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Compassion Focussed Therapy, Anxiety and People with Intellectual Disabilities

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Introduction

Approximately 1.2 million people in the UK are thought to have mild to moderate intellectual disability (Department of Health, 2001). In a large-scale assessment of mental health among those with mild intellectual disability in the catchment area of the Greater Glasgow Health Board in 2002-2004, the overall point prevalence rate for anxiety disorders (excluding specific phobias) was 6% (Cooper et al., 2007). A smaller study in 2001 suggested a rate of 6.6% for anxiety and phobic illness combined based on diagnosis by trained psychiatrists using standardised interviews (Deb, et al., 2001).

One approach to supporting people experiencing high anxiety is Compassion-Focussed Therapy (CFT; Gilbert, 2010a; Welford, 2010). Compassion has been conceptualised by the Dalai Lama (1995) as 'an openness to the suffering of others with a commitment to relieve it', a definition which is mirrored within CFT. Self-compassion has been found to be negatively associated with anxiety (MacBeth & Gumley, 2012; Neff et al., 2007a) and neuroticism (Neff, et al., 2007b) and positively linked to well-being (Byer et al., 2012; Zessin et al., 2015).

Gilbert (2010a, 2010b) adopts a more therapeutically oriented approach incorporating evolutionary theory and neuroscientific perspectives on self-compassion, proposing three emotion regulating sub-systems: threat, soothing and drive (Gilbert, 2010c). The first of these detects threat and prepares us to deal with them using a range of adapted responses including fight, flight, freeze, submission, or demobilisation. Threats may be real or perceived, may function on a physical or psychological level, and may be triggered externally or internally (Gilbert, 2010a). Operating on a 'better safe than sorry' principle, the threat sub-system gives rise to many fundamental emotions such as fear and anxiety (Gilbert,

2010c). The soothing sub-system is designed to deliver contentment, defined by Gilbert (2010a) as '… *a form of being happy with the way things are and feeling safe* …' (p.48).. Finally, the drive system is designed to generate positive feelings that motivate us to locate resources that are needed to achieve our goals. In essence, Gilbert (2010a) argues that the way in which the three sub-systems interact gives rise to one's emotional experience. The aim of CFT is to achieve a more adaptive balance between the three emotion regulation systems and to help people move beyond feelings of shame which so often underpin emotional difficulties, see Gilbert & Irons (2005), Gilbert & Procter (2006) and Gilbert (2009) for further details.

According to Welford (2010), CFT may be useful for dealing with anxiety, particularly where clients are insecurely attached and experience high levels of self-criticism. Werner et al (2012) reported lower levels of self-compassion in a sample of people (n=72) with social anxiety disorder than in healthy controls. The authors suggested that a CFT intervention might enhance self-compassion and act as a buffer against negative cognitive biases and excessive self-criticism. In a study of six students with self-reported social anxiety, CFT was found to be effective in three cases, probably effective in one, and questionably effective in the remaining two (Boersma et al., 2014). In a group-based CFT intervention for people with mental health difficulties, Gilbert and Proctor (2006) reported reduced levels of anxiety and depression. Recent reviews of the research evidence (Beaumont & Hollins-Martin, 2015; Leaviss & Uttley, 2015) suggest that CFT has beneficial effects on psychological well-being for people with anxiety and depression. The only studies of CFT with PWID are a recent single-case study (Cooper & Frearson, 2017) and a thematic analysis involving six participants (Clapton, et al., 2017). Long-term exposure to stigmatising and devaluing conditions may make PWID more likely to perceive themselves negatively and to fall back on

evolved defences such as submissiveness as an emotion-regulating safety strategy (Gilbert, 2010b). Such defences may often be associated with feelings of shame. Such displays of appeasement and avoidance when faced with interpersonal conflict (Gilbert, 2007a) might make PWID more vulnerable to anxiety, depression and low self-esteem.

The aim of the current study was to carry out a mixed-methods investigation of the effects of a CFT intervention. This intervention was principally focussed on developing self-compassion as the most novel therapeutic component of this model for PWID who were referred for treatment for high levels of anxiety. It was hypothesized that they would show significant reductions in anxiety and concomitant increases in self-compassion post therapy and at follow-up.

Methods

Design and Measures

This study employed a mixed-methods design (explanatory QUAL + quant (Cresswell & Plano Clark, 2011)) in which data will be pragmatically (Voparil & Bernstein, 2010) synthesised to produce final inferences. Quantitative data collection consisted of measures of self-compassion and anxiety as well as an initial mental health screening using the Mini PAS-ADD (Prosser, et al., 1998).

For the qualitative arm, an interview schedule was prepared (Smith, et al., 2009, p. 58) focusing on the general themes of anxiety, self-compassion and the therapeutic relationship. The number of questions in the schedule was slightly higher than normally recommended for this type of interview (Smith, et al., 2009, p. 58) due to the possibility of less rich responses being obtained to each individual question.

The Self Compassion Scale (SCS) (Neff, 2003), Neff (2016), is a 26-item self-report measure which can be evaluated as a two-factor model (self-compassionate attitude; self-critical attitude) (Costa, et al., 2015). It measures compassion directed towards the self, but does not measure compassion flowing either from or to others. Responses are on a five-point Likert scale ranging from 'Almost Never' to 'Almost Always'. The scale is suitable for those aged 14 and above and with at least an eighth-grade reading level. The measure was reviewed by a Speech and Language Therapist, who substituted high frequency for low frequency words and reduced grammatical complexity where possible without risking the intended meaning. It was read to participants, who were supported to understand and respond to the items. A short-form version of this scale is now also available but was not used as it only became available around the same time that the study received ethical approval.

The Glasgow Anxiety Scale for People with an Intellectual Disability (GAS-ID) is a 27-item self-report measure with three response options: 'Never', 'Sometimes', 'Always'. It has been found to be both reliable and valid (Mindham & Espie, 2003).

Procedure

Following ethical approval, and having obtained easy-read informed consent, measures were administered pre-intervention, within two weeks of completion of therapy alongside the qualitative interviews, and again at three months follow-up. The therapeutic intervention involved a 12-15-week course of CFT (Gilbert, 2010a,b; Welford, 2010), in keeping with NICE guidelines for high intensity psychological interventions for anxiety (NICE, 2011).

The intervention was primarily based on CFT exercises and practises which were mainly focussed on developing self-compassion. These included Soothing Rhythm Breathing,

Compassionate Image/Other, Safe Place. These were practised each weekly session with clients encouraged to practise in between. Adaptations were made including Easy Read and visual imagery to enhance understanding of verbal material. For example, one client chose cheerleaders as a compassionate image. He was asked about who he felt might be compassionate, kind, benevolent etc. and chose a cheerleader. He had a history of watching cheerleaders on Youtube and seemed to be drawn to them as cheerful, benevolent folk (no apparent sexual connotation present).

The therapist who delivered the intervention (CW), and the therapist who carried out the interviews (MH), are both Counselling Psychologists with knowledge of the CFT model. They were supervised by an experienced Counselling Psychologist who was also familiar with the model . They do not have formal training in CFT.

Data analysis and synthesis

Transcripts were analysed using Interpretative Phenomenological Analysis (IPA) (Fade, 2004; Reid et a;., 2005; Shinebourne, 2011; Smith et al., 2009; Smith & Osborn, 2008). IPA is an idiographic phenomenological methodology consistent with the case study nature of this research. It acknowledges the impact of the researcher on their interpretation of transcripts as they attempt to understand the phenomenological experience of the participant in relation to the research questions (Larkin et al., 2006; Smith, 2007; Wagstaff, et al., 2014). The therapist was not involved in the IPA analysis process and reflexive supervision of thematic development was provided by the overall project supervisor (JW). Interviews were transcribed then analysed following Smith et al's (2009) process of thematic development. Quantitively, the Reliable Change Index (RCI; Jacobson & Truax, 1991; Zahra & Hedge, 2010) was used to determine if change in questionnaire scores for each participant following the intervention could be considered to represent reliable change. The RCI is a numerical

indicator of the magnitude of change in a variable needed for a clinician to be confident that a real change has taken place (over and above measurement error). Reliability data to calculate the RCI was drawn from Mindham & Espie (2003) for the GAS and from Costa et al. (2015) for the SCS. In the current study, change may be said to have reliably occurred following a four-point change in self-compassionate or self-critical attitudes, or a three-point change in anxiety.

The quantitative and qualitative arms were analysed individually, and inferences drawn for each arm. Meta-inferences were then drawn from across the study by merging the two data-sets and comparing the findings with the original research questions (Cresswell & Plano Clark, 2011, p. 217).

Participants

The sample comprised of three white British adults with mild to moderate intellectual disability who had been referred to a community-based ID team for psychotherapy regarding anxiety. In keeping with routine therapeutic practice, and to maintain good ecological validity, identification of degree of intellectual disability was based on clinical judgement and recent BPS Guidelines (The British Psychological Society, 2015). All participants were known to local ID services and in receipt of support from them. Anxiety was diagnosed using the Glasgow Anxiety Scale for people with Intellectual Disabilities (GAS-ID) (Mindham & Espie, 2003). Sampling was purposive and opportunistic. Mild to moderate intellectual disability and clinical anxiety constituted the inclusion criteria. Exclusion criteria were defined by the presence of an autistic spectrum disorder or a non-affective co-morbid psychiatric disorder. Two additional clients were identified but did not enter the study (one

was unfortunately admitted to hospital under section, the other did not meet the criteria for degree of intellectual disability).

Pen Portraits

MA is a 48-year-old male with moderate intellectual disability who lives with his mother. He cannot read or write and appears at times to rely on echolalia and acquiescence in his verbal communication. MA reported being "*a bit shaky"* when outside or near people. He also reported that "*my heart goes"* and he gets "*bit panic"* at times. In addition, he described "*freezing*" when near roads.

AW is a 47-year-old female with mild to moderate intellectual disability who lives with her parents. She experienced several deaths in her family and the subject of death continued to worry her. She described feeling "*panicky"* when people upset her. She also worried about her future and about meeting people. She feared going down stairs.

GP is a 31-year-old female with mild intellectual disability who lives with her husband and four children. She had previously been the victim of rape and sexual assault. She was unable to leave the family home on her own; she believed it had been about five years since she last did so.

Results

Qualitative Analysis

Four superordinate themes were identified in the qualitative analysis: 'Concealment vs Joining the World'; 'What Helped'; 'Experiencing Compassion'; 'Understanding Change'.

Concealment vs Joining the World

Before therapy, all three participants appeared to believe that their negative emotions should not be expressed for fear of their impact on others. Perhaps not only is their distress not important enough to be shown to others, but participants appear to feel responsible for any impact their negative emotions may have on others.

MA *If something 'set me I don't tell no one I don't tell me mum sometimes*
Mark *Mm why do you keep it to yourself*
MA *You know I get I don't like people get upset*

GP also described feeling the need to conceal her distress from her family, whilst for AW, concealing her distress was something she did by not reacting if distressed by others.

Post-therapy, all three participants describe a change in how they view themselves;

GP *Just felt like normal for once like everyone else just walking about kind of thing. I still like keep an eye out over my shoulder just in case but not as bad as I was kind of thing*
Mark *Mm yeah just like everyone else*
GP *Yeah*
Mark *What's that like to think about*
GP *Uh just being like normal kind of thing*
Mark *So if you're now normal what were you before*
GP *I just felt different kind of thing like I was stupid from everyone else kind of thing*

For GP, the experience of becoming normal when she previously believed herself to be different to everyone else must have seemed dramatic. MA described a shell opening, perhaps capturing a sense of previously having been hidden away from the world, perhaps where no one would see him. AW describes feeling more empowered, able to take social risks and speak first:

AW *Um sometimes you gotta speak before they speak to you sometimes*

What Helped

All three participants position the therapist as a source of change in their lives and appear to appreciate the experience of being able to both understand and feel understood by someone.

> *MA* *You know you know she she done wonderful*
>
> *GP* *Um I just feel different I don't know why I think (the therapist) helped me a lot with the breathing and the room I don't know 'at just felt like a weight lifted off my shoulder kind of thing so when I was walking down the road with the kids I just felt I don't know that no one would harm me kind of thing…*

Mindful breathing was felt to be helpful as a focused intervention to rely on when distressed, perhaps rather than as regular practice.

> *AW* *Um take er like deep breaths and like uh if I go to the centre and come home and then take me teeth out she normally say take five deep breaths and take them out and that's been a lot better*

AW appears to understand mindful breathing as a relaxation strategy to use when anxious; she did not discuss compassionate imagery. Whilst MA had little to say about mindful breathing, he did describe how he found imagery of cheerleaders helpful. GP described how she developed an image that helped when she needed to go outside on her own.

> *GP* *Um we made up like a room so I could think of a comfy room so when I was walking about I could imagine I was sitting in a room with a big TV and a bed and units and that in there*

Participants' understanding, use and recollection of this type of imagery appears to be idiosyncratic, ranging from not recalled at all through to its use as a distraction or behavioural intervention when needed.

Experiencing Compassion

CFT & People with Intellectual Disabilities

Given its central position in CFT, it was surprising that participants' experience of compassion flowing in any direction (self-compassion, or flowing to or from the therapist) was not more obviously a theme in their narratives.

MA discussed the therapist's calmness and that she listened:

> *MA* *She calm she listen you know you got troubles like I had I had a load of trouble I had she phoned not phoned up um I been crying she um on the 'puter in a white cap she put word on there*

The therapist's calmness appears to be a key factor for both AW and MA. Maybe calmness is the best term participants can find to make sense of their experience of compassion flowing from the therapist towards themselves.

GP did not talk about the therapist as calming or compassionate. However, she did discuss her experience of the use of compassionate imagery:

> *GP* *Um can't remember… I remember one of them having like where my heart used to beat fast but when I walk like past people now we drawed one where it didn't beat or anything or my hands used to sweat they just like normal kind of thing when I walk past people cos I think of that room so that calms me down kind of thing*

Perhaps GP is describing her use of self-compassionate imagery as a tool to help down-regulate immediate threat responses around strangers.

AW also focussed on the absence of risk of (self) harm when asked about self-compassion:

> *AW* *No I wouldn't harm myself. No I wouldn't harm myself that ain't worth it*

Maybe for GP and AW, self-compassion represents a tool to help regulate a sense of threat rather than a positive experience of compassion or self-kindness. By contrast, MA offered a response which did imply some sense of a positive aspect to self-compassion; '*Warm place'.*

It's striking that after completion of a CFT intervention, this is not an area that participants were able to describe in much detail. However, between them participants have highlighted

a potentially down-regulated threat response, an absence of desire to self-attack and a sense of inner warmth, all of which can be understood as evidence of increased self-compassion, perhaps in keeping with Jones and Dowey's (2013) view that PWLD can make use of psychological constructs without always being able to effectively articulate them.

Understanding Change

For all three participants, their understanding of distress pre-intervention appeared to have a static, embodied and unchangeable nature. GP appears to understand the process of therapeutic change as one in which her sense of self has changed from being less than others to being the same as others:

GP *Um I thought I was like cos I've got learning difficulties I thought I was thick kind of thing but then after passing me English I knew that weren't I was not different from anyone else kind of thing cos there was other people in there from nearly the same levels so*

There appears to be a sense of permanence about her description of herself as '*being thick*' because she has learning difficulties. Perhaps to GP, *'being thick'* and therefore different or perhaps less than others had become an accepted part of who she was, not something that could ever be changed. GP later states that she now thinks she was '*stupid to think that way'*. Perhaps the scale of the change is so dramatic that to her it seems to be categorical rather than dimensional.

MA also describes how he feels different now compared to before therapy. Change because of therapy appears embodied:

Mark *Mm how will you know when you're getting better*
MA *Uh by um by bit changed*
Mark *Mm*
MA *By 'at's easy to tell a bit tense up*

It was clear in context that he was describing an absence of '*tense up*' as a positive change. '*Tense up'* appears to have been a constant, regular part of his life pre-intervention. AW also describes an absence of long-running physical symptoms as an outcome of therapy.

> *AW* *Um I in't had them er panic attacks since I started er bit er talking to her and I ain't had that horrible feeling in my legs mm I get it in my leg*

For all three participants, their distress pre-intervention seemed such a fundamental part of themselves that it wasn't possible to conceive of being any other way. They described feeling that they needed the external intervention of therapy to remove the unhelpful beliefs ('*I was thick'*) or unwanted physical sensations ('*tense up'*, panic attacks, shaking).

Quantitative Analysis

Total scores on the GAS-ID and SCS, are presented in Table 1 below.

Insert Table 1
about here

All three participants reported reliable general increases in self-compassionate attitudes pre-post intervention. Two participants (MA & AW) reported further significant improvement at follow-up. GP reported a decrease at follow-up, though they still reported a reliable improvement compared to pre-intervention.

MA reported an increase in self-critical thoughts post-intervention. Possibly this reflects an increase in insight on their part. AW & GP reported decreases in self-critical thoughts both post-intervention and at follow-up.

Regarding anxiety, all three participants reported reliable improvement from pre-intervention to three months follow-up. Post-intervention, MA and GP showed reliable decreases in levels of anxiety, maintained at follow-up. AW showed a slight, though non-

reliable, reduction in anxiety post-intervention. However, this decrease was clearly reliable at follow-up, although post-intervention and follow-up scores remained above clinical cut-off levels. To assess the clinical importance of changes in anxiety from baseline to follow-up, results have been interpreted in relation to Matthey's (2004) categories: recovered, improved but not recovered, no change, and deteriorated. MA's anxiety levels improved but did not recover fully. AW's anxiety improved reliably although it just failed to recover to non-clinical levels and so they cannot be categorised as recovered. GP's anxiety levels also fell considerably but remained in the clinical range.

In summary, self-compassionate attitudes have shown clear improvement for all participants, with evidence of continued improvement at follow-up for two participants. Self-critical attitudes deteriorated for one participant and improved for two. All three participants reported reliable reductions in anxiety, but remain above the clinical cut-off for diagnosis.

Data Synthesis

Data synthesis follows the recommendations of Cresswell and Plano Clark (2011, pp. 203-250).

Inference One: Participant Anxiety Decreased

All three participants reported statistically reliable reductions in anxiety at follow-up. The reduction in anxiety appeared to have been sufficiently large to be experienced as categorical rather than dimensional change. However, all three participants remain in the clinical range of anxiety. This may be related to issues of learned helplessness (Seligman, 1972), with participants continuing to feel that their well-being and life choices are dependent on others rather than themselves. Overall, while each participant appears to

have ongoing issues with anxiety, their anxiety appears to have become noticeably less intense, less intrusive, and less debilitating during the period of the study.

Inference Two: The Faulty Self

Participants appeared to feel a sense of difference from others pre-intervention, so powerfully captured in GP's statement '*I just felt different kind of thing like I was stupid from everyone else…'*. At follow-up, all three participants reported reliable reductions in anxiety which they appear to have experienced as categorical state changes. Since they appeared to feel that the anxiety was originally a part of themselves, as opposed to them feeling that they were 'normal' but suffering from anxiety, they appear to have experienced a change of selfhood away from being 'faulty'.

Inference Three: Mixed Impact on Self-Compassion

There were reliable changes in self-compassionate attitudes for all three participants. Self-critical attitude changes were less clear with two showing improvement and one showing deterioration (perhaps because of increased insight). Scores generally continued to improve at follow-up. However, there was almost no mention of self-compassion in the interviews, GP even stated she had never heard of self-compassion. Conceptually, self-compassion may be a complex idea for participants to understand. Although mixed evidence for change emerged using questionnaires and interviews, this does not preclude the possibility that change may have taken place which might not have been captured by the methods used (see Jones & Dewey (2013)).

Inference Four: Increased Sense of Common Humanity

Participants described the experience of becoming normal like everyone else rather than separate from and different to others. This change is also echoed in Common Humanity and

Isolation subscale scores on the SCS. All three participants showed improvement in their common humanity scores at follow-up while two participants showed improvement in isolation scores post-intervention and at follow-up.

However, GP suggested that there may still be limits to the extent to which she feels safe around others. She described creating an imaginary shell when talking to others rather than perhaps fully engaging with other people. Additionally, MA reported a slight reduction in common humanity scores post-intervention but did subsequently report an increase at follow-up. Possibly this reflects natural variation in the scoring or it may reflect growing insight into the limited extent to which he had previously experienced a sense of common humanity. The same participant also reported higher scores for Isolation at both post-intervention and follow-up, though there was improvement between these time points. Whilst the balance of evidence may suggest an improvement in participants' sense of common humanity, the picture remains quite complex.

Inference Five: Mindful Distraction Techniques

There was no clear direction of change for either mindfulness or over-identification scores, either post-intervention or at follow-up. Additionally, where GP and AW discuss mindfulness, they do so entirely within the context of using exercises to manage acute episodes of distress. By contrast, MA appears to suggest that he engages in regular exercises, though his account is somewhat unclear on this point.

On balance, there is no clear evidence to suggest that participants have developed effective and easily recalled regular mindfulness practices, although they may have learned to use mindful breathing (and perhaps compassionate imagery) as effective interventions to help manage short term distress.

Discussion

In support of the main hypothesis, reliable reductions in anxiety were noted for two participants immediately after the intervention and for all three at follow-up. These findings are similar to those reported by Ashworth et al (2014) and Lawrence and Lee (2013) and provide support for Welford's (2010) argument that CFT may be beneficial for people with anxiety. Participants appear to have understood their reduction in anxiety as a categorical change in self-hood. This accords with Ashworth et al's (2014) participants who reported 'revaluing' the self, while Lawrence and Lee (2013) described a superordinate theme of "*who am I if not self-critical*?". Collectively, these findings point to changes in the self-construct, as a possible mechanism underpinning the beneficial effects of CFT on anxiety. It must be noted, however, that all three participants remained clinically anxious even at follow-up. This may be due to high levels of anxiety at baseline, perhaps reflecting issues of case identification and diagnostic overshadowing whereby symptoms, which in others might be seen as suggesting mild mental health difficulties, are attributed instead to the diagnosis of intellectual disability and therefore not identified as anxiety symptoms until they become severe in nature (Reiss et al, 1982).

The quantitative data also showed evidence of reliable improvement in self-compassionate attitudes for all three participants, less clear evidence for self-critical attitudes as one participant reported higher levels post-intervention. Possibly this represented an increased level of self-insight. However, the component scores suggest that participants tended to reduce their levels of self-critical attitudes (self-judgment, isolation and over-identification) more so than they increased their self-compassionate attitudes (self-kindness, common humanity and mindfulness). At the same time, discussion of self-compassion was largely

absent from participants' narratives and was mostly re-interpreted into ideas such as not hurting themselves, possessing a sense of inner warmth and no longer feeling different. It may be that some aspects of self-compassion were too complex for participants to readily conceptualise and articulate. Talking instead about the therapist's calmness and using compassionate imagery may be within their comfort zone.

When working with PWLD, it is often suggested that behavioural interventions should be prioritised over more cognitively-focussed therapies (e.g., Lucre & Corten,2013). Making mindful breathing a more central feature of a CFT intervention for PWLD may be particularly helpful.

Strengths and Limitations

In the absence of a measure of self-compassion designed specifically for PWLD, the performance of the SCS (Neff, 2003) is worth noting. Though not intended originally for use with this population it seems that when the questionnaire items and response categories are read carefully to PWLD they may be able to respond in line with what might be expected following a CFT intervention, though obviously the need to read and interpret the measure potentially impacts on reliability.

Whilst participants met the criteria for homogeneity in intellectual disability research laid out by Nezu & Nezu (1994), there are noticeable differences in their individual experiences and responses to CFT. In small group research and case study designs, perhaps these individual differences may have a bigger impact than in larger-n studies, especially in fields such as intellectual disabilities. Small-n research may therefore need to be more aware of issues of heterogeneity.

Ultimately, the data were all self-report of one form or another (e.g., questionnaire, interview). We therefore cannot rule out self-report bias as an explanation for the observed findings.

Although a key strength of the study is the use of different research methods and the way in which the data was synthesised, nevertheless the nature of the design does not enable causal inferences to be drawn in relation to the provision of CFT and reductions in anxiety. A larger scale randomised controlled study is needed to establish the utility of CFT among people with intellectual disability. Nevertheless, it is felt that the mixed methods approach used here shows promise as a methodology with which to conduct future clinical research.

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Table 1. Scores for SCS (Domain and Two-Factor Model Summary) & GAS-ID.

	MA			AW			GP		
Domain	Pre-Intervention	Post-Intervention	Three Month Follow Up	Pre-Intervention	Post-Intervention	Three Month Follow Up	Pre-Intervention	Post-Intervention	Three Month Follow Up
Self-Kindness	1.60	4.20	4.20	3.40	3.60	4.60	2.60	3.80	3.40
Common Humanity	1.50	1.25	3.25	3.00	4.25	4.25	2.50	2.75	3.00
Mindfulness	2.50	2.00	3.00	3.25	2.25	2.75	2.75	3.75	2.75
Self-Compassionate Attitudes	29.60	41.45	56.45	51.65	54.10	62.60	41.85	55.30	49.15
Self-Judgement	1.00	1.40	2.20	2.60	1.40	1.20	3.80	3.00	2.20
Isolation	2.75	4.25	3.00	2.75	2.25	1.75	4.50	3.00	2.50
Over-Identification	3.00	3.00	4.00	3.75	1.75	2.00	2.75	3.25	2.25
Self-Critical Attitudes	34.75	44.65	48.20	48.10	28.40	25.95	59.05	49.25	36.95
GAS-ID Scores	32	25	26	23	21	14	37	18	20

Note 1: A change of four points or more in self-compassionate and self-critical scores is considered reliable.
Note 2: SCS Domain scores represent mean responses, Attitude Summary Scores represent sum total scores.
Note 3: A cut-off score of 13 or more is considered diagnostically significant for the GAS-ID. A change of three points or more is considered reliable.