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The Compassionate Kitbag: A creative and integrative approach to compassion-focused therapy

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Purpose. This paper outlines the concept of the 'Compassionate Kitbag', a novel multi-sensory-based means of helping draw together the various elements of compassionate mind training and processes within compassion-focused therapy (CFT), to help clients cultivate and facilitate their capacities for compassion. Building on the work of Lucre and Corten (2013, *Psychology and Psychotherapy: Theory, Research and Practice*, 86, 387), this is the first published work exploring this concept and the theoretical underpinnings, with a specific focus on how this can be used to support people with attachment and relational trauma.

Methods. A narrative review of the literature on multi-sensory stimulation in facilitating people's capacities for compassion was conducted, coupled with a review of the literature of the use of non-human and transitional objects as explained by attachment theory and the broader scientific research underpinning the CFT model.

Results. Clinical examples of how to use the Compassionate Kitbag to help stimulate compassionate therapeutic processes demonstrate the benefits of and how to begin utilizing this approach in compassion-focused work with clients with complex needs.

Conclusions. The Compassionate Kitbag's potential therapeutic value lies in offering multifarious creative and tangible means of accessing compassion to a wide range of individuals whom are typically fearful of, blocked, and/or resistant to compassion. Further research into the wider application of the concept of the Compassionate Kitbag is needed.

Practitioner points

- Many patients with ruptured and/or traumatized early attachment relationships can find more traditional talking therapies difficult to access.
- Compassion-focused therapy (CFT) can offer an evolutionary-based understanding of interpersonal difficulties which can be helpful for such patients.
- Creatively harnessing and utilizing multi-sensory and non-linguistic social signals in CFT is key to exercising the care-giving and care-receiving social mentalities that facilitate compassionate flow.
- There is considerable evidence to support the use of a multi-sensory component to the therapeutic work to help patients cultivate and facilitate their capacities for compassion.

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- The Compassionate Kitbag can be a way of supporting patients to create concrete representations of compassion in the context of the compassionate mind training component of the therapeutic work. Some of these objects can become transitional objects which can aid the therapeutic work.

Understanding the challenges of working therapeutically with attachment trauma

Undertaking psychological therapy with clients who have complex attachment and relational trauma can be exceedingly challenging for both client and therapist. This often results in such individuals being found unsuitable for psychological therapy, repeating a familiar pattern of rejection and disappointment (Pearlman & Courtois, 2005). Equally, many such individuals are unable to engage in and complete therapeutic interventions and dropout rates remain high (McMurran, Huband, & Overton, 2010). It is possible to link the complex and often confusing presentation of this group with the prevalence of childhood maltreatment, often in the form of intrusive or abusive caregivers and ruptured or absent early attachment relationships (Schore, 2003, 2015). Such experiences can have an enormous impact on the developmental trajectory, operation and functioning of evolved psychobiological and neurophysiological systems, such as the attachment and social rank systems (Liotti & Gilbert, 2011; Sloman & Taylor, 2016). Gilbert, Cheung, Grandfield, Campey, and Irons (2003) describe the social rank system as an evolutionary development in the context of increased group-based societies, which functioned to keep social order and can also been seen clearly in the mammalian kingdom. This rupture in the development of these systems typically manifests in the individual having a severely compromised ability to feel socially safe (Gilbert, 2005a, 2010; Kelly & Dupasquier, 2016), seek appropriate care and support, and self-soothe (Sloman & Taylor, 2016; Gilbert & Procter, 2006; Gilbert, 2010, 2015; Gallop, 2002), and a multitude of shame-based difficulties (Andrews, 1998; Feiring & Taska, 2005; Gilbert & Irons, 2005; Karan, Niesten, Frankenburg, Fitzmaurice, & Zanarini, 2014; Matos & Pinto-Gouveia, 2010; Matos, Pinto-Gouveia, & Costa, 2013; Pinto-Gouveia & Matos, 2011).

Often these individuals will present to services with a complex history of relational difficulties including a pattern of abusive or abusing relationships in their adult lives, which replicates the early trauma dynamic. These defensive strategies often play out in the therapy room, making it extremely difficult for such individuals to benefit from some forms of therapy such as cognitive behavioural therapy (Rector, Bagby, Segal, Joffe, & Levitt, 2000; Stott, 2007). Indeed, such individuals are often categorized as having a *severe personality disorder* which has been linked to questions about amenability to psychological therapy. Therefore, providing effective psychotherapies and community-based services for this group has remained a challenge to mental health service providers (Crawford *et al*., 2008). In order to develop the capacity of services to engage with such individuals, there is a need to explicitly work creatively at the deeper emotional and body-focused/sensory-motor level, with therapies now being developed that understand the impact of trauma on our neurobiology and neurophysiology (Fay, 2017; Ogden & Fisher, 2015; Ogden, Minton, Pain, Siegel, & van der Kolk, 2006; Payne, Levine, & Crane-Godreau, 2015; Van der Kolk, 2015).

Compassion-focused therapy

Compassion-focused therapy (CFT) is a motivational, integrative, and multimodal approach to working with shame and self-criticism (Gilbert, 2009, 2010, 2014), specifically developed for individuals with complex mental health difficulties (Gilbert & Irons, 2005; Gilbert & Procter, 2006). A central focus in CFT is to help people develop

affiliative motives, emotions, and competencies underpinning compassion that play important roles in threat regulation, well-being, and prosocial behaviour (Gilbert, 2014, 2015, 2017a). As such, this model is well placed to offer therapeutic opportunity to those whose capacity to engage meaningfully with themselves and others has been compromised by early trauma.

Central to CFT is a model of affect regulation referred to as the 'Three Circles' model (Gilbert, 2005a, 2009, 2014; Kelly, Zuroff, Leybman, & Gilbert, 2012), which is derived from and integrates work on threat processing (LeDoux, 1998), positive and affiliative emotions (Depue & Morrone-Strupinsky, 2005), and more complex models of emotion (Panksepp, 2010). Through the lens of *evolutionary functional analysis*, CFT proposes that humans have evolved (at least) three such emotion regulation systems: (1) the Threat and Self-Protection system; encompassing threat emotions (e.g., anger, anxiety, disgust) and associated defensive behaviours (e.g., fight, flight, freeze, submit, immobilize) that serve the functions of (rapid) detection and response to threats and to keep safe/harm-free; (2) the Drive system, encompassing activating/energizing emotions and those linked to rewards (e.g., drive, excitement, joy, pleasure) that serve the functions of detecting, seeking out, and acquiring resources that are essential to survival and reproduction; and (3) the Affiliative/Soothing system, encompassing affiliative emotions (e.g., contentment, soothing, safeness), and serving the functions of detecting and responding to cues of (social) safeness that facilitate calming, settling, quiescence, peacefulness, 'rest and digest', and openness. This latter system has been adapted/co-opted through evolution for some of the functions of affiliative and attachment behaviour (Porges, 2007; Uvnäs-Moberg, 2013), in that the care, kindness, support of and connection to others helps to calm us down. Importantly, the Affiliative/Soothing system is proposed to be the natural regulator of the Threat and Drive systems.

These three systems are in a constant state of interaction and co-regulation, influenced by an individual's social shaping and emotional learning. People who have experienced complex relational trauma typically struggle with over-activity of and regulatory problems with the Threat system, related to under-activity of and inaccessibility to the Affiliative/Soothing system (Lee & James, 2012; Lucre & Corten, 2013).

Additionally, CFT proposes that evolved *motives* organize the mind and body and that the relative balance, operation, and co-regulation of these three systems are dependent on the underlying *social mentality* that is operating and/or predominant at any one time (Liotti & Gilbert, 2011). Social mentalities can loosely be described as a collection of evolved motives that coordinate patterns of attention, emotion, cognition, and behaviour in the service of orienting us towards, co-creating and enacting certain (social) roles with others that are essential for survival (Gilbert, 1989, 2000, 2005b, 2017b). Furthermore, as a consequence of the uniquely human evolved new brain abilities (i.e., socially intelligent competencies), social mentalities are proposed not only to be activated in relation to others but also in *self-to-self* relating (Gilbert, 2005b, 2017b; Hermanto & Zuroff, 2016). In order for compassion to flow optimally towards the self, both the *care-seeking* and *care-giving* social mentalities need to be simultaneously activated, recruited, and coordinated (Gilbert, 2005b; Hermanto & Zuroff, 2016; Hermanto, Zuroff, Kelly, & Leybman, 2017).

A central theme and premise of this paper is the need to harness powerful (often multi-sensory, body-focused, and non-linguistic) social signals, through various creative means, to start exercising the care-giving and care-receiving social mentalities. These social mentalities are typically under-activated and/or thwarted in individuals with complex relational trauma, instead having to rely on operating from (threat-focused) social rank mentalities where any sense of safeness is feared and/or absent. Within CFT, it is these

imbalances in the system which provide the rationale for the importance of compassion and compassionate mind training (CMT).

Compassion, safeness, and the dual functions of soothing and courage-stimulating

Compassion is clearly defined in CFT as 'a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it' (Gilbert & Choden, 2013). This encompasses two separate but overlapping and complimentary psychologies: (1) *Engagement*, requiring the development of competencies to effectively engage with (as opposed to turning away from, avoiding, being insensitive and/or indifferent to) suffering; and (2) *Action*, requiring the development of skills and competencies to wisely and courageously alleviate and prevent suffering (Gilbert *et al.*, 2017). Compassion in this context is also made up of three distinct but overlapping flows, to the self, from the self to others and from others to the self (Gilbert, 2017b).

Compassionate mind training within CFT, and in keeping with polyvagal theory (Porges, 2007) and neurovisceral integration theory (Smith, Thayer, Khalsa, & Lane, 2017), stresses the importance of stimulating vagal pathways that also influence heart rate variability (HRV) and thus optimal functioning of the prefrontal cortex but also mind–body integration (Kirby, Doty, Petrocchi, & Gilbert, 2017; Petrocchi & Cheli, 2019) (cf. Petrocchi & Cheli, 2019; Porges & Dana, 2018). These neurophysiological systems and processes are responsive to (social) signals and cues of *safeness* that leads to a sense of *social safeness*. CFT defines social safeness as a warm, calming affective experience of feeling cared about, reassured by and connected to other people (Gilbert *et al.*, 2008; Kelly & Dupasquier, 2016), that not only gives rise to states of contentment but also the corresponding openness and freedom to explore. CFT thus makes a very important distinction between safety and safeness. Safety is associated with constant vigilance to, escape from, and/or avoidance of threat, in that clients can feel threatened and unsafe thus activating the survival-focused Threat system. The motivation is to escape with the associated emotions of fear, anxiety, and anger. So, in the context of developing compassion, the capacity to self-soothe is only one aspect, with the other being courage-stimulation (i.e., motivating and invigorating).

This is supported through the vast work on attachment security (Mikulincer & Shaver, 2007). Having an inner safe haven, secure base, and related sense of inner (social) *safeness*, as indicated by attachment security, has been linked to increased compassion, behavioural and psychological flexibility, prosocial feelings, and care-giving behaviours (Mikulincer & Shaver, 2009; Mikulincer, Shaver, Gillath, & Nitzberg, 2005). Secure consistent attachment figures provide a secure base for the child and an important means of threat regulation, whereas inconsistent, uncaring, or over-controlling primary attachment figures fail to provide a secure base/safe haven function and this can link to the development of a disorganized attachment style (Bateman & Fonagy, 2004; Holmes, 2004).

CFT for people with attachment trauma

Within the psychotherapeutic process of CFT, the issue of ruptured attachments is addressed initially through the explicit teaching, training in the cultivation of compassion to the self, to others, and to tolerate receiving it from others (Gilbert *et al.*, 2017). The CMT focus of this aspect of the work is to develop a safe haven within the therapy space to enable habitation to the experience of social safeness and in time to enable the movement

to a secure base. Lucre and Corten (2013), in an early group work programme for people with a diagnosis of personality disorder, found that the experience of shame reduced in the context of group members reporting a sense of safeness from the 'comfort of shared group experiences' (p. 9). Often in the early stages of the therapeutic process, in groups and individual settings, it is helpful to titrate the explicit offering of compassion, validation, and soothing to enable the individual to habituate to the experience of warmth from another (Bates, 2005; Cuppage, Baird, Gibson, Booth, & Hevey, 2018; Hermanto *et al.*, 2017; Lawrence & Lee, 2014). The explicit, consistent, and gradual experience of compassion from others, coupled with the invitation to offer compassion to the self in time, offers an opportunity for this experience to be internalized and form part of the client's 'internal working model' (Holmes, 2004).

Sensory stimulation, use of objects, and transitional objects in CFT

Research suggests that many people with a diagnosis of borderline personality disorder report weak imagery ability and its inhibitory effects, in subsequently experiencing less positive affect following attempting to engage in compassion-focused imagery (CFI) tasks (Naismith, Ferro, Ingram, & Leal, 2019). These difficulties in being able to receive and give compassion to themselves are in the context of having experienced adverse childhood experiences (ACEs) such as abuse, invalidation, neglect, and lack of warmth (Naismith, Mwale, & Feigenbaum, 2018). Such experiences typically differentially lead to low self-compassion and/or high fear of self-compassion (Naismith *et al.*, 2018) but also related fears of receiving compassion from others (Naismith *et al.*, 2019). A paucity of experiences of receiving compassion from others leaves little to no emotional memories of safeness to draw on and thus a severely compromised ability to soothe/regulate oneself (Naismith *et al.*, 2019).

In further helping facilitate their capacities for compassion, early research suggests that engaging multi-sensory modalities (Naismith *et al.*, 2019) is one helpful way that those with such low imagery abilities and who are fearful/unfamiliar with self-reassurance can start to benefit from the elements of CMT integral to CFT. This research is supported by an early CFT group work programme for people with a diagnosis of personality disorder who identified the significance of the use of objects and the experience of transitional objects, such as 'I still have my stone and use it often to ground my thoughts, sometimes I use it just to remind me that there are others out there who understand' (Lucre & Corten, 2013, p. 9).

Winnicott (1971:1) in his writings on child developmental theory, developed the idea of transitional objects as the first 'not me' possessions that the infant makes a connection to. These objects are generally used by the child to soothe and placate when the primary attachment figure is absent. Over time and with the development of emotional maturity, this process is internalized and the need for the actual object therefore becomes redundant (Winnicott, 1971). Despite the obvious significance of the transitional objects within the child development literature, there has been comparatively little literature detailing the function in adult psychotherapy (Arthern & Madill, 1999).

In early developmental stages of childhood, the transitional object supports the process of attaching to and managing absence from the primary attachment figure. Arthern and Madill (2002) also link to the particular difficulty for patients with attachment trauma who often find it difficult to internalize the experience of the therapist in the absence of a secure internal attachment template. Bateman and Fonagy (2004) have identified the specific difficulties that patients with a diagnosis of borderline personality disorder experience in mentalizing, that is, holding mind in mind, and therefore having a

concrete symbol of the positive regard of the therapist can be helpful to mediate the often-overwhelming feelings. This is supported by recent neuroscientific data showing that transitional object usage in a group of female patients with a diagnosis of borderline personality disorder activated attachment-related neural circuitry in the right prefrontal and orbito-frontal cortex, which was not the case when compared to using other familiar or unfamiliar objects (Kiefer *et al.*, 2017). The functions of these were to cope with feelings of anxiety about abandonment by significant others and for emotion regulation (Kiefer *et al.*, 2017). The transitional object can also serve the function of the secure base to mediate the impact of threat-based stimuli which could be the material that the patient brings to the therapy space (Keefer, Landau, & Sullivan, 2014).

Arthern and Madill (2002) also illustrate the significance of the ritual which is often associated with the use of the transitional objects in early childhood, within the CFT therapy space there is also ritual associated with the availability of such objects, which are present every week with the explicit invitation to take whenever needed. However, the invitation to take objects from the therapy as a gift from the therapist or group members has the additional important function of symbolizing the developing sense of a compassionate self which in the early stages of therapy the client will often struggle to hold in mind (Arthern & Madill, 2002; Lucre & Corten, 2013). Within CFT, this emerging sense of self can be linked with the cultivation of the compassionate mind, the capacity to engage with the flows of compassion to the self, to others, and to receive from others and in time put this compassion to work to turn back to the suffering. Additionally, clients are invited to bring objects to the session which already have a particular significance, so that the objects can be held and seen by the therapist and group members, often playfully. These could be already a transitional object or the experience of bringing them to the therapy session can shift the significance. The group members and/or therapist can take on a role of a mentalizing other, imbibing the objects with interest in, approval and validation. Clients, in this context, report an experience of feeling validated by the passing of objects to others which can be linked to the value of haptic touch in deepening an emotional connection to the objects.

Transitional objects in CFT with a *multi-sensory* focus can be extremely powerful and helpful for individuals with a paucity of experiences of soothing and safeness. A client with a history of complex trauma came up with the idea of having a soft huggable object that they could also put in the microwave (to very literally experience warmth) and this was also infused with their chosen compassionate smell. Upon introducing this, the client's ability to sleep gradually improved alongside managing flashbacks during the night. By placing it on their neck where they were held during past abuse, this process seemed to act as a form of somatic reversal involving haptic perception, somatic experiencing, and memory reconsolidation (Elbrecht & Antcliff, 2014; Högberg, Nardo, Hällström, & Pagani, 2011; Payne *et al.*, 2015), slowly beginning to change the nature of the imagery they experienced. There also seemed to be a positive impact on the flow of compassion in that the client reported feeling more able to receive compassion from others. Over time, the function and meaning associated with the transitional object developed and deepened to provide both safe haven and secure base functions, that is, facilitate soothing but also stimulating the courage to begin to explore. The above example demonstrates how transitional object usage can draw on and integrate ideas from attachment theory (Bowlby, 1988; Feeney & Collins, 2015; Mikulincer & Shaver, 2007), social thermoregulation theory (IJzerman *et al.*, 2015; Ijzerman, Heine, Nagel, & Pronk, 2017), social touch (Maratos *et al.*, 2017; Morrison, 2016; Uvnäs-Moberg, Handlin, & Petersson, 2015), and huggable communication mediums (Nakanishi, Sumioka, &

Ishiguro, 2016; Takahashi *et al.*, 2017). Furthermore, this links back to Harlow's (1958) work with infant monkeys in discovering the importance of soft tactile sensations accompanied by (physical) warmth in imparting the emotional security (i.e., safeness) to explore (Harlow & Suomi, 1970).

Humans have a seemingly unique ability to attribute human-like qualities to material objects, which emerges out of evolved 'new brain' abilities and competencies for social intelligence that have greatly influenced our survival and flourishing (Gilbert, 2017a, 2017b). Research indicates that the tendency for humans to attribute human-like mental states to objects – anthropomorphism – increases when people feel lonely and thus activates motives for affiliation and belonging (Epley, Waytz, Akalis, & Cacioppo, 2008). Intriguingly, individuals higher in trait anthropomorphism not only report greater feelings of security when reminded of a favourite object (as opposed to a close other), but also express greater motives for personal growth (Keefer, 2016). From a CFT perspective, transitional objects can be further creatively used to harness and develop our evolved new brain abilities and competencies, such as the imagination to endow an object with a mind, motivation, and mental/emotional states. One of the functions of endowing an object with such capacities acts to gradually introduce receiving compassion from others in conditions of greater autonomy and therefore safeness. Over time, the client can internalize the function of the transitional object and begin to develop the capacity for self-compassion more explicitly.

Introducing the Compassionate Kitbag

Lucre and Corten (2013) established the need for concrete representations to accompany the compassion-focused work for people with attachment trauma. As previously outlined, various forms of non-human support can provide the safe haven and secure base functions afforded by human attachment figures (Bell & Spikins, 2018; Keefer *et al.*, 2014). Humans' tendency to seek out and derive a sense of security from non-human sources of support typically emerges under conditions of threatened, unreliable, or absent connections to close others (Keefer, Landau, Rothschild, & Sullivan, 2012). Furthermore, receiving some form of physical contact with certain objects which are imbibed with emotional significance can mitigate against the negative effects of social exclusion, whilst simultaneously increasing prosocial behaviour (Tai, Zheng, & Narayanan, 2011).

Self-soothing bags, boxes, and kits are not new concepts and are used in other therapeutic modalities such as dialectical behaviour therapy (Linehan, 1993, 2014) and trauma-focused psychotherapies. The use of these typically serves the function of helping to develop and stimulate people's capacities for self-soothing, that may have been severely compromised by early traumatic experiences and attachment ruptures. Recent research indicates that personalized self-soothing kits for adults in mental health services, containing multi-sensory and multimodal items, can have significant positive effects on arousal and emotion regulation, and increased participation in valued current and future roles (Sokmen & Watters, 2016).

The rationale for a 'Compassionate Kitbag' as opposed to a 'toolkit' or 'first aid kit' is an important distinction: A toolkit implies something is broken and needs to be fixed, and a first aid kit equally implies injury and something you only use in an emergency. A kitbag however, as the concept is derived from and used within the context of mountaineering, is something which contains the necessary and essential items to nourish and sustain along the journey. This fits with the concept of self-compassion as a journey which is undertaken

and continued through the course of one's life and not merely an activity to be mastered. Equally, focusing the attention of the kitbag solely on developing the capacity for soothing can create confusion for patients who may mistakenly believe that soothing and compassion are synonymous. It is of significance to the therapeutic process to make the distinction, in that soothing is only one element of the multidimensional nature of compassion, which importantly includes strength, courage, and wisdom (Gilbert, 2017b). This confusion can often lead to self-compassion being rejected as something which will weaken rather than strengthen the individual, and so making this distinction (and their complementarity) is crucial.

A Compassionate Kitbag will likely contain many diverse sensory objects and items that can be powerful and rapid non-verbal ways of accessing and stimulating states of safeness (and thus compassion), with the dual purpose of both self-soothing and courage-stimulating. It is of note that the kitbag will also contain objects which represent imaginal processes or attributes. Crucially, the Compassionate Kitbag allows client and therapist to harness the full range of ways to cultivate compassion. This is particularly important for chronically traumatized individuals who often struggle with typical and foundational CMT practices such as breathing or imagery (Naismith *et al*., 2018), and thus is more attuned to the emotional developmental level and competencies of this client group (Pascual-Leone, Gillespie, Orr, & Harrington, 2016).

The Compassionate Kitbag therefore provides a way of drawing together the CMT elements of the therapeutic work. It is important, however, to be clear that the practical techniques are woven alongside the process-driven nature of the therapeutic work which aims to stimulate motivational systems and processes, rather than working just at a symptomatic level.

The multi-sensory components of the Compassionate Kitbag

Compassionate smells

The olfactory system is an extremely powerful and rapid means of attempting to influence and helpfully impact on a whole array of neurophysiological, emotional, and sensory-motor processes. Smell and odour-evoked memories are viscerally powerful because they are somewhat uniquely privileged and processed by the amygdala–hippocampal complex of the limbic system (Herz, 2016), and thus, odour-evoked memories tend to be more emotional than those elicited by other sensory stimuli (Herz & Cupchik, 1995; Herz, Eliassen, Beland, & Souza, 2004; Herz & Schooler, 2002). These are areas of the brain that process emotion, associative learning, and memory (Herz, 2016), and there are likely sound evolutionary reasons why such olfactory processes are privileged over our other senses (Lübke & Pause, 2015; Stevenson, 2010). Crucially, odour-evoked autobiographical memories that are associated with positive emotions can induce a whole array of physiological responses, including increased positive and decreased negative mood states, reduced heart rate, and improved immune functioning due to inhibition of systemic inflammation (Matsunaga *et al*., 2011).

As the olfactory sense is one of the most powerful of all of our senses, emphasis is placed on the exploration and discovery of a compassionate smell, something which is stimulating or soothing. These 'smells' are brought to the session and can be used as part of (a) the initial breathe and intention-focusing aspect of the therapeutic process; and (b) for more targeted purposes such as grounding and managing flashbacks (Lee & James, 2012). The nature of these smells is of course diverse and unique to each client, which specific

connections and associated emotional memories. One such example was a client with eating-related difficulties who found that the body focus during the initial soothing rhythm breathing (SRB) practice triggered early trauma memories. She found a solution to this difficulty through the discovery of the soothing properties of pine tree oil, which connected her to being in a forest which was her calming/welcoming place (otherwise referred to as safe place). This enabled her to engage in the practice and access a sense of soothing. Over time, using the oil she was able to shift attention to the sensation of the breath, noticing but not being triggered by the body memories.

Through a process of conditioning/associative learning (Herz, 2012, 2016), these smells may also over time become associated with a growing sense of safeness with the therapist and thus be a powerful way to evoke similar feelings when away from the therapy room. This is perhaps particularly important for those individuals who struggle with exercises such as safe place imagery, who may have little to no experiences in their lives of ever having experienced safeness in *any* context, but may gradually be able to experience, access, and (eventually) internalize this with the help of a compassionate smell.

Compassionate music

There are many important references to the evolved functions of music (Schulkin & Raglan, 2014). Music is often used in everyday life for the functions of affect regulation, mood evocation, and self-enhancement (Elvers, 2016; Saarikallio, 2011; Van Goethem & Sloboda, 2011), and is an incredibly powerful means by which not only to evoke specific emotional but also influence underlying *motivational* states. Neurophysiologic research suggests that different types of music differentially impact activation in the prefrontal cortex and on indices of HRV, with excitatory (invigorating) music associated with higher vagal withdrawal (Bigliassi *et al*., 2015) but that both excitatory and calm(ing) music significantly impact on aspects of *parasympathetic* rather than sympathetic nervous system activity (Bigliassi *et al*., 2015; Iwanaga, Kobayashi, & Kawasaki, 2005). Such data thus support the proposition of polyvagal theory that music directly engages and exercises the social engagement system (Porges, 2011). From the perspective of social mentality theory that is an integral part of CFT, the social signals sent through and communicated by music would have the power to stimulate particular social mentalities in the receiver, as music is inherently (socially) relational (Aucouturier & Canonne, 2017; Elvers, 2016). This is supported by recent research into the social cognition of music (Aucoutrier & Cannone, 2017), in part due to the intriguing possibility that humans can detect the underlying relational social intent in music, as a kind of sonic trace of social relations between real or virtual/imagined agents (Aucouturier & Canonne, 2017).

Research has demonstrated that strong positive emotions evoked by music can result in increased motivation to engage in a broad range of activities and thus fuels constructive engagement, even when listening to music that might be considered aggressive and/or violent (Thompson, Geeves, & Olsen, 2018). For some, listening to angry music can serve the helpful functions of emotional resonance, catharsis, processing, validation, and transformation (Thompson *et al*., 2018). Similarly, for some, listening to sad music can be used as an acceptance-based coping strategy when seeking consolation, particularly for adverse events/situations (Van den Tol, Edwards, & Heflick, 2016), but can also be experienced affiliatively because it can reduce feelings of aloneness and increase feelings of social connectedness (Sachs, Damasio, & Habibi, 2015; Taruffi & Koelsch, 2014).

In considering the use of music within the context of a Compassionate Kitbag, curious playful exploration and guided discovery of music together in-session (aided by functional analysis) can be used to discover self-selected music that serves the multiple functions outlined, depending on what is needed. Using music in-session may also be a safer way to stimulate attunement, entrainment and synchrony, shared co-operative awareness, collaborative learning and facilitate emotional integration (Trevarthen, 1999). In the context of compassion-focused group psychotherapy, group members are invited to choose a piece of music which resonates for the group, this is then played at the end of the session, encouraging the affiliative connections and sharing between group members.

One client took the idea of music as part of her Compassionate Kitbag a stage further, in the context of feeling overwhelmed with a sense of not deserving the compassion that she was working to develop. This is a common difficulty for clients who have compromised and ruptured early attachments, in that the experience of warmth from self or others can trigger unresolved trauma and therefore activate the threat system (Boykin *et al.*, 2018; Gilbert, McEwan, Catarino, & Baião, 2014; Lawrence & Lee, 2014; Miron, Seligowski, Boykin, & Orcutt, 2016). Her response to this difficulty was to write a song about her experience of the therapeutic process, which contained the key very personal messages that she would need to hold onto. This also linked to a metaphor used in the therapy which became part of the shared language between client and therapist, which can deepen the affiliative connection and support with the process of meaning-making for the client (Finlay, 2015; Heine, Proulx, & Vohs, 2006; Martin, Cummings, & Hallberg, 1992; Park, 2010). The client reported that performing and recording this song and making it available to others had the transformative effect of stimulating all three flows of compassion, through the medium of compassionate courage and drive-based action: to others through the performance and sharing, from others in allowing others to be appreciative of her work, and to herself by turning back to and not away from the struggle with compassion.

Compassionate imagery

As previously outlined, many individuals with complex relational trauma can initially find CFI practices of CMT extremely challenging, due to experiencing such imagery as threatening (Duarte, McEwan, Barnes, Gilbert, & Maratos, 2015; Rockliff *et al.*, 2011), exhibiting higher levels of negative affect and weaker mental imagery abilities that can inhibit the generation and sensory-motor power of CFI (Naismith *et al.*, 2018). Despite the fact that these difficulties can be overcome with regular practice (Kelly, Zuroff, Foa, & Gilbert, 2010; McEwan & Gilbert, 2016), the kitbag may help clients begin by playfully experimenting with various forms of external imagery, given that external stimuli and internal stimuli (i.e., mental imagery) stimulate and operate through the same socio-emotional information-processing systems (Gilbert, 2010; Holmes & Matthews, 2010; Lang, 1979; Wilson, Schwannauer, McLaughlin, Ashworth, & Chan, 2018).

There are many creative ways of generating and using compassionate imagery that do not require clients to generate and hold images in mind, and/or might be initially more easily accessible if it is concretized in some external visual form. These can be self-chosen or self-created physical images (Beaumont, 2012; Williams, 2018) that have enough positive vividness to evoke a sense of safeness (Wilson *et al.*, 2018), and visual attributes/properties that can stimulate self-soothing and/or courage. Clients can thus also be invited to use a variety of expressive art activities to create safe/calm/welcoming places; give form to and make a compassionate image more tangible and accessible (Beaumont, 2012; Williams, 2018). A client who is working to develop a capacity for compassionate

courage may, for example, have a picture or object which represents this work in progress and may also link it with an imagined compassionate other who embodies courage.

Another creative use of compassionate imagery can involve body art/tattoos. The evolutionary origins and motives for body ornamentation have been traced back to the emergence of symbolic thought and the importance of social signalling for survival and reproduction (Carmen, Guitar, & Dillon, 2012). The functions of obtaining tattoos are diverse, including assisting changes in self-perceptions and behaviours (Mun, Janigo, & Johnson, 2012). Such chosen permanent imagery on the body can serve as important reminders and cues about one's life experiences, learning and growth, and deepening connection to the self, as well as serving to increase the tattooed individual's strength, self-confidence, and feel empowered (Mun *et al.*, 2012; Painter, 2017). One client obtained two tattoos throughout the course of therapy, both at different stages of the therapeutic journey: one a Phoenix, and the other a Lotus Flower. The meaning of these compassionate images for the client included the following: (1) a powerful and permanent reminder of one's journey, compassionate strengths and resilience; and (2) being imbued with wisdom about the nature of pain and suffering, and the power of compassion to transform and heal suffering. These tattoos also provided an immediate and visual reminder of the work undertaken and the necessary courageous drive-based motivation required to complete the therapy process.

Compassionate touch

Touch (in many forms) can down-regulate threat processing systems by accessing affiliative systems that give rise to an increased sense of comfort and safeness (Maratos *et al.*, 2017). This is evidenced by the fact that oxytocin is released in response to low-intensity stimulation of the skin (Uvnäs-Moberg *et al.*, 2015).

Drawing on the research and guidelines on self-applied touch (SAT; Seoane, 2016) from dance/movement therapy, clients can be helped to develop and utilize 'safe' forms of touch (from self and/or objects) to begin to develop the capacity to self-soothe and self-regulate and eventual integration of experiences (Seoane, 2016). Focused touch is thus a potentially feasible and acceptable intervention for individuals with complex emotional/psychological difficulties, as demonstrated by research indicating that high self-critics respond in a comparably favourable manner to low self-critics when hand massage is administered (Maratos *et al.*, 2017).

Other forms of haptic touch, in terms of touching, holding, and/or feeling certain items or objects (e.g., pebbles, beanbags, cloths), can also be incorporated into the kitbag. Experimental research suggests that people seek out soft haptic sensations when faced with uncertainty (van Horen & Mussweiler, 2014, 2015) and that people tend to show preferences for soft over hard objects (van Horen & Mussweiler, 2014, 2015).

Touching or having contact with such objects can be paired with the breathing practice, which may be more comfortable and tolerable than focusing on breathing for many traumatized individuals (Lucre & Corten, 2013). Furthermore, they may be present in-session to foster increased social safeness, the ability to engage and work with avoided aspects of the self (that can be represented in objects), and to aid the processing of traumatic material. Within CFT, clients are invited to utilize objects, smells, music within the therapeutic process to provide containment, soothing, and a secure base function to manage the therapeutic process which involves turning back to the sources of suffering to understand, explore, and repair early ruptured attachment relationships.

Concluding comments and call for further research

The use of the Compassionate Kitbag within the psychotherapeutic intervention of CFT has the capacity to provide a shared means between client and clinician to start accessing, stimulating, and cultivating compassionate flow that otherwise might be extremely difficult for individuals with complex attachment trauma. Harnessing the full range of social signals through the various outlined creative means within the kitbag has the potential to broaden opportunities for individuals to start developing and internalizing two important (separable but overlapping) functions of compassion: the capacity for self-soothing and the capacity for courage (stimulation).

This paper outlines how the methods used within the Compassionate Kitbag to facilitate these processes are based on integrating diverse scientific theory and research. However, this is within the overarching evolutionary model of CFT that centrally places the importance of affiliative processing and relating for our evolved minds and bodies to function optimally. The hope is that this introduction to and review of this novel concept of the Compassionate Kitbag will provide those at the edge of therapeutic opportunity (and those working with them) more accessible and tolerable ways of harnessing humans' most powerful source of healing, transformation and growth: compassion.

Given that the evidence provided is anecdotal and practice-based, more systematic empirical research is required to test the utility of the Compassionate Kitbag for clients at the edge of therapeutic opportunity. Future research may focus on a component analysis of different elements of the kitbag or as an integrated whole in comparison with CFT and CMT delivered in a more standardized manner.

Other client groups who experience challenges with traditional talking therapies may also benefit from such a creative approach to CFT. This includes but is not limited to CFT for people with intellectual and developmental disabilities (Clapton, Williams, Griffith, & Jones, 2018; Cowles, Randle-Phillips, & Medley, 2018), acquired brain injury (Ashworth, Clarke, Jones, Jennings, & Longworth, 2015), and dementia (Craig, Hiskey, Royan, Poz, & Spector, 2018). The Compassionate Kitbag can also be used as an adjunct to stabilization, resourcing and reprocessing work in trauma-focused approaches such as EMDR for people with PTSD and CPTSD (Beaumont & Martin, 2013; Kennedy, 2014; Whalley & Lee, 2019). The feasibility and utility of this creative approach with these populations thus requires further research.

Conflicts of interest

All authors declare no conflict of interest.

Author contributions

Both authors contributed equally to the writing of this paper.

Data availability statement

Research data are not shared.

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