# Compassion-Focused EMDR

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Compassion-focused therapy was developed to enhance physiological systems related to well-being, safeness, and connectedness in people where shame and self-criticism inhibited progress in therapy (Gilbert, 2000; Gilbert & Irons, 2005). This system links attachment experiences with emotion regulation capacities, with integrative capacities of the mind and also with the interplay between different motivational systems, which are played out in multiple self-states (Cortina & Liotti, 2010; Cozolino, 2010; Gilbert, 2009; Liotti & Gilbert, 2011). Hence, a compassionate focus could potentially prove valuable in eye movement desensitization and reprocessing (EMDR), particularly where shame or attachment trauma is involved or for those traumas that have impacted on the structure of the self, for example, dissociation. A structured compassion-focused EMDR (CF-EMDR) seems likely to be particularly useful for therapists wishing to pay positive attention to strengths and well-being. The primary task of the CF-EMDR therapist would therefore be to facilitate a warm and wise relationship to the problems that brought the person to EMDR. This article outlines the potential benefit of a compassionate focus in the processing phases of EMDR to address self-critical blocks, giving clinical examples in tables to illustrate the process and language.

**Keywords:** compassion; shame; eye movement desensitization and reprocessing (EMDR); self-criticism; trauma; therapy

Compassion is a felt experience relating to sympathy that motivates people toward need or distress and is demonstrated by care-giving behaviors (Gilbert, 2009, 2010). It is generated from a sensitivity to suffering and a motivation to do something active to help that suffering (Dalai Lama, 2005). Humans are social animals with evolved systems of attachment and social behaviors which enhance our survival (Cortina & Liotti, 2010). Such survival is linked to compassionate behavior that evolved to enhance cooperation, which protects others within a social network (Goetz, Keltner, & Simon-Thomas, 2010). Compassion may manifest in thoughts, an emotional state, bodily experiences, and behavioral impulses. MacLean (1990) developed the idea of the evolved triune brain that demonstrates the central position of care-related motivations in our psychology. The reptilian brain is the oldest and controls arousal and drives and is responsible for basic threat defenses and ranking in the group. The mammalian brain mediates emotion, attachment motivation, and memory and is governed by the limbic system, which lies over the reptilian brain. The neocortex is responsible for self-conscious awareness, abstract ideas, planning, and accessible thought processes and is the most recently evolved aspect of the human brain. It likely evolved in conjunction with our complex social systems (Gilbert, 1989; Irons & Gilbert, 2005; MacLean, 1990). Although many motivational systems are concerned with resources, survival, reproduction, or exploration, a compassionate motivation is linked to archetypal influences over our behavior in social situations (Gilbert, 1989, 2007). These social motivations include the capacity to give and receive care, both to oneself and others.

Depue and Morrone-Strupinsky (2005) found two types of positive emotion. One was related to caregiving, affiliation, and social safeness, whereas the other was related to agency and pleasure. Compassion is linked to emotion regulation through good, safe, affiliative experiences. Such attachment experiences are highly related to soothing capacity, persons' mindfulness of their own mind, and their ability to appreciate the motivations of others (Bateman & Fonagy, 2012).


 http://dx.doi.org/10.1891/1933-3196.8.3.135

These abilities have evolutionary advantages to enable survival and social functioning and bring out innate strengths (Belsky & Pluess, 2009; Bowlby, 1980; Cortina & Liotti, 2010; Whitehead, 2001).

Experiencing the behavior of others teaches us how we are perceived by them and this in turn influences what we think of ourselves (Bateman & Fonagy, 2012). Loving relationships create a sense of self-worth through internalized expectations of patience and kindness. Self-compassion is about self-acceptance, which directs kindness and support toward the self even when faced with challenges (Neff, 2003a). It encourages reflective capacities about oneself and others. Compassion-focused therapy has an emphasis on affiliative-based soothing because internal models of positive relationships can downregulate threat even in the imagination. Such neurobiological soothing capacities can engage with suffering rather than avoid it and build resilience by moderating the brain's threat-based alarm system (Germer, 2009; Gilbert, 2009; Siegel, 2010).

## Impact of Trauma on Compassion

The capacity to be sensitive to suffering and the motivation to facilitate well-being are connected to a sense of belonging and secure safe relationships (Gilbert, 2009). Such social conditions create internal capacities to regulate emotion and the ability to trust in others for support, which can mitigate against the impact of any traumatic event (Schore, 2012). Trauma and our response to it may provoke two types of social fears in addition to any fears regarding physical safety (Gilbert, 1998). The first type is externally focused on how we are perceived by others and is closely linked to lack of trust in others and paranoia (Matos, Pinto-Gouveia, & Gilbert, 2013). External fears can contribute to posttraumatic difficulties through expectations of punishing or rejecting attitudes from other people and changes in social behavior which are linked to one's position within the social hierarchy and sense of belonging. Compassion and well-being are then further inhibited by threat, shame, and isolation, which allow other motivations, such as competition or cruelty, to emerge instead.

In addition to externally focused social fears, trauma can lead to a negative internal relationship with the self, dominated by shame and self-criticism. Such internally directed anxieties about the self can inhibit therapeutic progress by undermining the persons' confidence, criticizing their efforts, cutting them off from sources of support through appraisals of worthlessness, and creating additional layers of emotional dysregulation.

Trauma and suffering have the potential to provoke personal growth (Tedeschi & Calhoun, 2004). However, sometimes life's challenges can have a negative impact on compassion as demonstrated in three levels of information processing corresponding to the triune brain: cognitive, emotional, and sensorimotor (Wilber, 1996).

### Self-Critical Cognitions

A cognitive theory developed by Ehlers and Clark (2000) proposed that trauma experiences can be appraised in a self-critical manner, and this critical appraisal can become a primary organizing principle for the impact of the trauma. In posttraumatic stress disorder (PTSD), previously held assumptions about the world may have been shattered. In attachment trauma, the assumptions made about the world and self are inherently problematic from the start and later, trauma simply confirms them (Allen, 2013). Such cognitions are emotionally disabling by their impact on self-worth and sense of efficacy (Tracy, Robbins, & Tangney, 2007). Meta-analysis of research using the self-compassion scale showed that critical judgements about the self were strongly associated with psychological disorder (Neff, 2003b). Compassion-focused therapy initially evolved out of cognitive behavioral therapy as issues of social comparison, shame-based cognitions, and *tone* of alternative appraisals began to be understood (Gilbert, 2014). It is notable that people can feel threatened by their own self-critic, which may manifest as depressive thoughts or psychotic voices (Gilbert et al., 2001). Self-criticism can be functional when it is safer than blaming the parent on whom you are reliant even if that person is abusive (Bowlby, 1980; Gilbert & Irons, 2005). Therefore, abuse-related dominance-submissive patterns may be played out internally in relation to the self. A nonjudgmental but assertive stance toward unwanted thoughts or memories is likely to be more helpful than internal criticism or hatred toward those aspects of self-experience. The person can begin to find ways of engaging with those challenging parts of themselves with a calmer, kinder attitude. Destructiveness can then be contained and managed so that their origins or functions can be understood. Such attitudes reflect true wisdom (Meeks & Jeste, 2009).

### Shame

Shame is the appraisal of the self as worthless and bad. It elicits hypoarousal and a motivation to hide from others, attack others or the self, and avoid internal experience and self-knowledge (Gilbert, 1998;

Nathanson, 1987). Avoidance of unwanted aspects of internal experience can lead to a phobia or lack of containment of some self-states, and trauma memories may become compartmentalized away from the core self and contribute to the maintenance of PTSD or dissociative disturbance (Steele, van der Hart, & Nijenhuis, 2005).

Gilbert (1998) describes "internal shame" as that which is directed from the self to the self. "External shame" is that expected from other people. Shame can be particularly an issue for people who have experienced early attachment trauma or abuse (Herman, 1997), and shame can have a role in PTSD as well as fear (Harman & Lee, 2010; Lee, Scragg, & Turner, 2001). As social animals, extreme social emotions caused by neglect, abuse, isolation, bullying, and others can be as psychologically damaging as a threat to life (Fonagy, 1996; Gilbert, 1998; Herman, 2011), and shame memories can act as trauma memories (Matos et al., 2013). However, shame memories exceed being feelings and beliefs; they are held as procedural (i.e., automatic) memories of patterns of relating (Allen, 2013), which may often involve *submission* to negative appraisals (Gilbert et al., 2001). Such shame-based fear of compassion and difficulties in attachment style have been implicated in a range of emotional issues (e.g., Gilbert, McEwan, Matos, & Rivis, 2011).

### Impaired Self-Soothing and Emotional Regulation

Liotti and Gilbert (2011), Fonagy (1996), and many other developmentally based researchers describe how people cannot learn to emotionally regulate in the same way as they learn facts. Social encounters can soothe us when in distress, and it is through repeated experiences of such support that people can come to learn to sooth and emotionally regulate themselves in an automatic and implicit way (Fonagy, Gergely, & Jurist, 2003; Germer, 2009; Gilbert, 2009; Schore, 2012; Siegel, 2010). Babies begin their lives experiencing extreme and unintegrated bodily sensations (Allen, 2013). Allen (2013) states "integration of disparate experiences is a developmental achievement, and such integration rests on a mentalizing infant–caregiver relationship in which the caregiver holds the infant's mind in mind" (p. 82). There is much evidence from the child development literature that demonstrates the important ongoing role that attachment figures have in helping us tackle challenges and anxieties in life. For example, Sorce, Emde, Campos, and Klinnert (1985) showed that infants who saw an encouraging figure at the other end of a visual cliff felt enabled to walk across transparent Perspex and overcome any uncertainty about the apparent drop beneath them. Infants whose mothers looked afraid did not move across the Perspex because they were signalled of danger. Compassionate internalized representations of self and other can therefore give us courage to approach problems and fears. Interpersonal trauma, however, compromises the development of emotion regulation capacities (Schore, 2012; Siegel, 2010) and the capacity to integrate various aspects of experience (Liotti & Gilbert, 2011). Gilbert (2009) describes how there can follow an escalation of difficulties because when the soothing system is compromised by threat, less caring impulses will emerge. Such behaviors shut out possible sources of reparative emotional support.

## Compassion-Focused Therapy

Compassion-focused therapy (CFT) engages each client toward caring for his or her own well-being and pays particular attention to the emotional tone of self to self relating during the therapeutic process (Gilbert, 2009, 2010). It facilitates a mindfulness to the person's own needs and addresses adaptive emotional processing by harnessing a warm, wise, and nonjudgmental appreciation of the client's own predicament. That is, experiencing the process with "affiliative emotion" (Gilbert, 2014). It may do this by including image-based skills training and then using that to address attachment-based fears, learnt survival strategies regarding self-care, and emotional conditioning (Gilbert & Irons, 2005).

### Theory Underlying Compassion-Focused Therapy

The neurobiological model of CFT sees key anxieties as emerging from the interaction between the life history of the person and the "tricky" nature of our evolved brains (Gilbert, 2000, 2009, 2014). Traumatic memories are tagged by the brain's threat-based alarm system, called the amygdala, as emotionally significant (Steel, Fowler, & Holmes, 2005). In addition, complex subsystems in the brain unconsciously record expectations regarding social experiences (Fonagy, 1996; Siegel, 2010). Such emotional learning brings about protective actions (Gilbert, 2000; Ogden, Minton, & Pain, 2006). Trauma and its impact on the amygdala compels us to act in particular self-protective ways, for example, fight, flee, freeze, collapse, cry for help, and appease. Such reactions will be represented in people's best efforts to cope and may unfortunately have unintended consequences which reinforce the key fears and impulses (Gilbert, 2009). The CFT model

uses the soothing and drive systems (Depue & Morrone-Strupinsky, 2005) to moderate threat responses and facilitate emotional recovery. Compassion is an *active* engagement with suffering motivated *toward* well-being (Gilbert & Choden, 2013).

### Research Studies on Compassion-Focused Therapy

The CFT model has been used successfully with a range of different presentations including psychosis (e.g., Gumley, Braehler, & Macbeth, 2014) and eating disorders (e.g., Goss & Allan, 2010). Its application to PTSD and emotionally unstable personality difficulties shows the effectiveness of harnessing the power of compassionate motivations and skills in managing trauma-related conditions (Beaumont, Galpin, & Jenkins, 2012; Lee, 2012; Lucre & Corten, 2012).

## Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) is an established treatment for trauma-related issues (Shapiro, 2001), with strong evidence for its efficacy in the treatment of PTSD (Bisson & Andrew, 2007; Maxfield & Hyer, 2002). The theory underlying EMDR posits that when a memory of a disturbing event is inadequately processed, neural networks can hold related perceptions, emotions, bodily sensations, and cognitions in a state of potential activation similar to the time of the event. EMDR therapy was developed to process disturbing memories and to address associated bodily sensations of distress, beliefs, triggers, maintenance factors, and skills needed to enhance prospective functional behaviors. It uses bilateral stimulation to facilitate connections between neural networks and disparate streams of information processing, including more adaptive compassionate aspects of self (Shapiro, 2001).

### How EMDR Addresses Shame and Self-Criticism

There are many ways in which EMDR can already address issues of shame and dysregulation. The use of interweaves to address self-critical cognitions is part of standard processing (Shapiro, 2001). Parnell (1999) discusses how shame can be resolved by more emphasis on stabilization, a focus on symptom relief rather than memory retrieval, and addressing attachment issues with the therapist and others. Blore, Holmshaw, Swift, Standart, and Fish (2013) uses a blind therapist protocol to minimize provoking inhibiting levels of external shame while targeting memories. This trains the client to monitor his or her own change so that the therapist does not need to know the details of the target image. Wesselmann et al. (2012) describes successfully using EMDR methods to address shame emerging from attachment experiences. This article is an attempt to outline another framework to address such issues.

## Integration of EMDR and Compassion-Focused Therapy

When integrating CFT and EMDR, Phases 3, 4, and 5 follow a typical protocol process, but the compassionate focus alters the content. This modification is described in the following sections and illustrated with clinical examples.

### During Phase 1

Engaging the client in EMDR is essential from the beginning, and the very presence of the clinician will alter what is observed in the client during the processing (Dworkin, 2005). However, EMDR may appear as if it is applied by one person to another (Dworkin & Errebo, 2010). The addition of intersubjective attunement can facilitate processing during EMDR, particularly if the nature of therapeutic relationship evolves over the different phases (Dworkin & Errebo, 2010). To take an example of a potential relational barrier, one of the expectations of EMDR is that clients are honest. Shame is a natural barrier to openness (Gilbert, 2009). In addition, clients with learned responses of submission may not be conscious of the ways that they seek approval from the therapist to avoid perceived disapproval or rejection. To deal with this, Dworkin (2005) states that EMDR therapists benefit from awareness of their own blocks and unresolved networks that may resonate with that of their clients. Such awareness prevents barriers emerging, which are cocreated by the alliance. CFT training involves much practice of the principles and techniques on the self so that one can have firsthand experience of the struggle our "tricky" minds have in dealing with competing motivations and the suffering of life (Gilbert, 2009).

Shapiro (2001) acknowledges the importance of unconditional regard and safety in therapeutic engagement, and Parnell (1999, p. 66) elaborates this by describing how the EMDR patient with attachment trauma could come to incorporate the kind presence of the therapist as a "positive self-object." Therefore, the therapeutic relationship may play a key role in transforming someone from a threat state to one of

safeness. Because our brains are sensitive to social cues, how we experience the mind of the therapist can be a healing process in itself (Gilbert, 2007). We think and feel differently when in the presence of someone who we feel holds us in mind kindly to when we imagine they might condemn us.

CFT supposes that working with threat is not just a matter of reduction in negative arousal. Compassionate affiliations create a context not only for soothing but also for growth and well-being. CFT does not just process threat states and associated defenses, but it also stimulates oxytocin-based networks of safeness (Gilbert, 2009, 2013). In this way, it pulls resources from different adaptive networks toward the processing of threat. The evolutionary stance of compassion-focused therapists means they engage with clients from a position of shared humanity and innate principles, which is deeper than empathy. A warm and nonjudgmental stance is critical in CFT, although this in itself can trigger conditioned fears for those with relational trauma (Gilbert, 2007).

***Case Example.*** A woman with postnatal depression had fears of hurting her child. She had a history of abuse, so the fears already appeared to make sense in terms of her experiences. However, as the therapy emerged, she was able to disclose that during her own abuse, she had been made to hurt another child. Such a disclosure may have been unlikely if the therapist had not been experienced by her as nonjudgmental.

## During Phase 2

EMDR uses images in resource building, in particular, the "safe place." Resources are not always limited to a sense of physical safety (e.g., see Shapiro, 2001, p. 435). Dworkin (2005) describes his personal use of a movie character as a resource representing emotional resilience. Parnell (1999) uses nurturing figures, inner advisors, wise figures from history or culture, and positive memories. Recent attachment-based research would support such ideas. Imagery involving good internal attachment figures has the potential to regulate arousal. Mikulincer and Shaver (2007) found ways of encouraging patients to bring to mind secured attachment experiences. This had the effect of enhancing caregiving, improving self-worth, reducing distress relating to trauma, and even reducing attachment issues temporarily. Selcuk, Zayas, Änaydin, Hazan, and Kross (2012) used an experimental design to examine if recalling an attachment figure could help affect regulation after recalling an upsetting event. Bringing to mind a positive person in his or her life had an impact on both reported distress and implicit measures of distress. It also lessened the amount of negative thinking that the person engaged in. CFT links people to emotion regulatory capacities through such imagery. Scripts for compassionate image work are documented in the CFT literature (e.g., Lee, 2012). The image can be an ideal self (perhaps based on a memory of when one has been kind to another), another archetypal being (such as a character from literature or a perfect nurturer), or a perceptual representation (maybe a color). Compassionate mind training has been demonstrated to be a useful resource to patients struggling with adversity (e.g., Gilbert & Proctor, 2006; Mayhew & Gilbert, 2008). Such research supports the use of compassionate images and an encouraging relationship toward oneself as resources during EMDR. Beaumont and Martin (2013) describe using such compassionate mind training successfully as a resource strategy in an EMDR case study. Resourcing the self is a precursor to processing in Phase 2 of EMDR protocols, for closing incomplete sessions and for resourcing future-focused targets (Shapiro, 2001). In this way, the resourcing of a compassionate self aids the engagement with a functional ego state characterized by wisdom, safeness, warmth, and authority. This wise and caring mental network elicits a supportive relationship toward oneself and one's problems. Having a compassionate self state is an additional resource that uses a specifically positive emotion system as a therapeutic way of bringing emotional regulation within the therapeutic window (Siegel, 1999). In keeping with EMDR resourcing, it allows the person the capacity to experience traumatized states with resources at hand but ones which are specifically tied to internalized soothing relationships (e.g., Lee, 2012). This can be further enhanced by using an object which is conditioned to the image or attachment/soothing memory to elicit embodied safeness. Such compassionate objects are more akin to transitional objects than grounding objects (Winnicott, 1953).

***Clinical Example.*** The character that was chosen from a Japanese animation series (see Table 1) had "guardians" that reflected the person's own fragmented and dissociated self structure. However, the character was somewhat heroic and accepted as part of a desired social group. This helped the person create a narrative for accepting his or her fragments of experience as part of a whole. It also had wisdom and sociability that could guide the person to reflect on his or her life goals and patterns of illness behavior. The merchandizing around this character gave the person opportunity for objects that helped keep him or her on task between sessions.

**TABLE 1. Summary of Case Examples Using a Compassion-Focused Eye Movement Desensitization and Reprocessing Framework**

| History | Target Problem | Critical Fears | Compassionate Image | Compassionate Wisdom |
|---|---|---|---|---|
| Daughter died in accident | Depression | *She is alone, so I am a bad mother for remaining alive.* | Self as good mediator of conflicting needs in family; other was father who had died | She is cared for by my father in the sun and not cold and alone. It is understandable to feel torn loyalties, but I am a good mother needed by my family here. |
| Bullying by peers | Psychotic beliefs | *The world is ending as punishment.* | Tiger that embodies a quiet strength | I am safe and it was not my fault. My experiences have led to a lot of nameless dread which makes me believe terrible things are about to happen to the whole world because of me. I have practiced ways of dealing with this terror and know that when I do, these ideas do not take hold. |
| Abused as a baby | Medically unexplained abdominal pain | *I am neglected and unlovable.* | Japanese manga Animation character | I am worthy of care. I see that medical staff are doing their best and intervention may make things worse. I can find ways of managing the pain. I know there may be other causes for pain related to my history. |
| Uncertain memories of sexual abuse at age 3 years | Conspiracy anxieties | *I am alone in the world. I am tainted.* | Feminist character from novel | I have people now to support me. I can connect to others when I need to. I am a strong political woman whom people like. My quietness has its value, too. |
| Found person hanging during a walk | Flashbacks | *I can't control my mind.* | Ideal self | I can accept that I found the situation challenging and that I can overcome this. |
| Child sexual abuse | Anxiety | *I am bad.* | Ideal self | It was not my fault. |
| Ritual abuse | Dissociative identity disorder | *I am mad.* | Sunlight | I have discovered the abuse was real. My dissociation has helped me survive. |

## During Phase 3

The negative cognition reflects the maladaptive self-assessment which accompanies an image (Shapiro, 2001). However, CFT would frame this differently to avoid negative judgments about the person's responses to threat. Compassion-focused EMDR may call this thought the *key fears of the inner critic*. It avoids language that may be perceived by the clients as suggesting their thought is "wrong" because it is very likely to be linked to attempts to make sense and protect oneself. It also defines the thought as one possible thought of the whole self. The therapist could ask, "What words go best with that experience that expresses your inner critic and deepest hidden fears?" The positive cognition has an important role in establishing a goal and stimulating neural processing. However, the CFT model of the mind incorporates the tonal quality of internal wisdom. The positive cognition in compassion-focused EMDR (CF-EMDR) may be slightly different from a "positive" one in that it would be framed within the "soothing" system (rather than "drive") to ensure it has warmth and connection inherent in it. In CF-EMDR, the positive cognition is reframed as *compassionate wisdom* using the mindset of the compassionate image to reflect on the thought, "When you bring up that picture (or feeling state), what would your compassionate self say about

the idea, remembering to use a supportive tone of voice toward yourself?"

## During Phases 4 and 5

***Starting Phase Four.*** When initiating the standard process of desensitizing the memory in Phase 4, the CF-EMDR therapist would use a slight adjustment to the words, reflecting the compassionate reframing of the negative cognition, "I'd like you to bring up that experience, the words of your inner critic (repeat the words), and notice where you feel it in your body. Now follow my fingers with your eyes."

***Using a Compassionate Focus to Work With Abreaction.*** Focusing on bodily sensation is an important first-line method of addressing a block in EMDR (Shapiro, 2001). However, sometimes the arousal is so high or so low that the person is unable to process material or continue with bilateral stimulation. Shapiro suggests that manipulating the image during processing can limit abreaction (p. 179). CFT may look for ways to positively bring into the image something from the compassionate resourcing (Lee, 2012). Dworkin (2005) proposes that EMDR is enhanced by noticing when a client is outside of the therapeutic window and supports strategies to bring the client back to a state where processing can occur. Such strategies can give a capacity to return to the target so that it can be processed manageably in its original form.

Focusing on bodily sensation may be triggering in itself if the person is afraid of his or her own reaction. So, if the CF-EMDR clients become too unregulated, remind them to bring their attention to their compassionate resources. A key component of compassion as conceived within CFT is the courage to face and contain unwanted emotions and reactions (Gilbert, 2009). CFT elicits the soothing system, which holds positive strategies and networks for building containment and resilience.

*Case example.* One person told me of a slug-like "entity" which she felt on her leg. It was associated with terror and disgust. For a long time she thought it was some kind of nonhuman spirit that could do her harm. Compassionate resourcing helped her to face the fear enough to choose it as a target in EMDR. She realized that it represented an incident of sexual assault. She had previously interpreted a body memory as a concrete and current perception, making sense of it as best she could in the absence of a full picture. The memory of the assault had not been forgotten, but it had not been connected to this emotional memory and sense perception. Compassionate resourcing during sets of eye movements kept the terror and delusional interpretation manageable, which enabled her to link the event memory with the bodily perception. This resulted in the delusion and the terror disappearing. The process of integrating such elements into the "self" is challenging for people, but the soothing system has an important role in facilitating integrative processes. Ultimately, to own an entity as representing part of one's life history recovers a sense of safety in the present.

***Using a Compassionate Focus to Identify Feeder Memories Blocking Processing.*** The attention training in CFT is helpful to scan for other cues in the memory. Shame and its tendency to hide things away from view can be a critical block for processing, particularly with attachment-based trauma. CFT can support the disclosure of challenging or subconscious elements of experience that create shame of the self. Such shame-based feeder memories and their avoidance can be demonstrated to be functioning as trauma memories (Matos et al., 2013). Feeder memories are those early events that shape the development of the "self-critic" and fears of compassion or affiliations. Such memories often emerge spontaneously during processing sets (Shapiro, 2001, p. 190). They can also be elicited by such techniques as the "floatback" (Young, Zangwill, & Behery, 2002).

*Case example.* The woman with postnatal depression who disclosed about hurting another child when young experienced her own compliance with the abuser as shameful and traumatic. It had shaped her perception of herself as "bad" and made her fearful of becoming attached to others or submitting to the requests of others. Being able to identify and disclose this early memory was a turning point in therapy.

***Using a Compassionate Focus to Work With Shame-Based Blocking Beliefs.*** Shame-based blocking beliefs are based around the global condemnation of the self, either from the person themselves or from others (Gilbert, 1998, 2000, 2009). They prompt emotional avoidance, withdrawal, and possible dissociation (Gilbert, 1998; Nathanson, 1987; Steele, van der Hart, & Nijenhuis, 2005). CFT has found that change is prompted by the tonal intention of such thoughts (Gilbert 2009, 2013). Such self-critical cognitions can then be addressed using a compassionate reframe, using the mindset of the compassionate image rather than the shamed, critical, or traumatized self-state.

Secondary gain from a client's current level of functioning may be to avoid the grief of accepting losses or the damage they have done. These and other blocks as well as protective behaviors can be understood as making sense and reframed as safety strategies within

a CFT formulation. Their unintended consequences can often be shown to reinforce the original fear. This framework of understanding lessens the threat from awareness, which allows for some motivation toward change to emerge.

*Case example.* The woman with postnatal depression needed to develop a compassionate perspective toward herself as a child, which allowed them to understand why she submitted to the command to hurt someone else. There followed an outpouring of grief not only at the damage that had been done to that other child but also to that done to themselves when carrying around the shame and fear of one's own capacity. A compassionate tone was needed toward the image of them as a small child. However, this tone in itself triggered fears. The anxiously dismissive pattern of relating needed to be understood not only as protective from that event but also as coming at a cost of loneliness and isolation. Some work also needed to be done around her impulses of hurting others. The belief that she was a cruel and dangerous person needed evaluating with adult wisdom and kindness. The skills to contain such impulses also benefitted from the resilience of staying within a caring mentality.

***Using Compassion-Focused Interweaves to Address Self-Care/Self-Respect.*** Compassionate interweaves may be required if the earlier strategies for dealing with blocks are not successful. Such strategies often require the therapist to introduce a new perspective. CFT works with organizing frameworks in the mind rather than beliefs on their own. A compassionate perspective is useful here in two main respects, although other areas may emerge as CF-EMDR develops. The first relates to the block against self-care or self-respect. Compassion and connection are sometimes frightening for traumatized people because they are not protectively "on their guard." Such emotional loops or blocking beliefs can be addressed with compassion (see Table 2). Eliciting care toward the self and overcoming the learned resistances to such care are the main businesses of CFT (Gilbert, 2009).

***Using Compassion-Focused Interweaves to Enhance Adaptive Processing.*** The second main use of a compassionate interweave is in the joining of different state-dependent networks. The person's internal compassionate resources can be used to regulate themselves when they have intrusive perceptions and when the processing becomes blocked in EMDR.

**TABLE 2. Examples of Interweaves**

| Component of Compassion | Block to Self-Care Because of Shame | Joining Different Networks |
|---|---|---|
| Attention | Ask, "What impact does this shame have on you/your life?" | Illustrate their inner conflicts and ego states and elicit a compassionate moderator. |
| Reasoning | Add some element of education from the compassion-focused therapy (CFT) model, for example, the evolved nature of our limited responses to threat and the importance of attachment in emotional regulation; link their conditioned response to how this was learned from experience; and refer to the formulation. | Ask, "What wisdom can your compassionate mind bring to bear on this feeling of shame?" or "What would your compassionate image say about this?" |
| Imagery | Ask them to think of a visual metaphor for what their "stuckness"/"critic" may look like. | Ask, "Can you picture your compassionate image alongside this distressing image?" |
| Behavior | The use of a method acting strategy to imagine themselves in a compassionate social mentality. | Ask, "How is your inner critic/shame trying to protect you?" or "Notice the difference between the bodily impulses and posture in different frames of mind. What do you need to do differently right now?" |
| Motivation | Ask, "What would your fear be if we could remove your inner critic?" or ask, "What feeling is this critic directing to you and does it have your well-being at heart?" | Ask, "What would your compassionate wisdom say about this loop/critic?" or "How can you appreciate the conflict that you are in right now?" |
| Emotion | Ask them to return to soothing rhythm breathing, compassionate smile, and upright posture. | Ask, "What does your body need from your compassionate image to help you here?" |

Gilbert (2009, 2013) suggests that experiential divisions are typical of how the mind works. Clearly, acknowledging some degree of multiplicity in the self in terms of ego states has huge benefit in managing the relationship between a critical thought about the self or conflicts between states and a more "positive" or compassionate mindset. Such a view of the self allows the "compassionate" self to stay resourced while dealing with the target memories and states. It creates a distance from the traumatized elements so they no longer define the "self." Internal dialogue between a traumatized state and a state of compassion harnesses the conversations that someone has in their mind which others cannot hear (Fernyhough, 1996). Again, this model of the mind is consistent with adaptive information processing (AIP) of different neural networks, and an interweave will help prompt the persons' own intuitive wisdom as represented by their compassionate self state. The wise mind of this state will aid generalization of processing and break cycles of looping regarding emotional material (see Table 2).

***Phase 5: Case Examples of Installation.*** The compassionate wisdom that has emerged during the sets of bilateral stimulation can be installed after the subjective units of distress (SUDs) to the target have reduced to zero.

The ideal self of the person who had flashbacks after discovering a suicide changed somewhat during sets (see Table 1). Initially, they were primarily courageous and resilient. However, as the sets progressed, it became clear that acceptance of some vulnerability was needed. It is not always possible to control the contents of our minds, and this is one of the universal wisdoms that CFT uses to generate to show how our brains work (Gilbert & Choden, 2013). This client learned that his or her mind could be as unruly as other people's and that it was not his or her weakness that led to the flashbacks but rather the fear of loss of control. Embracing this meant the suicide did not remain in potential activation of threat. A compassionate stance enhanced conditions for the possibility of growth toward more self-care and also less contempt for perceived "weakness," whether in themselves or others. The installation therefore helped toward posttraumatic growth.

## During Phase 6

Compassionate bodywork involves learning to recognize what postures and activities ground and center the person. Breath and bodywork, image work, and the internalization of constructive relationships all contribute to the strengthening of soothing internal representations (Germer, 2009; Gilbert & Irons, 2005). Many therapies already use such mindfulness and sensorimotor attention. The difference is the primacy of the compassionate intention to be warm and accepting toward the experience of the body. Compassionate body scans are described by Gilbert and Choden (2013, pp. 203–205) as including both awareness of the sensations and tolerance of them. It is the second element that harnesses compassionate motivations, which are important to be present with warmth. Relating to the body with compassion opens the soothing system, which brings with it a capacity to contain and integrate experience (e.g., Gilbert & Choden, 2013; Schore, 2012).

## During Phase 7

Shapiro (2001, p. 167) suggests closing sessions after ensuring that clients are in a positive state of mind and safe enough to return home. CFT uses strategies to regulate emotion that do more than reduce threat in the body. They are positive strategies for a bodily experience of well-being. These can be achieved through the kind of image work outlined for Phase 2 but also by the practice of soothing rhythm breathing (Gilbert, 2009; Gilbert & Choden, 2013). Soothing rhythm breathing is a way of finding a calming rhythm which is usually slower than routine breath, and hence, it harnesses the body's natural mechanism to downregulate arousal. This, too, can be part of Phase 2 when patients are helped to stabilize themselves (Gilbert, 2009; Lee, 2012) but is usefully employed at the end of an incomplete session in lieu of a safe place in the standard protocol.

CFT can add practice at home. This might include nonjudgmental journals about their daily practice of compassion. This practice may be image work, breathing, thought journals, or gratitude journals. What this is intended to do is first to shift the focus of attention from threat to something supportive, in particular, their caregiving motivation toward themselves. Second, it reinforces that effort and practice are required to build a sense of safeness and healthier inner relationships.

## During Phase 8

Such homework or therapeutic attunement can illustrate the nature of the fears, blocks, and resistances to compassion and recovery. These issues need to be worked through using standard EMDR phases. However, CFT acknowledges that such blocks are inevitable when working with attachment traumas

because of the fears that became conditioned to care, dependency, and closeness. The language of CFT would seek to accept such "blocks" into a broader understanding of the nature of our brains. Its focus on strengths and resilience building suggests CFT could be particularly helpful for work on dealing with future anxieties and assimilation into a satisfying life. There are scales and questionnaires that can help show changes in the clients' fears and self-compassion (Gilbert et al., 2011; Neff, 2003b). Otherwise, discussion of changes in behavioral reactions to events is critical to knowing when issues are resolved sufficiently to move on.

***Case Example.*** One client was tormented by a voice that told him his dead son could not reach heaven without him. However, processing showed that this voice gave some link to his child that he would lose if the voice was to disappear. This connection needed to be fulfilled in other ways. While imagining his child in a safe place where he was looked after, the client noticed that he felt great relief of his anxieties for his child. As he came to trust that he could bring to mind images of his son having fun and being loved by his deceased grandmother, the voice began to be quiet. He used a soothing breathing and upright posture to ground himself into his compassionate image. For him, this image was an embodiment of his capacity to be a firm, loving parent. It became apparent that the voice was triggered by anxieties about his other children. The voice had the effect of making him overprotective toward them. His installation supported him to make wiser decisions about his children's care.

## Conclusion

Therapies that harness the power of compassionate caregiving mentalities are now increasingly popular and evidence-based (Bateman & Fonagy, 2012; Germer, 2009; Gilbert, 2010; Lee, 2012; Siegel, 2010). Such therapies have principles which could be helpful in addressing complexity and attachment issues in EMDR. This article has been an initial attempt at scoping how EMDR could be adapted to incorporate a compassionate focus. EMDR could benefit from the additional resourcing that compassionate mind training allows because it keys people in to important neurobiological regulatory systems which emerge from our evolved attachment needs. The compassionate mind may prove useful in addressing blocks to processing and in finding interweaves by directly targeting barriers created by shame, criticism, and multiple ego states.

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***Acknowledgements.*** Many thanks to Paul Gilbert and David Blore for their very valuable supervision during the development of the ideas in this article.

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