Chapter 4: Not ashamed to love. The Compassion Focused Therapy approach to the treatment of shamed-based difficulties in sexual minorities

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"And as long as you are in any way ashamed before yourself, you do not yet belong with us."

― Friedrich Nietzsche, The Gay Science: with a Prelude in Rhymes and an Appendix of Songs

Shame is a particularly intense, and often incapacitating, emotion involving feelings of inferiority, social unattractiveness, defectiveness, powerlessness and self-consciousness, along with a desire to escape, hide or conceal deficiencies (Gilbert, 1998; Tracy, Robins, & Tangney, 2007). It has been recognized as a critical force in human psychosocial functioning and development, with a central impact on one's sense of self, social relationships and behavior (Gilbert, 2002).

Jordan (2004), highlighting the interpersonal facet of this emotion, defined shame as "a sense of unworthiness to be in connection, an absence of hope that empathic response will be forthcoming from another person" (p. 122). Even if shame is ubiquitous in our everyday lives, sexual minorities such as LGBT communities, are particularly characterized by high levels of shame and shame related issues (McDermott, Roen & Scourfield, 2008).

In fact, according to the minority stress model (Meyer, 2003), sexual minorities face unique experiences (e.g., stigma, discrimination) related to their sexual minority identity. The model suggests that there are distal (e.g., discrimination) and proximal chronic stressors. Proximal stressors relate to the internalization of sexual prejudice (i.e., internalized homophobia), anticipation of distal stressful events (i.e., rejection sensitivity), and the concealment of one's sexual identity. All these factors are strongly related to shame (Allen & Oleson, 1999), and have been found to perniciously affect mental and physical health of LGBT individuals (Meyer, 2003).

Consistent research has shown that shame leads to poor mental health especially among sexual minorities (Bybee, Sullivan, Zielonka, & Moes, 2009). Furthermore, recent evidence shows that early shame experiences can function as traumatic memories, eliciting intrusions, hyperarousal symptoms and avoidance, and become central to self-identity and life story. Shame traumatic and central memories have also been found to increase current shame feelings and vulnerability to

psychopathological symptoms, namely depression (Matos & Pinto-Gouveia, 2010; Matos et al., 2012).

Shame is also detrimental to the physical health of gay individuals. In a study examining the incidence of infectious and neoplastic diseases among 222 gay men, those who concealed the expression of their sexual identity (mostly due to shame; Miller, 2003) experienced a significantly higher incidence of cancer and several infectious diseases over a 5-year follow-up period (Cole, Kemeny, Taylor & Visscher, 1996). Similarly, HIV-positive gay men who blame themselves for negative events (another characteristic highly linked to shame and self-criticism; Petrocchi, Ottaviani, & Couyoumdjian, 2014) showed more rapid CD4 declines than those who did not manifest this attributional style (Segerstrom, Taylor, Kemeny, Reed, & Visscher, 1996).

Shame has also negative relational effects, such as difficulties experiencing mutual and authentic connections. When LGBT individuals feel shameful, they might keep parts of themselves out of relationships with others, including romantic partners, out of fear of rejection or ridicule. This often leads to lack of mutuality in relationships and exacerbates disconnections (Hartling et al., 2004), withdrawal or avoidance of people and communities, generating loneliness. In fact, shame is negatively related to perceived social support and commitment in relationships (Greene & Britton, 2015).

However, even when sexual minority individuals decide to stop concealing their identity, the stressors associated with the coming out process can have a deleterious impact on physical and psychological health. These stressors might include family rejection, with display of anger, blaming attitude and even disgust, with consequences ranging from depression, negative LGBT identity, and substance abuse to, in some extreme cases, suicide (Baiocco et al., 2014a).

This is confirmed by a recent investigation on a large sample of Italian and Spanish subjects (N = 1882), which has shown that lesbian, gay, and bisexual (LGB) people experience significantly higher levels of suicidal ideation (about two times) than heterosexuals (Baiocco et al., 2014b). Sexual orientation was the strongest predictor, after depression, of suicidal ideation both in Italy

and in Spain. Moreover, Feinstein, Goldfried, and Davila (2012) found that internalized homonegativity mediates the relationship between victimization and risk for suicidal ideation.

On the other hand, a supportive and positive family environment is associated with positive young adult health outcomes, such as low level of internalized sexual stigma, depression and suicidal idealization, and high level of social support and self-esteem (Ryan et al. 2010). Early positive affiliative interactions and memories of experiencing safeness, warmth and nurture during childhood are associated with well-being and health, heightened self-accepting and nurturing abilities, and ultimately they protect against psychopathology, such as depression (Cacioppo, Berston, Sheridan, & McClintock, 2000).

Recently, protective processes against shame and shame memories, such as self-compassion and psychological flexibility, have been explored according to sexual orientation. In particular, self-compassion has shown a powerful impact on several mental and physical well-being indicators (e.g. psychopathology, positive affect, life satisfaction, happiness, resilience, emotion regulation, adaptive coping; Barnard & Curry, 2011 for a review). Self-compassion entails being kind and understanding in instances of pain and failure rather than self-critical, recognizing them as part of the human experience, and maintaining a mindful accepting awareness of painful thoughts and feelings (Neff, 2003). In a recent study with 53 heterosexual and 53 gay men, Matos and colleagues (2015) concluded that those who identified as gay reported shame memories to be more central to their self-identity and life story, and had increased levels of internal shame and depressive symptoms. On the other hand, these men recalled fewer memories of warmth and safeness within their family as a child, and reported lower levels of self-compassion and psychological flexibility, a willingness to contact the present moment fully and without defense, which also entails compassionate acceptance of our experiences (Hayes, Pistorello & Levin, 2012). In addition, although shame memories and affiliative memories were associated with internal shame, depressive symptoms, self-compassion and psychological flexibility in both groups, the magnitude of correlations was stronger in the gay sample. In these men, shame and the lack of affiliative

memories were strongly associated with internal shame and depressive symptoms, and negatively correlated with self-compassion and psychology flexibility. Importantly, in gay men both self-compassion and psychological flexibility mediated the impact of shame memories and affiliative memories on internal shame and depressive symptoms. The role of self-compassion in fostering sexual minorities' well-being has been further confirmed by recent research, which has identified self-compassion as a significant predictor of life satisfaction in gay men while controlling for age, income, and openness about sexual orientation (Jennings & Philip Tan, 2014). Recently developed psychotherapeutic approaches, such as Compassion Focused therapy (CFT; Gilbert, 2010), are specifically designed to help people develop and work with experiences of inner warmth, safeness and soothing, via compassion and self-compassion. CFT, and in particular Compassionate mind training, which refers to specific activities designed to develop compassionate attributes and skills, could therefore represent a useful intervention for LGBT shame-based difficulties.

CFT conceptualization of shame related issues and its implications for treatment

Compassion-focused therapy and compassionate mind training arose from clinical observations on people with high levels of shame and self-criticism, which usually have strong difficulty in being kind to themselves, feeling self-warmth or being self-compassionate when they experience setbacks and suffering. Problems of shame and self-criticism are often rooted in histories of abuse, bullying, high expressed emotions in the family, invalidation and/or lack of affection (Schore 1998). Individuals subjected to early experiences of this type can become highly sensitive to threats of rejection or criticism and can quickly become self-blaming and self-attacking, as a way to correct themselves, retain a sense of control, and avoid future adverse events (humiliation and rejection; Gilbert, 2010). It has also been suggested that people who have a fear of others (e.g. rejection/ criticism) may adopt perfectionistic striving, or seek high rank to try to put

themselves beyond rebuke, have social control, and defend against fears of inferiority (Gilbert, 2002). In this state of insecure dominance, failures are not experienced with a sense of acceptance and compassion, but they are felt as disasters that threaten with feelings of powerlessness, inferiority and vulnerability at deep implicit levels. Thus, self-critical and shame prone individuals experience both their external and internal worlds as hostile, which is often the case for lesbian and gay subjects with high internalized homonegativity (Feinstein, Goldfried & Davila, 2012).

Self-devaluation, inner hostility, self-invalidation are all key processes in the explanation of how pathological suffering arises and how normal recovery processes are hindered. In fact, CFT suggests that self-evaluating systems (such as self-criticism) operate through similar brain processes that are stimulated when other people are critical or compassionate to us, generating the same emotional and physiological responses of criticism or compassion received by the external word (Longe, Maratos, Gilbert, Evans, & Volker, 2010). This mechanism might explain why self-criticism and inner shame play a major role in many forms of psychological difficulties (Gilbert, 2010). In the case of lesbian and gay individuals with high internalized homonegativity, self-attacking exacerbates stress responses already triggered by an ostracizing external world, amplifying negative affect and ultimately increasing the chances to develop psychopathologies.

Individuals prone to high levels of shame and self-criticism can find it very difficult to generate feelings of contentment, safeness or warmth in their relationships with others and "themselves", especially when frustrations and suffering are faced. CFT approaches this problem focusing on the evolved functions that underpin certain types of feelings and styles of social relating (Gilbert, 2010). Research into the neurophysiology of emotion suggests that we can distinguish at least three types of emotion regulation system (Depue & Morrone-Strupinsky, 2005): the threat and protection systems; the drive, resource-seeking and excitement systems; and contentment, soothing and safeness systems (for a detailed description of how the three systems are conceptualized and used in CFT see Gilbert, 2010).

The threat and protection system

The function of the threat and protection system is to notice threats quickly and to give rise to a set of emotions such as anxiety, anger, disgust, or shame, which alert and urge us to take action to protect ourselves. The behavioral outputs include fight, flight and submission, with serotonin playing a role in the synaptical regulation of threat responses (LeDoux, 1998). The excessive activity of this system is considered to be the source of many aspects of psychopathology (Gilbert, 1998). The CFT formulation explores how early life events may have sensitized the individual's threat protection system, leading to the development of safety strategies, such as submissive safety strategies (e.g., appeasing behaviors, self-blame, self-criticism, avoidance of interpersonal conflicts). Such strategies, which increase vulnerability to anxiety and depression (Gilbert, 2010), are identified by the clinician, in order to validate their functions and origins (partly to de-shame them).

This formulation facilitates the emergence of compassion because it helps the client recognize that their pathologies and symptoms are "not their fault", but have often arisen with safety strategies (for a detailed description of CFT formulation see Gilbert, 2010). From here, patients can begin to develop compassionate and validating reflection on the fact that they needed to develop these safety strategies. In CFT, once individuals stop criticizing themselves for their symptoms, they are freer to move towards taking responsibility and learning to cope with them.

The drive and excitement system

The function of this system in humans is to generate positive "energizing" feelings (excitement, curiosity, enthusiasm, pride) that motivate us to seek out resources (e.g. food, sex, friendships). It is a system connected to our desires, which guides us to important life goals. The feelings associated with this system are linked to arousal, feeling energized and even "hyped up", and are mediated by the dopaminergic system (Depue & Morrone-Strupinsky, 2005). The drive system and the threat protection system can be linked in complex ways. For example, when blocks to our wants and goals become a threat, the threat system becomes active with corresponding feelings of anxiety, frustration and anger. Moreover, some individuals pursue status, material

possessions and achievement in order to feel safe and avoid feelings of rejection, subordination or inferiority. They may feel the need to prove themselves and to be constantly achieving, in order to feel accepted and "OK". Status-seeking, competitiveness and working to avoid rejection are all linked to the drive system (Gilbert, 2010).

Contentment, soothing and social safeness

In Buddhist psychology, positive feelings linked to satisfying desires (such as those elicited when the drive and excitement system is activated) give us pleasure but not happiness because they are dependent on acquiring rewards, resources and achievements. Happiness comes from cultivating a calm "non-striving" mind that is mindful and compassion focused. Research into the neurophysiology of emotion seems to confirm this affirmation. When animals don't have to be attentive to, or deal with, threats and dangers, and they have sufficient resources, they may enter states of quiescence and contentment (Depue & Morrone-Strupinsky, 2005). The positive emotions of the contentment system, differently from those of the driving system, are associated with a sense of peacefulness, well-being and soothing – a state of "not-seeking". The contentment system, synaptically mediated by endorphins and oxytocin, is not just the absence of threat or low activity in the threat protection system. It is a particular system, developed with the evolution of attachment behavior, and linked to feeling of social safeness, such as being loved, wanted and safe with others (Carter, 1998). Activation of this system is triggered by the caring behavior of the parent, especially physical proximity, and has a soothing effect on the infant's physiology. As adults, feelings connected to affiliation, warmth and affection still exert their soothing effect, through their physiological profile (increased activity of the vagus nerve and corresponding higher heart rate variability, Porges, 2007), which facilitates the downregulation of the threat system (anger, anxiety, sadness). Activation of the soothing system can also turn off excessive activity of the drive and excitement system (seeking, doing, and achieving). In fact, these three systems can become unbalanced, and rebalancing them is one of the goals of CFT. People with high shame and self-criticism often show heightened sensitivity and increased activity of the threat protection and/or drive systems. They find it difficult to feel content or safe within themselves and in their inter-personal relationships. According to the principles of CFT, the soothing system is insufficiently

accessible to them, because it might have been understimulated during early life, or chronically deactivated by repetitive traumatic experiences, which had led to the functional prevalence of the threat system.

Given this developmental, social, and neurophysiological model, it becomes clear why CFT specifically focuses on the activation of the soothing and contentment system in therapy. This system is particularly sensitive to interpersonal cues of social safeness, acceptance and being cared for (e.g., voice tone, facial expressions, kind tactile signals). It is also key to the regulation of the drive and threat protection systems. Thus, the first role of the therapist is to help the client experience safeness in their interactions with them, to tolerate and feel safe with what is explored in the therapy (Gilbert, 1998). Afterwards, the client is helped to develop an internal compassionate relationship with themselves to replace the blaming, condemning and self-critical one.

In CFT, the therapist clarifies with the patient that "compassion" is not pity, or being soft or weak. Compassion is the "sensitivity to the suffering of self and others, with a deep commitment to try to relieve it" (Gilbert, 2010). According to CFT, learning to be compassionate requires us to learn how to be open to, and tolerate, our painful feelings, and to be more accepting of things (e.g., emotions, desires, especially when they cause us pain) as they arise in us. Compassion does not mean turning away from emotional difficulties and discomfort; rather, compassion is strictly linked to the courage, honesty, and commitment to learn to cope with the difficulties we face, with the goal to heal and alleviate them. Activating a compassionate mind set constitutes a strong mechanism of change because it helps us disengage from the inner stimulators of the threat system (self-criticism and shame for our own suffering), which are responsible for negative internal feedback loops that exacerbate and maintain emotional suffering. Thus, one of the main goals of CFT is helping patients recognize when they are "shifting" into the threat mind (e.g., ruminating, self-criticizing, attacking the self, both psychologically and physically), and deliberately refocus and activate a compassionate mind-set.

Held and soothed by a transgender deity: Federico's compassionate image

In CFT compassion is understood in terms of specific attributes and skills which need to be

cultivated and enhanced with practice. Thus, central to CFT is compassionate mind training: a set of compassion focused exercises designed to stimulate brain systems connected to affiliation and soothing, which physiologically tone down the threat system.

Compassion focused exercises can be orientated in different ways: developing compassion for other people, for the self, and opening up to the compassion coming from other people. Moreover, these different "flows" of compassion can be trained using different psychotherapeutic practices (which are common to many other psychotherapies), such as attention refocusing, breathing exercises to tone down the sympathetic nervous system, the chair work to enact different "parts of the self" (for example, the compassionate self), and expressive writing ("compassionate letter writing"). A core practice of CFT is defined "compassionate imagery", which involves a series of exercises that help the client generate compassionate feelings for themselves. In this practice, the therapist works to help the client create and explore an image of their "ideal" of compassion. The client may, for example, explore how their ideal "compassionate other" might look like, their facial expressions, their voice tone, and gestures. The therapist guides the patient through such imagery exercises, helping him become aware of the feelings associated with various images. Sometimes clients prefer non-human images such as an animal, a tree or an ocean. These images should be imagined as sentient, with specific compassionate qualities of wisdom, strength, warmth and non-judgment. Clients often imagine that their image has been through similar situations to themselves, as opposed to being some "higher deity" that has never dealt with shadows, conflicts and tragedies of human experience. Thinking about what makes the compassionate image "ideal for them" is an important part of the exercise. Like in a process of guided discovery, patients can think about what they really want from feeling compassion from another (if protection, understanding, to be known fully, strength, or wisdom). Humans have evolved to seek out care from others (Hrdy, 2009) and our brain systems are particularly sensitive to signals of social safeness and affiliation from others. The thought (and feeling) that we are emotionally "represented" with love and pleasure in the mind of others, triggers in us a sense of safeness and of being valued, which is crucial to our emotion regulation. Thus, imagining this motivation (having deep concern and wishes for the person) arising from the compassionate image and directed to us is a crucial component of this exercise. Several studies have shown the efficacy of this imagery intervention in implementing several psychopathological outcomes (Mayhew &

Gilbert, 2008; Lincoln, Hohenhaus, & Hartmann, 2013).

We will now briefly describe how this intervention has helped Federico, a patient of the university based counseling center "Sei come Sei" (Sapienza- University of Rome, Italy), which is specialized in the treatment of LGBT individuals with mood and anxiety disorders[1].

Federico was a 26 years old gay man seeking therapy for his depressive symptoms. He reported a history of severe bulling, which he experienced before moving to Rome to attend university. During his junior high school years, a group of older students used to wait for him outside of the school where they systematically insulted and beat him up in front of all the other students. He experienced constant and deep feelings of fear and shame. However, once at home he could not vent and find support in any member of the family. His older sister was married and had left the house years before, and his parents were the first to show a "silent disgust" for his femininity and sexual orientation, which was systematically denied by them. In fact, the main rule at home was "if we don't talk about problems, they don't exist". In the few occasions when Federico tried to confront his parents about his sexuality, they both became "silent and depressed", generating a deep sense of guilt and self-blame in him. As a consequence, he had learned how to conceal his tendencies, continuously monitoring his own gestures and tone of voice, and attacking himself whenever he felt that these self-controlling strategies were not enough to "protect his parents". This type of gender self-policing is a common consequence of stigma and self-stigma in sexual minority communities (Herek, Gillis, & Cogan, 2015). Federico felt that there was something intrinsically wrong with him, which was the cause of both his parents' depression and the constant harassment from other people. Ultimately, he felt that he was the cause of his own unhappiness. The only way he found to cope with these feelings of guilt, shame and unworthiness, was trying to become a perfect student and give his parents all the satisfactions that he could not give them in other ways ("by being normal"). In therapy, during the case formulation (for CFT case formulation see Gilbert, 2010), it became clear how this excessive "striving toward success" was just a safety strategy Federico built to protect himself from painful feelings of shame and guilt (the "threat system"). However, as an unintended consequence of this strategy, Federico became increasingly anxious and scared of failing, using self-criticism as an attempt to motivate himself "to

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[1] The center "Sei come Sei" is directed and supervised by Roberto Baiocco (the fourth author), who is also a family therapist. Nicola Petrocchi, a CBT therapist with a full training in CFT, conducted the therapy with Federico, whose story and name have been modified to protect his privacy.

push harder and avoid to be swallowed in the black whirlpool of feeling a lonely piece of crap". He could not experience any feeling of self-warmth, compassion and reassurance. Importantly, he could not access any memory of reassuring figures who saw and validated his difficulties, and who reminded Federico that he did not choose to be gay, that he simply was born like this and that it was OK. He felt that it was his fault if people like his parents did not accept him, and that he could not "afford" to feel sad and alone for something he had caused. When the guy the he was dating, who suffered of bipolar disorder, left him due to a depressive episode, Federico blamed himself for not having been good enough to prevent this relapse. Not only he was feeling sad for the end of the relationship, but he was also feeling disgusted by his low mood and sense of abandonment that were interfering with his being productive at the university. In therapy, Federico became fully aware of the severity of his boyfriend's diagnosis. Cognitive restructuring helped him to realize that there was nothing more he could have done to prevent the depressive episode of his boyfriend, and the end of the relationship. Even if he came to "know" that his feelings of sadness and apathy were normal human reactions to his loss, he was not able to feel completely comforted by this thought: he deeply felt that it was not right and safe to mourn, because friends would abandon him ("people know me as an always happy guy, they wouldn't like my sadness"), and there wouldn't be anyone to help him stop the down road spiral to depression. This invalidating and self-critical attitude towards his own suffering was clearly exacerbating his depressive mood.

Compassion focused imagery helped Federico to overcome this excessive self-blaming and fear of negative emotions, and to reach an increased ability to validate and compassionately take care of his "abandoned and fragile part". After having realized that criticizing himself for feeling sad and apathetic only worsened his depressive state, he was guided to imagine a perfect compassionate image, who showed complete compassionate qualities. This ideal creature would know everything about Federico's inner life and it would completely understand and accept the difficulty and complexity of his situation. Moreover, it would be deeply animated by a strong commitment to him, a sincere desire to make him feel safe, and help him heal, cope with and relieve his suffering. It would also show great warmth, acceptance and wisdom: at one time, the image had lived the same life experiences, and it would deeply know "how it feels to be that way", from the "inside", and not from a separate "divine mind" that has little idea of human struggles. During the first compassionate visualization, Federico cracked a smile. He then revealed that the only way he

could conceive a completely non-judging, compassionate and strong creature, was to imagine a "weird and colorful" transgender deity. He visualized this image warmly smiling at him, reassuring him that there is not a "right or wrong way to feel and to live", and that even being a man and a woman at the same time, as the deity was, could be seen as "one of the many colors of this inscrutable design that is living in this planet". Federico clarified to the therapist that being in front of the image "made him *feel* a little more OK, understood and protected" and that he felt that this compassionate image would have been there with him, patiently, holding him silently when he needed to vent his pain and cry. This type of compassionate imagery greatly helped Federico overcome his depressive spiraling. He was asked to visualize his compassionate at least once a day, especially at late night, when he would usually feel sad and anxious because he could not call anyone to support him. Gradually, he felt that it was ok to be sad in bed for a while: at those time, visualizing the deity's warm smile was enough for him to stop feeling anxious and self-critical about his sadness, and to sleep without nightmares and a pervasive sense of being "under attack" by his own negative emotions. Federico's depressive episode, treated also with other CFT practices, remitted after 3 months.

Conclusions

Compassion Focused Therapy builds on evolutionary theory and on the neuroscience of affect regulation: it proposes that whatever the intervention a therapist uses, it should be done with a clear picture of the role of self-relating processes, such as self-compassion and self-criticism, in easing or exacerbating emotional suffering. This is particularly relevant for the treatment of sexual minorities, where internalized homonegativity often takes the form of self-invalidation, shame and self-criticism, which might explain why LGBT individual are at increased risk for poorer mental and physical health outcomes than heterosexuals (Mereish & Potetat, 2015). CFT, with its strong focus on lessening self-attacking attitudes and increasing the ability to soothe the self when we face pain and distress, might represent a critical advancement in the treatment and health promotion of sexual minorities. CFT has already been proved to be effective in the treatment of several psychopathological conditions (for a review see Leaviss, & Uttley, 2015). Future clinical investigations are warranted to specifically test the efficacy of CFT on reducing shame-based

difficulties of LGBT individuals.

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