SAMPLE CHAPTER

Compassion Focused Therapy

The CBT Distinctive Features Series
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The evolved mind and Compassion Focused Therapy

The Buddha and early Greek philosophers understood well that our minds are chaotic, subject to conflicts and being taken over by powerful emotions, which can throw us into problems of anxiety, depression, paranoia and violence. What they could not know is why. The beginnings of an answer came with the publication in 1859 of Darwin's *Origin of Species*, which revealed that our minds and brains are the result of natural selection. Slow changes occur as species adapt to changing environments; environments are therefore challenges that favour some individual variations within a population over others. Importantly, evolution cannot go back to the drawing board but rather builds on previous designs. This is why all animals have the same basic blueprint of four limbs, a cardiovascular system, a digestive system, sense organs, etc. Brains, too, have basic functions, which are shared across species. This has huge implications for understanding how our minds are designed and came to be the way they are (Buss, 2003, 2009; Gilbert, 1989, 2002, 2009a; Panksepp, 1998).

Darwin's profound insights had a major impact on psychology and psychotherapy (Ellenberger, 1970). Sigmund Freud (1856–1939), for example, recognized that the mind contains many basic instincts and motives (e.g., for sex, aggression and power), which need to be regulated (lest we all just act out our desires) in a whole host of ways. So, we have various ways of keeping our lusts, passions and destructive urges under control—such as with defence mechanisms like denial, projection, dissociation and sublimation. Freud made a distinction between primary (id thinking generated by innate desires) and

secondary (ego-based and reality-based) thinking. In his model the mind is inherently in conflict between desires and control. For Freud these conflicts could be overwhelming to ego consciousness and so become unconscious and a source of mental disorder. The role of the therapist was to make conscious these conflicts and help the person work through them.

Today there is much evidence that the brain does, indeed, have different systems that are linked to our passions and motives (e.g., implicit vs. explicit; Quirin, Kazen, & Kuhl, 2009) located in old brain systems such as the limbic system (MacLean, 1985), and to the regulation of motives and emotions—primarily through the frontal cortex (Panksepp, 1998). Damage these areas of the brain and impulsiveness and aggressiveness are often the major symptoms. Numerous studies using subliminal processing have shown that unconscious processing can have a major impact on emotions and behaviours (e.g., Baldwin, 2005)—in fact, consciousness is quite a late stage in information processing (Hassin et al., 2005). We also know that the mind is riddled with conflicting motives and emotions (see Point 4). Today there is also scientific study on the nature of defence mechanisms such as repression, projection and dissociation and how these affect psychological functioning, self-constructions, social relating and therapy (Miranda & Andersen, 2007).

Archetypes, motives and meanings

Few now accept the tabula rasa view of human psychology. Rather, it is recognized that the human infant comes into the world prepared to become a viable representative of its species (Knox, 2003; Schore, 1994). If all goes well the child will form attachments to his/her care givers, acquire language, develop cognitive competencies, form peer and sexual relationships and so forth. In other words, there are innate aspects to our motives and meaning making. This is not a new idea as its origins can be traced back to Plato and Kant. A person closely associated

with attempts to illuminate the innate nature of the human capacity to *create different types of meaning* in psychotherapy was Jung (1875–1961).

Jung called our innate guiding systems (e.g., to seek and form early attachments to parents/carers, to belong to groups, to seek status, to discern and seek out sexual partners) *archetypes*. Archetypes influence the unfolding of development (e.g., to seek care, to become a member of a group, to find a sexual partner and become a parent, and to come to terms with death; Stevens, 1999). So, Jung postulated that humans, as an evolved species, inherit specific predispositions for thought, feeling and action. These predispositions exist as foci within the collective unconscious and serve to guide behaviour, thoughts and emotions.

Jung noted that we can see these themes of: parent–child caring, family and group loyalties and betrayal, seeking romance and love, seeking status and social position in heroic endeavour, self-sacrifice and so on—in all of the cultures, literatures and stories stretching back thousands of years. These are themes that will play out time and again in mental-health difficulties, because they are part of us—they are archetypal.

Jung also suggested that the way an archetype matures, functions and blends with other archetypes is affected by both our personality (genes) and our experience. For example, although we have an archetype that inspires and guides us towards love and comfort in the arms of our mothers when we are infants, if this relationship does not work well we can have a stunted mother archetype. Stevens (1999) refers to this as *thwarted archetypal intent*. In this case, as adults, we might spend a lot of our lives searching for a mother or father figure—trying to find someone who will love and protect us like a parent, or we can close down our need for care and love completely and shun close caring. Researchers studying these early relationships and what is called "attachment behaviour" have found that children (and adults) can indeed behave in such ways: While some are open to love and care, others are anxious about losing love and need much and constant reassurance,

while yet others avoid close relationships because they are frightened, or are contemptuous and dismissive of closeness (Mikulincer & Shaver, 2007).

Jung also suggested that because our inner archetypes are designed to do different things and pursue different goals *they can be in conflict with each other* and this often causes mental-health difficulties. For Jung it is the way that these archetypal processes mature, develop and become integrated, are thwarted, or are in conflict within the self, that is the source of mental-health problems.

Social mentalities

Gilbert (1989, 1995, 2005b, 2009a) combined archetype theory with modern evolutionary, social and developmental psychology and suggested that humans have a number of "social mentalities" that enabled them to seek out and form certain types of relationship (e.g., sexual, tribal, dominant–subordinate, caring of–cared for). The basic idea is that to pursue "species general, evolved biosocial goals and motives"—such as seeking out sexual partners and forming sexual bonds, looking after one's offspring, forming friendships and alliances, developing a sense of group belonging, operating as a group member, and competing for status—brain patterns are organized in different and particular ways. A social mentality can be defined as "the organization of various psychological competencies and modules (e.g., for attention, ways of thinking, and action tendencies) *guided by motives* to secure specific types of social relationship". For example, when we are in care-*giving* mentalities we focus our attention on the distress or needs of the other, feel concern for them, work out how to provide them with what they need, engage in behaviours to do so, and feel rewarded by their recovery or prosperity. In humans this may even become linked to self-identity, e.g., "I would like to be a caring person". In a care-*seeking* mentality we are seeking inputs *from* others that will relieve distress or help us grow and

develop. We turn our attention to those who are potentially helpful, signal our needs or distress and orientate our behaviours to approach others who seem to be able to offer what we think we need. We feel good if those inputs are achieved, but may feel angry, anxious or depressed if we can't find the caring inputs sought. We might then feel that others are deficient in what we need or are withholding.

In contrast, if we are competing with others we socially compare ourselves with them on relative strengths and weaknesses. We make decisions to try harder or give up. We might increase aggressive feelings or actions towards them and *turn off* concerns and feelings for any distress they might have. In this mentality our thoughts about ourselves are in terms of inferior–superior or winner–loser. If we win we might feel a buzz of good feelings, but be mildly depressed if we lose or feel inferior or defeated (Gilbert, 1984, 1992, 2007a). Linked to a self-identity, a social rank mentality can become a need to achieve (more than others), with status recognition, or a depressive sense of being a subordinate and lacking in certain qualities. There are, however, different types of achievement motivation (see Point 14). Seeing others prosper might actually make us feel envious and annoyed or bad, while seeing them fail or drop behind makes us feel good—which is, of course, quite different to being in a caring mentality!

In contrast again, when we are in co-operative alliance-building mentality our attention is focused on seeking and linking with people who are like us, who will co-operate and support us and/or pursue joint goals (playing in an orchestra, working on a team). This is linked to the evolution of our intense desires to share. We feel good when getting along with others but bad if rejected, marginalized or we feel people are cheating in some way. "Getting along" versus "getting ahead" has long been recognized to involve very different psychologies (Wolfe, Lennox, & Cutler, 1986). Lanzetta and Englis (1989) showed that priming people for co-operative or competitive relationships produced major differences in skin conductance,

heart rate and EMG; with co-operation promoting empathy but competitiveness "counter-empathy". So, different social mentalities can organize a whole suite of psychological and physiological processes in different ways, turning some aspects (e.g., care, sympathy or aggression) on but others off.

A simple comparison diagram for competing versus caring mentalities is offered in Figure 1.

So, according to the CFT approach our minds are organized and motivated for different goal pursuits and to create different mentalities according to the biosocial goal(s) being pursued. Clearly, mentalities overlap, some are more conscious than others, some are compensations (e.g., competing for status could be because we want affection; see Point 14), and people switch between them. Indeed, the ability to switch between them is a mark of health (Gilbert, 1989), e.g., such as the man who can compete in the job market but be a loving father at home, rather than also trying to compete with his children for his wife's affection and time. Individuals who get trapped in a particular mentality, for example, who are competitive or submissive all the time and really struggle with being co-operative or care giving or care receiving, can be disadvantaged in many ways. Paranoid patients, for example, find care receiving extremely threatening because of basic mistrust. Psychopaths find care giving and having empathic concern very difficult, but might mentalize very well in a competitive situation. So, the argument is that we have evolved brains that pursue certain social strategies, roles and relationships, and in order to pursue them different aspects of our minds are turned on and off. If we are in a (say) tribal mentality and see the other group as enemies, empathic concern and care giving (for the suffering we cause them) is firmly turned off, enabling us to behave aggressively without concern or guilt for the harm we do. There is much in psychotherapy of complex cases where we're trying to tone down some mentalities and activate others. Beck, Freeman and Davis (2003) took a somewhat similar evolutionary view in their approach to personality disorders.

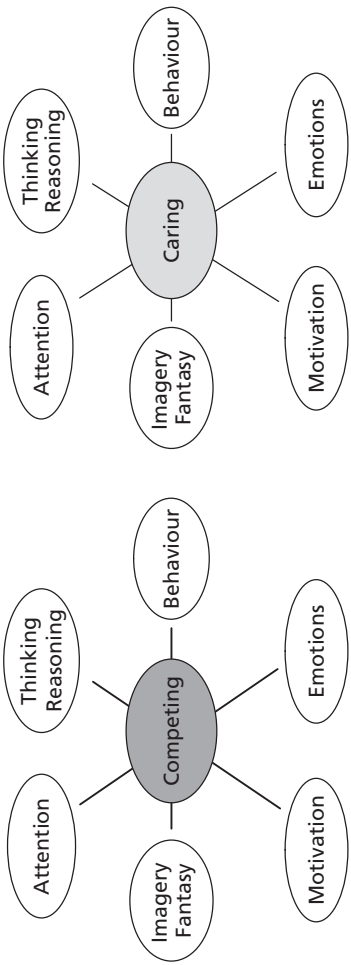

Figure 1 A comparison of competitive and caring mentalities

The way that social mentalities develop, mature, blend and are activated is linked to genes, background and current social demands. This is important because CFT takes an *interactional and compensatory* view of the way the mind is organized. For example, children who are abused or neglected learn that care eliciting, turning to others for help and being soothed by them is unlikely to happen, is unhelpful or even threatening/dangerous. Rather, the need to pay attention to the power and potential for being harmed/shamed by others is needed. This will shift their development into a threat-focused, social rank mentality (competitive system), which will orientate them to be very attentive to cues of aggressiveness/rejection. Liotti (2000, 2002, 2007) outlined how children can become disorganized in their attachment behaviour especially when the care giver becomes the source of both safety and threat. In such cases children can become disorganized in their social mentality coherence, switching between submissiveness, aggressiveness withdrawal and closeness seeking in ways that are difficult for them or others around them to understand.

CFT also takes an interactional view to the extent that work on one social mentality, such as care eliciting or care providing (through compassion), can have profound effects on the organization of other social mentalities (Gilbert, 1989). Again, this is not a new view. Buddhism has long argued that compassion transforms and reorganizes the mind; and Jung argued that the process of individuation was a process of organizing and reorganizing our archetypal potentials.

The bottom line is that we need to understand that the brain is an evolved organ that is *designed to function in certain ways* and change its patterns in different contexts and goal pursuits. It seeks out certain inputs (e.g., affiliative relations with other minds), responds to those inputs, and shows defensive, developmental deviations if those inputs are not forthcoming. Some psychotherapies and most psychiatric classifications do not address this and are content to rely on how things look from the outside. CFT sits within the tradition of understanding our

minds in terms of their evolved design and particularly our human biosocial goals and *needs*, e.g., for affection, care, protection, belonging; and human competencies such as mentalizing, theory of mind, empathy, capabilities for fantasy and imagination, as we now explore.