

Integrating Emotionally Focused Therapy, Self-Compassion, and Compassion-Focused Therapy to Assist Shame-Prone Couples Who Have Experienced Trauma

The Family Journal: Counseling and Therapy for Couples and Families
2015, Vol. 23(4) 346-357
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DOI: 10.1177/1066480715601676
tfj.sagepub.com


Mark Karris¹ and Benjamin E. Caldwell¹

Abstract

Emotionally focused therapy (EFT) for couples in which one or both partners have a history of trauma and are shame prone presents unique challenges that can potentially impede the therapeutic process. Neff's conceptualization of self-compassion and research has demonstrated the benefits of self-compassion for both oneself and interpersonally. Gilbert's compassion-focused therapy (CFT; 2010) is an evidence-based, integrative approach that specifically works with trauma and chronic consequences of affect dysregulation and shame. This article reviews the empirical research on EFT, self-compassion, and CFT and includes a brief review of trauma and shame. This article also discusses various ways in which Neff's conceptualization of self-compassion and Gilbert's CFT can be integrated into EFT for the benefit of both the EFT therapist and couples taken over by trauma and shame.

Keywords

emotionally focused therapy, self-compassion, trauma, shame, mindfulness, dysregulation, compassion-focused therapy

There has been a recent increase in research regarding self-compassion since Kristin Neff (2003a), a researcher from the University of Texas at Austin, operationalized the concept and created a scale to measure its constructs. A growing body of research indicates that self-compassion is linked to intrapersonal (Gilbert, 2005, 2014; Neff, 2003a; Neff, Kirkpatrick, & Rude, 2007; Neff & McGehee, 2010) and interpersonal (Neff & Beretvas, 2013; Neff & Pommier, 2013; Yarnell & Neff, 2013) benefits. Another model with extensive research is Gilbert's compassion-focused therapy (CFT). CFT is a model of psychotherapy that places self-compassion at the core of its approach and was developed for individuals with trauma backgrounds struggling with psychological problems linked to self-criticism and shame (Gilbert, 2010). This theoretical article will explore the integration of self-compassion and CFT with emotionally focused therapy (EFT; S. M. Johnson, 2002), to assist couples overcome the impact of trauma in couples' therapy. Self-compassion practices and principles will be used for the explicit purpose of regulating negative and constrictive affect with couples to move toward the preferred strategy of coregulation of difficult emotional states (Beckes & Coan, 2011; S. M. Johnson, 2004; Sbarra & Hazan, 2008). This article will include an exploration into how self-compassion-based interventions can reduce both couple and therapist shame, which is a particular affective state that can impede the trauma work essential to EFT (S. M. Johnson & Williams-Keeler, 1998; Macintosh & Johnson, 2008).

Emotionally Focused Therapy

Although other people are often the source of trauma (e.g., in war, abuse, or assault), it is within safe and significant interpersonal relationships that trauma victims can heal and recover (Herman, 1992; van der Kolk, McFarlane, & Weisaeth, 1996). Relationships are vital for human existence and necessary "from cradle to the grave" (Bowlby, 1982). Emotional resilience and a fortified sense of self cannot exist in the absence of relationships (Mikulincer, 1995), especially in the aftermath of trauma (Mikulincer, Shaver, & Horesh, 2006). EFT, which is one of the most empirically supported approaches to couple therapy (Lebow, Chambers, Christensen, & Johnson, 2012), takes advantage of the healing power and primacy of relationships and is currently used as an efficacious treatment approach with couples affected by trauma (S. M. Johnson, 2002, 2004; Macintosh & Johnson, 2008).

EFT is an experiential approach to couples therapy that Sue Johnson and Leslie Greenberg developed in the early 1980s (Greenberg & Johnson, 1986; S. M. Johnson & Greenberg, 1995). EFT emphasizes the emotional attachment bond

¹ Alliant International University, San Diego, CA, USA

Corresponding Author:

Mark Karris, 13122 Sienna Court San Diego, CA 92129, USA.
Email: markgkarris@gmail.com

between couples and is grounded in attachment, humanistic, systemic, and experiential theories (S. M. Johnson, 2004). Fundamentally, EFT is an attachment-based model. While Bowlby (1982) and others (e.g., Ainsworth, Blehar, Waters, & Wall, 1978) applied attachment theory to children, S. M. Johnson and Greenberg applied it to couples. Our needs for secure attachment do not change over time, S. M. Johnson and Greenberg argue, but rather are refocused on the romantic partner as the primary attachment figure. EFT focuses on creating a safe and secure attachment bond with that partner.

Distressed couples typically come into therapy overwhelmed by intense emotions that have the capacity to keep them stuck in a pernicious pattern of negative interactions (S. M. Johnson, 2004). In the process of EFT, emotions that are typically constricted, unprocessed, and hidden from the self and the partner, such as fear, sadness, loneliness, shame, and anxiety, are tenderly and vulnerably brought out into the open and shared. As these new vulnerable emotions are experienced and processed, they can create new healing emotional experiences for the couple that transcend the therapy office and continue into their everyday lives. Emotions in EFT are considered the “music in the dance” (S. M. Johnson, 2004, p. 67). When therapists can help couples change the music (emotions), they can change the dance (interactions; S. M. Johnson, 2004).

The process of change in EFT consists of nine prescribed steps within three stages, with the overall goal of forming a secure emotional bond (S. M. Johnson, 2004). Stage I involves an overall assessment and de-escalation of the couple’s pernicious negative interaction cycle. Stage II involves a shift from the couple’s rigid interactions toward new bonding experiences. Stage III, the final stage, involves the consolidation of these changes and the integration of new interactions in the couples’ everyday lives.

EFT is one of the few empirically validated models for couples (S. M. Johnson, 2004). In a meta-analysis, S. M. Johnson, Hunsley, Greenberg, and Schindler (1999) showed that approximately 90% of couples who completed EFT reported having more satisfying relationships than the average no-treatment control couple.

EFT and Trauma

Trauma involves psychological damage in the midst of intense fear, helplessness, and horror, whether through personal or witnessed experience of traumatic events (American Psychiatric Association [APA], 2013). Trauma causes an inner shift that alters one’s view of self and the world (S. M. Johnson, 2002). According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013)*, trauma may result from various forms of abuse, combat, loss of a loved one, violent personal assault, and other direct or indirect traumatic events. S. M. Johnson (2002) added that serving in an occupation that frequently places a person in danger or in close proximity to others’ trauma can also be traumatic. Those who experience intense trauma may then suffer the affect dysregulation disorder known as

posttraumatic stress disorder (PTSD; Amir & Kaplan, 1996) or other subclinical levels of emotion dysregulation.

EFT is gaining traction with regard to being efficacious for couples dealing with trauma and who meet criteria for PTSD (Greenman & Johnson, 2012; S. M. Johnson, 2004). For instance, Naaman (2008) demonstrated a significant reduction in PTSD symptoms using EFT with couples in which the wife suffered from breast cancer. War veterans had a significant decrease in PTSD symptoms after they engaged in an average of 30 sessions of EFT (Weissman et al., 2011). In another study, EFT successfully decreased PTSD symptoms experienced by 10 highly distressed couples in which one partner was a survivor of childhood sexual abuse (MacIntosh & S. M. Johnson, 2008).

McLean and Hales (2010) conducted a case study using EFT with couples in which one partner was terminally ill and the other partner had a history of childhood trauma. EFT was shown to help the couple navigate through the complications of the terminal illness and help lessen the complications of spousal bereavement. Halchuk, Makinen, and Johnson (2010) showed that EFT was also effective at helping couples heal through the trauma of infidelity, with sustained forgiveness and trust at 3-year follow-up. More recently, S. M. Johnson et al. (2013) demonstrated through an functional magnetic resonance imaging (fMRI)-based hand-holding study that EFT can foster a loving bond that comforts couples and soothes their threatened brain in the midst of potentially threatening stimuli, in addition to reducing the perception of or neutralizing previously arousing stimuli. Additionally, EFT’s potential to become a powerful approach to help couples traverse the trauma of terminal illness has been examined using a theoretical lens (Tie & Poulsen, 2013).

EFT, Trauma, and Shame

Although shame does not affect every person who has experienced trauma, it has now been included in the criteria for PTSD in the newly published *DSM-5* (APA, 2013). Although it is mentioned only by name and not specifically detailed in the *DSM-5*, shame can be one of the most difficult consequences of trauma, particularly when perpetrated maliciously by other human beings (Herman, 2011). According to Herman (2011), when shame becomes a central feature of a victim’s inner world, the posttraumatic condition can be thought of as a “shame disorder” (p. 262). Shame can be considered “the default setting for insidious emotional trauma” (Cates, 2014, p. 45). Shame is considered a key emotion that could exacerbate PTSD and is an important emotion for the clinician to address throughout therapy (Harman & Lee, 2010; La Bash & Papa, 2014; Lee, Scragg, & Turner, 2001). Finally, the recently designed and effective Trauma Related Shame Inventory, which is a 24-item measurement instrument that assesses for shame within the context of trauma, points to the importance of assessing for trauma-related shame (Øktedalen, Hagtvet, Hoffart, Langkaas, & Smucker, 2014).

It is helpful for clinicians to distinguish shame from guilt. Guilt is an emotional and cognitive state experienced after one

has *done* something wrong and is focused on one's behavior and a desire to make amends (Tangney & Dearing, 2002). In contrast, shame is an individual's experience that he or she is something wrong. Shame-prone people believe that there is something terribly wrong with them and that the core of who they are is bad, flawed, or even disgusting (Beck, Rush, Shaw, & Emery, 1979). Shame proneness is the experience of shame that continually resides within an individual as opposed to situational shame that arises in particular moments (Dearing & Tangney, 2011). Bradshaw (1988) discussed the negative effects of toxic shame, and noted shame is a "rupture of the self with the self" (p. 30). Those who experience deep shame believe that they are intrinsically flawed, defective, and unlovable and can never be good enough for themselves or others (Efron & Efron, 1989). Shame and the aforementioned intrapersonal consequences of trauma can wreak havoc on relationships (Dorahy et al., 2012; S. M. Johnson, 2002; Lee, 2008).

The ultimate goal of working with shame in EFT is to have the partner who is experiencing shame vulnerably share it with an open and receptive partner and to have the partner respond with understanding and soothing to create a new positive cycle of interaction (S. M. Johnson, 2002). This is accomplished in Stage II of EFT after the couple's surface conflict has been calmed ("de-escalation" in EFT terms), and the couple is able to see their trauma-based responses as part of the negative interaction cycle (S. M. Johnson, 2002). Moving to Stage II, toward optimal coregulation and the sharing of vulnerable primary emotions, can be difficult to achieve with traumatized couples. EFT with such couples may take 30 sessions or more, which is significantly longer than EFT with nontraumatized populations (S. M. Johnson, 2004).

It can be difficult to de-escalate traumatized couples in Stage I of EFT because of the inability of trauma survivors to regulate their intense emotional states (S. M. Johnson, 2002; S. M. Johnson et al., 2005). Shame is one of the most powerful emotions that can prevent de-escalation and engagement in new corrective and healing experiences (S. M. Johnson, 2002; S. M. Johnson & Williams-Keeler, 1998; Lee, 2008). This finding is in line with the attachment framework postulated by EFT; for a person to securely attach to another, they must perceive the other as available and receptive, but they must also perceive themselves as fundamentally deserving of love and safety (S. M. Johnson, 2004). For example, shame was a major cause in complicating the EFT process with a couple affected by childhood sexual abuse (Macintosh & Johnson, 2008). When the emotionally dysregulated trauma survivor was triggered by something they perceived as threatening from their partner, they became flooded with shame, which triggered the negative cycle. Communication with the partner would then cease, and deep emotional processing would come to a halt in the service of containing the trauma survivor's overwhelming affect.

Self-Compassion

Self-compassion has a rich history in Buddhist concepts and practices (Kornfield & Walsh, 1993) and has only recently been

recognized in the West as an important psychological construct (Gillath, Shaver, & Mikulincer, 2005). There are different conceptualizations regarding self-compassion. Goetz, Keltner, and Simon-Thomas (2010) emphasized compassionate appraisals and action tendencies, including costs and benefits, while the Dalai Lama (2001) highlights focused attention immersed in compassion and an intention to alleviate the suffering of others.

Neff's (2003a, 2003b) conceptualization of self-compassion is derived from Buddhist thought and social psychology. Neff's research has been mostly conducted with her Self-Compassion Scale (Neff, 2003a), which measures dispositional levels of compassion toward oneself. Neff's breadth of research provides ample evidence about the correlation between self-compassion and interpersonal and intrapersonal health. This body of research highlights the importance of reflecting on its development and use for EFT clinicians and clients. Additionally, this article will explore Gilbert's (2005, 2009) CFT, which is a form of psychotherapy developed for individuals who are shame prone, self-critical, and have trauma backgrounds. CFT interventions and principles will be used to enhance EFT and provide practical interventions that can help shame-prone traumatized couples learn how to self-regulate when coregulation with their partner is not a viable option.

Most of the empirical research on self-compassion has been correlational using the Self-Compassion Scale (Neff, 2003b), which is a 26-item self-report measure that focuses on the three components mentioned earlier (the instrument has six subscales, one for each component and one for each component's counterpart): self-kindness, self-judgment, common humanity, perceived isolation, mindfulness, and overidentification.

Self-kindness involves treating oneself as one would a loving friend in the midst of his or her pain and suffering: with kindness, warmth, and genuine care. This is in contrast to attacking and being harsh, judgmental, and critical toward oneself in the midst of a failure or difficult experience (Neff, 2003b, 2009). Instead of engaging in self-flagellation, self-kindness allows people to treat themselves gently and compassionately, despite their flaws and foibles. Common humanity is central to self-compassion and recognizes that all human beings are flawed, fractured, wounded, broken, and prone to make mistakes to some degree (Neff, 2003a). Keeping common humanity in mind during personal failure provides an invitation to bring compassion into one's experience. The converse of common humanity is the tendency to isolate oneself and feel alone in the midst of distress. Isolation tends to breed self-judgment and feelings of disconnection from other human beings (Neff, 2003a, 2003b). Mindfulness is the last component of Neff's self-compassion trinity. Germer (2005) defined mindfulness as "awareness of present experience with acceptance" (p. 7). Mindfulness involves being aware of one's experience and seeing thoughts and feelings as separate from oneself in contrast to overidentifying and fusing with them (Neff, 2003a). Mindfulness helps keep a balanced view of negative emotions and experiences while cultivating an open and flexible perspective (Neff, 2003a).

Self-Compassion Research and Benefits

Research has indicated that self-compassion is significantly correlated with self-report measures of happiness, hopefulness, positive affect, wisdom, motivation, curiosity, engaging in new experiences, agreeableness, extroversion, and conscientiousness (Neff, 2003b; Neff, Rude, & Kirkpatrick, 2007). Self-compassion is also correlated with lower levels of depression, obsessive thinking, neurotic perfectionism, and anxiety (MacBeth & Gumley, 2012; Neff, Pisitsungkagarn, & Hseigh, 2008; Van Dam, Sheppard, Forsyth, & Earleywine, 2011).

The interpersonal benefits of self-compassion have recently been examined as well. Neff and Beretvas (2013) found that self-compassion was associated with greater intimacy and healthier interpersonal relating. More specifically, self-reported self-compassion levels were associated with feeling valuable, content, happy, and able to be authentic with others. Additionally, people whose partners scored higher in self-compassion described them as being significantly more warm, considerate, and affectionate. In contrast, people whose partners were lower in self-compassion described them as being more self-absorbed, detached, and controlling. Using self-compassion interventions, such as responding to yourself as you would a dear friend, can reduce shame and inhibit the activation of the threat system when exposed to shame-activating memories (E. A. Johnson & O'Brien, 2013).

There are other interpersonal benefits to having more self-compassion. For example, self-compassion serves to foster trust and equip partners to have more compassionate, mutual goals in relationships (Crocker & Canevello, 2008). Self-compassion can help partners take the perspective of their loved ones and motivate them to be more forgiving (Neff & Pommier, 2013). Self-compassion is also linked to partners being more likely to resolve ruptures in a relationship (Yarnell & Neff, 2013). Finally, the brain activity of those experiencing feelings of self-compassion, as revealed through fMRI technology, is associated with similar neuronal activity as that of feeling empathy for others (Longe et al., 2010).

CFT

Gilbert's CFT (2010) draws on insights from Buddhist practices, evolutionary biology, attachment theory, social psychology, Jungian psychology, and clinical experience. Gilbert bases his approach on the distinction between three interacting and distinct affect systems (Depue & Morrone-Strupinsky, 2005), which correspond to threat, incentives, or drives and soothing while triggering feelings of threat, excitement, and soothing (Gilbert, 2005). The threat detection system or *threat mind* evolved for protection and can include emotions such as anxiety, anger, disgust as well as behaviors of fight, flight, freeze, and submission (Gilbert, 2010). The incentive or drive system moves people toward goals and achievements and results in feelings of excitement. The soothing system (i.e., oxytocin-opiate system) brings a sense of calmness, contentment, and

safeness. The primary focus of CFT is to help clients skillfully access their soothing affect system to experience affiliative emotions, which enable them to downregulate the threat system (Gilbert, 2010). CFT helps clients cultivate compassion toward themselves and others through the safety of the therapeutic relationship, compassion-based experiential exercises, and cultivation of compassion-based insights and skills (Gilbert, 2005, 2010).

In CFT, shame can be differentiated between internal shame (how we exist in our mind) and external shame (how we exist in the mind of others; Gilbert & Irons, 2005). Internal shame is experienced when a person makes critical judgments or is discontented toward oneself. External shame occurs when we believe that there is condemnation or disapproval in the mind of other people or fear that other people do not like us or are not happy with us. Both internal and external shame activate the threat system and have an adaptive evolutionary function for both survival and reproduction (Gilbert, 1989; Gilbert & Irons, 2005). Those with trauma and intense shame can have difficulties being compassionate with themselves and experiencing affiliative emotions (Gilbert, 2009). CFT has shown to be effective in helping clients work through the fear of affiliative emotions and experience self-compassion with greater ease (Lawrence & Lee, 2013).

EFT, Self-Compassion, and CFT

The principles of attachment theory help elucidate why self-compassion may be a useful concept to integrate into EFT. As described earlier, EFT suggests adults in a romantic relationship become each other's primary attachment figure. In such a relationship, it is vital for partners to be able to approach one other with vulnerability and experience a responsive and accepting other to develop and maintain a secure attachment bond. EFT is an experiential model that utilizes therapy to create bonding events that involve vulnerability and responsiveness (S. M. Johnson, 2004). However, to the degree that individuals experience themselves as damaged or broken (e.g., the degree that individuals experience shame), it becomes increasingly difficult to approach the partner with openness and vulnerability and to trust that the partner will be accepting. The exercise of Neff's self-compassion correlates can help people become mindful and aware of their fears and feelings of inadequacy and feel comforted knowing that their feeling of shame is common to humanity. Offering self-compassion and kindness to his or her self in the midst of their mistakes allows them to experience a greater openness to interact with their partner. And engaging in an accessible, responsive, and engaged manner to their primary attachment relationship is the primary goal of EFT (S. M. Johnson, 2004).

EFT and CFT share some commonalities. Both EFT and CFT are rooted in attachment theory with an overarching goal of activating the caregiving system (Gilbert, 2010; S. M. Johnson, 2004). In EFT, interventions are used to activate the caregiving system of partners, which increase the security of the

attachment bond. For example, in a typical EFT enactment, one partner may be instructed to turn to the other and openly express a particular emotional need—an expression that naturally activates the attachment caregiving system and elicits compassion in most partners (S. M. Johnson, 2004). Signals of kindness and compassion from one partner naturally activate the attachment processes of feeling soothed and cared for by the other partner (Gillath et al., 2005). Gilbert's CFT (2005) identifies attachment systems of caring as one of the two sources of altruism that underlie compassion. The first is kin altruism and evolved to care for those who are related to each other. The second is a desire for justice and morality within relationships and is geared toward the wider context of social relationships. Focusing specifically on self-compassion, though it is a largely intrapsychic process, has interpersonal impact. Self-compassion makes a person more available and open to their partner's attachment. The process of self-compassion when observed by a partner serves two important functions. It not only serves as a model of self-acceptance but also reassures the partner that one is ready and willing to offer compassion and acceptance if shown vulnerability.

Furthermore, EFT and CFT emphasize the role of the therapist as an important attachment figure that offers a corrective emotional experience for clients (Gilbert, 2010; S. M. Johnson, 2004). Therapists in both approaches use depathologizing frameworks and interventions such as validation, reflection, and normalizing while using tone and pace of voice to help create safety for clients to explore their emotional experiences. In EFT, the focus is on present-moment process and bringing awareness to client's experiences, which is consistent with Neff's (2003a) and Gilbert's (2010) use of mindfulness. The EFT and CFT therapist seeks to focus on the here-and-now as a way to expand client's experiences and integrate hidden parts of their psyche while helping them create new meanings (Gilbert, 2010; S. M. Johnson, 2004). EFT's integration with Buddhist thought, particularly the use of mindfulness, has been explored elsewhere (S. M. Johnson, Faller, Bradley, & Amadeo, 2011).

Of course, these theories also offer points of divergence. Although teaching self-compassion interventions and skills can be done in a bottom-up experiential manner (Gilbert, 2005, 2009), there is still a didactic component that falls outside the EFT model, as it is primarily a present process and experiential approach that does not teach skills explicitly (S. M. Johnson, 2004; S. M. Johnson & Faller, 2011). In EFT, couples naturally gain emotional regulation skills such as mindfulness and the ability to attune to their partner's emotions and needs as well as their own over the course of therapy with a collaborative and experiential therapist (S. M. Johnson, 2004). In other words, unlike CFT therapists, it is not a common practice for EFT therapists to explicitly teach clients self-regulation skills such as mindful breathing (MB), mindfulness meditations, and compassionate imagery exercises in session or ask them to do them as homework. Further, an EFT therapist would not explicitly

teach shame-prone traumatized clients how they could relate to themselves compassionately but instead model compassion and allow that corrective emotional experience to internalize within the client over time. This key difference is why these authors suggest that CFT can enhance EFT with shame-prone couples effected by trauma.

To date, no research studies have included an integration of EFT, self-compassion, or CFT. However, Beckerman and Sarracco (2011) explored the use of mindfulness, one of the core components of self-compassion, as a way to enhance EFT. The researchers demonstrated the use of mindfulness practice within the framework of EFT using the case study of a wife suffering from depression. The researchers concluded that both the couple and the therapist were better able to access underlying attachment-related emotions and concerns. The couple reported significant gains, including improvements in the wife's level of depression and a reduction in marital conflicts. The couple attributed their gains to their mindfulness practice, and these gains were maintained at a 6-month follow-up.

Clinical Integration

Therapists can use self-compassion principles and practices both from Neff's self-compassion research (2003a, 2003b) and Gilbert's (2010) CFT to enhance EFT. Self-compassion-based interventions may be used in EFT to help clients downregulate clients' triggered threat systems and help the clients move into their affiliative soothing system (Gilbert, 2005). Once in their soothing system and experiencing subsequent feelings of calm and safety, clients would be more apt to take in information, respond empathically with themselves and their partner, and engage more freely in the overall therapeutic process (Gilbert, 2010; Longe et al., 2010).

As noted earlier, self-compassion interventions have the capacity to improve EFT outcomes when utilized with clients and by therapists to regulate their own experiences of shame. Subsequently, several examples of the use of self-compassion interventions with clients are described, followed by a brief discussion of specific exercises for therapists.

Clinical Interventions

Achieving Stage I de-escalation can be difficult with traumatized couples stuck in negative interactions because one or both partners are prone to being flooded by trauma symptoms such as debilitating shame or other secondary emotions (S. M. Johnson, 2002; Macintosh & Johnson, 2008). An important clinical implication of enhancing EFT with a self-compassion component is using self-compassion work to help escalated partners self-soothe in Stage I of EFT. Although S. M. Johnson (2004) focused more explicitly on couples coregulating one another, Greenberg and Goldman (2008) emphasized self-regulation and self-soothing strategies to help couples avoid negative interactions. Therapists typically act as coregulators of both partners' emotional experiences in Stage I of EFT

because partners are escalated and cannot soothe each other (S. M. Johnson, 2004). Therapists can help coregulate partners by bringing self-compassion work into therapy via using self-compassion psychoeducation, imagery work, breathwork, and meditation to help emotionally flooded partners self-soothe.

The ability to self-soothe through self-compassion interventions could enhance EFT by allowing the traumatized or shame-filled person to achieve a calmer state in session and experience a greater ability to engage in the therapeutic process with his or her partner. Couples who learn self-compassion interventions have the additional benefit of gaining skills that they could then use at home to self-soothe if they become triggered and dysregulated, and their partners are unable to comfort them. Couples who are able to learn self-compassion interventions in session and practice them at home may move through Stage I de-escalation more quickly and then continue to Stage II, which involves inviting couples to achieve a greater degree of coregulation and a more secure emotional bond, and can heal wounded areas of the psyche (S. M. Johnson, 2002, 2004). Indeed, S. M. Johnson (2002) noted, "To be seen and understood by the one we love best may be the most powerful weapon against shame" (p. 60). The best-supported interventions for accomplishing this include psychoeducation, imagery, and MB.

Psychoeducation. Psychoeducation is an important early intervention in CFT (Gilbert, 2010) with individuals and groups and also in EFT with couples affected by trauma (S. M. Johnson, 2002). Since trauma symptoms can feel unpredictable and overwhelming, the ability to make sense of clients' experiences can be beneficial in the beginning stages of trauma work (Allen, 2001). Neff's (2012) research regarding self-compassion can provide valuable psychoeducation to clients. Gilbert's (2010) theory and model of psychotherapy can also enhance EFT by providing therapists with a nuanced depathologizing perspective on trauma, shame, and the brain.

For example, in the early phase of treatment, CFT therapists use psychoeducation and diagrams to inform clients about the "threat mind" and "compassionate mind," which are related to the "threat" and "soothing" affect regulation systems, respectively (Depue & Morrone-Strupinsky, 2005; Gilbert, 2005). Therapists inform their clients how the threat mind and compassionate mind evolved with their unique set of thoughts, behaviors, feelings, images, focus, and fantasies (Gilbert, 2010). The threat mind is protective and geared toward fighting, fleeing, freezing, and triggers painful thoughts, memories, and fantasies activating emotions such as anger, anxiety, or disgust (Gilbert, 2010). The compassionate mind, which can activate the soothing affect system, is related to feelings of warmth, safety, calm, and soothing. It is also related to the motivation to alleviate suffering and to the tendency of having tender and compassionate thoughts and memories (Gilbert, 2005). EFT therapists could use CFT-based psychoeducation in the beginning of treatment to help clients become more mindful when in the

constrictive threat mind to help soothe and slow them down, enabling them to respond from a calm and compassionate state.

For example, after a few sessions with a couple, the therapist could help clients distinguish between the threat and compassionate mind by saying in a slow, compassionate tone, "Mary, I noticed your face turned flush and you turned away and shut down when Jim was talking about how you could be demanding at times. I know how difficult it must be for you to hear that from someone who is so important to you. It seems like you are in the threat mind right now, is that right?" In another session, the therapist says, "Mary, I noticed one part of you was tender and kind with Jim about his feeling inadequate, and another part of you wants to turn away and beat yourself up for not showing him enough love. Can you allow that shameful part of you to step to the side for one moment, and could you stay with that compassionate part of you? Could you take a breath and respond from your compassionate mind?" Psychoeducation, when done in an empathic and compassionate manner, teaches clients about affective states they may experience in therapy and validates and normalizes their emotional experiences as they occur (Leahy, 2002). Once the coregulatory function of the attuned therapist is achieved, the client is then able to respond from a more calm and compassionate mind.

Additionally, CFT therapists use psychoeducation to explain to clients that much of what goes on in their brains is not their fault, which helps externalize their debilitating symptoms, thereby allowing them to see themselves in a more compassionate way (Gilbert, 2010). CFT therapists also give clients psychoeducation about the difference between guilt, shame, and other constricting emotions as a way to organize and normalize their experiences (Gilbert, 2010). The use of CFT's simple terms and diagrams of the two-minds and its evolutionary explanation of shame and other emotions could be incorporated into EFT with its basis in attachment theory, ultimately providing a nuanced psychoeducation for clients in the beginning stages of therapy.

Imagery. Compassion-focused imagery (CFI) exercises are practical self-compassion interventions EFT therapists could use in their work with traumatized couples. CFI is one of the most important interventions of CFT (Gilbert, 2009) and has the potential to act as a catalyst to stimulate the soothing affect system, decrease cortisol, and bring a sense of subjective calm (Gilbert, 2009; Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008). Therapists have used imagery work as an intervention for many psychological issues such as trauma (Arntz, Sofi, & Breukelen, 2013; Barry, 2012; Shachar, 2010; Van der Hart, 2012), adult relationship problems (Barry, 2012), self-criticism, and shame (Gilbert & Irons, 2004; Gilbert & Procter, 2006).

S. M. Johnson (2002) suggested the use of "safety nets" in Stage I of EFT to manage overwhelming emotional states or maladaptive behaviors that can be detrimental to traumatized couples. We suggest therapists can use CFI interventions as safety nets in Stage I of EFT and as needed to help manage moments of hypervigilance and dysregulation, which according

to research has on occasion “derailed” the EFT process (Macintosh & Johnson, 2008). Part of the reason that the therapeutic process can be halted is because couples whose threat systems are intensely activated no longer have access to their prefrontal cortex’s rational faculties and become subject to the amygdala’s primitive self-protective processes (Arnsten, 2009; Thayer, Hansen, Saus-Rose & Johnsen, 2009). Gottman (2009) listed self-soothing imagery as one of many interventions couples can use when their fight-or-flight response system engages, they become flooded and are unable to engage in relational intimacy or effective dialogue. The use of CFI can allow couples to de-escalate, activate their soothing systems, and reengage the therapeutic process with greater ease.

One example of a CFI intervention for shame-prone traumatized partners who are unable to self-soothe and self-regulate is having them create and engage with an ideal compassionate image or perfect nurturer (Gilbert, 2009; Lee, 2005). Compassionate image scripts for individuals affected by trauma are found in the CFT literature (e.g., Gilbert, 2010; Lee, 2012). The therapist would help the traumatized partner or partners create an ideal image that embodies wisdom, strength, warmth, and a nonjudgmental compassionate presence. The perfect nurturer could be a human, animal, deity, or whatever the partner wishes. Ideally, it should embody the preferred physical and sensory characteristics (smells, voice tones, somatic expressions, etc.) the partner desires. Partners on the avoidant attachment spectrum and those prone to shame and self-criticism might not be able to have contact with safe attachment inner working models and therefore find some imagery work difficult (Gilbert, Baldwin, Irons, Bacchus, & Palmer, 2006; Mikulincer, Gillath, & Shaver, 2002; Rockliff et al., 2008). Therefore, creating their own perfect nurturer could fill in these gaps and also create a retrieval advantage over harsh images and memories from the past (Lee, 2005).

Having the partner create and engage with a compassionate perfect nurturer in Stage I of EFT could be vital when a person is unable to soothe his or her dysregulated partner. The compassionate perfect nurturer over time could function as an internalized attachment figure that is able to generate warmth, compassion, and stability in times of disruptive dysregulation, enabling the couple to engage fully in the EFT process as well as providing a comforting image they could engage with at home. Although extremely rare in the EFT literature, S. M. Johnson (2004) demonstrated the use of compassionate imagery with a wife who was prone to self-judgment and had difficulty trusting her husband. Instead of needing to create a perfect nurturer, the therapist used “her angel” (p. 315), which was the wife’s grandmother. Experiential engagement with the internalized image of her grandmother became a turning point in her ability to soften and move closer to her husband.

MB. In addition to imagery, MB is also an effective tool EFT therapists can use for de-escalation. MB, although not exclusive to self-compassion work, is a self-compassion-focused intervention used in conjunction with many compassion-focused exercises (Gilbert, 2009). Kabat-Zinn (1999) defined

mindfulness as “moment-to-moment awareness” (p.2). Germer (2005) added *acceptance* to the definition of mindfulness and defined mindfulness as “awareness of present experience with acceptance” (p. 7). MB is a way of paying attention to one’s breath in the present moment with acceptance and finding one’s soothing rhythm (Gilbert, 2009). It is a way of noticing in the present moment the many experiences associated with breathing, such as the breath going in through the nose or mouth, noticing the diaphragm lifting and falling, noticing the coolness or warmth of the breath, and so forth. If a partner is distracted or overtaken by painful thoughts or feelings, he or she can compassionately refocus on his or her breath without judgment of the stressful dynamics at hand.

The practice of MB is associated with less rumination, negative thinking, brooding, and depression (Burg & Michalak, 2011). Feldman, Greeson, and Seniville (2010) showed that MB was able to reduce emotional arousal and help participants view their internal experiences with greater objectivity. Mindful breathing was also shown to offer psychological benefits over and above progressive muscle relaxation exercises and loving-kindness meditations. Neff and Germer (2013) use an MB practice with participants in their Mindful Self-Compassion 8-week self-compassion training program. Gilbert and Procter (2006) used an MB practice with his group-based therapy program called Compassion Mind Training, which is aimed toward helping those who deal with intense shame and self-criticism.

EFT therapists can use MB when working with trauma, especially in Stage I, where de-escalation and loosening of rigid interactional patterns can be difficult. Because of trauma partners’ difficulty regulating emotions and hypervigilance to threat cues, keeping them in the “window of tolerance” (Siegel, 1999, p. 253) where there is access to higher brain processes and ability to integrate experience is important. Beckerman and Sarracco (2011) showed through a case study that using a deep breathing mindfulness exercise was efficacious in helping a couple diffuse an escalating conflict in an emotionally focused couples session. MB and CFI can be done at home and at the start of therapy sessions to help couples feel grounded and at any point in the session when partners are triggered and become hyperaroused past the window of tolerance.

Integrating CFT with EFT is not meant to be a clinical path in which therapists teach compassion-focused self-regulation skills and isolate the traumatized partner or partners, essentially performing individual therapy. The goal is for emotionally reactive clients who are overtaken by constricting emotions such as shame, fear, and anger to learn skills to help reduce flooding and continue toward the EFT goal of coregulation and creating a secure bond (S. M. Johnson, 2004). The teaching and use of self-regulation skills within couples’ therapy is a common practice. For example, Gottman (1999a) listed self-soothing imagery and breathing practices as one of many intervention couples can use when they are flooded by their triggered fight-or-flight response system and are unable to engage in the therapeutic process. Atkinson’s 2015

Pragmatic-Experiential Therapy for Couples (PET-C) approach to couple's therapy employs mindfulness-based practices to help clients slow down, regulate their emotions, be present, and listen to the deeper messages their partners are conveying. Additionally, Dialectical Behavior Therapy for couples is an approach that centers around the idea that highly aroused, negative emotion keeps couples in conflict, and that learning skills to downregulate is essential for effective communication and a satisfying relationship (Fruzzetti, 2006; Kirby & Baucom, 2007). Enhancing EFT with self-compassion skills, principles, and practices follows the path of other models that teach self-regulation skills to clients with the overall goal of achieving a more secure bond. The goal of self-regulation toward coregulation would be made explicit to clients when teaching any self-compassion skills.

There are additional benefits of learning self-compassion practices in EFT sessions. For example, these skills could be used at home when trauma symptoms arise and partners are unavailable or when partners are at home but not acting as a safe attachment figure due to the negative cycle. Self-regulation is difficult under many circumstances including intense negative emotions (Baumeister & Heatherton, 1996) and positive affiliative emotions (Gilbert, 2010); however, through repeated practice with a warm, empathic, and compassionate therapist consolidation of compassion skills can be achieved (Gilbert, 2010). Clients are encouraged to practice these skills when it is easy and they are not in their threat mind. Finally, many couples affected by trauma have invariably been in individual therapy or are in individual and couples' therapy concurrently (S. M. Johnson, 2002). Individual therapy with trauma survivors typically includes some form of self-regulation skills to downregulate overwhelming affect (Briere & Scott, 2014). EFT therapists can engage in collaborative care by solidifying the self-compassion-based self-regulation skills clients have been learning in their individual therapy if they have been practicing these skills. Regardless, practicing imagery and breathing serves to enhance the overwhelmed partners in home, work, and therapy settings and allows for them to overcome previously learned deficits in emotion regulation.

Brief Self-Compassion Intervention for Therapists

Clients, of course, are not the only ones in therapy who can become overwhelmed with trauma work. In her seminal work on EFT and trauma, S. M. Johnson (2002) warned that having a majority of a therapist's practice focused on couples with relationship distress and trauma in particular "renders one vulnerable to burnout" (p. 204). The best strategy for struggling therapists is to seek a safe haven in the form of trusted colleagues and supervisors (S. M. Johnson, 2002). Self-compassion could also be used in EFT with traumatized couples as a way to manage the therapist's own dysregulation in therapy, thus being able to be more effective for the couple.

For example, the components of self-compassion as defined by Neff (2003a) could be turned into a brief silent

meditation and used when a therapist becomes dysregulated, fearful, or unsure of what to do in a session with an escalated couple overtaken by trauma. The therapist could pause, take a deep breath, and use *mindfulness* to become aware of his or her internal emotional process. Being more mindful and present with his or her experience could help the therapist remember that all therapists struggle at times in session, especially with dysregulated couples. Reminding oneself of the universality of struggling emotionally and cognitively as therapists exemplifies the theme of *common humanity*, which is another component of self-compassion. The dysregulated therapist could then extend *kindness* to himself or herself instead of shame and judgment, which is the third component of self-compassion. The therapist could say to himself or herself, "May I be compassionate to myself in this moment" or "May I be free from my harsh critic and accept myself as I am." As dysregulated therapists engage in Neff's trinity of self-soothing, they can regulate their fear, become more present, and continue the therapeutic process.

Conclusion

Therapists can potentially use self-compassion and its various practices and interventions to enhance EFT with shame-prone couples struggling with the aftermath of trauma. Self-compassion, through Neff's research and Gilbert's cohesive model of therapy, has the potential to help dysregulated therapists maintain an attuned, compassionate and calm presence while moving delicately through the EFT process with traumatized couples. Although moving to EFT Stage II coregulation is the best antidote to a partner overtaken by trauma and shame (S. M. Johnson, 2002), it is not easily achieved when traumatized partners can get stuck in Stage I due to seeing his or her partner as the enemy and high dysregulation. Neff's (2003a) self-compassion and interrelated components of self-kindness, common humanity, and mindfulness as well as Gilbert's (2009) compassion-focused interventions and framework could contribute to self-regulation strategies in the form of psychoeducation, imagery work, MB practices, and meditations that could help both the couple and the therapist when they become dysregulated. As the partners in a trauma couple are able to experience a calmer state, they can move along the EFT stages toward a more coregulatory, safe, and secure bond with greater ease. When dysregulated therapists use self-compassion in and out of session, they can achieve a more calm, mindful, and compassionate state that enables them to become a more present and compassionately attuned therapist who can better model and embody the skills they are trying to impart to their clients.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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