Chapter 10

Compassion Focused Group Psychotherapy for people who could attract a diagnosis of personality disorder

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Abstract

Some people with complex mental health problems are labelled 'personality disordered' but are better conceptualised in terms of suffering from ruptures in their attachment and interpersonal relating systems. These make it difficult to utilise the psychophysiological mechanisms underpinning affiliative and compassionate care systems. A five-phase approach to Compassion Focused Group Psychotherapy to address these early ruptures is described. Cultivating the conditions for safeness, is introduced, as the basis for compassionate Mind Training (CMT) and Compassion Focused Trauma Therapy. Clinical examples and qualitative data are presented from our group-based intervention that support the use of specific embodiment and trauma focused interventions enabling patients to work with and through their fears, blocks and resistances to the giving and receiving of compassion.

"The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery therefore is based upon empowerment of the survivor and the creation of new connections." (Herman, 2002, p.s98)

Introduction

There is now considerable evidence that the quality of early life relationships has a fundamental impact on the subsequent maturation of a range of physiological systems (for reviews see Cozolino, 2014; Music, 2019) including epigenetics (Cowan et al., 2016; Lippard, & Nemeroff, 2020). When children lack a secure base and safe haven their capacity to mature helpful interpersonal skills, regulate emotions and have a positive self-identity is comprised as is the ability to see others as a source of emotional and social support. Thus, creating ruptures in their attachment and general interpersonal relating systems (Music, 2017 2019; Schore, 2015). These backgrounds make individuals particularly vulnerable to harsh forms of self-criticism, shame, concerns with social disconnection and exclusion (Sloman & Taylor, 2016; Liotti & Gilbert, 2011). Using attachment findings and social mentality theory Gilbert (2005) describes how children who do not mature within caring environments automatically switch to a different social mentality and see the world as a potentially harmful and threatening place. Thus, requiring highly threat focused coping strategies, particularly fight, flight submissiveness. In addition, they often become focused on issues of social power and rank. In adulthood they struggle to trust others and/or themselves which sets up and maintains cycles of interpersonal conflict, isolation and disconnection (Herman, 2002; Music, 2017, 2019).

They often present to mental health and other statutory services with complex emotional and interpersonal difficulties and multidimensional needs that can attract the unhelpful diagnosis of personality disorder. There is often a complex history and pattern of relational difficulties of abusive and abusing relationships which can replicate the early trauma dynamics. These can be also be played out in the therapy resulting in high attrition from services (Lucre & Clapton, 2020; McMurran et al, 2010). These difficulties can be complicated by the prevalence of substance misuse, mood difficulties, self-harm, offending behaviour, reliance on psychiatric medications and social deprivation (Tomoko et al., 2012).

Such behavioural manifestations can be more helpfully understood as *"complex adaptations to early adversity"* which have important functions to regulate stress (Brune, 2016, p.61). Given the often dangerous and impracticable nature of the early environment, these 'adaptations' were functional at the time. However, in the absence of new learning, these strategies remain fixed and appear 'dysfunctional' in a seemingly less hostile environment, thus giving rise to stigma and judgment (Brune, 2016; Molina et al. 2009).

These patients have often had extensive, often problematic, contact with services. Due to past experiences they can be difficult to engage, distrustful and resistant to the idea of engaging in compassion as a way of dealing with their difficulties (Gilbert, 2011; 2017; Lucre & Corten, 2013). Indeed, fears and resistances to compassion that involves trust, sharing, empathic insights, and giving and accepting the help of others are extremely common in the early stages of psychotherapeutic work. However, there has been considerable work in recent years to develop interventions which can address directly some of these issues which interfere with the capacity to engage in psychotherapeutic work (Gilbert, 2011; Lawrence & Lee, 2013; Lucre & Corten, 2013; Lucre & Clapton, 2020). Especially important is to help patients to feel some sense of both safety and safeness (Gilbert, 2010, 2020; Lucre & Corten, 2013; Van der Kolk, 2015).

Compassion Focused Group Psychotherapy (CFGP) – A Five Phase Approach

There is good evidence that group-based psychotherapies are as good as individual ones and may well be better for facilitating change through interpersonal relating (see Griner, Beecher, Burlingame, Erekson & Cattani, this volume). As Gilbert (2003, p.2) puts it *"A group format is ideal for delivering CFT partly because it focuses on developing affiliative experiences and de-shaming".* Lucre and Corten (2013) devised a 16-week compassion focused therapy (CFT) group program for people diagnosed with a personality disorder, demonstrated therapeutic gains which were maintained at one-year follow up. Time was given to establish *safety*, reducing the need for vigilance to threat and *safeness* as in experiencing others as helpful in the group. The focus of this group was primarily Compassionate Mind Training (Gilbert & Procter, 2006). Feedback from the group, coupled with exploration of the literature, guided the development of a longer, rolling program, to provide the opportunity for greater opportunities for grounding, creating a secure base, safe

haven and facilitating the context for trauma focused group therapy (Arlo, 2017; Wehle, 2016; Leiderman, 2016). As such this approach sought to offer therapeutic opportunity to those whose capacity to engage meaningfully, empathically and compassionately with themselves and others has been compromised by ruptures in their attachment systems.

CFT involves the explicit cultivation of compassionate care giving and receiving motivational systems. Essentially CFT is a motivation switching therapy because the motivation we are in organises all other processes including attention, thinking, behaviour and physiological reactivity to events. Building and experiencing compassion seeks to create the conditions to experience a secure base and safe haven which are central to the process of therapeutic change for these patients (Holmes & Slade, 2017). Crucially there is an invitation to consider fears, blocks and resistance to compassion as indicative of inner wisdom because as patients begin to engage with compassion, attachment memories are activated and this can result in traumatic grief or unprocessed anger.

CFGP integrates a process-driven group psychotherapy format with more structured components to foster a sense of social safety and safeness, a secure base and safe haven between group members (Arlo, 2017; Kalleklev & Karterud, 2018; Yalom & Leczez, 2006). This model is compassion focused therapy (Gilbert, 2017; Lucre & Corten, 2013), with elements of group analytic theory and practice (Dalal 1998), delivered in part through a medium of action methods (Tomasulo 1998; White, 2006). Dyadic and small group tasks, with careful attention development of the capacity of group members to tolerate the shared group space/processes (Gilbert, 2009; & Bateman & Fonagy, 2016), aim to foster affiliative connections and shared experiences between group members. This is a slow open program with five integrated phases. It was developed as a model to rebuild some of the functions of attachment such ‘safe-relating’ as a secure base and safe haven. These offer empathic engagement, connectedness, validation, confidence building and working through unprocessed emotions and traumatic memories. Patients come to experience being compassion to others, receiving compassion from others and developing it for themselves.

Phase One – Assessment and Formulation

The important task of building the therapeutic alliance and preparing for the psychotherapeutic process begins with the assessment (Bateman & Fonagy, 2016). Indeed, this is where the highest rates of attrition often arise (Hanson, Lambert & Forman, 2002). The assessment therefore requires a number of sessions which are spaced out to allow time for a therapeutic alliance to be established and some initial shared understanding and trust to be developed (DeSaeger, et al. 2014; Gilbert, 2003). Within this extended early encounter (and throughout the therapeutic process), an explicit process of de-shaming personal experiences, with attention to language, pacing and tone is undertaken to begin a process of exploration with open curiosity (Gilbert, 2003; 2017; Kamphuis & Finn, 2018). We sought to develop an intervention for patients whose difficulties were described above and are often excluded from psychotherapy services. An initial collaborative formulation process starts at this stage, but it is then a template to return to within the psychotherapeutic process, to enable adjustments to be made as needed (Bateman & Fonagy, 2016; Gilbert, 2017). The essence is to help the patient become familiar with the evolutionary basis of CFT (see Gilbert, 2020). This helps people make sense of some of their emotional difficulties, for example that a primary motive in life is self-protection. Therefore, hostile environments are likely to activate threat-based emotions and make trust very difficult. Through the formulation, problematic responses are validated as understandable reactions to toxic environments.

Phase Two – Waiting List Support Group

A further level of containment and support is offered through the monthly one-hour supportive space for those waiting to commence the group program. This space is held without an expectation of attendance, in that the place in the group program will not be lost if they do not attend.

The co-facilitation with a senior therapist and Lived Experience Practitioner (LEP), who has graduated from the program, is designed to establish the group as an informative and not a therapy space. Participants are invited to raise questions about the practical and emotional aspects of the program and consider what will be needed to facilitate engagement. It is

important for the therapist therefore to employ a light conversational style to modulate the intensity of the intervention.

Phase Three - The Preparation and Engagement Group - Cultivating the conditions for safeness

Psychoeducation: During the 12-week Preparation and Engagement Group, three modules are introduced to begin the first two components, the psychoeducation and CMT. The psychoeducation component covers a number of different aspects, relating to the nature of groups, using guided examples to demonstrate how members have intuitive wisdom about the reality of suffering and the nature of compassion.

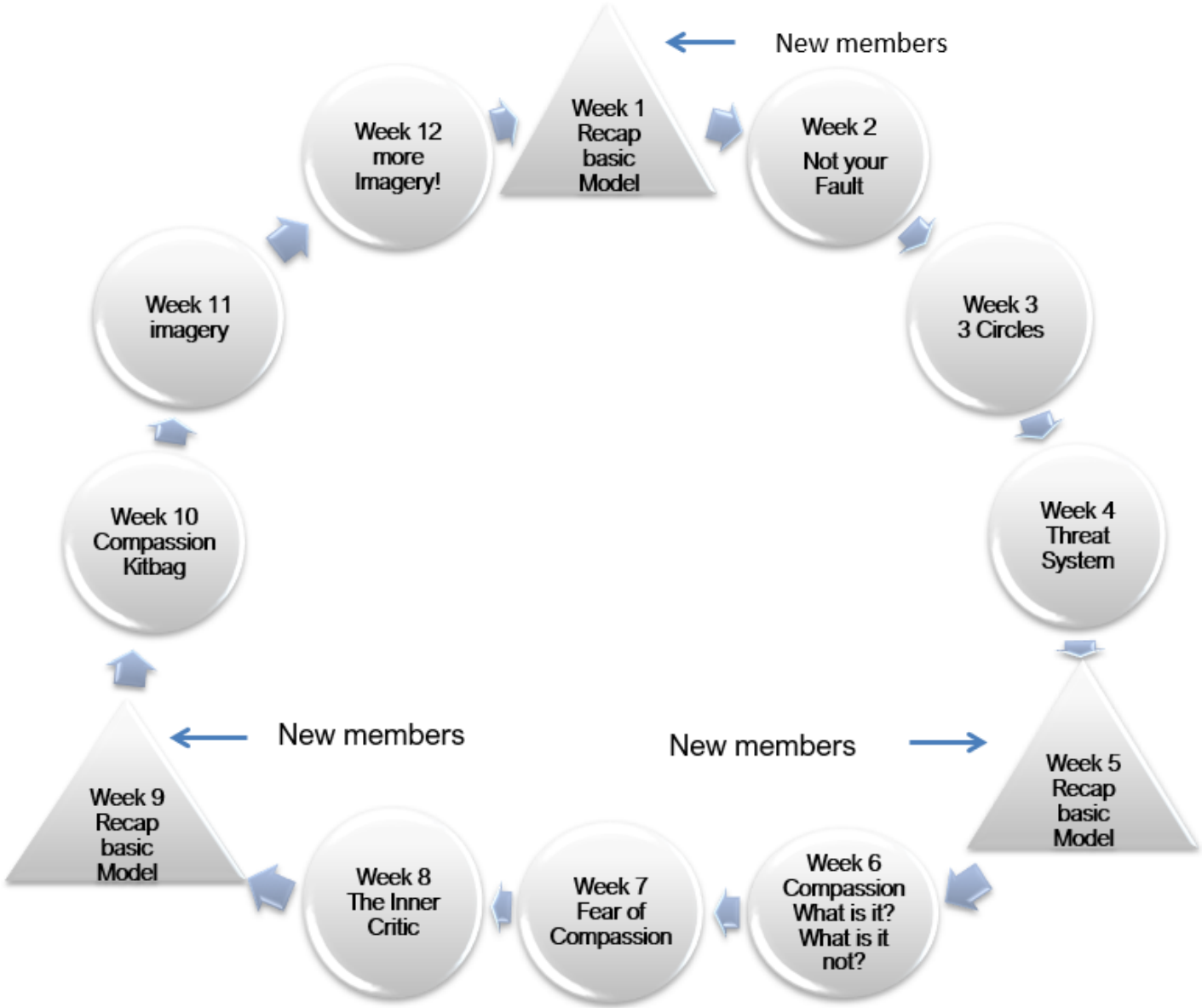
The next aspect of psychoeducation is on how and why evolution has created a human mind that so tricky, that is so easily tipped into painful emotional states with the risk of being harmful to self and others. The group reflect on the theme that we all have brains that have been built for us not by us and a sense of ourselves that has been created according to our social circumstances. Key to this is the idea is that many of our motives and desires, fears and emotions are products of these processes and hence not our fault. This is very de-shaming and builds within the group the basis of a common humanity, we are all in this same situation (Gilbert, 2009). However, to develop a more settled mind, avoid being harmful to self and others, and move towards wellbeing we can learn about our mind works and how to take responsibility to try and change.

While we all have basic motives and emotions, we also have a new type of brain compared to other animals. We have different ways of reasoning, gaining insight and with unique mindful awareness of self, to support *knowing intentionality*. Our new mind allows us to do scientific things but also can create loops of negative feedback. Members are given opportunities to explore this. It is important to help them recognise that how and what they think has an impact on them physiologically.

> *"Before I'd think I'm an idiot there's somit wrong with me but it (the old brain new brain teaching) got rid of that and the feeling of helplessness" (AC).*

The ‘triangle’ sessions depicted in Figure 1 represent the sessions when new participants join the program. These sessions have a particular structure designed to introduce the new participants and explain how the groups will be run. An essential component of this joining session is the ‘safe space agreement’, which is a group based collaborative behavioural contract which everyone agrees to abide by. This is returned to each time new members join, thus ensuring the principles of maintaining safeness within the group are held in mind by everyone. *“It’s the people that you respect and trust and all the rest of it and because the ground rules are the ground rules we came up with and all that trust and shared history is still there” (JA)*.

Figure 1 Preparation and Engagement Group Format



The group has an open format in that participants join at specified time points, in pairs, within a rolling continuous 12 weeks cycle (see Figure 1). The rolling program has a number of key functions; managing waiting lists, throughput and perhaps most importantly exposure to the experience of change associated with movement through the program. There is a compromise, as some group members have their modules in a different order. The key elements of the psychoeducation and CMT are revisited, however, during the program, to ensure that the basic model is embedded.

A further benefit to the rolling program is to promote new group members being supported by existing 'senior 'members to begin to make sense of the process and content of the groups, thereby encouraging the sense of group cohesion (Haigh, 2013).

"so having that rolling program is a great benefit if we had all started on the same day … a room full of frightened silent people wouldn't have been of great benefit but where some had been there for months and were ready to move on .. seeing people at different stages of development that kind of gave me hope". (TS)

In explaining the basic model to new members, senior group members can rehearse and explore their own learning, reflect on their journey in the flows of compassion, whilst being empowered by the opportunity to practice compassion to others. This group structure, content and process has been designed to explicitly and implicitly develop the capacity of group members to experience compassion from others, offer compassion to others and to begin to practice giving compassion to themselves in a gradual way.

Using the body to support the mind: Once members have understood the value and point of breathing exercises, how we use the body to support the mind each group commences with a guided, soothing breathing rhythm practice (SBR). This is designed to settle people into the session and also create a predictable consistent starting point and therefore a secure base for the group (Arlo, 2019; Lucre & Corten 2013). During this practice, an emphasis is placed on an increased postural awareness, straight slightly concave back, grounded upright posture, playful facial expression and warm friendly inner voice tone. This can facilitate the activation of the vagal nerve, which is associated with an increased sense of safeness and affiliative social engagement (Flores & Porges, 2017; Porges, 2011).

Some members can find these practices difficult particularly if in the past safeness and body awareness has been associated with threat stimuli. Group members are invited to make use of objects, such as pebbles, small cubes, buttons, beanbags, which are available in the group room as a sensory focus and also as a gift from the group (Gilbert & Proctor, 2006; Lucre & Corten, 2013; Lucre & Clapton, 2020). One member suggested that,

> *"I say relaxation it's actually not it's bringing yourself into the moment so it's the breathe .. Helps you sit back and gather yourself in really.. Then the group share that was really important" (JA).*

Feedback from each group member after each breathing practice is important to ensure that any misunderstandings and resistance can be explored understood and addressed with collaborative problem solving.

Social skills: The social skills acquisition component of the group is explicitly to stimulate and balance the three flows of compassion. This process of listening and inquiring facilitates mentalisation, also recognising the importance and reparative experience of other's curiosity and connection (Arlo, 2017; Lucre & Corten, 2013). Rather than waiting for contributions, each member is individually invited to take turns to offer a short, emotion focused check-in about their week, before passing it to another group member. Over time, group members are encouraged to take responsibility for time keeping the check-in and supporting each other. Managing the time boundary around the feedback and check in is an ongoing challenge, as this aspect of the program can be very time consuming. Therapists are therefore required to model a firm compassionate response to ensure that there is time to cover the module specific materials.

The development of the modules has been informed by the now substantial published work on CFT as a modular short-term intervention (Leviss & Uttley 2015; Kirby et al. 2017; Fox, Cattani & Burlingame, 2020). Our experience in developing the Phase 2 preparation and engagement has highlighted that reducing the content, in favour of a slower pace has enabled group members to emotionally engage with the material and their own responses.

Personal connections: Following the introduction and discussion of key ideas which are woven around the check in material, the group are encouraged to use creative means to explore the personal connections and associations to the ideas presented. These activities could take the form of movement-based activities and games (White, 2006; Arlo 2017), or using art materials to externalise an aspect of the self to allow for emotional distance and an alternative perspective (Lucre & Corten, 2013).

> *"we were all struggling with the inner critic.. so they said give it a physical form.. I went for plasticine and made this little gremlin thing .. it was really useful you could put your inner critic on the table over there and just separate from it for a second.. and it wasn't about squashing it or anything …over time I could then explain it.. my monster is being a pain in the butt today.. and over time not such a screaming voice in my head.." (AK)*

This phase of the program serves to normalise symptoms of emotional distress within an understanding of human neurobiology and threat-focused emotional processing (Lucre & Corten, 2013; Gilbert, 2017). The above example illustrates the first stage in the process of differentiating the different aspects of self, this work is built on in phase four with greater exploration and bringing compassion to the multiple aspects of the self. The development of compassion skills and wisdom is linked with multi-sensory based objects that we call a 'Compassionate Kitbag'. This helps in anchoring and drawing together the various elements of the Compassionate Mind Training process, helping members to bridge into their compassion mind (Lucre & Clapton, 2020). Members are invited to gather together, share with each other in group and utilise in the explicit stimulation of the drive and soothing systems. Objects are also given by therapists to support the psychotherapeutic work and in such cases these objects can also become transitional objects, (Arthern & Madill, 2002; Lucre & Clapton, 2020).

> *"It's a virtual kitbag you might keep the breathe exercise in there and for me it was the little stones.. A picture .. A smell .. That calms and reminds you of the group" (AC)*

This concept focuses on the development of a compassionate motivation or identity, rather than just symptomatic relief, the latter being the usage of toolkits, first aid kids and self soothe boxes, which are common in mental health and therapeutic settings (Linehan, 2014).

Setting personal practice: Throughout the program, between-session personal practice is encouraged and supported. Sometimes these are through play-based 'challenges' which group members are invited to set for each other. Their intention is to support the development of independent practice rather than responding to a group-based instruction. Over time the group also acts as a secure base for the participants to courageously undertake this work (Gilbert, 2009; Porges and Flores, 2017).

Shared sympathy and empathy between group members becomes a vehicle for self-compassion, "*It was a natural response of compassion sympathy empathy and wanting to sort of reach out.. Then the penny dropped that it was time to do it for myself" (AJ).* As members develop their insight into what a compassionate mind is, how it can act as an internal secure base and safe haven, how it uses body-based practices, reasoning, empathy, with a genuine motivation to be helpful not harmful, this becomes the lens for engaging with early attachment ruptures, trauma and absence of care.

Phase Four: Compassion Focused Trauma Therapy (CFTT)

Movement into the CFTT group represents a graduation into the more intensive exploratory phase of the program, as well as an opportunity to reconnect with group members who have moved up previously. The structure however remains the same, with the aim of creating an environment of familiarity and a secure base for members to begin to make relational explorations.

One of the therapeutic practices is called multiple selves. Here members are helped to understand that we commonly experience a number of different threat emotions at the same time. Hence, CFGP explores the big three of: anger anxiety and sadness associated with the trauma. Multiple emotion selves work is therefore fundamental to the CFGP program and woven into every aspect of the CFTT. CFTT draws on key elements of Action Methods, whereby participants are invited if they wish to work through traumatic memories

in action. Sometimes members are invited to use objects to represent people and places (White, 2006; Tomasulo, 1998). This process of symbolising and engaging with their compassionate mind states enables group members to achieve emotional distance from a particular memory or experience. The memory is then compassionately transformed (e.g. the ending changed), thus offering an opportunity for reattribution or new understanding to be made of the experience (Lee, 2012). *"It is the first time I was upset without being angry and part of that was because I felt safe" (AJ).*

Case Example of Compassionate Transformation

Saran, is a group member in Phase 4 of the program. She had chosen to use the group to work on an early abuse memory that had taken place within her family home. The aim of this piece of work was a compassionate transforming of her relationship with the memory. First a 'stage' was created in the room, by pushing the chairs into a semicircle with a space at the front for the work to take place. This separation allowed for some emotional distance and if needed, Saran could return to her place in the group leaving the stage and the memories encountered there.

Saran was invited to use objects from the room to represent the different people who had been present during the abuse, this scene was clearly marked out using scarfs, ensuring that the scene was contained. Saran talked through her choices of objects to present the different characters and placed them within the boundary marked by the scarfs. During this time the therapist stayed close to and mirroring the actions of Saran to provide an experience of affiliative safeness.

At the point where the scene had been set, Saran was invited to use an object to represent herself. She choose a pebble which had been a gift from the group and as such was imbibed with the group's belief in her. The pace and tone of the process was slowed at this point to allow for some space for Saran to observe the scene and settle with the emotional connection. Saran noticed at this point that her young self in this scene was much younger than she remembered and this connected to a compassionate wisdom and realisation that she could not have prevented this abuse. She was invited to focus on the soothing rhythm of the breath to help ground herself and bring her compassionate self to this scene. Some time was spent utilising a standing guided imagery practice to support Saran to connect with and embody the qualities of strength, wisdom and courage.

The therapist then invited Saran to turn back to the scene and consider what this very young Saran needed and her response was to be rescued from the scene by her adult compassionate self. A request was made for volunteers to hold the place of Saran's child self, holding the object that had represented her in the scene and also another to hold the place of Saran's compassionate self.

Saran was then invited to gently direct her fellow group members who had volunteered to ensure that body postures, words, emotional meaning and actions fitted for her. She then stepped out of the scene, to allow the scene to be replayed by the volunteer group members with the compassionately transformed ending. Once it had been established that Saran was satisfied with the scene, time was taken to ensure that the group members who had held places in Saran's scene had 'de-roled' and were not left holding any of the trauma material worked through in the scene. Saran was guided to 'de-role' the objects and put away the props that had been used.

The group then returned to the circle to reflect on personal responses to the experience. This was an opportunity for validation and reinforcement of the courage and connection for all group members. Group members spoke of being deeply affected by the experience and a strong sense of connection with their own experience of early abuse and intrusion. Time was taken for this to be discussed, explored with a commitment from others to use the group in a similar way.

In the final stages of a group enactment like this, the group are invited to join up together for a period of reflection (White, 2006). This explicit closing component of the group is an opportunity to process some of the emerging feelings (Tomasulo, 1998), reinforce the examples of compassionate behaviours across the giving, receiving of compassion and being self-compassionate, and strengthen a sense of affiliative connection between the group members by highlighting the shared experiences (Wehle, 2017; Cooke, 2017). If the emotional arousal has been particularly high, there may be occasions when this closing phase requires more active interventions. In this context the model offers the opportunity for spontaneous play focused activities (White, 2006). These 'games' are contextualised to what is required by the group to either leave difficult unresolved feelings behind, increase the emotional energy, or reduce tension in the room.

The facilitation of differentiation, integration and transformation: Another core principle of the Phase 4 is to facilitate differentiation, integration and transformation. *Differentiation* relates to the ability to distinguish multiple textures of emotions and motives that can appear in the mind at the same time. An example is when individuals are guided and supported to identify a particular kind of emotional state or aspect of the self and then take on the role of this part, to become and enact it (Kipper, 1986).

The process of *integration* involves the participant explicitly inviting a perspective from the Compassionate Self and switching into that motivational system, as practiced during the therapy work and as self-practice between the sessions. The purpose of the practice over time is to enable participants to integrate the experience of warmth, wisdom, courage commitment and understanding from the Compassionate Self. The repeated differentiation of the parts of the self (e.g. different emotions and desires) also serves to enable a process of integration and acceptance of one's multiple aspects (Bell this volume; Bell et al., 2020). A transformation occurs in the context of the change in the experience that participants have of the relationship with self. Often critical inner dialogues are softened by the experience. Traumatic reoccurring memories are transformed; painful memories serve as a reminder of the inner strength of the individual (Bell et al., 2020; Lee, 2012).

'**Taking the Role'** Another therapeutic intervention that can be very helpful for aiding differentiation, subsequent integration and transformation is called 'Taking the Role'. This technique is derived and adapted from Jacob Moreno's concept of role theory (Blatner, 1991). This was designed as a means of exploring, expanding and strengthening the more functioning aspects of self, via an explicit intentional process (Blatner, 1991).

Within CFGP this therapeutic intervention has been adapted for multiple potential uses, such as to conduct functional analysis of a particular behaviour, a mentalising task to gain greater understanding of another or aspect of the self. One can 'Take the Role' of just about anything, including a particular object to deepen the emotional connection to the object, exploring meaning and significance. This technique also offers an opportunity to creatively stimulate the flow of compassion to self through imagery, gently exposing the member to the care giving and care receiving mentalities.

Case Example of Role Taking

Jon was a member of a CFGP Program and had been invited to bring objects from home which had significant meaning and could become part of his compassionate Kitbag. Jon had been reluctant to engage in this aspect of group and had stated that he did not have anything that helped him feel calm or courageous.

In this context, he had shared with the group that as a child there had been an abundance of toys around the home but they remained in their boxes and were not allowed to be played with. He described a feeling of terror associated with the idea of playing and resisted exercises which involved playing such as using art materials and compassion focused games.

Jon quite unexpectedly came to group with a bag which he said contained something that '*might do as a compassionate object'*. Very tentatively he shared a brightly coloured elephant which had been a gift from his teacher, early in his education. He had kept the elephant in a box in a cupboard which he rarely looked at. As it was passed around the group he spoke of feeling very fearful and anxious that that the elephant would be damaged.

Jon agreed to take the role of the elephant which he called 'Bruce', but only with the agreement that he could stop the exercise if it became too much. He was invited to hold the elephant and stand up and then as he sat down he took on the role of Bruce. After an initial introduction he was asked about how long he had been in Jon's life and the sort of situations which Jon might think of him. He (as Bruce) described with tears in his eyes that Jon would often think of him when he felt alone and despairing. Bruce reminded Jon that the teacher who had made the gift had cared very much for him and had seen his strengths and ability. When asked, Bruce (through Jon) spoke of feeling very warm towards Jon, coupled with a motivation to help him see the things that he struggles to hold in mind, that people have cared about him and that he is strong (like Bruce). At the end of the process, Bruce was invited to give a message to Jon: "*you are stronger than you know and you need to take me out of the box because I am an elephant and I can remember this for you."* He stood up to step out of role and sat again to step back into being Jon.

The following sharing session enabled Jon to settle with the things that he had learned from being Bruce, he resolved to take him out of the box and place him by his bed so he could be reminded more often. This exercise enabled Jon to connect with the unconscious meaning

associated with the elephant and the connections with his early life which he was repeating by denying himself access to opportunities for soothing.

This example demonstrates how role taking can be used to support group members to bridge into and experience the qualities of the compassionate self. Jon was then supported to continue with this practice between sessions, by following the advice of Bruce and keeping him in full view. Following the role taking exercise Jon was invited subsequently to notice what *'what would Bruce say about how hard it is to share your feelings in group today?'* and also to offer a compassionate perspective as Jon moved into the more explicit Compassion Focused Trauma Therapy. Over time this exercise supports the integration and acceptance of the messages of the compassionate other.

Once the technique has been established in the therapeutic work, taking the role of the fearful, blocked, resistant or contemptuous aspect of the self can be a light, playful, non-cognitive method for working with FBRs. During the interview the blocked aspect of self is invited to say what they needed and most definitely not attacked or criticised. This can often give rise to a useful way forward to recruit the compassionate self to offer respite to the block, who is invariably expressing exhaustion with the relentless task of blocking and resisting! Indeed, one of the central therapeutic interventions within CFGP is helping members to recognise how they can be caught in specific social mentalities, such as a competitive mentality, and how to switch into a care focused and cooperative mentality (Gilbert, 2017). Role taking is therefore a useful means of practicing and developing the capacity for motivational switching.

Managing Endings

"I suppose it's not grieving it's actually quite positive but you still feel upset that I wasted most of my life being the person that I was when I am actually beginning to like who I am .. that makes a massive difference" (JA)

Managing endings in the context of group therapy has been a source of much focus in clinical research and commentary (Bernard et al. 2008; Burlingham, 2016; Yalom & Leszcz, 2006). The ending phase for CFGP, has a specific protocol developed to facilitate the

consolidation of the compassionate mind training work, integration of the affiliative experience of the group, consolidation of the CFTT, saying goodbye and allowing for a process of grieving. The date of ending is planned from the outset and clearly articulated to the group. The rolling program format means that group members will leave at different times and therefore each group member is invited to make choices about their ending process. The regular experience of ending rituals in the CFGP program is designed to habituate the group members to the reality of ending and also hopefully model tolerating the process.

Over time, a group-based ritual has emerged whereby the group member who is leaving chooses a cake or sweet treat which is then prepared by the group therapist. This is intended to provide a reparative experience of marking significant events, in that many participants will have had the experience of birthdays and special occasions either being ignored or marred by trauma.

A gift-giving exercise follows, in that the group members who are leaving write a message for the group which is contained in a book, which is available for all to read. Cards are also given to the group member leaving from each remaining member who is invited to either read them or have them read by the group. These are important because they offer experiences of belonging and having been part of something and recognised as such, this can form part of the internal secure base.

Phase Five – Moving on Group

Following completion of the program, all group members are invited to attend a monthly 1-hour group which mirrors the process and format of the Waiting List Support Group, co-facilitated by a Lived Experience Practitioner. This group is again rolling and members are invited to join for a one-year period, after which time they will be discharged.

Facilitation shifts back to a playful and friendly conversational style to support group members in separating from the therapists and focusing on supporting each other. *"we talk about check in and stuff you know strengthening what we are going through but like I said self-compassion is a work in progress so we help each other" (*HM)

Within this process group members are also invited to reconnect to the secure base and with it the sense of belonging.

Working with common group problems

A good deal of CFGP is working with the fears, blocks and resistances to compassion particularly for people who have come from difficult backgrounds. Although the program is designed to develop a safe haven and secure base, the slow-paced affiliative focus of the group, coupled with a clear structure, can trigger adverse responses. This may be linked to the members limited capacity to tolerate the experience of warmth and care from others. For some the experience of kindness or even interest indicates emotional closeness and this can be a signal of imminent danger.

The activation of the attachment system, in the context of experiencing validation, understanding and compassion from others, can stimulate a powerful threat focused response of rage, grief, terror or shut down (Liotti, 2014; Gilbert, 2017). This could occur in the context of receiving compassion from other group members / and or therapist, or indeed any context where there has been an activation of similar conditions to the early trauma *"paradoxical fear of the much desired emotional closeness and compassionate feelings"* (Liotti, 2014, p.119).

Addressing these implicitly and explicitly enables group members to see when these fears are emerging. The work is exposure based, via the experience of care giving and receiving through the slow pace, tone and compassion focused content of the intervention.

> *"Compassion was an alien concept .. scared the crap out of me.. but feeling compassion for everybody understanding that it **was** compassion for everybody and that they were feeling compassion towards me …without any other motives .. it was very very strange.. you were with a group you were asking for help and they're asking for help and you were helping each other .. asking for help in the beginning was hard" (JA)*

Similarly, the structured elements of the group which are designed to offer containment can also present significant challenges for many, in particular to those whose survival strategies manifest in seeming contempt or disregard for the group. Some examples of this may be consistent timekeeping issues, struggling with 'turn-taking', altering the layout of the chairs.

These can be understood and formulated in the context of understandable fears associated with the sense of connection and belonging to the group and the activation of the attachment system which inevitably accompanies this experience. One group member who insisted on moving his chair every week so that it was not line with the others, noted that his need to move the chair lessened as the weeks passed and he was more able to tolerate the sense of belonging to the group and being open to compassion from and for the others in the group. This example demonstrates, how the slow-paced consistency of the group program enables members to create new care-affiliative relationships with peers and therapists (Flores & Porges, 2017; Millar-Bottome et al. 2019; Stone, 2017).

As the intensity of the group intervention increases, there is often more conflict between the group members and difficulties can arise in the transference with the therapists, particularly in the transition between phases of the program. Much has been written about the importance of understanding the 'enactments 'and finding ways to work with the material that is emerging, in the room but also attending to the links with past relationships which may be unresolved (Arlo, 2017; Bateman & Fonagy, 2014; Leiderman, 2019). *"early familial conflicts are relived, but they are relived correctively."* (Yalom & Lesczc, 2005, p.86).

The Role of the Therapist

Managing the general group process and in particular the difficult group dynamics, the therapist's stance and style are paramount to model the evocation of a compassionate mind. An empathically attuned responsive therapist can support group member's becoming more able to more able to give/receive feedback and act as agents for change for each other, within an atmosphere of safeness and mutual respect (Burlingham, 2016; Stone, 2017).

> *"Things were said made me realise that they were paying attention .. that means a lot if you have a negative self image .. when somebody pays attention 2 or 3 months later and they remember something you said.. that is worth a lot"* (HD).

The role of group therapist is thus akin to that of a conductor (Dalal, 1998), guiding rather than instructing the orchestra how to play and when they are playing 'stepping back', allowing the process to unfold. It is also important for therapists to see and embrace conflicts as opportunities for group members to experience rupture-repair and reaffiliation

processes that have often been starkly absent from their early attachment relationships (Yalom & Leszcz, 2005; Flores & Porges, 2017). Much of the CFGP structure and process is geared around creating sufficient safeness in the room to allow for disagreements, challenging of authority and protests at feeling treated unfairly/misunderstood (Flores & Porges, 2017) to occur and be compassionately worked through. Such in-session safeness (i.e. attachment security) is associated with higher levels of rupture resolution (Miller-Bottome et al., 2019).

Also central to the successful facilitation of therapeutic processes and tasks, is the ability of the therapist to be playful and thus facilitate *playfulness* in the group members (Gilbert, 2009; Marks-Tarlow, 2012). Play is essential to human learning and growth, a neural exercise that engages evolved social engagement systems (Porges, 2015) that allows us to cooperatively explore, experiment, learn, and experience joyful connection to others (Durand & Schank, 2015). But importantly can only occur when we feel a sense of safeness (Gilbert 2017).

> *"It was friendly banter with each other .. brother and sister stuff .. it would make people feel comfortable and relate to things that had happened.. helped them know they were in a safe environment you know" (HM).*

It is also key for therapists to engage in their own self-practice in compassion, which mirrors the CMT process (Kolts et al., 2016). This enables therapists to learn about compassion from the inside out, rather than on a purely theoretical basis. Additionally, this also supports the work of therapists in attending to their own responses within the therapeutic work (Kolts et al., 2016).

Conclusion

> *"So you think you're strong because you are keeping up all the barriers, then you go through this* [therapy*] and you realise how strong you are because you managed to take them all down and do what you needed to, yes it takes strength to let the barriers down" (PM).*

This chapter provided a selective overview of the five phases of the CFGP program and the key components of this model. The CFGP program seeks to create the conditions for group members to experience interactional flows of sharing and caring that link to important psychophysiological processes underpinning wellbeing. Group members can seek 'emotional proximity' to others by sharing experiences of the group as safe haven and a secure base. This creates the context for developing insights into the nature of compassion and cultivating those capacities through CMT. In addition, members increasingly learn how to attune, tap into and activate their compassionate motivational states, that can switch them out of other threat or self-focus motives. The nurtured capacity to receive and give compassion is used to harness and help re-set member's attachment and interpersonal relating systems and bring a new compassionate perspective to early shame-based trauma memories.

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