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PRACTICE

A Compassion-Focused Approach to Nonsuicidal Self-Injury

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Mental health counselors working with adolescents and young adults often encounter nonsuicidal self-injury. Compassion-focused therapy (CFT), a form of cognitive behavioral therapy designed to help people relate to themselves with greater compassion, is proposed as an approach for addressing the most common underlying functions of nonsuicidal self-injury. This article reviews the theoretical underpinnings and goals of CFT and discusses how it can be used in counseling clients who self-injure. It describes strategies and techniques that target client attention, imagery, feeling, thinking, and behaviors and offers guidelines and considerations for using compassion-focused interventions for nonsuicidal self-injury.

Nonsuicidal self-injury (NSSI) has been occurring at alarming rates among youth. In Canada and the United States, prevalence ranges from 12% to 41% in community samples of adolescents and young adults (Gratz & Roemer, 2008; Klonsky, 2007; Laye-Gindhu & Schonert-Reichl, 2005). Similar rates have been reported in the United Kingdom and Australia (De Leo & Heller, 2004; Hawton, Rodham, Evans, & Weatherall, 2002). For youth receiving mental health treatment, NSSI prevalence is considerably higher; some studies suggest that as many as 40% to 60% of adolescents in psychiatric samples self-injure (Klonsky & Muehlenkamp, 2007; Nock & Prinstein, 2004).

The reasons why people self-injure differ from person to person, and multiple motivations may co-exist (Nock & Prinstein, 2005). However, it appears that

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self-injury is most often motivated by the need to regulate negative affective states, to punish the self, and to influence or communicate with others (Briere & Gil, 1998; Chapman & Dixon-Gordon, 2007; Klonsky & Muehlenkamp, 2007). These motivations must be addressed in working with people who self-injure. In particular, there is a need for counseling approaches that strengthen client emotion regulation, self-acceptance, and positive ways of relating with others.

This article proposes compassion-focused therapy (CFT; Gilbert, 2009, 2010) as one approach for working with adolescents and young adults who self-injure. Recently developed by Paul Gilbert and his colleagues (Gilbert & Irons, 2005; Gilbert & Procter, 2006), CFT is a form of cognitive behavioral therapy aimed at helping people with mental health problems that are related to shame and self-directed hostility. The main goal of CFT is to change the ways individuals relate to themselves through processes that generate warmth, understanding, nonjudgment, and kindness toward the self. In contrast, traditional cognitive behavioral strategies seek to identify and directly challenge faulty cognitions and thus may inadvertently reinforce people's perceptions of themselves as fundamentally flawed. As a therapeutic approach that attempts to encourage self-soothing behaviors, foster self-acceptance, and help people feel connected to others, CFT may be particularly well-suited to address the most common functions associated with self-injury.

We begin by defining NSSI; describe its forms, characteristics, risk factors, and functions; and review current counseling approaches used in the treatment of NSSI. Next, we define compassion and self-compassion and briefly summarize recent studies of the relationship between self-compassion and psychological well-being. This is followed by an introduction to the theoretical bases and aims of CFT and discussion of how CFT principles and techniques can be applied to counseling clients who self-injure. Finally, we conclude with considerations for mental health professionals using compassion-focused interventions for NSSI.

NONSUICIDAL SELF-INJURY

Definition and Forms of NSSI

This article defines NSSI as the deliberate destruction or mutilation of one's own body tissue without the conscious intention to die and excluding socially accepted behaviors (Klonsky & Muehlenkamp, 2007; Nock, Teper, & Hollander, 2007). Some alternative terms for NSSI are deliberate self-harm, self-injury, self-mutilation, and nonsuicidal parasuicide. NSSI is contrasted to suicide attempts or wounds inflicted with suicidal intent. Among common forms of NSSI are skin cutting, burning, severe scratching, biting, banging, hitting, wound picking, and hair pulling (Klonsky, 2007; Ross & Heath, 2003;

Whitlock, Eckenrode, & Silverman, 2006).In some cases bone breaking, swallowing toxic substances, and self-surgery may occur (Wester & Trepal, 2005; Whitlock et al., 2006). Most people who self-injure use multiple methods of self-harm (Klonsky & Muehlenkamp, 2007).

Characteristics of NSSI

NSSI is associated with a range of other mental health problems, including depression, anxiety, substance abuse, borderline personality disorder, eating disorders, suicidality, and posttraumatic stress reactions (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006; Zlotnick, Mattia, & Zimmerman, 1999). Although by definition NSSI is not suicidal in intent, self-injurers are at an increased risk of serious physical injury or death (Whitlock et al., 2006). NSSI may also lead to increased shame, guilt, and social isolation (Gratz, 2006). While the average age of onset of NSSI is between 12 and 16 years old (Heath, Toste, Nedecheva, & Charlesbois, 2008; Nock et al., 2007), self-injury has been reported in children as young as 6 (Nock &Prinstein, 2004). Between 63% and 75% of self-injurers engage in self-injurious behaviors more than once, and 17% to 25% self-injure more than 10 times (Borrill, Fox, Flynn, & Roger, 2009; Gratz, 2006; Whitlock et al., 2006). Some studies of clinical samples have found higher rates of self-injury among clinical samples of females than males (Laye-Gindu & Schonert-Reichl, 2005; Nixon, Cloutier, & Jansson, 2008). However, other studies have found no gender differences in either clinical and community samples (Briere & Gil, 1998; Whitlock et al., 2006).

NSSI occurs across cultures and ethnicities, though there is some indication that rates are higher among Caucasian adolescents and young adults than among non-Caucasian youth (Gratz, 2006; Ross & Heath, 2003; Whitlock et al., 2006). However, some studies have found no ethnic differences in the incidence of self-injury (Borrill et al., 2009; Hilt, Cha, & Nolen-Hoeksema, 2008).

Risk Factors

Difficulties with emotional regulation and distress tolerance are common in cases of NSSI. People who self-injure often struggle with recognizing and expressing their emotions (Gratz& Roemer, 2008; Horne & Csipke, 2009; Sim, Adrian, Zeman, Cassano, & Friedrich, 2009). Studies of NSSI have reported higher levels of negative emotions and subjective emotional distress and increased physiological reactivity to stress (Klonsky & Muehlenkamp, 2007; Nock & Mendes, 2008). NSSI may also be related to having a limited repertoire of healthy strategies to cope with intense emotional arousal (Gratz & Roemer, 2008; Heath et al., 2008). Individuals who self-injure may employ fewer problem-solving strategies and more avoidance behaviors than those without a history of NSSI (Brown, Williams, & Collins, 2007; Chapman, Gratz, & Brown, 2006).

High levels of self-criticism and a negative self-concept have also been observed in people who self-injure (Adams, Rodham, & Gavin, 2005; Chapman & Dixon-Gordon, 2007; Glassman, Weierich, Hooley, Deliberto, & Nock, 2007). NSSI appears to be associated with self-hatred, self-doubt, feelings of worthlessness, and a sense of inadequacy (Adams et al., 2005; Sim et al., 2009). Childhood abuse, including sexual, physical, and emotional abuse or neglect may further place individuals at risk for NSSI (Briere & Gil, 1998; Gratz, 2003). However, many people who self-injure have no history of being maltreated, and research on childhood physical abuse and neglect is inconclusive (Briere & Gil, 1998; Heath et al., 2008).

Main Functions of NSSI

There is considerable evidence that emotion regulation may be the primary function of NSSI (Briere & Gil, 1998; Chapman et al., 2006; Gratz, 2003; Klonsky, 2007). It may serve as a means of self-soothing or avoiding unwanted feelings in response to emotional distress. In numerous studies adolescents and adults who self-injure have reported intense negative affect before self-harm, followed by temporary feelings of calmness and comfort afterwards (Briere & Gil, 1998; Chapman & Dixon-Gordon, 2007; Harris, 2000; Klonsky & Muehlenkamp, 2007). It has also been suggested that NSSI may trigger the release of endorphins (Nock & Mendes, 2008), which have been hypothesized to be related to self-soothing brain functions (Gilbert, 2010). Temporary feelings of comfort and tension reduction may thus reinforce self-harming behaviors (Briere & Gil, 1998; Gratz, 2007).

The likelihood of self-injury may be exacerbated by the feelings of shame and isolation that often result from NSSI (Gratz, 2006). Thus, the individual may be trapped in a painful cycle of negative emotional arousal and self-injury. For some people who self-injure, NSSI may also be motivated by the desire to feel more alive in response to emotional numbness or to disrupt states of dissociation or de-realization (Briere & Gil, 1998; Klonsky & Muehlenkamp, 2007).

Another major function of NSSI is self-punishment or the expression of self-contempt (Chapman & Dixon-Gordon, 2007; Klonsky & Muehlenkamp, 2007; Laye-Gindhu & Schonert-Reichl, 2005). NSSI may be an attempt to cope with shame by punishing the self for perceived defects or "cutting out the bad" inside oneself (Harris, 2000). It has also been suggested that the self-punishment function may be a way of pre-empting punishment from other people, thereby maximizing a sense of control (Chapman et al., 2006). This echoes psychoevolutionary perspectives that see self-criticism as a possible form of submission aimed at averting attack from dominant, hostile people (Gilbert, 2009; Gilbert & Irons, 2005).

Although less common than the functions mentioned, self-injury is also often motivated by the desire for interpersonal influence or communication (Klonsky

& Muehlenkamp, 2007). For example, self-harm may be used to communicate distress, elicit caring or attention from others, or, in the minority of cases, manipulate people into behaving in ways that they would not otherwise do (Horne & Csipke, 2009; Nock & Prinstein, 2005). Among adolescents, self-harm may also provide a way for people to bond with friends who self-harm (Klonsky & Muehlenkamp, 2007).

Counseling Interventions

There has been relatively little research on counseling outcomes for NSSI, and what there is has shown mixed results. There appears to be some evidence that cognitive-behavioral therapies, particularly dialectical behavior therapy (DBT; Linehan, 1993) and problem-solving therapy (PST; D'Zurilla & Nezu, 2001) have been effective in reducing NSSI (Gratz, 2006; Muehlenkamp, 2006), and that psychodynamic and cognitive analytic therapies also help people who self-injure (Bateman & Fonagy, 2001; Ryle, 2004). However, in a meta-analysis of 20 NSSI outcome studies, Hawton and his colleagues (1998) found that only PST showed a positive, though statistically insignificant, trend for decreasing self-harm.

Moreover, most NSSI treatment outcome studies have been limited specifically to individuals with borderline personality disorder—a population with a high incidence of self-harm; and in these and other outcome studies, NSSI is often grouped with suicidal behaviors (Muehlenkamp, 2006). Furthermore, many treatment studies do not have control groups.

Despite these limitations, a number of common elements for appropriate NSSI treatment can be identified. In particular, researchers have emphasized the need for therapeutic interventions that improve emotion regulation and help people develop alternative strategies to cope with emotional distress (Heath et al., 2008; Klonsky & Muehlenkamp, 2007). Acceptance-based interventions that help individuals to become aware of and accept their emotions, so that emotions are approached and tolerated rather than avoided, may be important (Gratz, 2007; Nock et al., 2006). As Laye-Gindu and Schonert-Reichl (2005) have indicated, adolescents who self-injure may benefit from learning that emotions, regardless of how extreme they may be, are transitory and not intrinsically harmful. Where self-injury is rooted in the desire for interpersonal influence, clients may also benefit from finding more effective ways of relating to other people (Klonsky & Muehlenkamp, 2007).

COMPASSION-FOCUSED THERAPY

Self-Compassion and Psychological Functioning

Although compassion has a long history in Eastern philosophy and Buddhist tradition, it is only in the past few years that it has become the focus of psycho-

logical research and clinical interventions. Gilbert and his colleagues (Gilbert, 2005; Gilbert & Irons, 2004; Gilbert & Procter, 2006) identified several core components of compassion, including caring and concern for the well-being of others; empathy and sympathy, which are the cognitive abilities to understand and be moved by another's distress; recognition and tolerance of another's pain, without judging that person's situation or behaviors; and emotional warmth, which permeates all other aspects of compassion. With self-compassion, these components are directed toward the self. Similarly, Neff (2003) has defined self-compassion as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, [and] generating the desire to alleviate one's suffering and to heal oneself with kindness" (p. 87). Self-compassion, according to Neff, also involves a nonjudgmental stance toward one's failures and inadequacies, where the experience of pain is seen as part of the general human condition.

An increasing number of studies have linked self-compassion to adaptive psychological functioning. Neff and McGehee (2010) found the tendency toward self-compassion to be negatively associated with depression and anxiety in adolescents and young adults. Other studies have suggested that among college students self-compassion is correlated with adaptive coping and well-being in response to academic failure (Neely, Schallert, Mohammed, Roberts, & Chen, 2009; Neff, Hsieh, & Dejitterat, 2005).

Moreover, specific compassion-focused interventions have shown promising results. For example, in a pilot study of compassion-focused group therapy for people struggling with shame and self-criticism, participants showed decreases in depression, anxiety, shame, and self-criticism and increased ability to self-soothe in response to emotional distress. Together these studies suggest that self-compassion is important for emotional regulation.

The Theory Behind CFT

Compassion-focused therapy is a unique, acceptance-based cognitive-behavioral approach with roots in evolutionary psychology, neuroscience, and Buddhist teachings (Gilbert, 2009). Conceptually it is based on Gilbert's social mentality theory (Gilbert, 1989, 2005), which describes social mentalities as conditioned patterns of relating to others and oneself that are created through neurobiological activation of the affect regulation systems in the brain. These systems may be activated either externally by signals located outside the self or through internal stimuli. Signals that are perceived as threatening, such as hostility from others or self-criticism, activate the safety-seeking threat protection system, which is thought to involve the neurotransmitter serotonin (Gilbert, 2005). Activation of the threat protection system generates fight, flight, submission, or avoidance responses and associated feelings of anger, fear, shame, or disgust. Chronic overstimulation of the system can create a social rank

mentality, characterized by extreme concern about how one's own power or status compares with others. People who are highly sensitive to social comparisons may be more susceptible to depression, anxiety, shame, and self-criticism (Allan & Gilbert, 1995; Cheung, Gilbert, & Irons, 2004; Gilbert, 2000).

In contrast, signals of compassion from others or from the self activate the human warmth/contentment system, which is related to the care-giving mentality associated with feelings of care, affiliation, soothing, and safety. Activation of the human warmth/contentment system through compassion helps to calm the threat protection system, possibly through the release of opiates and oxytocin (Gilbert, 2005). Support for Gilbert's theory on the neurobiological correlates of the human warmth/contentment system comes from research that suggests a link between opiate functioning and affiliative bonding and from functional magnetic resonance imaging studies showing how compassion and self-soothing activate the brain regions responsible for stress reduction and positive affect (Depue & Morrone-Strupinsky, 2005; Longe et al., 2010; Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008). From a neurobiological perspective, a major goal of CFT is to help people regulate their emotions by developing the self-soothing centers in the brain.

Building Self-Compassion

CFT uses a multimodal approach to help people develop compassionate attributes and skills. Compassion-based techniques focus on attention, imagery, feeling, thinking/reasoning, and behavior in ways that are infused with warmth, kindness, and soothing (Gilbert, 2009, 2010). In what follows we describe how CFT targets each of these areas and offer suggestions and examples for how CFT can be applied in working with clients who self-injure. Importantly, the therapist's compassionate presence and ability to provide a safe base for clients through the therapeutic relationship are necessary if any specific technique is to be effective (Gilbert, 2010).

Compassion-focused attention. Compassion-focused attention is a form of mindfulness, where mindfulness is defined as deliberately paying attention to one's experience as it unfolds in the present moment, without judgment and with kindness and gentleness (Gilbert, 2009; Kabat-Zinn, 1994). Mindfulness is at the foundation of a number of acceptance-based therapies, including mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990, 2003); mindfulness-based cognitive therapy (MBCT; Segal, Teasdale, & Williams, 2002); dialectical behavior therapy (Linehan, 1993); and acceptance and commitment therapy (ACT; Hayes, Luoma, Bond, Masuda, & Lillis, 2006). There is increasing evidence that mindfulness is effective in alleviating psychological problems associated with emotion dysregulation, such as depression, anxiety, stress, eating disorders, and addictions (Baer, 2003; Hoppes, 2006; Kabat-Zinn et al., 1992; Kristeller & Hallett, 1999). From a CFT perspective, it is hypothesized that

mindfulness stimulates and builds up areas of the brain associated with the human soothing system, thus helping people become better able to calm their minds in response to perceived threat (Gilbert, 2009). In support of this hypothesis, a recent brain imaging study found that adults who engaged in mindfulness practice for an eight-week period exhibited increased activation of the brain regions that are associated with anxiety reduction and increased positive affect (Davidson et al., 2003).

A core CFT activity is mindful breathing in which the individual directs attention to the sensations of breathing and gently brings attention back to the breath when the mind wanders to other sensations, thoughts, and feelings. Throughout mindful breathing, the person maintains an attitude of warmth, kindness, and acceptance toward the self (Gilbert, 2010). Examples of other mindfulness activities are noticing the sensations of taking a bath or lying in a warm bed; paying attention to the experience of relatively mundane activities, such as washing the dishes or preparing a meal; and being mindful during gentle exercise, such as walking, gardening, or yoga (Gilbert, 2009, 2010; Hanh, 1992).

In cases of self-injury, mindfulness may be an effective strategy for regulating emotion. Through mindfulness practice, clients can learn to consciously observe the internal and external stimuli that trigger the urge to self-injure without acting upon them. To facilitate this, it may be helpful for counselors to provide clients with a variation of the following instructions:

> As you bring your attention to the sensations of breathing, you may notice your mind wandering to thoughts, feelings, or sensations that may feel uncomfortable or upsetting to you. You may even notice the urge to harm yourself. It is perfectly understandable to be distracted by these thoughts, feelings, and urges. It doesn't mean that you have to act on them or that you're doing mindfulness the wrong way. The fact that you're noticing your mind wander means that you are being mindful of what is happening for you in the here and now. So whenever you notice your mind wandering away from your breath, simply label the experience as thought, feeling, or urge, and gently, without judgment, bring your attention back to the sensations of breathing.

With practice, clients may learn to replace self-harm with mindfulness as a means of self-soothing, and the impulse to avoid painful feelings may give way to increased tolerance of emotional distress. Moreover, the practice of accepting experience without judgment may help counteract the negative self-judgment that so often plagues people who self-injure.

Gilbert (2009, 2010) suggested that it may be best for clients to begin practicing mindfulness when they are not feeling overwhelmed and then gradually build up to practicing during times of distress. This would help minimize the possibility of experiencing discouragement and failure, which might exacerbate urges to self-injure. Clients can begin with just a few minutes of mindfulness daily and slowly extend the length of their practice to, e.g., 15 to 20 minutes.

Regardless of how frequent or infrequent they are, all client attempts at mindfulness should be recognized as a positive step toward change.

Where self-injury is being used as a strategy for disrupting extreme states of dissociation or de-realization, focusing on inner sensations may be contraindicated. The reason is that some people in dissociative states—especially those with a history of severe physical or sexual abuse—may at first feel unsafe focusing on physical sensations (Rothschild, 2000). Such clients may benefit from starting with a more external sensory focus, such as the sounds and sights in the room (see Williams, Teasdale, Segal, & Kabat-Zinn, 2007) or a physical object (e.g., a smooth stone, a string of beads) that generates feelings of comfort (Gilbert, 2009).

Compassion-focused imagery. A central CFT strategy is the use of compassionate imagery to help people build their self-soothing skills. This is based in part on research suggesting that internal stimuli can affect regions of the brain in ways similar to external stimuli (Gilbert, 2010). For example, imagining drinking a warm cup of cocoa while snuggled under a blanket can stimulate the same warmth/soothing centers in the brain that would be stimulated by doing the same thing in real life. In CFT clients are invited to imagine compassion flowing both inwardly toward themselves and outwardly toward other people.

One of the main CFT techniques is creating an ideal image of caring and compassion (Gilbert, 2009; Gilbert & Procter, 2006; Lee, 2005). This image, which is unique to the client, can be human or nonhuman. Most importantly, the image has qualities of warmth, kindness, wisdom, and strength; is nonjudgmental; and can communicate with the client. The more vivid the image the better. Clients can be encouraged to flesh out visual, auditory, and other sensory qualities of the image and visualize how the compassionate image and the client relate to each other. Once the image has been created, the client spends a moment mindfully breathing and then brings the compassionate image to mind. As much as possible the focus should be on the feelings of warmth and soothing that the image evokes.

Another way to generate an inward flow of compassion is through memories of people being kind and caring toward the client. Recalling times when the client felt kindness and caring for another person in distress can also help generate an outward flow of compassion (Gilbert, 2009, 2010). Clients may also imagine themselves directing feelings of kindness toward someone they care about and concentrating on their desire for the person to be peaceful and contented (Gilbert, 2009, 2010).

Applied to NSSI, compassionate imagery can become an alternative means of feeling the calmness and comfort that is a major function of avoiding self-harm. Through mindfulness, clients will become more aware of when they begin to feel overwhelmed by negative emotions and urges to self-injure. They can then redirect their attention toward the compassionate image created in

therapy. For example, in response to feelings of self-hatred, a self-injuring client might bring to mind the image of a wise and caring being who wraps the client in a warm blanket and whose facial expressions and soothing tone of voice communicate complete kindness, understanding, and acceptance. If the mind wanders back to the urge to self-injure, the client can once again redirect attention to the image. Thus, the soothing triggered by the compassionate image becomes a means of desensitizing clients to self-injurious impulses. At the same time, the generation of compassion toward self and others may help reduce the sense of social isolation associated with NSSI and become the basis for healthy interpersonal relating.

Some people who self-injure may derive comfort from the image of someone bandaging or otherwise tending to wounds inflicted through self-injury (Klonsky, 2007). A possible danger of using this image, however, is that it may actually reinforce the self-injury by conditioning the person to associate self-injury with soothing. With NSSI, one goal of CFT is to uncouple self-injury and self-soothing. It may be advisable, therefore, to help clients find images of self-soothing that are not directly related to self-injury. Furthermore, therapists need to be sensitive to the possibility that clients may feel sad and frustrated about having no memories of kind and caring people in their past (Gilbert, 2010; Gilbert & Irons, 2005; Gilbert & Procter, 2006). Often grief work may be a necessary component of therapy.

Compassionate coping with emotions. A goal of CFT is to help people become tolerant of and compassionate for their feelings, rather than avoiding those feelings or judging them harshly. Indeed, emotions are essential for human survival because they mobilize the individual to respond to situations related to self-relevant aims and needs (e.g., see Frijda, 2000; Pluchik,1989). Avoidance of feelings, therefore, may cut a person off from crucial sources of information. This is not to say that avoidance is without merit as a coping mechanism—in the short term, it can reduce excessive emotional arousal activated by a distressing or a traumatic event (Lindy & Wilson, 2004; Zeidner & Saklofske, 1996). However, as a long-term defense, suppression of emotions can constrict adaptive functioning and resurface as unwanted intrusions, depression, and self-injury (Chapman, et al., 2006; Ehlers & Steil, 1995; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). CFT encourages people to approach their emotions with a gentle, nonjudgmental openness and a sense of curiosity.

Because NSSI is often motivated by the desire to cut out the "bad" or release negative feelings (Harris, 2000), with CFT people who self-injure can be gently and slowly encouraged to face their feelings and regard them not as toxins to be eliminated but as experiences that are understandable and helpful in mobilizing them for action. Clients may benefit from learning how to respond to the messages of their emotions in positive ways. For instance, training in pro-social

forms of communication, such as Marshall Rosenberg's (1999) nonviolent communication training, which puts compassion at the center of its assertiveness model, may help clients channel anger into constructive behaviors rather than turning it in on themselves through self-injury.

Compassion-focused thinking and reasoning. Once clients learn mindfulness, they can consciously shift to more compassion-based patterns of thinking and reasoning. CFT attempts to help people balance threat-focused thoughts with cognitions that are comforting and supportive. This is achieved not through attacking negative thinking or judging thoughts as wrong but by validating the client's thoughts and related feelings as being normal and understandable. At the same time, because there are numerous equally legitimate ways of thinking about any given circumstances, clients can be encouraged to think in ways that promote well-being (Gilbert, 2009).

One cognitive technique for developing compassion-based thinking is a self-report diary (Gilbert & Procter, 2006) in which clients record self-critical thoughts and then construct self-reassuring thoughts that help calm the threat-protection system. Because NSSI often involves self-directed anger and contempt, this technique may be particularly useful for clients who self-injure. Here is an example of how shame-inducing self-critical thoughts can be countered with compassion-based thinking and reasoning:

> **Self-critical thought:** There I go, cutting myself again today. I'm so messed up. I'm such a freak.
>
> **Self-reassuring alternative:** I've been going through so much stress lately. It's understandable that I felt overwhelmed. Most people would feel the same way in my situation. And there are many people just like me who struggle with cutting.

Other compassion-focused strategies that target cognition are compassionate letter writing and chair work (Gilbert 2009, 2010). With the first, clients write a caring and supportive letter to themselves in relation to an upsetting situation or problem. In crafting the letter, clients write from the stance of their compassionate image, a compassionate friend, or the compassionate self. In compassionate chair work, which is similar to the two-chair technique used by Greenberg and others (Greenberg, Rice, & Elliot, 1993), the client envisions a dialogue between the compassionate self and the part of the self that is self-critical, fearful, or angry. The goal of this exercise is to balance the threat-based system with warmth and caring. Regardless of the intervention used, it is important that clients feel the alternative thoughts and self-statements as helpful (Gilbert, 2010)—in other words, for the intervention to be effective, the warmth/soothing system must actually be activated.

Compassionate behavior. Compassionate behavior involves a conscious choice to resist destructive impulses and redirect action toward kinder alterna-

tives for dealing with difficult emotions. As Gilbert stated, compassionate behavior is about "protecting ourselves from our own drive system and self-criticism—not being passive in the face of our self-focused frustration and anger at not getting what we want, making mistakes, or not being as we want to be" (Gilbert, 2009, p. 390). Thus, compassion means having the strength to tolerate and take control of anger and anxiety rather than being controlled by them. Compassion also means having the courage to translate compassionate intention into action and to work on the issues that stand in the way of our flourishing (Gilbert, 2009, 2010). This becomes more possible with increased awareness and understanding of feelings and motives, combined with decreased self-condemnation for having destructive urges. Furthermore, compassionate action requires *motivation* to be compassionate. In other words, it is essential for people to recognize the benefits of behaving compassionately toward themselves as well as others.

For people who self-injure, compassionate behavior can be framed as a way to increase personal control, self-efficacy, and general well-being, without some of the undesired consequences of self-harm. Another benefit may be improved relationships with other people. When self-injury is triggered by feelings of social alienation and a desire for interpersonal influence, it may be helpful for clients to learn how self-compassion, combined with compassionate action toward others, may improve social connections and interpersonal relations.

While there are myriad ways in which NSSI can be rechanneled into compassionate actions, an overarching goal is for the client to act in ways that activate the warmth/soothing system and nurture the self. As part of therapy it may be helpful for the client to generate a list of self-soothing activities to turn to when the urge to self-harm arises. For example, faced with overwhelming anxiety clients might talk to a caring friend, take a warm bath or shower, engage in gentle exercise, or listen to relaxing music. These strategies have been found to be effective in reducing NSSI (Klonsky & Glenn, 2008).

Wester and Trepal (2005) have suggested that where self-injury is motivated by the desire to feel more alive through stinging, burning, or other intense sensations it can be useful to find noninjurious alternatives for generating similar sensations without damage to tissue. Within a CFT framework, sensory alternatives should be not threat-based but gentle and soothing. For example, instead of snapping an elastic band on the wrist or holding an ice cube against the skin to generate stinging (Wester & Trepal, 2005), the client might use a menthol rub to generate a pleasant tingling or cooling sensation. Nurturing other living beings may also be helpful. Expressing gratitude to another person (Gilbert, 2009; Lyubomirsky, Sheldon, & Schkade, 2005), taking care of a pet, or tending to a garden are all compassionate alternatives to NSSI.

CONCLUSION

NSSI is a mental health concern with potentially severe consequences. To be effective, counseling interventions must address the underlying functions of NSSI, which are generally emotion regulation, self-punishment, and need for interpersonal influence. Here CFT may be particularly beneficial. Through a multimodal range of CFT techniques, self-injuring clients can become aware and tolerant of their moment-to-moment experience and learn self-compassionate ways of soothing themselves in the face of emotional distress. A compassion-focused approach may also counteract self-directed hostility through self-directed warmth, understanding, and kindness. Techniques such as compassion-based imagery that focus on both the inward and outward flows of compassion may also help clients relate to other people in more positive ways. With CFT, all these strategies are initiated in the context of a trusting therapeutic relationship where the counselor's empathy, refusal to judge, and warmth are central. Finally, it should be noted that CFT is a newcomer to the family of acceptance-based, cognitive-behavioral therapies. While we have presented some evidence that supports its effectiveness, there is need for outcome research specifically on the use of CFT for NSSI.

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