EFPT Psychotherapy Guidebook • EFPT Psychotherapy Guidebook

Compassion-Focused Therapy (CFT)

Ana Filipa Lopes, Filipa Martins Silva

Published on: Dec 05, 2020

DOI: 10.21428/fc0b32aa.3296abfc

License: [Creative Commons Attribution 4.0 International License \(CC-BY 4.0\)](https://creativecommons.org/licenses/by/4.0/)

Brief historic overview

The beginnings of Compassion-Focused Therapy (CFT) go back to the 1980s, in the form of observations by British psychologist Paul Gilbert. Paul approached psychotherapy from a diverse training background that included cognitive behavioural therapy, Jungian analysis, evolutionary psychology, neurophysiology, and attachment. In his therapy work, Paul noticed that some individuals responded poorly to the classic Cognitive Behavioural Therapies (CBT), despite the ability with cognitive and behavioural tasks. It was founded that these individuals presented high levels of shame and self-criticism that was implied with difficulties to generate kind and self-supporting inner voices. They could understand the logic of changing how they thought about and judged things (and did do that), but this was ineffective at changing deeply felt experiences of the self, especially shame and a long-lived inner sense of worthlessness or badness. Thus, CFT was founded by Paul Gilbert to promote affiliative feelings and compassionate inner voices in these individuals. It emerged as a part of the third generation of CBT based in principles of Buddhist tradition and based upon a growing body of neuroscientific evidence that demonstrated that affiliative motives and emotions can have a major impact on self and affect regulation.

Description

CFT is an integrative and transversal psychotherapy, whose theoretical framework and intervention strategies are influenced by evolutionary, social, developmental psychology, Buddhism and neuroscience.

As fundamental pillars of the concepts of CFT are the evolutionary perspective of the human mind, the three systems of regulation of affection and the biopsychosocial model of shame.

According to the **evolutionary perspective of the human mind**, the brain can be divided into three functional units:

- Reptilian Brain - includes the most archaic structures (brainstem and cerebellum) that control sleep, the most instinctive and fundamental motivations and behaviors for the survival/preservation of the organism and genes, such as reproduction, defense and acquisition of resources. Information processing is automatic, fast, unconscious and, therefore, often difficult to control;
- Brain of lower mammals - includes the limbic system, responsible for processing emotions, motivation, learning and memory, making behaviors more complex and flexible. It is the area responsible for looking for and providing care, which is fundamental for the adaptation and evolution of most mammals;

- Rational Brain - includes the neocortex and telencephalic cortex. It is considered the new brain, responsible for the unique characteristics of the human being such as abstract thinking, planning, communication, imagination, self-knowledge and self-identity. Information processing is slower, intentional and controlled.

As humans, we all have universal, automatic, and instinctive reactions to threats (linked to our reptilian brain, part of the “old” brain area), which are crucial for surviving and thriving. Most problems arise when the reptilian brain conflicts with affiliative motivations (linked to the mammalian brain, also part of our “old” brain) and with the unique cognitive skills of the human cerebral cortex (linked to the “new” brain).

To regulate emotional states, such as anxiety, sadness, angry or even positive as happiness, humans may resort to **three emotion regulation systems**:

- The threat system is shared by all species and it is central to the ability to detect and respond to threat, functioning to protect individuals from threats. Activation of this system can give rise to attention focusing/bias, and results in negative emotions such as anger, anxiety and disgust. These emotions lead to fight, flight or submission behaviours.
- The drive system allows individuals to experience positive feelings that guide, motivate, and encourage them to seek out resources to survive and prosper, giving rise to the positive emotions of drive, excitement and vitality.
- The soothing system, which evolved alongside attachment/affiliation, allows individuals to experience peacefulness, safeness, well-being, not-seeking and contentment. Warm interpersonal relationships, based on sharing and affection, are central to the development and maturation of this system, which is why it is important to create safe bonds since early childhood. A child who has a secure bond, who has been reassured and loved, can easily evoke these emotional memories in stressful situations, which will help him, throughout his life, to regulate affection through a self-reassuring mechanism. Thus, the extent and degree of affiliation that we experience from the day we are born to the day that we die has a huge impact on the quality of our lives. In fact, the affiliative processes influence the architecture of our motivational and emotional systems and even influence genetic expression.

Psychopathological symptoms and disorders arise when there is an unbalance of these three emotion regulation systems, particularly when the threat activation commands the individual’s functioning. As we all share the need to create positive feelings about ourselves in the mind of others, when individuals feel devalued, neglected, and/or abused since early ages, they tend to become vulnerable

to shame, which, in turn, over-stimulates the threat system and its archaic responses (freeze, flight, fight).

Figure 1- Affect regulation systems (Gilbert, 2009)

CFT aims to redress imbalances within these three affect regulation systems, seeking to help individuals who have difficulty accessing the soothing system in response to threat. This difficulty may have an environmental or a biological basis, for example understimulation of the soothing system in early life. CFT aims to help such individuals respond to self-criticism with selfkindness and compassion, with the goal of treatment being improved psychological well-being. A key part of this process is to help the individual understand that many cognitive biases/distortions are built-in biological processes, constructed by genetics and the environment. CFT encourages individuals to develop compassion motivation and practise compassionate behaviours to access the soothing systems.

The **biopsychosocial model of shame** defends shame as one of the emotions with the greatest impact on functioning in general and psychopathology in particular. The conceptualization of this emotion divides it into *external shame* and *internal shame*, influencing each other. The first is defined as a painful social experience, linked to the perception that one is judged and seen by others as inferior, defective and unattractive, which may result in their rejection or discrimination. In *internal shame*, the subject judges himself and makes negative attributes to his characteristics, feelings and fantasies, directly influencing the way he feels. Shame therefore influences how individuals in general think and feel, not only in relation to themselves, but also in relation to their acceptability and social desirability, which, consequently, has a great impact on their behavior in social contexts. Gilbert also defends the

impact of self-criticism in the development of feelings of shame. Self-criticism is a response to situations in which the individual considers that he has failed important tasks or objectives with a consequent negative self-assessment that triggers feelings of shame, frustration and contributes to a negative view of himself. When self-criticism is frequently used, the individual hinders the development of the soothing system, maintaining a relationship with himself based on devaluation, hostility and humiliation.

Unlike classic CBT, CFT does not aim to show the patient the irrationality or the lack of logic in his thinking, but to understand where and how the patient got stuck in useless (even if comprehensive) ways to try to increase their sense of security in the face of threats. In general, it can be said that the main objective of CFT is to achieve the balance of the three systems of regulation of affection, promoting the activation of the soothing system. By stimulating this system, we seek to develop self-reassurance and self-compassion skills, thereby reducing the levels of shame and self-criticism. In CFT, the assessment of the individual with high shame and self-criticism integrates cognitive, behavioral and bonding models, highlighting the patient's genetic and experiential background that gave rise to the fears and threats that led to internal or external security strategies which result in unwanted consequences, such as self-criticism, that will generate more discomfort and enhance more safety strategies, feeding the cycle of dysfunctionality. CFT assumes that the subjects must acquire knowledge and insight about their own minds, as well as about the genetic and evolutionary inheritance that all human beings have. Therefore, a significant part of the intervention implies that the patient gains insight into the functioning of the mind. The first step in the intervention is the establishment of a safe and contentious therapeutic relationship, which will "de-shame" and "depathologize" the patient, facilitating adherence to the intervention strategies. The therapist must resort to empathetic validation of the patient's emotional states and behavior, so that the patient feels that the therapist is genuinely interested in him and that he is there to help him, promoting the activation of the soothing system, which is the central objective of CFT. CFT works not only with feelings of shame, but also with coping with shame (self-criticism, attack on the other, avoidance and escape from the experience of shame). Thus, CFT stands out from CBT movement because of its evolutionary underpinning and focus on the evolutionary origins of, and mechanisms for, experiencing reassurance, connectedness and calming via social relationships, promoting of a compassionate motivation in individuals.

Another central objective of CFT is to promote self-compassion in the patient. Gilbert conceptualizes compassion from an evolutionary perspective, focusing on the evolution of the mammalian affiliative system. Grounded in Buddhist tradition, compassion is defined as a sensitivity to suffering in self and

other, allied with the wisdom, strength, and commitment to prevent and/or alleviate that same suffering. Thus, compassion can be understood as a skill that everyone can train, developing compassionate attributes and competencies that will influence the regulation of affection. The concept of compassion is linked to the concept of self-compassion, which implies being open to one's own suffering, experiencing feelings of warmth, care and understanding towards the self, in an attitude of curious observation and non-judgmental understanding of errors and inadequacies, while recognizing the experiences as part of a common human experience. Self-compassion is a positive emotional regulation strategy, important for psychological resilience, life satisfaction and social connection and acceptance, with a dampening effect on the development of psychopathology. The development of self-compassion stimulates the soothing system, promoting feelings of acceptance, reassurance and care for self and others. To promote self-compassion the therapist can resort to various exercises, such as writing a compassionate letter, through which he guides the patient in a mindful manner and involved in a climate of warmth, affection, encouragement, support and kindness. First of all, it should focus on empathy for discomfort, enabling the patient to reflect on common humanity, showing acceptance for difficulties and limitations, distinguishing self-correction from self-criticism and helping to access encouraging memories that help in performing the therapeutic task. It is essential that the therapist has already developed a compassionate mind within himself, which will allow him to establish a compassionate therapeutic relationship with the patient. Therapists serve as models, guiding and helping individuals overcome their fears, blocks, and resistances to compassion and bringing forth the different flows of compassion: having compassion toward the self, giving compassion to others, and receiving compassion from others.

Overall, in a CFT-based intervention, therapists compassionately guide patients to discover that our functioning is actually not our fault, as we are just one version of ourselves, which was shaped by evolutionary, genetic, epigenetic, and environmental influences that we did not choose. However, it is also our responsibility, once we can know ourselves better, learn and practice new regulation strategies and guide our automatic responses instead of being guided by them. To encourage this responsibility, CFT provides training on specific practices that are designed to address the triggering of the threat system, balance the emotion regulation systems and cultivate compassion in individuals. This is called compassionate mind training (CMT), a cross-cutting ingredient throughout a CFT intervention.

Main uses (indications)

CFT is part of a growing global movement that recognizes the potential of compassion to provide benefits in a range of sectors, from business, education and healthcare to science, research and environment.

It was initially conceived for patients with high levels of shame and self-criticism. It is currently implemented, either in individual or group format, with patients with depressive, anxious, psychotic, eating disorders and personality disorders (such as antisocial personality disorder). Bearing in mind that this is an innovative therapy model, several teams continue to test its impact on different populations (e.g., caregivers of patients, health personnel from oncology services) and its application in certain areas is still under evaluation .

Efficacy

In general, studies on the effectiveness of CFT currently available have shown that patients, after the intervention, show a significant reduction in depressive symptoms, anxiety, shame, self-criticism and submissive behaviors, as well as an increase in the ability to self-reassurance and self-compassion.

Preliminary, small-scale studies have shown CFT to be safe and beneficial in treating anxiety and depressive symptoms and a further 2015 literature review of 14 different studies showed promising psychotherapeutic benefits of CFT, especially when treating mood disorders, with particular efficacy in reducing depression symptoms. A 2012 randomized controlled trial showed CFT to be a safe and clinically effective treatment option for psychosis patients, especially vulnerable to feelings of isolation and internal states of hostility. A slightly modified version of CFT for eating disorders, CFT-E, has had promising results in treating adult outpatients with restrictive eating disorders as well as with bingeing and purging disorders due to the fact that it confronts the "high levels of shame and self-criticism" that patients often experience. More recent primary studies have further proved CFT-E to be a safe and effective intervention for eating disorders.

Quotes from famous psychotherapists

«So from the very first hours of our lives right through to our last moments, kindness, gentleness, warmth and compassion are the things that can sustain us and help us bear the setbacks, tragedies and suffering that life will rain on us.» Paul Gilbert

Manuals and Training

Manuals:

Paul Gilbert (2005), *Compassion: Conceptualisations, Research and Use in Psychotherapy*. Routledge

[Paul Gilbert](#) (2009), *The Compassionate Mind*. Constable.

[Paul Gilbert](#) (2010), *Compassion Focused Therapy: Distinctive Features*. Routledge

[Mary Welford & Paul Gilbert](#) (2013), *The Power of Self-Compassion: Using Compassion-Focused Therapy to End Self-Criticism and Build Self-Confidence*. New Harbinger Publications.

[Russell L Kolts & Steven C. Hayes](#) (2016), *CFT Made Simple: A Clinician's Guide to Practicing Compassion-Focused Therapy*. New Harbinger Publications.

Training:

In 2011 the first Post Graduate Certificate in Compassion Focused Therapy (CFT) was launched at The University of Derby. Key individuals within the Compassionate Mind Foundation are integral to the courses' development and delivery. The course offers an in depth practice based training. It is an academic year long, it begins in September and finishes in May. The course is delivered via blended learning, which means that there are two block study weeks that require attendance at Derby. One block of 5 days is in September the other block is in April. The rest of the time the course is delivered online with live supervision every week via the virtual classroom, monthly live seminars which are recorded, and various material including video skills demonstrations and reading materials. There are also discussion forums and blogs to ensure course participants feel connected despite being geographically distant.

For further details see the link below:

<https://www.derby.ac.uk/postgraduate/therapeutic-practice-courses/compassion-focused-therapy-pg-cert/>

The Association for Psychological Therapies offers five levels of accreditation for practitioners of Compassion-Focused Therapy, from introductory to advanced. The levels 1 to 3 serve to acquaint with Compassion-Focused Therapy and the four and five levels to specialize in Compassion-Focused Therapy. For further details see the link below:

<https://www.appt.ac>

Otherwise, after learning the foundations of the evolutionary model involved in CFT and the preliminary exercises involved in Compassionate Mind Training, professionals can go on to deepen their practice and hone their skills through supervision. The CFT community exists internationally, and is connected through local supervision groups, individual supervision relationships, web based peer supervision groups, and on-line blended learning opportunities.

Links to Societies

<https://www.compassionatemind.co.uk/>

Name and affiliation of the trainees

Ana Filipa Lopes & Filipa Martins Silva (Child and Adolescent Psychiatry Trainees in Centro Hospitalar Universitário do Porto)

Revised by: Vânia Martins & Graça Fernandes (Child and Adolescent Psychiatrists in Centro Hospitalar Universitário do Porto)

References

1. Braehler, C., Gumley, A., Harper, J., Wallace, S., Norrie, J., Gilbert, P. (2012). *Exploring change processes in compassion focused therapy in psychosis: Results of a feasibility randomized controlled trial*. Clinical Psychology. 52 (2): 199–214. [Doi:10.1111/bjc.12009](https://doi.org/10.1111/bjc.12009).
2. Bulmarsh, E., Harkness, K.L., Stewart, J.G., Bagby, R.M. (2009). *Personality, stressful life events, and treatment response in major depression*. Journal of Consulting and Clinical Psychology 77, 1067–1077.
3. Carter, S. C., Bartel, I. B. A., & Porges, E. C. (2017). *The roots of compassion: An evolutionary and neurobiological perspective*. In E. Seppala, E. Simon-Thomas, S. Brown, M. Worline, C.D. Cameron & J. Doty (Eds.), Oxford handbook of compassion science (pp. 173-188). New York, NY: Oxford University Press.
4. Coan, J.A., Schaefer, H.S., Davidson, R.J. (2006). *Lending a hand: social regulation of the neural response to threat*. Psychological Science 17, 1032–1039.

5. Cowan, C. S. M., Callaghan, B. L., Kan, J. M., & Richardson, R. (2016). *The lasting impact of early-life adversity on individuals and their descendants: Potential mechanisms and hope for intervention*. *Genes, Brain and Behavior*, 15, 155-168.
6. Cozolino, L. (2007). *The neuroscience of human relationships: Attachment and the developing brain*. New York, NY: Norton.
7. Depue, R. A., & Morrone-Strupinsky, J. V. (2005). *A neurobehavioral model of affiliative bonding*. *Behavioral and Brain Sciences*, 28, 313-395. doi:10.1016/j.biopsycho.2007.09.001
8. Dunbar, R. I. M. (2010). *The social role of touch in humans and primates: Behavioural function and neurobiological mechanisms*. *Neuroscience and Biobehavioral Reviews*, 34, 260-268. Doi:10.1016/j.neubiorev.2008.07.001
9. Gilbert, P. (2000). *Social mentalities: internal 'social' conflict and the role of inner warmth and compassion in cognitive therapy*. In *Genes on the Couch: Explorations in Evolutionary Psychotherapy* (ed. P. Gilbert and K. G. Bailey), pp. 118-150, Brunner-Routledge: East Sussex, UK.
10. Gilbert, P. (2009). *Introducing compassion-focused therapy*. *Advances in Psychiatric Treatment*, 15(3), 199-208. DOI: 10.1192/apt.bp.107.005264.
11. Gilbert, P. (2014). *The origins and nature of compassion focused therapy*. *British Journal of Clinical Psychology*, 53(1), 6-41. DOI: 10.1111/bjc.12043
12. Gilbert, P. (2015). *An evolutionary approach to emotion in mental health with a focus on affiliative emotions*. *Emotion Review*, 7, 230-237.
13. Gilbert, P. (2019). *Explorations into the nature and function of compassion*. *Current Opinion in Psychology*, 28, 108-114.
14. Goss, K. & Allan, S. (2014). *The development and application of compassion-focused therapy for eating disorders*. *British Journal of Clinical Psychology*, 53, 62-77.
15. Kelly, A. C., Lucene, W., Ellen, H. (2016). *Group-based compassion-focused therapy as an adjunct to outpatient treatment for eating disorders: a pilot randomized controlled trial*. *Clinical Psychology & Psychotherapy*. 24 (2): 475-487. [Doi:10.1002/cpp.2018](https://doi.org/10.1002/cpp.2018).
16. MacLean, P. D. (1985). *Evolutionary psychiatry and the triune brain*. *Psychological Medicine*, 15, 219-221.
17. Rector, N.A., Bagby, R.M., Segal, Z.V., Joffe, R.T., Levitt, A. (2000). *Self-criticism and dependency in depressed patients treated with cognitive therapy or pharmacotherapy*. *Cognitive Therapy and Research*

24, 571-584.

18. Shirtcliff, E. A., Vitacco, M. J., Graf, A. R., Gostisha, A. J., Merz, J. L., & Zahn-Waxler, C. (2009). *Neurobiology of empathy and callousness: Implications for the development of antisocial behavior*. *Behavioral Sciences & the Law*, 27, 137-171.

19. Siegel, D. (2012). *The developing mind, second edition: How relationships and the brain interact to shape who we are*. New York, NY: Guilford Press.

20. The Dalai Lama (2001). *An Open Heart: Practicing Compassion in Everyday Life*. Little Brown & Company: Boston, MA.