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Integrating compassion into EMDR for PTSD and CPTSD

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Abstract

PTSD and CPTSD often involve feeling-states of shame and associated self-loathing.

Traditional exposure-based protocols, which are effective for fear-based PTSD, are sometimes limited in effectiveness when working with clients with high levels of shame as they can exacerbate a sense of self blame.

Compassion focused therapy (CFT) was developed to help people who suffer from pervasive shame and self-attack. CFT is based upon an evolutionary psychology framework and draws on research from human neurobiology and attachment theory to understand how humans respond to threat.

This paper describes a protocol for integrating compassion focused techniques with EMDR therapy for the desensitization of trauma memories. The protocol includes variants of traditional ‘resource installation’, ‘window of tolerance’, and ‘reciprocal inhibition’ principles. The protocol is carried out in stages. Stage 1 includes psychoeducation and compassionate resource identification. Stage 2 is a modified EMDR memory processing protocol. Significant efforts are made to keep a client engaged with the compassionate ‘mindset’ during the EMDR processing.

Case examples are given including client feedback on their experience of the compassion focused EMDR protocol.

Key words: EMDR, compassion, shame

Introduction

“Compassion may also require courage and direct engagement in exposure to threatening and feared situations, feelings or memories. Various therapies address this in different ways ... but they may all be easier to engage in if some compassion work is undertaken before or at the same time as the exposures and reworking” (Gilbert, 2009).

Post-traumatic stress disorder (PTSD) and complex PTSD (CPTSD) are associated with a wide range of peri- and post-traumatic emotional reactions. Although a majority of clients report having experienced fear during their traumatic event a significant minority report other primary emotional reactions during and after their trauma. These include shame, guilt, disgust, and anger (Lee, Scragg & Turner, 2001; Grey, Young & Holmes, 2002; Holmes, Grey & Young, 2005). PTSD responds well to a range of treatments including eye movement desensitization & reprocessing (EMDR), cognitive behavioural therapy (CBT), exposure, and narrative exposure therapy (NET) (Cusack et al, 2016). However, clinicians often report difficulty working with clients who present with feeling-states of shame, self-loathing, or self-criticism (Blore et al, 2013; Parnell, 2007), and a number of authors have hypothesised that when trauma presentations include a preponderance of non-fear emotions then treatments involving repeated and prolonged exposure may not be effective (Grey et al, 2001; Lee, Scragg & Turner, 2001; Pitman et al, 1996; Resick & Schnicke, 1992; Smucker, Grunert & Weiss, 2003). Experimental research has demonstrated that some emotional states such as shame and disgust appear to be more resistant to extinction and that as a result clients experiencing these states may fail to habituate (Kubany & Manke, 1995, Olatunji et al, 2009; Mason & Richardson, 2010).

Compassion focused therapy (CFT) was developed to help people resolve intense and pervasive feeling of shame, self-loathing and self-attack. It is a transdiagnostic and

integrative psychotherapy which draws on research from social, developmental, evolutionary, and Buddhist psychology, as well as neurobiological science. Its application in treating PTSD where shame is the predominant emotional response has gained momentum in the last decade (Lee, 2005; Lee, 2009; Lee & James, 2012; Kennedy, 2014; Au et al, 2017) and there is now emerging evidence of its utility in alleviating symptoms in complex PTSD (Lee & James, 2012, Lee, 2009, Lee, 2015). We believe that incorporating CFT approaches with EMDR is a clinically useful approach, particularly with clients who are high in shame or self-loathing. Compassion focused approaches within EMDR have been described previously in a case study where compassion was used as a resource in EMDR (Beaumont & Hollins Martin 2013), and in a model integrating compassion at multiple points within the 8-phase EMDR protocol (Kennedy, 2014). Our approach differs by focusing specifically on optimising trauma memory desensitization in EMDR using compassion focused approaches. We describe an addition to the standard EMDR protocol which integrates ‘resource installation’ (Leeds, 1998), ‘window of tolerance’ (Siegel, 1999; Ogden, Minton & Pain, 2006), and ‘reciprocal inhibition’ (Wolpe, 1968) concepts within a CFT framework. We emphasise that the key insight of the proposed technique is that bringing trauma memories to a care-giving mindset is more effective than bringing them to a mind that is in a threatened state.

Compassion Focused Therapy

The compassion focused therapy (CFT) approach developed by Paul Gilbert draws upon social mentality theory (Gilbert, 1989, 2001, 2005) and has the development of self-compassion as one of the goals of psychotherapy. In this paper, we have chosen to focus on the components of the approach which we find essential in order to integrate compassion within the EMDR desensitization phase. For a more comprehensive description of this

therapeutic approach, please refer to Gilbert (2009, 2014). For an introduction to CFT in relation to trauma see Lee & James (2012).

The fundamental premise behind CFT is that human beings are highly evolved social organisms that are designed to live, survive, and thrive in groups. Human brains have undergone specific adaptations which facilitate such social functioning, with biological ‘hardware’ that underpins the physiology of affiliative caregiving and helps us to regulate threats in our environments. Healthy attachments play a vital role (‘write the software’) in developing a child’s capacity to self-soothe. It is such caregiving interactions that determine an individual’s capacity to receive care, give care, and care for the self in the contact of the social group.

The CFT Model

CFT is built upon modern understandings of affective neuroscience. A central heuristic model of affect regulation in CFT is widely known as the ‘three circles’ (Gilbert, 2009; see figure 1). The model proposes that humans have three major emotional regulation systems, each of which is associated with different neuroanatomy and neurochemistry (Depue & Morrone-Strupinsky, 2005), and which govern an individual’s *motivational states*. These states are: threat; drive; and affiliative / caring / giving. The three circles model has compelling appeal for the treatment of trauma. PTSD can be conceptualized as a threat focused mindset maintained predominantly by the safety seeking behaviour of avoidance. Research suggests that those who struggle with shame and self-criticism have underdeveloped capacities or usage of the soothing system and tend to respond to feeling threatened with safety seeking behaviours such as avoidance, aggression, appeasement or freezing, rather than engaging soothing physiology by using compassionate self-soothing talk (Gilbert, 2010). The CFT model predicts that compassion can be an effective component of

trauma treatments: if clients can be trained to engage with their soothing systems, and use compassionate self-talk, then they may be better able to tolerate their shame-based trauma memories and find new meaning and compassionate perspectives.

Figure 1: ‘Three circles’ model of emotional regulation systems in compassion-focused therapy. Each system is a ‘social mentality’ (or ‘mindset’) associated with different motivations and focus of attention.

Motivational States

CFT theory proposes that an individual’s motivational state is governed by whichever emotional regulation system is currently most active. The *motivations* governed by these systems are very different: the threat system is motivated to ‘survive or protect’, the drive system is motivated to ‘achieve or win’ and the affiliative system is motivated to ‘soothe or heal’. The physiology of a particular system operates to direct the motivation, focus of attention, thinking, emotions, physiology, and behaviour in particular directions. We often describe these systems as ‘mindsets’ to our clients to make them more relatable.

Threat & protection-seeking mindset.

The threat and protection-seeking mindset is the default mode for human beings – we are born primed to recognise threats and to respond in ways which seek safety. For example, babies respond to the threats of hunger or discomfort by crying which may elicit a care-giving response from others. An individual in a threatened mindset is motivated to escape from the danger. In this mindset the focus of attention is on the threat, physiology is heightened in preparation for action. Common protection-seeking responses include: Freeze, Appease, Flight, and Fight (FAFF).

It is important to bear in mind that threat emotions include fear and anxiety, but also disgust (body threat) and internal / external shame. Shame is a threat-based emotion and emerges from a threatened social mind. It is a core threat to an individual to be rejected from a social group, and the human mind attends keenly to threats of how other people think of us (external shame) and what we think of ourselves (internal shame). In response to threats of internal and external shame safety-seeking behaviours (FAFF) can manifest in our own minds or in social context. For instance, attacking others verbally or physically, or attacking ourselves (self-criticism and self-harm).

Drive, resource-seeking and excitement mode.

An individual in a drive mindset is motivated to achieve, compete, acquire, and win. The physiological feelings associated with this state can vary from an ‘activated’ purposefulness to brief moments of euphoria. Feelings associated with achievement are typically short-lived, which can contribute to the somewhat reinforcing nature of the drive system. In an extreme form of the drive mindset the primary consideration is goal completion and there may be little empathy for others. The drive mindset can be seen in competitive states where the goal is dominance, and attention may be focused on the weakness of others.

The physiology is heightened in drive, and the individual will feel activated. Feelings associated with drive include excitement, arousal, and feeling energised (Gilbert, 2009).

Compassionate ‘mindset’.

An individual in a compassionate mindset is motivated to engage and understand the source of any pain or suffering, and is motivated to act to make it better. This motivation can be directed towards others (compassion) or towards the self (self-compassion). Helpful strategies driven by this motivational state may include engaging in soothing self-talk, and engaging in courageous action. In this mindset the physiology of threat is inhibited by engagement with the physiology of the care-giving system, and is associated with emotions such as connectedness, calmness, and equanimity.

Unlike the threat system (which is thought to be active with little ‘training’) the compassion system is developed through experiences of being soothed and cared for by others. We sometimes use the metaphor of the ‘software’ of compassion being written by our early life experience. Most people who had a ‘good enough’ childhood will have emotional memories of being cared for to use as templates for self-compassion. They will be able to respond to the question “*can you think of a time when you were upset and someone soothed you?*” by retrieving an emotional memory and its associated physiological response. Individuals with insufficient experiences of soothing will not be able to access this state through memories, and may struggle to regulate their emotions effectively.

This mindset has important attributes and qualities that can be developed and practiced through exercises and training (Compassionate Mind Training: e.g. Gilbert & Procter, 2006). These include warmth, empathy, distress tolerance, distress sensitivity, non-judgement, care for wellbeing, sympathy. Courage is at the heart of compassion as it

empowers us to move away from things that maintain our suffering. Compassion may require the quality of moral courage to be honest or to admit to mistakes in order for healing to occur.

Figure 2: Components of a compassionate mindset

The Importance of Self-Compassion

Shame and self-criticism have been linked to many psychopathologies such as depression, eating disorders, psychosis and PTSD (reviewed in Gilbert & Irons, 2005). Negative associations have been observed between measures of self compassion and PTSD symptoms (Maheaux & Price, 2015; Seoglis et al, 2015) and between self compassion and CPTSD (Karatzias et al, 2018), Conversely, numerous strands of research have identified the importance of self-compassion to human wellbeing. Self-compassion enhances mental health and social safeness and it can be trained and developed in those who struggle to be compassionate to themselves (Neff & Germer, 2013). Individuals vary in their ability to

access a compassionate mindset and to offer themselves compassion. Typically, clients who have had ‘good enough’ experiences of care-giving during childhood will be able to access emotional memories of having been soothed, and will be able to regulate threat based emotions. For others, where trauma has been experienced in childhood (especially in the context of attachment relationships) care giving systems may become conditioned to memories of abuse and feelings of threat and shame. Some clients react with confusion or threat reactions to being asked to consider self-compassion. Many clients who struggle with self-compassion feel that they don’t deserve it, or react with fear thinking it will make them more vulnerable. For many clients, working with deep-rooted fears and blocks is a core part of compassion focused therapy, and a necessary stage to reach in the path of developing self-compassion. When self-compassion does not come naturally as a skill of self-regulation clients can benefit from *compassionate mind training* which includes: psychoeducation, breath work, compassionate imagery, and developing compassionate reframes and perspectives on life challenges. The combination of emotion focused and cognitive techniques helps clients to develop a ‘felt sense’ of the care-giving mindset. This process, and some of these exercises, will be described in brief in this paper but can be accessed in more detail in Lee & James (2012).

Eye Movement Desensitization And Reprocessing (EMDR) Therapy

EMDR therapy is an integrative psychotherapeutic approach, with a particular focus on how life experiences have been encoded in memory. It is an evidence based therapy for PTSD (Cusack et al, 2016) and there is emerging evidence that it is effective in the treatment of comorbid traumatic events in conditions such as psychosis, depression, and anxiety disorders (Valiente-Gómez et al, 2017). EMDR is grounded upon the adaptive information processing (AIP) model (Shapiro, 2017, 2006; Solomon & Shapiro, 2008). The model

proposes that human beings can be conceptualised as processors of information, which is stored in associative memory networks. Pathology within the AIP model is seen to arise from inadequately processed experiences which can be stored in state-specific form, and unable to connect with other memory networks. EMDR has developed as a therapeutic approach for processing multi-sensory traumatic memories, and to help clients to integrate more adaptive perspectives into their view of events. Bilateral stimulation is used to facilitate information processing (Shapiro, 2017). EMDR has been described as an eight-phase treatment approach incorporating (1) patient history, (2) preparation, (3) assessment, (4) desensitization, (5) installation, (6) body scan, (7) closure, and (8) re-evaluation (Shapiro, 1995).

Resource Development And Installation, And Other Techniques For Working With Shame

Clients sometimes experience ‘blocks’ when using EMDR to process traumatic material. A number of techniques are commonly recommended for use within EMDR to manage such interruptions to successful desensitization. One method is to give direction for the client to change their focus of their attention by, for example, attending to body sensations (which are conceptualised as other nodes in an associative memory network). Alternatively, ‘cognitive interweaves’ are designed to help clients make connections to adaptive information that otherwise appears inaccessible to them – clients might be asked a simple yes/no question prior to bilateral stimulation. For example, a client who is ‘stuck’ believing that childhood abuse was their fault might be asked “Who is responsible for keeping children safe?”.

Leeds (1991, 1995) introduced the concept of Resource Development and Installation in to EMDR as a way of working with clients who would otherwise struggle with standard processing. Incorporating ‘ego strengthening’ ideas from the hypnotherapeutic literature (e.g.

Brown & Fromm, 1986) this set of techniques focus on “*strengthening connections to resources in functional (positive) ‘memory networks’ while deliberately not stimulating dysfunctional (traumatic) memory networks*” and includes directing a client focus towards positive memories / imagery combined with bilateral stimulation. Leeds (1991) describes the development of resource development in his work with a shame-prone client. Positive imagery resources are brought ‘on line’ and combined with bilateral stimulation before beginning work to desensitize trauma memories. Within the AIP framework time spent deliberately installing positive resources is thought to make these ideas more ‘available’ to adaptive processing within EMDR. Despite some controversy regarding mechanisms (Hornsveld et al, 2011; Leeds & Korn, 2012; Hornsveld et al, 2012) resource development techniques appear to have been widely accepted amongst clinicians (e.g. Steinert, 2016; Wesselman, 2012) and RDI is described in the third edition of the EMDR key text (Shapiro, 2017).

Knipe’s ‘loving eyes’ technique is another method for overcoming blocks in EMDR processing. Knipe proposes that part of what is difficult for traumatised individuals is that their inner experience was not lovingly acknowledged and validated by a caregiver. The Loving Eyes intervention involves a combination of bilateral stimulation with 1. encouraging clients to visualise their child self from an observer perspective, 2. Attending to the child self’s feelings, and 3. Attending to their adult self’s feelings about the child. Many clinicians report having found this intervention helpful for encouraging clients to identify with their traumatised self in a less judging way (Knipe, 2007).

We are not the first to suggest an integration of compassion focused therapy into EMDR. Kennedy (2014) describes a detailed protocol for integrating compassion-focused approaches into all eight phases of EMDR work, with the specific intention of increasing the

effectiveness of EMDR with shame-prone clients. Beaumont & Hollins Martin (2013) describe the use of compassion in the context of resource installation. Our approach differs by focusing specifically on optimising trauma memory desensitization in EMDR using compassion focused approaches.

Integrating Compassion Into EMDR

We describe a protocol for integrating techniques from compassion focused therapy with EMDR. An outline of the protocol is given in table 1. This protocol brings together ‘resource installation’, ‘window of tolerance’, and ‘reciprocal inhibition’ concepts and is described here in two parts: a preparatory phase (which includes information-giving and compassion imagery exercises), followed by techniques for integrating compassionate mindsets into EMDR desensitization sessions. The key insight is that bringing a trauma memory to an engaged compassionate mindset is more productive than bringing a trauma memory to what CFT would conceptualise as a threatened mindset and will lead to more adaptive information processing. Efforts are made to bring ‘on-line’ client resources, or to develop them through imagery, and then to sustain the ‘on-line-ness’ (as in the power or intensity – e.g. how engaged the client is with this imagery) of these during trauma memory processing.

Depending upon the client’s prior experiences of receiving care-giving they will vary in their ability to experience a ‘felt sense’ of compassion and to be able to connect with the concepts described. Some clients can bring this state ‘online’ by using a memory of an experience in which they felt soothed and will be able to integrate this into EMDR desensitization relatively quickly, while other clients may have to ‘build’ such a state from first principles using imagery and flow exercises. The latter work typically takes longer, and we have frequently incorporated it into a stabilisation phase of trauma work (Lee, 2015).

Details of the protocol are given below, incorporating outlines of the states with scripted sections offering phrasing suggestions.

Compassion Focused EMDR Protocol For PTSD and CPTSD
<p>Preparation Phase</p> <p>In the preparation phase the minimum information that the client needs to know about includes:</p> <ul style="list-style-type: none"> • CFT 3 circles model • Typical motivations when an individual is in each mindset: <ul style="list-style-type: none"> ○ Threat mindset (default) motivates you to survive and protect. You are likely to behave by freezing, appeasing, flight (avoiding), and fight (which includes self-attack) (FAFF) ○ Drive mindset motivates you to achieve, win, acquire, compete. ○ Compassionate mindset motivates you to ‘look after’, to ‘take care’, ‘feel soothed’, to ‘do what is right’. • The qualities of compassion. Many clients may have the misconception that compassion is simply about ‘kindness and fluffiness’. True compassion has a number of key qualities: strength, wisdom, moral courage, warmth, kindness, and empathy.
<p>Processing phase</p> <p>During an EMDR processing session we would go through the following procedure:</p> <ol style="list-style-type: none"> 1. Mindful attention – client encouraged to take an observational stance by becoming mindful of the breath. 2. Soothing rhythm breathing – client encouraged to deliberately slow their physiology via the breath. This is framed as ‘building the foundations for a compassionate mindset’. 3. Bring on-line the compassionate mindset (via compassionate memory or imagery, e.g. perfect nurturer) 4. EMDR desensitization 5. Monitoring & re-activating the compassionate mindset. Processing is enhanced when the completed in the compassionate context. Returning to the compassionate mindset, and strengthening or re-activating the compassionate mindset if client deviates from a soothed and calm position (noticing changes in breathing is one way to notice moves away from a compassionate mindset). <p>(Repeat steps 4 & 5, cycling back and forth until processing complete)</p>

Table 1: Compassion focused EMDR protocol outline

Psychoeducation

As outlined in the section above it is helpful, at minimum, for clients to be aware of the 3 circles model of human emotional regulation systems, an individual's motivations when they are in each mindset, and the qualities of compassion. It is also helpful for the client and therapist to have considered a client's willingness to be self-compassionate. The depth into which it is necessary to offer compassion education will depend upon how readily a client can identify with the concept of 'feeling soothed by the mind of another'. For instance, do they have emotional memories of receiving care-giving to draw upon? Or will they need to learn the concepts from 'first principles' and then to work through the fears and blocks of being open to self-compassion? Clients who can identify with the utility of being compassionate to others, and who can identify a 'felt sense' of compassion from past experiences tend to need less preparation. The clinician may need to use metaphors, stories, or guided discovery to get these points across. We often find it helpful to have a discussion with clients about what a young child would need if she were anxious about performing a new but necessary task. Would the compassionate thing be to let the child avoid the task? Likely not, but a compassionate response would involve non-judgementally offering support to help the child act courageously to achieve their goal.

In the preparation phase it is important to determine that the client is able to access the compassionate care giving mindset. We tend to find that clients either have accessible emotional memories of receiving compassionate care, or do not have 'good enough' care-receiving experiences to build upon, and who will need to enter the compassionate mindset 'from first principles'. Helpful questions to ask include: *"Can you think of a time when you were truly cared for?"*, *"Can you remember a time when you were distressed and you were*

looked after by someone without being judged and criticised?”, “Is there anyone you can be with where you can truly be yourself, without worrying about being criticised?”

Developing The Physiological Foundations For Compassion

This phase consists of practical training exercises to develop the mental and physiological ‘foundations’ of a care-giving mindset.

Mindful attention.

Mindful attention is used to encourage the client to decentre from their mind and body, and to begin to ‘notice’ rather than ‘experience’ thoughts, feelings, and body sensations. This helps clients to become aware that they can control their attention and choose to focus where they attend.

“To access the compassionate mindset first we are going to practice mindful attention. This will help you to step back from your own experiences, and to notice what is going on in your mind and body. To begin, just turn your attention towards your breathing. Just notice your breathing. Don’t try to change it ... just notice yourself breathing in and out. You might find your mind wandering, and that’s perfectly ok – that’s what minds do. If you notice your mind has wandered just bring your attention back to your breath.”

Soothing rhythm breathing.

Breathing exercises encourage clients to breathe in a rhythmical, smooth pattern slow pattern of breath with attention paid to elongating the out breath. There is evidence that these increase parasympathetic nervous system activity (Busch et al, 2012) and help clients access feelings of calmness and groundedness.

“Now I want you to begin to slow your breathing down – to deliberately make your breathing slower and deeper. By breathing in a slower and deeper way we are able to calm our physiology, setting the foundations for entering a compassionate mindset. Make your breathing slower, breathe more deeply and bring your attention to the centre of your chest. This activates your parasympathetic nervous system which allows your body to relax further. What this system likes is breathing that is very regular – the same pattern over and over – rather than the jerky breathing we do when we are anxious. Try to make your out-breath just slightly longer than your in-breath”

Smell.

It is possible to trigger the felt sense of compassion as a conditioned response by completing mindful attention, breath work, and compassionate images in the presence of a soothing smell (Lee & James, 2012). Clients can be encouraged to smell their compassionate smell (many use essential oils) to make links between a smell and the physiological feelings of soothing produced by compassionate mind training.

Using Imagery To Enter A Compassionate Mindset

Developing the qualities (e.g. care for wellbeing, distress sensitivity, distress tolerance, non-judgement, empathy, sympathy) and skills (i.e. reasoning, attention, physiology, emotions, imagery, behaviour) of a compassionate mindset is a central goal of compassion focused therapy, and these can be developed in group or individual sessions (Gilbert & Procter, 2006; Lee, 2015). Entering a compassionate mindset prior to and during EMDR desensitization helps to ‘bring on-line’ a felt sense of feeling soothed with the accompanying motivation to heal distress, and allows clients to access different (more adaptive) perspectives on cognitive and emotional meanings of traumatic experiences. Whatever the technique used, the aim is to bring online a felt sense of being soothed with the

accompanying compassionate motivation and focus of attention. We might introduce this phase as follows:

“Now that you have calmed your mind and body down we are going to bring that compassionate, care-giving and care-receiving, system on-line for you. Remember that our default position is ‘threat mode’, that our motivation when we are in threat mode is to protect ourselves and survive – and that we do this by fight or flight – by responding automatically by trying to escape or avoid, or fighting or self-criticising. The mindset we want to access is the compassionate care-giving and care-receiving mindset. When we are in this compassionate mindset our motivation is to take care, to give and receive care, to look after, and to heal. We do this best if our body is calm, soothed, and settled. When we are compassionate towards others we are a solid container that is able to contain whatever the other person brings without becoming overwhelmed, when we are compassionate towards ourselves we bring a motivation to care and heal, and we hold our best interests at heart.”

Using memories to enter a compassionate mindset.

Asking clients to access and elaborate an emotional memory of feeling ‘cared for’ is a helpful way to access feelings of compassion (warmth, empathy, kindness, non-judgement, caring, strength, wisdom). The therapist can ask *“Do you have a memory of a time when you felt genuinely cared-for and looked after? Perhaps a time when you shared something difficult and didn’t feel judged?”*. Such memories can be brought on-line:

“I want you to bring to mind that memory of the time when you went to someone feeling vulnerable and upset, and when you felt safe and soothed, and not judged. When you felt that it was ok to be you, that you knew that you were safe and not going to be judged. This time when you felt safe to be held in the mind of this other person ... this person who wants the best for you ... who doesn’t judge you ... who truly loves you and cares for you ...

this person who has the strength to tolerate any distress you bring to them and who can cope with whatever comes up. Notice how it feels in your body to be with this person. Maybe you feel warmth. Notice if there is a colour which represents these feelings of safety and warmth and empathy”

Using perfect nurturer imagery to enter a compassionate mindset.

Some clients may not have emotional memories of feeling cared-for, in which case ‘perfect nurturer’ imagery is often helpful. The perfect nurturer is imagery of a perfectly compassionate being which can be rehearsed and elaborated to produce a felt sense of being cared-for (see Lee, 2005, for further details).

“Bring to mind your perfect nurturer image. This perfectly compassionate being who truly has your best interests at heart ... this being who doesn’t judge you ... who truly cares for you. Notice how it feels in your body to be cared for by this compassionate being. Feeling safe in the mind of another – this being who knows what you have been through, and who doesn’t judge.” This being knows what you need and how to offer you comfort and give you the strength to do the right thing.

Using the qualities of compassion to enter a compassionate mindset.

Bring on-line the qualities of compassion (warmth, strength, non-judgement, wisdom, kindness, empathy) and imagine method-acting ‘as if’ you had these qualities.

Protocol During Memory Desensitization

Compared to the EMDR desensitization standard procedure, the aim of this protocol is to bring the trauma memory to the compassionate mindset. Once the compassionate mindset is ‘on-line’ the trauma memory is brought to mind and the client begins EMDR desensitization using bilateral stimulation. The steps involved are:

1. Bring the compassionate mind online (using a memory or compassionate image, and reminding the client of the qualities of compassion and their motivations when in this mindset). We recommend that therapists not be afraid to be quite didactic and ‘information giving’ in this phase (see scripted section below).
2. EMDR desensitization using the standard protocol, including interweaves, whilst in the care-giving mindset
3. Revivifying the compassionate mindset whenever necessary. It can be necessary to encourage the client to re-enter the compassionate mindset as frequently as after every set of bilateral stimulation.

Bringing the compassionate mind online.

We might introduce this phase with instructions as follows:

“We are going to use EMDR to process the trauma memory we have agreed to work on, but we will add an extra step this time. Remember that human beings have three basic motivational systems which shape ‘mindsets’. These are threat, drive, and compassion or care-giving. The motivation of the threat mindset is to protect you to seek safety by running away, avoiding, fighting, self-criticism. The motivation of the drive mindset is acquiring and goal focused. The motivation of the compassionate care-giving mindset is to heal, soothe, and make things better. So, if we take a trauma memory to a threatened mind, then the motivation of the threatened mind is to try to get safe – people may make efforts to avoid the memory (flight), or become very self-critical (fight). The compassionate mind is different. When we are in the compassionate mindset and offering care-giving to someone else we have empathy – we feel empathy for another person’s distress or our own distress. We also have the strength to sit with pain and suffering without turning away. When we are in a compassionate mind we are in a non-judgmental frame of mind – we’re not trying to ‘put the boot in’. In the

compassionate mindset, we genuinely want the best for ourselves or another person. Our motivation is to give care, to soothe, to heal, to make things better. When we are being cared-for by someone who is truly kind, caring, non-judgemental, strong, and wise we don't feel we have to keep our guard up, and we don't have to be ready to run away. It is that mindset that we are going to help you to bring on-line now before we start to work with your trauma memory."

Bringing a memory to the compassionate image.

Once a compassionate mindset has been brought on-line EMDR desensitization can then begin or continue using the appropriate protocol. Using the standard protocol:

"Now that you are in the compassionate care-giving mindset, where your motivation is to heal, I want you to bring your trauma memory to this place. Bring to mind your target image [description of target image as discussed] and your negative cognition [repeat negative cognition] and just notice what you feel in your body." [Begin bilateral stimulation]

Strengthening or re-instating the compassionate mindset.

An important observation is that some clients will very quickly revert to the threatened mindset, especially when trauma memories are activated. If clients appear to be outside their window of tolerance, or unable to make adaptive connections, they can be helped to recover their compassionate mindset.

"I can see that your physiology has changed, and that your threat system has tried to protect you by coming on-line. Let's re-set the foundations so that you can re-enter the compassionate mindset. Now take a moment to re-centre yourself and to settle back into the compassionate mindset. Begin by getting your breathing back under control by deliberately making it slower and deeper, allowing your breathing to settle into a regular rhythm which

calms your physiology. Making sure that your out-breath is slightly longer than your in-breath. Now bring your compassionate image back on-line, remembering that the motivation of this mindset is to give care, to look-after, to heal. The qualities of this place are non-judgement, where it is ok to feel what you feel, warmth and kindness, empathy, wisdom to know what is right, and strength to do what is right.”

Case Examples

Two case examples are given of clients with whom we have used this approach. Examples have been anonymised and clients have given their consent for their details to be included in this paper.

Case Example 1

A.B. was a policewoman who was raped on duty by a colleague whilst in a police car. She presented at the PTSD clinic two years after the rape. She had not disclosed the rape at her assessment, nor to her therapist until session 8, instead reporting that she had only been touched inappropriately. Her psychometric scores indicated high levels of shame and self-criticism, and she displayed high levels of cognitive avoidance and hyperarousal. Her therapeutic goals were to reduce her experiences of nightmares and hyper-arousal.

She chose to attempt EMDR to work on her trauma memories and was able to identify a target image of being assaulted in the police car, with a negative cognition of “*I’m weak*”. EMDR was initiated using the standard protocol but desensitization proceeded relatively slowly. New material would emerge every session, but the client experienced very high levels of physiological arousal despite extensive use of grounding techniques, safe place exercises, and techniques to view the images from distance. At appropriate points psychoeducation was given including information about involuntary sexual arousal during sexual assault (Levin &

van Berlo, 2004), and a scientific model of the threat cascade incorporating the ‘fright’ response which is associated with physical immobility (Schauer & Elbert, 2010). Off-line (non-EMDR) cognitive restructuring addressing blame for the attack, and the client and the perpetrators’ motivation to assault / to-be-assaulted was used to address negative client self-beliefs. This work led to cognitive but not affective change and subsequently formed the basis of interweaves.

A.B. was distressed by disgust imagery during processing – particularly associated with times of pain flashbacks (e.g. McDonald, Salomons, Meteyard, Whalley, 2018; Whalley, Farmer & Brewin, 2007). Imagery of purity and cleanliness was paired with disgust imagery using a ‘split screen’ technique (Spiegel, 1988) to address points of blocked processing around physical disgust. The client found some relief with this technique, but processing around physical sensations of the rape continued to arouse high levels of distress and processing of the event remained blocked to a considerable degree.

The client found it very difficult to articulate any cognitions around her experiences. During session 13 (10th desensitization session) she was able to identify a touchstone memory of being age 12 and feeling very powerless while sitting on the bed next to her mother as her father physically abused them both. Her negative cognition was *“I’m helpless (and I should have done something to stop it)”*. One session was spent using the standard protocol with this touchstone memory but the client did not experience any change in subjective distress. During session 14 the clinician introduced A.B. to ideas about compassion and suggested they explore the touchstone memory from that mindset. The client was able to identify a strong memory of being with a friend by whom she did not feel judged, and in whose company she felt safe. She described this place as a ‘home from home’ and she was able to access this memory strongly using imagery. She identified a warm yellow-orange colour

(*“like a sunset”*) which represented the compassionate feelings. When EMDR desensitization to the touchstone memory was attempted within this compassionate context A.B. quickly reached a SUDS of 0, and installed her (new) positive cognition *“It’s not my fault”*.

The focus of therapy then moved back to the memory of the rape, during which she had also felt powerless. Desensitization was completed in the context of compassionate image, paying particular attention to physiological soothing with strengthening of the compassionate imagery every time the client’s physiology deviated from an extremely relaxed and soothed state. A number of interweaves were introduced to unblock processing including *“Are you powerless anymore?”*, and a request to say *“[Perpetrator’s name] this is not your fault. This is my fault. I didn’t fight back”* (paradoxical injunction). In the compassionate mindset the client quickly identified with compassionate (non-critical) responses. After 2 sessions A.B. spontaneously brought up ideas about needing to forgive herself. She completed a site visit in between sessions. By the end of therapy (16 sessions total) her SUDS were zero and the positive cognition *“I’m strong now”* had been installed. After the penultimate session A.B. went away and wrote a narrative account of the rape – using the word ‘rape’ for the first time and incorporating multiple compassionate perspectives.

At the end of therapy A.B. was invited to reflect upon her experience of therapy, comparing her experience of the standard protocol to EMDR incorporating compassion. She reflected that with compassion she was less defensive, more able to identify thoughts and feelings, and could get ‘closer’ to the images without dissociation. Comparing the two types she said *“It’s completely different. It was hard keeping my breathing steady when the panic would come in but it made a difference because when the panic came up I would only get up to a [SUDS of] 6 rather than too high ... It was helpful getting to the compassionate place*

before the memory because it changed the scenery ... do you know what I mean? ... It was like I was looking at the memory from a different point of view ... I can't believe I thought it was my fault all my life ... I do have some of that compassion shit after all (laughs)".

Reflecting on the process during the final session she reported *"I don't think I would have let my defences down [using standard EMDR protocol] ... we could have been here for 2 years"*.

Case Example 2

C.D. was a 50-year-old woman who had experienced multiple traumatic events throughout her life. She experienced emotional neglect from her mother, was sexually abused by a neighbour from the ages of 8-12, experienced domestic violence during her 20's and 30's, and had been the victim of an attempted rape a few years prior to therapy (her attackers had gone on to rape another woman later that night). Her goals at assessment were to be less negative and self-critical, and to have a reduction in re-experiencing of her trauma. She reported that she was not hopeful of a positive outcome.

Following the development of safe place imagery C.D. chose to begin EMDR by working with her recent trauma. She identified a target image of being surrounded by a group of men who were threatening to rape her, feelings of fear, and a negative cognition of *"I'm weak"*. C.D. was able to successfully process this event using the standard protocol, achieving a SUDS of 0, in 4 sessions. C.D. subsequently agreed to begin working with her memories of childhood sexual abuse. She was able to identify 'first', 'worst', and 'typical' experiences, and felt able to begin by working with the event she identified as both 'first' and 'worst'. She identified feelings of fear and disgust, and negative cognitions of *"I'm dirty"* and *"It's my fault"*. EMDR desensitization was attempted using the standard protocol, and C.D. experienced a degree of dissociation during initial sessions working this this memory.

She also experienced frequent blocks in processing where she would ‘bottom out’ around themes of self-blame (*“I should have done something different”*) and self-critical dialogue.

C.D. and her therapist agreed to pause EMDR desensitization and spent some time reviewing the three circles model of compassion, then developing a compassionate image based upon real memories. C.D. was very close to her grandmother who had been her sole source of nurturing during her childhood. She was able to feel a definite physical soothing when she accessing memories relating to her grandmother, and reported feeling calmer and safer. A combination of physiological soothing and an image of being soothed by her grandmother was integrated into the EMDR desensitization, but despite C.D. reporting that she felt calmer, blocks continued to occur. For example, when interweaves were used to assist C.D. in accessing compassionate perspectives, (e.g. *“would your compassionate figure agree with that assessment of this situation?”*) her answers were sometimes confused with what this grandmother had actually said and done, or ways in which she feared her grandmother might react if she knew the truth.

In response to the blocks encountered when using a compassionate memory, C.D. and her therapist re-explored the qualities of compassion, and worked to develop a ‘perfect nurturer’ image which embodied these qualities (Lee, 2005). C.D.’s image was of a tom-cat named Tom. Her image of Tom was clear and vivid, and she experienced a notable softening in affect when she brought him (in imagery) to the sessions. C.D. reported that bringing on-line her perfect nurturer image before sets of EMDR desensitization was extremely helpful. Within 4 sessions her SUDS for the first/worst event were at 0. And her VoC in the positive cognition *“It’s not my fault”* was 4. One non-EMDR session was spent exploring the consequences for C.D. of relinquishing her sense of self-blame for the abuse, and she was set homework of writing a compassionate letter to her younger self. During the subsequent

therapy session desensitization was completed for this event (SUDS = 0, VoC = 7), and upon re-assessment C.D. did not feel that she needed any further EMDR to her experiences of abuse. Her PTSD severity was significantly reduced by the end of therapy, and she was PTSD-free at follow-up.

A few months after the completion of her therapy C.D. was invited to reflect upon her experience of EMDR, and a number of themes emerged. In a similar manner to A.B. she reported that the integration of compassion made the process of desensitization feel less aversive – she reported that were it not for the use of the compassionate imagery she may have chosen to disengage after 4 or 5 sessions as she was finding the process too intense. She reflected that although the compassionate memory of her grandmother had been physiologically soothing she was still afraid of upsetting her grandmother (*“I didn’t want her to say ‘you should have told me’ and feel disappointed in me”*). She reflected that her perfect nurturer image of a cat embodied all of the qualities of her grandmother, without being bound up with worries about how that person might react. She described feeling shame in the context of disclosing her abuse to another person, but that the perfect nurturer image of the cat *“didn’t count because it had already seen all the abuse and I didn’t get any judgement from it so I felt safer with it there”*. She also described experiencing encouragement from her perfect nurturer, that it would *“egg me on to tell you everything, because I knew I needed to and I might not get this opportunity again”*. C.D. also reported that her nurturing image spontaneously interacted with her trauma imagery – she gave an example of a memory of being in the abuser’s kitchen and being threatened by him not to tell anyone. When using compassion-focused EMDR she experienced seeing her cat image walking around the perpetrator and say to her *“he’s lying to you, don’t listen to him”* and on multiple occasions experienced the cat coming between her and the perpetrator and baring its claws at him.

Finally, she reported that being allowed to ‘leave’ Tom in the therapy room with the memories during the time between sessions allowed to leave feeling unencumbered.

Discussion

Both PTSD and shame can be effectively treated with EMDR therapy (Cusack et al, 2016; Balcom, Call & Pearlman, 2000) but clinicians often find that clients with experiencing high levels of shame or self-criticism frequently experience blocks during processing (Blore et al, 2013; Parnell, 2007). Clients who are high in shame and self-criticism are more likely to experience ruptures during therapy (Gilbert & Leahy, 2007) and may fail to benefit from cognitive and behavioural therapies despite becoming skilled in generating alternatives to their negative thoughts or beliefs (Rector et al, 2000). Compassion focused therapy is a psychotherapeutic approach developed for working with the blocks associated with shame and self-criticism.

We have described a protocol which integrates memory processing in EMDR with elements of compassion focused therapy, illustrating it with case examples. The key insight of the approach is that bringing trauma memories to a care-giving mindset is more productive than bringing them to a mind that is in a threatened state (Gilbert, 2009), and post-therapy reflections from clients appear to support this view. The present protocol can be considered an addition to phase 2 of the standard protocol ‘resource installation’ in which alternative ways of thinking about and relating to oneself are brought on-line prior to desensitization, thereby making such material more available for adaptive processing within EMDR. However, although some clients are able to access compassionate resources relatively quickly via emotional memories, others do not possess an emotional understanding of safety or nurturing, and may need significant psychoeducation before being able to generate effective compassionate imagery. An additional process with our compassion-focused approach is to

attend to keeping the client in a compassionate mind-state during EMDR processing, re-engaging this mindset as necessary.

Reciprocal inhibition may be a helpful way of conceptualising the role of compassion within EMDR desensitization. Wolpe's (1954, 1968) theory of reciprocal inhibition argues that two incompatible psychological states cannot exist simultaneously (Tryon, 2005) and that the induction of, say, relaxation during exposure to phobic stimuli facilitates the extinction of fear. Gilbert has likened the operation of CFT to *"a reciprocal inhibition model to the extent that by creating physiological patterns for compassion, one is stimulating for example the vagus nerve which is a natural evolved regulator of threat processing"* (Gilbert, 2017). With reference to other anxiety conditions it has been noted that although relaxation has not been found to be an essential component of exposure treatment (McNally, 2007), anxious clients who are able to feel relaxed in the presence of a phobic stimulus might feel empowered by such an event, resulting in adaptive belief change (Parrish, Radomsky & Dugas, 2008). According to the compassion model, if a client can be helped to enter a soothing or affiliative motivational state this will inhibit the operation of threat responses – in the compassionate mindset they are able to access non-traumatised cognitions and perspectives, and to feel differently about their experiences. Such a conceptualisation would appear to be consistent with Shapiro's AIP model whereby a focus on traumatic material accompanied by bilateral stimulation helps clients to access more adaptive perspectives upon their experiences (Shapiro, 2017, 2006; Solomon & Shapiro, 2008).

Qualitative feedback from clients whose PTSD has been treated using this protocol suggests that they find it easier to tolerate shameful memories during EMDR processing when the memories are taken to a compassionate mindset (e.g. *"It was like I was looking at the memory from a different point of view"*, *"I don't think I would have let my defences*

down [using standard EMDR protocol]”, “[with my compassionate image present] I didn’t feel any more of shame ... I was able to talk more freely”). One testable hypothesis is that any benefits of the present protocol are attributable simply to physiological relaxation due to the additional emphasis our protocol places upon physiological arousal. We aim to test this by comparison of this enhanced protocol with one which emphasises physical relaxation prior to each set of bilateral stimulation.

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