Recovery through affiliation: a Compassionate Approach to Schizophrenia and Schizoaffective Disorder (COMPASS)

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Abstract

Described as a contextual behavioural approach, Compassion-focused Therapy (CFT) aims at helping people develop compassionate relationships both with others and with the self. CFT has been used to promote recovery in psychosis with promising results. The development process of the Compassionate Approach to Schizophrenia and Schizoaffective Disorder (COMPASS) builds upon the available research on contextual behavioural approaches for psychosis. Its main framework is the affect regulation system's model and the compassion-focused therapy rationale as it was adapted for psychosis. Other theoretical and empirical influences are presented and innovations regarding CFT protocols for psychosis are highlighted. COMPASS is already being studied and details on the pilot study are provided. With further study and continuing improvement COMPASS has the potential to help foster recovery in psychosis.

Keywords: Compassion; Mindfulness; Psychosis; Recovery

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Contextual behavioural approaches for psychosis have been considered a natural evolution of traditional cognitive-behavioural therapy aiming at a broader conceptualization and treatment approach to psychotic symptoms (Tai & Turkington, 2009). These approaches seem to have a specific potential to help recovery due to characteristics as, for instance, absence of questioning regarding the specific content/ rationality of thoughts; specific focus on engagement with difficult experiences; and helping patients understand experiences as transient, separate from self and a part of a continuum (de-shaming). Additionally, focusing on values and motivations, the stimulation of behavioural activation and social interactions, and fostering emotional regulation may also be particularly useful for this population.

Compassion-Focused Therapy (CFT, Gilbert, 2009, 2014; Gilbert & Procter, 2006) was primarily developed for complex and chronic conditions linked to high levels of shame and self-criticism. Its main therapeutic focus is to develop compassion as a motivation to care for others and the self. Compassionate Mind Training (CMT) is a specific training developed to help people cultivate these qualities and skills through compassion-based therapeutic strategies and practices (Gilbert & Irons, 2005; Gilbert & Procter, 2006). CFT and CMT aim at helping people change the relationships they establish with self and others, through processes that generate kindness, warmth, and a non-judgemental attitude. People with psychosis often struggle with several internal (e.g. symptoms, shame) and external sources of threat (e.g. stigma). Moreover, there is usually a lack of abilities to (self)sooth and experience positive affect (e.g. safeness). Thus, authors recommend that along with reducing the sense of threat there is also need to learn positive affect regulation strategies (Gumley, Braehler, Laithwaite, MacBeth, & Gilbert, 2010).

Compassion-focused approaches and CMT have been used to promote recovery in psychosis with promising results. Improvement has been found regarding social comparison, shame (Laithwaite et al., 2009), compassion, and clinical improvement (Braehler, Gumley, et al., 2013). Processes studies have found that increases in compassion were significantly associated with reductions in depressive symptoms and perceived social marginalization (Braehler, Gumley, et al., 2013), thus suggesting compassion as a therapeutic change mechanism. In working with people in an acute inpatient unit (with mixed diagnosis including psychosis), compassion-focused therapy showed improvement in distress and calmness ratings. Themes related to understanding compassion, experience of positive affect, and the experience of common humanity, emerged as relevant in qualitative analysis (Heriot-Maitland, Vidal, Ball, & Irons, 2014).

The development of COMPASS: COMPassionate Approach for Schizophrenia and Schizoaffective disorder

The COMPASS program builds upon the available research on contextual behavioural approaches for psychosis (Braehler, Gumley, et al., 2013; Chadwick, 2014; Johnson et al., 2011; Laithwaite et al., 2009). The program's main framework is the affect regulation system's model (Gilbert, 2005) and the compassion-focused therapy rationale as it was adapted for psychosis (Gumley et al., 2010). This rational is present from the beginning of the program and is constantly used to root the exercises, sharing of experiences and group dynamics. The program is introduced as an opportunity to engage with and further develop the soothing-safeness system (while coping with an overly active threat-defence system), develop a compassionate mind (Compassionate Mind Training) that promotes affiliation and self-soothing and stimulate compassionate qualities (e.g. distress tolerance, empathy, non-judgement) and skills (e.g. compassionate thinking, behaving) as conceptualized within the CFT model (Gilbert, 2014). Moreover, it is needed that therapists embody the compassionate qualities and a mindful presence in the context of the therapeutic relationship (paying attention with empathy, presence, and ability to listen in depth, Hick & Bien, 2008) is recommended. The therapists' intention for the group should be to help participants develop a warm, understanding, non-judgmental and proactive relationship with themselves, the

group, and people in their lives. Thus, the therapists have an important role in modelling compassionate behaviours and attitudes towards themselves, in their interaction and in the relationships within the group. In all sessions, the therapist promotes a 'Compassionate Group', that is, creates a compassionate collective mind. The idea is for participants to "look" at the 'Compassionate Group' as a model through the question 'What would the group's compassionate mind say/do?'.

COMPASS was primarily based on the group intervention protocol from Braehler, Harper, & Gilbert (2013). All recommendations regarding participants' selection, setting up the group (with the exception of the duration of the intervention), structure of sessions and support outside of sessions were followed.

Mindfulness is the necessary basis for all meditation practices and is also an adequate theoretical framework to understand human experience and psychotic experiences. COMPASS is based on the rationale for applying mindfulness to psychosis, developed by Chadwick and collaborators (Chadwick, Taylor, & Abba, 2005) and thus, we have adapted all the practices in order to meet the recommendations and adaptations of mindfulness practices for people with psychosis (Chadwick et al., 2005; Shonin et al., 2014). In COMPASS, Mindfulness exercises were used to both help participants focus and ground their attention in a non-judgmental way; and engage in an accepting way with difficult internal experiences that might arise in informal and formal compassion-based practices.

Considering preliminary but encouraging results from Loving-kindness meditation (LKM) in negative symptoms of schizophrenia (Johnson et al., 2011), as well as its theoretical rationale (Johnson et al., 2009), COMPASS also includes brief and simple LKM practices, namely loving kindness to a loved one (person/object/animal) and loving kindness to the self.

Although COMPASS is rooted in CFT rationale for psychosis and this was the rationale discussed with participants, we considered that some Mindful Self Compassion (MSC; Neff & Germer, 2013) constructs such as self-kindness, common humanity and mindfulness (components of self-compassion, Neff, 2003) would also be of great importance in establishing de-shaming and normalization. These constructs are not presented to participants as a theoretical conceptualization

of self-compassion. Instead, self-kindness and non-judgement are encouraged as a part of the compassionate response towards self and others and a common humanity perspective (one of the core messages of CFT - "it's not your fault") is fostered with sharing of experiences and discussion. Some of the MSC practices, such as the 'present moment stone', 'compassionate check-in' or the 'compassionate walk', were also adapted and used.

Participant's and clinicians' observations and feedback from previous pilot and exploratory studies(Castilho et al., 2015; Martins, Castilho, Santos, & Gumley, 2016), were also taken into account (e.g. difficulties presented by patients were used to try to facilitate practice; some exercises were adapted considering patients' feedback) to help tailor the intervention to the population.

Innovations: Fears of Compassion and Observing Compassion

Fears of compassion (FOC) have been pointed out as important variables in psychological distress (Gilbert et al., 2012) including patients with psychosis (Martins, Castilho, Barreto Carvalho, Pereira, Carvalho, et al., 2017). In COMPASS there is a session entirely dedicated to fears of compassion in all flows of compassion (giving compassion, receiving compassion from others and self-compassion). The session starts with an experiential exercise aimed at creating the opportunity for FOC to arise: after a brief mindfulness of the breath exercise, participants are asked to remember a moderately difficult situation connecting with the emotions, thoughts and sensations. In pairs one participant is asked to share the situation focusing mainly on the internal experience and the other is asked to give compassion (without further instructions). The discussion of this exercise is focused on sharing experiences on both roles and the therapists share their observations (e.g. non-verbal demonstrations of compassion and behaviours of discomfort/avoidance) in a compassionate and validating way. After the discussion, the therapist and co-therapist engage in a similar real-play. The therapists share their experiences (including FOC if any arisen) and participants are asked to share their experiences (thoughts, emotions) in observing compassion. Only after this experience of giving, receiving and observing compassion noticing FOC arising, rational on FOC is discussed. FOC are explained as an activation of the threat system when in contact of compassion and discussion on several affirmations depicting FOC is encouraged. The

participants are then given the opportunity to practice giving and receiving compassion again. This topic is also approached and discussed throughout the rest of the program.

Other important innovation of COMPASS is the inclusion of the flow 'observing compassion between others' as a form of getting in contact with compassion. Considering that people with psychosis often struggle with FOC in all compassionate flows it might be useful to start practicing compassion at a more basic, less threatening level. We hypothesize that observing compassion without engaging with active behaviours of compassion might be easier for people with psychosis. Participants are encouraged to informally observe acts of compassion in their everyday lives (e.g. between other people, with animals, acts benefiting the community, etc.). While observing acts of compassion, participants should be aware of emotions and thoughts that arise in that moment. Observing compassion is also trained in session. Therapists point out acts of compassion when they occur in-session and ask participants to share associated emotions/thoughts.

COMPASS: Session outline

COMPASS target population is people with a psychotic disorder diagnosis. The COMPASS program evolves through three phases and comprises 12 modules that were developed to be delivered in 12 consecutive weekly sessions (minimum). The duration of each session is 90-120 minutes (5-10-minute break).. With the exception of the first session, all COMPASS sessions follow the same structure: welcome and remembering last session; brief mindfulness or compassion practice; session theme; main session practice and discussion: summary, key ideas and 'compassionate homework'. COMPASS main practices and exercises are presented in Table 1. A compassionate message is sent weekly to each participant.

[Table 1]

In addition to the group sessions each participant also has the possibility to schedule two individual sessions with the therapist(s). It is given to each participant the Participants' Manual encompassing a set of materials useful for consolidating the sessions' themes, deepening additional themes and assist the participants in their practice between sessions (with the recorded practices).

The Manual is supposed to become a part of each participant's "compassionate kit" as it has a compassionate intention (help building a more meaningful life).

Phase 1: Building Trust and Group as a Safe Place

The first phase of COMPASS corresponds to the first four sessions and aims at creating a safe environment in order to promote trust that will enable sharing of experiences throughout the program. Expectations and fears of coming into a group therapy are discussed and from them group "rules" and "objectives" are created. This phase is also dedicated to understanding the program's underlying model through psychoeducation on the three-affect regulation systems model and the consequences of the imbalance between them. Detailed focus is given to the outputs of each system and session 3 is dedicated to the threat-system and the role of shame. Psychotic symptoms are conceptualized as responses of an overly activated threat system. Session 4 is dedicated to acceptance and compassion as an alternative and recovery as a process is introduced. Gradually participants are introduced to experiential exercises and short mediation practices (starting with mindfulness of breath and grounding and progressing to soothing breathing rhythm and mindfulness of acceptance).

Phase 2: Compassionate Mind Training

The specific aim of Phase 2 is to build on the basic competencies learnt on phase 1 to help patients develop a 'compassionate mind' based on the group as a safe place. Phase two includes sessions 5 to 10 and start by discussing and experiencing what compassion is and is not (session 5). Session 6 is dedicated to practicing giving and receiving compassion and fears of compassion through the real/role-plays presented above. Flows of compassion are also practiced through observing compassion, loving kindness meditations and development of compassionate thinking (Session 7). Session 8 is dedicated to appreciation and joy with appreciation being directed to mindfully observing the environment, being compassionate in relationships with others and the self. Self-compassion is specifically practiced in sessions 9 and 10 with more intrapersonal practices (e.g. compassionate postcard, safe place imagery). In session 10 is discussed in-depth the practice in daily-life (formal and informal opportunities for practicing).

Phase 3: Revisiting Recovery and Compassionately Planning Ahead

The last two sessions constitute Phase 3 and are aimed at preparing for the ending of the program. The therapists revise and summarize the main competencies and revisit their applications at the service of the Recovery process, reframed as 'living a meaningful life' based on motivations and values. Motives and values as underlying recovery is introduced with the visualization and discussion of the TED talk "Eleanor Longden: The voices in my head" in session 11. In session 12 participants discuss important values for them and a discussion on compassion and self-compassion as motivations is encouraged. A plan for compassionate action in crisis is individually tailored for each participant and the session ends with a final practice defined by consensus.

After three months there is a booster session in which competencies are reviewed, practice is encouraged (with sharing of strategies to make practicing easier) and a compassionate message to new participants is written by each participant.

Brief overview of the pilot study

COMPASS program is currently in its validation process with groups being delivered in several hospitals and mental health institutions. The present study has been reviewed and approved by the Portuguese Data Protection authority and by the ethics committees of the four hospitals that take part in the clinical trial. Our aim is to understand the feasibility and preliminarily assess the possible benefits of COMPASS. Specifically, our pilot study will analyse if, following COMPASS intervention (and re-assessed at 3-months follow up), people with psychosis improved in outcomes related to functioning, community inclusion, social safeness (primary aims), psychotic symptoms, general psychopathology, and medication adherence (secondary aims). We also expect improvement in process variables (mechanisms of change: mindfulness, self-compassion, fears of compassion, self-criticism, shame, empowerment and relationship with symptoms) to be associated with improvement in outcomes (correlational and mediational analysis). For a detailed overview of the variables under study see Table 2.

[Table 2]

The validation sample has the following inclusion criteria: a) participants over 18 years old; b) with a DSM-5 diagnosis of schizophrenia, schizophreniform disorder, brief psychotic disorder, or schizoaffective disorder; c) in the critical period (first episode of psychosis within 5 years): d) without severe cognitive deterioration/psychotic symptomatology. Participants were assessed and divided into experimental group and control group (treatment as usual). The assessment moments were before, after the program and 3 months follow up.

Aiming at illustrating adequacy and feasibility of COMPASS intervention, we tested preliminarily the potential benefits on a small sample of patients. Participants are a subsample of the larger clinical trial and correspond to the participants that completed the first groups (n = 10). Participants in this subsample were predominantly male (80%), single (80%) with a mean age of 28.50 (SD = 5.76) and with an average of 12.50 (SD = 3.38) years of education. Seventy per cent had a diagnosis of schizophrenia and the sample had a mean of 1.30 (SD = 1.49) hospitalizations. In Table 3 are presented the preliminary results regarding primary (social functioning) and secondary (symptoms) outcome and process measures.

Final remarks

COMPASS was designed to foster recovery and help people with early psychosis develop more compassionate relationships with themselves and others. Mindfulness practices give participants the competencies to ground themselves and observe internal experience in the present moment with abilities of acceptance, nonjudgement and openness. However, in COMPASS, regulation is fostered through affiliation and not primarily through attention (the foundation from which compassion can be cultivated).

The aim is to activate the soothing system without (un)expected outputs of the activation of the threat system (fears of compassion). Therefore, compassionate relationships in COMPASS are developed and trained from its more basic forms, for instance, observing compassion and emphasizing the group as a safe place. This is aimed to minimize unexpected activation of the threat-system while in contact with compassion. The group is the context in which the participants can: build their compassionate abilities and train observing, giving and receiving compassion.

Being more affiliative than contemplative in nature COMPASS combines intrapersonal practices with interpersonal ones. With the evolution of the group as a safer place and the

individual competencies, more complex practices are introduced. Nevertheless, various levels of complexity are always present and participants may remain in basic levels of compassion if needed/wanted.

Although the clinical trial is still taking place, preliminary results are encouraging regarding both primary and secondary outcomes and process measures. Participants significantly reduced social functioning difficulties, positive and negative symptoms. Although mediational or correlational analysis were not yet performed, improvement was found in the hypothesized processes of change in COMPASS. Significantly reduced self-criticism and fears of compassion at post-intervention were observed and a positive trend towards increased self-compassion and self-reassuring abilities and decreased external shame also emerged. We believe that through understanding the way our minds evolved and work, following the better safe than sorry rule (including a CFT-based rationale for psychotic symptoms which fosters de-shaming); and through developing compassionate skills such as being attentive to suffering (of self and others) in a non-judgemental, kind and proactive way, people with psychosis might gain and/or further develop important abilities to engage in more compassionate relationships with others and the self.

With further study and continuing improvement, COMPASS has the potential to be implemented as a complementary psychological intervention to promote recovery in psychosis.

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Table 1.

COMPASS main intrapersonal and interpersonal practices

Practice name	Type	Main aim	Observations
1-minute/3-minutes mindfulness of breathing	Intrapersonal	Practicing mindfulness	
Activating the three systems' imagery exercise		Identifying the three systems	Remembering three situations in which the three systems were activated
The case of John			Trying to guess the system being activated in a story
Soothing breathing rhythm		Practicing soothing breathing rhythm	
Grounding mindfulness exercise		Practicing mindful grounding	
Mindfulness of Acceptance		Introducing experiential acceptance	
Compassionate smile		Introducing the idea of practice as activating the soothing system	
Compassionate check-in		Introducing/Practicing compassion	Gradually is introduced the compassionate smile and touch
Present moment stone		Practicing mindfulness	
Loving-kindness to a loved one Loving-kindness towards the self		Practicing loving-kindness	
Compassionate touch		Practicing self-compassion	
Observe… Appreciate... exercise		Practicing appreciation and mindfulness	Mindfully paying attention to pleasurable stimuli using the 5 senses
Pleasurable activities list		Planning self-compassion and appreciation practices	
My compassionate postcard Compassionate color Safe place		Practicing self-compassion	
Action plan exercise		Planning coping strategies	

Building the three-system poster	Interpersonal	Identifying the outputs of the three systems	Matching physiological, emotional, cognitive and behavioral outputs with the systems
Activating embarrassment		Illustrate threat activation and introduce discussion on shame	Looking into each other's eyes in pairs
What compassion is not exercise		Demystify preconceived ideas about compassion	Discussion with the group about several ideas usually mistaken as compassion
Compassionate phrases to other exercise		Practicing compassion to others	
My three systems	Both	Reflect on the activation of systems and promote common humanity	Drawing and sharing the way each participants' systems usually are
How I dealt with…		Illustrate strategies of the different systems to deal with threat. Share adaptive coping strategies	Choosing a coping experience and identify the system used to cope with threat activation
Road to recovery exercise			Drawing and sharing a timeline with recovery steps
Activating fears of compassion/Giving and receiving compassion		Illustrate the emergence of fears of compassion. Training receiving and giving compassion	Real/Role-play in pairs: giving and receiving compassion
Observing compassion		Being mindful while observing compassion	Observing Real-play: giving and receiving compassion
My/Group compassionate phrases		Training compassion and self-compassionate phrases	Building the Group Compassionate Mind poster and personal compassionate phrases
Compassionate Walking		Training compassion to others and self-compassion	
Group exercise on Values and Motivations		Linking values, motivations and recovery	Discussing on values and motivations (with cards)

Note: All practices defined as 'intrapersonal' are discussed with the group and sharing of experiences is always encouraged (intrapersonal level), on the other hand, all practices defined as 'interpersonal' encompass an intrapersonal reflection. Therefore, this division is merely for simplifying the presentation of practices from a theoretical perspective.

Table 2

Measures used and variables under study

Instrument	Type	Variable(s) under study	Outcome/Process
Clinical Interview for Psychotic disorders (Martins, Barreto Carvalho, Castilho, Pereira, & Macedo, 2015)	Clinician-rated	Psychotic and mood symptoms; psychosocial correlates; empowerment	Outcome
Personal and Social Performance Scale (Morosini, Magliano, Brambilla, Ugolini, & Pioli, 2000)		Functionality	
Global Assessment of Functioning (American Psychiatric Association, 1998)		Functionality	
Social Safeness and Pleasure Scale (Gilbert et al., 2009)	Self-report	Social Safeness	
Response to Stressful Situations Scale (Barreto Carvalho et al., 2015)		Stress reactivity	
Depression, Anxiety and Stress Scales-21 (Lovibond & Lovibond, 1995)		General psychopathology	
Adherence to anti-psychotic medication Scale (Martins et al., 2016)		Medication adherence	
Community Integration Scale of Adults with Psychiatric Disorders (Cabral, Carvalho, Motta, & Silva, 2014)	Family member	Community Integration	
Family Questionnaire (Quinn, Barrowclough, & Tarrier, 2003)		Behaviors and symptoms	
Southampton Mindfulness Questionnaire (Chadwick et al., 2008)	Self-report	Mindfulness	Process
Types of positive Affect Scale (Gilbert et al., 2008)		Positive affect	
Other as Shamer Scale (Goss, Gilbert, & Allan, 1994)		External Shame	
Forms of self-criticism and reassurance scale (Baião, Gilbert, McEwan, & Carvalho, 2015)		Self-criticism and Self-reassurance	
Self-Compassion Scale (Neff, 2003)		Self-compassion	
Fears of Compassion Scales (Gilbert, McEwan, Matos, & Rivis, 2011)		Fears of compassion	
Voices Acceptance and Action Scale (Shawyer et al., 2007)		Relationship with voices	
Willingness and Acceptance of Delusions Scale (Martins et al., 2018)		Relationship with delusions	

Note: Portuguese versions of all instruments will be used.

Table 3.

Descriptive statistics, measures' Cronbach's alpha and differences between baseline and post intervention assessments in outcome and process measures (Wilcoxon signed-rank test) with effect size measures

			Baseline			Post intervention					
		α	*M*	*DP*	*Mdn*	*M*	*DP*	*Mdn*	*z*	*p*	*r*
Outcome measures	Social functioning	-	2.00	1.15	2.00	1.20	1.03	1.00	-2.070	.038	-.65
	Positive symptoms	.67	14.10	4.40	13.00	10.90	4.28	11.00	-2.371	.018	-.75
	Negative symptoms	.78	14.30	3.59	15.00	11.80	3.52	11.00	-1.969	.049	-.62
	Self-compassion - Positive	.79	7.26	1.80	7.05	7.75	1.53	1.78	1.683	.092	.53
	External Shame	.98	40.00	18.52	36.00	38.30	16.85	35.50	-.912	.362	-.29
Process measures	Fears of giving compassion	.90	21.00	9.52	19.00	20.00	9.76	20.50	-.358	.720	-.11
	Fears of receiving compassion	.88	28.80	10.82	30.00	25.50	13.48	22.50	-1.021	.307	-.32
	Fears of self-compassion	.96	24.60	17.15	21.00	17.00	13.41	17.50	-2.143	.032	-.68
	Inadequate self	.93	23.00	8.34	22.00	22.50	8.45	21.50	-.256	.798	-.08
	Hated self	.82	8.50	5.66	5.50	6.90	5.30	5.50	-2.257	.024	-.71
	Reassuring self	.71	14.20	5.41	13.50	15.60	5.48	17.50	.776	.438	.25

Note: α = Cronbach's alpha calculated at baseline*;* Social functioning = difficulties in social functioning item from the Personal and Social Performance Scale; Positive symptoms = Positive symptoms subscale of the Positive and Negative Syndrome Scale; Negative symptoms = Negative symptoms subscale of the Positive and Negative Syndrome Scale; Self-compassion – positive = Positive composite of the Self-Compassion Scale; External Shame = total score on the Other as Shamer Scale; Fears of giving compassion = Fears of giving compassion subscale of the Fears of Compassion Scales; Fears of receiving compassion = Fears of receiving compassion subscale of the Fears of Compassion Scales; Fears of self-compassion = Fears of self-compassion subscale of the Fears of Compassion Scales; Inadequate self = Inadequate self subscale of the Forms of Self-Criticism and Reassurance Scale; Hated self = Hated self subscale of the Forms of Self-Criticism and Reassurance Scale; Reassuring self = Reassuring self subscale of the Forms of Self-Criticism and Reassurance Scale.