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Theory and Interpersonal Processes in Compassion Focused Therapy

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Abstract

This paper reviews key theories underlying the interpersonal process in Compassion Focused Therapy (CFT) and links these to purported mechanisms of action in CFT. The paper goes on to provide a concrete practice example of an exampled dialogue between a clinician and client and narrates the interpersonal processes and mechanisms of action in an attempt to elucidate how interpersonal processes can be leveraged to facilitate therapeutic change. In so doing, this paper seeks to advance scholarship on precise mechanisms of change in psychotherapy, especially interpersonal processes in psychotherapy. Furthermore this paper seeks to provide a useful account of how interpersonal theory can be enacted in a clinical interaction.

Keywords

Interpersonal process; compassion focused therapy; psychotherapy; attachment; social mentality theory; therapeutic relationship

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1. Theory and Interpersonal Processes in Compassion Focused Therapy

Compassion Focused Therapy (CFT) is an integrative, evolutionary, contextual and biopsychosocial approach to therapy [1]. Like many therapies, interpersonal processes are a key component within the CFT framework, and the aim of this paper is to describe the core theory and clinical applications of the interpersonal processes crucial to CFT.

CFT helps clients access and pursue the dual capacities of *being sensitive to suffering* and *taking action to reduce that suffering,* whether the sources of that suffering be internal or external [2]. To do this effectively, clients are required to give and receive compassion both interpersonally (e.g., self-to-others and others-to-self) and intrapersonally (e.g., self-to-self). In CFT, this is commonly referred to as the flow of compassion, with some finding directing compassion outwards easier than receiving compassion or being self-compassionate [3]. CFT identifies and differentiates various attributes crucial for engaging with suffering, as well as skills and competences to alleviate suffering (see Figure 1). Across the course of the CFT therapeutic journey, time is dedicated to cultivating and applying these compassionate attributes, skills, and competencies, supported by compassionate mind training (see Figure 1) [4].

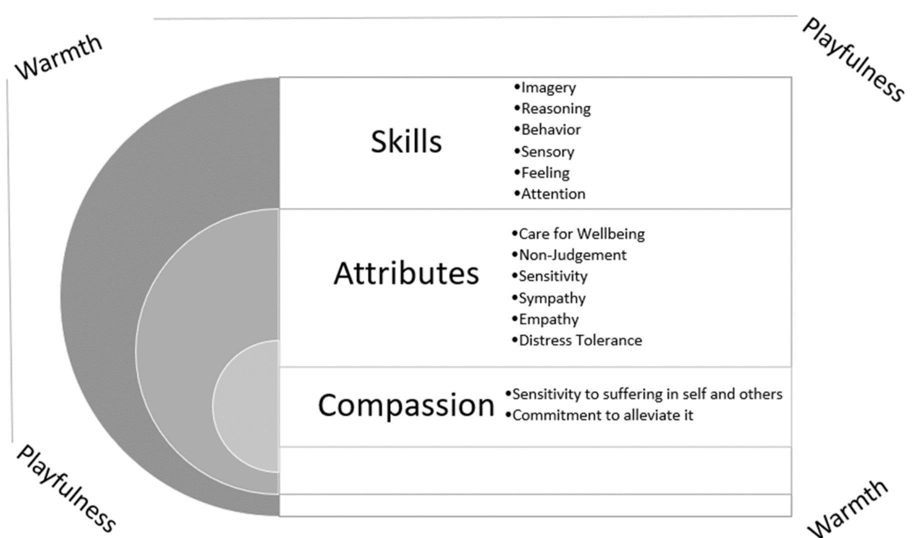

Figure 1 Skills and attributes promoted in CFT framed within the relational context of warmth and playfulness. NB: This figure was adapted from the original publication in that the style of the graphic is changed and that playfulness was added in the relational context as per the arguments in this paper.

CFT is grounded in social mentality theory, which is informed by evolutionary and neurobiological theory [4]. Social Mentality Theory suggests that evolutionary motives (such as acquiring and competing for resources, gaining and maintaining social rank, seeking sexual partners and caring for offspring) are a primary driving force behind our social interactions. These different motives require specific role-forming 'mentalities' that texture patterns of thought, action, and emotion to achieve related social goals [5]. Our social mentalities are used to create and modulate relationships within our external world, however, as a result of verbal language and metacognitive ability, the same mentalities that evolved for interpersonal behavior are recruited within our internal world to form self-to-self relationships [6, 7].

When developing formulations of client difficulties, clinicians are encouraged to consider interpersonal and intrapersonal domains, such as the client's history of giving and receiving care, injuries and successes in the domain of attachment and belonging, injuries and successes related to goal pursuit and self-determination, and injuries and successes in developing physical and emotional safety. Clinicians are also encouraged to consider these same domains in the client's current context and to also consider current experiences related to attachment and affiliation, agency and agentic striving, and interpersonal threat-based protective strategies [2].

Nonetheless, while the literatures on the evolutionary and neurobiological science of compassion, attachment, and social hierarchies are well articulated, and while the literatures on CFT skills and therapy processes are well described, there is a gap in the literature on how to apply these interpersonal literatures across the course of CFT with clients.

The goal of this paper is to articulate one possible account of how interpersonal dynamics might interact with both the acquisition and use of CFT skills, as well as the ways in which the therapeutic relationship can be intentionally leveraged to facilitate therapeutic change. Because the empirical literature on this subject is scant, rather than providing summary of empirical research, the purpose of this paper is to continue the discussion on interpersonal process in CFT with the hopes of promoting future research and supporting practice. A brief account of Social Mentality Theory [4], attachment theory [8], and metatheoretical interpersonal theory [9] will be provided and concrete behavioural and practice examples of these theories is explored. We first layout each theory independently and then end with a clinical example (see Table 1) that provides commentary on how these theories are integrated into practice. We organize the paper in this manner because we believe that the application of these theories to practice occurs fluidly and concurrently. We hope to first establish a theoretical understanding of each area and then seek to demonstrate how they are integrated concurrently.

Table 1 Clinical Example Displaying the Interpersonal Process and Relevant Links to Theory.

T: Let's change focus for a sec. Take a moment and turn your attention inwards. What are you feeling right now in this moment? [vocal tone conveys curiosity, warmth, and concern]	The therapist is prioritizing the client's emotional needs, rather than formal skills practice, modelling qualities from a secure attachment partner
C: Sad, maybe a bit of shame, I always struggle with this imagery stuff	
T: Yeah, I can see you're sitting with some painful feelings. [with candour and appropriately attuned concern] Forget about the imagery for a bit, this is important. I am right here with you. Are you willing to go into that sadness and shame for a bit and see what it's about?	The therapist is signalling that the client's current needs matter more than a formal agenda. The therapist signals connection and makes a bid to attend to the painful experience, demonstrating and modelling sensitivity to suffering. This is consistent with attachment theory and the use of the therapeutic relationship in CFT to explore and promote compassionate repertoires

C: Yeah…OK…I guess	The client expresses assent verbally but non-verbal responses signal ambivalence
T: It is always your choice…but I see you here and I see the pain on your face and I feel moved to join you in that pain if you think it would be helpful to you…	The therapist gives agency and choice to the client and takes a more collaborative role; rather than enacting rank dynamics, the suggestion is framed from a motive of caregiving/care receiving. This is consistent with the meta-theoretical interpersonal model. It also leverages attachment theory to explicitly convey that the client is safe to explore or not and that the quality of the therapeutic relationship is not contingent on the client's compliance. While the verbal empathic overture is strong, this decision may be appropriate if the client struggles with blocks to compassion and would benefit from explicit mentalization.
C: yeah I can let myself feel it for a bit	The client expresses a willingness to enter into the painful experience with more self-determination. The client's response suggests that she did not interpret the earlier comment as promoting emotion avoidance, but rather, that the freedom giving was useful. If the client had not wanted to contact the emotion the therapist would leverage the same principles as before, perhaps saying something like 'you don't need to go there. But I am curious, what would be bad or scary or dangerous about allowing it. What is your mind protecting your from?' or something that encourages exploration of the resistance without using power differences to press for compliance
T: OK, if you let the shame be there, maybe even welcome it. 'Hello shame, welcome back!', [in a playful tone]	Given the ambivalence earlier, the therapist begins to enter the space with humour and playfulness. By using humour to modulate the affective intensity, the therapist is meeting the client's implicit need to go slowly. This links to social mentality theory by inviting compassionate responding to the threat system, attachment theory by signalling safeness, interpersonal theory by positioning the Self as being powerful and in control of what shows up, and the therapeutic

	relationship by using a playful overture to promote contact with difficult experiences.
C: [chuckles] yeah…hi shame.	
T: OK, let it rest in you and grow…let it extend…see if it has any messages for you…or see where your attention is pulled when the shame is here, what thoughts or images or fantasies get conjured up…just speak from the shame. What is the shame saying?	The therapist makes a bid to deepen the experience and guides the client to allow the emotion and express it. This is outside the interpersonal process in CFT but is consistent with CFT chairwork and other process-based interventions.
C: I am so embarrassed. I am such a mess. We have been working together for so many weeks and I still suck at this. I am so self-critical and I can't feel the warmth or compassion. I am so pathetic.	The client responds and engages with the emotional content
T: (Softens voice, non-verbal expression of empathic resonance like 'ugh') That is such a painful way to feel. I am right here with you in that. I can hear the criticism, the anger there, and also your disappointment and vulnerability that the critic attacks *Is there anything else it is saying or worrying about? Just let it keep talking, what else does that shame want to express?*	The therapist gives compassion and signals attunement and presence. The therapist helps to label the client's experience. This supports mentalization and is consistent with attachment theory. This intervention also demonstrates empathy whilst helping the client to deepen their awareness of self-self relationships and different elements of threat experience. This is congruent with the use of the therapeutic relationship in CFT to leverage interpersonal dynamics to deepen and extend the work. At this point, it is unclear whether the client is allowing that compassion to flow in or not- the therapist is beginning to make bids for the client to enter care-receiving position and switch mentality. This would require the therapist to use the interpersonal process as a means of assessing the client's self-to-self and unspoken other-to-self process.
C: That's it I guess…	
T: I could imagine that it also feels pretty vulnerable to be this exposed in front of me…is there anything about that…	Knowing that receiving compassion is usually hard, especially when one is in a threat mentality, the therapist assesses possible external shame with the client and expresses advanced empathy for skills-based difficulties or emotional resistances to allowing compassion to flow-in (normalising and expecting their presence)

	Here the therapist is using the therapeutic relationship to help the client explore and differentiate between the self-to-self and other-to-self processes. The therapist is also attuned and responsive to social mentality theory in order to track the threat mind in the client.
C: Yeah, I just come here and cry and can't get my life together	The client affirms an experience of external shame
T: OK, yeah. And if you try to shift your perspective a bit, how do you imagine that I experience you?	The therapist attempts to use an empathic intervention to create more flexibility with respect to the flows of compassion. The therapist is using both social mentality theory and meta-theoretical interpersonal theory to help the client increase their flexibility in moving through a dance of mentalities.
C: Well you are a therapist so you would be nice but you would probably see me as a "hard client" or that I am really messed up or something	The client seems unable to make the shift at this time and continues to be stuck in a threat mind, struggling with mentalization. The client is also in the submit-attack quadrant of meta-theoretical interpersonal theory.
T: Yeah, is that what <u>you</u> would think of <u>you</u> or how you imagine that <u>I</u> think of you?	The therapist uses themselves as a concrete interpersonal referent to help the client develop discriminative abilities related to interpersonal and intrapersonal processes. This is consistent with mentalization in attachment theory and use of the metatheoretical interpersonal theory.
C: That's how I would think of me	Indicating a difficulty in mentalization and in being stuck in a threat mind and self-to-self attack and submission.
T: Look at me for a sec [client looks up]. What I am about to say is what I honestly feel. I see someone who is fighting, fighting hard, to change old patterns and heal old wounds. You are doing this for future you, for your kids, for your community. I see someone strong and brave who is going into the darkest and hardest parts of herself. And I feel honoured to be invited on that journey. I feel nothing but kindness and warmth towards you [therapist is emotionally moved at this time and conveys their emotion, saying this without emotion	The therapist continues to use interpersonal cues (e.g., look at me) and uses themselves to provide compassion to the other (knowing that the client is currently unable to give or receive compassion themselves). Again, skills-based difficulties and emotional fears or resistances to compassion are expected and used as a further focus for understanding and care. Again, helping the client to differentiate, distinguish and label internal experiences but redirecting their focus to interpersonal interaction.

activation in the therapist could be problematic because the overture is so explicit]. *And I know that having people get this close is really scary and difficult, as people have hurt you when you've shown them your distress. It makes sense why your threat system would expect me to act and think that way…But I am here and all I feel is warmth and care and admiration at your courage to go to these hard places.*	By verbally labelling their experience, the therapist challenges the mentalization difficulty in the client and leverages the different surfaces in meta-theoretical interpersonal theory to help augment the dance of mentalities in the client.
C: …	
T: Can you let that in or is there a resistance? Maybe you don't believe me, or it doesn't feel safe, or…It makes sense if you did feel that way, nothing is going wrong, its understandable this is hard, we can take our time	The therapist makes an explicit bid to encourage the client to open to the compassion. In this way, the therapist uses the CFT therapeutic relationship to create both an exposure to the caring/soothing repertoire, shaping that repertoire, engaging in flexible movement between the different interpersonal surfaces through a mentalization process, and linking past to present by co-creating a compassionate narrative that gives her permission to allow any emotional resistances to be present
C: I was resisting it but [breaths] I can let it in a bit	The client is practicing flexibility related to the flows of compassion but is still struggling. In doing so, the client is moving away from the attack-submit quadrant of the metatheoretical interpersonal theory towards the dominant-caregiving quadrant.
T: I am right here with you. These struggles are normal, they are human. Instead of getting caught in self-criticism and a drive to get it right which takes you away from your vulnerability, you are doing the brave thing in sharing this with me. It is going to hurt and it is going to take time. That's totally fine. We will go at whatever pace it takes, there is no rush or race	The therapist normalizes the client's struggles and knowing their past areas of rigidity (i.e., perfectionistic striving), affirms that the client's current level of 'success' is normal. This is an attempt to undermine perfectionist drive-based responses which appear therapist-appeasing rather than goal-congruent striving.
C: Thanks [appearing more calm and regulated]. Yeah, I need to remind myself that it is OK to struggle.	The client seems to have shifted and is receiving compassion
T: Yeah and can you give yourself that support with some warmth and caring?	Therapist checks to see if the shift has occurred
C: I can now	The client confirms that it has

T: If you couldn't that would be OK too, but I am glad that you can receive that compassion now. Just let it sink in and savor it for a moment	The therapist makes another bid to ensure that the client's response is not a pleasing-response or performative. The therapist continues to shape the repertoire of allowing care to flow-in by encouraging the client to rest their attention on that experience and to savour it
C: … [client breathing in]	
T: OK, so what would feel helpful to talk about? Is it worth spending time looking at the imagery to understand that experience or does something else feel more alive or relevant now?	The therapist provides agency to the client in directing the next part of therapy, while still tracking the flow of the session and providing containment to the client by reminding them how they got to that process-experiential guided discovery

In the current paper, the term *intrapersonal* will represent self-to-self behaviours, which is in contrast to the term *interpersonal*, which could mean self-to-other behaviour, as well as other-to-self behaviour. Despite this distinction, we note an assumption, which is that the felt sense of 'Self' can experience behavioural repertoires (e.g., self-criticism) from the perspective of either the actor, the recipient, or both [10].

2. Theoretical Context

2.1 Social Rank and Social Mentality Theory

2.1.1 Social Rank Theory

Social Rank Theory is a well-established model of dominance and submission [11, 12] in both human [13-15] and animal populations [16, 17]. It is thought that the main purpose of social dominance hierarchies is to efficiently allocate physical (e.g., food) and social (e.g., sexual mates, prestige) resources in a way that limits unnecessary competition, loss and injury [11, 14].

Since members are often striving to secure resources to advance their survival and reproduction goals, challenge for these resources can emerge; succeeding or failing in these challenges impacts one's place in the hierarchy [18]. Humans perceive these hierarchy negotiations both cognitively [19, 20] and experientially [21]. The motive to acquire more resources, status, esteem, and power is natural and results in contests for upwards movement within a hierarchy [22]. When these contests occur, one actor makes a bid for dominance and the other actor can respond with either a counter-dominating response and compete or with a withdrawing and submitting response.

From a Social Rank Theory perspective, individuals also possess an Involuntary Subordination Strategy (ISS) that is automatically elicited when one fails in a competition with another or expects to fail that competition [14]. This ISS is an automatic repertoire involving withdrawal, low motivation, negative affect, absence of positive affect, rumination, and social signals of submissiveness [14]. When confronted with a more powerful other, an "inner-referee" is activated to help individuals implicitly decide to submit or respond with a counter-dominating response [23]. If the 'inner-referee' guides an individual to submit, ISS becomes activated and the subordinated individual responds with withdrawal and inhibition. In addition to acute experiences of subordination, there are many

broader contexts where the ISS can be elicited, such as societal contexts where systemic inequities or oppressive practices are prevalent, where individuals experience a sense of stigma or exclusion from their community, family contexts where expressing needs or non-regulated self-expression is punished or contingently reinforced, or personal experiences of trying to meet a goal and being stymied. These examples are mentioned here to describe some contexts where the ISS can be elicited because these situations are often more subtle and "seeming commonplace" than one might initially think but can still result in an over-expression of interpersonal submission [24]. In other words, automatic and involuntary subordination is common, and this repertoire is shaped by our evolutionary history, social-cultural context, family history, and personal lived histories. Moreover, individuals with strong histories of involuntary subordination are often more sensitive to bids for submission and may be more likely to submit with automaticity. In some ways, their "inner-referee" becomes hypersensitive to threat and the person's capacity to notice and respond to the urge to submit becomes blunted [23]. This is relevant because there are many power dynamics evoked in a therapeutic context that might unintentionally elicit submissiveness in unhelpful ways, outside the awareness of both the clinician and client.

In contrast to bids for dominance, counter-dominance, and submission, when there is no competition for resources or threats to survival with a collective, social animals engage in bonding and cooperative behavior [25]. This promotes group selection [26] and underlies nurturance behaviors required to help infants mature to adulthood [27]. Of particular importance, is the provision of care and soothing to injured individuals [28]. This compassionate behavior serves an important function because it not only preserves the ability for injured members to continue to contribute to group survival, but also because it helps foster group cohesion and a sense of social safeness among individuals within the group [28].

2.1.2 Social Mentality Theory

Social Mentality Theory (SMT) takes a broader view of the whole person when considering interpersonal dynamics. In SMT, it is argued that humans (and non-humans) have evolved different motivational systems that promote successful completion of various biosocial goals [28, 29]. These systems allow the individual to enter a motive-oriented state of mind where their attention, cognition, emotion, and actions are coordinated to help promote survival, reproduction, and thriving in different ways [2]. Each state of mind coordinates the pursuit of different types of biosocial goals.

In this model, motivations are hypothesized to act like an algorithm that links stimulus and response [5]. As such, motives operate as organizing features that coordinate the whole person to respond adaptively to their context in that moment. In this way, enacted motives organize the function of stimuli on the basis of our evolutionary history in addition to our learning history [30]. In other words, motives contextually exert influence (sometimes outside of conscious awareness) in the ways an individual interprets and responds to stimuli. When these motives are enacted in response to social stimuli and relata, it is hypothesized that *Social Mentalities* are enacted. Social mentalities are motive oriented states of mind that coordinate the whole person in relation to social stimuli and goals. These Social Mentalities are socially mediated mindsets that coordinate the sending and receiving of social signals in a reciprocal dance with one's relational partner [31]. These mutually reinforcing exchanges serve a role in forming different types of relationships (e.g.,

competitive, sexual, help seeking). As a result of a person's social learning history, an individual may become 'encapsulated' or stuck in a specific mentality, causing a restriction in role-formation and relating (both interpersonally and intrapersonally. In CFT, we seek to promote flexible shifting between mentalities (sometimes referred to motivational switching).

Although not exhaustive, Gilbert [32] proposes five core Social Mentalities that are crucial to facilitate life tasks and engage in interactive role relationships: care-seeking, care giving, cooperating, competing, and sexual. Such Social Mentalities are served by emotions which change body states and facilitate different types of processing and action. Gilbert [32] clusters emotions into three affect regulation systems, linked to their evolved function: the Threat System, the Drive System, and the Soothing System. To support the discussion on the interpersonal processes in CFT, these distinctions will be delineated below.

2.1.3 Threat System

The threat system alerts individuals to social and non-social threats. Different emotions signal different sorts of threat; for example, disgust signals a possible biological or social contaminant, whereas fear signals a physical threat such as a fall from heights or attack by a dangerous other. The adaptive and information-processing nature of threat-based emotions also extends to the social domain where feelings of guilt signal that an individual injured another and needs to repair the relationship rupture to maintain social inclusion and cooperation, whereas shame signals a major transgression of group norms or rules and leads to involuntary submission in the hopes of being invited back into the group [33]. When activated, the threat system coordinates an entire behavior repertoire involving information processing style (i.e., narrow, rigid, increased use of heuristics, quick), cognitions (i.e., hostile attribution biases, self-criticism, criticism of others, blame, defensive justification), behaviors, and physiology. As such, the threat system promotes aversive tracking and potentiates responses that are rigid and automatic. The content and form of the behavior repertoire is also influenced by personal learning histories, which means that the specific expression of any given threat-based repertoire will differ between individuals and the stimuli which elicit the activation of the threat system will also differ between individuals.

Furthermore, as a result of their personal learning history, individuals will also learn and internalize different social scripts that create a context within which they respond to themselves, others, and the world. These repertoires of self and other relating will be under the contextual control of the threat system whilst activated, meaning that they will be more rigid, inflexible, and automatic. Because symbolic language and metacognitive abilities allow for deictic framing [34], our social learning history also results in the enacting of social scripts between our felt sense of Self and other "part-selves". For example, a person approaching a task may anticipate shame, criticism, rejection from others, and can re-create such relating within themselves as internally generated and self-focused condemnation and criticism, despite the absence of external cues or real-world threats. How individuals respond to those self-attacks has a significant impact on physiology [35] and mood [33]. As clinicians, we seek to convey signals of warmth and helpfulness. When a client has an activated threat system, these signals can actually be interpreted as dangerous or intrusive, especially if the client has a lived history where caring responses were associated with harm. As such, it is important for clinicians to remain attuned to the ways in which social signals are being received by clients and to titrate our level of warmth and affiliation (or use other interventions) to

ensure that our bids of offering help actually promote therapeutic change, rather than serving to further encapsulate clients within a threat-based social mentality.

2.1.4 Drive, Competition, and Resource Acquisition System

The drive-system motivates individuals to mount goal pursuits, counter-dominate bids for superiority from others (instead of submitting), and acquire resources including social resources like status, sexual partners, and esteem. In CFT, a goal is to help clients flexibly engage in a dance of mentalities to support behaviour that will alleviate or reduce suffering. For example, withdrawal in depression can be understood as an under-utilized or threat-blocked drive system. In addition to underutilized drive system activation, mental health difficulties can also arise because of a reciprocal and automatic shifting between Threat and Drive mentalities as an attempt to regulate the threat system emotion. For example, perfectionism, disordered eating, addictive behaviours, narcissism, hypersexuality, binge eating, and sensation seeking can all be seen as ways of stimulating the drive system to enact feelings of control, power, esteem, safety, or pleasure, which serves the function of reducing threat-based emotions.

With respect to the interpersonal dynamics in therapy, awareness of Drive system activation is important for two reasons. First because inflexible and over-use of Dive-based ways of relating to the world can result in achievement-oriented contingencies of worth and safety, which in turn, reduces sensitivity to suffering [36]. Second, because Drive system activation is readily associated with power dynamics which are implicitly embedded into a therapy relationship, where the therapist is likely experienced by the client as an expert or authority. When therapists use technical jargon, provide interpretations, or make recommendations, they are moving into a position of authority. When clients comply, it can be experienced as submission which can trigger the ISS and other threat-based repertoires (or in terms of SMT, the enactment of competitive rank-based relating). When clients experience therapist bids to give help form a position of being subordinate, their pliant responding can interfere with optimal therapeutic outcome because it reinforces a sense of self as inadequate or powerless. Similarly, many clients might experience “failures” to effectively use therapy skills as agentic failures, which can elicit shame, hopelessness, or defeat. Conversely, some clients will experience “successful” use of therapy skills as an agentic win and will experience drive-system stimulation as a result. The Drive System can cover a multitude of processes, some of which can be helpful such as experiencing joy or pride in making progress in therapy, but others can be detrimental especially when the client is responding to monitor and address criticism or approval from the therapist for its own sake. In this way, we intentionally promote self-compassion (being attuned and supportive to one’s needs) rather than self-esteem (which is related to achievement and dominance) [37]. While it is important to promote and support increased agency in the client when they are making active efforts and relishing progress to attain their goals, therapists might mistakenly overlook occasions where clients are responding to bids for approval from the therapist instead of following their (the client’s) own agenda. When clinicians track these subtle interpersonal processes, they are better equipped to provide support and recommendations in a manner that is received by the client as collaborative, which can help clients build a greater sense of dominance and mastery in the domains in which they struggle.

Many interpersonal ruptures and challenges in therapy can occur because of competition for dominance between the therapist and client, even when the therapist is not intending to seek

dominance. For example, well intentioned bids for clients to use skills or make changes in their life can be experienced by clients as the therapist taking a more powerful position of authority and "knowing what's right", which can elicit a counter-dominating response in clients (often experienced as "resistance" by the therapist). CFT is typically used for difficulties where shame, self-criticism, and self-subordination are core features of the presenting problem, and these self-to-self repertoires are frequently linked to submission, subordination and defeat. As such, according to Social Rank Theory, the collapsed or counter-dominating response in clients are more potentiated by virtue of their presenting problem, which adds more reason to track Drive System activation and dominance in session. The goal of CFT is not to promote Safeness per se, we suggest that harms or inefficiencies in therapeutic effect can occur when the Drive System inadvertently activates threat-monitoring or approval seeking. Drive System activation is important for helping clients to develop agency, experience pleasure and joy, and to articulate and pursue goals that will reduce their suffering and promote wellbeing.

2.1.5 Soothing System

Whereas the threat and drive systems are associated with activation of the sympathetic nervous system, the soothing system is associated with activation of the ventral vagal branch of the parasympathetic nervous system [37, 38]. Whilst the soothing system can be activated outside of affiliative and interpersonal contexts, for example, in relaxation training [39], it is associated, in mammals, with the attachment system and involves affective experiences related to affiliation and care. Interpersonally mediated Soothing System activation may be especially effective because humans experience reductions in distress via co-regulation [4].

Unique and important to Social Mentality Theory is the articulation of differences between caregiving and care-receiving motives and capacities. CFT helps clients differentiate their "fears, blocks, and resistances" [40] for three different "flows" of compassion: self-to-other, other-to-self, and self-to-self [1]. The clinical applications of this distinction will be discussed below; however, it is worth articulating here because it further highlights the different intrapersonal roles individuals can take whilst self-relating.

The soothing system is activated when individuals are in the context of a securely attached relationship [5] and are rooted in a motive of 'tend-and-befriend'. Safeness is differentiated from safety, where *safety* is understood as being sufficiently equipped to defend against threats and *safeness* is understood as the absence of hostile actors or needs to acquire or achieve [5]. When mammals are in contexts characterized by safeness, they engage in play, exploration, and nurturance behaviors [41]. In CFT, clinicians are instructed to intentionally monitor and track moment-to-moment experiences in clients to remained attuned to micro-processes related to threat and drive systems and to meet the client's interpersonal needs to help them shift into motives of safeness and caring [42, 43]. Moreover, clinicians are encouraged to intentionally develop social contexts characterized by playfulness, openness, authenticity, and caring as a way of helping elicit a context of social safeness. This "safeness" is differentiated from "safety" in that CFT clinicians are seeking to promote a therapeutic context where clients are free to "be" as they are (absence of threat and opportunities for exploration) as opposed to being equipped to respond to and minimize threat [44]. In concert, these processes are believed to help promote secure

attachment between the therapist and client so that clients can then develop a secure attachment relationship with themselves.

2.2 Attachment Theory

Attachment theory is an evolutionary model for understanding and predicting human behaviour in the contexts of relationships, especially with respect to emotional and interpersonal difficulties [8]. The development of adult attachment is multi-determined and influenced by early parenting experiences, salient interpersonal and shame-based experiences outside of the home during childhood and adolescence (e.g., bullying, failing an important task publicly, betrayal in a romantic relationship, abuse by a non-parental caretaker), and current interpersonal contexts. Regardless of how it develops, it is clear that attachment styles meaningfully impact interpersonal behaviour, emotional wellbeing, and therapy outcomes (see [45, 46] for reviews).

While CFT formulation and clinical reasoning acknowledges traditional attachment schemes along the dimensions of avoidance and anxiety [4], less emphasis is placed on the description of global attachment patterns than in traditional attachment research areas. Rather, CFT clinicians consider salient experiences of receiving emotional care, contingencies of worth related to attachment security, and experiences of being encouraged to pursue self-authored goals and the ways in which these domains are enacted in a client's current struggles [5]. Relevant to the current paper is the argument that attachment patterns can exist and be enacted in both state- and trait-based expressions. For example, Mikulincer and Shaver [47] have demonstrated that state-based attachment orientations can be manipulated experimentally and when secure attachment is elicited, individuals act in a manner consistent with a Soothing/Affiliative orientation, rather than a Threat or Drive based orientation.

Depending on an individual's attachment history, they may come to therapy with readily elicited transference reactions of the therapist as being judgmental, dismissive, hostile, misattuned, or other interpersonal stances that are not conducive to change [44]. Moreover, while there is a trait-based orientation towards these attachment patterns, in-the-moment experiences can elicit state-based attachment orientations that might be either helpful or hindering. From an Attachment Theory perspective, accurate and consistent attunement to a client's enacted attachment orientation is important for facilitating good therapy outcomes. By developing new lived experiences of being seen and cared for - even in the context of client-expressed anger, shame, cravings, or stigmatized behavior or identities- in the manner a client requires with the therapist, the function of interpersonal vulnerability is transformed. The therapist can then help the client either generalize new learning about interpersonal relationships to ongoing relationships or work through grief processes about unmet interpersonal and attachment needs in other relationships in the client's life. The same processes are true of the 'secure base' component of attachment, where clients feel safe and empowered to approach tasks that are difficult or anxiety provoking for them. Having a securely attached relationship with a clinician provides a context where the clinician can encourage change behaviors in a perspective that is received as collaborative and supportive. We acknowledge that positive therapy outcomes can occur independent of a securely attached therapeutic relationship as is evidenced by computer delivered therapies that have minimal or no interpersonal processes [48]. Nonetheless, we propose that therapeutic outcomes can be maximized for a wider array of clients when a secure attachment relationship is established [49].

The CFT relationship is ideally characterized by openness, play, genuineness, attunement, and helpfulness. Notably, this is not that distinct from other therapy approaches. Nonetheless, CFT takes an intentional approach to attending to the different micro-interpersonal processes that unfold in therapy and use the therapist-client relationship to help promote healing via these interpersonal processes.

2.3 Metatheoretical Interpersonal Theory

Wiggins' metatheoretical interpersonal theory [9] places individuals along two broad dimensions, dominance-submission and attacking/detached-nurturance/warmth (see Figure 1). This model has been applied in personality research where dominance is also associated with agency, submission is also associated with passivity, attack is associated with disaffiliation, and nurturance is associated with communion, openness, and belongingness [50]. This model was further elucidated by Benjamin [51] in her seminal and transformative work, Interpersonal Diagnosis and Treatment of Personality Disorders. In this work, Benjamin suggests that there are three distinct interpersonal *surfaces* that can all unfold differently both across relationships and within relationships. The three surfaces are self-to-other, other-to-self, and self-to-self. Interestingly, process-coding research suggests that dominance towards one's inner-critic is associated with lower depressive symptoms and that changes in dominance are associated with clinical gains in depression [33]. Similarly, in semi-structured interviews, it was established that intrapersonal submission was associated with higher state negative affect and that one's intrapersonal submission was not associated with trait-based interpersonal submission [10].

In CFT, we leverage interpersonal processes to facilitate greater interpersonal flexibility in clients, in particular, to support them in developing more agentic stances towards life challenges and by developing a more affiliative and supportive stance to themselves and people in their lives. CFT also uses inter-personal principles to help clients shift their self-to-self relationship styles and behaviors.

2.4 From the Interpersonal to the Intrapersonal

In CFT, self-compassion and self-criticism are conceptualized as an internalized version of interpersonal repertoires (submission, dominance, compassion, criticism; [6]). This is believed to occur through symbolic language [7] and a transitive property of social mentalities. Symbolic language orients people to stimuli that are not immediately detectible by the senses [52]. Despite the absence of sensory inputs, symbolic representations trigger bodily responses in much the same way as the represented stimuli themselves; for example, bullying or chastising oneself (as is the case with self-criticism) will result in neurological, somatic, and motivational responses similar to that which would occur if one were being bullied or chastised by another [53].

CFT clinicians both leverage and monitor the transitive properties (self-to-other, other-to-self, self-to-self) of social mentalities to appropriately encourage clients to practice both giving and receiving compassion from the self and others. This occurs in many ways, for example, if a client is struggling to respond to their distress with sympathy (perhaps due to fusion with a critical statement), the clinician helps the client increase their flexibility of moving between the various interpersonal surfaces by using themselves as a concrete interpersonal referent (see the clinical example in Table 1).

Because intra-personal patterns are conceptualized as internalized interpersonal repertoires, CFT clinicians support clients in developing more dominant and simultaneously care-based response to their felt sense of self and towards their inner-critic. This is believed to occur through a shaping process where clients both develop greater fluency in these repertoires (work through Blocks in CFT parlance) and where they transform stimulus functions of their self-to-self interactions (working through Fears and Resistances in CFT language).

2.5 Relationship Skills

In CFT, a common approach is to teach clients skills and help them develop fluency with those skills (called working through blocks) with two intentions. One intention is to help the client effectively meet their needs in important domains in their life. The other intention is to notice fears or resistances to using the skill. For example, many clients fear that using self-compassion will result in failure or rejection [54] or the experience of being kind to themselves elicits anger, disgust, or hopelessness. This dual goal straddles both directive skills-based therapy approaches, as well as interpersonal and process-based approaches to therapeutic change.

Some relationship skills that may be fostered in CFT (depending on a client's needs) include assertiveness, loosening or tightening interpersonal boundaries, relationship repair, modifying interpersonal vulnerability, emotion coaching and interpersonal attunement, ending relationships, and conversation skills [55]. Past research suggests that interpersonal skills can be trained and that interpersonal skill training is associated with prevention and health promotion [56].

In the process of teaching these skills, therapists are not only interested in helping clients learn these skills, but also work through past emotional wounds and related conditioning that are evoked when clients try to use these skills. In so doing, the clinician helps the client effectively foster safe and supportive interpersonal networks in a manner that feels emotionally safe for them. Indeed, from a CFT perspective, wellbeing requires more than strong coping skills; it requires rich and supportive interpersonal relations and space to pursue meaningful agentic tasks. Both of these goals require effective interpersonal skills and an intrapersonal relationship that is supportive and gentle.

2.6 Therapeutic Relationship

Like all psychotherapeutic interventions, the therapeutic relationship is the primary medium in which the interpersonal process in CFT unfolds. Unsurprisingly, in CFT, clinicians are encouraged to use the therapeutic relationship intentionally to help facilitate change [32]. Although a full discussion of the therapeutic relationship in CFT is outside the scope of this paper, a brief account of how the therapeutic relationship promotes change is provided. There may be at least four mechanisms by which this occurs but future research is required to support these mechanisms and explore whether other mechanism might be present or more important.

One potential mechanism involves using interactions within the therapeutic relationship as a means of assessment; for example, the therapist might pay attention to how the client receives direction and guidance, is able to assert their needs, or how they react to bids for intimacy or care [57]. This assessment can be formal guided discovery, but more importantly, it takes the form of the therapist being attuned to moment-to-moment shifts in the client's non-verbal signals of threat, as well as the therapists' own threat-system activation [57]. Because most clients enter therapy with the goal of receiving help in some way, the gross social overtures are often those of cooperation

and help seeking; however, by remaining intentionally attuned to both therapist and client threat-system activation the therapist can help identify fears and resistances that are just outside the client's realm of awareness, which can lead to important lines of intervention [57].

A second mechanism that could be addressed through the therapeutic relationship is by enacting and supporting the dance of mentalities, aiming for flexibility rather than encapsulation in one mentality or reciprocal exchange [57]. By enacting the dance of mentalities from an attachment-based perspective, the therapist is attuned and supports both exploratory soothing-related behaviours and celebrates those in appropriate ways, while also receiving and caring for emotional wounds and unmet needs that unfold as clients direct their lives. This process might be supported when therapists have an accurate trust in their clients' abilities, are accurately attuned to their client's emotional pain, are freedom giving and encouraging, hold accurate hope and optimism and express that to clients, and provide a context of emotional warmth. In this present-moment and experience-focused interchange between therapist and client, the client is supported in allowing and feeling any interoceptive experience related to both goal pursuit and nurturance [44]. Related to this is an ongoing awareness of cues of dominance and submission. When therapists use technical language, give direction and suggestions, or provide interpretations, they are taking a dominant role unless done in collaboration with, and driven-by, the client. Because compassion can never come from a place of powerlessness and submission [58], clinicians aim to provide only as much support as needed to help clients move in a productive direction with the goal of facilitating an empowered and agentic stance in the client. Some more subtle ways clinicians might inadvertently take a dominant role relate to how the room is set up (ideally both parties have similar seating, not behind a desk, equal access to beverages and the type of cup, etc.), how admin and supports staff interact with clients and respond to scheduling and other challenges that inevitably occur (e.g., avoiding experiences of 'you are inconveniencing us with this'), and discussions about the logistics of therapy (spending time discussing the client's feelings as they come to therapy for the first session, collaborating on the goals of the first session rather than assuming it is an assessment session, respecting client's schedules and life challenges, etc.). By being attuned and responsive to these dynamics, clinicians could potentially model a flexible shift between different mentalities while also creating opportunities for clients to inhabit different social positions in a way that facilitates a flexible shifting of different mentalities [57].

A third potential mechanism is by modelling compassion and using process-based and process-experiential interventions to help the client internalize this model of compassion. For example, disclosing motives of caregiving and feelings of acceptance, non-judgement, and warmth in response to suffering and then supporting clients in noticing that, allowing it to flow-in, and eventually noticing their own feelings of warm, non-judgement, and self-acceptance and allowing that to flow-in [5]. Related to this is the coaching of compassionate skills and standing in to provide compassion when clients are unable to do so themselves. For example, in CFT chairwork, clinicians are encouraged to take the role of an inner-caregiver or inner-defender if the client cannot do so themselves and enact that role for the client until the client can internalize and enact it themselves [59].

A fourth potential mechanism is using the therapy relationship as exposure. Clinicians are encouraged to titrate their levels of warmth, emotional expressiveness, excitement, and freedom giving to meet the level of readiness in their clients. When this process is relevant for clients,

clinicians disclose the use of the relationship as exposure and get consent from clients to "play" with these dynamics to explore and discover their needs and then to pursue those needs [57].

Through these processes, the social space facilitates authenticity, playfulness, and a willingness to explore threat reactions and protective strategies without fear of judgment or reprisal. The social context is one of warmth, playfulness, encouragement, and tenderness.

3. Clinical Example

In this next section, we provide an example of how the theory described above might be enacted in session. We chose a frequent example that is an amalgam of many clients. Rather than describing a formal technology (like imagery), we seek to demonstrate an interchange that reflects the process-based nature of CFT and how the interpersonal processes described above might be leveraged to promote the client's flexibility in giving and receiving compassion. The left column portrays either the client (C) or therapist (T)'s dialogue and the right column portrays commentary on the interpersonal processes unfolding in the dialogue. In this example, the therapist's aim is to notice, understand, and prioritize the caring for the felt sense of Self in the client.

This hypothetical exchange takes place following the therapist's guidance of compassionate other imagery. This exercise involves the client creating an imaginal being that embodies compassion, extends their care to the client. As the client opens their eyes, and re-adjusts, they avert their eyes and become quiet. Although they respond to debriefing questions, there is a stilted reticence to their vocal quality and volume. Rather than debriefing the imagery, the clinician notices non-verbal cues associated with Threat System activation, submission/withdrawal, and the enactment of avoidant attachment patterns, and asks about the client's current experience.

The creation of this example and commentary on interpersonal process was jointly created by all three authors. The example was written by the first author after discussing a scenario with the writing group, and then the example and its commentary were iteratively revised over several months by all three authors. All three authors are clinical psychologists or psychotherapists who use CFT in their practice, conduct research on CFT, and provide teaching and training in CFT. All three authors have a shared focus on evidence informed CFT interventions. Additionally, the first author's focus centers on adolescents, caregivers, and evidence informed clinical teaching; the second author's focus centers on chairwork, process based CFT interventions and the multiplicity of self, as well as, evidence-informed clinical teaching; and the third author's focus centers on examining the effectiveness of compassion focused approaches for parents, adults with depression, as well as the neurophysiological changes that occur across compassion focused therapy programs.

The following example depicts an interchange with a professional in their early-to-mid forties. The client is generally overcontrolled and struggles with severe self-criticism. She has made slow but steady gains in therapy and the following example occurs within the context of a strong therapeutic relationship. The client has already completed psychoeducation on the purpose and goals of CFT and has been engaged in the therapeutic process for approximately two months. The themes of her self-criticism center around being inadequate and are often elicited when either she fails to meet an internal standard of behavior or when she expresses her needs. Rather than focusing on formulation, the following example attempts to demonstrate an ongoing sensitivity to the client's moment-to-moment changes experience and the therapist's attempts to promote both agency and safeness and a secure client-therapist attachment process.

In the above interchange, the therapist remained attuned to the client's moment-to-moment unfolding of experience. By frequently taking a stance of freedom giving, the therapist is subtly encouraging the client to take a more dominant and agentic role in the interpersonal exchange. Social Mentality Theory would suggest that when clients are entering this more empowered stance interpersonally, they will be more able to use that same capacity in self-to-self relating. Throughout the above interaction, the therapist also made several bids for connection to let the client know that she was not alone. In this, the therapist is moving towards enacting a securely attached interchange. Relatedly, the therapist also used self-disclosure to demonstrate authenticity, made a joke to convey that it is a safe place and OK to struggle, and continued to check-in with how the client was experiencing the interchange in the moment. Lastly, the therapist is actively shaping Compassionate Skills and Attributes (Figure 1) by encouraging the client to practice perspective taking, notice resistances to allowing compassion to flow-in, and savor and allow compassion to be there. The exchange began with the therapist guiding the client to allow and feel her emotions fully, which is another CFT skill (see Figure 1). By helping the client differentiate between how they would see themselves VS how the therapist sees them, the therapist gently moves the client towards a motive of caregiving and care receiving while also building skills related to Empathy and Compassionate Reasoning. This example shows how ongoing attunement to client micro-processes and interpersonal dynamics can result in important clinical work. Although this example was in response to an imagery task, a similar subtle shutting down can occur after practicing compassionate reasoning, exploring barriers to completing exposures or experiments, disclosures of interpersonal difficulties outside of therapy, or any other 'typical' therapeutic task. The above example demonstrates how an ongoing sensitivity to the client's felt sense is an essential interpersonal task in CFT and other process-based therapies. It should be noted that the specific phrasing of clinical overtures will differ between clinicians. In this example the clinician is using authentic responses rather than 'canned' compassionate phrases. We propose that authentic expression of self, rather than pre-rehearsed phrases, is a component of empathic attunement. We also propose that demonstrating caring is more important than 'saying you care' and that this is largely conveyed through non-verbal communication and accurate reflections.

4. Summary

In this paper, we sought to describe the interpersonal processes in CFT and to discuss the therapeutic application of these processes. We outline various interpersonal theories as they relate to CFT in the hopes of advancing research agendas that will empirically evaluate the processes and mechanisms described above. We also outline various components of CFT from an interpersonal lens to add clarity to the field. In particular, we discuss some of the interpersonal content in CFT (teaching compassion skills, interpersonal skills, exposing clients to interpersonal signals and shaping effective responses) and the ways in which responding to the moment-to-moment interpersonal processes can facilitate or hinder change.

We discuss Social Rank Theory and Social Mentality Theory to encourage clinicians to track the mentality of their client and to note how clients can misinterpret advice, teaching, and interpretation as a bid for dominance by the therapist and how that can promote unhelpful responses in the client. We go on to discuss attachment theory and how CFT uses mentalization and the therapeutic relationship to promote exploration and agency while also signaling that clients can

recover from emotional pain in a non-judgmental and supportive therapeutic context. We discuss the various dimensions and interpersonal surfaces in Metatheoretical Interpersonal Theory and how these can be leveraged to help clients internalize interpersonal repertoires into self-to-self interactions. Specific use of CFT technologies and the therapeutic relationship are also discussed in relation to these other domains.

We acknowledge that other therapies also address the therapeutic process in therapy. In particular, Interpersonal Behavior Therapy [60], Functional Analytic Therapy [61] and Accelerated Psychodynamic Psychotherapy [49] focus explicitly on the domains addressed in this paper. We are excited and encouraged by the burgeoning interest in the explicit leveraging of interpersonal process to promote change in clients. We hope that this paper adds to the discussion and promotes future empirical research in the area.

Indeed, we end with a call to action - urging the evaluation of interpersonal processes in contextual-behavior therapies as a mechanism of therapeutic change themselves. In a world with increasingly short and computer-delivered therapies [62], we argue that there are specific interpersonal processes in therapy that can be leveraged to promote change and urge researchers to describe and evaluate those processes.

Author Contributions

Eli Cwinn and Tobyn Bell developed the initial idea to integrate the various theories to create a possible framework for teaching and researching the interpersonal process in CFT, as well as, the theme of the clinical difficulty in the case example. James Kirby reviewed and augmented the integration of the theories and focus of the clinical example. Thereafter, through an iterative process, all three authors contributed to writing, deepening and clarifying the theory and clinical example, and proof reading and finalizing the manuscript.

Competing Interests

The authors have declared that no competing interests exist.

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