Motivational interviewing in compassion-based interventions: Theory and practical applications

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behaviour change, compassion, motivational interviewing, self-compassion.

Abstract

Background: Definitions of compassion include aspects of motivation, commitment, and action. Compassion-based interventions designed to cultivate compassion and self-compassion incorporate various practice and behavioural change goals. This article proposes that motivational interviewing (MI), which has been extensively used as a prelude to other psychological and health-related treatments to enhance behavioural change outcomes, could be used in a similar way to enhance outcomes of compassion-based interventions.

Methods: This article provides an overview of definitions of compassion, common compassion-based interventions as well as their structure and behaviour change components, and describes MI as an approach to enhancing motivation, commitment, and action around these behaviour change components.

Results: Three main compassion-based interventions were reviewed, namely Compassion-Focused Therapy, Mindful Self-Compassion, and Compassion Cultivation Training. It was identified that at least four aspects of motivation, commitment, and action could be the focus of MI as a prelude to these interventions, including attendance at sessions, meditation self-practice, active engagement with the suffering of self and others, and embodiment of compassionate action in daily life. Transcripts of example MI conversations in the context of compassion-based interventions have been provided, as well as recommendations regarding assessing motivation and commitment in this context.

Conclusions: MI is proposed to be a promising prelude to compassion-based interventions, to enhance compassion motivation and commitment, and increase the likelihood of embodying compassionate action in daily life.

Key Points

1 Common to definitions of compassion are notions of motivation, commitment and action.
2 Central to compassion-based interventions are attendance to sessions, homework and self-practice, a willingness to approach suffering, and embodying compassionate action in daily life.

The world continues to evolve, and while abuse, violence, war, and trauma still seem to be ever-present, there is a growing worldwide movement that is trying to tip the balance: cultivating compassion and self-
Compassion is generally considered to be a human response to suffering, where suffering may refer to the painful experience of another person (e.g., socially, emotionally, or physically), or one’s own struggle with the difficulties they are experiencing (e.g., anger, depression, loneliness, or anxiety). Compassion has been defined in many different ways (Kirby, 2016; Strauss et al., 2016), with some defining it as an emotion or affective state (Goetz et al., 2010), others highlighting its multidimensional construct (Jazaieri et al., 2013; Strauss et al., 2016), and others understanding it as emerging from human caregiving motives combined with social competencies (Gilbert, 2014). Despite the variety of definitions, common across all of them is a motivational component. Jinpa (2015), who designed the Compassion Cultivation Training (CCT) program at Stanford University, indicated that compassion is comprised of four key components: (1) an awareness of suffering (cognitive component), (2) sympathetic concern related to being emotionally moved by suffering (affective component), (3) a wish to see the relief of that suffering (intentional component), and (4) a responsiveness or readiness to help relieve that suffering (motivational component). The motivational element in Jinpa’s definition is echoed by Gilbert (2014) who developed Compassion-Focused Therapy (CFT) and defines compassion as “the sensitivity to suffering in self and others, with a motivation and commitment to try to alleviate and prevent it” (p. 19). Within Gilbert’s definition is an understanding of the “flow” of compassion, where one can direct compassion to others, to themselves (self-compassion), and also be open to receiving compassion from others (Gilbert, McEwan, Matos, & Rivas, 2011). The notion of self-compassion has been further defined by Neff (2003) as part of her Mindful Self-Compassion (MSC) program, and includes three components: (1) being mindful, rather than over-identifying with problems, (2) connecting with others, rather than isolating oneself, and (3) adopting an attitude of self-kindness, rather than being judgmental. The MSC program includes an important focus on motivation and commitment, identifying in times of personal suffering “What am I needing right now?” (Neff, 2011, p. 52), and taking steps to treat oneself with kindness (Neff & Germer, 2013).

Studies in neuroscience have found that the feeling of compassion is associated with the “bonding hormone” oxytocin, which results in humans wanting to approach and care for others (Goetz et al., 2010; Klimecki, Leiberg, Ricard, & Singer, 2014). From an evolutionary point of view, there exists an innate motivation to nurture, comfort and care for one another and this caring motivation was an important part of human survival and the success of early Homo sapiens (Gilbert, 2014).

Motivation for specific actions is often further enhanced by an awareness of the benefits of those actions, as well as more deeply felt values around those actions, and ultimately coming to a commitment to take steps (Miller & Rose, 2009). Many benefits of compassion and self-compassion have been identified. High levels of compassion have been associated with improved emotion regulation and mental health (e.g., Jazaieri et al., 2013; Keltner, Kogan, Pfif, & Saturn, 2014; MacBeth & Gumley, 2012; Seppala, Rossomando, & Doty, 2013), improved interpersonal and social relationships (e.g., Crocker & Canevello, 2012; Yarnell & Neff, 2013), and improved immune functioning and physical health (e.g., Fredrickson et al., 2013; Klimecki et al., 2014; Simon-Thompson et al., 2012). Similarly, high levels of self-compassion have been found to correlate with a greater sense of emotional well-being, enhanced quality of life, and less emotional turmoil when resolving relationship conflict (Yarnell & Neff, 2013). By contrast, individuals with low levels of self-compassion and compassion have been found to have high levels of self-criticism, guilt, rumination, and worry (Gilbert et al., 2011; Raes, 2010). Given the overall benefits of compassion to individuals, groups and society in general, the last two decades have seen significant advances in identifying and further developing strategies and programs to help cultivate compassion (Kirby, 2016).
Motivation can also be reduced, and therefore change or action less likely, when a range of personal beliefs or concerns argue against change (Pace et al., 2017). In terms of compassionate action, several fears, resistances and blocks have been identified (Gilbert et al., 2011). Any given person may feel that they would like to be more compassionate to themselves or others, but feel too frightened to do it. Alternatively, they may not feel frightened about it at all, but feel resistant to the idea because they do not see the point. Regarding fear of self-compassion, this is especially the case for those who have had an interpersonally averse or traumatic background (Gilbert, 2010; Gilbert et al., 2011). Gilbert and Procter (2006) found that fear of self-compassion was linked to feeling undeserving of compassion, a belief that self-compassion was a weakness, a desire for love and kindness but instead feeling lonely and rejected, and simply “never considering the value of self-compassion.”

A number of factors can lead to fear of, or resistance to, being compassionate towards others. Feelings of contempt for the other, or discomfort in the presence of others’ suffering, can cause people to avoid compassionate action, as can a desire to compete or dominate when compassion is seen as submissive or weak (Gilbert et al., 2011; Goetz et al., 2010). Importantly, motivational conflict between self-interest and compassion can also inhibit compassionate action (Cameron & Payne, 2011). For example, Cameron and Payne (2011) found that as the number of people in need of help increases, the degree of compassion people feel for them tends to decrease. In the series of experimental studies, Cameron and Payne found that (1) participants’ compassion was more likely to decrease when they expected to be asked to take action (in this case, being asked to donate money), (2) decreases in compassion emerged for those participants who were skilled at emotion regulation, and (3) participants skilled in emotion regulation prevented themselves from experiencing as much emotion towards the larger group compared with towards individuals who were suffering (Cameron & Payne, 2011). One conclusion of these findings is that people regulate their emotions associated with the larger number of people in need, thereby reducing their compassion, in order to cope with the overwhelming distress associated with many people suffering. Thus, although compassion intentions can be cultivated, this may not translate into motivation or specific action.

Recent research has also highlighted the importance of being open to receiving compassion from others. Hermanto et al. (2016) found across four studies with a total sample of 701 participants across cultural contexts including Canada, England and Portugal, that it was people’s fear of receiving compassion from others that moderated the impact of depression ($d = .53$), with low levels protecting against depression and high levels exacerbating depressive symptoms.

Thus, as in all behavioural choices and changes, people may experience both facilitators (e.g., awareness of the benefits, holding compassion as a guiding principle) and inhibitors (e.g., fears, resistances, blocks) to compassion for others and for oneself, as well as receiving compassion from others. It may be that two major facilitators to compassionate action are related to a sense of being able (knowing what to do, how to do it and feeling able to cope with the situation) and with a sense that it is important (because of values, guiding principles and a desire to help others). A number of practices and programs are designed to broadly enhance these facilitators and reduce inhibitors, however motivation, commitment and action are also involved in program engagement in the first instance and in practice implementation throughout the program.

**Cultivating Compassion through Meditation**

Throughout the spiritual traditions, meditation has long been a pathway to developing love, kindness and compassion for others and for oneself (Gilbert & Choden, 2013; Tirch, Silberstein, & Kolts, 2016). Now also incorporated into widespread general community and clinical practice, meditation refers to a family of self-regulation practices that focus on training attention, and have been found to improve resilience, and stress and coping for adults (Galante, Galante, Bekkers, & Gallacher, 2014). Loving-kindness meditation (LKM) and compassion meditation (CM) are fundamental exercises across mindful-compassion programs (Galante et al., 2014; Hoffmann, Grossman, & Hinton, 2011; Kirby & Gilbert, 2017; Shonin, Van Gordon, Compare, Zangeneh, & Griffiths, 2015). These practices are largely derived from Tibetan Buddhist traditions and perspectives of human suffering, and emphasise the four immeasurables: loving-kindness, compassion, joy, and equanimity (Hangartner, 2013).

LKM typically involves following a structured approach from mindfulness of breathing to directing caring feelings toward oneself, loved ones, acquaintances/strangers, someone with whom one experiences interpersonal difficulties, and all people and all living beings without distinction (Hoffmann et al., 2011). At each step, the LKM involves the repetition of short phrases or well-wishes (e.g., may I/you be safe, may I/you be peaceful, may I/you be healthy, may I/you live with ease) towards
oneself and others. CM is also a meditative practice, however, unlike LKM, CM focuses specifically on suffering and involves the development of affective empathy specifically directed toward the sharing of another’s suffering (Shamay-Tsoory, 2011). During CM, the participant directs compassionate feelings or intentions toward a specific individual or group of individuals (which can include other sentient beings as well), and involves a conviction that they may tangibly prevent or alleviate the suffering of those others who are concerned (e.g., *may I/you be free from suffering*; Shonin et al., 2015). In their review, Hoffmann et al. (2011) found LKM and CM to have moderate but significant effects on alleviating depression, social anxiety, marital conflict, and anger. Moreover, a systematic review and meta-analysis of 22 randomised controlled trials (RCT) found LKM and CM to have moderate but significant effects on increasing mindfulness, compassion and self-compassion, and reducing depression (Galante et al., 2014). Finally, Shonin et al. (2015) found in their systematic review and meta-analysis of 20 RCT and non-RCT studies that LKM and CM can improve psychological distress, levels of positive and negative affect, the frequency and intensity of positive thoughts and emotions, interpersonal skills, and empathic accuracy.

Regarding the Galante et al. (2014) meta-analysis, it is noteworthy that out of the 1 747 participants in the 22 studies, approximately 67% were female. The over representation of females compared to males in psychological research is a common finding (Cuijpers et al., 2014), however, it may be more common in meditation-related research. It raises the question how to involve more men in these practices, and it may be that certain fears, resistances or blocks are making men more reluctant, and less motivated or committed, to being involved. Furthermore, Galante et al. (2014) found that longer LKM interventions showed high attrition, without studies providing reasons for participants dropping out. None of the studies included in their review had more attrition in the LKM intervention groups than active control groups, and the authors therefore suggested that drop out may have been related to the time commitment required rather than the content of the intervention or any associated adverse effects. Shonin et al. (2015) did report on studies where intervention and control groups differed in terms of attrition rates; however, some studies they reviewed reported that participants in LKM and/or CM interventions had higher drop out, while others reported higher attrition among active controls. Nevertheless, these findings raise another question regarding strategies for enhancing engagement with, and commitment to, these programs to further enhance their effectiveness and impact.

**Compassion-Based Interventions**

While LKM and CM practices have been found to have moderate effectiveness on a range of psychological measures, broader, more-comprehensive compassion-based interventions, often incorporating LKM or CM, have also been developed and evaluated. A recent meta-analysis of 21 RCTs and data from a total of 1 285 participants (Kirby, Tellegen, & Steindl, 2017) demonstrated significant moderate effect sizes for compassion-based interventions improving participant mindfulness, compassion, self-compassion, and psychological well-being, as well as depression, anxiety, and psychological distress. This review found a mean of 74% female participants across trials. Furthermore, there was an average of 17.5% attrition in the treatment group from pre- to post-intervention (Kirby et al., 2017). Some of the notable programs that have been evaluated through RCTs include: CFT (Gilbert, 2014), the Mindful Self-Compassion program (Neff & Germer, 2013), and the CCT Program (Jazaieri et al., 2013). These will be discussed in more detail below, especially from the point of view of motivation, commitment and action components of the programs.

**Compassion-Focused Therapy (CFT)**

Paul Gilbert developed CFT over the last 20 years, and it is heavily based on evolutionary approaches to understanding the human mind (Gilbert, 2014). CFT focuses on two psychologies of compassion. The first psychology is a motivation towards being sensitive to, and engaging with, suffering. This involves six compassion attributes: sensitivity, sympathy, empathy, distress tolerance, non-judgement, and care for well-being. The second psychology is focused on action, specifically a motivation and commitment to alleviating and preventing suffering, which draws upon six skills related to imagery, attention, emotion, sensory qualities, cognitive reasoning, and behaviour. One important aim of CFT is to provide psychoeducation on the human brain, specifically in regards to its three basic motivational systems: (1) the threat/self-protect system, (2) the drive-reward system, and (3) the affiliative/soothing system. CFT emphasises how people often find themselves trapped between the threat and drive systems, which can bring about a sense of failure and high levels of self-criticism and shame (Gilbert, 2014). The affiliative/soothing motivational system helps facilitate compassion, and exercises are incorporated in order to make this the person’s organising motivational system.

CFT incorporates a range of in-session exercises and home practices that focus on cultivating the first and
second psychology in order to develop the individual’s own ideal compassionate-self. For example, a range of attention and grounding-based exercises are incorporated to help individuals to attend to and tolerate suffering (first psychology), such as psychoeducation, body posture and mindfulness techniques. Exercises and practices activate the affiliative/soothing system via imagery (e.g., safe space imagery, compassionate friend), breathing (e.g., soothing rhythm breathing), and behavioural rehearsal (e.g., compassionate letter writing, compassionate method acting). For more detail regarding CFT exercises and practices, see Kolts (2016) and Irons and Beaumont (2017). CFT is the process of applying a compassion model to psychotherapy and as such it has no specific time limitations or restrictions. CFT does address fears, resistances and blocks, and time may be spent discussing these concerns and enhancing motivation and commitment. Compassionate Mind Training (CMT) was developed as a compassion-focused, group-based program to help people with high levels of shame and self-criticism (Gilbert & Irons, 2005). CFT is a form of therapy and there is as yet no published manual of the therapy itself (Kirby & Gilbert, 2017), thus the structure of CFT when applied in therapy will be tailored to the specific needs of the individual based on an evolutionary functional analysis (Kirby & Gilbert, 2017).

CMT is a protocol of CFT that follows a set of specific trainings to help cultivate a compassionate mind. The specific stages typically involved in CMT include: (1) psychoeducation about the evolved functions of the human mind and our emotion systems; (2) understanding safety strategies/behaviours and the functional analysis of self-criticism; (3) developing attention strategies and grounding exercises, such as introducing soothing rhythm breathing; (4) developing compassionate images and warmth, such as recalling compassionate motives flowing outwards towards others; (5) the importance of imagery-based exercises to stimulate warmth and compassion, such as developing a safe space; and (6) cultivating compassionate behaviours such as letter-writing and small daily compassionate actions. CMT differs from the therapy itself, as CMT does not focus on understanding individualised case histories of clients or developing specific case formulations (Kirby & Gilbert, 2017).

To date, CFT has been examined in a number of trials, and a systematic review was conducted in 2014 that included 14 studies, three of which were RCTs (Leaviss & Uttley, 2015). The review concluded that CFT shows promise as an intervention for mood disorders, particularly for those high in self-criticism. However, the review did not use meta-analytic techniques, due to the lack of available studies with data. The review found that the majority of studies on CFT had been uncontrolled studies conducted as part of service delivery. One recent study conducted an RCT on a 2-week CMT program compared to a waitlist control, examining a range of psychological and physiological outcomes (Matos, Duarte, Gilbert, & Pinto-Gouveia, 2017). Participants (84% female) were instructed on core CMT exercises and then asked to practice these exercises across the following 2 weeks. The attrition rate overall was 20.5%, with the dropout rate being higher in the control group (36.21%). Compared to the control group, the experimental group showed (1) significant increases in self-compassion, compassion for others and compassion from others, (2) significant increases in positive emotions associated with feeling relaxed and also safe and content, and (3) significant reductions in shame, self-criticism, fears of compassion, and stress. Furthermore, only the experimental group reported significant improvement in Heart Rate Variability (Matos et al., 2017). These recent results are very encouraging and further RCTs examining the impact of CFT and CMT compared to control groups are needed.

**Mindful Self-Compassion (MSC)**

MSC was developed by Kristin Neff and Christopher Germer specifically as a program to help cultivate self-compassion (Neff & Germer, 2013). MSC is an 8-week program, with each session lasting between 2 and 2.5 hr, with an optional half-day meditation retreat. MSC contains core meditations (e.g., affectionate breathing, LKM for beginners), other meditations (e.g., compassionate body scan, giving and receiving compassion), and informal self-compassion practices (e.g., self-compassion break), along with the rationale for those exercises (Neff & Germer, 2013). According to Neff and Germer (2013), the program is considered a “hybrid” program, one which is applicable to both the general public and also some clinical populations.

The program initially begins by introducing what self-compassion is and why it is important, referring to research evidence to support these principles. Mindfulness is then introduced in the following session, which then leads to practicing LKM in session three. In session four, the focus is on developing your compassionate voice, with an emphasis on distinguishing between the inner critic and compassionate self. Session five is aimed at addressing core values of the individual to enhance living a life of meaning. Session six is focused on how to manage difficult emotions—where the strategy “soften, soothe, allow” is introduced. Session seven is aimed at transforming pain in relationships with others, and finally session eight is focused on addressing the human negativity bias, which is targeted at detecting threat (Neff & Germer, 2013). Sessions involve instruction and
guided practice, as well as group inquiry, however, the MSC program does not include opportunities for participants to individually explore their personal facilitators and inhibitors, or enhance their motivation and commitment in preparation for the program and its practices.

Neff and Germer (2013) evaluated MSC in a single case study, as well as in an RCT, and there have been other variations of the MSC program evaluated in RCTs in briefer 3-week formats (Alberton, Neff, & Dill-Shackleford, 2014; Smeets, Neff, Alberts, & Peters, 2014), and also examined in an RCT for patients with diabetes (Friis, Johnson, Cutfield, & Consedine, 2016). Current evaluations show encouraging results for MSC, however, more controlled evaluation studies are warranted, specifically with clinical populations, to evaluate its efficacy.

**Compassion Cultivation Training (CCT)**

The CCT program was developed by Jinpa and colleagues at the Center for Compassion and Altruism Research and Education (CCARE) at Stanford University (Jazaieri et al., 2013). CCT has a structured protocol and spans 9-weekly sessions, with each session lasting 2 hr. Each session includes: (1) pedagogical instruction with active group discussion, (2) a guided group meditation, (3) interactive practical exercises, and (4) exercises designed to promote feelings of open-heartedness or connection to others. The sessions are designed to deliver both didactic and experiential training in compassion practices across six steps. Step 1 consists of settling the mind and developing mindfulness skills. Step 2 involves experiencing loving-kindness and compassion for a loved one. Step 3 includes practicing LKM and compassion for oneself. Step 4 involves compassion towards others through embracing our shared common humanity. Step 5 focuses on compassion towards all beings. Step 6 involves an “active compassion” practice where one imagines taking away others’ pain and sorrow, and offering to them one’s own joy and happiness. Finally, participants are introduced to an integrated practice where all six steps are included in a complete daily compassion-focused meditation (Jinpa, 2015). Given CCT is presented as a structured group program like MSC, it also does not include opportunities for exploring participants’ personal facilitators and inhibitors, or targeting motivation enhancement.

The CCT program has been evaluated in two RCTs, one in the United States (Jazaieri et al., 2013, 2014) and the other in Chile (Pons, 2014), and both found CCT was able to help increase compassion and also to improve the mental health and emotion regulation of participants.

**Cultivating Compassion Involves Taking Action**

As highlighted in the definitions above, compassion involves a motivational or action component (Gilbert, 2014; Jazaieri et al., 2013; Strauss et al., 2016). Compassion is being aware of, and sympathetic towards, another’s suffering, coupled with a motivation to do something to prevent or alleviate that suffering. Indeed, being truly compassionate takes “…the courage to descend into the reality of the human experience” and thereby take action. Indeed, this definition of compassion (attributed to Paul Gilbert) highlights the two distinct psychology processes required in compassion. The first is to be sensitive and to engage with what the suffering might be, and the second is being committed to doing something to alleviate it. In relation to the first psychology, Gilbert (2017) proposes that the components of sensitivity, empathy, sympathy, distress tolerance, non-judgment and care for wellbeing are important elements that contribute to being able to successfully engage and approach suffering. The second component of compassion includes being committed to alleviating the suffering, which is proposed to include behavioural components, imagery, reasoning, sensory, attention and feeling competencies. To provide compassionate action requires the two psychologies to work together.

Self-compassion, too, is defined with action in mind, identifying “what is it that I really need right now?” and acting with self-kindness (Neff, 2011). The process of self-practice can be viewed as any specific compassion practice, both formal (e.g., specific meditations) and informal (e.g., spontaneously generated acts such as helping an individual who is distressed), that aims to alleviate suffering, which an individual engages in outside of therapy or the intervention. Importantly, compassionate action is a complex phenomenon. That is, there is no “one single behaviour” that can be deemed compassionate action. In the context of suffering there can be many varied compassionate responses, therefore making it difficult to measure. Moreover, there can be discrepancies as to whether an action is consider compassionate. For example, the individual may perceive their action to alleviate another’s suffering to be compassionate, but the recipient may view the act as intrusive and unhelpful. In terms of self-report measurement, our initial focus is on whether the individual views their action towards self or others as being compassionate.

From a practical point of view, this notion of taking action is important on two levels. First, compassion-based interventions generally recommend LKM, CM and other exercises be practiced on a regular basis.
between formal sessions and beyond the end of formal sessions. Such interventions range widely in terms of number and length of formal sessions, and an essential element of these programs is self-practice for homework. There are examples of single session LKM interventions, such as a 20 min initial training session followed by self-practice (May, Weyker, Spengel, Finkler, & Hendrix, 2014), through to more intensive programs, such as CCT, an 9 week, 2 hr per week group program with 15–30 min daily self-practice using pre-recorded guided meditations (Jazaieri et al., 2013; Jazaieri et al., 2014). With all these interventions, self-practice is a key component. It is noteworthy that, while these interventions have been found to have a significant effect on outcome variables in the short-term, longer term follow-up has been less well-evaluated (Shonin et al., 2015). A dose–response effect has been found to mediate the outcome of LKM and CM, meaning the more frequently an individual engages in formal self-practice the more significant the outcomes (Hoffmann et al., 2011). Thus, consistent, ongoing formal self-practice, such as meditation, may offer a greater chance for the interventions to produce lasting behaviour change and therefore be effective in the long-term. Little research has examined what factors contribute to increased meditation practice; however, one study suggested that personality characteristics, such as openness to experience and agreeableness, increase the likelihood of more frequent mindfulness practice (Barkan et al., 2016). However, it must be noted that despite the appeal of meditation practices, not all individuals will respond positively (Farias, Wikholm, & Delmonte, 2016). Thus, one needs to gauge how participants are responding to meditation practices across the course of interventions, and this could be one of the reasons for individuals disengaging from regular practice (Farias et al., 2016). It is recommended that helping participants to explore and enhance their motivation for ongoing self-practice from the perspectives of both confidence and ability, and values, guiding principles and needs, could help to enhance commitment to home practice.

Second, the notion of taking action is also important from the point of view of people becoming more helpful, supportive, generous and caring for others and themselves as a result of these interventions. Active compassion has a “twofold benefit” (Ricard, 2015), in that not only does it help alleviate the suffering of others and all the benefits that go along with that, it also benefits the compassionate person, whose own physical, mental and social health can improve (Keltner et al., 2014; Simon-Thomas et al., 2012). Recent research by Matos et al. (2017) found that beyond formal meditation practices, the ability to embody compassion by bringing compassion to one’s life challenges and by incorporating compassion into one’s daily life may be of key importance for promoting the effectiveness of compassion-based interventions. However, a number of barriers to compassionate action have been identified through qualitative, anecdotal, and survey data, including many people still having a fear of compassion (Gilbert et al., 2011). It seems that many people worry that being compassionate will make them weak or vulnerable, or that others will take advantage of them (Gilbert et al., 2011; Gilbert & Irons, 2005). Furthermore, people also hold fears of self-compassion, concerned that it will lower their standards, make them self-indulgent, or that they might become lazy and lose their motivation (Leaviss & Uttley, 2015; Neff & Dahm, 2014). A further contributing factor is there are biases that also impact on one’s ability to respond compassionately to others, biases including, but not limited to, in- and out-group biases, diffusion of responsibility, and attributional errors (e.g., the person deserves their suffering; Ekman, 2014; Kirby & Gilbert, 2017) all diminish compassionate responding. Furthermore, not knowing how to respond and/or lacking the skills to respond effectively have also been cited as a barrier to compassionate responding to others in daily life (Gilbert, 2014).

Thus, compassion-based interventions that aim to build skills and reduce fears towards compassion are developing into empirically validated approaches to reducing various forms of psychological distress and improving psychological well-being and happiness. However, can these interventions become more effective through finding avenues to enhancing the motivational component of compassion, helping people to commit to, and carry out, more self-practice and more embodiment of compassion through compassionate action in daily life? The compassion-based interventions so far developed are psychoeducational and experiential, however they are not necessarily explicitly or individually evocative of participants’ own motivations and commitments. That is, these interventions do not tend to incorporate formal processes that work towards specifically evoking identifiable, compassion-related motivational thoughts, feelings and language from each participant, thereby assisting participants to resolve the ambivalence between their personal compassion facilitators and inhibitors. MI is an empirically validated approach that offers the possibility of enhancing motivation and commitment towards compassionate action through assisting participants to make their own personalised arguments for being more compassionate towards others and themselves in their life.
Motivational Interviewing

Given definitions of compassion include motivational components (Gilbert, 2014; Jazaieri et al., 2013), as well as the importance of taking action to self-practice the components of compassion-based interventions and to embody compassion by beginning to take compassionate action in daily life, it is important to explore avenues that help enhance the motivation, commitment and action. MI (Miller & Rollnick, 2013), and the insights it has gained regarding enhancing motivation for behaviour change generally, may provide a model for assessing and enhancing motivation and commitment for compassionate action.

MI is a therapeutic approach that aims at facilitating and enhancing a person’s motivation for change. MI is defined by Miller and Rollnick (2013) as “a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for a commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.” (p. 29) As indicated, MI itself incorporates compassion, along with partnership, evocation and acceptance, as part of the MI Spirit, or the relationship context within which the motivational interview is conducted. According to Miller and Rollnick (2013), “To be compassionate [in the context of MI] is to actively promote the other’s welfare, to give priority to the other’s needs.” (p. 20).

Initially developed for problem drinkers, MI has been found to be an effective approach to helping people change a range of health-related behaviours such as drinking, smoking, drug use, gambling, diet and exercise, and treatment adherence (Copeland, McNamara, Kelson, & Simpson, 2015; Lundahl et al., 2013; Miller & Rollnick, 2013). Miller and Rollnick (2013) suggest that MI is clinically relevant and useful in any situation when a person is considering a behavioural change, choice or decision.

The theorised components of a person’s motivation to change, referred to in the above definition of MI as “the person’s own reasons for change” (p. 29) (Miller & Rollnick, 2013) and collectively known as change talk (Moyers & Martin, 2006; Moyers, Miller, & Hendrickson, 2005), include their desire (what they would like to change), their ability (how they would make the change and how confident they are that they can do it), their reasons (why they would make the change), their need (what makes change important to them personally), and their commitment (what they will do). As part of MI, the clinician evokes change talk from clients on these five dimensions, generally by asking open-ended questions, providing affirmations, and using reflections, as well as summarising what the client is saying, thereby helping the client to formulate their own coherent argument for change. Client change talk during an MI session has been found to predict better client outcomes (Apodaca & Longabaugh, 2009). Also important are the client’s experience of discrepancy between their values and their behaviours (Apodaca & Longabaugh, 2009). And finally, change has been found to be more likely when the therapist avoids certain MI-inconsistent behaviours, such as giving advice without permission, confronting, directing, raising a concern without permission, and warning, and instead adheres to the MI Spirit (Apodaca & Longabaugh, 2009; Copeland et al., 2015). In fact, it has been hypothesised that the therapist’s adherence to the MI Spirit increases the change talk from the client, which in turn is associated with positive behaviour change outcomes (Copeland et al., 2015; Moyers, Martin, Houck, Christopher, & Tonigan, 2009). A recent meta-analysis found equivocal support for the predictive role of client change talk, however it did find that more sustain talk (i.e., when participants express their own arguments against change) was predictive of poorer outcome (Pace et al., 2017). In terms of client language, commitment language specifically has been found to be an important predictor of behaviour change (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Copeland et al., 2015).

MI has been found to be a useful prelude to other forms of treatment, improving the adherence to, and effectiveness of, subsequent treatment programs (Burke, Arkowitz, & Menchola, 2003). In the treatment of substance use disorders in particular (Carroll, Libby, Sheehan, & Hyland, 2001), and other behaviour change interventions (targeting smoking, diet and exercise, HIV risk behaviours and medication adherence), MI has been found to improve treatment engagement and program adherence (see reviews by Burke et al., 2003; Hettema, Steele, & Miller, 2005; Noonan & Moyers, 1997).

MI has also been combined with cognitive-behaviour therapy interventions targeting depression and anxiety to increase treatment initiation, adherence and completion (Arkowitz & Westra, 2009; Arkowitz, Westra, Miller, & Rollnick, 2008; Westra & Arkowitz, 2011). MI is often used as a prelude to treatment (Merlo et al., 2010; Westra, Arkowitz, & Dozois, 2009; Westra & Dozois, 2006; Zuckoff, Swartz, & Grote, 2008), and it has been shown to improve treatment outcomes (Merlo et al., 2010; Westra et al., 2009; Westra & Dozois, 2006), as well as to predict higher self-efficacy (Westra & Dozois, 2006), greater homework adherence (Westra et al., 2009; Westra & Dozois, 2006), and decreased resistance (Aviram & Westra, 2011) among participants. Importantly, current compassion-based interventions are only moderately successful at improving compassion and
decreasing suffering (e.g., depression, anxiety, distress), as found in a meta-analysis by Kirby et al. (2017). Although moderate effects are very important and encouraging, it does indicate that interventions can be improved. We propose that incorporating MI as a prelude to compassion-based interventions may offer similar benefits to program engagement, initiation, adherence and behavioural change.

**Change Talk in the Context of Compassion-Based Interventions**

In MI, the role of the clinician is not to persuade or convince a person to change, but rather to skillfully evoke change talk that is relevant to the target behaviour the client wishes to cultivate. In relation to compassion interventions, it is important to note that compassion interventions tend not to be prescriptive in specific practice components. Rather the emphasis is on skilful practice of techniques, or as CFT emphasises, drawing upon the client’s own intuitive wisdom regarding the specific practices one feels resourced to engage in meaningfully. Thus, MI could be particularly useful in helping clients when he/she express a clear desire to be compassionate but may have conflicting beliefs about what behaviours may result in being compassionate.

In the case of compassion-based interventions, the behaviours that could be the focus of MI include (1) to attend the intervention’s sessions, (2) to complete the self-practice for homework, (3) to engage with aspects of suffering that the participant would rather avoid, and (4) to take steps towards embodying compassionate or self-compassionate actions in daily life. Importantly, the clinician is very gently guiding the client towards this change talk, while at the same time ensuring that the client’s sustain talk are accepted and validated. From the point of view of compassion, change talk might relate to a participant’s perspective on facilitators of compassion as they relate to themselves personally, such as benefits, alignments with values, and confidence and coping ability. On the other hand, sustain talk might relate to fears, resistances and blocks as discussed above. Arguments between the clinician and the client where the clinician is arguing for change (arguing for facilitators) while the client is arguing against change (expressing their inhibitors) are predictive of the client not changing (Amrhein et al., 2003), and are therefore preferably avoided.

Examples of the kind of change talk that could be evoked through MI in the context of compassion-based interventions can be found in Table 1.

And thus, an MI conversation regarding the topic of compassion might sound something like that outlined in Table 2.

### Fears, Resistances and Blocks to Compassion

One of the key advantages of including MI formally as both a prelude to, and/or continuing throughout, compassion-based interventions is working with participants’ barriers to compassion. In MI, the client is assisted to explore and resolve their ambivalence about behavioural change or action. Often people feel two ways about change, represented by change talk on the one hand and sustain talk on the other. “Sustain talk and change talk are conceptually opposite—the person’s arguments against and for change” (Miller & Rollnick, 2013, p. 165).

Thus, sustain talk is a person’s expression of their own personal arguments against change, and often involves their desire, reasons and need for the status quo, as well as their sense of inability to change. People will often feel and express sustain talk regarding taking compassionate action in the form of fears, resistances and blocks (Kolts, 2016). Compassion is misunderstood by many, with fears of compassion being prevalent, including that it is a weakness or self-indulgence, fearing that compassionate efforts will be incompetent or unhelpful, and fears of behaving inappropriately (e.g., bystander effect; Vitai liano, Zhang, & Scanlan, 2003). Others will have blocks to compassion, which are linked to environmental/contextual factors, for example a workplace that is understaffed but overwhelmed to deliver on outcomes (e.g., a school or hospital setting), thus creating blocks to being compassionate (Brown, Crawford, Gilbert, Gilbert, & Gale, 2014). Finally, resistances are those instances

<table>
<thead>
<tr>
<th>Change talk type</th>
<th>Change talk example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion</td>
<td></td>
</tr>
<tr>
<td>Desire</td>
<td>I would like to be kind and caring towards others</td>
</tr>
<tr>
<td>Reason</td>
<td>Supporting and nurturing others has many benefits</td>
</tr>
<tr>
<td>Need</td>
<td>Helping those in need is an important value for me</td>
</tr>
<tr>
<td>Ability</td>
<td>I feel confident that I can help people who might be suffering</td>
</tr>
<tr>
<td>Commitment</td>
<td>I will act more compassionately towards others</td>
</tr>
<tr>
<td>Self-compassion</td>
<td></td>
</tr>
<tr>
<td>Desire</td>
<td>I would like to be tender and warm towards myself</td>
</tr>
<tr>
<td>Reason</td>
<td>There are advantages to being kind and caring towards oneself</td>
</tr>
<tr>
<td>Need</td>
<td>It is important to me to be accepting of my whole self</td>
</tr>
<tr>
<td>Ability</td>
<td>I am able to be loving towards myself when I feel emotional pain</td>
</tr>
<tr>
<td>Commitment</td>
<td>I’m going to act more compassionately towards myself</td>
</tr>
</tbody>
</table>

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when a person wants to be compassionate, but resists. For example the person could be more focused on competitive motives (engage in self-focused interests as opposed to sharing), or resist being compassionate to another because the suffering is not “intense” enough to deserve action. It is very important not to argue with these kinds of fears, resistances and blocks. When we argue with sustain talk, it often becomes entrenched with the person arguing even more strongly against change or action (Miller & Rollnick, 2013). In MI, the clinician listens to and empathises with the person’s sustain talk, honouring the fact that there might be two sides to the decision about whether to act more compassionately towards others or oneself. Feeling heard and understood regarding fears, resistances and blocks towards compassion, the person may then feel more willing and able to also explore the change talk side of their ambivalence, and eventually resolve their ambivalence in the direction of change (Miller & Rollnick, 2013). See Table 3 for an example of a clinician working with sustain talk in the context of a compassion-based intervention.

### Measuring Compassion-Related Motivation

Oddly, despite the centrality of motivation and commitment in definitions of compassion, current measures of compassion do not assess these components (MacBeth & Gumley, 2012). To date, compassion towards others and oneself have been separately measured (MacBeth & Gumley, 2012), with the Fear of Compassion Scale (FCS; Gilbert et al., 2011) being a widely used measure to assess for compassion towards others, from others and towards oneself, and the Self-Compassion Scale (SCS; Neff, 2003) being a widely used measure to assess self-compassion. The FCS includes 38 items and the SCS has 26 items, and both have good psychometric properties.
Table 3  Accepting and validating sustain talk and guiding back to change talk

| Clinician | So, it sounds like you are really quite nervous about how to get started with incorporating more compassion into your life. (reflection of sustain talk) |
| Client | Yeah, I really want to to it, but I’m just so busy with work and I have to keep performing, you know? I always seem to be having to do work on my own time. |
| Clinician | I really appreciate that your desire to be more compassionate is strong. I’m also hearing that it’s difficult. Do you mind if we explore that side of it for a few minutes? (asking permission to explore sustain talk side of ambivalence) |
| Client | Yeah, that’s ok. |
| Clinician | So tell me a bit more about your concerns being able to fit it all in. (open question) |
| Client | Well, I’m new to my company, and there are a lot of young guns there, hitting their targets, winning awards. I’m really trying to establish myself, but I’m a bit older and a bit slower than them. I feel like if I want to compete then I have to do more. |
| Clinician | Work is really important to you and you have a very strong work ethic. (affirmation) |
| Client | Yeah, I guess so. I want to be successful, you know? I want to get some runs on the board and feel comfortable in my job. So when I think about trying to do something more community-based then I start to worry about whether I can fit it in, and whether I can do it properly. (sustain talk) |
| Clinician | I can see that the idea of trying to bring more compassionate action into your life actually makes you feel a bit anxious. You almost feel like it would be impossible to fit in. And you worry you won’t do it properly. Can you tell me more about that piece? (expressing empathy, exploring sustain talk further) |
| Client | Well if I’m going to do it, I want to do it well. |
| Clinician | You really like to have high standards of yourself. You have high standards of yourself at work, and you would also have high standards if you were to do some other things in the community. (affirmation, linking) |
| Client | If it’s worth doing, it’s worth doing right. |
| Clinician | Yes, I see what you mean. |
| Client | But that makes me feel like I probably shouldn’t even bother getting started. |
| Clinician | It makes it all feel a bit disheartening and impossible. It all feels too much. (reflection, expressing empathy) |
| Client | Mm. That’s right. (feels heard and understood) |
| Clinician | Mm. (silence, inviting the client to continue) |
| Client | I just wish I could find a way. I really want to do something. (desire change talk) |
| Clinician | Even if it were something small, perhaps. (guiding towards change talk) |
| Client | Yes, some sort of first step. Maybe if I aim for something a bit more achievable. |
| Clinician | Yes. You don’t have to do everything at once. But you could start with a little something. (reflecting ability change talk) |
| Client | Yeah, I could do a little something. That might make me feel a bit better about it all. |
| Clinician | Well, I respect the fact that your life is busy and it’s difficult to add anything more to the mix. However, you really have a strong desire to take more compassionate action in your life, even if it is something small. Would you mind if we go on to talk about what that could be be? (asking permission to discuss ability change talk) |
| Client | Yeah, I think that’d be a good thing to do next. |

(Gilbert, 2014; Neff, 2003). However, a significant limitation of both these compassion measures is that neither assesses the motivation or commitment of compassionate action of the individual. Motivation and commitment are important to measure to determine if compassion programs can enhance an individual’s willingness to act on compassion (MacBeth & Gumley, 2012).

In MI, motivation is often measured through Change Rulers, 0–10 subjective scales that invite clients to rate their confidence and importance for change. For example, in the event that a focus of MI in the context of a compassion-based intervention is self-practice of core LKM meditations, the following scaling questions could be used:

On a scale of 0 to 10, how confident are you that you could practice these loving-kindness meditations in your own time at home?

On a scale of 0 to 10, how important is it for you to practice these loving-kindness meditations in your own time at home?

Importantly, these questions are asked in the Spirit of MI, including a sense of partnership, acceptance and compassion. They are then followed by further inquiry, namely “What makes you give yourself that number and not zero?” and “What could you do, do you need, might help you to increase your confidence/importance?”

Such questions can be used early in the intervention and later in the intervention, to assess changes in motivation for, and commitment to, homework self-practice and/or embodied compassion-related action.

It is likely that confidence will be particularly valuable to assess. The MI literature discusses the combination of confidence and importance of change. One frequent combination is where a person is high in importance for
change, but low in confidence. In other words, the person might indicate, “I really need to change, but I’m not sure whether I can.” Given the research into fear of compassion and self-compassion, it is hypothesised that an vital task of compassion-based interventions will be to build confidence in terms of enacting compassionate action and coping with the distress that may emerge when approaching suffering via affirming strengths and qualities, and careful action planning. Being able to identify low confidence at the outset of a compassion-based intervention could be a very useful indicator of what the focus of MI in the intervention should be.

**Measuring Compassion-Related Action**

Compassionate action itself is also not directly measured by the established compassion-related questionnaires. Often, research into compassion-based interventions (for a review see Kirby et al., 2017) include pre- and post-intervention administration of the FCS or SCS, as well as outcome measures, such as those that measure various aspects of psychological well-being (eg., depression, anxiety, psychological distress). However, these studies rarely measure actual changes in compassionate action from pre- to post-intervention. It is becoming established that compassion-based interventions are effective at improving compassion, self-compassion, and psychological well-being, however, whether participants actually start or increase their embodiment of compassionate action in daily life is hitherto not assessed and therefore not known.

From an MI perspective, commitment language has been found to be most predictive of actual change (Amrhein et al., 2003; Copeland et al., 2015). As such, inviting participants of compassion-based interventions to make statements of commitment can be a useful way to increase the chances that they will follow through with those behavioural changes or actions. A commitment question, based on LKM self-practice being the focus behaviour of a motivational interview, may be phrased as, “Given all we have discussed today, including how important this is for you, and the steps you feel confident being able to take, what will you do regarding your LKM practice this week?” The following scaling question could also be used to gauge a person’s strength of commitment and to explore ways to strengthen commitment further:

*On a scale of 0 to 10, how committed are you to practice these loving-kindness meditations in your own time at home? “What makes you give yourself that number and not zero?” and “What could you do, do you need, might help you to increase your commitment?”*

It can be difficult to measure compassionate action itself. In other areas of behaviour change, the changes themselves can be easier to define and measure (e.g., number of standard drinks, hours in the gym, medication adhered to). With respect to compassionate action, the possibilities of change are wide-ranging and therefore difficult to operationalise. However, as a starting point, the general themes of items that could be further explored include:

*On a scale of 1 to 5, where 1 is “a lot less” and 5 is “a lot more”: Compared to usual, I have acted more compassionately towards others over the past week; and Compared to usual, I have acted more self-compassionately over the past week.*

Naturally, in the context of compassion-based interventions, there is an urgent need for the development of a measure that assesses the potential changes in motivation and commitment to compassionate action, as well as the potential changes in the compassionate action itself.

**Conclusion**

While compassion is defined in various ways and with different levels of detail and nuance, across all definitions are the core components of motivation, commitment and action. Several compassion-based interventions have been developed to help participants cultivate compassion for themselves and/or others, and often these interventions include certain aspects of behavioural change. The interventions require good engagement and attendance at sessions, and incorporate meditative practices, such as LKM and CM, or other exercises and strategies, which then require self-practice between sessions. Furthermore, interventions attempt to develop participants’ willingness to approach suffering they may observe and increase embodiment of compassionate action in daily life. MI offers an opportunity to increase the motivation, commitment and action of participants in compassion-based interventions across all four of these behavioural domains. Developing a relationship with participants that adheres to the MI Spirit and then using reflective listening skills to evoke participants’ change talk and commitment language as a prelude to compassion-based interventions could make an important contribution to enhancing participants’ likelihood of engagement, self-practice and compassionate action. Future research could explore the effect of incorporating MI as a prelude to compassion-based interventions on treatment outcome.

**References**


