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Chapter 11

The perfect nurturer

A model to develop a compassionate mind within the context of cognitive therapy

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As discussed in Chapter 10, many people with emotional difficulties can be burdened with self-critical and self-condemnatory thoughts and feelings. While traditional cognitive therapies help people focus on the evidence against their negative self-evaluative thoughts (and the possible distortions in thinking that underpin them), this chapter explores the impact of a way to help people who are self-condemning, by developing compassion and inner warmth for the self. Two case studies are presented to illustrate the therapeutic process in developing self-compassion. Both cases are characterised by presentations of chronic posttraumatic stress disorder (PTSD), a thinking style characterised by highly self-critical thoughts and a lack of ability to self-soothe.

The therapy described in these cases aims to facilitate an *emotional* shift towards a more caring and supportive approach to the self that undermines self-attack, facilitates self-acceptance and reduces emotional disturbances, thus enabling a person to become more self-soothing and self-regulating. A key component of this approach, outlined here in detail, is the use of an imagery intervention called 'the perfect nurturer'. This imagery is used to harness the experience of a nurturing relationship that becomes internalised and is used to evoke feelings of self-soothing and safeness (Gilbert, Chapter 2). It is also used to bring about a *compassionate reframe* of dysfunctional thinking within a traditional cognitive therapy framework (Beck, 1976), whereby self-attacking thoughts are challenged/reframed by the nurturing image, so that self-soothing feelings predominate.

Follow your heart, not your head?

For nearly 20 years, cognitive therapy has enjoyed a key position as an effective treatment for a variety of Axis I disorders (Beck, 1976; Beck & Emery, 1985; Clark & Steer, 1986; Salkovskis *et al.*, 1998) and, more recently, Axis II disorders (Beck *et al.*, 1990; Layden *et al.*, 1993). Traditional cognitive therapy seeks to introduce emotional change in clients by altering thought processes. There is now substantial evidence that helping people (i) focus on

and re-evaluate their thinking styles, and (ii) alter their behaviours, is beneficial in fostering a shift in emotional state, such as in depression and anxiety (Clark & Steer, 1996).

Yet for some people, particularly those with longstanding difficulties, this process fails to engage them on an emotional or implicit level. They report that they understand how to challenge and reframe dysfunctional thoughts (they know it 'in their head') but they do not experience any substantial or sustained emotional shift (hence they do not feel it 'in their hearts'). They may say, 'I understand what the alternative view is, in my head, but I just don't feel it' or 'Now I can see that I am not a bad person but I still *feel* bad'. There seems to be a mismatch between implicit self-processing, which operates through automatic, affective and unconscious processing, and explicit self-processing, which operates through controlled and conscious self-processing (Baldwin & Fergusson, 2001; Haidt, 2001). Hence there appears to be a discrepancy or 'lag' between what the person understands from a cognitive perspective and what they feel emotionally. Indeed, many theorists draw the distinction between intellectual reasoning and emotional reasoning, or propositional and implicational cognitive systems (Power & Dalgleish, 1997; Teasdale & Barnard, 1993).

This is an issue that, to date, cognitive *therapy* has not fully mastered. This is partly because the therapy suggests that emotions are linked to schemata or beliefs that can, without too much difficulty, be brought into consciousness, and it is because these beliefs do not change sufficiently that affect disturbance remains. Ways to influence affect have been suggested, such as the following.

1 'Relentless but gentle' and consistent cognitive challenges will eventually facilitate a shift in emotion.
2 A discussion highlighting the drawbacks of 'emotional reasoning' may suffice to promote the desired change.
3 Lack of emotional change in the face of intellectual understanding may indicate the need to revisit the formulation and/or further explore safety behaviours and maintenance factors that may be blocking the pathway to the desired emotional change.
4 A large enough body of evidence has not been collected to promote the new/alternative core belief.
5 Cognitive change needs to occur in the context of aroused emotions or 'hot' cognitions.

In many cases these are powerful and useful avenues to explore in order to facilitate a desired emotional change.

The heart–head lag

Even using such interventions, the 'heart–head lag' in therapeutic change is observed in a number of people, and particularly in those who present with longstanding difficulties relating to self-worth. Moreover, in a clinical setting, one observes that a common theme in these patients is their *lack of emotional warmth to the self*; that is, their efforts to re-evaluate negative information about the self are in a coldly rational or even hostile form (Gilbert & Irons, Chapter 10). They appear to have a reduced capacity to be empathic to the distress their self-attacking causes them or to *emotionally nurture* themselves via self-soothing and reassurance. An ability to feel warmth for the self may be underdeveloped and under-elaborated for a variety of reasons, which will be discussed briefly, with reference to social mentality theory.

Self-attack and compassion

Social mentality theory (Gilbert, 1989; Chapter 2 this volume) proposes that self-relevant information is often processed through systems (social mentalities) that were originally evolved for social relating. In essence, self-focused thinking and feelings are forms of internal self-to-self relating. Thus, a part of the self can enact a hostile, attacking, condemnatory, dominant role. Another part of the self responds and feels beaten down by being attacked. Similarly, part of the self can recognise the need for nurturance and be soothing, which enables the beaten-down self then to feel regulated and soothed. It is understanding the nature of this internal relationship with the self that is important in the emergence of some forms of psychopathology. Gilbert & Irons (Chapter 10) have emphasised the value of focusing on self-compassion and generating new feelings in the self-evaluative process as a important task of psychotherapy.

Why use the compassionate approach in cognitive therapy?

Gilbert & Irons (Chapter 10) have highlighted the need *to train* patients to develop inner compassion and warmth as this will aid the formation of and/or strengthen existing neuronal networks in a way that makes them sensitised and readily triggered. They also suggest that this is a prerequisite to cognitive challenging of critical thoughts (in people that lack the ability to self-soothe), as a cognitive focus alone may not create or stimulate the emotional experience and neurophysiological networks that are necessary for self-acceptance, self-soothing and abilities to tolerate distress. Distress is easier to tolerate and work with in the context of self-soothing abilities.

Self-attack and PTSD

As mentioned above, both the cases presented below are characterised by chronic PTSD and high levels of self-attacking thoughts. There is an interesting similarity between ongoing threat/current threat in PTSD sufferers and ongoing threat in self-critical people. In people who self-attack, via a continual internal dialogue of hostile and critical comments, a sense of ongoing threat to their sense of self is manifest (Gilbert & Irons, Chapter 10). The observation of manifest *current threat* (to physical or psychological sense of the self) has also been identified in contemporary models of PTSD (Brewin *et al.*, 1996; Ehlers & Clark, 2000). In PTSD the original threat is typically external (traumatic event), but the way the event is processed and stored in memory leads to a sense of current threat. When people experience flashbacks, the memories of the event are experienced with the full force of the peri-traumatic emotion (fear, anxiety, shame) – a sensory-based memory. It is as if it is happening again, with poor discrimination between 'now' and 'then'.

Brewin *et al.* (1996) explain this phenomenon in dual representation theory, by suggesting that trauma memories are stored in two parallel forms. First, they refer to situationally accessed memories (SAMs). These are *sensory-based* memories that contain information processed about the traumatic event (for example, 'I am being attacked'), including all peripheral stimuli (for example, darkness, alley, noise, smell of rubbish), sensory information (for example, fear responses) and its meaning (for example, 'I am going to die'). Information about meaning is derived from previous conditioning and innate, non-conscious appraisal mechanisms concerned with achievement of goals such as care receiving and establishment of safety (Gilbert, 1989). The creation of these memories can be characterised by data processing and hence they tend to be primitive, sensory based, and lacking in conceptual detail and integration into autobiographical memory.

Most importantly, they have no temporal context and, when triggered, they are experienced by the individual 'in the here and now', with the full force of the peri-traumatic emotion (fear), i.e. a sense of *current threat* is manifest and it feels as if the event is happening again. Situationally accessible memories are thought to be stored in the amygdala and cannot be consciously accessed. They are referred to as 'situational accessible' as they are triggered by internal or external cues without conscious awareness.

Second, Brewin *et al.* (1996) refer to another type of trauma memory, which they call verbally accessible memories (VAMs). These are characterised by autobiographical memories and can be deliberately accessed and edited. These memories contain conceptual meaning and are stored in a historical and meaningful way. Thus they have temporal context and carry meaning conceptualised on the basis of the person's pre-existing experience of the self, their world and other people. These are thought to be stored in the hippocampus (Williams, 1992).

In the treatment of PTSD, a task of therapy is to achieve a full verbally accessed account of the traumatic event, which contains all the information in the situationally accessed memory, but with a change of meaning. This is achieved by activating situationally accessed memories (using a reliving paradigm) and changing/updating their meaning, via cognitive restructuring, to the present context. For instance, in the example above, the update of the memory may be 'I don't die, I am safe'. An extensive discussion on the treatment of PTSD is beyond the scope of this chapter: suffice it to say that this can be achieved by pairing the sensory memory (SAM) with new, explicit information about meaning, such as with the cognition 'You are safe now' (a cognitive update) (Grey *et al.*, 2001) and, more implicitly, 'And how does that make you feel, now you know that you are safe?' (an emotional experience update (Lee, 2004)). Brewin (2001) argues that in PTSD the new memory has a retrieval advantage due to its 'distinctiveness' (Eysenk, 1979; Lockhart *et al.*, 1976). Thus this process creates a new, updated memory (with updated meaning) that blocks access to the original one (Brewin, 1989).

As with the treatment of PTSD, with people that self-attack and manifest a sense of current threat to the self it may be possible to access sensory-based memories associated with threat to the self (hostility) and 'update' them with new information about safeness (self-soothing), as seen in the PTSD treatment paradigm.

The premise in this approach is of course that people can access feelings of safeness. Yet people who self-attack to the level observed in clinical cases often do not have the ability to make themselves 'safe' from their own attack. Once this is learned (through training in developing compassion and the ability to self-soothe), the task of therapy is to update the sensory-based memories of attack with a new experience of self-soothing. One could hypothesise that eventually, via a process of conditioning, self-soothing comes to inhibit reciprocally the anger/hostility of the self-attack. Furthermore, this process may be greatly enhanced by creating a new sensory-based memory that has a distinct retrieval advantage, perhaps with a novel characteristic. Effectively, the process of threat arousal (associated with the amygdala) may be suppressed by the emotions produced by self-soothing in an individual, in the presence of threat perception (internal attack).

Therapeutic implications of these observations

The 'head–heart lag' presents a sizeable challenge to the cognitive therapist, as within this context, it is rare to see notable psychological recovery and symptom reduction that is sustained over time. This is because without the congruent emotional shift, the changes in thinking style seldom retain their ability to change behaviours. Indeed, from a clinical perspective, it is as if a congruent shift in emotion is the *glue* that makes the alternative thinking

patterns *stick*. Thus therapy needs to address, more explicitly, the issue of emotion-based meaning as well as cognition-based meaning, as they may be quite different (Teasdale, 1993, 1997).

Furthermore, emotion-based reasoning requires a different type of therapeutic intervention from cognitive work to promote change, as it does not speak the language of cognition. At the risk of oversimplification, therapy needs to use 'language' the amygdala understands – the sensory experience of attack – to change meaning at an emotional level and create congruence between the cognitive and affective states.

Patients who have (i) self-loathing, feelings of shame and inadequacy, *characterised by high levels of self-critical thoughts*, and (ii) a reduced capacity to *nurture themselves emotionally and to self-soothe*, are less likely to experience an emotional shift, in the context of traditional cognitive therapy. This process may be enhanced by training in the practice of how to emotionally nurture and self-soothe and access to sensory-based, self-soothing memories associated with a novel stimulus, to promote a retrieval advantage in the presence of internal threat (or self-attack). Once self-soothing processes have been established and brought to predominance, the patient may be better able to reframe effectively, and *with sustained improvement*, the highly self-critical negative thoughts that are hypothesised to maintain mood states (Beck, 1976). Thus, in these cases, emotion-based reasoning, rather than being challenged on a cognitive level (as in traditional methods of cognitive therapy), creates the milieu for the therapeutic intervention. Exploring the patient's ability to nurture themselves emotionally can be viewed as opening a window to their inner conflicts as well as providing a forum to foster feelings of compassion and warmth, so influencing their reasoning during the task of reframing highly negative thoughts about the self.

One way to elicit feelings of warmth and acceptance is via helping patients generate an image of a perfect nurturer. This image is then used to generate and direct warmth, acceptance and new meanings for the self. The use of an image of a *perfect nurturer* to facilitate this process in cognitive therapy conveys that the image is whatever the person wants it to represent (angel, fairy, Mother Nature, God); thus it is not prescriptive. It has the qualities (individually worked out) to nurture the person's emotional needs in an unquestioning way – meeting their needs perfectly. In this sense, the image always gives the answer that is in the person's best interest (because it has been designed to do so) – it does not suffer from human failings.

For some time now the use of imagery in therapy has become increasingly widespread. This is because its power to evoke change of meaning for troubling memories and emotions has been noted (Hackmann, 1998; Chapter 12 this volume). Also, imagery work involving the development of a compassionate figure has been used to good effect for people with personality disorder (Layden, 1998). Imagery can activate brain systems and produce physiological change (Gilbert & Irons, Chapter 10; Hackmann, 1998), compassionate

imagery may produce physiological changes associated with self-soothing. Repeated use of the perfect nurturer imagery to activate self-soothing emotions will increase the laying down of sensory-based memories in the neural networks, and will also increase the likelihood that this sensory memory will be triggered again.

Although one might argue that self-soothing emotions can be generated without imagery, the advantage of using the perfect nurturer image is that it can create a new and *distinctive* memory that may be more readily triggered and accessible (Brewin, 2001; Eysenk, 1979; Lockhart *et al.*, 1976). It also allows for social and relational processing. As noted previously (see Chapter 2), people who self-attack may have strengthened neuronal pathways associated with hostile emotional experiences (readily triggered when they perceive threat). The amygdala is the most likely site for these attack-based sensory memories (Christianson & Loftus, 1990; LeDoux, 1992; Wessel & Merckelbach, 1994). We cannot change the output from the amygdala (as it is akin to a read-only memory system), but we are able to introduce new learning and memory. This may become more readily triggered (by introducing a retrieval advantage) and thus have the effect of suppressing the output from the amygdala. In this case the aim is to develop new conditioned emotional responses (self-soothing) that will be triggered in situations where threat is perceived (internal self-criticism), as opposed to hostility.

The use of a distinctive image, the perfect nurturer, thus may be used not only to generate the feelings of warmth and compassion, but also to make that memory distinctive from others as suggested in the PTSD treatment approach. This in turn may increase the likelihood that neuronal pathways associated with self-soothing emotions will be activated under the conditions of perceived threat.

Case examples of using the perfect nurturer to develop a compassionate mind within the context of cognitive therapy

Having outlined in brief something of the theory underpinning compassionate mind training and introduced the concept of the perfect nurturer, the rest of the chapter will focus on two clinical examples of how it has been used with complex cases. These cases demonstrate techniques that have been developed to:

1 identify the source and extent of the self-critical dialogue
2 train people in how to self-soothe, in order to strengthen neuronal pathways and associated physiological reactions
3 use an image of the perfect nurturer to generate feelings of self-soothing and to introduce novelty in order to create a distinctive sensory-based memory that has a retrieval advantage over old memories of self-attack

4 bring congruence to the cognitive meaning and emotional meaning, by using the new sensory experience associated with the perfect nurturer to reframe self-critical thoughts (*compassionate reframe*).

First case example

The first example concerns a woman with internalised body shame, depression and PTSD. The therapy initially followed a traditional model of working with feelings of internalised shame and self-loathing at a cognitive level to promote an emotional shift. After this proved to have little success, training in compassion and self-soothing was introduced to the work, which produced some remarkable reductions in symptomatology.

Background to the case

Amy's entry into therapy at the age of 25 years was precipitated by an emotional collapse two months prior to the referral. When Amy was 10 years old her nightdress caught fire on an open gas fire and she suffered horrific burns from her neck to her ankles, was admitted to hospital for several months thereafter and nearly died from her injuries and associated complications.

Amy remembers the fire clearly. On the morning of the accident, she got up and was having breakfast with her younger sisters. Her mother was asleep upstairs. Amy recalls 'twirling' around the hearth and then her dress caught fire. She ran screaming for her mother who put her in the shower and Amy recalls an image of her skin dripping from her body.

Interestingly, in the months and years after the event, Amy did not recall any specific symptoms of PTSD, which is not uncommon in those who suffer horrific injury after a life-threatening event. She spent nine months in hospital before embarking on a series on painful skin-grafting operations, which are still needed to this day. Amy recalled that she never discussed her thoughts and emotions about the fire; she was not given the opportunity to do so.

Her mother plays a key part in understanding Amy's presenting psychological difficulties; this will become more apparent later. For now, suffice it to say that Amy recalled her mother as an emotionally abusive and neglectful woman, who was self-obsessed, obsessive, perfectionistic, psychologically damaging and (Amy thought) cared little for her children. Of note was the fact that Amy's mother could never accept the permanence of her daughter's scars and spent many years visiting specialists to try to repair the damage to Amy's skin. Amy attributed her mother's efforts for a 'cure' not to a sense of care for her, but to her mother's own need not to have a scarred child.

In spite of this, Amy functioned well at school and went on to university. She enjoyed her work and had a supportive group of friends. Fifteen years

after the fire, Amy was invited to her mother's house for a family celebration. There she encountered a room full of lit candles and her mother wearing a 'floaty' dress. Amy almost immediately suffered a powerful flashback with dissociation to her own accident.

The problems

Thereafter Amy suffered what she described as an emotional collapse: she developed fear-based PTSD (Lee *et al.*, 2001), depression with suicidal ideation and intent, severe anxiety and panic, and an intensification of other premorbid problems. These related to intense self-loathing, disgust and shame, hatred of her scarred body and eating problems characterised by restrictive eating.

For the purpose of this chapter, I will focus on working with her depression, body shame and internalised shame. In order to convey the depths of Amy's self-loathing and despair, some of her internalised shame cognitions are listed below.

- I feel bad, invalid, redundant, purposeless, pointless.
- I feel so deeply ashamed I have nothing to say.
- If people see my scars they will know how disgusting I am inside and out.
- The knowledge that I will always look like this makes me very unhappy.
- My scars contribute to my feelings of inadequacy to the point where I cannot bear to look at them myself.
- I am absolutely disgusted with my body.
- I loathe myself.
- I want to curl up and die.
- People stare at me like I am a freak.

Amy also engaged in self-harm, triggered by thoughts and feelings of self-loathing. At times of great despair she would cut her arms and cross-hatch on top of the scar tissues on her stomach. She described a sense of purging and relief when she saw her blood. Marked weight loss was associated with pleasure and satisfaction. Amy dreamt of unzipping her body and stepping out of it. She also had dreams of infected wounds, of her body splitting open and plants sprouting out of her wounds. These dreams repulsed her.

At the core of Amy's psychological difficulties was a theme of internal shame. Her depression was maintained by high levels of critical thinking (you're disgusting, you're fat, you're repulsive, no one will ever love you). Her desire to die was a desperate attempt to escape the shame and self-loathing she lived with every day.

The course of therapy

In total Amy had 60 sessions of cognitive behavioural therapy (CBT). Her fear-based PTSD was treated with reliving at around session 12. The last eight sessions will be the focus of this remaining section, but some information about the previous 52 sessions may be of use.

- *Sessions 1–33:* From an in-depth formulation of Amy's difficulties, CBT was indicated to begin work on her severe depression, self-harm and suicidal ideation. These sessions were characterised by: daily activity monitoring, identification/challenge of negative automatic thoughts, identification of core beliefs, written and verbal accounts of the fire and aftermath. Amy was admitted to hospital in week 8 of therapy with marked suicidal ideas and intent. After five weeks she resumed therapy. At the end of 33 sessions Amy was well versed in the language and techniques of cognitive therapy. There was, however, no change in her symptoms of depression, feelings of shame and self-loathing. Her Beck Depression Inventory score averaged 45, indicating severe depressive symptomatology. However, there was hope for change and Amy was desperate for help and committed to therapy.
- *Sessions 34–50 (17 sessions):* This next phase of treatment was characterised by schema-focused techniques, core belief work, positive data logs and behavioural experiments (Padesky, 1994). The purpose of this was to rebuild positive core beliefs and reduce the power of Amy's core beliefs of unacceptability and disgust. At the end of this phase of therapy Amy's symptoms of depression remained unchanged (objectively and subjectively). Her Beck Depression Inventory score, after each session, averaged 45. However, she said that she did not feel exclusively defined by her mental state. Nevertheless, she reported that she loathed and detested her body. She believed her self-identity had merged with her body and while her body remained unacceptable and disgusting, so did she. She reported in reference to the cognitive therapy and the work we had done on her core beliefs: *It all makes sense to me but I don't feel it in my heart.*
- *Sessions 51–57 (7 sessions):* After a four-month gap we embarked on our final stage of therapy. What became ever more apparent was that cognitive therapy was not 'touching' the shame and disgust that fuelled Amy's self-critical attacks. Although able to identify her thoughts, challenge them, identify core beliefs and collect data to support new beliefs (in fact Amy was an ideal patient for cognitive therapy, as she religiously did her homework), she remained full of self-loathing and shame. The intellectual shift had not precipitated the desired emotional shift.

  What also became apparent was the extent to which Amy's inner dialogues were punishing and abusive. She seemed unable to feel any degree of warmth or compassion for herself. Her negative thoughts were punitive,

scathing and mocking and her attempts to reframe her thoughts, although apt, *were devoid of warmth and compassion and delivered in a neutral way*.

We began to discuss a way forward that would facilitate self-acceptance and Amy's ability to nurture herself on an emotional level. Amy had little experience of emotional nurturance as a child, and at first she found it difficult to discuss. She was able to say that she experienced her relationship with her mother as having been damaging and lacking in love and warmth. We discussed the impact of this environment on Amy's psychological make-up and introduced the notion that perhaps we could learn to soothe and emotionally nurture ourselves in the absence of such a learning experience in childhood.

Self-acceptance

A starting point for Amy had to be that should she choose to live, she would need to find a way to accept her scarred body, appreciate that she could not change her body but also understand that she could change the way she felt about her body and herself. We embarked on discussions about the difference between Amy and her body. We worked on creating distinctions between these by finding examples of other disabled, burnt people and discussing Amy's thoughts about them. We were able to move to Amy's acceptance that her body did not define who she was as a person. Amy found it perplexing that she judged herself by different rules to others. She was adamant that she would never speak or think about another person the way she spoke and thought about herself. Amy would not be as critical or judgemental of others.

Given this observation, we hypothesised that Amy's critical thoughts might stem not from her own authentic beliefs about herself and her body but from another source (perhaps she had internalised her mother's critical voice during her childhood and developed a self-bullying role).

In order to test this hypothesis we generated a diary of Amy's critical thoughts. Using Worksheet 11.1, Amy filled in what she was doing at the time of the thought (column 1), what the thought was (column 2), the emotion she felt when she had the thought (column 3), how much she endorsed the thought (column 4), and whose voice she heard in her head (column 5). Worksheet 11.1 contains some examples of her critical thoughts (which she was able to identify with her mother).

These findings were a revelation to Amy, as she had not appreciated quite how much her mother influenced the way she now thought about herself. We then proceeded to place a historical perspective on these voices by linking them to key themes of her childhood. The purpose of this was to enable Amy to make links back to her childhood experiences in order to understand what made her so critical of herself. Using Worksheet 11.2, Amy wrote down prominent memories, rules and events and experiences of her childhood.

Worksheet 11.1 Identifying critical voices (Amy)

Date and setting	*Critical/self-attacking thoughts*	*Emotions*	*Endorsement of critical thoughts*	*Source of self-critical thoughts*
What day is it? *What time of day is it?* *What are you doing?*	*Write down any self-attacking thoughts that you can identify at this moment, e.g. I am useless, nobody likes me, other people are better than me*	*Write down what you feel now when you have these thoughts, e.g. sad, anxious, ashamed, guilty, frightened*	*Write down how much you believe these thoughts (out of 100%)* *0 ..... 100* *Disbelieve Believe*	*Think about whether this is something you think about yourself or whether someone else said these things about you, e.g. You, mother, father, sister, friend, teacher, etc.*
Tuesday 10.00 a.m. Getting dressed	You're too fat You're an embarrassment because of the way you dress and speak	Shame Shame, humiliated	75% 100%	Mother Mother
11.00 a.m. Walking to shop	You're a jinx, you've put a curse on the house	Worried	100%	Mother
11.30 a.m. In house, tidying up	You're a liar	Angry	10%	Mother
11.45 a.m. Talking on phone	You're malicious and devious	Sad	25%	Mother
2.00 p.m. Trying to do some work	You're narrow-minded, lazy and bad	Shame, worry	75%	Mother

Worksheet 11.2 Putting a historical perspective on the critical voices and drawing conclusions (Amy)

Examples of experiences/memories, thoughts, standards/rules for living that help you understand the critical voices

For example: *My mother was anorexic and hated seeing me eat (critical thought: 'you're fat')*
- Mother thought physical perfection was paramount
- Disappointment to mother
- My mother made me feel my body was disgusting
- Put on diet by mother at 11 years
- Bought clothes that covered my scars
- Would not accept permanence of scars
- Teased at school and made to feel like a freak
- First boyfriend was abusive and cruel about my scars

The conclusions I came to about myself

I WAS MADE TO BELIEVE THAT I WAS UNACCEPTABLE PHYSICALLY

These were then used to discuss what sort of beliefs or conclusions Amy may have come to about herself, given these experiences.

Crucially at this stage Amy came to the realisation that she was made to believe she was unacceptable physically, rather than being inherently unacceptable. Given this we discussed how much credence Amy had given to her mother's opinions and judgements throughout her life. Did her mother warrant such credence? Did she value her mother's opinions? Were they balanced and informed? Using Worksheet 11.3, we discussed what Amy thought of her mother and to a lesser extent her father (who was somewhat absent throughout Amy's childhood).

This exercise allowed Amy to (i) view her mother from a different perspective, (ii) begin to question why she held her mother's beliefs so strongly, and (iii) begin to question the lack of love she had as a child. Interestingly, it also allowed Amy to see that her father had been loving and affectionate and that although it was buried somewhere in her mind, Amy had been loved. This experience was very important, as it allowed us to foster in Amy memories of being loved and given physical affection by her father (to strengthen Amy's ability to self-soothe).

The next phase of work became key in facilitating a shift in Amy's emotional state. Having identified the punitive, emotionally abusive environment of her childhood and the lack of love she perceived from her mother, we embarked on the task of creating an internal image of the perfect nurturer. Amy brainstormed around the qualities of her ideal mother (unconditionally loving; wants me; accepts me for who I am; warm, peaceful and tranquil; nurturing; uncritical). Crucially, we focused on fostering the

Worksheet 11.3 Credentials of my critics (Amy)

Name: mother		*Name: father*	
Positive aspects	*Negative aspects*	*Positive aspects*	*Negative aspects*
	Blond, skinny, underfed, highly strung, highly critical, disorganised, perfectionist, cruel, devious, manipulative, careless, self-centred, dangerous driver, domestic fascist, rude, opportunist, selfish, incapable of love, humourless, indescribable, incapable of self-doubt	Loving and physically affectionate. Unlike my self-obsessed, vain mother he is capable of loving but only on his own terms A good man but a bad father	Disinterested, reluctant to take on any responsibility that isn't immediately self-serving

feelings of warmth, compassion and acceptance. It is useful to help people focus on different domains such as physical characteristics, sensory features (facial expression, voice tone, smell), touch/closeness, and the acceptance, emotions and knowledge (wisdom) 'in' the imaged other.

We spent a session generating Amy's image and the feelings that image generated in her. She practised generating the image and feelings every day for several weeks. Worksheet 11.4 contains what Amy wrote about her perfect nurturer.

The final stage of treatment came with the introduction of the *compassionate reframe*. Amy was asked to fill in a critical thought diary (as before), but with a difference. Using Worksheet 11.5, every time she had a negative and critical thought she was asked to imagine her perfect nurturer and, when the feelings of warmth and compassion were aroused, she then asked the image to reframe the critical thought. As can be seen in Worksheet 11.5, Amy wrote down her critical thoughts in column 1. She identified the source of the criticism and identity of the critic in column 2. Then Amy imagined her perfect nurturer and, when she felt the soothing emotions, she asked the image to reframe her critical thoughts, which she wrote down in column 3. Column 4 was used to measure the extent to which Amy endorsed the reframe, and column 5 recorded the mood rating.

This technique proved remarkably powerful in changing her mood. As she became practised at imagining her perfect nurturer, she also developed a short-cut image. After time, this short-cut image had the effect of producing the same feelings of emotional warmth.

Worksheet 11.4 Description of my perfect nurturer (Amy)

Compassionate image: Perfect nurturer. Description of attributes, physical appearance, qualities

I imagine my perfect nurturer to look like one of Blake's angels. Radiant and ephemeral, hovering between earth and sky, physically human but purely spiritual all at once. My perfect nurturer would be my guardian angel. Neither male nor female but both at once. Always there but never visible. Perfectly beautiful but perfectly understanding of human flaws. It is made of love and forgiveness the way I am made of flesh and bone. What hurts me also hurts it, but it can never be fatally wounded or permanently damaged. Because it is made of love and forgiveness it can permanently renew and regenerate. It shows me how to renew and regenerate in the same way.

My angel is my guide, nurturer and protector. It shows me that I am lovable. Its presence shows me that I am worth protecting. It supports me when I do not have the strength to support myself. It keeps me safe when I cannot. It decides I should live when I have wanted to die. It is infinite joy, love, peace, compassion, help, and guidance.

And who am I to refuse that?

Description of emotional responses associated with image
When I imagine my angel I feel a sense of calm and peace. I feel soothed, loved and accepted.

Outcome

Amy's use of her perfect nurturer image as a means to reframe her critical thoughts with compassion proved to be the turning point in therapy. Harnessed with the ability to self-soothe, her progress was staggering and after only six sessions (spread over six months) and two follow-up sessions (over another 1.5 years), her score on the Beck Depression Inventory was 1; this gain was maintained at 1.5 years' follow-up. At discharge Amy was working again (after 2.5 years' sick leave), planning a new career, accepting of her body and accepting of herself.

There are a number of issues to highlight from Amy. The first is that working only with cognitions in 'the here and now' and on the fear aspects of the trauma was of limited help. Second, clearly identifying the self-critical part as the voice of another who Amy had simply internalised was important. Many psychotherapies have indicated that separating what comes from self and what comes from others, and is internalised, is important in letting go of self-criticism. It begins the process of separating 'what I think about me from what others think (or thought); or how I can relate to myself versus how others have related to me'. Cognitive therapy too can address this crucial issue. Understanding that how one evaluates others (who may be suffering the same as self) is different from how one evaluates oneself is common to many cognitive and other therapies. However, these can get stuck at an intellectual, cognitive or explicit level. Moreover, as Gilbert has argued (Gilbert, 2000; Gilbert & Irons, Chapter 10 this volume) in such situations it is feeling

Worksheet 11.5 Using the perfect nurturer to reframe critical thoughts with compassion (Amy)

Self-attacking thought	*Source of critical thought and identity of critic*	*Compassionate reframe (image)*	*Extent to which I endorse reframe (0–100)*	*Mood rating (1–100)*
Write down any self-attacking thoughts that you can identify at this moment, e.g. I am useless, nobody likes me, other people are better than me	*Where does this thought come from? Can you identify a critic?*	*Imagine your perfect nurturer and when you feel soothed, ask the image to reframe your critical thought*		*What do you feel now you have reframed your criticism?*
Went out not wearing my neck scarf. My scars are repulsive to others and should be hidden from sight.	My mother, who was obsessed with physical perfection. SHE could not accept my scars. SHE thought they were disgusting and tried to hide my body with ridiculous clothes.	True beauty is everywhere: just let yourself see it. Your scars are a sign of your strength and courage in a battle fought and won. Let people stare at you and know that it does not matter. What matters is that you live your life for you, not for others.	100%	Peaceful and calm 100%

genuine compassion for the self that may be crucial for change, as it fosters change at an implicit level of meaning – the emotional meaning.

Hence, a crucial component was not to rely (only) on a therapist giving experiences of warm acceptance, but to provide an opportunity for Amy to start to create internal signals that would stimulate her *own self-soothing system*. Deliberately generating images of a perfect nurturer, and thinking that this can also be like an internalised other, offered Amy the opportunity to start a new self-to-self inner dialogue and relating style that was infused with feelings of warmth. The perfect nurturer also introduced a novel characteristic to new learning, thus creating a retrieval advantage over old sensory-based memories. In many ways it appeared that stimulating the inner experience of warmth for her, via imagery, produced the marked change. While all the

elements of the therapy played a part, it was the activation of inner warmth and compassion that Amy found most healing.

Second case example

The second example again outlines the use of compassionate imagery to foster self-acceptance in a young woman with PTSD, poor self-worth, shame and depression. In this case, training in self-soothing was introduced early in therapy.

Background

Sylvie, a woman in her late twenties, nearly died after an emergency Caesarean. The medical staff told Sylvie that she had been 10 minutes from death. In the aftermath of this event, Sylvie became symptomatic with PTSD. She constantly replayed images of the events surrounding the birth of her son and ruminated about the care she received in hospital. When she thought back to this event she was overwhelmed with sadness and grief. She was particularly troubled with the thought 'I don't count'. She believed the hospital staff did not care about her enough to want to save her life. She experienced feelings of being alone and disconnected from people around her.

Sylvie also reported suffering from daily symptoms of anxiety, building up at times to feelings of panic (particularly triggered by thoughts of the event). She had moderate to severe levels of depression (her Beck Depression Inventory score was 29). She was able to articulate that she felt sad and ineffectual in her life. She was plagued by self-critical thoughts that made her feel bad about herself. Sylvie reported that she felt stigmatised and that somehow she had 'fallen from grace'. She described feeling deeply ashamed and humiliated about what happened to her. Prior to the birth of her son, Sylvie was involved in an unsatisfactory relationship with the father of her son. This relationship was characterised by emotional abuse.

As a child she went to several different schools and had painful memories of 'always being the new girl who had to fit in'. She developed a strategy of working hard in order to get people to like her, and indeed she recalled being a popular child. During her adolescence (between the ages of 14 and 18 years) she developed an eating disorder characterised by binge/vomiting. At this time she believed herself to be 'fat and disgusting'. Of note was the fact that her mother had a history of anorexia. As in the first case, it will become apparent that Sylvie's mother plays an important role in understanding her self-criticism. Sylvie felt very ashamed of her 'puking days'; she thought it was a dirty habit and should be kept secret.

Interestingly, this behaviour stopped when she went to university. During her early twenties Sylvie had a termination of pregnancy. After this she recalled sinking into a deep depression. She felt guilty and full of self-loathing.

At around this time she began to cut herself. She described how she wanted to 'give my pain a face as the throbbing pain in my leg would distract me from my emotional pain'. Sylvie described aptly the function of her self-harm – 'I could tend to my physical wound by caring for it, bathing it, cleansing it, putting some cream on it to soothe the pain and then put a plaster on it to make it better'. This task was something she was unable to do with her emotional pain.

Sylvie's last incident of self-harm was just before the birth of her son. She was made homeless and had split up from her partner. In desperation she smashed a glass on her forehead.

We were able to link the traumatic birth of Sylvie's son (and the way she responded to it) to her profound sense that she was unlovable and that nobody cared about her. She believed on one level that the medical staff did not want to save her life. We were also able to link Sylvie's heightened feelings of shame and self-loathing to her premorbid psychological make-up. In essence her near-death experience intensified underlying beliefs of feeling neglected – as if she did not count, and was not good enough even to save from death. At this time, although tempted, she did not engage in self-cutting as she felt she needed to be a responsible mother.

The course of therapy

In total Sylvie had 16 sessions of cognitive therapy. The first four sessions focused on the traumatic birth of her son and PTSD. The final 12 sessions focused on developing inner compassion and warmth, as Sylvie's problems were characterised by (i) self-critical thoughts fostering feelings of self-loathing and shame, (ii) patterns of self-harm and (iii) evidence of a reduced ability to self-soothe her emotional pain (poignantly captured in her description of self-harm).

We used the same techniques as with Amy to develop acceptance and compassion. Thus we began with a discussion about self-acceptance. This included a discussion about how Sylvie viewed and judged her friends. We discussed whether she would speak to friends the same way she spoke to herself – would she have similar thoughts about her friends' appearance and behaviour? Sylvie was able to identify that she was harsher on herself than on others. She already knew that she heard 'the voice of my mother in her head', and would joke about it. She recalled that her mother was a perfectionist with unrelenting standards and rigid beliefs, and was highly critical of Sylvie. Using Worksheet 11.6, Sylvie was asked to focus on her critical thoughts, note the associated feelings, rate her endorsement of the thought and, finally, note the source of the self-critical thoughts.

This exercise proved fruitful for Sylvie, as she was able to tease out her own evaluations from those of her mother. As with Amy, we continued to elaborate on this information by exploring, in more detail, Sylvie's memories of her

Worksheet 11.6 Identifying critical voices (Sylvie)

Date and setting	*Critical/self-attacking thoughts*	*Emotions*	*Endorsement of critical thoughts*	*Source of self-critical thoughts*
What day is it? *What time of day is it?* *What are you doing?*	*Write down any self-attacking thoughts that you can identify at this moment, e.g. I am useless, nobody likes me, other people are better than me*	*Write down what you feel now when you have these thoughts, e.g. sad, anxious, ashamed, guilty, frightened*	*Write down how much you believe these thoughts (out of 100%)* *0 .....100* *Disbelieve Believe*	*Think about whether this is something you think about yourself or whether someone else said these things about you, e.g. You, mother, father, sister, friend, teacher, etc.*
Saturday 7.00 a.m. Getting dressed	You look unkempt You dress thoughtlessly Your arse looks enormous	Shame Embarrassment Anxiety Irritation	90% 100% 80%	Mother Mother Mother
10.30 a.m. Buying clothes	You spend too much money	Anxious Worried	80% 100%	Mother Mother
7.00 p.m. Having a beer in home	You drink too much (80%)	Sad, shame	100%	Me
8.00 p.m. Talking on phone to mum	I am always a disappointment to my mother (100%)	Shame, worry	80%	Me
	I never do things perfectly I don't care enough for other people (75%) I am thoughtless (80%)	Shame, worry	75%	Me

Worksheet 11.7 Putting a historical perspective on the critical voices and drawing conclusions (Sylvie)

Examples of experience/memories, thoughts, standards/rules for living that help you understand the critical voices

For example: *My mother was anorexic and hated seeing me eat (critical thought: 'you're fat')*
- My mother was obsessed with physical perfection
- My mother was always pristine
- Academic achievement was highly prized
- I never had any praise
- I was never good enough
- My mother called me insulting names
- My mother could be mean and tyrannical
- She threw my stuff away if I didn't tidy up
- Re vomiting: 'If you think you are going to manipulate me with this you are wrong'
- She would often completely ignore me for weeks on end
- She would lay the table but not for me

The conclusions I came to about myself

I WAS MADE TO FEEL UNLOVED AND A DISAPPOINTMENT

childhood experiences and the feelings she associated with them, in order to make links with how Sylvie thought about herself as an adult. Worksheet 11.7 contains examples of some of more prominent thoughts/memories.

It is worth mentioning that at this stage in Sylvie's life she had a positive relationship with her mother. As in the first case, the purpose of this exercise is not to foster blame but to 'seek to understand' the development of her critical thoughts. At the end of the task she was able to appreciate why she found it difficult to soothe her emotional pain. She realised that her emotional pain was never soothed as a child; instead, her attempts to seek comfort were usually met with punitive criticism. Perhaps as a consequence, she had been unable to internalise mechanisms to self-soothe in an adaptive way. She had rarely experienced this as a child. However, she had ample experience of critical attacks. This strategy of attack had been internalised and became the prominent feature of her inner self–self dialogues.

To continue with the task of reducing the extent of Sylvie's self-critical dialogues, we explored the credentials of her main critic – her mother – by using Worksheet 11.8. The exploration of the positive and negative aspects of her mother's beliefs and behaviour enabled Sylvie to crystallise the difference between her beliefs and thoughts (the evidence for which was found mainly through her views of her friends' appearance and behaviour) and those of her mother.

As with Amy, we then spent a session developing a comprehensive image of Sylvie's perfect nurturer, which is described in Worksheet 11.9.

Worksheet 11.8 Credentials of my critics (Sylvie)

Name: mother		*Name: father*	
Positive aspects	*Negative aspects*	*Positive aspects*	*Negative aspects*
Warrior	Stubborn	(only a small part)	A nonentity
Rebel	Sharp tongue	Physically affectionate	Absent
Stands up to people	Insecure	Proud of family	Expects success
Dry sense of humour	Dominant	Successful self-made man	Too ambitious
Attractive	Highly strung		Moody
Pristine	Nervous wreck		Stubborn
Classy	Worrier		Ignorant
Tries to overcome her fear	Insomniac		
	Scary		
	Not affectionate		
	Distant		
	Overbearing		
	Cruel		
	Coward		

After *repeated practice* of conjuring her image and the feelings of warmth and compassion, Sylvie developed a short-cut to her image. She imagined just a pair of arms outstretched. She combined this with smelling the skin on her arm (which she described as comforting and 'mummy-ish'). Later in therapy, the smell alone triggered her feelings of warmth and acceptance.

Worksheet 11.9 Description of my perfect nurturer (Sylvie)

Compassionate image: Perfect nurturer. Description of attributes, physical appearance, qualities

My perfect nurturer rises still and tranquil, high from the ground, her arms open in an anticipation of an embrace. Her garments are loose and linen. Her overall texture is warm, breathable, sandstoney skin, matt, warm, soft, alive. Her face is relaxed, her eyes closed in the moment of tasting that impending hug. Her smile is slight, calm and almost otherworldly spiritual and content.

Her embrace comes at times when I feel like a failure. She strengthens me. Her embrace comes at times of discomfort and disappointment when she tells me how special I am. How much she loves me and what she thinks might be right for me. She tells me to listen to me.

She trusts me and my opinion counts with her and that I am worthy. She whispers in a warm soothing voice 'Hey, it's OK, everything is going to be fine'.

But she is not a person, she is a moment of affection and acceptance. She marvels at me as I marvel at my child. Life isn't always going to be good and fun but she will always be waiting for me with her arms open, encouraging, soothing, trusting, holding me . . . just holding me.

Description of emotional responses associated with image
When I imagine my image I feel accepted, safe and loved, warm and comforted.

The final stage of the therapy focused on developing skills to reframe critical thoughts with compassion. As before, Sylvie used a worksheet to keep a diary of her critical thoughts, but this time she reframed them by conjuring up her feelings of warmth and compassion (smelling her arm) and asking her perfect nurturer to respond to the critical thought. Worksheet 11.10 is an example of Sylvie's work. As Sylvie continued to use the compassionate reframe diaries, she expanded the identities of her critics to include the perfectionist, the unforgiving self and the bully as well as her mum. This was interesting, as it appeared that Sylvie began to identify many aspects of herself that played out different roles in different situations.

Outcome

At the end of therapy, Sylvie said she felt strong and positive. At a three-month follow up, her Beck Depression Inventory score was 8. Sylvie's progress pleased her greatly, and she was delighted with what she called the 'new me'. Crucially, she identified her compassionate reframes as central to her continued well-being. She had already observed that when she forgot to use this technique for a period of time her mood would drop.

Worksheet 11.10 Using the perfect nurturer to reframe critical thoughts with compassion (Sylvie)

Self-attacking thought	*Source of critical thought and identity of critic*	*Compassionate reframe (image)*	*Extent to which I endorse reframe (0–100)*	*Mood rating (1–100)*
Write down any self-attacking thoughts that you can identify at this moment, e.g. I am useless, nobody likes me, other people are better than me	*Where does this thought come from? Can you identify a critic?*	*Imagine your perfect nurturer and when you feel soothed, ask the image to reframe your critical thoughts*		*What do you feel now you have reframed your criticism?*
Went out looking unkempt, oily hair, no make-up. This is not acceptable: I am completely unattractive, off-putting, not worthy of positive attention.	My mother. She's obsessed with perfection and always unhappy with herself. She thinks I should wear make-up to make me attractive.	I am attractive and I don't need make-up. I have my own style, of which looking pristine is not part. I can accept this is me and I like it.	100%	Good, strong (100%)

Summary of stages

This section summarises the stages discussed in the casework and discusses how they might work in cognitive therapy. It is always worth reiterating the importance of the therapeutic relationship and timing when working with individuals who experience chronic and deep-seated problems with self-worth. Leahy (Chapter 7) and Gilbert & Irons (Chapter 10) both indicate that the therapy context may be the first time an individual has experienced a compassionate relationship. It may take many months before some of the concepts can be introduced or worked with.

The ability to self-soothe is not necessarily something that comes naturally to some people, and training is an essential component of the approach, especially when people cannot access any feelings of warmth or compassion. A key process in therapy involves recalling experiences/memories that were associated with love and affection. However, this is not always the case, and Gilbert & Irons (Chapter 10) have illustrated techniques that may be used to try to develop compassion.

- *Identifying critical voices:* This is often the starting point of traditional cognitive therapy – the practice of 'catching' thoughts and noting how they make you feel. In individuals where these thoughts are characterised by self-criticism, delivered in a punitive and harsh manner, highlighting the identity of their internal critic can be useful in the first steps to self-acceptance. Rating the extent to which the person endorses their critical thoughts allows them to see the variance between thoughts, and to focus on particularly compelling or 'hot' cognitions. By identifying the source of the self-critical thoughts (whether a person or an early experience), the person may begin to separate out their own thoughts from others' opinions that have become part of their attacking self-dialogue. Two further exercises, the historical perspective and the credentials of the critic, can strengthen this process.
- *The historical perspective:* An examination of prominent memories and experiences of childhood can offer an important insight – we are not born useless, unworthy, disgusting, etc. Rather in early life we are made to *feel* that way by the treatment of others because we may not have any other experiences or resources by which to refute their condemnations. Thus, as in cognitive therapy, our core beliefs can be viewed as the conclusions we have come to about ourselves based on our experiences.
- *Credentials of critic:* Individuals that self-attack give enormous credence to their internal bully – it is literally unquestioning. For individuals who can identify the source of their attack (their mother, father, step-parents, etc.), a discussion about what sorts of people they admire, respect and listen to, and what kind of qualities those people have, is a useful preamble to an examination of their critic's credentials. In many of my cases

this exercise has proved very helpful in beginning to end the internal critic's 'hold' over the person, as the negatives usually far outweigh the positives. This is not an exercise in seeking blame; rather it seeks to help people understand themselves. Given the sensitivity of this and the level of emotional pain these individuals have suffered, it is vital that they understand the purpose of the exercise and that it is conducted in the context of a compassionate and warm therapeutic relationship.

- *Using the perfect nurturer to facilitate a compassionate reframe:* Using the perfect nurturer (as opposed to the person) to make the compassionate reframe of self-critical thoughts appears to have several advantages. It is difficult to undermine the perfect nurturer and make 'exceptions to the rules' to cognitive reframes. This approach also deals with the problem that arises in individuals with a reduced ability to self-soothe – rarely are they able to choose emotionally nurturing friends and partners. Hence the cognitive therapy technique of using 'And what would you say to a friend, or what would a friend say to you?' can become unstuck. It also appears to work faster at dealing with negative thoughts and undermining negative affect. Perhaps this is because it provides the emotional experience at the time of the reframing, thereby facilitating a 'feeling in the heart' as well as 'in the head'.

  Developing the perfect nurturer is both an experiential and a cognitive exercise. Hence the self-soothing emotions associated with the image directly undermine the affect of self-attack, while the compassionate reframe directly challenges the cognition by using emotion-based reasoning – a two-pronged approach.

Concluding comments

Compassionate mind work is focused on developing new self-to-self relating out of which can flow new insights and thoughts about, and experiences of, the self. The key to working this way is to provide opportunities for people to *feel warmth* for the self. For some people this system may be seriously underdeveloped and under-elaborated. People may have few feeling memories of being cared for, or those they do have can be submerged under others relating to shame. Imagery and practising imagery can be one way to start to activate this system and bring it into the experience of self.

Compassionate warmth has special soothing qualities for the self that may be linked to a number of neurophysiological systems. Change for some people, then, is not only about redirecting attention, re-attributing, re-evaluating or re-framing, powerful as these may be – it is also about recognising that we have evolved systems for social and self-processing, for being soothed by others and for becoming capable of self-soothing and self-accepting. For some people these systems will come (back) on line as they change their thoughts and behaviours, but for others, for whom they have

never been well developed, they do not. Blending compassionate mind training into more standard cognitive (and other) therapies offers a possible avenue to help people who have become stuck in self-loathing and contempt.

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Although I have disguised their identities, Amy and Sylvie are real people and this chapter contains the work they did in therapy. They kindly agreed to let me write about their experiences and I want to extend my heartfelt thanks to them.

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