Chapter 9

Compassion-Based Therapies

Introduction to Compassion-Based Therapies

The previous chapter of this book was devoted to 'self-compassion' and the importance of directing compassion towards ourselves, as well as cultivating compassion towards others (Chapter 8). Compassion is not a zero-sum game. The more compassion we feel, the greater the likelihood we will feel further compassion in the future. This applies to compassion towards ourselves just as much as compassion towards others. Compassion begets compassion. The aim of this book is to facilitate this process in clinical settings and in the broader lives of healthcare professionals.

With this in mind, this book has, so far, presented definitions of compassion (Chapter 1: 'What Is Compassion?'), examined the 'Background to Compassionate Healthcare' (Chapter 2), explored 'What Compassion Is Not' (Chapter 3), outlined the relationship between 'Medical Professionalism and Compassion' (Chapter 4), provided further perspectives on 'Compassion in Healthcare' (Chapter 5), outlined advances in the field of 'Neuroscience and Compassion' (Chapter 6), investigated the relationship between 'Resilience and Compassion' (Chapter 7), and emphasised the importance of 'Self-Compassion' for healthcare professionals (Chapter 8).

To complete Part I of the book, the current chapter focuses on 'Compassion-Based Therapies', before Part II presents practical approaches to developing and deepening compassionate care on a day-to-day basis in clinical settings. Compassion-based therapies are a relatively new development in this field, and they explicitly place compassion at the heart of treatment paradigms that are novel, progressive, and filled with potential both now and for the future. That is why they are the focus of this final chapter in Part I of this book.

This chapter starts by exploring the origins of compassion focused therapy (CFT) and key attributes for the cultivation of compassion, before considering compassion and shame in clinical contexts. Shame can be an especially powerful emotion with a profound influence on health-related behaviour. Compassion can be a valuable way to address this issue. This chapter examines CFT in practice and notes the growing evidence base to support its use. The chapter concludes with further reflections on compassion and self-compassion as key skills and vital resources in healthcare.

Compassion, Mind, and Body

One of the key features of compassion explored throughout this book is that while compassion does not change the fact that difficult situations and challenging experiences occur in life, compassion helps us to face these in a more balanced way, navigate their complexities, and maintain an attitude of kindness as best as possible. Certain skills support

https://doi.org/10.1017/9781009390217.010 Published online by Cambridge University Press

this approach and help us to develop and sustain compassion even in circumstances that are far from ideal. Against this background, recent decades have seen a remarkable growth of theoretical and research interest in compassion, along with the development of novel therapeutic paradigms which focus primarily on compassion. These compassion-based therapies form the central theme of this chapter.

In 2006, the Compassionate Mind Foundation was founded as an international charity by Professor Paul Gilbert, a leader in this field, and colleagues including Professor Deborah Lee, Dr Mary Welford, Dr Chris Irons, Dr Ken Goss, Dr Ian Lowens, Dr Chris Gillespie, Diane Woollands, and Jean Gilbert.[1] The Compassionate Mind Foundation advances an evolutionary and bio-psycho-social informed approach to compassion and this constitutes the basis of CFT and 'Compassionate Mind Training'. The evidence base for CFT has grown considerably in recent years and is discussed later in this chapter.

In 2020, Paul Gilbert outlined the background to CFT in a paper that explored the nature of compassion 'from its evolution to a psychotherapy':

> One of the early observations that inspired CFT was finding that while working with cognitive behavior therapy (CBT), clients could sometimes generate helpful thoughts to counteract negative, self-accusatory, and attacking ones, but these were not always helpful. When I asked a particularly severely depressed client to speak out her 'helpful' thoughts *as she actually heard* them in her mind, her emotional tone was aggressive and contemptuous. Helping her begin to develop a compassion motivation and genuine caring emotional textures to her depression, life tragedies and internal dialogues proved a lot more difficult than I had anticipated. I began to explore the same issues with other clients and sure enough they could generate coping thoughts with helpful content but not with any sense of a compassionate motive or emotional texture. Many clients found that even talking to themselves in a compassionate, sensitive, and caring way is very difficult. (Gilbert, 2020; p. 12)

Millard and colleagues note that CFT is regarded as belonging to the 'third wave' of cognitive and behavioural therapies:

> Drawing on various approaches from neuroscience, evolutionary, developmental and social psychology and Buddhist traditions, Compassion Focused Therapy (CFT) is considered part of the 'third-wave' of cognitive and behavioural therapies, which apply emphasis on mindfulness, acceptance, meta-cognition, emotions, values and goals. (Millard et al., 2023; p. 168)

Gilbert outlines a care-focused, evolution-informed, bio-psycho-social, contemplative approach to compassion and CFT, all directed towards alleviating mental health difficulties and promoting well-being (Gilbert, 2020). This is based on close analysis of cognitive function and habits of mind, and their relationship to the generation of compassion. In this way, CFT is directed towards managing habitual patterns in our brains so that certain ways of responding are advanced in preference to other, less helpful habits. This involves moving away from what 'should be helpful' to an exploration of what truly helps. It means monitoring what happens in the body when we explore images and perceptions of what might be helpful, and thus generating greater, deeper compassion.

Making this shift away from exclusively cognitive-focused coping can be initially challenging, non-linear, and even unsettling. It requires courage to realise the benefits:

[1] www.compassionatemind.co.uk/about (accessed 14 June 2024).

https://doi.org/10.1017/9781009390217.010 Published online by Cambridge University Press

> CFT helps clients recognize the importance of insight into our multifarious 'multiple selves' and often *conflicting* nature of the mind, and hence, the need to develop mind awareness and *abilities to differentiate the complex of motives and emotions and beliefs*, the texture the mind. Mind awareness gives rise to compassionate wisdom and the issue of integration. (Gilbert, 2020; p. 26, emphasis original)

Body awareness is also central to this process:

> Mind awareness goes with body awareness and also body cultivation. CFT offers insight and guidance into how to train/use the body to support the mind. For example, the importance of developing vagal tone, how to use breathing exercises to settle and ground the body and mind, how to use posture and exercise, pay attention to diet which can influence the vagal nerve, learning to process threatening information in ways contextualized with a secure base and safe haven, and how to increase certain activating positive emotions and helpful desires. (Gilbert, 2020; p. 26)

While the process can be complex, it allows the therapist and client to discover what lies at the root of how we respond to suffering, and why there may be conflict between underlying motives. It also facilitates the emergence of compassion and identifying ways of sustaining compassion over the longer term, even in challenging environments such as healthcare.

Compassion Focused Therapy (CFT)

CFT is informed by evolution and neuroscience, among other influences. In his book *The Compassionate Mind*, Gilbert describes compassion as behaviour that seeks to nurture, teach, guide, mentor, soothe, protect, look after, and offer feelings of belonging and acceptance (among other things) in order to benefit a person (Gilbert, 2013). Key attributes include sympathy, distress tolerance, empathy, sensitivity, non-judgment, and care for wellbeing. Training in specific skills helps to develop these attributes, which Gilbert explores in detail in the book.

Care for wellbeing, for example, can be directed towards the self or towards others, and is rooted in a genuine interest in wellbeing, as well as a desire to alleviate suffering. Sensitivity towards distress and need requires paying attention to changes in one's own thoughts, emotions, feelings, and physical body. Sensitivity towards other people requires an awareness of these processes in others, as best as possible. We do not know the contents of another person's thoughts or internal life, but bringing an awareness to their mental state can point to changes arising for them that can indicate distress. Healthcare professionals often have pre-existing skills in this domain because many receive formal training in mental state examination and can be very attuned to the emotional, affective states of others, including non-verbal cues. Being mindful and observant of our own mental states and those of other people enhances sensitivity towards distress and evolving human needs.

Sympathy is the ability to be emotionally moved by the pain of other people (Gilbert, 2013). It is a fundamental component or precursor of compassion. Empathy is another element or precursor of compassion, and is the ability to put oneself in another person's shoes. Empathy requires an imaginative intuitive response, imagining how another person is feeling. Empathy is complex, and some empathic people can use it for nefarious ends, such as the con-artist who understands that a text-message purporting to be from your child is more likely to elicit money than a message from a complete stranger. Empathy is a powerful tool, but must be used wisely.

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Finally, distress tolerance and non-judgment are also important attributes for the cultivation of compassion (Gilbert, 2013). Tolerance of distress is not a stoic determination to get through the suffering no matter what, or even a suppression of feelings. It is more like a calm abiding. It is the ability to stay with our emotional responses, which are seen as a normal aspect of being human. This sense of tolerance and acceptance is different to resignation or giving up, which are feelings that can be associated with hopelessness and resentment. Tolerance means staying the course, calmly.

As part of this process, it is important to tolerate and accept positive emotions as well as negative ones (Gilbert, 2013). This is a reminder for healthcare professionals that there are many moments of joy, relief, and accomplishment at work, notwithstanding the difficulties. Staying with these positive emotions is important, without secondary questioning, over-thinking, rationalising, or transforming positive emotions into ego or arrogance. Many people find experiencing positive emotions difficult by virtue of mood states such as depression, or childhood experiences or issues in their upbringing. Positive emotions are just as important as negative ones, and often – clearly – more so.

In a similar vein, non-judgement means becoming engaged with the complexities of other people's lives and emotions, and our own, but not judging or condemning them (Gilbert, 2013). Social context matters a great deal to how people think, feel, and act, but it is tempting to over-attribute people's actions to their personalities and to under-estimate the role of circumstance. That is not to say that absolutely everything is acceptable, but rather that noting a different preference, contrasting opinion, or inexplicable action by someone is different to judging, and remembering that we might act similarly if we were in their circumstances.

Non-judgement about the self can be especially challenging because we are often our own worst enemies and our own harshest critics. With this in mind, Gilbert's emphasis on warmth is especially apt – recognising distress and having sympathy towards suffering, while also bringing kindness and warmth to the experience, along with the consequent compassion.

Compassion and Shame in Clinical Contexts

Cultivating some of the attributes associated with compassion can be challenging in clinical settings, but that makes them more important, rather than less. Compassion is needed in a very deep way when someone is ill or in distress. Compassion is also an especially powerful tool for healing in these situations, so it matters more than ever in such circumstances.

From the patient's perspective, attending a medical encounter can invoke intense emotions which range from hope to fear, and sometimes include a sense of shame. Shame is an especially powerful experience which can be challenging to manage. We are at our most vulnerable when we become patients or potential patients. We feel limited power as we become unwell. We might feel self-conscious when we are physically examined in sterile, clinical settings. There is often information asymmetry with the healthcare professional. We are exposing, literally and metaphorically, the most vulnerable parts of ourselves for strangers to examine and evaluate. This can involve feelings of anxiety, vulnerability, and shame.

This feeling of shame is without basis, but it can be a powerful emotion, nonetheless. Moreover, shame can induce profound emotional memories with traumatic associations, and can be central to depression (Matos and Pinto-Gouveia, 2010). In practical terms, there

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is evidence that shame impacts on whether a person will seek medical help and their willingness to attend for follow-up and engage with treatment (Harris and Darby, 2009; Dolezal, 2015).

Many of these negative consequences of shame can, however, be addressed, at least to a degree. When patients are met with compassionate acceptance, validation, and kindness, the medical encounter can mitigate shame and facilitate positive patient experiences (Gilbert, 2017). Compassion is central to this process. Compassion is a powerful antidote to shame because it emphasises shared humanity and a common desire to alleviate suffering. Placing compassion explicitly at the heart of therapy is an especially powerful way to articulate this shared vision.

Unfortunately, shame can also be a common experience for people working and training in health services. The hierarchical medical training that many of us experienced routinely generated experiences of embarrassment and shame when we answered questions wrongly or were openly criticised by seniors in front of peers, patients, and relatives. From a biological and evolutionary perspective, hostility, criticism, rejection, and shame are perceived as threats by the human brain, eliciting a physiological response that can ultimately lead to poor physical and mental health. More specifically, performance that could be negatively judged by others (which is a common feature of medical training) is associated with elevated cortisol responses and longer time to recovery (Dickerson and Kemeny, 2004). Including such experiences in medical training is simply unhealthy and has no educational value. Shame does not facilitate learning. Compassion does.

Primary responsibility for shame-inducing situations lies with those who generate such situations in the first place, without taking sufficient account of how other people feel. For people experiencing these difficult emotions, however, it can help to recognise what is happening, reappraise the situation, and re-frame the perceived threat as a challenge whenever possible. Enhanced communication skills can help with this, as Bosshard and colleagues point out:

> The balance between perceived situational demands and perceived coping resources determines whether a stressful performance situation … is experienced as challenge (resources > demands) or threat (resources < demands) . . . we expect the benefits of stress arousal reappraisal to spill over to similar stress-inducing communications with patients or other motivated performance situations, which are ubiquitous in education and the medical workplace environment. Finally, improved communication also benefits health related outcomes of concerned patients. (Bosshard et al., 2023; pp. 1, 11) (citations omitted)

Teaching healthcare professionals to work from a more compassionate, open stance is vital in this context, mitigating the threat response and activating other physiological systems in the body, including the soothing system (Gilbert, 2013). CFT is an exceptionally useful tool in this context, placing compassion at the centre of the therapeutic enterprise and powerfully counter-balancing emotions such as shame.

Compassion Focused Therapy (CFT) in Practice

Against this background, how does CFT operate in practice? Mascaro and colleagues describe CFT as 'an evolutionarily and neurophysiologically informed approach to psychotherapy that aims to improve mental health by understanding and promoting a compassionate motivational system' (Mascaro et al., 2020; p. 2).

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Gilbert points out that CFT can involve several different techniques, all informed by its overall approach, values, and goals:

> CFT offers clients a range of mind and body training practices that include breathing, posture visualizations, meditations, behavioral practices, and other traditional western therapeutic skills such as: compassionate writing and journaling, compassionate acting, using chairs to help differentiation of feelings and motives, compassionate behavioral planning; use of art, music and dance. (Gilbert, 2020; p. 26)

In this way, 'CFT helps clients to reflect on what is *meaningful* to them, the self-identities they want to foster and carry through life, and how they might like to look back on their life as it draws to an end. Compassion is typically experienced as a source of meaningful action' (Gilbert, 2020; p. 26, emphasis original). Further information about the therapy is available on the website of the Compassionate Mind Foundation.[2]

What is the evidence that CFT actually helps? In 2023, Millard and colleagues published 'a systematic review and meta-analysis' of 'the effectiveness of compassion focused therapy with clinical populations' (Millard et al., 2023). The results from studies to date are positive:

> Fifteen studies from 2013 to 2022 were included. Findings suggested that CFT was effective in improving compassion-based outcomes and clinical symptomology from baseline to post-intervention and compared to waitlist control. A range of small to large effect sizes were reported for improvements in self-compassion (0.19–0.90), self-criticism (0.15–0.72), self-reassurance (0.43–0.81), fear of self-compassion (0.18), depression (0.24–0.25) and eating disorders (0.18–0.79). Meta-analyses favoured CFT in improving levels of self-compassion and self-reassurance than control groups. (Millard et al., 2023; p. 168)

The authors conclude that their 'review highlights the potential in CFT for improving compassion-based outcomes and clinical symptomology in those experiencing mental health difficulties, particularly those with eating disorders':

> Meta-analyses significantly favoured CFT in improving levels of self-reassurance and reducing fear of self-compassion. However, the long-term effects of CFT are yet to be established. Findings indicated that CFT was more effective than waitlist control but could not determine its effectiveness against alternative psychological interventions. However, these conclusions must be viewed with caution due to the unclear risk of bias shown across many of the included studies. Future research should implement longitudinal designs and aim to reduce the heterogeneity in the analysis of outcome measures to strengthen the evidence base of CFT research. (Millard et al., 2023; p. 181)

Overall, then, there is growing evidence of the effectiveness of CFT and there will likely be further evidence available over the coming years. Inevitably, more research is needed, but the most likely outcome is that future evidence will further refine the application and understanding of CFT, possibly in the context of specific groups of people or for particular kinds of problems that present. Overall, CFT is effective. Compassion helps.

Compassion and Self-Compassion as Key Skills in Healthcare

So far, this chapter has explored the origins of CFT and key attributes for the cultivation of compassion, before considering compassion and shame in clinical contexts. Shame can be

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https://doi.org/10.1017/9781009390217.010 Published online by Cambridge University Press

an especially powerful emotion with a profound effect on health-related behaviour. Compassion, on the other hand, can be a valuable way to address shame. This chapter then examined CFT in practice and noted the growing evidence base to support its use. CFT continues to develop and expand in various ways with each passing year (Gilbert and Simos, 2022).

Against this background, the remainder of this book focuses largely on cultivating compassion in healthcare and clinical educational settings, and optimal ways to demonstrate and teach compassion to health professionals. This can involve modelling compassionate care for trainees, sharing experiences which are relevant to compassion in our workplaces, and exploring the value of other fields such as narrative medicine in supporting compassion. The overarching approach is to view compassion as a central value in person-centred care *and* a professional competency which can be developed (Van der Cingel, 2022). And, as previously discussed, self-compassion is an important part of any consideration of compassion (Neff, 2003a; Neff, 2003b), including compassion in healthcare.

This compassion-based approach is increasingly supported by evidence. The research base continues to expand, as Mascaro and colleagues confirm:

> Over the last decade, empirical research on compassion has burgeoned in the biomedical, clinical, translational, and foundational sciences. Increasingly sophisticated understandings and measures of compassion continue to emerge from the abundance of multidisciplinary and cross-disciplinary studies. Naturally, the diversity of research methods and theoretical frameworks employed presents a significant challenge to consensus and synthesis of this knowledge. (Mascaro et al., 2020; p. 1)

This growing body of cross-disciplinary, inter-disciplinary, multi-disciplinary, and trans-disciplinary research has resulted in much heterogeneity in the literature, with different theoretical frameworks and a diversity of research methods presented. The development of measurement tools to identify, quantify, and describe compassion and to empirically evaluate interventions has supported this work, albeit that heterogeneity in methods, populations, and definitions makes comparisons across studies complex. As a result, it can be challenging to interpret and integrate this research when it is performed in silos or without consideration of other approaches to this kaleidoscopic topic.

Even so, certain matters can be agreed. Compassion is a positive value and compassion in healthcare benefits the patient, their family, and the healthcare professional. In addition, compassion is a skill that can be taught and which therefore holds particular promise in the education of healthcare professionals. The next part of this book presents practical approaches to developing and deepening compassionate care on a day-to-day basis in clinical settings. The ultimate aim is to routinely cultivate greater levels of compassion for all, including ourselves.

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