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Compassion focused therapy for eating disorders: A qualitative review and recommendations for further applications

Stanley R. STEINDL,[1] Kiera BUCHANAN,[2] Kenneth GOSS[3] and Steven ALLAN[4]

[1]School of Psychology, University of Queensland and [2]Centre for Integrative Health, Brisbane, Queensland, Australia and [3]Coventry & Warwickshire Partnership Trust, Coventry Eating Disorder Service, Coventry and [4]Clinical Psychology Unit, University of Leicester, Leicester, UK

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Correspondence
Stanley R. Steindl, School of Psychology, University of Queensland, St Lucia, Brisbane, Queensland 4072, Australia.
Email: s.steindl@uq.edu.au

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Abstract

Background: People suffering from an eating disorder (ED), or more generally with eating, body image, and weight concerns, have been found to experience high levels of self-criticism, self-directed hostility, and shame. Furthermore, these individuals tend to have difficulties generating and activating affiliative and self-soothing emotions.
Methods: Compassion focused therapy (CFT) specifically addresses these issues, and CFT for eating disorders (CFT-E) was designed to incorporate the development and practice of compassion for self and others into standard ED treatment programs to assist with these issues.
Results: This article describes (1) the theoretical rationale for cultivating compassion for self and others as part of ED treatment, (2) the adaptation and incorporation of CFT-E within ED treatment programs, and (3) a qualitative review of the current evidence base for CFT-E.
Conclusions: Finally, the article will explore recent and potential future developments in CFT-E, and recommendations for the use of CFT-E in clinical practice, including its application for those who present with other eating and weight concerns (such as being overweight or obese), and various modes of inpatient and community-based delivery.

Key Points

1 Eating and weight concerns have been found to be associated with higher self-criticism and shame, and lower self-compassion.
2 Compassion focused therapy (CFT) was developed to address these issues, and has been effectively adapted into eating disorder treatment programs CFT for eating disorders (CFT-E).
3 Other applications for CFT-based interventions are being explored, especially CFT-E for other eating and weight concerns, such as obesity.

Eating disorder prevalence in Australia remains high, and contributes significantly to the burden of disease associated with mental health disorders, especially for young adults aged between 20 and 40 years (Whiteford et al., 2013). Simultaneously, the rates of obesity in Australia continue to rise, having increased by 75% among Australian adolescents in the past three decades (National Eating Disorder Collaboration, NEDC: http://www.nedc.com.au/eating-disorders-in-australia). Adolescent girls with obesity are reported to have high rates of disordered eating. In fact, co-morbid obesity with disordered eating has escalated at a rate more quickly than either obesity or eating disorders (NEDC: http://www.nedc.com.au/eating-disorders-in-australia).

While recognised as a significant problem, eating disorders are also often under-identified, remaining undetected even when a person presents to outpatient treatment for other psychological or psychiatric problems, such as anxiety or depression (Fursland &

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Watson, 2014). One of the major barriers to accessing treatment is that people with an eating disorder continue to experience high levels of stigmatisation from others (McLean et al., 2014), and find certain stigmas ("I should be able to just pull myself together" and "I am personally responsible for my condition") particularly damaging (Griffiths, Mond, Murray, & Touyz, 2014). Griffiths et al. (2014) found greater frequency of stigmatisation to be positively correlated with low self-esteem, severity of eating disorder symptomatology, duration of illness, and reluctance to seek help. Real and perceived stigmatisation, as well as the resulting feelings of shame, appears to play a significant part in the development and maintenance of eating disorders, as well as being barriers to seeking treatment.

There is now a well-established evidence-base for the effectiveness of cognitive behavioural therapy (CBT) treatments for bulimia nervosa (BN, Fairburn et al., 2009; National Institute for Clinical Excellence, 2004), with remission for around 50% of patients at up to 60 weeks follow-up (Fairburn et al., 2009). Despite this, the high prevalence of eating disorders, relatively poor therapy outcomes for some types of eating disorder (e.g., anorexia nervosa [AN]) and the rising prevalence of obesity makes it imperative that novel, adjunctive treatment approaches continue to be explored and developed. This article will discuss the role of shame and self-criticism in the development and maintenance of eating disorders and obesity, recent findings regarding the positive role self-compassion can play in prevention and recovery from eating disorders, and the advent of compassion focused therapy (CFT) as an effective adjunct to established CBT treatments.

Shame and Self-Criticism in People with an Eating Disorder

The damage of stigmatisation for people with eating and weight concerns might be partly because they themselves typically experience a high degree of self-shame as part of their condition. Shame has been examined for many years, with distinctions being made between internal and external shame. Internal shame, first described by Kaufman (1989) and further developed by Nathanson (1994), relates to a sense of the self as being flawed, inadequate, inferior, powerless, and/or personally unattractive. It is often associated with intense self-criticism and even self-hatred (Gilbert, 2002). Distinguished from guilt, the sense of having done something bad, internal shame is self-directed; "I am bad" (Lewis, 1992). External shame also relates to the negative beliefs one has about oneself. In this case however, it is from the perspective of others; believing that others see the self as being flawed, inadequate, worthless, and/or unattractive. Here the concern is that the self will be exposed negatively to others, leading to diminished social status or value and ultimately, rejection (Lewis, 1992). Thus, external shame has often been associated with attempts at concealment and submissiveness (Gilbert, 2002).

> Where shall we bury our shame?
> Where, in what desolate place,
> Hide the last wreck of a name
> Broken and stain'd by disgrace?
> Death may dissever the chain,
> Oppression will cease when we're gone;
> But the dishonour, the stain,
> Die as we may, will live on.
>
> Thomas Moore, *Where Shall We Bury Our Shame?*

Shame has long been hypothesised to be an important part of the development and maintenance of eating and weight concerns (Bruch, 1973). In fact, some have posited that eating disorders are "culture bound syndromes" driven by society's emphasis on slimness as the most desirable state (Bemporad, 1996), thus putting people at risk of feeling flawed and thereby engaging in maladaptive behaviours as a means of escaping such feelings. One such behavioural response to shame is dieting. Dieting is recognised as a major risk factor for the development of both eating disorders and obesity. The risk of adolescents developing an eating disorder is 18 times more likely if they are on a diet (Kenardy, Brown, & Vogt, 2001). Simultaneously, adolescents who diet are significantly more likely to become obese as adults. Another maladaptive response to shame is disengagement from physical activity, with higher rates of shame linked to lower levels of exercise (Vartanian & Shaprow, 2008).

Over the last 25 years, increasing research interest has become focused on the relationship between shame and eating behaviour. The findings of this more recent research has suggested that people with an eating disorder (as well as those in remission from an eating disorder) experience higher levels of shame than other clinical groups (Cook, 1994; Frank, 1991; Masheb, Grilo, & Brondolo, 1999) even when controlling for levels of depression (Gee & Troop, 2003; Troop, Allan, Serpall, & Treasure, 2008). Disordered eating behaviour has been shown to increase following an experience of shame (Kelly & Tasca, 2016). This pattern is also noted among those classified as being obese, with those experiencing greater levels of shame also showing increases in weight (Wardle & Beinart, 1981).

Cooper, Todd, and Wells (1998) found that, compared to non-clinical populations, women with an eating

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disorder reported increased levels of negative self-belief as well as a greater emphasis on the importance of controlling weight and eating behaviour. The negative self-beliefs contained themes of worthlessness, uselessness, inferiority, failure, abandonment, and being alone. Not surprisingly then, themes of self-acceptance and happiness were related to weight, size, and shape. These themes are central to Fairburn's (Fairburn, Cooper, & Shafran, 2003) transdiagnostic model in which the over-evaluation of weight and shape is conceptualised as the main contributor to the onset and maintenance of all eating and weight concerns.

People with eating disorders have also been found to be highly self-critical (Goss, 2007) and experience high levels of self-directed hostility (Williams et al., 1993, 1994). Two forms of self-criticism have been identified: one that is focused on inadequacy and making mistakes (and thereby serves a function of self-correction or self-improvement), and the other that is focused on self-disgust/hate (and has the function of self-harm and self-persecution; Gilbert, Clarke, Kempel, Miles, & Irons, 2004). People with an eating disorder are more likely to criticise themselves for the purposes of self-harm or self-persecution (Barrow, 2007) and such self-criticism is a strong, independent, and robust predictor of eating disorder symptoms (Fennig et al., 2008).

> What is this self inside us, this silent observer,
> Severe and speechless critic, who can terrorise us
> And urge us on to futile activity
> And in the end, judge us still more severely
> For errors into which his own reproaches drove us?
>
> T. S. Elliot, *The Elder Statesman*

Self-Compassion in People with an Eating Disorder

Self-compassion, conceptually the opposite of self-hating self-criticism, has gained increased interest in the eating disorder literature (Braun, Park, & Gorin, 2016). Self-compassion can be defined as approaching oneself with kindness and acceptance, especially in the face of one's own personal distress or disappointments (Gilbert, 2009; Neff, 2003). Paul Gilbert, who developed CFT, incorporates self-compassion in the broader definition of compassion, which is defined as "*the sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it* (Gilbert, 2014, p. 19)." Importantly, some people experience a fear response to self-compassion, especially when they have an interpersonally aversive or traumatic background (Gilbert, 2010; Gilbert, McEwan, Matos, & Rivis, 2011). Gilbert and Procter (2006) found that fear of self-compassion was linked to feeling undeserving of compassion, a belief that self-compassion was a weakness, a desire for love and kindness but instead feeling lonely and rejected, and simply "never considering the value of self-compassion."

Several studies (e.g., Kelly, Vimalakanthan, & Carter, 2014) have illustrated that those with an eating disorder demonstrated lower self-compassion and higher levels of compassion fear than non-clinical participants. Self-compassion has been demonstrated to be negatively associated with external shame, general pathology, and eating disorder symptomatology (Ferrieira, Pinto-Gouveia, & Duarte, 2013) while increased levels of compassion fear have been associated with higher levels of shame and eating disorder pathology (Kelly, Carter, Zuroff, & Borairi, 2013). Self-compassion has been implicated in responses to treatment and treatment outcomes with low levels associated with poorer responses to treatment (Kelly et al., 2013) and increases in self-compassion early in treatment linked to improvements in eating disorder symptomatology (Kelly, Carter, & Borairi, 2014).

These results have been replicated with non-clinical populations, with higher levels of self-compassion found to be negatively associated with eating disorder symptomatology (Taylor, Daiss, & Krietsch, 2015), binge eating severity (Webb & Forman, 2013), eating disorder pathology, eating concerns, weight concerns, shape concerns, and dietary restraint (Kelly, Vimalakanthan, & Miller, 2014). Overall, the data seems to suggest that self-compassion is inversely related to eating and weight concerns in both clinical and non-clinical populations. Furthermore, a meta-analysis of 28 studies provided preliminary evidence that self-compassion operates as a protective factor against the onset of eating disorder pathology (Braun et al., 2016).

> Come sit down beside me, I said to myself.
> And although it doesn't make sense,
> I held my own hand as a small sign of trust
> And together I sat on the fence.
>
> Michael Leunig, *Come Sit Beside Me.*

Compassion Focused Therapy: Targeting Shame, Activating the Compassionate Self

CFT was first developed to target self-criticism and shame as they were regarded as key components of a number of mental health disorders (Gilbert, 2000, 2009, 2010; Gilbert & Irons, 2005). As described in Gilbert (2009), it was recognised early in the development

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of CFT that traditional therapies (such as cognitive-behaviour therapies), while evidence-based and effective, often left clients with a sense that they *knew* how to think more rationally about whatever concerned them however they still did not *feel* any better about it. Similarly, it is commonly recognised that clients with eating and weight concerns are not necessarily seeking to *look* better as much as they are concerned with wanting to *feel* better. According to Gilbert (2009), the difference was that self-criticism and shame, especially as these constructs were represented in the person's relationship with themselves and the tone of voice they might use with themselves, had not been resolved. Thus, self-criticism and shame became recognised as key factors in the aetiology, maintenance, and increased risk of relapse for a whole range of psychological disorders.

Gilbert (2014) outlines the nature and origins of CFT, which importantly is derived from an evolutionary and neuroscience model of affect regulation. Namely, CFT posits that the human brain is a product of evolution and that most aspects of human thought, emotion, motivation, and behaviour can be best understood through the lens of Darwinian "selection for function" (Buss, 2009; Panksepp & Watt, 2011). By extension, many mental health problems can also be seen in terms of their relationship to evolutionary adaptations (Gilbert, 1989) and an important message for clients is that human beings have these "tricky brains" and the way their brains work is "not their fault." In particular, CFT identifies three specific affect regulation systems, often referred to as motivational systems, that are thought to have been evolutionarily adaptive for early humans and continue to play a role with people today, including in relation to their mental health.

- The threat detection and protection system (known as the *threat system*) relates largely to the fight/flight/freeze response and is associated with rapidly activated emotions (such as anxiety, anger, and disgust) as well as defensive behaviours (such as aggression, avoidance, and submissiveness). A key part of human survival, the threat system is designed to help identify threat and then act accordingly to seek protection from the threat. However, the threat system also has a biased attention, and operates from a "better to be safe than sorry" perspective; preferring to err on the side of perceiving threats that are not actually present rather than ever missing a threat that is present.
- The drive, vitality, and achievement system (known as the *drive system*) is associated with emotions related to wanting, seeking, aspiring, and striving, as well as behaviours associated with approach and engagement. This motivational system created the drive in early humans to venture out and acquire food and other resources, as well as finding a mate. In modern humans, this system motivates people to succeed and obtain, however it can be maintained by other potential aspects of the system referred to as "hedonic adaptation." This term describes the process by which acquiring something is initially followed by feelings of satisfaction and pleasure, however these pleasurable feelings inevitably fade and are followed by the experience of desiring more.
- The contentment and affiliative-soothing system (known as the *soothing system*) is associated with the emotional experiences of contentment, wellbeing and safeness, as well as behaviours associated with giving and receiving affection, care, nurturance, bonding, and affiliation. Unlike other mammals whose young develop quite quickly and become physically more independent at a young age, humans bore extremely vulnerable young. Subsequently, caring for one's young via the soothing system was an essential aspect to the survival of the human species. This system allowed for the experience of social connectedness and belonging, as well as soothing from others and from oneself. It is in this system that people can experience the "flow" of compassion, including compassion to others, from others, and from themselves to themselves (also known as self-compassion).

CFT proposes that mental health problems develop when these three systems are unable to regulate each other. For example, people who are unable to effectively regulate their own emotions, especially threat-based emotions including shame, through a well-developed soothing system will often resort to an over-reliance on the drive system, where they develop an inflated need to strive, achieve, succeed, and accomplish things. In those with eating and weight concerns, the drive system may be activated to regulate the threat system through the quest for pride associated with control over weight and shape (Goss & Allan, 2009). Other researchers (Sassaroli et al., 2015) implicated the drive for autonomy and independence in response to social or cultural transitions in the onset of disordered eating. In fact, researchers have recently disputed one of the main diagnostic criteria of AN, stating that the drive for weight loss in AN is not a fear or avoidance of fat, but rather the pleasure obtained through losing weight (Clarke, Fladung, & Gorwood, 2016).

Alternatively, individuals with eating and weight concerns might become stuck in the threat-system,

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responding with aggressive or avoidant behaviours such as binge-eating, purging, excessive exercise, and/or further starvation and deprivation. In fact, difficulties in emotion regulation are considered a central part of the trans-diagnostic phenomena that are related across the spectrum of eating disorders (Brockmeyer et al., 2014; Svaldi, Griepenstroh, Tuschen-Caffier, & Ehring, 2012) and skills to assist patients with emotional regulation are considered very important (Ruscitti, Rufino, Goodwin, & Wagner, 2016). CFT aims to provide skills that assist with emotion regulation. Furthermore, difficulties in this area are often accompanied by more self-criticism. Given self-criticism, especially self-hating self-criticism, is conceptualised as an internal threat, the threat and drive systems are further activated, perpetuating the problem (Gilbert, 2009, 2010; Gilbert & Irons, 2005).

One assumption of this understanding of the affect regulation systems is that feeling cared for by others prompts feelings of safety and closeness in the face of difficult situations, thereby reducing the experience of threat. However, those with eating and weight concerns (particularly those with AN) tend to respond quite differently; disconnecting from others and turning inward in an attempt to conceal their negative experience and further fuelling feelings of shame. Drawing also on attachment theory (Bowlby, 1969), CFT conceptualises individuals in terms of their evolved brains and genetic predispositions as well as through the ways in which their brains have been shaped through social processing. Early attachment experiences, including the experience of having a secure base in the relationships with others (such as parents), provides the kind of affiliative, supportive, and soothing experiences that allow one to explore the external world. Such early experiences of having had a secure base also sanctions the exploration of one's own inner world of emotions and thought through the development of an internal self-soothing system in response to experiences of distress. A lack of feeling soothed as a child might thereby result in an impaired ability as an adult to seek comfort from others during times of difficulty. This early experience might also result in the underdevelopment of one's own soothing system, thus making the affect regulation role of the soothing system difficult to access.

Goss (2011) postulates that the soothing system is also closely related to eating. Eating, being fed, eating together, and sharing food are usually experienced as comforting by humans. In the absence of a well-developed self-soothing system, overeating may become problematic for those individuals who have learned only to seek food for comfort. Finally, given that the relationship an individual has with themselves (especially in terms of self-criticism and shame) is implicated in the development of mental health problems (Gilbert & Irons, 2005), the intention of CFT is to work within the soothing system to develop and activate a compassionate self.

Adapting CFT in the Treatment of Eating Disorders (CFT-E)

Recognising the relationship between shame, self-hating self-criticism and eating disorders, Goss and Allan (2010, 2011) proposed that (from the point of view of the evolutionary model underpinning CFT), eating disordered behaviours may serve a functional purpose in that they are designed to regulate affect (especially negative affect associated with the threat system). For these clients, it may be that the soothing system is underdeveloped and unable to be accessed in such a way that the threat and drive systems become interlinked in a vicious cycle that leads to further distress. Furthermore, the dominance of the threat and drive systems also may prevent the development and activation of the soothing system that might otherwise play the role of affect regulation and self-soothing.

Given Western society's modern day preoccupation with weight loss, disordered eating may partly evolve through a belief that the individual should or can control their physical bodies (that being, their eating behaviour as well as their weight). Owing to this, CFT-E extends on CFT's notion of the "tricky brain" through educating clients that humans also have a complex body. The set-point theory of weight regulation is introduced as a component of CFT-E; highlighting that these complex bodies evolved for energy conservation and weight gain in the context of food scarcity. Through an increased understanding of how their bodies operate (outside of their control), CFT-E assists clients in developing a compassionate understanding and acceptance of their body as well as its need for nutrition, activity, and rest. Through understanding the impacts of biological starvation and the need to avoid such consequences, clients are guided towards normalised eating (eating regularly and adequately); one of the main behavioural goals of CFT-E. Normalised eating is practiced throughout the program through presentations with real food, creating meal plans, and building motivation for positive changes to eating behaviour.

Eating disorders may also evolve as an attempt to regulate affect in a social context in which eating, weight, and shape have become involved in threat system activation. Certain eating- or food-related mindsets and safety behaviours may develop as a way to provide relief or distraction from difficult emotions. However, the vicious

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cycle begins as these mind sets and safety behaviours lead to unintended negative consequences biologically, psychologically, and socially. CFT-E emphasises the concept that this is not the person's fault but rather, the result of the tricky aspects of human beings' evolved brains and bodies. Thus, another behavioural change goal of CFT-E is for the client to develop alternative ways of managing the threat and drive systems (Goss & Allan, 2010, 2011). This is partly achieved through the development of a compassionate self, which can then be activated to support the self during social challenges, including the challenge of living in a dieting culture.

CFT-E was initially developed as a group program, and incorporated aspects of CFT and CBT-enhanced (CBT for eating disorders; Garner & Garfinkel, 1982; Fairburn & Cooper, 1989; Fairburn et al., 2009; Fairburn et al., 2003; Waller, 1993). CFT-E works incrementally through three core phases: psycho-education, capacity building, and recovery. During the *psycho-education* phase, largely didactic components are presented to assist clients to develop a functional analysis of their eating disorder, to explore motivation to engage in treatment and to introduce the CFT-E treatment program. The *capacity building* phase is designed to help clients develop CFT-informed skills to assist them in managing the challenges of recovery from their eating disorder. These skills include affect recognition, tolerance, and management skills, development of the soothing system (through breathing and imagery skills), and development of a "compassionate self" (through giving and receiving compassion in the group as well as using compassionate-self and compassionate-companion imagery). The *recovery* phase focuses on using this newly developed compassionate self to address the key challenges of recovering from an eating disorder, including working through the ways in which certain mind-sets (e.g., an eating disordered mind-set, a critical mind-set, or a food-as-comfort mind-set) may block recovery.

Ultimately, the aim of CFT-E is to develop the compassionate self and use it to:

- develop sensitivity, awareness, and understanding regarding the way their eating and emotions have become linked;
- develop empathy for themselves and the problems that their eating disorder may have tried to solve, as well as the unintended consequences of these attempts;
- develop wisdom around the challenges of recovery;
- develop motivation to care for the self in a way that is in one's own best interests and therefore commitment to engage in recovery; and
- develop the confidence and courage needed to offer understanding, support, advice, and encouragement to the self and other members of the group (Goss & Allan, 2010, 2011).

A Qualitative Review of CFT-E Outcomes

Research examination of CFT-E is still in an early developmental stage, however, the results of incorporating CFT into standard CBT treatment programs for eating disorders have been encouraging. Gale, Gilbert, Read, and Goss (2014) took a retrospective file audit approach that indicated reductions in self-reported eating disorder symptoms over the course of the CFT-E treatment program. This study found that clients diagnosed with BN benefited the most from compassion-based approach, with three-quarters of these clients making clinically reliable and significant improvements by the end of treatment. Clients diagnosed with eating disorder not otherwise specified (EDNOS) also benefited from the program, although their recovery rates were somewhat lower than those evidenced by clients with BN. Clients with AN benefited the least, although one third of this group did show clinically reliable and significant improvement.

It was recommended that these relatively poorer results for AN should be considered in the context that even the best treatment approaches for this particular group are often ineffective. The researchers also recognised that clients with an especially low body mass index (BMI) may have benefited from an extended treatment program (as is recognised in other treatment approaches such as CBT-E) owing to the additional complexity associated with such levels of starvation and malnutrition.

Other researchers (Kelly, Wisniewski, Martin-Wagar, & Hoffman, 2016) demonstrated improvements in treatment outcomes through the addition of CFT (delivered in a 12-week group setting) to treatment as usual (individual outpatient eating disorder treatment). Participants had a range of eating disordered including AN-purging subtype, BN, and binge eating disorder (BED). Participants who received CFT in conjunction with standardised treatment demonstrated greater reductions in eating disorder pathology than those who received standardised treatment alone.

Several recent studies have looked at the process or content specific variables involved in CFT-E. Holtom-Viesel, Allan, and Goss (submitted) looked more specifically at the impact of CFT-E on the hypothesised mechanisms underlying eating disorders (namely self-criticism and shame) over the course of treatment for people with a

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diagnosis of AN, BN, and EDNOS. The design of this study involved participants completing a transdiagnostic group program. The attended a general psychoeducation group for eating disorders component followed by a CBT-E treatment component prior to the CFT component being introduced. The study found that levels of self-criticism and shame significantly increased after the first two components were delivered. It was only after the CFT component was introduced that levels of self-compassion increased and levels of self-criticism and shame significantly decreased. Similarly, disordered eating symptomatology also began to decrease following the introduction of CFT. These findings are consistent with those reported by Kelly, Carter et al. (2014) in which clients who demonstrated the greatest increases in self-compassion early in treatment evidenced the greater reductions in eating disorder symptoms over the course of their 12-week program.

Simmonds, Allan, and Goss (submitted for publication) explored changes in heart rate variability (HRV) during CFT-E2. HRV has been used as physiological measure of the soothing system with higher levels of HRV associated with increased parasympathetic arousal (and hence increased ability to activate the soothing system). The researchers found that overall, HRV does improve during the course of treatment. However, practicing soothing and compassion imagery initially led to a reduction in HRV in the early phases of treatment, suggesting that clients' initial experiences of compassion and soothing may be difficult.

A qualitative study by Showell (2012) explored clients' experiences of compassionate letter writing, a core component of CFT-E (Goss & Allan, 2010, 2012, 2014). She noted that clients typically experienced the concept of self-compassion as "alien" and struggle to move beyond the familiarity of their eating disordered and self-critical beliefs and behaviours. However, Showell noted that through engaging in the compassionate letter writing, these clients progressed to a phase in which letter writing helped them to acknowledge the difficulties they have been experiencing and to develop an understanding of both the functions and consequences of their self-criticism as well as that of the eating disorder. From there, clients were shown to draw upon their letters as a means of developing a more self-compassionate identify and increased capacity for self-care.

Recent Developments in CFT-E and Implications for Clinical Practice

In response to the Gale et al.'s (2014) clinical audit, CFT-E has developed in two significant ways. The first was to develop a more focused CFT-E program (CFT-E2) and the second was to adapt CFT-E specifically for the needs of low weight clients. In CFT-E2, the amount of time in the program spent on CFT specific skills was increased while the time spent on CBT specific skills was reduced. Changes were also made to increase the intensity of the *psychoeducation* and the *capacity building* phases of the program before changes in eating behaviour were introduced. These changes aimed to reduce the overall time in treatment. Changes were also made to facilitate a longer period of in-session consolidation of the skills developed in the *capacity building* phase. A clinical audit of CFT-E2 has been undertaken and results are promising, particularly for those clients who did less well in CFT-E (e.g., clients diagnosed with EDNOS; Allan, Goss, Fergusson, & Walsh, submitted for publication).

The need for a longer course of treatment in cases in which the individual has a BMI below 17 is recognised in other treatment approaches such as CBT-E. Subsequently, CFT-E was also adapted in a similar fashion; delivered over the course of 40 weeks in instances that the individual had a BMI below 17.5. The pilot version on this program is currently being evaluated (Andrews, Goss & Allan, submitted), and early results appear to be promising. Clients demonstrated increases in weight, reductions in shame and self-criticism, and improvements in self-compassion and overall wellbeing. Despite being clinically significant, the improvements noted were relatively small at the conclusion of treatment. However, follow-up assessments have demonstrated ongoing improvements in outcomes. As yet is unclear why lower weight patients may have a poorer response to CFT-E in its sorter forms. A number of possible explanations may account for this, including structural changes to the brain as a consequence of starvation, pride in eating disordered behaviour, greater difficulties in processing soothing and safeness signals and emotions, higher fears of compassion, or perhaps the increased demands of food intake (and hence higher levels of fear) that are required to attain a normal weight compared to higher weight eating disordered populations. Further studies are required to explore these hypotheses.

Adapting CFT-E for Overeating and/or Obesity

Overweight and obesity is another area that has recently been addressed from a CFT-E perspective. Commonly, clients with obesity who seek treatment present quite similarly to those with a diagnosed eating disorder, including high levels of self-criticism and shame (Franks, 2011).

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In adaptions for those who are overeating or overweight, CFT-E again highlights that humans have a complex body, which evolved for energy conservation and weight gain in the context of food scarcity. For most of human history, food was scarce, a lot of energy was required to obtain food, and the food that was obtained was often low in energy. Subsequently, humans developed a "see food and eat it" approach (particularly in response to rarely encountered, high-energy foods), prompting overeating and weight gain (which was conducive to survival during times of famine). In the modern world, however, with the consistently high availability of energy-dense food and the absence of famine, these primitive approaches to eating are no longer necessary nor helpful. In fact, the interaction of such eating responses with the modern-day food supply has been implicated (along with other factors, including genetics) in the onset of obesity in developed countries (Marti, Moreno-Aliaga, Hebebrand, & Martinez, 2004; Wardle, 2005).

Society responded to the rising rates of obesity with a "eat less, move more" approach. Although well-intended, the suggestion of this overly simplified solution to a complex problem instilled a sense of complete responsibility and control over eating and weight, triggering feelings of shame and disgust in response to one's weight and eating behaviour. Feelings of judgment, stigma, and isolation are further perpetuated by society's "war on obesity." Increasing interventions aimed at preventing and reducing obesity have been implicated in evidencing greater fears of food and preoccupations with reducing or controlling weight than ever before. Subsequently, an increasing number of people report feelings of shame, guilt, anxiety, disgust, and anger in response to food, eating, and their body weight or level of adiposity. Just as these emotional experiences activate the threat and/or drive systems in those presentations that involve undereating and weight loss (such as AN and BN), they are speculated to operate in a similar manner (however, with a different outcome) in those eating and weight concerns which involve overeating and/or an excess body weight (such as obesity and BED).

Given the similarities in both sets of presentations (i.e., undereating and weight loss versus overeating and excess body weight), it makes sense to extend the same principals of CFT-E to this latter population. An emphasis on understanding the "tricky body" and recognition that it is not the person's fault, is likely to reduce feelings of shame and self-criticism. Through developing compassion for themselves, clients are encouraged to let go of their maladaptive focus on weight loss and develop alternative ways to manage their threat and drive systems. The important point here is to help clients to develop compassion for themselves and an understanding of how their eating behaviour became closely linked with their emotions. Through understanding the same set-point theory of weight regulation, clients can be assisted in developing a compassionate understanding and acceptance of their body's need for nutrition, activity, and rest as well as its ability to regulate its own weight in the absence of overt control strategies. Clients can be encouraged to understand the impacts of biological starvation and manage its consequences (overeating and further weight gain) through eating regularly and adequately.

Modifications to the CFT-E program have been developed for obese adult clients seeking treatment through the publication of a self-help book *Beating Overeating using Compassion Focused Therapy* (Goss, 2011). Research projects are currently underway, exploring the use of practitioner-guided self-help using this book in conjunction with dietetic treatment as usual in both individual and group settings.

In Australia, a CFT-E informed group program, known as *Radiance: Self-Compassion for Eating and Weight Concerns*, has been developed and piloted (Steindl & Buchanan, 2016), with encouraging results and very high participant satisfaction. *Radiance* is an eight-session community-based, group program for people who are experiencing subclinical eating and weight concerns. Sessions are 90 min each and are designed to integrate education and skills implicated in healthy-eating behaviour and weight management with the development of the compassionate self. Content and exercises for the program were drawn from a range of sources from both the CFT literature (Gilbert, 2009; Goss & Allan, 2012; Kolts, 2016; Tirch, Schoendorff, & Silberstain, 2014), and the eating and weight literature (Fairburn, 2013).

From a *compassion-focused* perspective, the program includes the development of awareness and sensitivity through mindfulness, the role of human evolution in the development of the three motivational systems and that difficult thoughts, feelings, and behaviours (as well as biology) are "not your fault," as well as the development of the compassionate self and ability to activate it in order to deal with difficult emotions (including those related to food and eating). A number of core CFT strategies are used to achieve this including soothing imagery, compassionate friend imagery, compassionate thought balancing, giving and receiving compassion, and compassionate letter writing. From a CBT-E perspective, the program includes addressing the over-evaluation of weight and shape through encouraging clients to let go of a focus on weight loss, education about set-point theory and starvation syndrome in an effort to introduce

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regular eating and reduce episodes of restriction and subsequent overeating, as well as the reintroduction of "forbidden" foods in an attempt to address the rules and emotions attached to eating certain foods, which is shown to perpetuate episodes of overeating. Again, a number of core exercises are incorporated into the program, such as developing a regular eating plan, monitoring eating behaviour through eating journals, exposure to "forbidden" foods, practicing mindful eating and intuitive eating exercises, and developing a sense of self-separate to eating and appearance.

Conclusion

Self-criticism and shame have been identified as important aspects in the development and maintenance of eating and weight concerns (at both a clinical and subclinical level) as well as negatively impacting treatment outcomes. Traditional cognitive-behavioural treatments for eating disorders have been found to be effective; however, they do not necessarily target these components of eating and weight concerns. CFT is an approach that was developed specifically to work with self-criticism and shame. A comprehensive and sophisticated theory has been developed incorporating evolutionary science, psychological science, and neuroscience. CFT-E therefore was developed to bring together traditional and effective CBT approaches with the theory and practice of CFT to enhance treatment outcomes. This integration contributes to the treatment of eating and weight concerns across the spectrum by introducing the development of the compassionate self to help people face the challenges involved in recovering from such concerns. In particular, CFT-E provides psychoeducation about the way the human mind has evolved and how this influences even modern humans' thoughts, emotions, motivations, and behaviours. It also brings a range of exercises that activate the soothing system and develop the compassionate self through soothing, breathing and imagery, compassionate imagery and compassionate-self training and practice. The goal is to help clients develop a way of engaging with difficult situations or challenges in their recovery from the perspective of the compassionate self. Ultimately, clients learn to treat themselves with kindness, wisdom, courage, and strength, rather than with criticism, hostility, and shaming. Similarly, CFT-E provides education and an appreciation of the way the human body has evolved to adapt to changes to access to food (as well as its modern day perceived access to food). The goal is to assist clients in developing an appreciation for and trust in their body's ability to regulate its own weight, at a weight it feels is healthy and adaptive for it. In doing so, clients are encouraged to let go of maladaptive behaviours aimed at controlling intake and weight and instead, to eat regularly and adequately, in response to physiological cues.

CFT-E has been found to have produced promising results for adult clients with a diagnosed eating disorder, especially BN. More research is needed to further substantiate the added contribution that CFT-E makes to traditional CBT-E approaches in the treatment of BED as well as subclinical eating and weight concerns. CFT-E has also been adapted for clients with obesity as well as community-based populations who have concerns about their eating and weight in the absence of a clinically diagnosable eating disorder. These programs are briefer (8–12 weeks) and provide opportunities for broader implementation and access of compassion-based interventions for the general population.

CFT-E is at a relatively early stage of development. Research studies and clinical audit suggest it is both an acceptable, feasible, and potentially useful new approach to treatment for people with a range of eating concerns. Feedback has indicated that clients value this approach. However, further evaluations are required, and exciting opportunities exist for clinicians and researchers to explore the added value of recent developments in compassion and self-compassion to the treatment of eating disorders.

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