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Compassion-focused therapy as an intervention for adult survivors of sexual abuse

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ABSTRACT

Child sexual abuse can have long-term negative impacts across psychological, physical, and interpersonal domains. Some of the common issues for survivors of sexual abuse include shame and self-blame, attachment-based difficulties, avoidant coping strategies, and reduced capacity for self-compassion. Compassion-focused therapy is a transdiagnostic intervention that specifically responds to these concerns. Compassion-focused therapy was originally developed for clients who experience high levels of shame and self-criticism and aims to strengthen the soothing and affiliative system through the cultivation of compassion. This article will highlight the theoretical alignment between some of the common issues and impacts associated with experiences of sexual abuse, with the core underlying principles of compassion-focused therapy. This includes (a) the capacity of the therapy’s evolutionary framework to reduce perceptions of self-blame, (b) the cultivation of compassion to respond to feelings of shame, (c) acknowledgment of the role of early attachment experiences and facilitation of corrective affiliative experiences, (d) regulation of the threat-based system following trauma, and (e) provision of an alternative to avoidant-based coping by responding to distress with compassion. It is proposed that the theoretical framework and core focus and aims of compassion-focused therapy are highly applicable for survivors of sexual abuse and therefore holds significant promise as a treatment option for this client group.

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A meta-analysis reviewing prevalence rates of child sexual abuse across 22 countries identified that approximately 8% of men and 19% of women had experienced some form of sexual abuse prior to age 18 (Pereda, Guilera, Forns, & Gómez-Benito, 2009). However, it is generally accepted that the true extent of sexual abuse is difficult to ascertain due to the significant underreporting of this crime, inconsistencies in data collection, and other methodological issues (Rosier, 2017; Tarczon & Quadara, 2012). For those who have experienced sexual abuse, the impacts can be significant and long-
Several reviews spanning the past few decades have consistently identified a relationship between child sexual abuse and a range of long-term psychological, interpersonal, and health-related difficulties (Briere & Elliott, 1994; Browne & Finkelhor, 1986; Cashmore & Shackel, 2013; Paolucci, Genuis, & Violato, 2001; Polusny & Follette, 1995).

These results are supported by a longitudinal study (Trickett, Noll, & Putnam, 2011) comparing females who had experienced child sexual abuse with nonabused females, from a mean age of approximately 11 years until approximately 25 years. In this study, the authors demonstrated that sexually abused females experienced greater difficulties across a number of biopsychosocial domains compared to the nonabused comparison group. Impacts included higher rates of depression, anxiety, dissociation, posttraumatic stress disorder symptoms, behavioral problems, substance misuse, maladaptive and risky sexual behaviors, obesity, cognitive and academic deficits, early onset of puberty, physical health concerns, and sexual revictimization.

Mediating variables
Survivor shame and self-blame, interpersonal difficulties, decreased emotional regulation, and maladaptive coping strategies such as avoidance may explain the relationship between child sexual abuse experiences and subsequent adult emotional distress (Müller et al., 2015; Rosenthal, Rasmussen Hall, Palm, Batten, & Follette, 2005; Ullman, Peter-Hagene, & Relyea, 2014; Whiffen & Macintosh, 2005). Treatment options therefore need to specifically target these presenting concerns and offer alternative strategies for understanding and responding to trauma-based symptoms. Whiffen and Macintosh (2005, p. 34) suggest that “clinicians should focus on softening feelings of shame, strengthening interpersonal relations, and promoting active coping strategies in the treatment of sexual assault survivors.” This article will propose that compassion-focused therapy is an intervention that specifically targets these therapeutic needs and may therefore be a suitable treatment approach for this client group.

Overview of compassion-focused therapy
Compassion-focused therapy (CFT) was initially developed by Paul Gilbert (2013) for clients who experience high levels of shame and self-criticism. CFT emphasizes the centrality of our affiliative system in reducing threat-based processing by allowing us to feel cared for and able to offer care to both ourselves and others (Gilbert, 2014). The primary aim of CFT is to help clients understand and respond to their distress from the perspective of a
compassionate mind, which incorporates a range of compassion-based skills, attributes, and qualities (Gilbert, 2009).

In CFT, compassion is defined as “the sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it” (Gilbert, 2014, p. 19). Expanding on this definition, Gilbert (2015) proposes that CFT involves two different psychologies in its understanding of compassion. The first psychology relates to the ability to effectively engage with and turn toward identified suffering and is cultivated via six attributes (sensitivity, sympathy, distress tolerance, care for well-being/motivation, nonjudgment, and empathy). The second psychology relates to the development of specific skills to assist with the alleviation and prevention of suffering (compassionate imagery, reasoning, attention, feeling, behavior, and sensory focus). The qualities of wisdom, strength, and commitment support the development and application of these interdependent skills and attributes.

The therapeutic process of cultivating these compassionate skills, attributes, and qualities is referred to as compassionate mind training (Gilbert, 2013). Preliminary studies using this approach have shown promising results for effectively reducing symptoms across a range of issues and conditions, including depression, anxiety, shame, and self-criticism in mental health patients (Gilbert & Procter, 2006; Judge, Cleghorn, McEwan, & Gilbert, 2012) and those with personality disorders (Lucre & Corten, 2013), eating disorders (Gale, Gilbert, Read, & Goss, 2014; Goss & Allan, 2014; Steindl, Buchanan, Goss, & Allan, 2017), and psychosis (Braehler et al., 2013).

Relevance for survivors of sexual abuse

These results indicate that CFT may also offer potential benefits for sexual abuse survivors, who present with similar concerns and demonstrate lower levels of self-compassion than people without an abuse history (Miron, Seligowski, Boykin, & Orcutt, 2016). This is likely to be important, as low levels of self-compassion are associated with increased severity of trauma symptoms in community-based samples (Maheux & Price, 2015; Thompson & Waltz, 2008) as well as emotion regulation difficulties in young people with an abuse history (Vettese, Dyer, Li, & Wekerle, 2011). Conversely, self-compassion has been shown to be an important factor in emotional resiliency and positive mental health in community samples (MacBeth & Gumley, 2012; Neff & Germer, 2013; Trompetter, Kleine, & Bohlmeijer, 2016).

In addition to this available empirical evidence, there is considerable theoretical alignment between common issues and impacts experienced by survivors of sexual abuse and some of the core underlying principles of CFT (see Figure 1). The specific principles relevant for this client group, to be discussed in further detail, are the following:
CFT is based on an evolutionary understanding of emotions, motives, and behaviors. CFT seeks to understand emotions and corresponding cognitions, motives, and behaviors according to the evolved survival functions arising from three important interacting systems (Gilbert, 2013). In simplified terms, the threat system is responsible for threat monitoring and protection and relates to feelings of anxiety, anger, and disgust. The soothing system helps to manage
stress and promote relational attachment and bonding and relates to feelings of safeness and contentment. The drive system relates to feelings and behaviors of achievement, pursuing, and striving.

Positive mental and emotional health relies on a balance between the systems. However, the overactivation and dominance of the threat system in response to trauma can interfere with this process, and many posttraumatic symptoms can be understood in the context of this imbalance (Cozolino, 2010; Lee, 2012). For example, a common experience for trauma survivors is reexperiencing, whereby the trauma experience is “re-lived” through flashbacks, nightmares, and intrusive thoughts and memories and can feel as though the past trauma is being reexperienced in the present moment (Hackmann, Ehlers, Speckens, & Clark, 2004). Reexperiencing is therefore treated as a current threat, and the brain and body instinctively activate primal safety strategies and physiological responses in order to manage this threat. Consequently, many trauma symptoms (such as avoidance, hypervigilance, somatic sensations) can be understood within the context of this primordial activation of the threat detection and response system, which has not been able to appropriately locate the trauma experience in the past (Lee, 2012).

CFT’s evolutionary framework also acknowledges the role of the more highly evolved human brain in understanding posttrauma symptomatology. CFT recognizes that our brains are a combination of both old brain and new brain capabilities, resulting in what Gilbert refers to as the “tricky brain” (Gilbert, 2014, p. 17). In other words, our brains still contain functions of early evolved systems relating primarily to basic survival and emotional states as described but also the more highly evolved executive functions of the uniquely human brain.

While these new brain functions can facilitate highly complex cognitive tasks and allow for fantasy, imagination, creativity, forward planning, and remembering, they can also become problematic in combination with old brain responses (Cozolino, 2010). For example, survivors of abuse can maintain activation of the threat system by imagining how the experience will continue to negatively impact their future, ruminate on the unfairness of the abuse, or fantasize about how they might have prevented it (Michael, Ehlers, Halligan, & Clark, 2005), which can contribute to perceptions of self-blame (Miller, Handley, Markman, & Miller, 2010).

Furthermore, rather than understanding such symptoms as innate neurobiological responses, trauma survivors can interpret symptoms as representative of their incompetence, inability to cope, or evidence of their mental instability, which further exacerbates posttrauma symptomatology (Steil & Ehlers, 2000). This idiosyncratic interpretation of trauma-based symptoms is consistent with more general negative self-appraisals shown to arise from
sexual assault experiences, including perceiving the self as “weak, unworthy, or flawed” (Fairbrother & Rachman, 2006, p. 90).

A CFT approach that conceptualizes trauma symptoms as a byproduct of the evolved brain’s efforts to respond to threat, rather than the pathology of the individual experiencing it, may therefore be valuable in reducing self-critical interpretations of posttrauma symptomatology. In particular, survivors can be supported to understand their symptoms within the context of the evolutionary functions of the three interacting systems and the complex relationship between these old brain systems and new brain capabilities.

**CFT was developed for clients with high levels of shame and self-criticism**

Gilbert (2009) initially developed CFT as an approach to treat high levels of shame and self-criticism after observing that clients with these presenting concerns found it particularly difficult to develop adaptive affect regulation strategies. This focus is particularly pertinent for sexual abuse survivors, as Gilbert himself noted that issues of shame and self-criticism were often experienced in the context of abuse histories. In fact, trauma-related shame and stigmatization has long been recognized as a consequence of child sexual abuse and a mediating factor in the ongoing emotional distress and psychopathology experienced by adult survivors (Finkelhor & Browne, 1985; Whiffen & Macintosh, 2005).

Early shame experiences can be particularly problematic as they demonstrate the same characteristics as traumatic memories, contribute to increased vulnerability to psychopathology in adulthood, and are positively associated with current experiences of shame (Matos & Pinto-Gouveia, 2010). The association between shame memories and current shame and posttraumatic stress symptoms is particularly relevant for those who identify the early shame experience as central to their life “story” and personal identity (Pinto-Gouveia & Matos, 2011).

Ehlers and Clark (2000) propose a cognitive model of posttraumatic stress disorder (PTSD) in which negative appraisals maintain an ongoing sense of threat, which is the core perpetuating factor in PTSD. The authors suggest that shame may pose an ongoing internal threat to a person’s sense of identity and self-perception that triggers shame-based reexperiencing symptoms and maladaptive coping. La Bash and Papa (2014) demonstrated that feelings of shame in relation to an interpersonal trauma are associated with increased PTSD symptoms and concluded that shame acts as a source of threat because social integrity is equally as important to “individual adjustment . . . and human evolution” (p. 164) as physical safety.

This conclusion is consistent with a CFT-based perspective, which contextualizes shame as an emotion that has evolved to support adherence to social norms and values and maintain levels of social status and attractiveness (Gilbert, 1997). Shame may offer a signal that this status is threatened due to violations of
culturally determined norms and expectations. Shame can therefore act as a source of threat if we perceive (or believe others perceive) that we have violated our social and cultural integrity and will be subsequently devalued by our societal group (Sznycer et al., 2016). This theory may explain why the negative social reactions that are commonly received by sexual abuse survivors can contribute to self-blame and increased PTSD symptoms (Ullman, Townsend, Filipas, & Starzynski, 2007) and why positive social support can serve as a protective factor against posttrauma psychopathology (Maheux & Price, 2016; Schumm, Briggs-Phillips, & Hobfoll, 2006).

Shame and self-blame have also been identified as a potential barrier to disclosure and help-seeking behavior for survivors of child sexual abuse (Collin-Vézina, De La Sablonnière-Griffin, Palmer, & Milne, 2015; Munzer et al., 2016). When such clients do engage in therapy, standard therapeutic processes are often less effective. For example, Gilbert (2009) noted that while a number of high-shame clients understood the concepts of traditional cognitive-behavioral therapy and were able to challenge and generate alternatives to maladaptive thoughts and beliefs, these skills did not translate into change on an emotional level. Lee (2005) referred to this phenomenon as the “heart-head lag” (p. 328), whereby there is a discrepancy between what clients know “in their heads” and what they feel “in their hearts.” For example, a trauma survivor may be told that they were not to blame for their experience; however, it is unlikely to make a difference to their level of distress until they can feel and believe it for themselves (Lawrence & Lee, 2014).

CFT offers an intervention that does not rely solely on rational, cognitive processes. Instead, it targets shame and self-criticism through the felt experience of compassion, cultivated both internally, as well as externally, within the context of the therapeutic relationship. Given the centrality of shame to the posttrauma experience for many sexual abuse survivors, its contribution to ongoing psychopathology, and the limitations of traditional therapies for this client group, an intervention that has been developed specifically for clients with high levels of shame holds significant promise.

**CFT acknowledges the role of early attachment experiences and social mentalities in shaping human development**

Gilbert (2014) identifies compassion as part of an evolutionary social motivation system that ensures capacity to care for offspring, kin, and other “in-group” members. In other words, compassion helps to reduce the sense of fear and threat inherent in our survival circuitry through reassurance that we are safe and cared for. Being aware of and sympathetic to suffering, and having a desire and readiness to do something to alleviate this suffering, has evolved from the necessity to ensure the survival of those we have direct primal care and responsibility for in the first instance, and extends to broader
kinship and social groups as necessary (Gilbert, 2015; Goetz, Keltner, & Simon-Thomas, 2010).

This evolutionary understanding is consistent with attachment theory, which also suggests that a child’s proximity- and care-seeking toward the parent, and the parents’ reciprocal care and concern for the child, is a function of survival and harm reduction (Bowlby, 1984). Attachment theory also acknowledges the crucial role of early social and attachment experiences in setting the template for our relationship with self and others, with Bowlby (1984) stating “the particular pattern in which attachment behavior becomes organized during development is much influenced by how it is responded to by a child’s principal caregivers” (p. 13).

Generally speaking, attachment styles are described as either secure or insecure (Bowlby, 1988). Secure attachment allows for the formation of healthy relational models. Conversely, insecure attachment contributes to internal working models of the self as unworthy and/or others as untrustworthy (Swanson & Mallinckrodt, 2001) and has been associated with low levels of self-compassion in both adolescents and adults (Neff & McGehee, 2010; Wei, Liao, Ku, & Shaffer, 2011).

Female survivors of child sexual abuse report higher levels of insecure attachment in their adult relationships compared to nonabused women (Aspelmeier, Elliott, & Smith, 2007). Furthermore, women who were perpetrated against by a family member exhibit greater attachment avoidance (a form of insecure attachment) than women who experienced extrarelational abuse (Swanson & Mallinckrodt, 2001). Child sexual abuse that occurs in the context of attachment-based relationships is therefore particularly problematic for the development of self and other relational templates. Unfortunately, the majority of child sexual offences are perpetrated by someone known to the child. For example, Quadara, Nady, Higgins, and Siegal (2015) reported that more than half of sexually abused girls were abused by fathers, stepfathers and other male relatives including siblings.

For many sexual abuse survivors, however, the impact of attachment-based sexual trauma may not just relate to an inability to offer self-compassion but fear and active resistance to doing so. The experience of positive emotions can be quite frightening in these cases especially if their history includes an abusive background (Gilbert, McEwan, Matos, & Rivas, 2011). Fear of self-compassion has been shown to contribute to symptoms of depression and PTSD in child sexual abuse survivors (Miron et al., 2016). Fear of compassion has also been associated with elevated self-criticism (Gilbert et al., 2012) whereby individuals may feel as though they are not worthy of receiving compassion from others or offering it to themselves.

CFT acknowledges the significance of social and attachment experiences in setting the template for our ability to give and receive compassion. Consistent with CFT’s evolutionary framework more broadly, this understanding
reinforces the fact that much of our early experience is out of our control and can therefore reduce perceptions of self-blame and shame. CFT may be able to offer a corrective experience by cultivating new internal working models of the self as worthy of care and compassion (both from themselves and others) and reduce the association of fear and threat with comfort and soothing.

**CFT aims to activate the soothing and affiliative system and reduce the dominance of the threat-based system**

Gilbert (2013) suggests three interacting neurophysiological systems to regulate emotions: the threat system, the soothing system, and the drive system. Distress and pathology can arise when these systems are out of balance, as is often the case with posttraumatic stress. In fact, the defining diagnostic criteria for PTSD (American Psychiatric Association, 2013) relates to over-activation of the threat system (e.g., through reexperiencing and hyperarousal) and maladaptive attempts to manage and soothe these symptoms (e.g., through avoidance behaviors and negative cognitions).

In the context of a trauma experience, the brain and body are instinctively activated to respond to threat and increase the chance of survival. In simple terms, the options for responses are usually categorized as “fight or flight” (or freeze if neither of these options are viable). Physiological responses can include increased heart rate, breathing, muscle tension, and decreased digestive, immune, and growth functions as well as alterations in attention, cognition, and memory (Cozolino, 2010). Once the threat has passed, homeostasis should resume. Problems can arise, however, with the emergence of “new” brain functions that enable reexperiencing and other trauma-focused symptoms (such as shame) to maintain a sense of threat and danger in the present moment. Trauma survivors can become locked into a process of perpetual threat appraisal, with corresponding habitual, reactive, dysregulated, and avoidant patterns of responding to any perception of threat and an inability to return to a calm, resting state to regulate emotions (Porges, 2011). This issue is particularly problematic for survivors of complex or cumulative trauma, whereby the threat system has been repeatedly activated in response to genuine threats and the world is experienced as an “unsettling and dangerous place” (Cozolino, 2010, p. 265).

Increased difficulty with emotion regulation is associated with increased PTSD symptom severity, particularly for survivors of early-onset chronic interpersonal trauma (Ehring & Quack, 2010; Kim & Cicchetti, 2010), generating a cycle of further threat system activation and reduced capacity to self-soothe. Self-compassion has been shown to mitigate against these effects and enhance the capacity for positive emotional regulation (Trompetter et al., 2016; Vettese et al., 2011). CFT can support survivors to develop and activate their compassionate self as a means to acknowledge and respond to distress from a more balanced perspective and counteract the dominance of a dysregulated threat system (Gilbert, 2014).
CFT encourages an approach rather than avoidance orientation toward suffering

Consistent with the definition of compassion discussed earlier, CFT identifies two different psychologies in its understanding of compassion (Gilbert & Choden, 2014). The first psychology relates to the ability to effectively engage with and turn toward identified suffering, and the second psychology relates to the development of specific skills to assist with the alleviation and prevention of suffering. This model recognizes that compassion is specifically defined by the context of suffering, arising only in response to negative antecedent events (Goetz et al., 2010). A capacity and willingness to first recognize and engage with this suffering is therefore a necessary prerequisite for the impetus, application, and effectiveness of these skills.

For trauma survivors, this prerequisite is often not met. Survivors often adopt an active avoidance of cues associated with the trauma experience. This is referred to as experiential avoidance and is a maladaptive coping strategy. Briere (2002) suggests that avoidance efforts can be related to thoughts and memories of the trauma experience (thought suppression), emotional responses to the memory of the trauma (such as through the use of drugs or alcohol or dissociation), or the trauma-related triggers themselves such as specific people, places, or anything else that may serve as a reminder of the traumatic memory.

The severity of avoidance has been shown to be negatively associated with self-compassion (Maheux & Price, 2015; Thompson & Waltz, 2008) and is a significant risk factor for ongoing posttraumatic stress symptomatology (Kaplow, Dodge, Amaya-Jackson, & Saxe, 2005; Palm & Follette, 2011; Polusny & Follette, 1995; Shin et al., 2015; Thompson, Arnkoff, & Glass, 2011; Ullman et al., 2014, 2007). Avoidance of trauma-related stimuli is one of the diagnostic symptom clusters for PTSD (APA, 2013).

CFT specifically cultivates six attributes to enhance the capacity to acknowledge and approach distress in a positive and skillful way. Collectively, these attributes can support survivors of sexual abuse to tolerate and respond to trauma-based stimuli with compassion, empathy, nonjudgment and acceptance and reduce the need to rely on avoidance-based coping.

Summary and future directions

CFT has been informed by a number of theoretical influences including evolutionary psychology, neuroscience, and attachment theory and is rapidly gaining an evidence base for a variety of mental health problems. CFT is adaptable and can be integrated into a variety of psychotherapeutic approaches for a range of presenting concerns. The case can be made that CFT may have efficacy for sexual abuse survivors due to typically low levels of self-compassion found in this client group. More specifically, CFT offers a way to de-shame and de-
pathologize abuse experiences and reduce the dominance of the threat system. CFT can offer new relational templates and assists survivors to facilitate positive affiliative experiences with themselves and others. Finally, CFT can provide an alternative and positive approach for regulating emotions and reduce self-criticism and avoidance in response to trauma symptoms.

Given the potential of CFT for sexual abuse survivors, it is recommended that future research develop a CFT manualized approach and test this in a clinical population in a treatment trial design.

Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

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References


Palm, K., & Follette, V. (2011). The roles of cognitive flexibility and experiential avoidance in explaining psychological distress in survivors of interpersonal victimization. *Journal of Psychopathology and Behavioral Assessment, 33*(1), 79–86. doi:10.1007/s10862-010-9201-x


