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10 Compassion Focused Therapy

Compassion Focused Therapy (CFT) is an integrated and multifaceted approach to working with individuals experiencing psychological and emotional distress (Gale, Gilbert, Read, & Goss, 2014; Gilbert, 2010; Gilbert & Irons, 2005). It has been described as part of the growing movement in Cognitive-Behavioural Therapy (CBT) which embraces compassion, mindfulness, imagery, and eastern philosophies as integral parts of psychological therapy (Gale et al., 2014; Gilbert, 2009a, 2014). Although sharing some similar principles with CBT (Westbrook, Kennerley, & Kirk, 2011), CFT differs in its philosophical underpinnings, understanding of psychological difficulties, and technical application. CFT aims to help people regulate affect and distress, and alleviate suffering, through the cultivation of compassion (Gilbert, 2010).

10.1 Historical Origins of Compassion Focused Therapy

CFT was developed by Paul Gilbert for people with complex and chronic mental health problems who were struggling to make progress in standard therapies (Gilbert, 2009a). Many of these people presented with high levels of shame and self-criticism, and had early life experiences characterised by high levels of threat (e.g., abuse, criticism, neglect) or the absence of care, affection, and love. Gilbert found that in using standard therapies (e.g., CBT), clients would report: "I know what you're saying, and I can see rationally that it wasn't my fault that I was abused, but I still feel like it was and that there's something wrong with me". This has been described as the head-heart lag, cognition-emotion mismatch, or rational emotional dissociation (Stott, 2007).

As Gilbert explored this experience with his clients, he recognised that, whilst many were able to generate helpful and evidence-based alternative thoughts in a standard cognitive way, the emotional tone of these new thoughts was often laced with a variety of negative emotions and feelings, such as anger, contempt, disappointment, or coldness. What also emerged was that, when asked to generate a more caring, warm, and compassionate feeling to go alongside the alternative thoughts, many clients found this very difficult, scary, or aversive. So, CFT developed initially as a way to help clients practice generating a certain type of positive emotional tone (e.g., in their tone of voice) that is rooted in a certain type of affiliative positive affect.

10.2 Theoretical Underpinnings and Central Tenets

CFT is grounded in a broad scientific literature and research base, and guided by findings from evolutionary, developmental, attachment, neuroscience, neurophysiological, and social psychological literatures. It also draws upon ideas from Buddhist philosophy and practice. There are a number of key theoretical ideas that underpin the approach:

10.2.1 Principle 1: Our Complex Minds and Motives Emerge from Evolutionary Processes

As an evolutionary psychology-informed approach, CFT suggests that, as part of the 'flow of life', humans evolved via the mammalian and then primate lines, and consequently share similar *motives* (e.g., to seek status, to form attachments, to nurture our children), *behavioural responses* (e.g., fight, flight, submission), and *basic emotions* (e.g., anger, anxiety, disgust). These are referred to as 'old brain' abilities. However, approximately two million years ago, pre-human ancestors began to evolve a range of new cognitive competencies linked to capacities for inductive and deductive reasoning, imagination, and anticipation, along with a capacity for complex self-monitoring and self-identity. Consequently, unlike other primates (as far as we know), we can anticipate things that haven't happened yet, ruminate about the past, and imagine various real and fantastic scenarios. Unfortunately, whilst evolution brings a variety of adaptive advantages, it does so via trade-offs. The way our minds have evolved has left them very 'tricky', with built in non-rational glitches which are vulnerable to unhelpful feedback loops (Gilbert, 1998). Examples can help clients understand this phenomenon, and a commonly used example in CFT is to consider a zebra running away from a lion. Once the zebra gets away, and the stimulus is no longer present in the olfactory visual or auditory domains (and nothing threatening remains), it will calm down relatively quickly. In contrast, a human would obviously be relieved to escape the clutches of a lion, but can recreate the stimulus profile in their own heads and imagine what might have happened if they had been caught (e.g., the lion eating them alive) or worry that the lion might come back. These processes will thus continually stimulate old brain emotions (e.g., anxiety) and defensive responses (e.g., flight, avoidance). Because we have a 'new' brain, we can bring threat stimuli that were once external 'inside the head', keeping them going even in the absence of an actual, current threat. Our old and new brain can get in to 'loops' that are not our fault (see Fig. 10.1). The key thing is that these loops can cause and drive much distress for people, and understanding the nature of these loops for our clients – and that these processes are not their fault – can be an important insight in CFT – a first step in formulation.

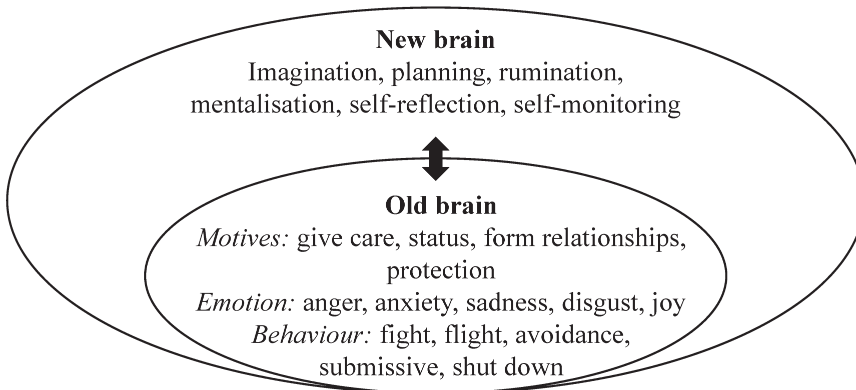


Figure 10.1: Old Brain/New Brain Interaction (adapted from Gilbert & Choden, 2013)

10.2.2 Principle 2: Our Sense of 'Self' is a Product of Our Genes and Socio-cultural Experiences

It is useful to help clients understand how our sense of 'self' emerges in the interaction between our evolved, genetically shaped minds and our social circumstances. Many of our clients have a sense of self – which often they describe in highly negative, denigratory terms – as somehow fixed or immutable; the 'I was born bad and defective' sense of self. However, we do not choose our genes, and for the most part, do not choose the types of experiences we have or social circumstances of our life (particularly in early life). Research has shown that our minds are highly plastic, as are our phenotypes (Belsky & Pluess, 2009), and scientific developments in understanding gene-environment interactions, including the study of behavioural epigenetics (e.g., Masterpasqua, 2009), are further contributing to our understanding that 'this version' of all of us is just one possible version of what might have been, given different genes and experiences. We ask our clients to imagine if we, as a therapist, had been abducted as a three-day old child by members of a violent drug gang. Here, clients are invited to imagine how the therapist might have been different if that had happened, how they might be more prone to certain emotions (e.g., anger), behaviours (e.g., aggression and violence) and types of relationship (e.g., mistrusting, abusive). These are not things that we ever wanted, but rather, emergent, phenotypic variations due to the interaction of our genes and experiences. There are a wide variety of different versions of us that may currently lie dormant, or could be shaped up with different experiences in the future. Therapy of course is one such experience that might help to bring a different version of self to the fore.

10.2.3 Principle 3: We Have Evolved Three Basic Emotion-regulation Systems

A key tenet of the model is developing an understanding of our basic evolved emotion systems and how they are balanced for our clients (see Fig. 10.2). Derived from the work of Panksepp (1998) and Depue and Morrone-Strupinsky (2005), CFT uses a simplified model of functional emotions in which we suggest that there are three basic emotion regulation systems:

The threat and self-protection system. This system evolved to help animals detect and respond to threats to themselves, but also important others (e.g., their offspring). To help in this process, this system utilises various brain systems (e.g., amygdala) and brain-body hormonal stress responses (the hypothalamic-pituitary-adrenal axis) to activate ancient behavioural responses (e.g., freeze, flight, fight, submission) and threat-based emotions (e.g., anger, anxiety, disgust) to help us manage threat and harm. Cognitive functioning under threat system activation often works on a 'better safe than sorry' basis, naturally biasing thinking and narrowing attention.

The drive seeking system. This system evolved to help animals seek out, pursue, and acquire important resources. This can include pursuing and acquiring important things like food, territory, and reproduction opportunities, along with social drives and rewards, for example, social approval, status, and power. It is a highly activating system, giving us bursts of energy that move us towards goals, and leaves us with certain types of positive feelings (joy, elation) when we have achieved them.

The contentment and soothing-affiliative system. When they are not managing threats, nor pursuing resources, it is important for animals to rest and recover. Sometimes known as the 'rest and digest' system, this affect regulation system is associated with a variety of lower energy positive emotions such as calmness, safeness, and contentment. It is linked to activation of the parasympathetic nervous system and vagus nerve (Porges, 2009) and to the neurohormones oxytocin and endorphin, and appears to have a naturally regulating effect on the threat system (e.g., Carter, 2014).

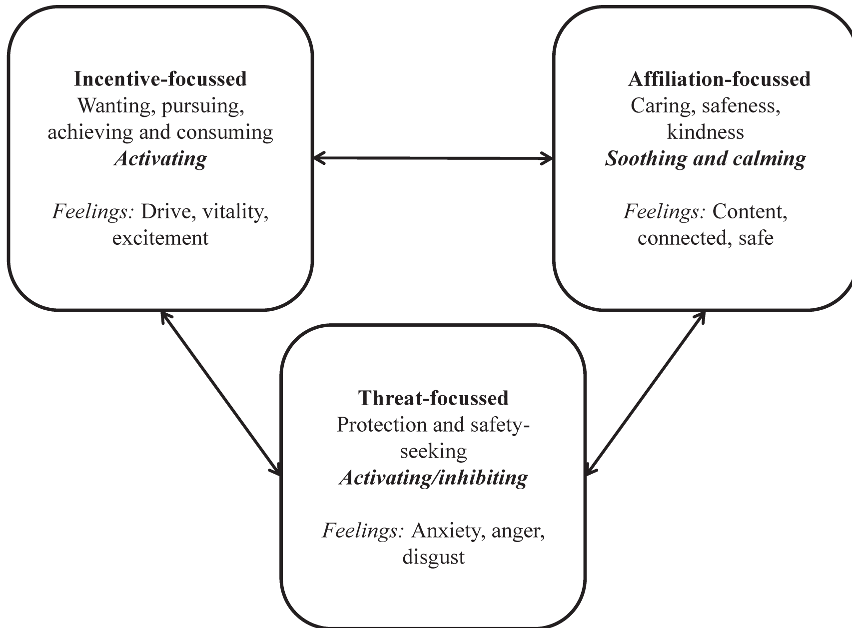


Figure 10.2: Our emotional regulation systems (adapted from Gilbert, 2009a)

10.2.4 Principle 4: Bringing Our Emotion-regulation Systems Into Balance Increases Well-being

CFT is concerned with the functioning of all three systems, but, in particular, the functioning and development of (or, in many cases, *block to*) the soothing-affiliative system. Mammals – and humans in particular – have evolved to be highly in need of, and responsive to, affiliative relationships and signals of care and affection (Carter, 2014). The experience of care and affiliative relationships impacts on a variety of threat-based physiological systems (e.g., Cozolino, 2007), genetic expression (Belsky & Pluess, 2009), and the way that we relate to ourselves and others (e.g., attachment theory; Bowlby, 1969).

10.3 What is Compassion?

Emerging initially out of parent-child mammalian dyads, the capacity to care for our young, the elderly, and for each other, is thought to have been a key behaviour in the success of mammals, including humans. Here, various qualities of caring and

affiliation helped to facilitate these abilities, and out of these attributes emerged the more complex psychological process of compassion. CFT uses an adapted version of a common definition of compassion: "a sensitivity to the suffering of self and others (and the causes of that suffering) with a deep commitment to relieve it, prevent it from returning, and promote wellbeing."

From a CFT perspective, this definition holds two different psychologies: (1) the attributes and capacity to be sensitive towards and engage with distress and suffering; and (2) the motivation and skill to try and alleviate suffering, prevent it from returning, and cultivate wellbeing. These two psychologies are represented in Figure 10.3, in which the inner circle indicates some of the key attributes of compassion that help us to engage distress (first psychology), and the outer circle the skills and interventions – as part of a multimodal therapy – that help to alleviate suffering (second psychology).

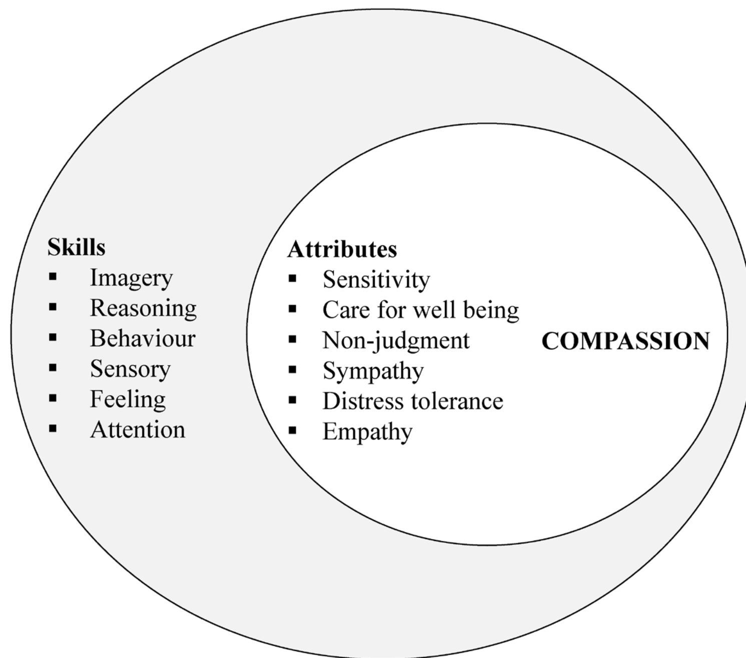


Figure 10.3: Compassion Attributes and Skills (adapted from Gilbert, 2009a)

The attributes within the inner circle relate to the first psychology and are crucial in helping one to notice and engage with distress and suffering. This begins with care for well-being – a sense of being motivated to care about ourselves and others. Sensitivity relates to our ability to tune into, notice, and engage with suffering, rather than moving away from or avoiding it. Sympathy involves being emotionally moved by one's own or others' experiences, but this can bring us into contact with painful

feelings, memories, and experiences – and therefore require us to have sufficient tolerance for distress, such that we can manage and regulate contacted experiences. Empathy is an important aspect of compassion, as it allows us to understand and make sense of our own and others' distress and suffering – to see clearly into the nature of it (e.g., its origin, form, triggers, etc.). Although not exhaustive, the final element here is non-judgement: an attempt to not criticise or condone, but rather to *accept* and allow things to be as they are in the moment (even if we may want to bring change to these in the future).

Whilst these above attributes of compassion can be helpful for enabling clients to move towards and engage with distress, in CFT we are also interested in how we might learn to alleviate suffering and prevent it from returning. This is where the second psychology of the outer-circle 'multimodal' skills interventions becomes apparent. These skills can be used to help stimulate some of the inner circle attributes of compassion (motivation, distress tolerance, empathy) which in concert, give rise to a 'compassionate mind' that can be directed to working on the client's difficult experiences in life.

10.4 CFT Interventions

CFT is rooted in the general psychological sciences rather than focusing on a particular process such as cognition, behaviour, or emotion, and then building a therapy around that. CFT focuses on what science tells us about how the evolved brain goes about its tasks; what it needs to function optimally, and what blocks it from doing so. In regard to therapeutic interventions, CFT is highly integrative of other evidence-based interventions such as guided discovery, exposure, imagery, and skills acquisition amongst many others (Gilbert, 2009b; 2010, 2014b).

10.4.1 Attention Training and Mindfulness

As in other approaches, understanding the significant role that attention can have in our distress – and its alleviation – is integral to CFT. What we attend to can have powerful physiological correlates. CFT promotes learning to notice where one's attention tends to lie or get drawn to, and cultivating greater stability of attention on things that are benign or even helpful in alleviating our distress (rather than avoiding it). Attention has overlaps with mindfulness, and in CFT it is important to help clients build their mindfulness skills. When developed, these can be utilised to notice the 'loops in the mind' between new (e.g., typical negative or self-critical thoughts) and old brain (e.g., anxiety or social avoidance), and, rather than remain stuck 'mindlessly' in these, use attention and mindfulness skills to manage these more helpfully.

10.4.2 Soothing Breathing Rhythm

Recent research has suggested that practicing certain types of breathing rhythm, often linked to slowing down and deepening the breath, can have a variety of physiological and psychological benefits (Brown & Gerbarg, 2012), and stimulates parasympathetic/vagal tone (Porges, 2009). There is growing evidence that stimulating the myelinated vagus nerve through various forms of training impacts upon prosocial behaviour (e.g., Kogan et al., 2014). CFT uses these ideas in helping clients to develop a soothing or calming breathing rhythm, in which a sense of grounding and slowing down is practiced.

10.4.3 Imagery

Developing certain types of imagery – particularly those in which affiliative-, care- and compassion-based feelings are evoked – can be important in stimulating emotion (Holmes & Mathews, 2010). CFT focuses on developing imagery to facilitate 'compassion as flow', in which compassion is seen as being experienced in three directions:

(1) From others to self. Here, we help clients to develop and practice an ideal 'compassionate other'. Clients are guided in considering the core qualities and attributes that they would like an ideal compassionate other to have, and, following identification of these, in developing imagery that helps to represent this ideal. Once developed, clients are encouraged and guided to experience compassionate qualities flowing from the image to them.

(2) From self to others. Here, the therapist guides clients, through imagery, acting, and body posture techniques, to help develop their ideal compassionate self. Once this 'self' is developed, clients are encouraged to practice directing this to others: towards people they care for and feel close to, towards strangers, or – when more experienced in this intervention – towards people that they may have more difficult relationships with.

(3) From self to self (self-compassion). Clients are supported to direct compassion-based thoughts and feelings from their 'ideal compassionate self' (developed in [2] above) to themselves. Through self-to-self relating, clients are encouraged to develop a compassionate understanding of the nature of their distress (first circle of compassion), and to facilitate mentalization and courage that may serve to alleviate underlying difficulties.

10.4.4 Directing the 'Compassionate Mind'

Once the ideal compassionate other and ideal compassionate self are developed, CFT therapists will then use a variety of techniques, many of which are derived from other

therapeutic approaches, to continue the process of engaging with and alleviating suffering. These include: completion of 'compassionate thought' forms, compassionate letter writing, compassionate chair work, 'multiple self' work, behavioural experiments, and so forth. Some of these are outlined in more detail in Gilbert (2009a).

10.5 CFT: Who Does it Work For and How?

CFT was originally developed as a transdiagnostic approach for people with high levels of shame and self-criticism (Gilbert & Irons, 2005). Leaviss and Uttley (2014) conducted a systematic review of the published literature to date. In a total of 14 studies (including three randomised controlled trials; RCTs) they found initial evidence for effectiveness, particularly in those with high self-criticism. However, they acknowledged that more research is needed before it can be considered to be an evidence-based intervention. Although originally developed to work with transdiagnostic problems like shame and self-criticism, studies have highlighted the potential effectiveness of CFT for people experiencing *psychosis* (e.g., Braehler et al., 2013; Laithwaite et al., 2009), *eating disorders* (e.g., Gale et al., 2014), *personality disorder* (Lucre & Corten, 2013) and *PTSD* (Beaumont, Galpin, & Jenkins, 2012). It is likely therefore that CFT is helpful for presentations that do not manifest with high levels of shame and self-criticism.

There is limited evidence identifying the mechanisms of change in CFT, although early research suggests that the effects of CFT may be mediated via reductions in self-criticism or increases in compassion (e.g., Braehler et al., 2013). It is important to note that, whilst identifying *psychological* mechanisms of change is important for CFT, we are also interested in the underlying *biological* and *physiological* processes involved, for which there already exists a broad scientific evidence-base (e.g., the powerful role of vagal tone and oxytocin on regulating the physiological processes linked to threat and stress; Carter, 2014; Porges, 2009). CFT seeks to build its interventions upon these broader scientific findings. Further large scale trials will be necessary to examine the efficacy of CFT and to develop an understanding of underlying mechanisms of change.

10.6 Criticisms of Compassion Focused Therapy

CFT is a relatively new psychotherapeutic approach, and as such the evidence base is growing but small in comparison to other active, efficacious treatments (e.g., CBT). It is unclear at this stage which components of treatment may be most effective but – as is the case for other process-based approaches (e.g., Dialectical Behavioural Therapy) – it may be difficult to manualise CFT interventions to fit strict RCT criteria. Finally, CFT has been criticised for over-simplifying complex neurophysiological processes

(e.g., the heuristic of old brain-new brain, and three affect regulation systems), although these were purposeful simplifications to facilitate practical and experiential understanding in therapists and clients. Moreover, these have been acknowledged in the CFT literature as being just this – i.e., simplifications of highly complex and interacting biological and physiological processes.

10.7 Formulation in Action

There are some key aspects of formulating in CFT:

- Formulations are, where possible, developed *with* clients, in a collaborative manner; with themes 'emerging' in-session, rather than the therapist presenting the client with a formulation that they have worked on between sessions.
- Therapists are encouraged to avoid becoming overly formulaic or restrictive in their method and language of formulating; we are not trying to diagnose or fit people in to boxes that they don't agree with.
- Language used by the therapist is congruent with the theory and principle of de-shaming. CFT therapists do not use terms like 'thinking errors', 'irrational thoughts' or 'maladaptive schema', or try and locate these inside a person, as such problematizing and internalising language can be very shaming for many clients. Rather, it can be more helpful to use normalising and de-shaming language ('it's understandable' and 'not your fault') to enable people to see (1) how their experiences in life have sensitised their threat system, and (2) that many of the behaviours they have engaged in, even if they caused other difficulties, were understandable given the circumstances.
- It can help to build formulations in small steps, particularly for those clients who feel overwhelmed, taking time to help people acclimatise and assimilate (often painful) information about their past experiences and current difficulties.
- Formulation has different functions. For example, to help the clinician and client make sense of what's happening, or for therapeutic planning.
- Two methods of formulating in CFT are: (1) developing a historically based, threat focused formulation, that links historical difficulties to current fears and safety strategies, and (2) a formulation based explicitly around the functioning and 'balance' of a client's 'three systems'. Below, we will highlight aspects of the case material that seemed key to help us formulate using these methods, and identify the links to the theoretical underpinnings of CFT.

10.7.1 Initial Formulations

10.7.1.1 Threat Focused Formulation

The threat focused formulation focuses, as the name suggests, on the nature of threats that Molly struggles with. We are particularly interested in the types of historical experiences that have sensitised the development of her threat system, and the type of key threats that she struggles with in the 'here and now'. We are also concerned about how she has tried to adapt to her environments by developing various safety or protective strategies (either consciously or non-consciously) to manage these threats, and the unintended consequences that have emerged from these strategies. Finally, we attempt to understand how these unintended consequences, via sensitising certain types of (e.g., self-critical) self-to-self relationships, may create a feedback loop (vicious circle) by fuelling current fears and threats.

A diagram of Molly's threat-based, four-column formulation is given in Figure 10.4. Below, we will explore each of the columns in more detail.

Historical influences. The threat focused formulation begins with an exploration of Molly's historical experiences and emotional memories. As noted elsewhere (e.g., Gilbert, 2010), CFT conceptualises emotion in terms of three basic systems, and thus, when assessing historical influences, we are keen to look out for the type of experiences that might have sensitised these, and try to understand how these systems have 'learned', developed, and express themselves.

There appears to be a variety of experiences that might have had a significant impact on Molly. She described experiencing her upbringing as lacking warmth, and it appears that her parents had a distant and emotionally avoidant relationship. It may be that early experiences of her mother being critical of her father behind his back prepared later tendencies to perceive other people as untrustworthy, dishonest, and privately judgmental. Although Molly described feeling very close to and able to rely on her sister, there are also difficulties in this relationship. Molly felt that her sister had an easier life when they were growing up – that she was more loved by their parents, and did not have to work as hard to earn their affection. In comparison, Molly described a sense that, within the family, she was seen as overly emotional, dramatic, and *different* (e.g., being 'ill' and in need of medical care).

Although Molly was liked by her teachers and had some friends, she found it difficult to form and maintain relationships with her peers, and felt that she was 'too controlling' and 'emotionally demanding'. Academically, she was expected to succeed but, from her mother at least, to do this without relying on help from others; moreover, if she failed to achieve as much as expected, she experienced her mother as disappointed in her. As she progressed, successfully, through school and college, she was initially excited about university but increasingly found it difficult to be away from home. Moreover, university posed its own threats; she described feeling 'exposed' in classes, and began avoiding going to classes, assignments, social engagements, and her housemates. After having sex with one of her housemates – during which she

experienced significant ‘shame’, after the other housemates burst in to the room – she felt rejected after trying to get closer to him, and was described as ‘clingy’. This was also associated with an increasing sense that people were talking negatively about her – in CFT, this might be an example of *external shame* (Gilbert, 2009b).

Key fears and threats. Variations in our early experiences can create very different mentalities in later life. In a simplistic way, our relational and social experiences can leave us feeling secure, safe, and at ease in relationships and in ourselves; or insecure, threatened, and fearful. There is of course a large literature on how certain types of early experiences are linked to the development of certain fears and threats that carry forward to later life (e.g., Bowlby, 1969; Cassidy & Shaver, 1999), and, as with other therapies, many of these in CFT involve archetypal concerns linked to rejection, abandonment, isolation, shame, and harm (Gilbert, 2010). Key in identifying a person’s fears and threats in CFT is to distinguish between external and internal threats.

External threats. External threats relate to concerns that we might have about the outside world (e.g., of harm/attack) and of what other people might think, feel, and do to us (e.g., reject, abandon, criticise). Given her historical experiences discussed above – particularly those linked to relationships with her parents, sister, and friends – it is likely that Molly will be fearful of others rejecting and abandoning her, or of them feeling like she is a burden to them in some way. It is also likely that she will feel concerned with/threatened by others’ thinking negatively of her or being critical of her.

Internal threats. Internal threats relate to difficulties that arise inside of us, such as our *emotions* (e.g., becoming overwhelmed by sadness, anxiety, or anger, or even a fear of positive emotions), *feelings* (e.g., vulnerable, alone), *memories*, or more broadly, issues around negative *self-identity* (e.g., self as flawed, bad, defective). Given our knowledge of Molly’s experiences in life, and the likely external fears described above, it may be that she struggles with internal feelings of loneliness, weakness, worthlessness, and unloveability. Moreover, we would also hypothesise that she might find the experience and expression of certain emotions – such as anxiety and sadness – quite threatening.

Safety, protective and compensatory strategies. Humans, like other animals, are endowed with a variety of strategies to deal with threats in the world. These are evolved competencies – for example, to seek others for reassurance or to stay away from harm – that can have subtle genetic and temperamental differences, and can also be shaped up through life experiences (Gilbert, 2010). These strategies emerge as ways to regulate threat experiences (threat system) and may differ depending on whether they are aimed at managing an external or internal threat. They often develop in childhood or adolescence, and over time, become reinforced (sometimes through operant conditioning processes; see Chapter 3) and continue to be a feature of adult life. These strategies can again be split between those that attempt to regulate external threats, and those that regulate internal ones.

External safety strategies. To deal with the external threat of rejection by others, it is likely that Molly attempts to seek closeness (e.g., as she did with Danny and Jack), and to appease or please others in some way. In terms of perceiving that others have negative thoughts or perceptions about her, it may be that Molly has developed a heightened sensitivity (vigilance) to monitoring other people (e.g., their reactions to her, or maybe even their facial expression, tone of voice, and moods) to help 'spot' any potential disruptions as early as possible. This may also involve her attempting to employ mindreading (thinking about what others are thinking, based on their reactions and actions towards her). At times, particularly when unable to manage these threats, Molly may try to move away from (avoid) others (as she did during university) to cut off from the threats and fears she experiences around them.

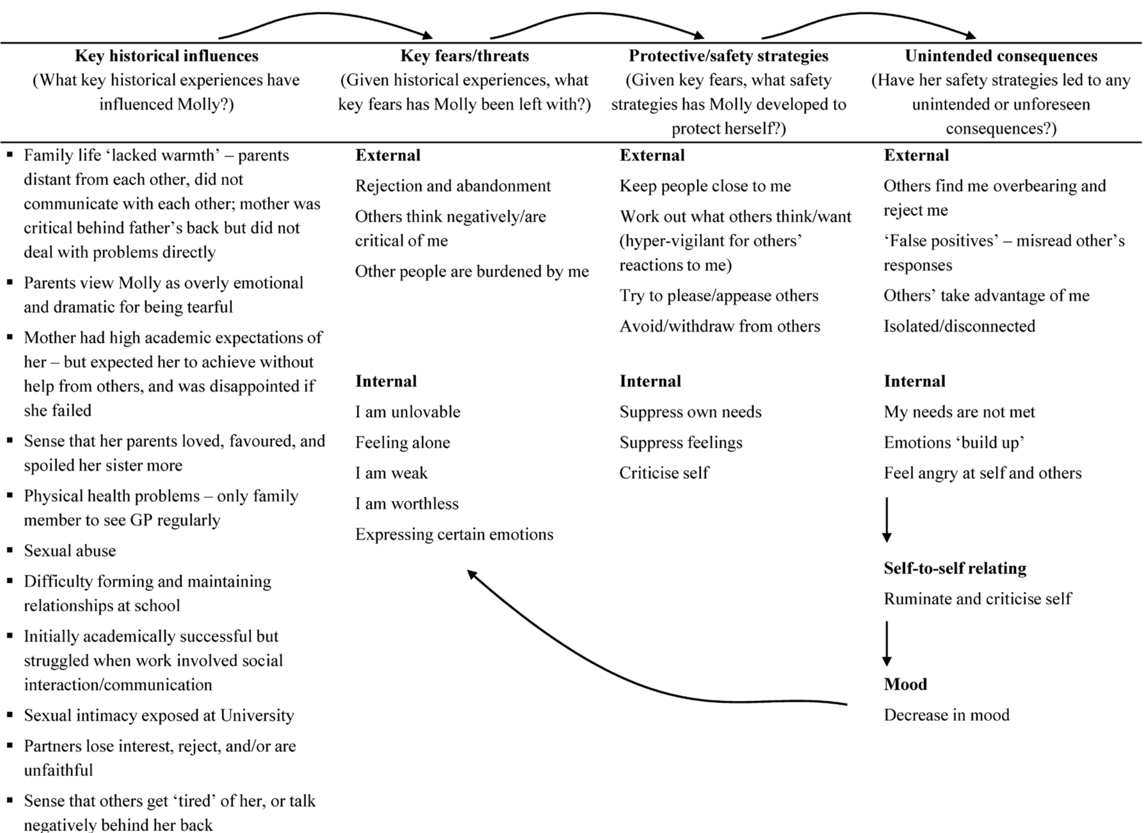
Internal safety strategies. It is likely that, in the face of a number of her internal fears (e.g., feeling unlovable, weak, and worthless) Molly protects herself by suppressing her own needs, distress, and emotions. She might share little with other people and keep much to herself. For many people with similar types of internal fears, self-criticism becomes a safety strategy in that 'it is safer to criticise and blame myself', and the function of this criticism may be to improve herself, or perhaps to punish herself for perceived flaws.

Unintended consequences and self-to-self relating. As with other psychotherapies (e.g., CBT), whilst safety strategies can be effective (at times) in the short-term management of threats and fears, they commonly lead to a variety of undesirable and unintended longer-term consequences. The language of unintended consequences is important here as it reinforces a message of 'not your fault' and can be experienced as de-shaming.

Given the type of *external safety strategies* she might engage in (e.g., trying to please others) it is likely that her needs are often overlooked or missed by friends and family. Moreover, shifting between strategies of approach (e.g., trying to keep people close/pursue close relationships) and avoidance (e.g., avoiding others and socially withdrawing) could leave others finding it difficult to establish consistent relationships with her, ultimately leading her to feel uncared for, abandoned, or rejected. Unfortunately, these feelings re- activate her external protective strategies of withdrawal and avoidance.

Given the internal safety strategies that she might engage in (e.g., suppression, self-criticism), it is likely that she will experience unintended consequences of her needs not being met, a 'bounce back' effect of her emotions building up and bubbling over, and an increased sense of anger at herself and others for the way she feels, and her life situation more generally.

It is worth noting the potential interaction between external threats, strategies, and consequences, and how these may stimulate internal threats, strategies, and unintended consequences. For example, external fears, such as feeling that she is a burden to others, may lead to attempts to avoid and withdraw (safety strategies), with associated unintended consequences of feeling isolated and disconnected. This



Key historical influences (What key historical experiences have influenced Molly?)	Key fears/threats (Given historical experiences, what key fears has Molly been left with?)	Protective/safety strategies (Given key fears, what safety strategies has Molly developed to protect herself?)	Unintended consequences (Have her safety strategies led to any unintended or unforeseen consequences?)
▪ Family life 'lacked warmth' – parents distant from each other, did not communicate with each other; mother was critical behind father's back but did not deal with problems directly ▪ Parents view Molly as overly emotional and dramatic for being tearful ▪ Mother had high academic expectations of her – but expected her to achieve without help from others, and was disappointed if she failed ▪ Sense that her parents loved, favoured, and spoiled her sister more ▪ Physical health problems – only family member to see GP regularly ▪ Sexual abuse ▪ Difficulty forming and maintaining relationships at school ▪ Initially academically successful but struggled when work involved social interaction/communication ▪ Sexual intimacy exposed at University ▪ Partners lose interest, reject, and/or are unfaithful ▪ Sense that others get 'tired' of her, or talk negatively behind her back	**External** Rejection and abandonment Others think negatively/are critical of me Other people are burdened by me **Internal** I am unlovable Feeling alone I am weak I am worthless Expressing certain emotions	**External** Keep people close to me Work out what others think/want (hyper-vigilant for others' reactions to me) Try to please/appease others Avoid/withdraw from others **Internal** Suppress own needs Suppress feelings Criticise self	**External** Others find me overbearing and reject me 'False positives' – misread other's responses Others' take advantage of me Isolated/disconnected **Internal** My needs are not met Emotions 'build up' Feel angry at self and others ↓ **Self-to-self relating** Ruminate and criticise self ↓ **Mood** Decrease in mood

Figure 10.4: Threat focused formulation

type of inner experience (e.g., feeling lonely) is likely to be an internal fear, leading to engagement in safety strategies and unintended consequences. It can be helpful to draw these interactions out with people, and, when moving into the intervention phase of therapy, to clarify the different compassion-based qualities needed to manage these interactions.

Ultimately, we would suggest that these unintended consequences are likely to fuel a particular type of self-to-self relationship, characterised by high levels of self-criticism (Molly intimates these in the assessment, e.g., references to having 'never been enough', being 'weak and useless', and 'not interesting'). These self-critical thoughts, as research has highlighted, may constitute a powerful vulnerability and/or maintaining factor for depression and distress (Blatt, Hart, Quinlan, Leadbeater, & Auerbach, 1993; Teasdale & Cox, 2001). As with other models of psychotherapy (e.g., CBT), the combination of these unintended consequences, self-critical thinking styles, and associated low mood, is likely to create a feedback loop (vicious cycle) to Molly's key fears/threats, 'heating' them up and, consequently, driving the need to engage in safety behaviours which, in turn, further exacerbate unintended consequences.

10.7.1.2 Three System Formulation

The formulation described above is often helpful in bringing together key aspects of past experience, and how these have textured current struggles and attempts to manage. It can help to facilitate wisdom and empathy for one's distress, attempts to cope, and life more generally (an insight in to the nature of one's mind, and the events that have led to distress and difficulties; an understanding that these difficulties are not attributable to personal faults or failings). Another helpful way of formulating in CFT is through the three system (threat, drive, soothing) affect regulation model described earlier in this chapter.

When using a three system formulation, we could ask Molly to focus on the 'here and now' – that is, how she feels each of the three systems functions in her average, day-to-day life (or in an area of life that we know she might struggle in particular with, e.g., relationships). We could also think about the three systems in historical terms, guiding her to consider what experiences from her past sensitised or influenced the development of each system. Below, we will discuss just the 'here and now' understanding.

Current functioning of Molly's 'three systems'. After describing to Molly the basic psychoeducation around the three systems (see above), we would then go on to collaboratively explore each system in turn, focusing on how each currently functions for her. With each system, we would be keen to explore:

Common triggers for activation of this system (including what these are, how often they occur, how long they trigger the system for, whether they are 'external' or 'internal' in origin)

- The type of emotions most common when the system is activated. Here it is key to also explore which emotions may be blocked, avoided, or not experienced (for example, for some people struggling with depression, sadness can be experienced but anger is considered too threatening or dangerous)
- The type of behaviours engaged in when the system is activated (these can also be seen in terms of safety strategies but involve basic evolved defences – e.g., flight, fight, submission, avoidance, etc.)
- The type of thinking styles associated with it. These commonly involve forms of self-criticism, rumination, worry, and a variety of 'better safe than sorry' patterns.
- When thinking about Molly, we could depict her three systems below (in a simplified representation):

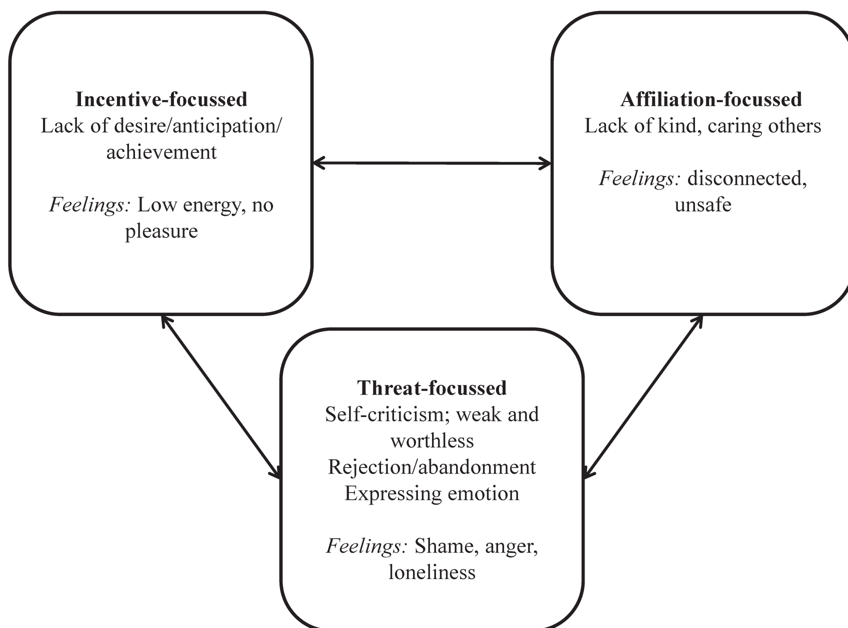


Figure 10.5: Three systems formulation (adapted from Gilbert, 2009a)

Threat system. From a CFT perspective, mental health difficulties and distress often relate to the functioning of the threat system. From a historical point of view, it is clear that Molly had many threat-based experiences during her childhood, adolescence, and young adult life, and we have explored much of this in the threat-based formulation described above. When formulating her current threat system activation, we could help her to consider current external triggers (e.g., sensing that others are critical or burdened by her) and internal triggers (e.g., self-criticism for her problems in life or rumination on events from the past). It is likely that when this system is

activated, Molly engages in a variety of defensive behaviours, including avoidance and social withdrawal. She may also struggle to down-regulate certain emotions (shame, anger), and may find the expressing of other emotions and feelings, such as sadness, difficult.

Drive system. The drive system is an important source of motivation, initiative, and energy in moving us towards things that are important in our lives. Unfortunately for Molly, we would hypothesise that she has significant problems in accessing this system in a balanced and consistent way. It is likely that she finds it difficult to feel motivated to pursue things in life (work, a stable boyfriend, friends), partly as this is likely to active her threat system (e.g., concerns about failure, not being good enough, or being abandoned if she did develop a relationship). Moreover, when achievements arrive in life, we would suggest that Molly would find it difficult to experience pleasure from these events. This may partly be due to an over-activation of her threat system, comparing her achievements negatively to others, or a more profound fear of happiness (e.g., Gilbert et al., 2012).

Soothing-affiliative system. The soothing-affiliative system is hypothesised to develop through repeated affectionate and caring experiences through life, and has a powerful impact upon regulating threat system activation. Unsurprisingly, given her historical experiences and developed 'sense of self', we would suggest Molly has significant difficulties accessing her soothing-affiliative system. Given her early experiences (her relationships with her parents and sister, sexual abuse), along with more recent difficulties relating to and developing close relationships with other people, it is likely that she has few external sources of affiliative soothing, reassurance, or contentment. Moreover, if these are actually present, her threat system (linked to shame, rejection, and so forth) is likely to activate in such a way that it down-regulates her capacity to *really* connect with and experience the helpful presence of others. It is likely that she feels disconnected and separate from others, and may find it difficult, at present, to experience family or friends as soothing, calming agents. Moreover, it is likely that Molly will struggle to treat herself with self-reassurance or engage in things for herself that have a soothing/calming function; thus, her internal capacity to stimulate this system is likely to be compromised. Given this, we would expect that she would find it difficult to regulate her own distressing thoughts and feelings, and will therefore be locked in to threat-based protective strategies rather than more helpful, supportive, and encouraging responses and behaviours.

10.7.1.3 Further Information

From the case material provided, there was no information that we felt was superfluous to developing our formulation, although some aspects were more crucial in highlighting key threats and safety strategies, and the development of the different emotion regulation systems.

From a CFT perspective, we would be interested in gaining further information to shape our understanding of Molly. For example, it would be helpful to know about any core emotional memories that may have shaped her sense of self-identity and self-other relationships. We would be keen to learn more about her emotions, and in particular, which negative emotions (e.g., anger, anxiety, sadness, shame, guilt) and positive emotions and feelings (e.g., happiness, joy, contentment) she was able to notice, describe, experience, and express, and which of these she felt blocked to or fearful about. This would help to identify areas for therapeutic work, as developing compassion skills can help clients to move towards, experience, and tolerate the emotions that they find scary and unpleasant. We would also be interested in finding out more about the type of relationship she had with herself (her self-to-self relationship) and, in particular, the nature of her shame and self-criticism.

We would also be interested in further exploring the different responses Molly has when she is threatened. For example, helping her to explore what leads to a more externalising, blaming, or angry response, versus occasions in which she blames or criticises herself. Similarly, it would be helpful to understand more about her attachment style, and how this might help to conceptualise her relationship with others, the way that she relates to herself, and, crucially, the therapeutic relationship.

10.7.2 Intervention Objectives

In the broadest terms, the intervention would involve a mirroring of the definition of compassion as described above: to help Molly become more sensitive to her own suffering, and increase her capacity/ability to find ways of alleviating this suffering. More specifically, within this, we would be keen to:

- Develop – through the formulation(s) – a greater understanding and empathy for the nature of her difficulties and distress, what maintains them (safety strategies), how these lead to a variety of unintended consequences, and how the development of all of these are not her fault, but rather a result of factors that she could not control (e.g., having an evolved brain that is naturally threat sensitive; a set of genes that may predispose difficulties; a variety of early experiences that she did not choose) that left her with high threat activation and low soothing-affiliation.
- Recognise the functioning of her 'three systems' and the effect of imbalance between these systems: the overactive and powerful nature of her threat system, the difficulty in engaging in helpful drive-achievement, and, in particular, the role of the soothing-affiliative system in regulating distress and suffering (either through others or internally through self-compassion).
- Develop the attributes of compassion (inner circle of compassion – Fig. 10.3) to help engage with and facilitate the regulation of affect and her key external and internal threats/fears.

– Develop the skills, strategies, and techniques (outer circle of compassion – Fig. 10.3) to help to alleviate Molly's suffering.

More precisely, we would want to help Molly to develop the above qualities so as to turn towards, and find ways to alleviate, her key fears and threats – as identified in her threat formulation (Fig. 10.4). To help Molly with her fear of rejection and the approach/avoidance protective strategy responses often utilised, we would first help to build capacity in her soothing system (e.g., through breathing and imagery interventions) to enable her to better regulate these fears, before developing specific compassion skills (facilitating courage to tolerate her concerns, and empathy and mentalizing skills to better understand other peoples' thoughts, feelings, and responses/behaviours towards her). We may also seek to reduce her self-criticism – which is likely to be keeping much of her distress and difficulties regarding rejection locked in place – by helping her develop a more compassionate (validating and empathetic) relationship with herself and the difficulties she experiences.

10.7.3 Potential Difficulties Working with Molly

During therapy, we would expect Molly might have a number of difficulties in engagement, motivation to attend sessions, and that, given the description of her initial presentation and previous relationships with others, she may oscillate between a critical-criticised position in relation to the therapist. We would expect that Molly would initially find it very difficult to engage with the concept of 'not your fault', and that she might become quite self-critical and/or angry with this idea and towards the therapist. We would also expect that Molly would find the idea of developing compassion – in particular, the experience of receiving compassion from others and the nurturing of self-compassion – very difficult, and in fact, frightening. Whilst this type of block to or fear of compassion is quite common (Gilbert et al., 2012) it would be important to formulate any difficulties that Molly experiences, and help her to overcome them.

10.7.4 How Would We Measure Progress?

There are multiple ways in which we would want to gauge progress in CFT for Molly. First, we would ask her to complete a number of self-report scales at different stages of therapy. Commonly in CFT, these might include scales that measure *shame and self-criticism* – e.g., the Other as Shamer scale (Goss, Gilbert, & Allan, 1994) or the Forms and Functions of Self-Criticism scale (Gilbert, Clarke, Hempel, Miles, & Irons, 2004) – levels of *self-compassion* (e.g., Self-Compassion Scale; Neff, 2003) and *fears of compassion* (e.g., Fears of Compassion Scale; Gilbert, McEwan, Matos, & Rivis, 2011). We would also look to use a variety of commonly used symptomology measures.

Alongside this, we would also listen for self-reported subjective change, indications that other people in Molly's life had noticed positive changes in her, and of course, our own appraisal of change. Crucially, we would use the initially developed formulation as a guide to progress; in particular, we would look for specific examples and a generalised sense of whether Molly was experiencing a reduction in the key threats, safety strategies, and unintended consequences described in Figure 10.4. Moreover, we would hope to see that when she experiences threats in her life, Molly is able to use the skills acquired in CFT – mindfulness, breathing, imagery, and cognitive/behavioural strategies linked to her 'compassionate mind' – to actively manage experienced threats in different, less deleterious ways. We would also want to see evidence of impact in her everyday life – in terms of her enjoyment at work and development of healthy relationships with work colleagues and friends.

Louise Braham & Sharron Smith

10.8 CFT Formulation: Critical Commentary

We could firstly identify a number of similarities between our Integrative approach and the approach of Compassion Focused Therapy (CFT). These include having a strong basis in cognitive-behavioural theorising, alongside acknowledging the importance of supportive relationships in facilitating learning of healthier emotion-regulation strategies. The CFT approach certainly has something to offer our understanding of how to engage someone therapeutically, the importance of holding in mind the human condition, and our need for compassion. CFT integrates many of the same literatures that our Assimilative integration did, and the approach is theoretically based in a number of stories that might enable clients to feel that their difficulties are 'not their fault', whilst simultaneously opening up possibilities for change. CFT was developed in response to clinical need, and the rationale for its approach to treatment seems intuitively sensible when thinking about clients in distress and our responses to them. The mismatch described between changed cognitions and unchanged emotions offers an example of how a lack of personal integration could be associated with poor mental health.

However, in considering criticisms of the CFT approach outlined here, it seems that the model might be characterised as overly constrained by its focus on evolutionary accounts of development and the 'all healing' nature of compassion, but also appears to lack theoretical specificity in some areas. For example, what is the mechanism by which self-to-self compassion occurs? How does one become compassionate to oneself? Is a lack of self-compassion at the root of all difficulties or just some of them? If it is just some difficulties, which ones, and how can we tell?

Additionally, CFT promotes an evolutionary account of brain development that might not fit with clients' other beliefs; particularly, perhaps, religious belief systems.

It was not clear to us if this would suggest the approach was inappropriate for religious clients or if there is any adjustment that might enable therapists to minimise this aspect of the work, and hence its potential conflict with the client's broader beliefs. Are there other clients who are unsuitable candidates for CFT intervention?

Further, the authors suggest that CFT interventions are developed on the basis of broader scientific findings relating to physiological processes underpinning stress. Cognitive, behavioural, and neuropsychological models already do this adequately and many such models are well-developed. Given this, does CFT offer anything distinct to our understanding of psychological distress other than the idea that compassion might be a focus for intervention?

How an individual relates to others in the world, and within their mind, is central to their experiences and, consequently, is often implicated in their distress. However, these (external and internal) relationships are poorly explicated within this account of a CFT approach. The account does not sufficiently explain how Molly relates to others, or how her relational style and others' expectations of her might impact on her relationship difficulties. At the level of formulation, we wondered about the advantages and disadvantages of using a 'threat based' or 'three systems' approach to formulating; how the information gathered by these formulations would inform the treatment approach; and how to choose between these approaches at different points in therapy.

Essentially, the authors seemed likely to choose between a very limited range of specific treatment-approaches, on the basis of supportive efficacy research and clinical judgement. Although this mirrored our Assimilative integration approach, CFT appeared more constrained in terms of the treatment approaches it draws upon, due to an over-focus on compassion-development – despite the lack of clear evidence to suggest that this construct is more important or central than others when working with clients.

There is an acknowledged emphasis on distinguishing internal and external factors in understanding safety behaviours, but this separation might contribute to a limited conceptualisation of how these factors may interact. By trying to conceptualise the separation of internal and external factors, we would be concerned that important information is needlessly neglected within the formulation.

We are aware that, to date, there is limited evidence regarding CFT outcomes – and, of course, psychological therapies are continually developing in terms of their evidence-base. Perhaps we could consider CFT as being in its infancy as a theory and treatment approach, with a number of large steps yet to be taken. As an integrative approach, it is a challenge to know the extent to which you need to specify the bases of your theoretical allegiances and how to do this concisely enough to cover the material within a single chapter. Any explanation can only ever be partial and limited, and we value accounts that simplify complex processes as useful explanatory guides for clients. CFT offers a framework for a particular way of understanding patterns of relationships and distress that some clients may find useful. However, we would

question the assumptive focus on compassion, shame, and self-criticism as central factors (underlying difficulties) for all clients, particularly when the thinking around these concepts and inter-relationships remains inchoate.

Vanessa Dale-Hewitt & Chris Irons

10.9 Author response

There are a number of points raised by the commentators that we do not feel accurately reflect CFT as an approach.

First, it is unclear how an approach can be ‘overly constrained’ by an evolutionary understanding of the human mind, distress, and mental healthiness – evolutionary understanding underpins many psychotherapeutic approaches, and provides a basic scientific grounding for clients and therapists. Of course, for some clients an evolutionary explanation may not fit with their broader beliefs, but, in our experience, key aspects of the approach (e.g., old/new brain, three systems) still stand as helpful psychoeducational heuristics even without an evolutionary back story.

Second, whilst compassion may not be a panacea, there is a large and rapidly developing scientific literature – both from within psychotherapy research and more broadly – that highlights how the cultivation of compassion for self and others, and the experience of receiving compassion, is highly physiologically and psychologically regulating for humans. There is emerging evidence of how compassion may be associated with epigenetic changes, immunological improvements, improvements in heart-rate variability, reduction in negative affect and mental health symptomology, satisfaction in relationships, and altruism. These are not studies that CFT has directed, but certainly we are interested in what the scientific literature is telling us about the consequences of cultivating compassion. We would also like to highlight that, whilst cultivating the different flows of compassion is central to the approach, CFT embraces and uses a variety of other interventions (e.g., attention training, mindfulness) that fit coherently within the model and are likely to be important components of therapeutic change.

Third, whilst we clearly highlighted that CFT emerged initially through working with people who had high levels of shame and self-criticism, the approach is also used with people who do not have problems in these areas. Given much of mental health distress involves high threat processing, the CFT model, with its focus on threat regulation, has much to offer.

Fourth, in regard to the scientific understanding of the physiology of stress, we are unclear about the commentators’ point that “cognitive, behavioural and neuropsychological models already do this adequately and many models are very well developed”. It is unclear which of these models try to base their theoretical understanding or interventions on a similar underlying physiological model – incorporating an

understanding of polyvagal theory (Porges, 2007) or the powerful role of oxytocin in regulating stress systems. We do not agree that CFT is “in its infancy as a theory and treatment approach” – in fact we would suggest that there is a great deal of depth and integration across multiple levels of psychological and biological science – but certainly expect adaptations and developments in years to come.

In terms of formulation itself, of course there is a lot in the process that is hard to convey here. Contrary to the commentators’ concerns, we find that failure to explicitly separate external and internal processes can lead to confusion. But of course it is important to recognise how external and internal processes interact, and drawing out these interactions is a key process in CFT formulation and understanding.

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