

A pilot study exploring compassion in narratives of individuals with psychosis: implications for an attachment-based understanding of recovery

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There is increasing recognition that cultivating compassion for oneself and others can act as an antidote to feelings of threat, shame, humiliation and paranoia. This study aimed to explore the further development of a narrative-based measure of compassion. We hypothesised that greater compassion would be associated with lower levels of positive symptoms, negative symptoms, cognitive disorganisation, excitement and emotional distress. Participants were 29 individuals with psychosis. Greater narrative compassion was associated with less negative symptoms, less cognitive disorganisation and less excitement. We found no correlations between narrative compassion and the Self-Compassion Scale. Notwithstanding the methodological problems of our study, our findings have important implications for developing an attachment-based understanding of compassion and the use of compassion to support recovery from complex mental health problems such as psychosis.

Keywords: compassion; attachment; recovery; psychosis

Introduction

Psychosis brings with it a series of life challenges that can block recovery and well-being. The inability to feel in control of psychosis is closely linked to the development of depression (Birchwood, Mason, MacMillan, & Healy, 1993) and social anxiety (Gumley, O'Grady, Power, & Schwannauer, 2004). These feelings are grounded in the reality of individuals' experiences of their psychosis and are rooted in problems such as persisting psychosis, involuntary admission, heightened awareness of the negative consequences and stigma of psychosis, being out of work, and loss of social status and friendships (Rooke & Birchwood, 1998). People can feel marginalised, stigmatised and shamed by their psychosis and the labelling of these experiences as "schizophrenia" leading to social withdrawal (Birchwood et al., 2006; Gumley, 2007). Feelings of shame are linked to trauma, depression (Turner, Bernard, Birchwood, Jackson, & Jones, 2012) and social anxiety (Michail & Birchwood, 2009). Feelings of shame are accompanied by hateful self-attacking. Hateful self-attacking is more common in people with persecutory delusions than in healthy and depressed controls (Hutton, Kelly, Lowens, Taylor, & Tai, 2013). Early memories of threat, shame and submissiveness predict paranoia (Pinto-Gouveia, Matos, Castilho, & Xavier, 2014) and early shameful memories are strongly related to paranoid anxiety (Matos, Pinto-Gouveia, & Gilbert, 2013). Relationships with voices mirror

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dominant–subordinate interactions observed in external relationships (Gilbert et al., 2001). Although voices are experienced as controlling and shaming, they can also meet individuals' needs for company and affiliation (Connor & Birchwood, 2013). The capacity to self-reassure self-critical thoughts influences the shaming content of voices (Connor & Birchwood, 2013). Imagining a compassionate other is associated with reduced paranoia and reduced negative affect (Lincoln, Hohenhaus, & Hartmann, 2012).

Leamy, Bird, Le Boutillier, Williams, and Slade (2011) have provided a conceptual framework to understand the complexity of recovery. Their synthesis places an emphasis on developing feelings of connectedness (to self and others), hope and optimism for the future, sense of having an identity, having a sense of meaning and empowerment. They place their understanding within the ethological context encompassing individuals' community, culture, religion and spirituality as space within which people make sense of their experiences and interact with others to construct their recovery. Religiosity and spirituality have been linked to improved health and well-being. In a recent study, Steffen and Masters (2005) showed that this relationship has been shown to be mediated by compassionate attitudes. In addition, compassion was associated with less depression and stress, greater satisfaction with social support.

Compassion

There is increasing recognition that cultivating compassion for oneself and others can act as an antidote to feelings of threat, shame, humiliation and paranoia. In Buddhism, there is a long tradition of scholarly contemplation of compassion. HH The Dalai Lama (2001) has defined compassion as a sensitivity to suffering in ourselves and others with a deep motivation and commitment to prevent and alleviate it.

In recent years, western theorists have become interested in developing understandings of compassion and its relationship to well-being. Neff (2003, p. 87) defined self-compassion as:

Being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness ... Self-compassion also involves offering nonjudgmental understanding to one's pain, inadequacies and failures, so that one's experience is seen as part of the larger human experience.

Neff's definition of self-compassion is conceptualised as having three interrelated components that are exhibited during times of pain and failure: (i) being kind and understanding towards oneself rather than being self-critical, (ii) seeing one's fallibility as part of the larger human condition and experience rather than as isolating and (iii) holding one's painful thoughts and feelings in mindful awareness rather than avoiding them or over identifying with them. There is robust evidence showing that self-compassion is associated with greater well-being as reflected in lower depression, anxiety and stress (Macbeth & Gumley, 2012). Feldman and Kuyken (2011, p. 143) offer a definition of compassion that includes the notion of compassion as being extended to others as well as the self where

compassion is an orientation of mind that recognizes pain and the universality of pain in human experience and the capacity to meet that pain with kindness, empathy, equanimity and patience. While self-compassion orients to our own experience, compassion extends this orientation to others' experience.

In this way, Feldman and Kuyken explicitly recognise the importance of compassion as having flow from self to self and from self to others. Gilbert (2010) has defined compassion as a "social mentality that becomes focused by intention and motivation to alleviate distress in others,

recruiting key attributes for attentional sensitivity, sympathy, distress tolerance, empathy and non-judgement” (p. 98). This conceptualisation of compassion is rooted in evolutionary theory emphasising the importance of compassion as an evolved set of social mentalities designed to promote affiliation, attachment and connectivity. Gilbert (1989, 2005, 2009) has proposed that to act competently within any social role – our motives, emotions, attentional focus, thinking and behavioural outputs have to be coordinated and integrated appropriately. This organising principle, of coordinating these different psychobiological processes for the *purpose of creating a particular type of relationship*, is labelled as a social mentality. Social mentalities track and adjust appropriate psychobiological processes in line with dynamic reciprocal interactions (Gilbert & McGuire, 1998). The compassionate social mentality is rooted in our developmentally based attachment needs for safeness and security. The compassionate social mentality facilitates the capacity for us to be engaged with, moved by, understanding of and being able to tolerate suffering. Accompanying this capacity are a set of skills or competences related to the process by which we try to alleviate suffering and the wisdom we bring to bear on what will be helpful.

Attachment and compassion

In recent years, we have been concerned to articulate the developmental roots of compassion (Gumley et al., 2010) and in particular the competences, which underpin our capacities to attend to suffering in ourselves and others, and to act to alleviate this suffering. Attachment theory (Bowlby, 1982) provides a framework to understand the developmental trajectories, which foster capacities for the attunement to our own and others’ minds, the empathic engagement with our own and others pain, and the expression of forgiveness and compassion in relation to these experiences. These capacities are reflected in the way in which attachment security is coded using the Adult Attachment Interview (George, Kaplan, & Main, 1987) but also are reflected in our understandings of the relationships between security of attachment and the development of mind-mindedness (Meins, 2003) and mentalisation (Fonagy, Target, Steele, & Steele, 1998). Freely autonomous and secure attachment states of mind are characterised by a valuing of the influential nature of interpersonal relationships, openness to both positive and negative aspects of difficult life experiences, the capacity to discriminate reality from appearance, an ability to regulate painful affects whilst maintaining relative objectivity, the capacities to reflect upon difficult experiences without loss of metacognitive monitoring and the expression of compassion and forgiveness. These competences are reflected in coherent narratives of individuals’ attachment experiences, which have been shown to promote attachment security in others, particularly children (Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Fonagy, Steele, & Steele, 1991). Arguably, these characteristics of attachment security as outlined above are intimately linked to our sensitivity to suffering in ourselves and others (e.g., empathy, mentalisation, and curiosity), alongside our ability to follow through our deep motivation and commitment to prevent and alleviate suffering (e.g., the ability to regulate painful affects in ourselves and others, appearance reality discrimination). Freely autonomous and secure attachment states of mind resemble closely the compassionate social mentality as described by Gilbert (2010). Indeed Bowlby’s conceptualisation of the affectional attachment bond as (i) providing a *safe haven* in times of threat or stress and (ii) serving as a secure base from which to explore the environment and develop new mental and physical skills is intimately a compassionate stance cultivated in the service of attunement to the needs of others and concern for their growth, development and autonomy.

Compassion and psychosis

Compassion focused therapy (CFT) was developed specifically to build the capacities to experience compassion in high shame and self-critical individuals; those who are most likely to have difficulties regulating fear with the use of affiliative systems. A key aspect of CFT in psychosis involves helping individuals to develop a warm, caring and attuned attitude towards difficult inner experiences. The development of a meaningful and coherent narrative of recovery has long been considered as an important measure of coping in psychosis (Gumley, 2011; Lysaker, Lancaster, & Lysaker, 2003; McGlashan, 1987). In a recent randomised controlled trial, exploring the feasibility of CFT for people with psychosis ($n = 40$; Braehler et al., 2013) found that CFT was associated with increasing compassionate narrative compared to treatment as usual. Over four months, increasing compassion reflected in individuals' narratives was significantly correlated with reducing depression ($r = -0.78$), reducing shame about psychosis ($r = -0.71$) and reducing fear of relapse ($r = -0.52$). These associations were observed in those who received CFT but not amongst those who did not receive CFT. Since the primary focus of this study was on emotional recovery, it did not include measures of psychotic symptoms. In addition, the study did not utilise a self-report measure of compassion. Although there is robust evidence that the Self-Compassion Scale (SeCS; Neff, 2003) has excellent validity reflected in associations between greater self-compassion and lower anxiety, depression and stress (Macbeth & Gumley, 2012), the use of the scale has been identified as problematical amongst people with psychosis (Mayhew & Gilbert, 2008). They found that although people with psychosis reported themselves as being self-compassionate struggled to engage with self-compassion exercises. Mayhew and Gilbert found that all participants rated themselves as highly self-compassionate and later revealed that they had not comprehended self-compassion until engaging in CFT. Indeed, Neff (2003, p. 224) noted that the SeCS was "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".

Aims

Therefore, this study aimed to rectify these earlier limitations. The primary aim was to explore associations between compassion and clinical symptoms in a group of individuals with psychosis. It was hypothesised that greater compassion would be associated with lower levels of positive symptoms, negative symptoms, cognitive disorganisation, excitement and emotional distress. A secondary aim of the study was to investigate the association between the narrative-based measure of compassion and the SeCS. We did not have any specific hypotheses regarding the association between our narrative measure and the SeCS.

Method

Participants

Participants were under the care of NHS Greater Glasgow and Clyde (NHS GG&C) mental health services, with recruitment throughout the NHS GG&C area. Participation was voluntary, participants were fully informed as to the aims and procedures involved in the study and all participants gave informed consent. Eligible participants were identified in collaboration with keyworkers and Responsible Medical Officers. The researcher visited potential participants to discuss consent in the context of a routine visit or appointment. Ethical approval was granted by the NHS West of Scotland Research Ethics Committee (10/S0703/67). Managerial approval was also obtained before conducting the study. Participants were recruited from Community Mental Health

Teams and Forensic Mental Health Services. Participants met Diagnostic and Statistical Manual of Mental Disorders - 4th Edition (DSM-IV) criteria for an affective or non-affective psychotic disorder with a diagnosis of psychotic disorder. Potential participants were aged between 18 and 64 years, and were excluded if substance misuse, head injury or organic disorder was adjudged the primary cause of the individual's symptomatology. Participants were judged by the clinical team as able to exercise capacity to consent. Patients legally detained in hospital were eligible to be considered for participation.

The clinical and demographic characteristics of participants are illustrated in Table 1. There were 29 participants with psychosis who were recruited to the study. They were on average 40.6 years old (SD = 9.9), predominantly male ($n = 25$, 86.2%), white Scottish ($n = 27$, 93.1%) and single ($n = 20$, 69.0%). Positive and Negative Syndrome Scale (PANSS) subscales were non-normally distributed and therefore median (interquartile range) scores are presented.

Measures

Narrative Compassion Interview (NCI; Appendix) is a recorded 30–45 minute semi-structured interview. Appendix illustrates the key questions in bold and possible follow-up probes in italics. Not all questions were required rather the aim was to develop an understanding of individuals social network and coping and locate this in a specific example. The interview was designed to permit the expression of qualities of compassion but did not demand reflection on compassion. Interviewees were asked to discuss sources of social support, providing an interpersonal context for the discussion of recovery and compassion. The interview structure was designed to access recovery/compassion-related thoughts, feelings and behaviours by providing an opportunity for

Table 1. Clinical and demographic characteristics.

Variable	Psychosis ($n = 29$)
<i>Age</i>	
Years (mean, SD)	40.7 (9.9)
<i>Gender</i>	
Male (n , %)	25 (86.2)
<i>Ethnicity</i>	
White Scots (n , %)	27 (93.1)
Asian (n , %)	2 (6.9)
<i>Diagnosis</i>	
Schizophrenia (n , %)	23 (79.3)
Schizoaffective disorder (n , %)	4 (13.8)
Unspecified psychosis (n , %)	1 (3.4)
Persistent delusional disorder (n , %)	1 (3.4)
<i>Relationship status</i>	
Single (n , %)	20 (69.0)
Married (n , %)	3 (10.3)
Divorced (n , %)	6 (20.7)
Years since diagnosis (mean, SD)	12.8 (6.3)
<i>PANSS</i>	
Positive symptoms (median, IQR)	9.0 (6.0–13.5)
Negative symptoms (median, IQR)	13.0 (8.0–17.0)
Cognitive disorganisation (median, IQR)	14.0 (11.0–18.0)
Excitement (median, IQR)	5.0 (4.0–6.0)
Emotional distress (median, IQR)	8.0 (4.5–12.5)
Total score (median, IQR)	52.6 (15.4)

the interviewee to discuss autobiographical memories and reflections of potentially stressful interpersonal experiences. The researcher took a non-directive stance within the interview. To maximise engagement and rapport, it was made clear that the interviewee was not expected to give a detailed account of a traumatic or highly distressing experience, nor were interviewees obliged to reflect on their responses. The interview was transcribed and anonymised, according to guidelines developed for the Adult Attachment Interview (Main, Goldwyn, & Hesse, 2002).

Narrative Compassion Scale (NCS: Gumley & Macbeth, 2011) permits coding of manuscripts via bottom-up analysis of features of the narrative structure; and top-down analysis of the interview themes. For this study, the inter-rater reliability of all subscales was excellent (r_{range} 0.90–0.95). An earlier version of the NCS coding frame had been piloted previously (Braehler et al., 2013). In this study, the NCI was used to generate transcripts. The NCS coding frame yielded scores for self-oriented compassion, other-oriented compassion and an overall compassion rating. Compassion was based on Gilbert's definition of compassion as a caregiving, affiliative mentality (Gilbert, 2005) and was operationalised in terms of a narrative strategy whereby painful aspects of recovery from psychosis were related to warmth, acceptance, and understanding of self and others whilst relationships are valued as part of recovery (scored from –1 to 9). The 11-point NCS is anchored by –1 (Anti-Compassionate), 1 (Lacking), 3 (Minimal but present), 5 (Emergent), 7 (Marked) and 9 (Exceptional Compassion). The coding for the SeCS is given in Table 2, which provides an example of the criteria applied to transcripts. The following quotation is offered as an example of Exceptional Compassion.

I'm not ashamed by it in any way, shape or form and to be quite truthful – and this probably sounds really strange but – as much as there has been an awful lot of heartache surrounding my illness and my family, my mum, my dad erm my sister, my friends and stuff, and to an extent myself you know but – if I was to go back and change, if I had the power to go back and change that – I would say no because then I wouldn't be – who I am today with the insight that I have got and the experiences I have got so why – I wouldn't, I wouldn't change it. Elements of it, I would. Hurting other people but no "takes a deep breath", the actual illness. You know ...

At the transcript level, prototypical indicators of compassion include valuing of relationships and support from others. This is relatively common and reflected in statements such as:

... and that was very beneficial to me because for the first time I was actually open about experiences I was having and and and it was ran by other people who had been through very similar things

A statement in the form of the above would be coded in terms of other-oriented compassion, and would also be used in the overall compassion score. A more developed conceptualisation of compassion might be reflected in specific statements where a person is able to identify with a sense of common humanity how their experiences are similar to others. The following example contains elements of compassion to oneself, but also towards others. For example,

Because when it came round to the hearing voices group I discovered more about coping strategies and just listening to people talk made me aware maybe I wasn't the worse off person in the world there were other people who had been through very similar things and it was difficult for many people I wasn't alone and eh my experiences weren't isolated there were other people going through similar things.

Important characteristics of compassion are identified from within the transcript including the motivation to be more caring and sensitive to oneself and/or others; a sensitivity to the feelings and needs of oneself and others; sympathy, being open to emotionally in tune with feelings, distress and needs of oneself and others; the ability to tolerate rather than avoid difficult feelings,

Table 2. NCS coding.

NCS
Self-oriented compassion scale
–1, <i>Anti-Compassionate</i> : The attitude towards oneself as evidenced in the transcript reveals a harsh, cruel and actively non-compassionate stance towards the self. Self may be regarded as superior, stronger and more deserving
1, <i>Lacking in self-compassion</i> : There is an absence of compassionate responses towards oneself. There may be a tendency to normalise or be upbeat in relation to difficult experiences but evidence of a real sense of an attentional and/or behavioural orientation that is caring, warm, sensitive and empathising is absent. Alternatively, the transcript may contain evidence consistent with the individual taking a stance indicative of a high level of shame, criticism or self-attacking. The above considerations do not necessarily mean the transcript is especially cold or repudiating of compassionate responses
3, <i>Minimal but present self-compassion</i> : We see the development of compassionate responses and understandings reflected in some efforts towards empathic understanding, forgiveness, acceptance and understanding of one's own experiences. It may be that these responses are implicit and there is little or no evidence of an explicitly compassionate stance reflecting clear unambiguous compassion-related statements, for example, evidence of self-forgiveness or acceptance of one's own distress. These transcripts tend to show a valuing of one's ability to access support and relationships. Alternatively, it may be that this is expressed with greater difficulty towards the self and that the stance is not maintained. In this case, self-critical responses may emerge or avoidant responses become re-established
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5, <i>Emergent self-compassion</i> : On the whole, the speaker maintains a compassionate stance towards the self as reflected in expressions of understanding, warmth, self-forgiveness, acceptance and courage. This is reflected in a number of explicit and direct compassionate statements. It may be that the stance may not be maintained consistently in relation to all aspects of experience. Alternatively or additionally, the rater may note some significant areas of difficulty in maintaining a compassionate and non-judgemental attitude towards the self and one's experiences, particularly when those experiences are difficult or distressing
7, <i>Marked self-compassion</i> : The transcript is striking in that a compassionate stance is maintained in the retelling of the speaker's experiences. The rater has the sense that difficult experiences have been fully incorporated and elaborated within a compassionate discourse
9, <i>Exceptional self-compassion</i> : This is not to be confused with ideas of perfection or striving. Rather what we observe within the transcript is a clarity of thought and mind where there is a sense of an integrated and elaborated compassionate understanding of the self. At this level, the rater would anticipate that painful experiences will be presented, and reflected upon, while remaining embedded in a strong sense of common humanity

memories or situations and an accepting, non-condemning, non-submissive orientation to oneself and others. This might be reflected in balanced perspectives on one's own experiences in which differing perspectives are acknowledged and indeed the person's own perspective is owned. For example,

I felt, I-I-I feel that the experiences that I had could either be labelled – psychotic from a medical perspective or metaphorical if you come from a spiritual sort of perspective my my perspective is more spiritual than medical.

In addition, we considered examples of forgiveness and understanding both with regard to one's own experiences and those of other's. For example,

Em because she didn't understand eh the depth of what I was undergoing and an an and in her world going for a walk would be therapeutic and a good way of overcoming a stressful situation but she didn't realise I was in absolute bits. She couldn't understand that, I said I'd been invaded by evil and she didn't understand what I meant if she'd been through it herself she would have understood but because she never been through anything like that she couldn't have understood, it's not her fault.

PANSS (Kay, Fiszbein, & Opler, 1987) is a 30-item semi-structured interview of psychotic symptomatology, yielding interviewer rated scores on five factors: positive symptoms, negative symptoms, cognitive disorganisation, excitement and emotional distress (van der Gaag et al., 2006). Each item is on a Likert scale from minimal (1) to extreme (7). The PANSS has good inter-rater reliability and high concurrent validity.

SeCS (Neff, 2003) is a self-report measure exploring self-compassion in individuals; this 26-item scale gives a total score for self-compassion and contains 6 subscales measuring self-kindness and self-judgement; common humanity and isolation and mindfulness and over-involvement. Gilbert, McEwan, Matos, and Rivis (2011) reported results for two subscales summing items measuring self-compassion (13 items) and items measuring self-coldness (13 items). In this study, internal consistency for total score was acceptable ($\alpha = .76$), and internal reliabilities for the self-compassion and self-coldness subscales were excellent ($\alpha = .89$ and $\alpha = .93$).

Procedures

After informed consent, each participant met with a researcher on two occasions, for approximately 2 hours in total. In the first session, the narrative interview for the assessment of compassion was administered and the interview recorded using a digital recording device. At the second meeting, the PANSS interview and self-report measures were administered. The second session also presented an opportunity to debrief participants regarding the compassion interview, and address any concerns participants may have had regarding material discussed in the sessions. All participant interviews were conducted at the relevant clinical base or ward for each participant.

Data analysis

Data were analysed using SPSS version 18. All variables were checked for normality using the Kolmogorov–Smirnov (K–S) test and parametric/non-parametric analyses of within-subjects characteristics (e.g., gender, age) were conducted accordingly. Relationships between variables were examined using Pearson or Spearman correlations; and analysis of variances or Kruskal–Wallis tests. Associations between categorical variables were investigated using chi-square tests.

Results

Narrative and self-compassion scores

Narrative and self-compassion scores are summarised in Table 3. All scores were normally distributed. The mean scores for the three compassion scales ranged from 2.5 (1.7) to 2.8 (1.8), suggesting minimal but present levels of compassionate responding. There were no associations between the NCS scores and age. Females had significantly higher other-orientated compassion than males (mean score = 4.5 vs. 2.5; $F = 4.7$, $df = 28$; $p = .04$) although the number of females was noted to be small ($n = 4$). In all further analyses were conducted excluding our female participants. We noted no changes to the observed correlations and, therefore, correlations for the full sample are presented throughout. The NCSs were also highly inter-correlated. Self-orientated

Table 3. Compassion scales descriptive statistics.

Variable	Psychosis ($n = 29$)	
	Mean (SD)	Median (IQR)
<i>NCS</i>		
Self-orientated compassion	2.5 (1.7)	2.0 (1.0–3.0)
Other-orientated compassion	2.8 (1.8)	3.0 (2.0–3.5)
Overall compassion	2.7 (1.9)	2.0 (2.0–3.5)
<i>SeCS</i>		
Self-kindness	3.1 (1.0)	2.8 (1.8–3.4)
Self-judgement	2.8 (1.1)	2.8 (2.4–3.2)
Common humanity	2.7 (0.6)	2.7 (2.4–3.2)
Isolation	2.3 (0.9)	2.6 (1.7–3.0)
Mindfulness	2.7 (0.6)	2.7 (2.4–3.0)
Over-involvement	2.2 (0.8)	2.3 (1.5–2.8)
Total score	3.2 (0.5)	3.2 (2.9–3.6)
Self-coldness	8.4 (1.9)	8.6 (7.3–10.1)
Self-compassion	7.2 (2.5)	7.8 (5.1–9.0)

compassion was correlated with other-orientated compassion ($r = 0.85$) and overall compassion ($r = 0.93$). Other-orientated compassion was associated with overall compassion ($r = 0.96$). Given the high level of inter-correlation between scales, we utilise the overall compassion score in subsequent analyses.

Association between narrative compassion, clinical symptoms and self-compassion

Table 4 provides a summary of the correlations arising from the planned analyses. Greater narrative compassion (overall score) was associated with less negative symptoms ($r = -0.41$), less cognitive disorganisation ($r = -0.42$) and less excitement ($r = -0.52$). The excitement scale provides

Table 4. Correlations between narrative compassion, PANSS and SeCS.

Variable	Overall compassion score
<i>PANSS</i>	
Positive symptoms	−0.06
Negative symptoms	−0.41*
Cognitive disorganisation	−0.42*
Excitement	−0.52**
Emotional distress	−0.20
<i>SeCS</i>	
Self-kindness	−0.15
Self-judgement	−0.14
Common humanity	0.01
Isolation	−0.28
Mindfulness	0.12
Over-involvement	−0.23
Total score	0.12
Self-coldness	−0.04
Self-compassion	−0.22

* $p < .05$

** $p < .01$.

Table 5. Correlations between SeCS and PANSS.

Variable	SeCS total	Self-compassion	Self-coldness
<i>PANSS</i>			
Positive symptoms	−0.47*	−0.11	0.63**
Negative symptoms	−0.21	−0.09	0.31
Cognitive disorganisation	−0.49**	−0.12	0.57**
Excitement	0.13	0.30	0.14
Emotional distress	−0.51**	−0.19	0.69**

* $p < .05$ ** $p < .01$.

a measure of anger and impulsivity. We found no significant correlations between the NCS and the SeCS ($r_{\text{range}} = -0.26$ to 0.12 ; median $r = -0.14$).

Given the lack of associations between the NCS and the SeCS, we sought to verify whether a similar pattern of correlations between the SeCS and PANSS were observable. These are summarised in Table 5. As with the NCS, the SeCS total score was correlated with cognitive disorganisation ($r = -0.49$), suggesting greater self-compassion was associated with lower cognitive disorganisation. SeCS was also inversely correlated with positive symptoms ($r = -0.47$) and emotional distress ($r = -0.51$). We then explored the self-compassion and self-coldness subscales. There were no associations between the self-compassion subscale and the PANSS. However, greater self-coldness was associated with more positive symptoms ($r = 0.63$), greater cognitive disorganisation ($r = 0.57$) and emotional distress ($r = 0.69$).

Post hoc analysis

Given that the NCS and SeCS were both correlated with PANSS cognitive disorganisation, we conducted an analysis of mediation and moderation (Baron & Kenny, 1986). We were particularly interested in whether lower NCS and greater self-coldness would independently contribute to variance in cognitive disorganisation, or whether the relationship between self-compassion and cognitive disorganisation was moderated or mediated by self-coldness. Our previous experience has informed us that the narratives of individuals with persecutory paranoia are characterised by harsh and cold languages (Boyd & Gumley, 2007). Given the pattern of correlations observed, we hypothesised that self-coldness would mediate this relationship. We entered the NCS compassion score on its own. The association between NCS and cognitive disorganisation was significant ($R^2 = 0.21$, $F = 6.23$, $p < .05$). Then, we entered the SeCS self-coldness score on its own. The association between SeCS self-coldness and cognitive disorganisation was significant ($R^2 = 0.38$, $F = 13.61$, $p < .01$). We then entered the two variables together. The overall model was significant ($R^2 = 0.44$, $F = 8.29$, $p < .01$). NCS was no longer statistically significant in the model (standardised beta = -0.27 , $t = -1.49$, $p = .15$), whereas SeCS self-coldness remained significant (standardised beta = 0.51 , $t = 2.89$, $p = .009$). This finding suggests that the relationship between NCS and cognitive disorganisation is fully mediated by SeCS self-coldness.

Discussion

The primary aim was to explore associations between compassion and clinical symptoms in a group of individuals with psychosis. It was hypothesised that greater compassion would be associated with lower levels of positive symptoms, negative symptoms, cognitive disorganisation, excitement and emotional distress. We found partial support for our primary hypothesis. Greater narrative compassion was significantly associated with lower negative symptoms, cognitive

disorganisation and excitement. The association with excitement is interesting. This subscale provides a measure of greater impulsivity, anger and hostility. One would expect that greater compassion would be, therefore, associated with lower scores on this scale. Contrary to our hypotheses, we did not find an association between narrative compassion and positive symptoms and emotional distress.

A secondary aim of the study was to investigate the association between the narrative-based measure of compassion and the SeCS. We did not have any specific hypotheses regarding the association between our narrative measure and the SeCS. We did not find any associations between the NCS or any of the SeCS scales. Although this lack of association between the NCSs and SeCS may seem surprising, this is consistent with the observed tendency for lack of correlation between self-report and interview measures where psychological processes pertaining to the self and others are implicated (Riggs et al., 2007). The lack of correspondence between self-report and interview-based assessments of attachment has long been recognised (despite both measures having similar correlates). In a recent meta-analysis of 961 individuals, the correlation between self-report and narrative attachment was $r = 0.09$ (Roisman et al., 2007).

We were concerned that the pattern of correlations between NCS and PANSS, and the lack of association with the SeCS could be a threat to the validity to our narrative compassion measure. We considered that the observed correlations between the NCS and PANSS subscales may have reflected an artefact of disturbances in discourse arising from the symptoms themselves particularly negative symptoms and cognitive disorganisation. However, although we did not find associations between NCS and SeCS, both measures correlated with the PANSS subscales suggesting some evidence of convergent validity of measurements. The nature and direction of these associations were interesting. Both the NCS and SeCS were correlated with cognitive disorganisation. Greater narrative compassion was associated with less cognitive disorganisation. Similarly, higher SeCS total score was associated with lower cognitive disorganisation. However, there was no association between the self-compassion subscale and cognitive disorganisation. There was a significant association between greater self-coldness and higher disorganisation. Therefore, the association between SeCS total and PANSS disorganisation seemed to be largely attributable to the association arising from the self-coldness scale. This pattern of significant correlations between the SeCS and the PANSS followed a similar pattern where significant SeCS total score correlations with positive symptoms and emotional distress seemed to be attributable to the self-coldness subscale. Therefore, both narrative and self-report approaches to compassion show important convergence in relation to expression of symptoms. On the one hand, the SeCS appeared sensitive to the associations between greater self-coldness and greater symptoms, whereas the NCS seemed to be sensitive to associations between greater compassion and reduced symptoms. When we tested whether SeCS self-coldness mediated or moderated the relationship between NCS and cognitive disorganisation, we found evidence for a fully mediated relationship. We have previously found evidence that the narratives of those who experience persecutory paranoia are characterised by a harshness and brutality in their language. Subsequently, Hutton et al. (2013) found that hateful self-attacking is more common in people with persecutory delusions than in healthy and depressed controls. It may be that in the absence of self-compassion and the presence of cold self-attacking that psychotic experiences including cognitive disorganisation emerge.

Attachment and compassion

The association between NCS and negative symptoms is an interesting finding. In a recent prospective study of attachment and recovery following a first episode of psychosis (Gumley et al., 2014), greater coherence of narrative, as measured by the Adult Attachment Interview predicted greater recovery of negative symptoms over 12 months. Our narrative approach to understanding and

measuring compassion has important and significant overlaps with the conceptualisation of attachment security. First component of compassion is the sensitive, caring and warm attunement to the experience of pain and suffering experienced by oneself and others. It is not enough to be aware of suffering. Second, and hand in hand with this attunement is the courage and motivation to explore, understand and alleviate suffering. Underpinning this understanding of compassion is a series of competences that are arguably rooted in attachment and particularly in security of attachment. We propose that security of attachment facilitates the development of competences, which underpin our capacities to attune to and engage with distress in others (and ourselves) in the service of acting to alleviate pain and distress to support restoration of wellbeing, freedom and autonomy in others (and ourselves).

In this sense, the motivation and competences to attend to and alleviate distress in ourselves and others is developmentally organised.

Attachment theory was initially grounded in the observation that human beings appear to be born with an innate psychobiological system (the attachment behavioural system) that motivates them to seek proximity to significant others (attachment figures) in times of need as a way of protecting themselves from threats and alleviating distress (Bowlby, 1982). The first set of competences are related to the provision of a *safe haven* in response to another's distress during times of threat serves as an interpersonal context for the regulation of distress and suffering through the reciprocal soothing responses of a caregiver. Secure caregivers are those individuals who are able to effectively restore another's felt security when it is needed – by facilitating problem resolution and alleviating distress (Feeny, 2004). Therefore, and importantly, safe haven includes the sensitivity and attunement to distress, responsiveness to the other's needs and flexibility in responding to the attachment needs of another. A second and interconnected set of competences are related to the development of *secure base*, which is the type of support that facilitates another's exploratory behaviour. Bowlby (1982) described a central role of caregiving as that of providing a secure base from which an attached person can “make sorties into the outside world” (p. 11), knowing that he or she can return for comfort, reassurance and/or assistance should difficulties be encountered along the way. In this sense, secure base involves supporting an individual's personal growth, explorations and discoveries when the attachment system is not activated (Feeney & Brooke, 2004). More than this, qualities of exploration, trust, curiosity and autonomy remain important when the attachment system is activated. Consider, how we must act to address experiences of trauma, abuse and neglect, the experiences of which will inevitably act directly on the attachment system. Here qualities of courage and distress tolerance play a key role in facilitating explorative secure base behaviour during times of distress and suffering. Therefore, compassion, however, defined includes a skilful combination of both *safe haven* and *secure base* domains of the attachment system.

Methodological limitations

Notwithstanding the limitations of a small sample size of convenience, our study had a number of methodological limitations. First, during our interview, there was an emphasis on developing a shared understanding of the person's interpersonal network and their utilisation of this during a stressful experience. Following this, we then probed to encourage participants to consider how they accessed compassion from themselves and others during the portrayal of autobiographical memories. In retrospect, we could have spent more time exploring the meaning and understanding of the term compassion with participants before exploring their experiences of compassion in autobiographical memory. This would have provided a greater opportunity to directly explore experiences of compassion in the context of an agreed understanding between the interviewer and participants. Second, the correlations between self-orientated compassion and other-orientated compassion were almost unitary and thus we chose to analyse our data using the

overall score. It may be that our interview was insufficiently organised to discriminate between different ways in which compassion can flow including self to others, others to self and self to self. Future studies could, therefore, improve the methods we utilised to elicit compassionate discourse. Third, our study was correlational in nature and thus we cannot determine the directions of causality between compassion and symptoms. We have previously shown that increasing in compassion is correlated with reducing depression, shame and fear of relapse over time in people who receive CFT compared to controls. Further experimental studies could explore in more detail relationships between compassion and symptom expression over time.

Clinical and research implications

Our findings provide further evidence for the relevance of compassion for individuals with psychosis. In particular, we would suggest that greater attention to the attachment domains of *safe haven* and *secure base* are an important component of organising the timing and content of interventions to support emotional recovery. Granqvist, Mikulincer, and Shaver (2009) have previously argued how the Buddhist psychology of compassionate meditation and attachment theory emphasise the importance of developing a sense of security or safe haven. Compassionate meditation emphasises the visualisation of a loving, caring and compassionate being such as the Buddha. Loving kindness meditation is used to increase feelings of warmth and caring for self and others (Salzberg, 1995). The practice begins with contemplating a loved one (e.g., their child, a close loved one, a pet). The practice continues, the person extends their warm, tender and compassionate feelings to others; first to a few people they know well, then to all their friends and family, then to all people with whom they have a connection and finally to all people and creatures of the earth. In line with Granqvist et al. (2009), the development of compassionate meditation may provide a context in which to develop a surrogate secure attachment-based internal working model. In this way, the dynamics of attachment might enable us to understanding more fully the dynamics of recovery and key mechanism to develop this may be through compassion. Encouraging data are emerging that CFT (Braehler et al., 2013) and Loving Kindness Meditation (Johnson et al., 2011) may be helpful in alleviating emotional distress and reducing negative symptoms. As part of this greater clarity of important therapeutic processes and change, mechanisms within linked to recovery are important. An attachment-based understanding of the role of compassion may support the development of novel approaches to recovery.

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Appendix. Narrative Interview for Compassion

1) - Introduction

Today I would like to give you an opportunity to talk about how you respond at times when you are feeling stressed or upset.

For example, I'm thinking here of things like moving house, money worries, or social occasions. However, I'm most interested in examples that are relevant to your current circumstances. I would also like to hear about your sources of support at such times, how you feel when you are upset, and how you cope with such situations.

To help me get a picture of your own circumstances I would first like to spend some time getting an idea of the people and relationships that are important to you. Then we would like you to tell us about some specific experiences you have had where you have felt stressed or upset.

I understand that some of the experiences that I asking you about may be difficult for you to discuss. Therefore you do not have to tell me about the *most* distressing experience you have had, but I would like to hear an experience that you feel has been stressful, upsetting or challenging.

Before we start, are there any questions you have about today?

2) - Social support network

First of all, I would like to know a little more about who the important people in your life are at the moment. I'm going to write these down as you say them.

{After completing list}

2.1) To help keep me understand how much these people are involved in your life I am going to map what you've told me out on this piece of paper *{Introduce Social Network Diagram}*. First I'm going to write your name in the centre of the page, then I would like to take each of the people we have talked about and write their name on the page, with an arrow pointing to you, the shorter the length of the arrow from them to you the closer you feel your relationship. Lets start with Person 1 ...

2.2) Out of the people we've just talked about who would you say you have the closest relationship with?

2.3) Why would you say that you are closest to that person?

3) Everyone copes with stress in different ways. What do you do when you feel stressed or upset?

3.1) *Does anything in particular help when you are feeling stressed?*

3.2) *What do you do if your solution to the problem does not work?*

3.3) *Does anyone else ever help you when you have difficulties?*

3.4) *Would you ask anyone else for help if you needed it?*

3.5) *Sometimes things can just be so hard that we avoid them – have you ever done that?*

3.6) *Thinking of the people on the diagram, would you go to any of them for support?*

4) - Recent stressor/compassion frame

Thank you for explaining that to me. Now, I'm going to ask you about how you cope with stress. I would like you to tell me about a specific experience or thing that happened to you in the last month or so. Just something that sticks out in your mind.

I would like you to tell me about a time when you had to use your coping skills. There are a few questions I would like to ask you about this, but first I would like you, in your own words, to give me an idea of what happened:

If general response given – That’s a good general description, but I’m wondering if there was a particular time that happened?

If no example offered - The experiences I am thinking about are things like moving house, financial worries, or concerns about going out. Does anything come to mind from those examples?

4.1) Follow-up probes to establish context of autobiographical memory:

4.1.1) *What happened next?*

4.1.2) *What did you do?*

4.1.3) *Who was involved?*

4.1.4) *What were you thinking at the time?*

4.1.5) *How did you feel at the time?*

4.1.6) *Did you look to any of the people on the diagram for support?*

4.2a - If social support figure mentioned

4.2.1) *You said Person X was involved, How did Person X respond to you during the experience we’ve talked about?*

4.2.2) *At the time, did you feel supported by them?*

In what way?

4.2.3) *How did you respond to them doing/saying that?*

4.2.4) *What do you think was going through Person X’s mind at that time?*

*How do you think **they** might have been feeling?*

4.2.5) *Do you have any ideas about what made them feel that way?*

... Or what made them behave in that way?

4.2.6) *Reflecting on this now, do you feel they were supportive of you?*

4.2.7) *Do you think they realised the effect that response had on you?*

4.2.8) *Looking back, is there a different way Person X could have approached or supported you during this situation?*

4.2.9) *Is there anything that you would have liked them to do to help?*

4.2.10) *Thinking about the support you got from person X. Is that the same for all situations?*

If not, why?

4.2.11) *Would there be anyone else that you looked to for support?*

What did they do?

4.2.11) *I'm just wondering, how do you think someone else would deal with the situation you've just described ...?*

4.2.12) *What sort of things would you say to a friend, if they went through a similar experience but acted differently to you?*

4.2.13) *How do you think this experience has influenced your life?*

4.2.b - If no support figures mentioned

I'm just curious, did you talk to any of the people we've talked about on your diagram about this experience?

Then as for (4.2.1)

{If none offered}

Thinking about at experience, is there anyone whom you would have liked to have been supported by?

Then as for (4.2.1)

5 - Summing up

We've talked about quite a lot today, but is there anything you feel you have learned from the experiences we've talked about?

5.1 *What are your hopes for the future?*