context of the reviewed studies to be an effective therapeutic intervention. Also, analysis has demonstrated benefits of using CFT as an adjunct to psychotherapy and CBT. In essence, the evidence examined supports that people referred for psychological intervention may benefit from developing self-compassion.

Three of the studies examined were case studies (Ashworth 2011; Beaumont et al 2012; Bowyer et al 2014), one was a case series (Mayhew & Gilbert 2008), and a further three had 'sample sizes' of ($n=20$) or under (Gilbert & Proctor, 2006; Laithwaite et al., 2009; Lucre & Corten, 2012). Yet, because of small samples and lack of rigour from tight control groups, generalisation of findings to the wider population becomes problematic. Also there is ambiguity about whether or not

changes in self-compassion were in fact due to the CFT therapy alone. Due to therapy being combined with EMDR or CBT in some of the studies cited, it is advised that further research examines stand-alone CFT in clinical contexts.

Also, without a treatment control group (Braehler et al 2012), it is difficult to determine if individuals improved as a direct result of the CFT or because of external factors (Corney & Simpson, 2005), such as personality type, social support, relapse prevention, relapse indication issues and/or individual resilience. Increasing sample sizes and taking a gold standard RCT approach is essential to further validate effectiveness of the CFT technique (McLeod, 2010). To our knowledge effect sizes quantifying the difference between groups and the effectiveness of the treatment intervention was not reported in all of the studies reviewed. Reporting effect sizes in research is valuable for quantifying the effectiveness of the interventions examined (Huberty, 2002).

Triangulating quantitative data with qualitative approaches also helps identify palatability of CFT at an individual level. For example, Laithwaite et al., (2009) reported that some clients struggled with compassionate imagery tasks. In contrast, Harriot-Maitland et al. (2014) reported that their imagery sessions were particularly well-received by inpatients, and that they received the lowest attrition rate (25 per cent) of all the therapeutic interventions used. These conflicting results, support that some individuals appreciate CFT imagery exercises, whilst others do not. Consequently, rich detailed qualitative data is essential if therapists are to understand why particular aspects of CFT works and with whom.

Other aspects that require exploration include, mismatches between clients' diary reports and their self-compassion scores. For example, Mayhew and Gilbert (2008) report that self-compassion scores in their study did not mirror participants' diary

sheet scores. Also, some clients' rated themselves as highly self-compassionate, and later in therapy reported that they did not understand what the term meant. This highlights the importance of clearly defining the term 'compassion' and assessing client comprehension throughout therapy and before CFT commences. In addition, for the evidence-base to develop, it is important to gather follow-up data to ascertain longevity of scores.

A variety of measures and questionnaires were used in the 12 studies (refer to table 1) including: -

- Functions of the Self-Criticizing/Attacking Scale (Gilbert, et al., 2004)
- Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (Gilbert et al., 2004)
- Self-Compassion Scale-Short Form (Raes et al., 2010)
- Self-Compassion Scale (Neff, 2003)
- Other as Shamer Scale (Goss et al., 1994)
- Submissive Behaviour Scale (Allan & Gilbert, 1997)
- Social Comparison Scale (Allan & Gilbert, 1995).

A further question for researchers to consider is what outcomes measures are appropriate for future CFT research?

Conclusion

Counselling psychology welcomes the opportunity to integrate new developments within existing therapeutic approaches and it is essential that new treatment options be examined so that we as a counselling and psychotherapy profession provide therapy that meets the needs of clients referred for psychological intervention.

This review has shown benefits of using CFT to create a more affiliated orientation to ones-self and others. However, further research evidence in this area is needed in order to ensure that we as a therapeutic community offer the best

treatment for those individuals referred to us for psychotherapy. To date there is not enough evidence to suggest that CFT is as effective as other psychotherapeutic interventions.

The CFT model is advantageous because it can be integrated into a CBT program or incorporated into other psychotherapeutic frameworks. In conclusion, data provides promising support for the utility of CFT, with research already conducted an encouraging starting point for exploring structured, time limited, compassion-focused interventions for clients diagnosed with clinical conditions.

In terms of future research, there are a number of research questions that remain unanswered. For example:

- (1) What elements of CFT are the most effective, why and to whom?
- (2) What are the best measures of CFT?
- (3) How effective is CFT when used as a therapeutic intervention on its own?

In addition to examining symptom reduction, further research is required to examine improvements in quality of life, changes in individual resilience and social functioning. Introducing control groups, using larger sample sizes, implementing long-term follow-up and independent rating of changes in outcomes would also improve rigour. Also needed are qualitative studies that explore what is helpful during delivery of CFT to enrich and develop skills of therapists from the 'compassionate mind community'.

References

- Allan, S., & Gilbert, P. (1995). A social comparison scale: Psychometric properties and relationship to psychopathology. *Personality and Individual Differences*, 19, 293–299.
- Allan, S., & Gilbert, P. (1997). Submissive behaviour and psychopathology. *British Journal of Clinical Psychology*, 36, 467–488.
- Ashworth, F. M., Gracey, F., & Gilbert, P. (2011). Compassion focused therapy after traumatic brain injury: Theoretical foundations and a case illustration. *Brain Impairment*, 12, 128 –139. <http://dx.doi.org/10.1375/brim.12.2.128>.
- Baumeister, R. F., & Leary, M. R. (1997). Writing narrative literature reviews. *Review of General Psychology*, 1 (3), 311-20.
- Beaumont, E, Galpin, A. & Jenkins, P. (2012). Being kinder to myself: A prospective comparative study, exploring post-trauma therapy outcome measures, for two groups of clients, receiving either Cognitive Behaviour Therapy or Cognitive Behaviour Therapy and Compassionate Mind Training. *Counselling Psychology Review*, 27 (1), 31-43.
- Beaumont, E., & Hollins Martin, C. J. (2013). Using compassionate mind training as a resource in EMDR: A case study. *Journal of EMDR Practice and Research*, 7(4), 186-199.
- Bowyer, L., Wallis, J. & Lee, D. (2014). Developing a Compassionate Mind to Enhance Trauma-Focused CBT with an Adolescent Female: A Case Study. *Behavioural and Cognitive Psychotherapy*, 42, 248-254.
- Braehler, C., Gumley, A., Harper, J., Wallace, S., Norrie, J., & Gilbert, P. (2012). Exploring change processes in compassion focused therapy in psychosis: Results of a feasibility randomized controlled trial. *British Journal of Clinical Psychology*, 52, 199 –214. <http://dx.doi.org/10.1111/bjc.12009>.
- Brewin, C.R. (2006). Understanding cognitive behaviour therapy: A retrieval competition account. *Behaviour Research and Therapy*, 44, 765-784.
- Brooks, M., Kay-Lambkin, F., Bowman, J. & Childs, S. (2012). Self-compassion amongst clients with problematic alcohol use. *Mindfulness*.DOI 10.1007/s12671012-0106-5.
- Corney, R., & Simpson, S. (2005). Thirty-six month outcome data from a trial of counselling with chronically depressed patients in a general practice setting. *Psychology and Psychotherapy: Theory, Research and Practice*, 78, 127-138.
- Cosley, B.J., McCoy, S.K., Saslow, L. R., Epel, E.S. (2010). Is Compassion for Others Stress Buffering? Consequences of Compassion and Social Support for Physiological Reactivity to Stress. *Journal of Experimental Social Psychology*, Vol. 46, Issue 5, 816-823.

- Fishman, D.B. (2005). Pragmatic Case Studies in Psychotherapy, <http://pcsp.libraries.rutgers.edu> Vol. 1, Module 1, Article 2, pp. 1-50, 01-01-2005.
- Gale, C., Gilbert, P., Read, N., & Goss, K. (2012). An evaluation of the impact of introducing compassion focused therapy to a standard treatment programme for people with eating disorders. *Clinical Psychology & Psychotherapy*, <http://dx.doi.org/10.1002/cpp.1806>.
- Germer, C. K., & Neff, K. D. (2013). Self-compassion in clinical practice. *Journal Of Clinical Psychology*, 69(8), 856-867. doi:10.1002/jclp.22021.
- Germer, C.K & Siegel R.D (2012). *Wisdom and Compassion in Psychotherapy: Deepening Mindfulness in Clinical Practice*. New York:Guilford.
- Gilbert, P. (2010). *Compassion Focused Therapy: The CBT Distinctive Features Series*. London: Routledge
- Gilbert. P. (2009). *The Compassionate Mind*. London: Constable.
- Gilbert, P. (2000). Varieties of submissive behaviour: Their evolution and role in depression. In, L. Sloman & P. Gilbert (eds.). *Subordination and Defeat. An Evolutionary Approach to Mood Disorders* (3-46): Hillsdale: N.J. Lawrence Erlbaum.
- Gilbert, P., Baldwin, M. W., Irons, C., Baccus, J. R., & Palmer, M. (2006). Self-criticism and self-warmth: An imagery study exploring their relation to depression. *Journal of Cognitive Psychotherapy*, 20, 183-200.
- Gilbert, P. & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy*, 13, 353-379.
- Gilbert, P., Clarke, M., Hemel, S., Miles, J.N.V., & Irons, C. (2004). Criticizing and reassuring oneself: And exploration of forms, style and reasons in female students. *British Journal of Clinical Psychology*, 43, 31–35.
- Goss, K., Gilbert, P., & Allan, S. (1994). An exploration of shame measures: I: The 'other as shamer' scale. *Personality and Individual Differences*, 17, 713–717.
- Harman, R., & Lee, D. (2010). The Role of Shame and Self-Critical Thinking in the Development and Maintenance of Current Threat in Post-Traumatic Stress Disorder. *Clinical Psychology and Psychotherapy*, 17 13-24.
- Heriot-Maitland, C., Vidal, J. B., Ball, S., & Irons. C. (2014). A compassionate-focused therapy group approach for acute inpatients: Feasibility, initial pilot outcome data, and recommendations. *British Journal of Clinical Psychology*, 53, 78–94.

- Hollins-Martin, C. J., & Martin, C. R. (2013). A narrative review of maternal physical activity during labour and its effects upon length of first stage. *Complementary Therapies in Clinical Practice*, 19, 44-49.
- Huberty, C. J. (2002) 'A history of effect size indices'. *Educational and Psychological Measurement*, 62, 2, 227-240
- Hutcherson, C. A., Seppala, E. M. & Gross, J. J. (2008). Loving-kindness meditation increases social connectedness. *Emotion*, 8, 720-724.
- Judge, L., Cleghorn, A., McEwan, K., & Gilbert, P. (2012). 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*, 5, 420–429. <http://dx.doi.org/10.1521/ijct.2012.5.4.420>.
- Klimecki, O., Leiberg, S., Lamm, C., & Singer, T. (2012). Functional Neural Plasticity and Associated Changes in Positive Affect After Compassion Training. *Cerebral Cortex Advance Access published June 1, 2012*. doi:10.1093/cercor/bhs142
- Laithwaite, H., O'Hanlon, M., Collins, P., Doyle, P., Abraham, L., Porter, S., et al. (2009). Recovery after psychosis (rap): A compassion focused programme for individuals residing in high security settings. *Behavioural and Cognitive Psychotherapy*, 37, 511.
- Leary, M. R., Tate, E. B., Adams, C. E., Batts Allen, A., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality and Social Psychology*, 92, 887–904.
- Lee, D.A (2009a). Compassion Focused Cognitive Therapy For Shame-based Trauma Memories and Flashbacks in PTSD. In Grey, N. (eds) *A Casebook of Cognitive Therapy for Traumatic Stress Reactions*. Chapter 15. London: Routledge.
- Lee, D.A. (2009b): *Compassion focused therapy to overcome shame and relentless self attack*: In Sookman, D., & Leahy, R. (eds). *Treatment Resistant Anxiety Disorders*. New York: Routledge.
- Lincoln, T. M., Hohenhaus, F, & Hartmann, M. (2012). Can paranoid thoughts be reduced by targeting negative emotions and self-esteem? An experimental investigation of a brief compassion-focused intervention. *Cognitive Therapy and Research*, 37, 390–402. <http://dx.doi.org/10.1007/s10608-012-9470-7>.
- Lucre, K., & Corten, N. (2012). An exploration of group compassion-focused therapy for personality disorder. *Psychology and Psychotherapy: Theory, Research, and Practice*, 86, 387–400.
- Lutz, A., Brefczynski-Lewis, J., Johnstone, T., & Davidson, R. J. (2008). Regulation of the neural circuitry of emotion by compassion meditation: Effects of

meditative expertise. PLoS one, 3,
e1897.<http://dx.doi.org/10.1371/journal.pone.0001897>.

- Mayhew S. & Gilbert P. (2008) Compassionate mind training with people who hear malevolent voices. A case series report. *Clinical Psychology and Psychotherapy*, 15, 113–38.
- Neff, K., & Germer, C. (2012). A Pilot Study and Randomized Controlled Trial of the Mindful Self-Compassion Program. *Journal of Clinical Psychology*. 00:1–17.
- Neff, K. D., Kirkpatrick, K. L., & Rude, S. (2007). Accepting the human condition: Self-compassion and its links to adaptive psychological functioning. *Journal of Personality*. 41, 139-154.
- Neff, K. D., Hsieh, Y., & Dejitterat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity*, 4, 263–287.
- Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223-250.
- Neff, K. D. & Vonk, R. (2009). Self-compassion versus global self-esteem: Two different ways of relating to oneself. *Journal of Personality*, 77, 23-50.
- Popay J., Roberts H., Sowden A., Arai L., Rodgers H., Britten N., Roen K. & Duffy S. (2006). Guidance on the Conduct of Narrative Synthesis in Systematic Reviews. *ESRC, Swindon*.
- Raes, F., Pommier, E., Neff, K., & Van Gucht, D. (2010). Construction and factorial validation of a short form of the Self-Compassion Scale. *Clinical Psychology & Psychotherapy*. DOI:10.1002/cpp.702.
- Rein, G., Atkinson, M., McCraty, R. (1995). The physiological and psychological effects of compassion and anger. *Journal of Advancement in Medicine*, 8, 87-105.
- Schanche, E., Stiles, T., McCollough, L., Swartberg, M., & Nielsen, G. (2011). The relationship between activating affects, inhibitory affects, and self-compassion in patients with cluster C personality disorders. *Psychotherapy: Theory, Research, Practice, Training*, Advance online publication. doi: 10.1037/a0022012.
- Segal, Z., Williams, J. M. G., & Teasdale, J. (2001). *Mindfulness-Based Cognitive Therapy for Depression. A New Approach to Preventing Relapse*. New York: Guildford.
- Wheatley, J., Brewin, C. R., Patel, T., Hackmann, A, Wells, A., Fisher, P., & Myers, S. (2007). I'll believe it when I see it: Imagery re-scripting of intrusive sensory memories in depression. *Journal of Behavior Therapy and Experimental Psychiatry*, 38(4), 371–385.

