Open Access

OBM Integrative and Complementary Medicine

LIDSEN Publishing Inc.

Short Report

Compassion-Focused Therapy and People with Intellectual Disabilities: A Renewed Focus

Elisabeth Goad *

Surrey and Borders Partnership NHS Foundation Trust, Leatherhead, Surrey, England; E-Mail: elisabeth.goad@sabp.nhs.uk

* **Correspondence:** Elisabeth Goad; E-Mail: Elisabeth.goad@sabp.nhs.uk

Academic Editor: Chris Irons

Special Issue: Compassion Focused Therapy (CFT) - New Insights and Outcomes

OBM Integrative and Complementary Medicine
2023, volume 8, issue 1
doi:10.21926/obm.icm.2301002

Received: March 06, 2022
Accepted: December 19, 2022
Published: January 04, 2023

Abstract

Compassion-Focused Therapy is an integrative therapeutic model with a wealth of evidence behind its efficacy. Its accessibility leads it to be a helpful therapeutic modality for the intellectual disability population. Its ability to aid the understanding of the person, us as clinicians, and the wider context around us give a depth of understanding not prioritised across all therapeutic models. This article explores Compassion-Focused Therapy in the context of working alongside people with intellectual disabilities. It focuses on how understanding archetypal and social mentality processes can aid understanding in people with intellectual disabilities as well as exploring some of the clinical implications and practical applications. It ends with a call to consider more readily, the use of Compassion-Focused Therapy in people with intellectual disabilities.

Keywords

Compassion-focus therapy; CFT; intellectual disability, LD, disability, ID

1. Introduction

Many people know Paul Gilbert's compassion-focused therapy (CFT) to be synonymous with the three emotion regulation systems [1-3]. The simplicity of this part of the model makes it accessible and relatable to our clients. Yet there is also much more depth to this integrative model that can helpfully be applied in the context of people with intellectual disabilities.

CFT is an integrative, multi-model, therapeutic model based on Jungian ideas, attachment theory, evolutionary psychology and eastern philosophies [2]. It's ability to draw together and integrate information from the roots of our psychotherapeutic origins, enables it to draw forth from previous learning, and links it to newer, cutting-edge theories (for example neuroscience) in a way that other theories have not always done. It is a therapy specifically developed to address high levels of shame and self-criticism and focuses on facilitating people to access their own affiliative motives, emotions, and competencies to help regulate threat and manage well-being [4, 5]. It works by recruiting the two psychologies of compassion to support people engage with their own and other's suffering, but equally to take courageous action in engaging with that suffering as well [4].

For the purpose of this article, the term intellectual disability is used to describe what is now termed 'disorders of intellectual development' in ICD-11 [6] and DSM-IV's [7] 'intellectual developmental disorder'. Its key criteria include a significant impairment in both intellectual disability and adaptive functioning and for the onset to be within the developmental period.

In mainstream populations there is now a wealth of evidence for the application of CFT across a range of presentations [8, 9]. For people with intellectual disabilities the evidence base is starting to develop slowly too. There are single case series for a range of clinical presentations [10, 11] reviews on CFT for trauma [12], anxiety, [13] and groups [14, 15]. There is research on the efficacy of telephone CFT on the ID population [11] and the impact of CFT on shame and people with ID [16]. There are, yet, no randomized controlled trials completed to assess the efficacy of CFT in people with intellectual disabilities.

However, for a population who are well evidenced to experience significant levels of shame [17, 18] CFT is an important therapeutic modality to use in its entirety. It's ability to 'layer up' formulation from simple and accessible to the more complex, ensure its accessibility for people with different levels of intellectual functioning. It is a practical and experiential therapy with a focus on emotion rather than solely cognition. This makes it an obvious choice for a population who find expressing their inner most experiences and feelings through language more challenging due to the nature of their disability. The model holds the idea of common humanity at the center of it which is a refreshingly less 'othering' approach for a population who are so often ostracized, isolated and ignored.

This article aims to illustrate the extent to which CFT can be used to understand the inner worlds of people with intellectual disabilities. It explores the concepts of archetypes and social mentalities and their relationship with people who have intellectual disability. It also explores the three emotional regulation systems, the ways in which CFT can be adapted for people with cognitive challenges, as well as the fears, blocks, and resistance's that people face which always form an integral part of the work.

2. Main Text

2.1 Archetypes and Social Mentalities

CFT draws heavily on the Jungian concept of archetypal processes. Archetypes are described as innate patterns of potential that in certain circumstances translate to lived experience and can be recruited in or out of awareness [3]. Gilbert, describes archetypal patterns as rules of thumb; as old brain patterns that center around survival [3]. Humans are never too far from succumbing to the darkest of desires or the control and ownership that our archetypal minds so readily encourage. They also interact with social mentalities, differing from archetypes in that they are designed to track and notice social cues indicating social danger or attunement that might aid our survival [1] Archetypal processes and social mentalities are inherent in us all but how they can influence people with intellectual disabilities is described below.

The following archetypal patterns are some most centrally placed within the CFT framework [1].

2.2 Care Seeking and Receiving

The natural ability to elicit care is well documented in attachment theory [19]. It has obvious benefits by helping to ensure that both our own and members of our group get their needs met through reciprocal caring, thus significantly improving the chance of survival. Yet our natural and necessary propensity to seek and receive care is also a challenge for humans who are entirely reliant on those who 'care for' them during their early years (unlike reptiles and to a lesser extent some mammals). If early caregiving attachments are disrupted in some way, then the child is left feeling threatened and frightened. These are feelings that often repeat in patterns throughout that child's adult life. Specially, for the person with an intellectual disability, their reliance on others to provide physical and emotional care is likely to be more intense due to the challenges they often face with adaptive and intellectual functioning. People with intellectual disabilities are more likely to require physical and emotional care for a longer period (sometimes indefinite) than for those without disabilities. If the care giver is not able to meet the person's emotional and social needs it leaves people vulnerable to the experience of loneliness, isolation, and fear early on in their life. Additionally, given the non-negotiable need for care, those who have missed elements of care often spend life trying to seek it out. People with intellectual disabilities often have multiple experiences of being socially rejected and their early experiences in life may mean they are then drawn to more powerful others later in a continued quest for care seeking. This can often then lead people toward the 'wrong crowd' and thus potentially leading to an increased likelihood of repeated patterns of earlier abuse and neglect.

2.3 Alliance Formation and Co-operation

Being part of a group is another key evolutionary essential, providing safety and security, caring and connection and the sharing of resources. Most of us have experienced being in the 'outgroup' in one context or another, yet people with intellectual disabilities are often seen as the 'outgroup' by the whole of society. Many people within intellectual disability services are people who have been made to feel that they are outsiders or that they just do not 'fit'. From an evolutionary perspective this is designed to be an extremely distressing experience; theoretically to motivate us

to find ways to 'fit in' but this can come at a cost. We are all vulnerable to making unwise choices to fit in those who we see as our own tribe, yet people with intellectual disabilities who have been ostracized or rendered 'not one of us,' may be more vulnerable to being coerced in to doing things that they may not want to do in an attempt to fit in. This can lead to vulnerability to abuse but also to the risk of people becoming perpetrators (for example in gang culture) to try and be accepted somewhere in society. Even then, to fit in is certainly not the same as to belong, an experience perhaps even more difficult to achieve. The tribalistic nature of humans means that although people have a huge capacity for good, they also have capacity to be incredibly cruel to 'out groups'. There is no shortage of literature on the amount of exclusion and discrimination people with intellectual disabilities face as a result [20, 21]; these are good examples of how these sorts of dynamics can play out.

2.5 Rank Archetypes

The societal rank system enables people to compete for resource and for social place which is another prerequisite for survival. Those with more power can often use their power to be helpful but can also (when power is in the wrong hands) cause significant harm. People with intellectual disabilities are often 'down ranked' by others in society and are often put and held in an inferior position. This is a feeling that generally then internalizes itself and manifests in anxiety, depression, self-criticism, and shame. The human ability for self-reflection means that social mentalities can be activated in relation to the self as well as others [22]. Thus, self-criticism can be understood by rank-based mentalities with one part of the self-dominating and subordinating another [23]. This means that people with intellectual disabilities often experience criticism from both their external and internal worlds.

2.6 The High Ranked Hero

All humans have or have had a hero; someone to look up to or to admire. The 'hero' story is often played out in the media, in literature and in films. Heroes can be very influential, both positively and negatively, especially at times in life where we might be more vulnerable and be looking out for influence and guidance. This is perhaps, as Gilbert [3] suggests because of the hero's ability to touch upon our innate archetypal potential. It is very easy for dominant members of society to influence more vulnerable people (for example those with intellectual disabilities). This is because they represent power and high status which is attractive to all but the most dominant of us [3].

2.7 Clinical Applications

Gilbert [23] describes CFT as adopting an evolutionary functional approach to emotions, clustering them into three interactive groups dependent on the primary motives they serve. There is threat, protection, and harm avoidance; drive-based resource seeking and acquisition; and rest, digest and soothing. CFT works to balance these emotional systems with an emphasis on enhancing 'soothing' parasympathetic feeling-states and emotions which are interlinked with social safeness and care [4].

The activation of 'threat, protection and harm avoidance' mode often relates to relational threats due to the key part relationships play in survival. CFT draws heavily from attachment theory [19]

which evidences that early in life the human infant is completely unable to sooth, calm and regulate themselves. The caregiver is required not only to soothe and calm them, but also to slowly teach them how to start soothing themselves as they get older. Yet if those early attachment experiences are disrupted (for example through abuse, neglect, parental mental health difficulties or just the grief and loss often associated with having a child with a disability) then the affiliative system remains under-developed and unable to regulate both threat and drive. Relational problems such as those described above are remarkably common in people with intellectual disabilities and tap into archetypal themes of abandonment, rejection, and a lack of safeness (and safety). Many of the people with whom we work are people with heightened threat systems (with associated anger, sadness or anxiety) doing the best they can to protect themselves (e.g. with passivity, aggression, avoidance, concealment, people pleasing). Unintended consequences of these coping strategies often relate to the response of others, perhaps with fear or disgust or judgment. For all the complexity behind the emotional regulation systems, in practice, it can be reduced to a representation of a red (threat), a blue (drive), and a green (compassion) circle. Combined with the experiential exercises so integral to CFT, it can be an accessible way to formulate and intervene with people who have significant disabilities.

CFT is also an important therapeutic modality for the intellectual disability population because of its ability to support emotional intelligence (EI). A more recent focus on EI has suggested that it is equally as important as the intelligence quotient (IQ) in predicting success [24]. This relates to the idea that if you are aware of your own and other's feelings, you are better able to manage behaviours and relationships in a way that helps predict success [25]. A new model of emotional intelligence by Drigas and Papoutsi [24] highlight, within many of its nine layers, the importance of being able to become aware of, recognize, and classify our own emotional responses as well as then being able to build awareness of the emotional needs of others. These layers of emotional intelligence align with the work of CFT with its focus on building awareness of each emotional regulation system (and its associated emotions) and use of experiential exercises to build awareness (e.g. soothing rhythm breathing, distancing and wise observing), develop empathy for both the self and other (e.g. through compassion for 'self' and 'other' exercises, perfect nurturer and so on) as well as courage and wisdom (me at my best and qualities of compassion exercises). Therefore, it supports and prioritizes the development of emotional intelligence. This is welcome for a population who by nature of their disability do not have high IQ scores but are well able to have or develop high EI.

2.8 Practical Adaptions in Clinical Practice

One example of how people with intellectual disabilities can benefit from CFT is through its use of imagery and its ability to develop concrete representations of this. People with intellectual disability have been reported to have higher rates of adverse trauma such as poverty, violence, and abuse [26]. Those with moderate to severe intellectual disabilities are over three times more likely to be physically abused, over five times more likely to be neglected and over six times more likely to be sexually abused [27]. These are experiences that have a significant impact on developmental milestones and the functioning of evolved and neurophysiological systems such as attachment and social rank systems [28, 29]. There is a need for more concrete representations of imagery when working with people with attachment trauma who often struggle to hold imagery in their minds and

indeed may not have previous experiences of social safeness from which to draw [30]. People with intellectual disabilities also often struggle to hold visual images in their mind or to use language-based techniques to access their affiliative system. The work developed by Clapton and Lucre [31] on the compassionate kit bag is a good example of using multi-sensory and body focused strategies to access the affiliative system. It focuses on using the five main senses (touch, smell, taste, hearing and visual) and enables creative ways to access the affiliative system, something helpful for those with sensory preferences. Recent evidence on self-soothing kits for people with attachment trauma illustrates the positive impact on self-regulation of emotion [32].

The capacity to utilize all senses enables a creative but concrete way of self-regulating emotion that does not need to rely on language or even complex imagery. The ability to represent abstract concepts in simple, concrete, and accessible ways is why the model works so well with a population who often prefer to work with visual representations rather than verbal ones. For example, photos and pictures of places can support the use of imagery in safe place imagery exercises. Using cut out pictures of reptiles, mammals, and humans to explain psychoeducation around the evolutionary importance of relationships can also be helpful. Cue cards can be developed collaboratively to re-enforce key messages.

Where possible, using objects in addition to pictures can be even better. Using hula hoops or pieces of coloured rope can easily signify the three emotional regulation systems enabling you to move people quite literally in and out of them during sessions. Using bubble blowing to help get people practicing breathing out slowly can help people visually watch what happens to the bubble when they blow out slowly compared to a short sharp outbreath (bubble floating slowly aware versus burst bubble). Using actual blocks or homemade bricks that people can build up or take down to signify fears, blocks and resistances help make the often unvoiced, visual, and acknowledged.

Using characters from favourite cartoons or TV characters to illustrate points can make therapeutic work more relevant and engaging. For example, the perfect nurturer can be drawn out or taken from characters already known and loved (appropriately nurturing ones). Role plays can be completed using favourite characters and their advice drawn upon. Story telling can be used to make psychoeducation more accessible. Compassionate friends can be developed and imagined through characters that the person imagines would be in their corner should they be real.

Managing cognitive challenges is important because people with intellectual disability are already disadvantaged cognitively, but they are often also contending with the impact of longer-term relational trauma on hippocampal functioning and the associated impact on working memory. Using smart phones to record experiential exercises not only enables the person to replay the exercises again at home easily, but also serves as a transitional object, enabling the person to take a small part of their therapist home with them. The replaying of a compassionate person's voice helps to reactivate the affiliative system. Recording a session summary at the end of each session can aid memory and enable it to be shared, when appropriate, with supporting others. Using experiential exercises early in a session can add to settle people who are more impulsive and disinhibited as they come into the therapeutic space, or later, for those needing more time to adjust.

Despite its many strengths, there are areas of CFT that can be harder to grasp and require more time and explanation for people with intellectual disability to understand. In CFT the nuanced understanding of compassion is extremely important. It can take longer to support people to grasp the part of compassion relating to courage and wisdom than to kindness and empathy which are often a little more familiar. Similarly, nuanced understandings of the threat system are important

in understanding that the threat system is not 'bad'. Indeed, at times it can save our lives but yet at the same time can also seemingly sabotage our attempt at a more compassionate life. The duality of such concepts can take a little bit longer and a lot of practice examples to fully understand.

2.9 Blocks, Fears and Resistances

Blocks, fears, and resistances are a crucial part of the CFT model. They are not something to work through to be able to 'do therapy' but instead are a crucial and ongoing part of the therapeutic process. The distinction between blocks, fears and resistances is important for the person with intellectual disabilities to help support meaningful change. There are many fears in an already fearful population, many with repeated experiences of failure, having lived in a world not set up for people with intellectual disabilities to live to their full potential. *'I won't understand,' 'I'll fail at this too,' 'It's my fault,' 'what if you see the real me?',* and *'can I trust you?'* These are all very real fears in people where abuse from those who should have cared for them is all too common. Blocks might include having enough money for the bus or having to rely on a carer being on shift who can drive, something many people with intellectual disabilities often rely on. Resistances could be because a carer or family member has told the person to come, or because the problem has been located within the person when it actually sits elsewhere in the system. Of course, also taking the time to understand what our own fears, blocks and resistances are to the work of equal importance.

3. Conclusion

CFT is a well evidenced model with a growing evidence base within the intellectual disability population. It manages to hold on to the roots of psychological history yet draw on the latest of neuroscience. Its emotion focused nature makes it an ideal model to adapt and use alongside people with intellectual disabilities. It is less reliant on language than other therapeutic modalities and more focused on experiential and body-focused exercises. It can be formulated using a basic three emotion regulation model (green, blue, and red circle) making it collaborative and accessible to people with intellectual disabilities. However, its more intricate formulation can be used to support wider systems make sense of what is happening for the person and the socio-cultural influences surrounding them.

In intellectual disability services we could be utilizing CFT in its purist form much more and building its evidence base within this important population. However, even if all we do is use it to as a start to understand the systems of which both we and our clients are situated within; then that would be a step in the right direction.

Acknowledgments

A big thank you to the CFT community who never fail to inspire me and whose contributions are always so generously shared.

Author Contributions

Single author paper.

Competing Interests

The author has declared that no competing interests exist.

References

1. Gilbert P. The compassionate mind. London: Constable and Robinson Ltd.; 2009.
2. Gilbert P. Compassion focused therapy: The CBT distinctive features series. London: Routledge; 2010.
3. Gilbert P. Living like crazy. York: Annwyn House; 2017.
4. Gilbert P. The origins and nature of compassion focused therapy. Br J Clin Psychol. 2014; 53: 6-41.
5. Gilbert P. An evolutionary approach to emotion in mental health with a focus on affiliative emotions. Emot Rev. 2015; 7: 230-237.
6. World Health Organization. International statistical classification of diseases and related health problems. Geneva: World Health Organization; 2019; ICD-11.
7. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Washington: American Psychiatric Association; 2013.
8. Beaumont E, Hollins Martin CJ. A narrative review exploring the effectiveness of compassion-focused therapy. Couns Psychol Rev. 2015; 30: 21-32.
9. Leaviss J, Uttley L. Psychotherapeutic benefits of compassion-focused therapy: An early systematic review. Psycholl Med. 2015; 45: 927-945.
10. Cooper R, Frearson J. Adapting compassion focused therapy for an adult with a Intellectual disability—A case study. British J Intellect Disabil. 2017; 45: 142-150.
11. Rawlings GH, Wright KP, Rolling K, Beail N. Telephone-delivered compassion-focused therapy for adults with disabilities: A case series. Adv Ment Health Disabil. 2021; 15: 89-103.
12. Cowles M, Randle-Phillips C, Medley A. Compassion-focused therapy for trauma in people with disabilities: A conceptual review. J Disabil. 2020; 24: 212-232.
13. Hardiman M, Willmoth C, Walsh JJ. CFT & people with disabilities. Adv Ment Health Disabil. 2018; 12: 44-56.
14. Clapton NE, Williams J, Griffith GM, Jones RS. 'Finding the person you really are… on the inside': Compassion focused therapy for adults with disabilities. J Disabil. 2018; 22: 135-153.
15. Goad E, Parker K. Compassion-focused therapy groups for people with disabilities: An extended pilot study. J Disabil. 2020; 25. Doi: 10.1177/1744629520925953.
16. Marriott C, Parish C, Griffiths C. Experiences of shame and disabilities: Two case studies. J Disabil. 2019; 24: 489-502.
17. Ditchman N, Werner S, Kosyluk K, Jones N, Elg B, Corrigan PW. Stigma and disability: Potential application of mental illness research. Rehabil Psychol. 2013; 58: 206-216.
18. Werner S. Stigma in the area of disabilities: Examining a conceptual model of public stigma. Am J Dev Disabil. 2015; 120: 460-475.
19. Bowlby J. Developmental psychiatry comes of age. Am J Psychiatry. 1988; 145: 1-10.
20. Ali A, King M, Strydom A, Hassiotis A. Self-reported stigma and symptoms of anxiety and depression in people with disabilities: Findings from a cross sectional study in England. J Affect Disord. 2015; 187: 224-231.

21. Pelleboer-Gunnink HA, van Weeghel J, Embregts PJ. Public stigmatisation of people with disabilities: A mixed-method population survey into stereotypes and their relationship with familiarity and discrimination. Disabil Rehabil. 2021; 84: 9-25.
22. Hermanto N, Zuroff CD. The social mentality theory of self-compassion and self-reassurance: The interactive effect of care-seeking and caregiving. J Soc Psychol. 2016; 156: 523-535.
23. Gilbert P, Irons C. Compassionate mind training, for shame and self-attacking, using cognitive, behavioral, emotional and imagery interventions. In: Compassion: Conceptualizations, research, and use in psychotherapy. London: Brunner-Routledge; 2005. pp. 263-325.
24. Drigas AS, Papoutsi C. A new layered model on emotional intelligence. Behav Sci. 2018; 8: 45.
25. Gutiérrez-Cobo MJ, Cabello R, Fernández-Berrocal P. The relationship between emotional intelligence and cool and hot cognitive processes: A systematic review. Front Behav Neurosci. 2016; 10: 101.
26. Wigham S, Emerson E. Trauma and life events in adults with disability. Curr Dev Disord Rep. 2015; 2: 93-99.
27. Spencer N, Devereux E, Wallace A, Sundrum R, Shenoy M, Bacchus C, et al. Disabling conditions and registration for child abuse and neglect: A population-based study. Pediatrics. 2005; 116: 609-613.
28. Liotti G, Gilbert P. Mentalizing, motivation, and social mentalities: Theoretical considerations and implications for psychotherapy. Psychol Psychother. 2011; 84: 9-25.
29. Sloman L, Taylor P. Impact of child maltreatment on attachment and social rank systems: Introducing an integrated theory. Trauma Violence Abuse. 2016; 17: 172-185.
30. Lucre KM, Corten N. An exploration of group compassion-focused therapy for personality disorder. Psychol Psychother. 2013; 86: 387-400.
31. Lucre K, Clapton N. The Compassionate Kitbag: A creative and Integrative approach to compassion-focused therapy. Psychol Psychother. 2021; 94: 497-516.
32. Sokmen YC, Watters A. Emotion regulation with mindful arts activities using a personalized self-soothing kit. Occup Ther Ment Health. 2016; 32: 345-369.