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Using Compassion Focused Therapy to Work with Shame and Self-Criticism in Complex Trauma

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Abstract: Fear is often the primary diagnostic and treatment focus in the alleviation of traumatic distress. However, shame has equally debilitating effects, including being related to inadequacy, self-criticism, and secondary emotions, such as anger. Shame is a particularly potent component in PTSD. This paper outlines the principles and approaches of compassion focused therapy (CFT), based on the work of Gilbert (2014; Gilbert & Irons, 2005). It includes an overview of the three affect regulatory systems model and outlines ways in which clinical psychologists can assist clients to reduce shame and self-criticism by developing a compassionate understanding of themselves in relation to their trauma.

Keywords: compassion focused therapy, shame, self-criticism, trauma, self-compassion

Introduction

Posttraumatic stress disorder (PTSD) is a common and debilitating experience, with a lifetime prevalence of over 8.3% (Kilpatrick et al., 2013). Symptoms include reliving the event (e.g., through flashbacks or nightmares), avoiding being reminded of the event and hyperarousal. A variety of effective psychological treatments have been developed to work with PTSD, including cognitive-behaviour therapy (CBT) and eye movement desensitisation reprocessing (EMDR). Often the primary focus of both diagnostic and treatment programmes has been the affect of fear, and whilst other emotions and psychological factors are also seen as important, these are rarely seen as the primary focus of therapy.

In recent years, however, a number of researchers and clinicians have argued that other emotions may—and in fact should—be a central focus of the treatment of trauma, and its conceptualisation. Research appears to back this up. For example, Holmes, Grey, and Young (2005) found that fear was the primary "hot spot" emotion in reliving, with other emotions such as anger, sadness and shame also being common.

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Shame in Trauma

Shame is a powerful "self conscious", multi-faceted emotion. It tends to be experienced with an urge to conceal, hide and cover, and is often related to feeling powerless, inferior and a sense of social unattractiveness (Tangney, Miller, Flicker and Barlow, 1996). It often blends with other primary emotions (e.g., anxiety or anger; Gilbert, 1998) and has been found to be highly associated with psychopathology symptoms (e.g., Kim, Thibodeau & Jorgensen, 2011).

Numerous studies have found that emotions, such as shame, may also be important in understanding PTSD (Harman and Lee, 2010). For example, Andrews, Brewin, Rose and Kirk (2000) found that PTSD symptoms in victims of violent crime were associated with shame, both one month and six months following the incident. Research has found that people experiencing symptoms of PTSD also experience high levels of shame (Holmes et al, 2005; Grey, Holmes & Brewin, 2001), whilst Dorahy et al. (2013) found that increased levels of shame and self-criticism predict complex trauma in a group of veterans who have been in conflict zones.

One prominent model of shame suggests that *internal shame*—the sense one has about oneself as inferior, flawed and inadequate—is highly associated with self-criticism (Gilbert, 1998). Harman and Lee (2010) found that shame is also associated with self-criticism in trauma presentations. It has been hypothesised that evaluating oneself in a negative manner may not only maintain levels of shame, but also difficulties commonly associated with trauma (Boyer, Wallis and Lee, 2014). Moreover, high levels of shame have also been associated with difficulties relating to oneself in a reassuring, caring way. Crucially, research has found that emotions like shame may not respond to exposure based approaches to treatment in the same way that anxiety does; in fact, working in this way with traumatised clients may actually lead to an increased risk of non-attendance of sessions and even dropout rates in therapy (e.g., Adshead, 2000).

Given some of these findings, and our understanding about shame, it may be that approaches that work directly with shame in a trauma context may also have something to offer.

Compassion Focused Therapy

Compassion focused therapy (CFT) was developed by Paul Gilbert to work with people with complex and chronic mental health problems, many of whom struggled with high levels of shame and self-criticism. Many of these clients came from backgrounds characterised by difficult attachment relationships, and had experienced caregivers and others more generally as hostile, critical and abusive. Whilst many of these clients could bring a more balanced perspective to their thinking through standard CBT interventions, they struggled to feel any better: "I know now that I'm not to blame for the abuse I experienced, but I still feel like there is something bad and wrong with me". This phenomenon, sometimes referred to as the head-heart lag or rational emotional dissociation (Stott, 2007) is common in therapy but may block the effectiveness of psychotherapy. Similarly, Gilbert found this to be the case in many of his patients, some of whom described engaging in standard therapy interventions (e.g., thought forms) with inner voice tones that were laced with anger, hostility and disgust. Upon attempting to help clients to warm up their inner voice tone, many struggled to do this. In fact, some even found this to be an aversive experience. So CFT emerged from trying to understand the block to certain types of positive affect characterised by care, kindness and worth, and started in simple ways by helping clients to practice bringing a warm and caring voice tone. CFT now incorporates

a variety of practices designed to develop compassion (see Gilbert, 2014, for a further discussion) towards their difficulties with a sense of strength, wisdom and courage, thus changing those inner critical tones.

Basic Assumptions of CFT

We have tricky brains.

CFT is grounded in evolutionary psychology, which stresses the importance of understanding our brains and emotions in the context of how they have been shaped by evolutionary processes over millions of years (Gilbert, 2014). CFT therapists share a heuristic with our clients that humans have very old (in evolutionary terms) parts of our brains—referred to as our 'old brain'—which we share with other animals. Our old brains include basic *motives* to pursue food and reproductive opportunities, to care for our offspring and be orientated by status; basic *emotions* (e.g., anger, anxiety and disgust) and *behaviours* (e.g., fight, flight, freeze and submission). However, during the last million years or so, our ancestors evolved along a line that led to a rapid expansion of complex cognitive abilities (linked to the frontal cortex region of the brain) including the capacity to imagine, plan, ruminate, mentalise and self-monitor. These abilities lie at the heart of our creativity and intelligence, are likely to have been at the heart of our survival and flourishing in the world, allowing us to tackle complex problems and form large social groups (Gilbert, 2014).

However, these same abilities can also create problems for us. For example, if a zebra is chased by a lion and then escapes, relatively soon after this it will begin to calm down. However, if we escape a lion that is chasing us, it is unlikely we would calm down quickly; rather, under conditions of high, old brain emotion (e.g., anxiety), our new brains are shaped and influenced. We are likely to worry about could have happened if the lion had caught us, or worry about whether it will still be there later. In turn, these new brain patterns of thinking and imagining send signals to our old brain, keeping the threat going. As a result, through no fault of our own, we can easily get caught up in 'loops in the mind' that can drive much of our distress. This is salient in understanding some of the experiences of trauma, and in particular, shame and self-criticism in trauma. For many people who experience trauma, it can be the meaning making around this that keeps some of the distress going: "It's my fault that this happened, I'm to blame"; "If I'd just shouted out or fought him off, I wouldn't have gone through what I did"; and "I shouldn't still be struggling with this—it happened years ago and I should be strong enough to be over it now". So we can see that humans have a unique ability to self-reflect and make conclusions about traumatic events that tend to continue the threat.

Three emotion-system model.

Based on a variety of scientific theories and findings (Depue & Morrone-Strupinsky, 2005; LeDoux, 1998; Panksepp, 1998), CFT suggests we have three major emotion regulation systems.

- The *threat system* evolved to detect and help us respond to threats in the world. It is associated with certain protective behaviours (e.g., flight, fight, freeze and submit responses) and emotions (such as anger, anxiety and disgust). This system can often be dominant and directs attention to the nature of the threat, and creates "better to be safe than sorry" styles of thinking (e.g. overgeneralising, catastrophising, or "worst case scenario") which facilitate quick threat based responses. It is highly conditionable,

and plays an important role in understanding the development and maintenance of trauma, shame and self-criticism.

- The *drive system* evolved to direct attention energy towards pursuing and attaining beneficial resources (e.g., food, shelter, sexual opportunities). When successful in achieving or attaining these, this system can leave us experiencing positive emotions and feelings such as excitement, joy and elation. Whilst an important source of positive emotion and drive, this system can get hooked in to the threat system in trauma and shame experiences. This type of 'threat-based drive' often involves attempts to escape feelings of threat (e.g., flashbacks, a sense of inferiority or worthlessness) by trying to achieve and strive for things, or through addictive behaviours (e.g., drugs, alcohol).
- The *soothing-affiliative system*. When not threatened or pursuing things, animals need to be able to slow down, rest and recuperate, and experience periods or calm and peacefulness. This is sometimes known as the 'rest and digest' system, and is linked to a number of physiological responses (e.g., the parasympathetic nervous system) that are associated with calming and slowing the body down, and with feeling a sense of soothing, calmness and contentment. Over time, this system was adapted with the mammals to be linked to the experience of attachment, caring, and bonding, and may therefore be linked with a 'tend and befriend' motivation. The physiology underpinning this system appears to play an important role in regulating the threat system. There is now a large body of literature highlighting the powerful impact that being cared for has upon our physiology, emotions and mental wellbeing (e.g. Carter, 1998; Slavich and Cole, 2013). Unfortunately, for many people experiencing trauma, and shame-based experiences linked to trauma, this system is often absent, blocked or experienced aversively. In particular, complex traumas underpinned by interpersonal causes (e.g., physical or sexual abuse) can often lead to difficulties experiencing care, kindness and support in the here-and-now.

CFT uses a 'not your fault' approach to helping clients appreciate that we are socially shaped, and like the loops that can form between our old and new brains, our emotion systems are textured by our experiences in life. Helping clients struggling with trauma and shame experiences to understand how both the origin and maintenance of their problems are understandable, can be an important step in bringing compassion to one's experience. However, the three emotion system model also provides a basis of change, and in particular, with attempts to help clients manage their threat systems in helpful ways, often by learning how to bridge out of this and in to using the soothing-affiliative system to regulate their difficulties and distress. Much of this involves a "de-shaming" process, recognising that many of our difficulties in life were not of our choosing and over which we had little control, but that taking responsibility for how we can learn new ways of managing our distress is central to developing compassion for oneself.

What is Compassion?

CFT seeks to facilitate change through the development of a "compassionate mind". CFT uses a standard definition of compassion as *a sensitivity to the suffering of self and others, with a commitment to try to alleviate or prevent it*. There are two key psychologies that underpin this

definition. The first involves developing the ability to notice and turn *towards* and engage *with* suffering (as opposed to avoiding or dissociating from it). We recognise that engaging with distress and suffering is often difficult; the first psychology of compassion involves a form of strength and courage to do this. Interested readers can find out about the different attributes that increase compassion (Gilbert, 2014).

The second psychology of compassion involves developing wisdom and dedication to find ways to alleviate and prevent suffering. This requires practice in developing skills and techniques that aid our ability to manage suffering and advance our well-being. CFT is a multi-modal model, and pulls upon a variety of skills training including those linked to attention, reasoning, imagery practice, behavioural interventions and so forth. The CFT therapist will attempt to help their clients cultivate a 'compassionate mind' by toning up various qualities of mind.

CFT views the therapeutic relationship as a key mechanism for change, and sharing key techniques with other approaches such as the use of Socratic questioning, guided discovery, inference chaining, exposure, behavioural experiments, the use of imagery and breathing techniques.

CFT: Working with Shame and Self-criticism in Trauma

As a multi-modal approach, CFT draws from a variety of interventions to help clients learn how to manage their difficulties and cultivate a more compassionate approach to themselves. Some of these include:

Attention and mindfulness.

Like many other approaches, clients are supported in developing their attentional and mindfulness skills as a way to notice "loops in the mind" and unhelpful (although understandable) ways of managing their symptoms and distress. Developing skills in mindfulness facilitates groundedness in the here-and-now, and helps to facilitate emotion regulation.

Breathing and body posture work.

CFT uses the emerging "science of breathing" which suggests that certain types of breathing rhythm (e.g., smooth, rhythmic and slower) are associated with stimulation of the parasympathetic nervous system (Sovic, 2000). These may help to regulate the threat system; deeper breaths from the stomach are related to regulation of the threat system, which consequently decrease thinking biases focused on threat. We also help clients work on using body posture, facial expression and voice tones as potentially powerful ways of stimulating helpful physiological responses in the body that also help to regulate the threat system.

Developing the compassionate self.

Clients are helped to develop a compassionate part of themselves, linked to the qualities of wisdom, strength and commitment. This involves various skills training, including those linked to memory, imagery and acting (e.g., Gilbert, 2014). Once developed, clients are encouraged to use this part of them to relate to their trauma memories, sense of shame and self-criticism. Although self-compassion is a key focus, we are also interested in clients feeling able to relate to others in caring and compassionate ways, and also be open to the care, kindness and compassion of others. Collectively, these are referred to as the three flows of compassion.

Depending on the nature of the presenting difficulties, therapists will also help clients to utilise a variety of common therapy interventions that can be helpful in working with trauma, including those specifically related to trauma (e.g., rescripting, exposure) and those related to working with self-criticism and shame (e.g., chair work, letter writing, thought forms). In this sense, CFT is an integrative approach, pulling on interventions used in other therapies but using these through the qualities of the compassionate self.

A significant aspect of CFT generally, and certainly in working with trauma specifically, is working with the common fears, blocks and resistances to compassion that many people experience (Gilbert, 2014). In a qualitative study, Lawrence and Lee (2014) found that clients with trauma experiences initially had aversive and fearful responses to attempts to become more compassionate with themselves. However, over time and with the support of the therapeutic relationship, they were able to experience more positive feelings associated with self-compassion, and a more positive outlook generally to their future.

Evidence

CFT is a relatively "young" psychotherapeutic approach, and the evidence base for its use in a variety of difficulties is growing (Leaviss & Uttley, 2014), with particular approaches and models emerging to work specifically with PTSD and trauma (e.g., Lee, 2009; 2012). However, there are a number of studies that have looked at the outcome of CFT with trauma populations. For example, Beaumont, Galpin & Jenkins (2012) found that trauma clients receiving CBT, or those receiving a combined treatment of CBT and CMT (compassionate mind training) skills, both experienced significant reductions (and of a similar magnitude) in symptoms of anxiety, depression, avoidant behaviour, intrusive thoughts and hyperarousal symptoms post therapy. However, participants in the combined CBT and CMT treatment reported significant higher self-compassion scores than those just receiving CBT.

There have also been a number of studies that point towards the potential helpfulness of compassion in trauma. For example, Kearney et al. (2013) found reductions in PTSD symptoms in veterans experiencing symptoms following a 12 week loving kindness meditation course, and Neff (2003) found that self compassion was associated with lower levels of PTSD severity, and less rumination. In 115 war veterans, Hiraoka et al. (2015) found that lower levels of self-compassion predicted baseline PTSD symptoms, and 12 month PTSD symptoms.

Summary

Although shame and self-criticism are common experiences in traumatised clients, they may not take a central role in our formulations and interventions during treatments. CFT is a promising treatment for presentations high in shame and self-criticism, and provides an exciting approach to working with trauma presentations.

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