Clinical Psychology and Psychotherapy
Clin. Psychol. Psychother. **15**, 113–138 (2008)
Published online in Wiley InterScience (www.interscience.wiley.com). **DOI**: 10.1002/cpp.566

Practitioner Report

Compassionate Mind Training with People Who Hear Malevolent Voices: A Case Series Report

Sophie L. Mayhew[1]* and Paul Gilbert[2]
[1] *Department of Clinical Psychology, Derbyshire Mental Health Services NHS Trust*
[2] *Mental Health Research Unit, Derbyshire Mental Health Services NHS Trust*

This paper presents a series of case studies to explore the understanding, acceptance and value of compassionate mind training (CMT) with psychotic voice hearers. We were interested in the degree to which such people are able to access and feel the positive emotions of 'warmth' and 'contentment' to become more self-compassionate. We also explored how CMT affected participants' hostile voices, their levels of anxiety, depression, paranoia and self-criticism. Participants were invited to offer suggestions for tailoring this approach for voice hearers. Results showed decreases for all participants in depression, psychoticism, anxiety, paranoia, Obsessive–Compulsive Disorder and interpersonal sensitivity. All participants' auditory hallucinations became less malevolent, less persecuting and more reassuring. **Copyright © 2008 John Wiley & Sons, Ltd.**

INTRODUCTION

Compassionate mind training (CMT) was originally developed for people with high levels of shame and self-criticism (Gilbert, 2000; Gilbert & Irons, 2005). It rests on the premise that these individuals find it very difficult to be self-supporting or self-reassuring in part because they have never learnt to be so. They have usually come from traumatic, shaming and critical backgrounds. Helping people develop feelings for and become orientated towards self-reassurance and self-compassion has proved helpful for people with chronic difficulties (Gilbert & Procter, 2006).

The theory underpinning CMT is derived from recent developments in the neuroscience of positive emotion. This suggests that there are two basic positive affect regulation systems; one is focused on achieving and doing, while the other is focused on contentment and social soothing (Depue & Morrone-Strupinsky, 2005). Thus, when we feel content, we are no longer seeking or striving to achieve. The soothing system is believed to be a major evolved regulator of the threat system.

For example, in mammals with an attachment system, proximity and comfort from the parent is calming to an infant. In the normal course of events, repeated experiences of parental calming stimulates and integrates the soothing system as a natural regulator of threat (Carter, 1998). In con-

*Correspondence to: Dr Sophie Mayhew, Department of Clinical Psychology, Plymouth Teaching Primary Care NHS Trust, Glenbourne, Morlaix Drive, Derriford, Plymouth, Devon, England PL6 5AF.
E-mail: sophie.mayhew@pcs-tr.swest.nhs.uk

Copyright © 2008 John Wiley & Sons, Ltd.

trast, aversive early experiences may disrupt this process, making it difficult for people to access the soothing system as an affect regulator (Schore, 1994). See Panksepp (2004) for further examination of the neuroscience of emotion.

It is well known that paranoia is a disorder of threat attention and appraisal (Garety & Freeman, 1999). Many people with paranoid feelings and also people who hear hostile voices believe that they have to be highly vigilant to the environment to stay safe (Birchwood & Chadwick, 1997). In essence, both the external world and the internal world become sources of threat.

This study therefore set out to explore if trying to stimulate the soothing system could act as a natural regulator of threat. We wanted to know if people who have paranoid experiences and who hear malevolent voices would find the explanations of CMT helpful and 'fitting' with their own experiences. We were also interested in the degree to which people with these experiences are able to access and feel the positive emotions of 'warmth' and 'contentment' and to become more self-compassionate. We also explored how CMT affected participants' hostile voices, their levels of anxiety, depression, paranoia and self-criticism. There is an increasing recognition that when researchers collaborate and seek information on how patients experience a disorder, processes associated with a disorder, or interventions, patients are often pleased and able to offer insights from 'the inside' (Goodare & Lockwood, 1999). This study was conducted in a highly collaborative manner, making clear the nature and purpose of the research. Participants were invited to offer suggestions for tailoring this approach for other voice hearers.

METHOD

A case series design was chosen as the most appropriate methodology to explore the research questions. Ethical approval was granted by the Nottinghamshire Local Research Ethics Committee and by the Derbyshire Local Research Ethics Committee. At the start of the project, the researcher (SM) met up with members of The Hearing Voices Network, a national user-led support group, to discuss the proposed study. Relevant ideas and suggestions raised by members of the network (such as offering CMT on an individual rather than a group basis, exclusion criteria and the location of the therapy sessions) were incorporated into the study design and method. Participants were then invited to collaboratively explore CMT.

Participants

Potential participants aged between 16 and 65 years who had a diagnosis of schizophrenia and who experienced hostile auditory hallucinations were identified from Community Mental Health Teams in Derbyshire Mental Health NHS Trust and invited to participate in the study. Those who were experiencing a major psychotic relapse or who had symptoms severe enough to impede their ability to provide informed consent or who did not speak English were excluded. People experiencing a relapse were excluded as they were felt to be too unwell to participate. Seven people expressed interest and consented to take part: six men aged between 23 and 64 years old (mean age 36 years) and one woman aged 25. Of these, three completed the CMT. Reasons for disengagement from CMT were that one person became too unwell to participate, one suffered a bereavement and decided to withdraw from the study, one withdrew after session 3 as he was too paranoid to continue, and one withdrew after session 4 as she felt better and wanted to disengage from services.

Participant 1 was a 64-year-old white British man. He was a practising Christian who was married, living with his wife and retired. He had suffered with paranoid schizophrenia for the last 30 years. Participant 2 was a 26-year-old white British student. He was a non-practising Christian who was single and living with his parents. He had been diagnosed with schizophrenia 5 years ago. Participant 3 was a 44-year-old white British man who was unemployed. He was a non-practising Christian who was divorced and living with his new partner. He had suffered from paranoid schizophrenia for the last 21 years.

Measures

Participants were asked to complete six questionnaires before and after the CMT and at the 6-month follow-up: The Belief About Voices Questionnaire (BAVQ) (Chadwick & Birchwood, 1995), a shortened version of the Forms of Criticism/Self-Attacking and Self-Reassuring Scale (Gilbert, Clarke, Hemel, Miles, & Irons, 2004), a shortened version of the Functions of Self-Criticism/Attacking and Self-Reassuring Scale (Gilbert et al., 2004), a symptom inventory, the SCL-90 (Derogatis, Rickels, & Rock, 1976), the Voice Rank Scale (Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000), and the Self-Compassion Scale (Neff, 2003). Participants were also asked to keep a diary of their

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

voice activity, self-critical and self-compassionate thoughts each week (see Appendix 1).

The BAVQ

The BAVQ is a validated 30-item self-report measure that assesses key beliefs about voices including the voice content, power, purpose and the consequences of listening to the voice (Chadwick & Birchwood, 1995). All items require the participant to answer 'yes' or 'no', which attract a score of 1 or 0, respectively. The measure contains six items for malevolence, with a threshold score of 3 or more indicative of malevolence (Cronbach's alpha 0.82); six items for benevolence, with a score of 3 or more indicative of benevolence (Cronbach's alpha 0.86); eight items for engagement, with a threshold of 5 or more indicative of engagement (Cronbach's alpha 0.87) and nine items for resistance, with a score of 5 or more indicative of engagement (Cronbach's alpha 0.84). One item assesses the voices' power.

Forms of Self-Criticism/Self-Attacking and Self-Reassuring Scale

This 22-item scale measures peoples' self-critical (14 items) and self-reassuring responses (eight items) to setbacks. Factor analysis suggested that the self-critical factor could be separated into two sub-factors, one that focuses on feeling inadequate (nine items; Cronbach's alpha of 0.90) and one that focuses on a sense of disgust with the self (five items; Cronbach's Alpha of 0.86) (Gilbert et al., 2004). Participants rate statements designed to tap self-criticism and self-reassurance on a five-point Likert scale from 0 = not at all like me to 4 = extremely like me. The current study used a shortened six-item version of the Self-Criticism Scale, including only those items from the original 22-item scale, that loaded 0.73 and above on a single factor, such as '*I think I deserve my self-criticism*'. This six-item version was adapted to rate participants' beliefs about the forms of their most powerful auditory hallucinations, as opposed to their thoughts, such as '*I think I deserve the voice's criticism about me*'.

In the original scale there are eight items measuring self-reassurance such as '*I am able to remind myself of positive things about myself*'. The current study used a shortened five-item version of the Self-Reassuring Scale, including only those items from the original scale that loaded 0.73 and above on a single factor. This five-item version was also adapted to rate participant's beliefs about their most powerful auditory hallucinations, as opposed to their thoughts, such as '*the voice is able to remind me of positive things about myself*'.

Functions of Self-Criticism/Self-Attacking Scale

This 21-item scale measures the reasons for, and perceived functions of, why people may be self-critical or self-attack. Participants rate the 21 possible reasons for their self-attacking on a five-point Likert scale from 0 = not at all like me to 4 = extremely like me. Factor analysis suggested two separate factors: self-correction and self-persecution such as '*I get angry with myself to destroy a part of me*'. This scale has good internal reliability, with Cronbach's alpha of 0.92 (Gilbert et al., 2004). This study used an 11-item version of this scale, including only those items from the original 21-item questionnaire, that loaded 0.73 and above on a single factor, as these were most representative of that subscale. This 11-item version was adapted to rate participants' beliefs about their most powerful auditory hallucinations, as opposed to their thoughts, such as '*the voice gets angry with me to destroy a part of me*'.

SCL-90

The SCL-90 is a multidimensional symptom self-report inventory comprised of 90 items, each rated on a five-point scale of distress from 0 = 'not at all' to 4 = 'extremely'. The inventory is scored on nine primary symptom dimensions plus three global indices of pathology. The primary symptom constructs are somatization, obsessive–compulsive, interpersonal sensitivity (IPS), depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. The global indices are the Global Severity Index (GSI), the positive symptom distress index (PSDI) and the Positive Symptom Total (PST). The GSI combines information on numbers of symptoms and intensity of distress; the PSDI is a pure intensity measure and the PST is data on number of symptoms only.

Voice Rank Scale

The Voice Rank Scale is an 11-item scale that uses a 10-point Likert scale that measures the individual's rank relative to their dominant auditory hallucination. Participants responded to the probe statement '*in relation to my voice I feel. . . .*' The internal reliability of this scale is 0.80 and the re-test reliability

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

is 0.77 (Birchwood, Trower, Gilbert, & Plaistow, 2000). The higher the score, the higher the rank the person feels in relation to their voices.

Self-Compassion Scale

The Self-Compassion Scale is a 26-item scale that measures self-compassion (13 items) and coldness towards the self (13 items). There are six subscales, three of which measure self-compassion: common humanity, self-kindness and mindfulness. There are also three subscales to measure coldness towards the self: self-judgement, over identification and isolation. Responses are given on a five-point Likert scale ranging from 1 = 'almost never' to 5 = 'almost always'. This scale has good construct validity. Neff (2003) found this scale to have a significant negative correlation with the self-criticism subscale of the Depressive Experiences Questionnaire (Blatt, D'Afflitti, & Quinlan, 1976), $r = -0.65$, $p < 0.01$, a significant positive correlation with the Social Connectedness Scale (Lee & Robbins, 1995), $r = 0.41$, $p < 0.01$, and significant positive correlations with all three subscales of the Trait-Meta Mood Scale (Salovey, Mayer, Goldman, Turvey, & Palfai, 1995): Attention, $r = 0.11$, $p < 0.05$, Clarity, $r = 0.43$, $p < 0.01$, and Repair, $r = 0.55$, $p < 0.01$. The Self-Compassion Scale is also not tainted by social desirability bias. A non-significant correlation ($r = 0.05$, $p = 0.34$) was found between this scale and the Strahan and Gerbasi (1972) Marlowe-Crowne Social Desirability Scale (Neff, 2003).

Weekly Diary of Voice Activity, Self-Critical and Self-Compassionate Thoughts

This diary was adopted from previous studies exploring hostile and compassionate self-imagery (Gilbert & Irons, 2004; Gilbert & Proctor, 2006). See Appendix 1. An Interval Contingent format (Wheeler & Reiss, 1991) was used, whereby participants record their critical thinking over a set period of time. In this study, the set period was one week. Interval Contingent format diaries, as opposed to other diary methods, are helpful in recording self-critical thoughts, which may be variable in their frequency and duration. Previous studies had found that diary completion outside of sessions was not well adhered to (Gilbert & Irons, 2004), so participants completed the diary at the start of each session, with support from the researcher. Therefore, for analysis we used the sum of each variable to give an overall score for self-critical thoughts or voices and for self-compassionate thoughts or voices.

Procedure

The CMT was provided by one therapist on a 1:1 basis over 12 1-hour sessions. The therapist (author SM) who carried out the CMT was a Chartered Clinical Psychologist employed by Derbyshire Mental Health Services NHS Trust and specialized in working with adults with complex or severe mental health problems. Clinical supervision was provided to the therapist on a weekly basis (by author PG). Measures were taken before and after CMT (by SM) and a weekly diary was kept throughout. Participants were seen for a follow-up session six months after completing the CMT, where the measures were repeated (again by SM). Throughout the study, in addition to the CMT, participants continued to receive their usual support from their Community Mental Health Teams. The CMT was based upon the approach employed by Gilbert and Proctor (2006) and by Gilbert and Irons (2005). This approach helps people focus on their difficulties in terms of safety behaviours and to become understanding and compassionate to those safety behaviours (e.g., de-shame and de-pathologize). The therapist helps the person to have empathy for the fear and distress behind safety behaviours and develop tolerance for some of those fears. Discussion is then held on the function and value of self-compassion, the processes that underpin self-compassion and the various tasks that can be used to develop self-compassion. As part of this, participants were taught how to generate feelings of warmth and self-acceptance in response to their self-critical thoughts. These feelings are then utilized in the process of examining threat-focused thinking and also to practise compassionate attention, self-compassionate thinking, and self-compassionate behaviour.

As people begin to feel 'safer' they may be able to recognize more their internal self-critical and self-attacking style. The CMT views self-criticism as a form of safety behaviour and aims to help participants explore new ways of thinking rather than see their thinking as wrong. In this series of cases, a simple imagery and neurophysiological rationale was outlined to participants that helped explain the power of self-critical thoughts. For example, the therapist drew out the idea that if we are hungry and we imagine a meal, this can stimulate our saliva and stomach acids, equally though an image of a lovely meal can do the same. Another example can be sexuality where both an external source and an internal image can stimulate arousal in the pituitary. The participant is enabled to understand the

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

relationship between imagery, thinking and physiology. From there, one can make the same argument for external criticism and internal criticism (and incidentally the way paranoid thinking will stimulate the threat system). Also of course, the way external and internal soothing and reassurance can stimulate soothing systems. It is very important that the participant understands this basic process so that he or she can stand back and view CMT as a kind of physiotherapy for the brain.

Participants' self-critical thoughts were considered in the context of their history to help them view those thoughts as understandable and to develop empathy for their distress. Participants were taught progressive muscle relaxation and then helped via guided imagery to visualize a compassionate image or bring to mind emotionally textured memories when they were compassionate to someone else or when others showed them compassion. The imagery was based on the 'here and now' and asked participants to focus on compassionate qualities such as unconditional acceptance and to generate warmth with this image. Once participants were able to visualize the compassionate part of themselves and the associated feeling of warmth, they were asked to re-evaluate their critical thoughts. They were also asked to consider how they could attend and behave more compassionately to themselves. Participants' comments regarding their experiences of CMT were collated with the aim of using it to shape future therapy and research.

RESULTS

The results are provided with histograms, for each participant below. In summary, as is evident from Figure 1, there was a decrease for all participants in their PST as measured by the SCL-90, in particular decreases in their scores for Obsessive–Compulsive Disorder (OCD), IPS, Depression, Anxiety, Paranoia and Psychoticism (Figures 2–7 below).

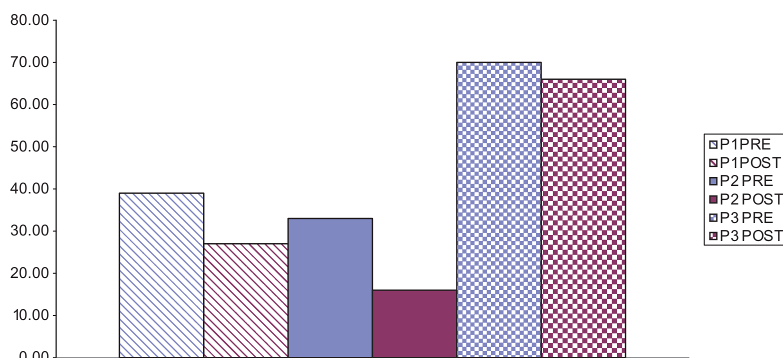

Figure 1. SCL-90 PST scores

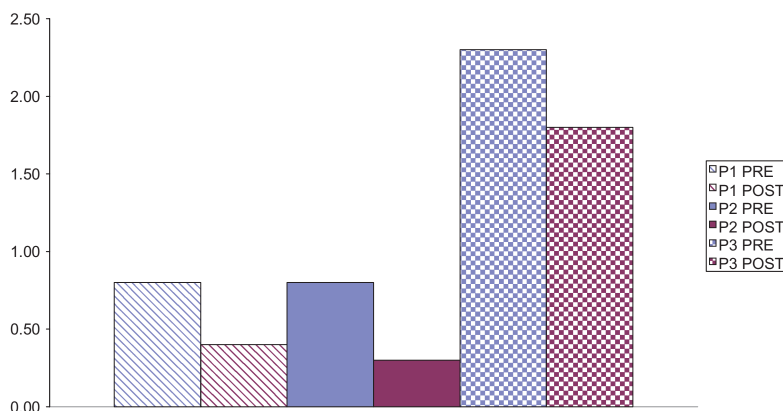

Figure 2. SCL-90 OCD scores

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

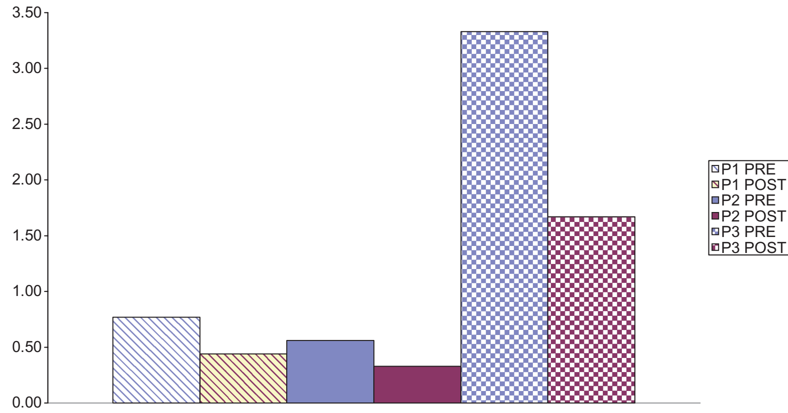

Figure 3. SCL-90 IPS scores

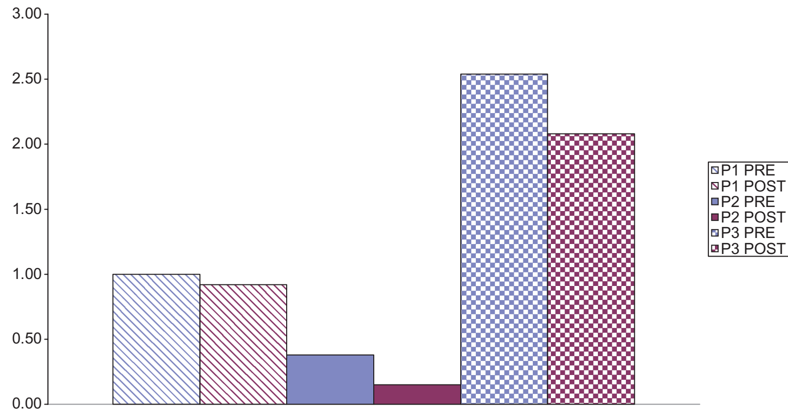

Figure 4. SCL-90 Depression Scores

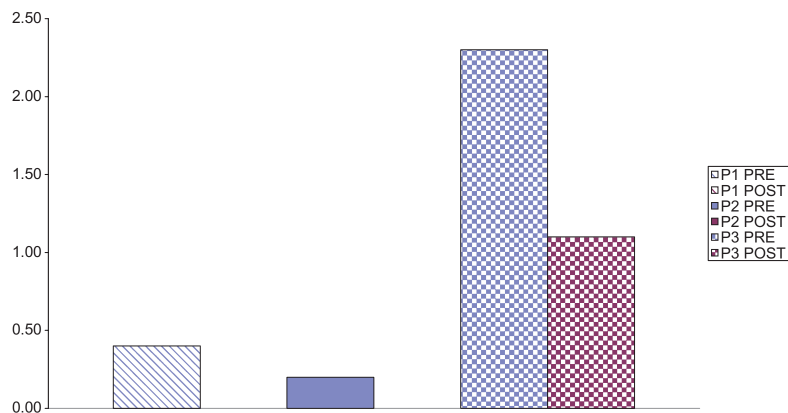

Figure 5. SCL-90 Anxiety scores

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

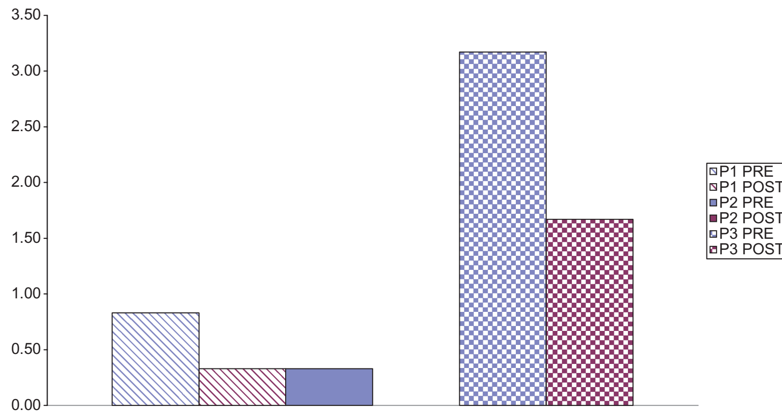

Figure 6. SCL-90 Paranoia scores

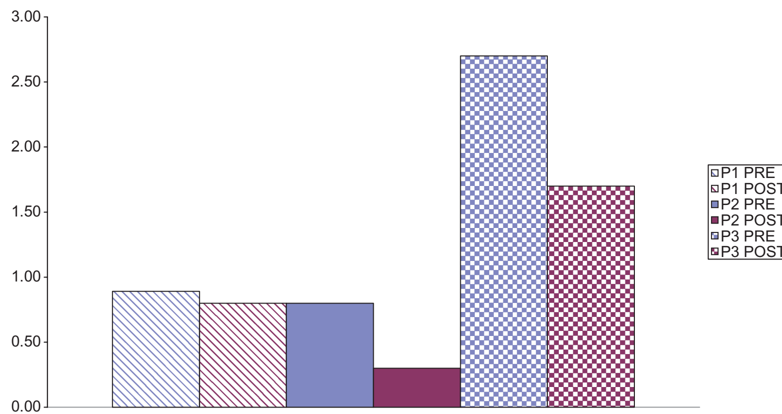

Figure 7. SCL-90 Psychoticism scores

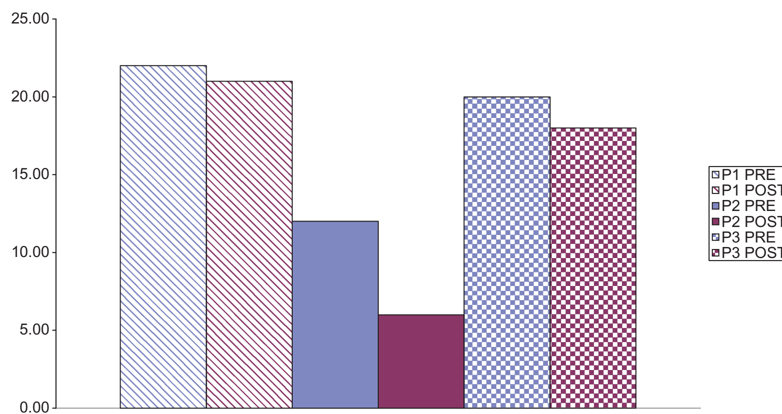

Figure 8. BAVQ Total scores
BAVQ = Beliefs About Voices Questionnaire

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

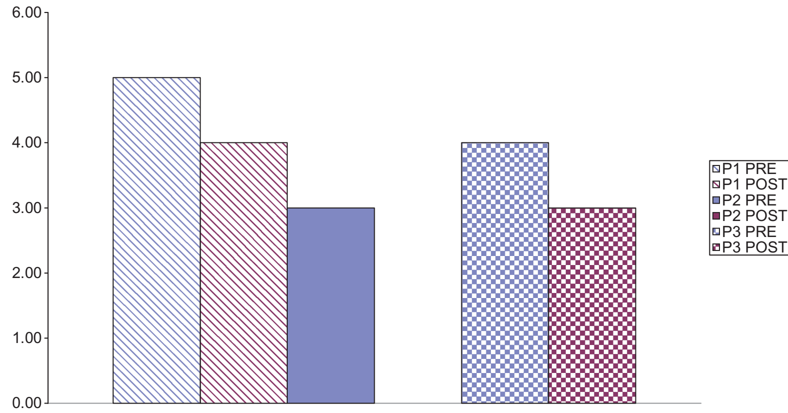

Figure 9. BAVQ Malevolence scores
BAVQ = Beliefs About Voices Questionnaire

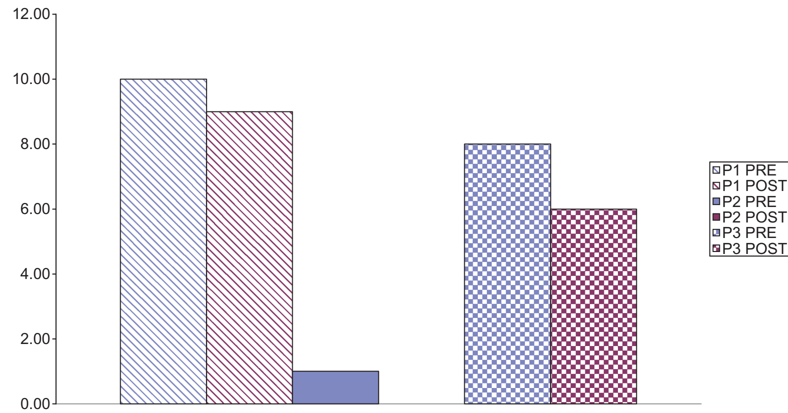

Figure 10. VRQ Persecutory scores

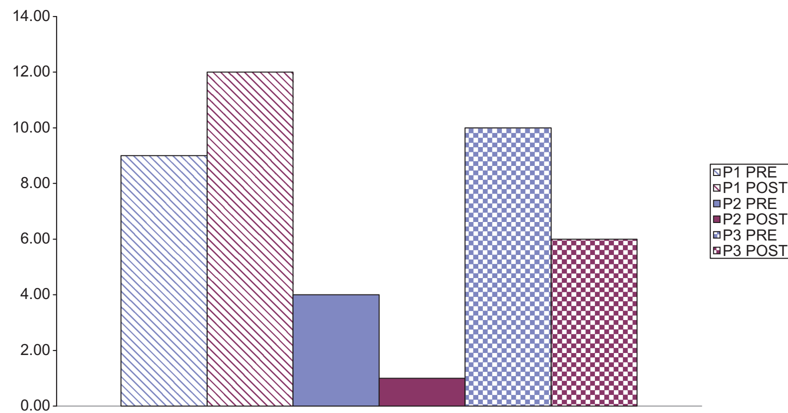

Figure 11. Inadequate-Self scores

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

All participants' BAVQ Total scores were reduced, as illustrated in Figure 8 below.

All participants' voices became less malevolent as shown in Figure 9.

All participants' voices also became less persecuting (Figure 10).

Two of the three participants heard more reassuring voices, while the other participant continued to hear a high level of reassuring voices as measured by the diary sheets. All participants had a reduction in their Inadequate-Self scores, as measured by the Forms of Criticism/Self-Attacking and Reassuring Scale (Figure 11).

PARTICIPANT 1

Participant 1 described the voices he heard as loud, powerful thoughts that sounded like someone talking in his ear. He said he was able to invite benevolent voices to talk to him if he was thinking self-compassionately and was equally able to encourage hostile voices if he thought self-critically. His form of self-criticism was 'self-persecuting' rather than self-correcting/improving. This participant had a sexual secret that he was ashamed of, that led him to worry about others discovering this secret and then punishing and rejecting him. Not being able to reveal this secret (because it was very bad) was a reason he felt he did not deserve self-compassion.

Pre- and Post-CMT

As can be seen from Figure 9, Participant 1 had decreases in his SCL-90 PST and GSI scores, in addition to decreases in the SCL-90 subscales for OCD, Interpersonal Sensitivity, Depression, Anxiety, Phobia, Paranoia, and Psychoticism. Somatization and Hostility increased.

Figure 13 illustrates a decrease in this participant's Self-Persecution Scores and an increase in his Self-Correcting Scores, as measured by the Functions of Self-Criticism/Self-Attacking Scales. His Reassured-Self Score remained high post-CMT. His Hated-Self and Inadequate-Self score slightly increased post CMT. As can be seen from Figure 14 his BAVQ Total score decreased, as did the scores for the subscales of Malevolent, Benevolent and Resistance. His level of engagement with voices remained the same post-CMT.

Participant 1's voices seemed to increase in rank in comparison with self, post-CMT, as can be seen from Figure 15.

He had no major changes in Self-Compassion and Self-Criticism Scores as measured by the Self-Compassion Scale, which remained high, as illustrated by Figure 16. It needs to be borne in mind that he rated himself as highly compassionate at the start of study.

Diary Measure

As reported on the weekly diary, Participant 1 ceased to experience auditory hallucinations, malevolent and benevolent, after three weeks of CMT. He reported hearing benevolent voices again from week 12 of the CMT (Figure 17). These voices praised him for recent successful decisions he had made. He ceased to have self-critical thoughts after week seven of CMT, until the last week of CMT when they reoccurred (see Figure 18). At that time he was undergoing a house valuation, which he found stressful, and worried that he was unassertive. His self-reported frequency of self-compassionate thoughts did not noticeably change and remained fairly frequent throughout CMT (see Figure 17). His self-reported self-compassionate thoughts consisted of statements such as '*I am a success*' and '*I have made good decisions*'.

Participant 1 appeared to have a difficulty in developing self-compassion. He initially struggled with bringing to mind a compassionate image. The image he chose to develop was one he called the 'Terrestrial Being', whom he perceived as wise and strong yet highly superior to him. He described the image as an '*ugly, repulsive, super-human*' with '*scaly, cold and slippery green skin*'; '*the size of a bear . . . a hermaphrodite with many arms*'. Participant 1 said he would comply with what he felt this being wanted, as he was afraid it might attack or kill him should he '*step out of line*' (sexually). When he practised bringing to mind this image he felt 'repelled' by it but insisted that it felt empathy, sympathy and compassion for him, like a '*mother to a child*'. He was resistant to change this image as he found it helpful to report to, to receive advice and feedback on his actions and to prevent him acting upon his sexual fantasies. Six weeks into the CMT, he came to realize that the image did not help him feel self-compassionate, as it could be critical and condemning of him. It was not until week 12, however, that the participant was able to generate an alternative compassionate image of his old psychiatrist, who accepted him unconditionally. He was able to bring to mind the qualities of warmth, acceptance, wisdom and strength when he brought to mind this image.

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

It appeared that Participant 1 intellectually understood the concept of self-compassion and the benefits of being self-compassionate but found it difficult to *feel* self-compassionate. In fact, he felt he needed to be 'harsher' with himself rather than compassionate. Interestingly, his Hated-Self score slightly increased after CMT. This may be related to him thinking more about his shameful secret and the 'bad' part of himself.

When Participant 1 was asked to think about the critical part of himself, he reported that the malevolent voices and his self-critical thoughts could be thought of as bullies. He likened the malevolent voice to his father, whom he described as highly critical of him. He felt the function of the voice was to keep him 'out of trouble' and also to keep him 'depressed and guilty'. He feared losing control to his automatic impulses and felt the inner bully prevented him from doing this. Interestingly, he said this voice did not bother him, as he knew it was self-generated and he felt more powerful than the voice, as his father was dead. He likened his self-critical thoughts to an inner bully with the voice of his sister. The function of his self-critical thoughts were to keep him 'out of trouble' and to keep him 'down' so his sister could be superior. He tended to listen to his self-critical thoughts and thought they were justified.

When it came to re-evaluating his self-critical thoughts and to considering how he could attend and behave more compassionately to himself, Participant 1 had a block to developing self-compassion. He was able to identify past experiences that may have led to him having self-critical thoughts but was unable to disclose the distress caused by these thoughts (and thus unable to feel

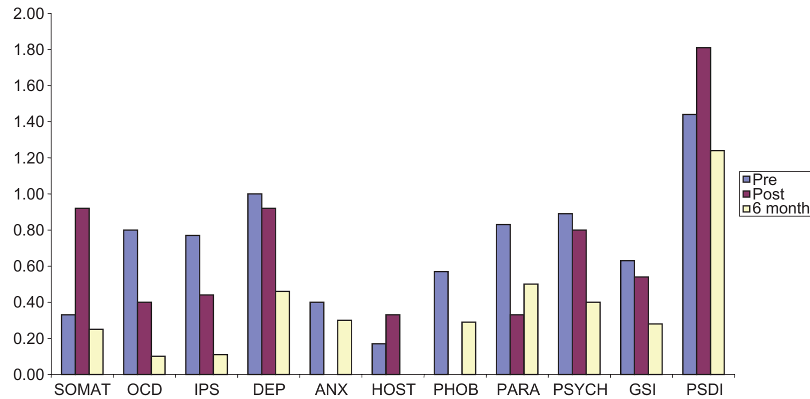

Figure 12. P1 SCL-90

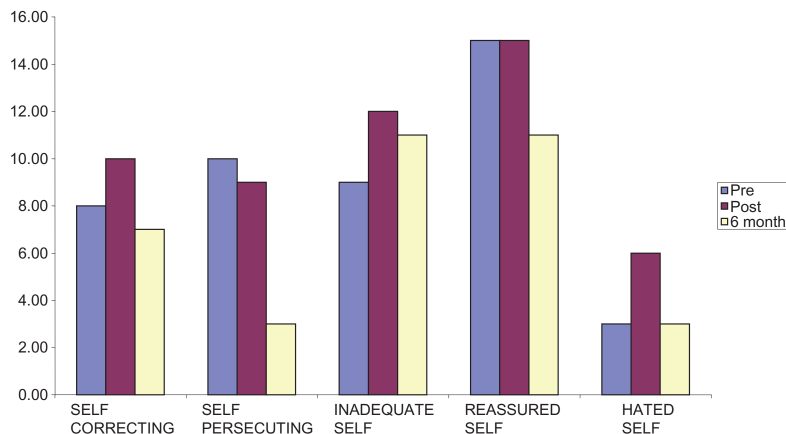

Figure 13. VRS Persecutory scores. VRS = Voice Rank Scale

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

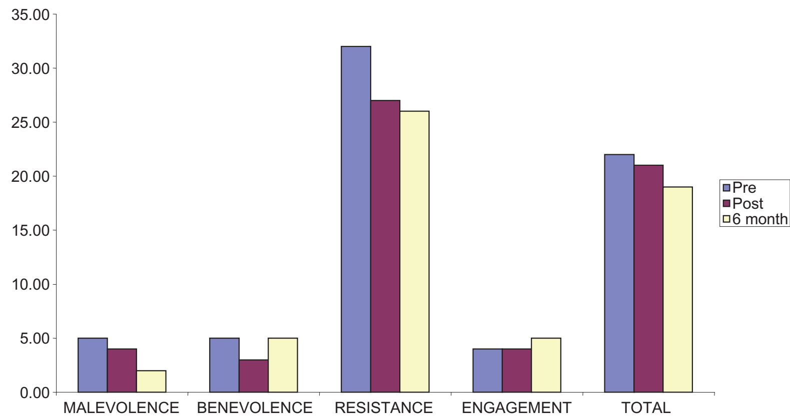

Figure 14. P1 Beliefs About Voices Questionnaire

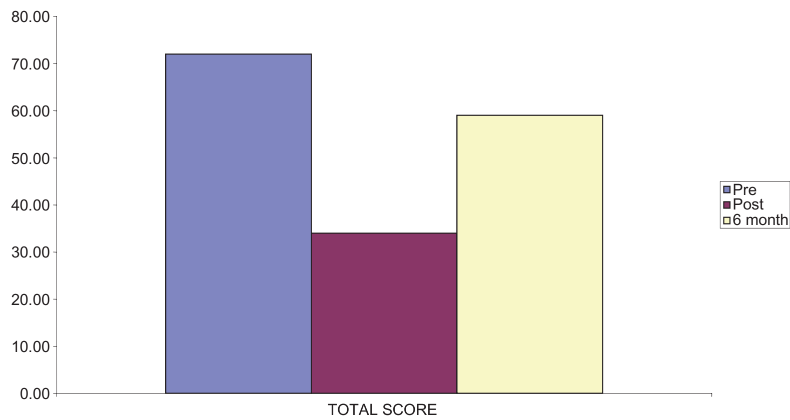

Figure 15. P1 Voice Rank Scale

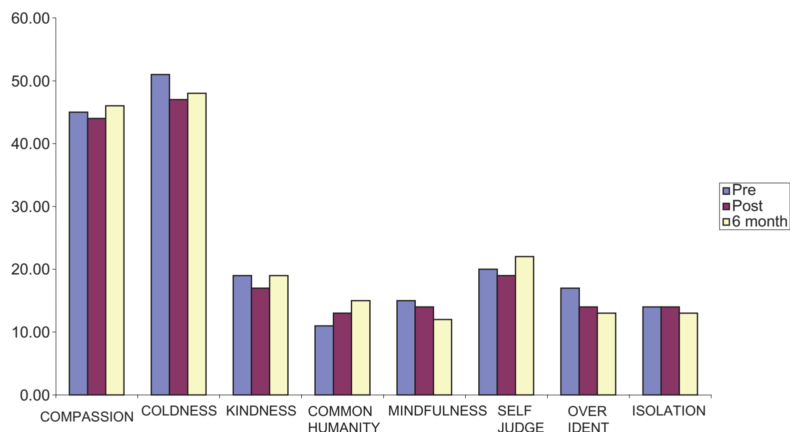

Figure 16. P1 Self-Compassion Scale

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

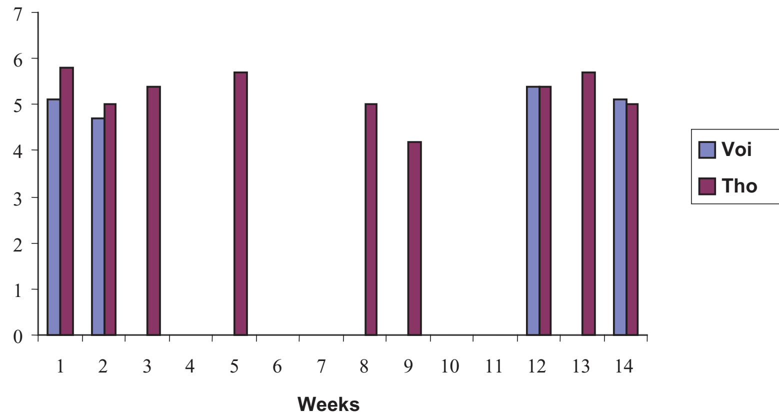

Figure 17. P1 Compassionate voices and compassionate thoughts

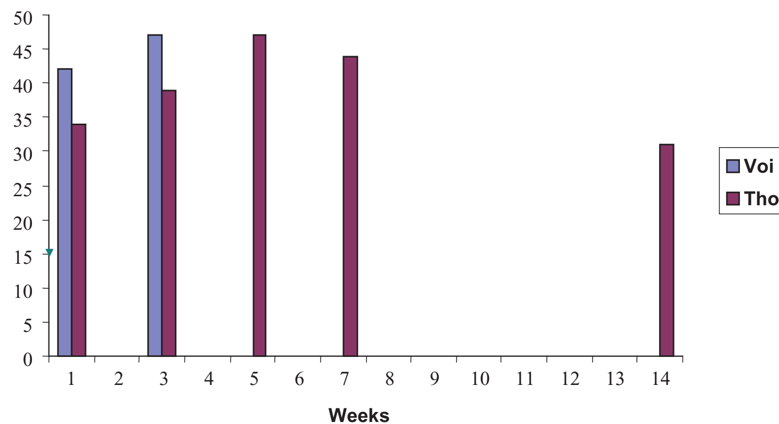

Figure 18. P1 Critical voices and critical thoughts

empathy for his distress) until late on in CMT, as he felt ashamed of his feelings. He also had difficulty generating alternative, compassion-focused thoughts. Despite reporting feeling safer with the therapist than the rest of the population, he felt paranoid that the therapist would secretly think less of him should he disclose his secret. He also feared of others punishing him if his secret was known.

Other than his shame related to his emotions, Participant 1 had numerous other blocks to developing self-compassion. First, he felt that to be self-compassionate was to 'let himself off the hook' (for his sexual secret). He felt that he needed to 'be harsher' with himself rather than compassionate. Second, it was very difficult to work with his self-critical thoughts, as he felt too ashamed to disclose many of them. Third, his 'compassionate' image (i.e., the 'terrestrial being') was hostile and thus a block to him developing compassion, as was his belief that he deserved the criticism from himself and from his voices. Fourth, he viewed compassion as weak and as 'sadness and pity', which he felt he did not want.

Six-Month Follow-Up

Following CMT, Participant 1 said he found CMT difficult, although he felt he had benefited from it and was now able to be 75% self-compassionate as opposed to 25%, which he felt he was at the outset. He felt that he had rated himself as highly self-compassionate at the start of the study, although

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

looking back realized that he had developed more self-compassion since then. He felt unable to allow himself to fully adopt self-compassion as '*there is a shameful secret that is a bad part of me*'.

Participant 1 stated that he had learnt there was a reason to be self-compassionate and that it '*helped me relax and it's good for my mental health*'. However, he feared that if he allowed himself to feel empathy for his distress '*I would open up a well of unbearable sadness*'.

All scores on the SCL-90 decreased further at follow-up, except for the anxiety and paranoia scores, which had started to increase again, as can be seen in Figure 12. All scores on the forms and functions of self-criticism decreased at follow-up as can be seen from Figure 13. At follow-up, malevolent voices decreased further, benevolent voices returned to baseline, resistance slightly decreased and engagement slightly increased. Participant 1 may have been less able to resist the voices because they became higher in rank in comparison to him, as shown by Figures 14 and 15. Interestingly, he reported his voices to be more like his own thoughts than external voices post-CMT. There were no major changes to his level of Self-Compassion or Self-Coldness scores, as measured by the Self-Compassion Scale (Figure 16).

PARTICIPANT 2

Participant 2 had concealed his psychotic symptoms for three years prior to being diagnosed with schizophrenia. Many of his self-critical thoughts related to previous sexual encounters that he felt were shameful. He kept his illness hidden from others as he felt ashamed of his diagnosis and felt that people would reject him if they found out. He also felt ashamed of his weight gain since commencing psychotropic medication. He tended to keep people at a distance from him as it felt safer and had difficulty trusting others as he felt they could read his mind. He had a history of self-harming by cutting, which he used to regulate his emotions. He felt that the function of his malevolent voices was to remind him of the 'bad things' he had experienced in life. He coped with his malevolent voices and self-critical thoughts by bringing to mind an image that helped him feel safe, such as the door of his local church, and found that this suppressed the auditory hallucinations and thoughts. He also used cognitive challenging but found that although this intellectually helped him, it did not impact on his emotions. Interestingly, Participant 2 rated himself as highly self-compassionate at the start of CMT.

Pre- and Post-CMT

As can be seen from Figure 19, Participant 2 had decreases in his SCL-90 PST and GSI scores, in addition to decreases in the SCL-90 subscales for OCD, Interpersonal Sensitivity, Depression, Anxiety, Paranoia and Psychoticism.

Figure 20 illustrates a decrease in this participant's Self-Persecution and Inadequate-Self scores and his Hated-Self scores, as measured by the Forms and Functions of Self-Criticism/Self-Attacking Scales. His Reassured-Self Score increased post-CMT.

As can be seen from Figure 21, his BAVQ Total score decreased, as did his scores for the subscales of Malevolent, Benevolent and Resistance. His level of engagement with voices increased slightly post-CMT.

Participant 2's voices decreased in rank in comparison with the self, post-CMT, as illustrated by Figure 22. This may be a reason why he chose to engage more with the voices post-CMT, or because they became more benign.

There were no major changes to his level of Self-Compassion or Self-Coldness scores, as measured by the Self-Compassion Scale, which both remained high post-CMT, as illustrated by Figure 23. It needs to be borne in mind that he rated himself as highly self-compassionate at the start of the study.

Diary Measure

Since consenting to participate, participant 2 appeared to be making a good recovery from his recent relapse. As reported on the weekly diary sheet, participant 2 only heard voices (both malevolent and benevolent) once in week 9 of the CMT. The malevolent voices told him they were missing talking to him and although intrusive, he did not find this distressing. He reported his self-critical thoughts to be decreased in frequency (Figure 24) and his self-compassionate thoughts to be increased after week eight of CMT (Figure 25).

Participant 2 was easily able to bring to mind a compassionate image of a tree. This image evolved as CMT progressed, developing more human features such as a smiling face. Interestingly, participant 2 reported that he initially felt threatened by

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

his image when it looked as though it was approaching him. He felt that allowing others to get close to him, including this image, would mean letting his barriers down, which he felt was unsafe and frightening. He also believed these barriers had helped slow his illness progression. He initially felt the image was angry, which scared him, but later felt that this anger was with the way others had treated him in the past. This helped him, he said, to understand that the image was empathic, accepting and wise. He struggled, however, with tapping into the emotional components of compassion and was aware that he was not 'letting the tree in emotionally'. Initially, for the first three weeks of CMT, he used the image to *block* self-critical thoughts, much in the way he had previously used imagery, rather than using it to tap into compassionate emotions. Later, although able to bring the image into mind, he struggled to *feel* self-compassionate, as he found it threatening to allow it close to him. However, he felt that if he was able to let these barriers down or soften them, he would learn to trust others, and as CMT progressed, he felt more comfortable in allowing the image to come close to him. In week 7 of CMT, participant 2 felt less wary of his compassionate image and was using it to help him counteract his self-critical thoughts. He found it easiest to generate his image and access the associated emotional components of compassion when he felt in a happy mood, such as when watching a

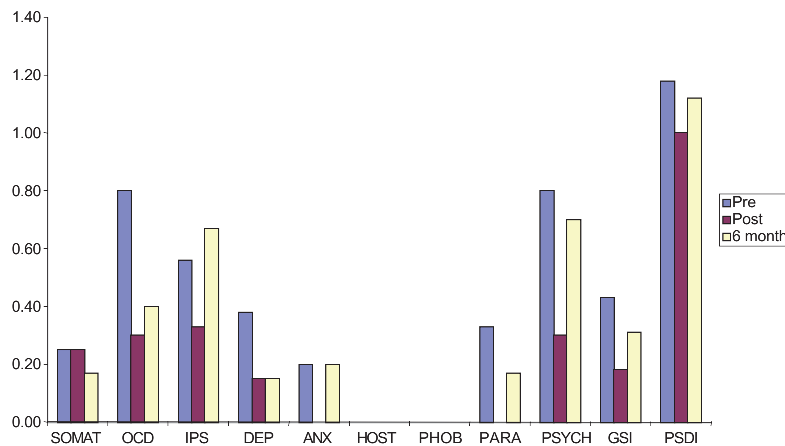

Figure 19. P2 SCL-90

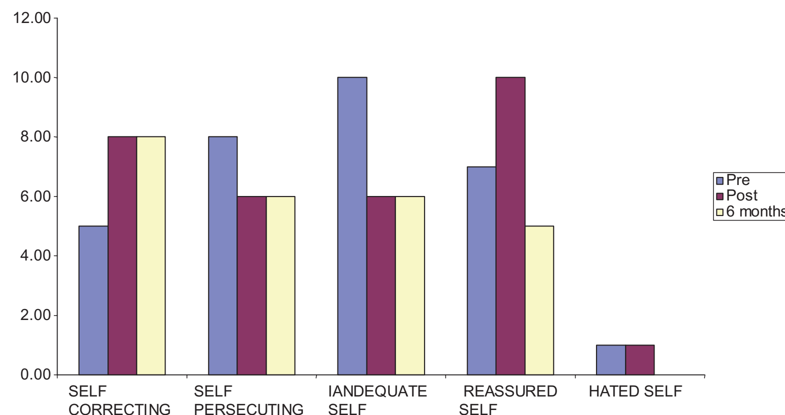

Figure 20. P2 Forms and Functions Scale

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

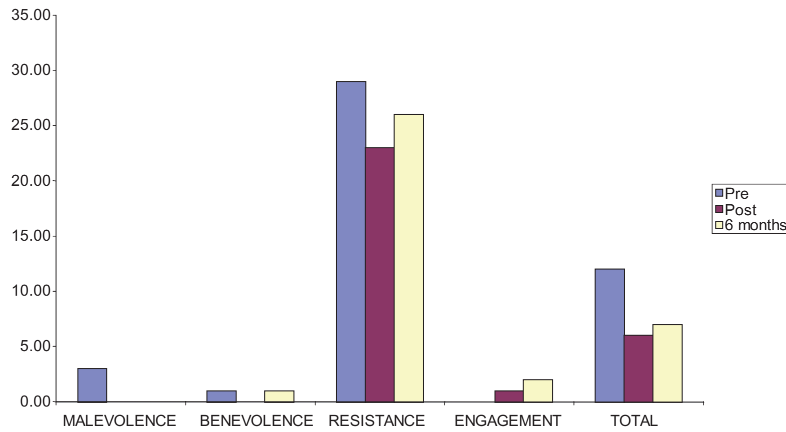

Figure 21. P2 Beliefs About Voices Questionnaire

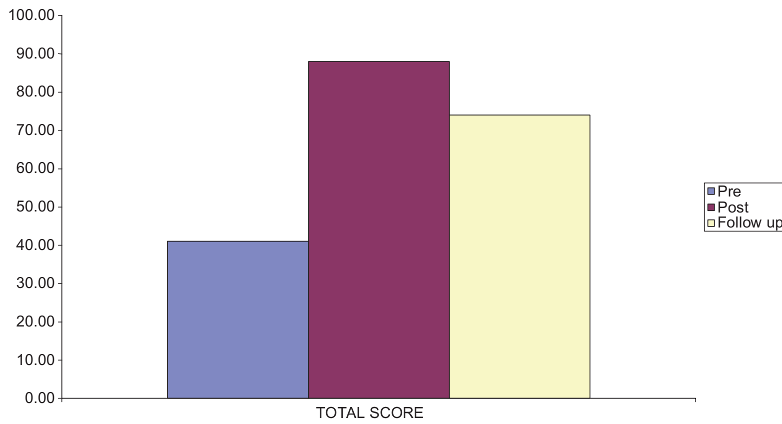

Figure 22. P2 Voice Rank Scale

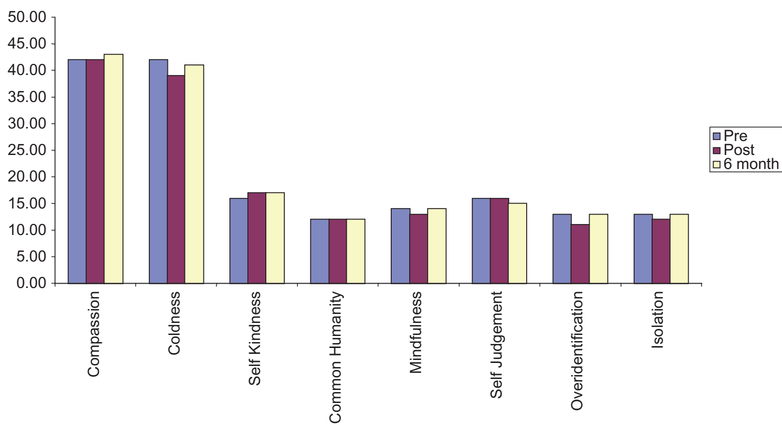

Figure 23. P2 Self-Compassion Scale

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

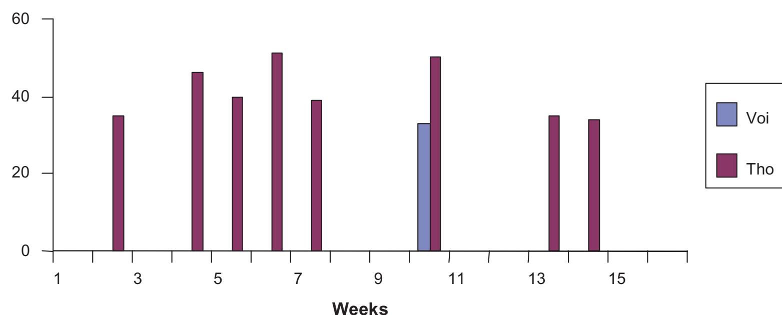

Figure 24. P2 Critical voices and critical thoughts

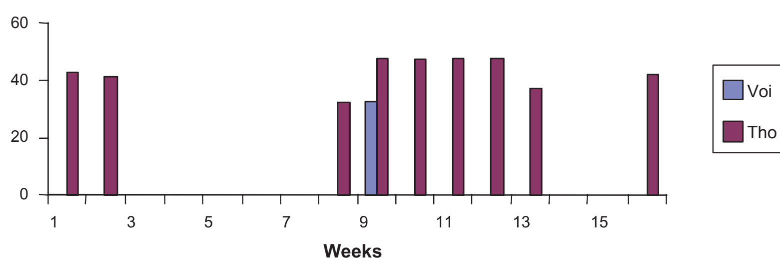

Figure 25. P2 Compassionate voices and compassionate thoughts

funny film, and used this to train himself to associate the image with feelings of warmth. In the following weeks, he was able to have empathy for his own distress and to generate evidence plus compassionate attention, thinking, feeling and behaving to counter his critical thoughts.

When invited to use imagery to help him think about the critical part of himself, he found it difficult to visualize his malevolent auditory hallucinations. He described one as a woman who refused to tell him what she looked like and one as a man who could read his mind. He found it easier to visualize his self-critical thoughts as a fat, bald, bullying man. He felt there were two functions of this 'inner bully'. One function was to put him down in relation to his weight (self-persecutory self-criticism) and the other function was to help him improve his college work (self-improving self-criticism). He found that the visualization helped him to recognize his self-critical thoughts when they occurred and to generate alternative, compassion-focused alternatives.

By week nine, he had noticed that when he felt happy and contented, the image of the tree had come into his mind, and also when he brought the image into his mind he felt contented, relaxed, happy, and warm.

Six-Month Follow-Up

Following CMT, participant 2 reported feeling stronger in himself and no longer saw schizophrenia as his identity. He no longer blocked his critical thoughts, but instead used a compassionate approach to work with them. Participant 2's PST slightly increased at follow-up, as did his scores on the OCD, Anxiety, Interpersonal Sensitivity, Paranoia and Psychoticism subscales of the SCL-90, as can be seen in Figure 19. However, his Depression Score remained low and his Somatization Score decreased. At follow-up, his inadequate self-score returned to baseline (Figure 20). Participant 2 showed slight increases in resistance and engagement on his BAVQ scores at follow-up (Figure 21) and a slight decrease in rank relative to the voices (Figure 22). There were no major changes to his level of Self-Compassion or Self-Coldness scores, as measured by the Self-Compassion Scale (Figure 23).

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

PARTICIPANT 3

Participant 3 heard numerous malevolent and some benevolent voices. He was highly self-critical and his self-critical thoughts mirrored his malevolent voice content. The malevolent voices told him he was a paedophile and he was concerned that others may think this of him. He stated that the criticism from his auditory hallucinations was unjustified, but he often tended to agree with what they said. He was also self-conscious of his appearance and felt that he was a failure. He tended to avoid people and to avoid looking at people, in particular children, to feel safer. He was excited about participating in CMT and said, '*I've been waiting all my life for this*'.

Pre- and Post-CMT Measures

As can be seen from Figure 26, participant 3 had decreases in his SCL-90 PST and GSI scores, in addition to decreases in the SCL-90 subscales for OCD, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobia, Paranoia, and Psychoticism.

Figure 27 illustrates an increase in this participant's Self-Correction scores and in his Self-Reassurance Score and a decrease in his Self-Persecution and Inadequate-Self scores as measured by the Forms and Functions of Self-Criticism/Self-Attacking Scales. His Hated-Self score remained low.

As can be seen from Figure 28, his BAVQ Total score decreased, as did his scores for the subscales of Malevolence and his level of Engagement with the voices. His scores for the subscales of Benevolent and Resistance increased post-CMT.

Participant 3's voices greatly decreased in rank post-CMT, as illustrated by Figure 29. This may be a reason why he felt more able to resist them post-CMT.

His level of Self-Compassion increased, as did his level of Self-Coldness post-CMT, as measured by the Self-Compassion Scale, as illustrated by Figure 30.

Diary Measure

As reported on the weekly diary sheet, participant 3 heard malevolent and compassionate voices throughout CMT. He reported that despite having many self-critical voices (Figure 31), he was able to respond to these with self-compassionate thoughts throughout CMT (Figure 32). The content of his self-critical thoughts tended to mirror his malevolent voices. The voices seemed to trigger his thoughts about himself, for example when the voices said '*you are a bad man*' he thought '*yes, I am bad*'.

For his compassionate image, participant 3 chose to bring to mind a female mental health worker that he was close to at the drop-in centre he attended. He chose to use her as he said she was strong, wise, warm, and non-judgemental and he trusted her. He was easily able to generate a clear compassionate image. When bringing the image to mind, he reported feeling safer and calmer and found that while imagining it, it weakened the malevolent voices. He found this image soothing and believed that it helped him to accept himself. Later

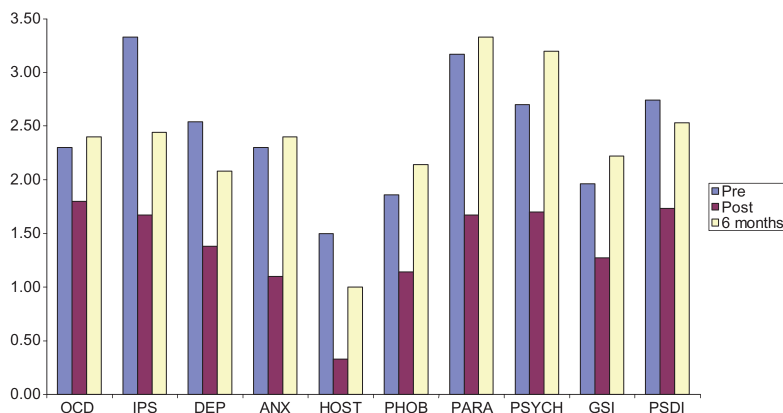

Figure 26. P3 SCL-90

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

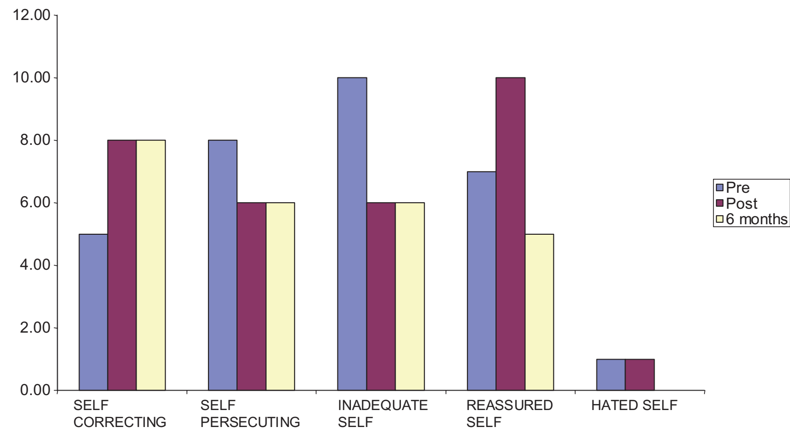

Figure 27. P3 Forms and Functions Scale

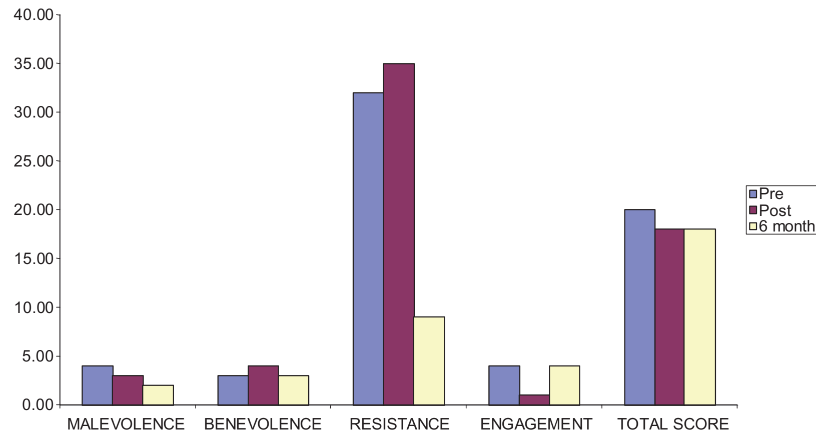

Figure 28. P3 Belief About Voices Questionnaire

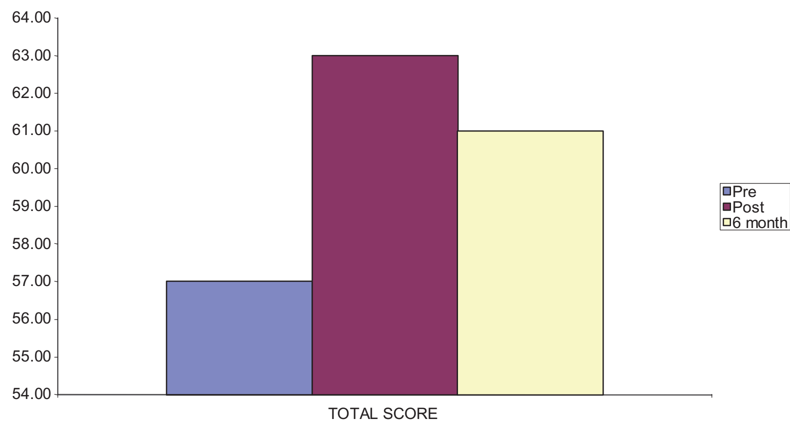

Figure 29. P3 Voice Rank Scale

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

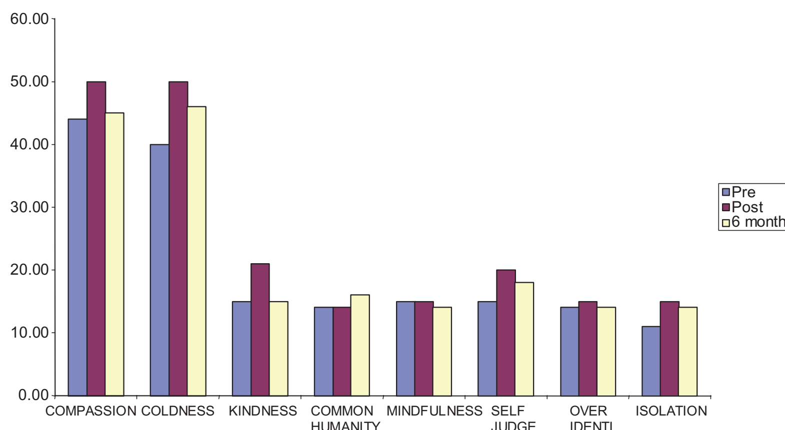

Figure 30. P3 Self-Compassion Scale

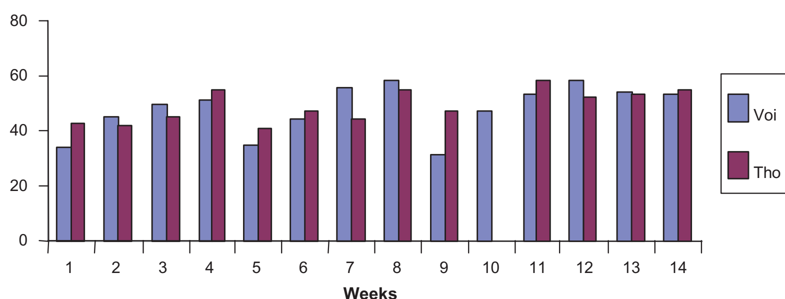

Figure 31. P3 critical voices and thoughts

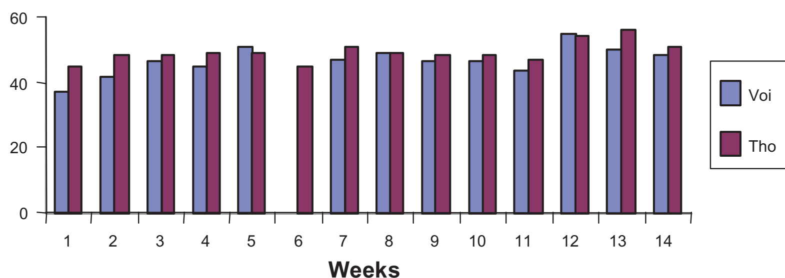

Figure 32. P3 compassionate voices and compassionate thoughts

in CMT, this participant began, on his own initiative, to use a transitional object that helped him to bring to mind the qualities of compassion. He found that when he touched his cigarette lighter, it reminded him of how much compassion he felt from his partner who gave him the lighter, and this acted as a cue to the compassionate image and associated feelings.

When invited to use imagery to help him think about the critical part of himself, he described a female neighbour of his who looked angry and dwarf-like. He felt the function of this inner bully was to 'keep him down'.

Participant 3 was able to feel empathy for his distress early in the CMT and reported that he had not previously been able to feel this sadness. With the

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

aid of the thought monitoring sheets he was able re-evaluate his self-critical thoughts and was able to engage in compassionate attention, behaviour, and feelings, although he found compassionate thinking more difficult.

Six-Month Follow-Up Measures

At 6-month follow-up, Participant 3 reported that instead of hearing voices from 'all across the street' he now only heard voices from his neighbour's house. He had also started to re-evaluate his auditory hallucinations as being part of his illness as opposed to coming from his neighbours. He felt this gave him more control over the voices and helped him feel less persecuted. He reported finding the CMT beneficial in helping him to re-evaluate his self-critical thoughts, change his behaviour, feel soothed and reduce the impact of the voices upon him. At follow-up, participant 3's positive symptoms had increased as illustrated in Figure 26. There were few changes in his forms and functions of self-criticism, with the exception of a slight decrease in self-reassurance (Figure 27). There were few changes in his BAVQ scores (Figure 28) and a slight decrease in his rank relative to voices (Figure 29). There were no major changes to his level of Self-Compassion or Self-Coldness scores, as measured by the Self-Compassion Scale (Figure 30).

DISCUSSION

This study is a preliminary case series to explore the value of CMT with paranoid psychotic voice hearers and their experience of it. In general, the rationale of CMT in terms of different affect systems, and the role of safety behaviours in symptom formation, made sense to participants. They acknowledged that if they could develop self-compassion they would feel less threatened and safer.

CMT facilitates a non-judgemental understanding of the origins of a person's self-criticism. It focuses less on the client's deficits and 'dysfunctional or distorted' cognitions and more on the fears and functions of such thoughts. It also focuses on self-soothing skills they can develop, including developing empathy for their distress and developing self-supportive thoughts. CMT does not focus people on challenging or arguing with their voices because this maintains a conflictual and aversive relationship that is likely to continually stimulate the amygdala. Some people find that this can make the voices worse, possibly because arguing and conflict increases aversive arousal. Having worked therapeutically with voice hearers for a number of years, one of us (SM) found that CMT enabled easier access to clients' cognitions and emotions in relation to their voice-hearing experiences and seemed to facilitate a quicker therapeutic alliance than traditional Cognitive Behavioural Therapy (CBT) might do. This may be because the CMT focuses on understanding safety behaviours with high empathy for the distress that is behind them and with emphasis on the importance of compassion rather than intellectual challenging of evidence.

CMT is an evolutionary-based approach and thus incorporates attachment theory (Gilbert, 2000, 2005). Some years ago, Bowlby (1973, 1980) noted that kindness on the part of the therapist could be experienced as threatening by the client. He explained this as the fact that kindness will activate the client's attachment system. In so doing, it will trigger the various memories, yearnings and fears that are part of attachment memory. Working through these can be key to the transformation of a person's attachment system. CMT takes essentially the same view and utilizes an emotional conditioning paradigm (Gilbert, 2000, 2007, in press). This suggests that care-receiving experiences have been conditioned with threat and punishment. Thus, whenever the person begins to experience feelings of kindness or being cared for, there can be an automatic triggering of aversive memories. It would therefore not be surprising to find that our participants were quite frightened of experiencing compassion for a variety of reasons in the first instance. The problem is that if they are unable to access this affect regulation system they may struggle to feel safe.

It is not uncommon to find that non-paranoid, depressed clients can find it very difficult to generate compassionate images to begin with. However, interestingly these participants found it easy to generate strong visual images, but (like depressed people) had difficulty tapping into compassionate feelings. Two participants found it difficult to imagine a compassionate human. Participant 1 generated an image of a tentacled, scaly alien who was compassionate because it had superior intelligence. It would watch over him, but if he became very bad it would 'compassionately kill him'. When asked why 'compassionately', he said it would do it with a 'tear in its eye'. The concept of human warmth was felt to be very frightening and untrustworthy. For other participants, feeling

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

threatened or paranoid and keeping others at a distance—even if they may be compassionate—could be viewed as a helpful defence against persecution. However, it can be a barrier to self-compassion. In two participants, their self-reliance and aversion of others' closeness led to an initial fear of their self-generated compassionate image as they believed that it might punish them. Hence, it was very hard for them to keep clear in their minds that compassion is always non-judgemental and never harmful no matter what. It is an ideal that is key.

When others or voices are seen as very powerful and threatening, self-criticism may be about *maintaining* oneself in a subordinate position (in an often punitive world) to appease others and keep safe (Gilbert et al., 2004). Participant 1 felt his self-criticism (and scaly creature) was functional as it protected him from criminal offending (possibly relating to sexual fantasies) and kept him safe from prosecution and further shame. Although functional in this way, his shameful secret was a block to him fully developing self-compassion. People who self-persecute have a poor ability to self-reassure (Gilbert et al., 2004), and the same may be true of those who hear persecutory auditory hallucinations.

A fascinating outcome from this study was that the CMT appeared to have a major effect on participants' hostile voices, transforming them into becoming more reassuring, less persecutory and less malevolent. By helping participants refocus on compassionate feelings we hoped to be able to stimulate self-soothing. It is therefore interesting that CMT seemed to help all participants feel less inadequate or one down in relation to their malevolent voices. CMT appeared to help participants feel safe without the need for submissive and appeasement behaviour. Interestingly, participants 2 and 3 felt socially safer around 'real' people and with their voices, and both extended their social circles after CMT.

An unexpected finding from this study was that two participants' self-compassion and self-criticism scores as measured by the Neff (2003) Scale did not reflect their diary sheet scores. This may be explained by the fact that the Self-Compassion Scale: '*Is limited in its ability to accurately assess individual levels of self-compassion as people may not be aware enough of their own emotional experiences to realize the extent to which they lack self-compassion*' (Neff, 2003). In fact, all participants rated themselves as highly self-compassionate at baseline and later revealed that they had not comprehended self-compassion until engaging in CMT. In retrospect, it may have been useful to administer the Self-Compassion Scale on a weekly basis. This might have then picked up on the participants' developing awareness of self-compassion.

Suggestions from participants for improving CMT with voice hearers were first, not to complete the weekly diary sheet, as it was often distressing to talk about voices each week, particularly when they had not heard them for a while. Second, for the therapist to dedicate more time facilitating the guided compassionate imagery exercises with them, as they found this beneficial. We should note here that this CMT was not meant as a stand-alone therapy, but as a specific intervention to try to stimulate self-compassion, and thus the soothing systems as natural regulators for threat systems. How CMT should be integrated with other therapies is for future research. More work is necessary on how people with paranoia come to understand and think about a compassionate focus, how the therapeutic relationship is key to that experience, and how insights into self-criticism emerge over time and may not be clearly noted in the early days of therapy. Some people from very traumatic backgrounds will be somewhat dissociated from those backgrounds and whether or not that needs to be worked with first before CMT, again, is a research question. In general, the participants thought CMT made a lot of 'sense' and that it was a helpful way to engage with their fears and voices. The direction of future CMT research is towards clinical trials. A comparison of CMT with cognitive–behavioural therapy for voice hearers who are self-critical may be a useful place to begin. There are obvious benefits to group interventions, although this client group may be fearful of engaging in such groups. Future trials might consider the participants' feedback provided in this paper. It may also be beneficial for some educational information about compassion to be provided to participants prior to baseline measures of compassion being taken. This may help them better understand at the outset what they are being asked to self-assess.

It is now over a year since this study finished. SM contacted all participants and asked if they were happy to provide an update. Participant 1 continues to not allow himself to fully adopt self-compassion due to his shameful secret. He said that thinking about the 'scaly creature' helps keep him from acting out his sexual fantasies. Participant 2 successfully completed his degree course, is about to start nurse training and is keen to use CMT with his patients once qualified. He said that '*CMT made me as well as I am today*'. He continues to hear occa-

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

sional malevolent voices but copes with these by using compassionate thoughts and focusing on feelings of warmth. He said that '*I battle with the voices every day, but not a battle in the traditional sense. I don't fight with the voices aggressively which could make them worse, rather I use compassionate mind techniques to help the voices fade away*'. Participant 3 reported feeling safer around other people and has started to attend college full-time, whereas previously he only ventured out twice a week to the day centre. His malevolent voices have further decreased in frequency and intensity, and he continues to use compassionate thinking to help him re-evaluate his occasional self-critical thoughts and in response to the voices' critical comments towards him.

ACKNOWLEDGEMENTS

Karen Barr, Rabiya Majeed and Kirsten McEwan.

REFERENCES

Birchwood, M., & Chadwick, P. (1997). The omnipotence of voices: Testing the validity of a cognitive model. *Psychological Medicine*, *27*, 1345–1353.

Birchwood, M., Meaden, A., Trower, P., Gilbert, P., & Plaistow, J. (2000). The power and omnipotence of voices: Subordination and entrapment by voices and significant others. *Psychological Medicine*, *30*, 337–344.

Blatt, S.J., D'Afflitti, J., & Quinlan, D. (1976). Experiences of depression in young adults. *Journal of Abnormal Psychology*, *65*, 383–389.

Bowlby, J. (1973) *Separation, anxiety and anger: Attachment and loss* (Vol. 2). London: Hogarth Press.

Bowlby, J. (1980). *Loss: Sadness and depression. Attachment and loss* (Vol. 3). London: Hogarth Press.

Carter, C.S. (1998). Neuroendocrine perspectives on social attachment and love. *Psychoneuroendocrinology*, *23*, 779–818.

Chadwick, P., & Birchwood, M. (1995). The omnipotence of voices II: The beliefs about voices questionnaire (BAVQ). *British Journal of Psychiatry*, *166*, 773–776.

Depue, R.A., & Morrone-Strupinsky, J.V. (2005). A neurobehavioral model of affiliative bonding. *Behavioral and Brain Sciences*, *28*, 313–395.

Derogatis, L.R., Rickels, K., & Rock, A.F. (1976). The SCL-90 and the MMPI: A step in the validation of a new self-report scale. *British Journal of Psychiatry*, *128*, 280–289.

Garety, P.A., & Freeman, D. (1999). Cognitive approaches to delusions; a critical review of theories and evidence. *British Journal of Clinical Psychology*, *38*, 113–154.

Gilbert, P. (2000). Social mentalities: Internal 'social' conflicts and the role of inner warmth and compassion in cognitive therapy. In P. Gilbert, & K.G. Bailey (Eds), *Genes on the couch: Explorations in evolutionary psychotherapy* (pp. 118–150). Hove, UK: Brenner-Routledge.

Gilbert, P. (2005). *Compassion: Conceptualisations, research and use in psychotherapy*. Hove, UK: Routledge.

Gilbert, P. (2007). *Psychotherapy and counselling for depression* (3rd ed.). London: Sage.

Gilbert, P. (in press). Evolved minds and compassion focused imagery in depression. In L. Stropa (Ed.), *Imagery and the threatened self: Perspectives on mental imagery in cognitive therapy*. London: Routledge.

Gilbert, P., & Irons, C. (2004). A pilot exploration of the use of compassionate images in a group of self-critical people. *Memory*, *12*, 507–516.

Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 263–325). Hove, UK: Routledge.

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*(6), 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.

Goodare, H., & Lockwood, S. (1999). Involving patients in clinical research: Editorial. *British Medical Journal*, *319*, 724–725.

Lee, R.M., & Robbins, S.B. (1995). Measuring belongingness: The social connectedness and social assurance scales. *Journal of Counseling Psychology*, *42*, 232–241.

Neff, K.D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity*, *2*, 223–250.

Panksepp, J. (2004). *Affective neuroscience: The foundations of human and animal emotions*. New York: Oxford University Press Inc.

Salovey, P., Mayer, J.D., Goldman, S.L., Turvey, C., & Palfai, T.P. (1995). Emotional attention, clarity and repair: Exploring emotional intelligence using the Trait Meta Mood Scale. In J.W. Pennebaker (Ed.), *Emotion, disclosure and health* (pp. 125–154). Washington, DC: American Psychological Asssociation.

Schore, A.N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development.* Hillsdale, NJ: Lawrence Erlbaum.

Strahan, R., & Gerbasi, K.C. (1972). Short, homogenous versions of the Marlowe-Crowne social desirability scale. *Journal of Clinical Psychology*, *28*, 191–193.

Wheeler, L., & Reiss, H.T. (1991). Self-recording of everyday life events: Origins, types and uses. *Journal of Personality*, *59*, 339–354.

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

APPENDIX 1: DIARY SHEET

Critical voices
Looking back over the week, can you recall any critical voices

1. What situations/events brought them about?

....
....
....
....
....
....

2. What did your critical voices say?

....
....
....
....
....
....

3. Thinking back over the week (please circle on each):

(a) How **often** did you have **critical** voices?
Had None 1 2 3 4 5 6 7 8 9 10 A lot of the time

(b) How **powerful** were your **critical** voices?
Not at all 1 2 3 4 5 6 7 8 9 10 Very powerful

(c) How **intrusive** were your **critical** voices?
Not at all 1 2 3 4 5 6 7 8 9 10 Very intrusive

(d) How **long** did your **critical** voices last?
Fleetingly 1 2 3 4 5 6 7 8 9 10 Most of the day

(e) How **distressed** were you by your **critical** voices?
Not at all 1 2 3 4 5 6 7 8 9 10 Very distressed

(f) How **angry/hostile** were your **critical** voices?
Not at all 1 2 3 4 5 6 7 8 9 10 Very harassing

(g) How easy was it to **distract** yourself from your **critical** voices?
Not at all easy 1 2 3 4 5 6 7 8 9 10 Very easy

Compassionate/soothing Voices
Looking back over the week, can you recall any soothing/reassuring voices

1. What situations/events brought them about?

....
....
....
....
....
....
....

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

2. What did your soothing/reassuring voices say?

....
....
....
....
....
....
....

3. Thinking back over the week (please circle on each):

(a) How **often** did you have **soothing** voices?
Had none 1 2 3 4 5 6 7 8 9 10 A lot of the time

(b) How **powerful** were your **soothing** voices?
Not at all 1 2 3 4 5 6 7 8 9 10 Very powerful

(c) How **intrusive** were your **soothing** voices?
Not at all 1 2 3 4 5 6 7 8 9 10 Very intrusive

(d) How **long** did your **soothing** voices last?
Fleetingly 1 2 3 4 5 6 7 8 9 10 Most of the day

(e) How **comforting** were your **soothing** voices?
Not at all 1 2 3 4 5 6 7 8 9 10 Very comforting

(f) How **calming/pleasant** were your **soothing** voices?
Not at all 1 2 3 4 5 6 7 8 9 10 Very calming/pleasant

(g) How easy was it to **maintain** your **soothing** voices?
Not at all easy 1 2 3 4 5 6 7 8 9 10 Very easy

Self critical thoughts
Looking back over the week, can you recall any self-critical thoughts

1. What situations/events brought them about?

....
....
....
....
....
....

2. What were your self-critical thoughts and feelings?

....
....
....
....
....
....

3. Thinking back over the week (please circle on each):

(a) How **often** did you have **self-critical** thoughts?
Had None 1 2 3 4 5 6 7 8 9 10 A lot of the time

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

(b) How **powerful** were your **self-critical** thoughts?
Not at all 1 2 3 4 5 6 7 8 9 10 Very powerful

(c) How **intrusive** were your **self-critical** thoughts?
Not at all 1 2 3 4 5 6 7 8 9 10 Very intrusive

(d) How **long** did your **self-critical** thoughts last?
Fleetingly 1 2 3 4 5 6 7 8 9 10 Most of the day

(e) How **distressed** were you by your **self-critical** thoughts?
Not at all 1 2 3 4 5 6 7 8 9 10 Very distressed

(f) How **angry/hostile** were your **self-critical** thoughts?
Not at all 1 2 3 4 5 6 7 8 9 10 Very harassing

(g) How easy was it to **distract** yourself from your **self-critical** thoughts?
Not at all easy 1 2 3 4 5 6 7 8 9 10 Very easy

Self compassion/soothing thoughts
Looking back over the week, can you recall any self-soothing/reassuring thoughts

1. What situations/events brought them about?

....
....
....
....
....

2. What were your self-soothing/reassuring thoughts?

....
....
....
....
....

3. Thinking back over the week (please circle on each):

(a) How **often** did you have **self-soothing** thoughts?
Had none 1 2 3 4 5 6 7 8 9 10 A lot of the time

(b) How **powerful** were your **self-soothing** thoughts?
Not at all 1 2 3 4 5 6 7 8 9 10 Very powerful

(c) How **intrusive** were your **self-soothing** thoughts?
Not at all 1 2 3 4 5 6 7 8 9 10 Very intrusive

(d) How **long** did your **self-soothing** thoughts last?
Fleetingly 1 2 3 4 5 6 7 8 9 10 Most of the day

(e) How **comforting** were your **self-soothing** thoughts?
Not at all 1 2 3 4 5 6 7 8 9 10 Very comforting

(f) How **calming/pleasant** were your **self-soothing** thoughts?
Not at all 1 2 3 4 5 6 7 8 9 10 Very calming/pleasant

(g) How easy was it to **maintain** your **self-soothing** thoughts?
Not at all easy 1 2 3 4 5 6 7 8 9 10 Very easy

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp

APPENDIX 2—THOUGHT MONITORING SHEET (5 COLUMN)

Form for exploring unhelpful thoughts and generating compassion-focused alternative thoughts and ideas

Triggering Events, Feelings or Images	**Depressing, Upsetting Thoughts**	**Feelings**	**Compassion-focused Alternatives to Self-Critical Thoughts**	**Understanding and change in feelings**
Key questions to help you identify your thoughts. *What actually happened? What was the trigger*	*What went through your mind?* *What are you thinking about others, and their thoughts about you?* *What are you thinking about yourself, and your future?*	*What are your main feelings and emotions?*	*What would you say to a friend?* *What compassionate alternatives might there be?* *What is the evidence for new view?* *(How) are these examples of compassion, care and support?* *Can you think these through with warmth?*	*Write down any change in your feelings*
	External shame (what I think others think about me) Key Feared Consequences Internal shame (what I think about me) Key feared Consequences Image and emotion: Function:		Empathy for own distress: Compassionate Attention: Compassionate Thinking: Compassionate Behaviour Image and emotion: Function:	

Copyright © 2008 John Wiley & Sons, Ltd.

DOI: 10.1002/cpp