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An Exploration of Compassion Focused Therapy for Grieving Individuals

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Abstract

In the past several decades, new understandings about grief have emerged. In the same time frame, a substantial body of literature has explored the components of compassion and their potential application to various clinical contexts. Compassion evolved from caring motivation associated with the evolutionary challenges of reproduction that involved the necessary care for offspring. Grief also has an evolutionary background that is rooted in core aspects of attachment and the assumptive world construct. Compassion Focused Therapy (CFT) translates the concepts of compassion into a form of therapy, which has the potential to address grief in an experiential and non-pathologizing way. Foundational components of CFT include a model of emotion regulation, experiential practices that enhance compassion-based responses, and the cultivation of wisdom and discernment regarding the nature of suffering. These aspects of CFT provide a uniquely oriented way to support those who grieve losses of all types. Compassion training enables clinicians to cultivate wisdom and discernment to accompany their intention and motivation to relieve suffering, including the grief that follows significant losses.

Keywords

Grief; chronic sorrow; compassion focused therapy; emotional dysregulation; compassion

focused imagery

1. Introduction

Compassion-based approaches have been widely reported in the recent literature and research in the field with many different populations. These approaches may hold promise in their potential application to individuals experiencing significant losses and the resulting grief afterwards. The literature and research in compassion has blossomed in the last 15 years; likewise, deeper understandings about loss, grief, and bereavement have led to a greater understanding of the grieving process, with a corresponding enhanced understanding of the role of clinical approaches in working with grieving individuals.

The clinical applications of compassion have been studied through several well-known centers of research; the studies from these centers have become widely published and drawn a great deal of interest [1]. While there are many schools of compassion training found throughout the world, Compassion Focused Therapy (CFT) [1] is the only form of compassion training that has been specifically delineated as a form of psychotherapy. There are a very small number of studies that have addressed the application of compassion-based approaches to situations of loss and grief [2, 3]. The majority of these studies explore the relationship between self-compassion and grief outcomes, pointing to a possible relationship between compassion and enhanced distress tolerance and resilience [4, 5]. However, the implementation of compassion-based approaches as a specific clinical application to grief therapy is an area of novel exploration.

For the purpose of this article, grief is defined as the normal and natural response to losses of all kinds, including those that occur after the death of someone, as well as non-death losses that create a scenario where it would be impossible to return back to the way things were before [6]. Grief, bereavement, and mourning are all terms that are often used interchangeably. However, these terms do have specific, distinct meanings. Grief is the response to losses of all kinds; bereavement is the grief experienced after the death of another person; mourning encompasses the public face of grief in the form of rituals, memorials, and other outward, public expressions.

For this article, compassion will be defined as the ability to notice and turn toward suffering with the intention and motivation to prevent or alleviate it [7]. A further understanding is that compassion-based approaches apply to both the clinician as well as the client. Training in compassion enhances the therapeutic stance of the clinician in a way that is sustainable and balanced [8]. Compassion-based approaches with grieving clients have many potential multiple benefits across several domains [9]. This article will attempt to integrate the current research and understandings about grief with some of the clinical approaches based on the CFT model.

2. Foundational Understandings About Grief

Grief is a unique indicator for therapy, as it is neither a clinical condition nor a diagnostic entity; rather, it is a normal human response to significant losses [10]. It is important to note that although

[1] Further information about training in Compassion Focused Therapy can be found at https://www.compassionatemind.co.uk

grief is a common experience for all human beings, the actual appraisal of grief is unique and subjective. How grief is perceived and expressed differs greatly from one individual to another. There are many variables that shape the grieving process, such as the presence of other stressors, the individual's history of loss, what losses have been experienced, and the overarching social messages about grief that exist in an individual's social network and location [11]. In addition, grief is not like a disease or illness that should be treated, or to which the goal is to return back to baseline in the same way that is expected when someone recovers from an illness. Interventionist or medically-oriented models of therapy do not readily apply to grieving individuals, as it makes no sense to try to "treat" something that is considered a normal, albeit painful, aspect of life [12]. Clinicians who support bereaved individuals should be aware that even though loss and grief are painful, the goal of their support is to journey alongside the grieving person, allowing the process to unfold while the individual pieces their world back together again in a way that allows a return to back to everyday life in a different, but meaningful way [10].

2.1 Grief and the Shattered Assumptive World

Early theories about the grieving process were based upon attachment theory, with grief being described as the result of a broken attachment bond when a loved one died [13]. However, converging research in the 1990s demonstrated that many bereaved individuals readily maintain a relationship (called a *continuing bond*) with their deceased loved ones in an intangible but poignant way [14, 15]. Thus, the attachment bond is not necessarily broken by the death of a loved one. As a result of these findings, a discussion of what activates the grief response ensued, with many in the field suggesting that the painful disequilibrium and sense of void that occurs with grief is directly related to the loss of meaning, purpose, and a sense of belonging [16, 17].

In an attempt to explicate the process of change and transition, Parkes [18] introduced the concept of the assumptive world, indicating that this internalized view entails all the guiding beliefs, expectations, and schemas that had formed in early life, reflecting all that a person assumes to be true about the world and the self, creating a sense of security, predictability, and meaning/purpose to life. He also emphasized that experiencing a significant loss can threaten one's assumptive world. Janoff-Bulman [19] further expanded upon the assumptive world construct, stating that schema regarding how the world should work are established in very early life experiences prior to when language develops. These early life experiences are then generalized and applied throughout the person's life. This suggests that the attachment system and the assumptive world construct are formed from similar mechanisms and most likely are intertwined with each other. The assumptive world is informed and cultivated along with the attachment system, and assumptions about the world form a core aspect of how individuals live their lives, form relationships, and perceive life events.

Harris [6, 20] described the assumptive world more broadly, with the main components that comprise one's assumptions about the world being centered upon:

1) How one finds safety in the world (which includes attachment figures and the resulting experience of *safeness*, and acts of self-preservation, which are related to a sense of safety)
2) How the world should work (focusing on perceptions of justice, fairness, cause/effect, and locus of control)
3) How one views the self (including roles, self-image, placement in various social networks, and

mirroring by significant others) (See Figure 1).

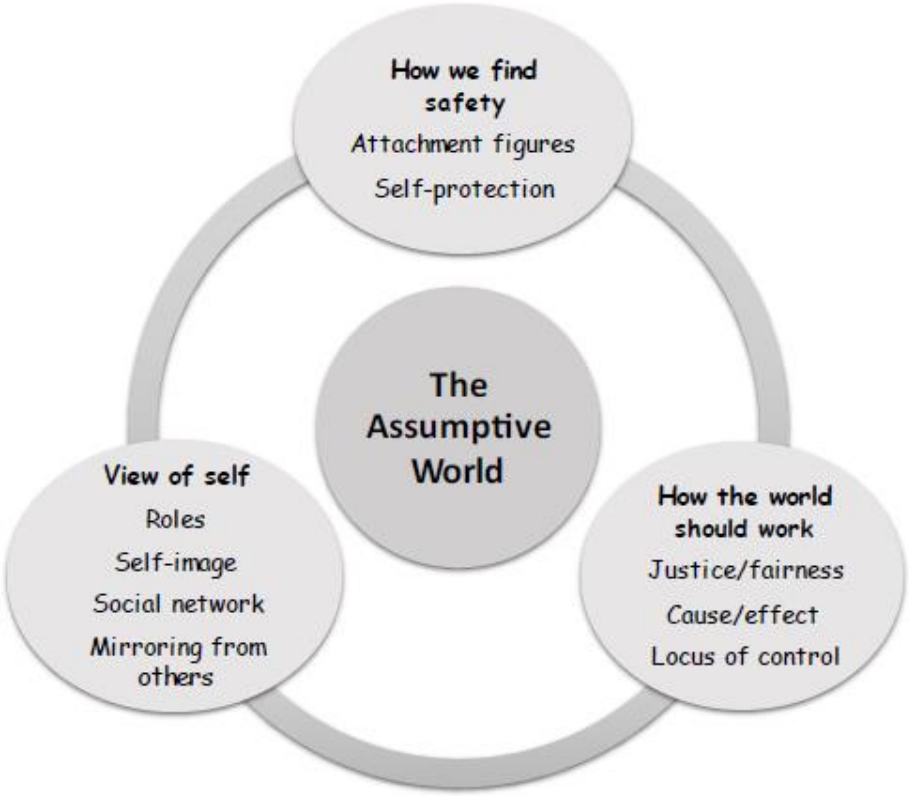

Figure 1 The Assumptive World.

Harris [6] further stated that experiences which shatter one or all these assumptions trigger grief; thus, *grief is the response to the loss or shattering of the assumptive world, along with the loss of the predictability and coherence that it provided*.

2.2 Meaning Making

A core process in grief is the need to find meaning in what has happened. Significant losses undermine the core beliefs that make up the assumptive world, and these events threaten the entire foundational system that has provided a sense of safety and coherence in life. The assumptions that have given meaning to life in the past may suddenly seem irrelevant and naïve. The crushing realization of how little control there is over what happens to the people, places, and things that form the core of the self is a stark contrast to the sense of predictability and meaning that was established through the formed assumptive world. There is no going back; the way the world made sense before no longer matters and is no longer relevant. Questions about identity, values, existential beliefs, relationships, and hopes for the future crowd out other aspects of daily life [21].

Neimeyer et al. [17] discuss grief occurring after events that "disrupt the significance of the coherence of one's life narrative," (p.30) and the potential for erosion of the individual's life story and sense of self that may occur. The process is often incredibly intense emotionally, adding to feelings of being out of control and the inability to make sense of what has happened. An overwhelming sense of loss and disorientation occurs as attempts are made to try to navigate in a

new, unfamiliar reality. Yearning for things to be the way they once were, or for a deceased individual to return is a common response, representing resistance to the gaping void that is left in the wake of what (or who) is no longer accessible. In essence, we grieve the loss of our assumptive world, and our grief (although painful and disorienting) provides us with the process that will eventually allow for the re-building of a new assumptive world that integrates the lived experience of what has happened [6].

2.3 Grief as An Adaptive Process

A central concept is that grief is a process that is typically both adaptive and necessary in order to rebuild the assumptive world after its destruction [6]. This understanding implies that loss of the assumptive world can occur from events that do not necessarily involve the death of someone. Not only can losses be death or non-death in orientation; they may also be tangible, intangible, or a combination of both. Sometimes, what dies may be more internal to the individual, such as the loss of hopes, dreams, identity, or beliefs [22]. In whatever way the rebuilding process occurs after a significant loss, the revised assumptive world opens the path to find meaning within these experiences, and in so doing, a restored sense of predictability and coherence develops.

Rather than being a symptom of a disorder, the grief that accompanies the shattered assumptive world is a multifaceted attempt to adapt to the disequilibrium, disorganization, and existential pain that can occur after a significant loss. Thus, instead of attempting to inhibit or suppress grief, it is important that grief be allowed to unfold so that the assumptive world can be rebuilt in a way that somehow makes sense of what has happened [10]. This understanding represents the primary difference between grief therapy versus work with clients who present with clinical issues, such as depression, anxiety disorders, or other forms of mental distress.

2.4 Social Expectations, Shame, and Grief

Another important topic to consider is the fact that grief does not occur in a vacuum. Social expectations and messages are readily directed toward grieving individuals by their friends, families, workplaces, and the underlying social norms. These messages are embedded in implicit rules about grief; for example, whether the loss is considered to be valid or significant, how the individual should or should not express their grief, how long grief should last, and many more messages that further complicate the grieving process by either sanctioning it or disenfranchising it [10, 23]. Many of the "rules" about grief include social pressure to get on with life again as quickly as possible, expectations to remain functional and productive amid a life-shattering loss, and social rewards given for those who remain emotionally stoic (often referred to as being "strong"). These rules have much more to do with a society that is steeped in capitalistic values that encourage productivity at all costs rather than acknowledging the human need to take time to grieve significant losses [23, 24]. Grieving individuals often feel shame when their grief does not conform to these norms, leading them to suppress or deny the grief that they are actually feeling and experiencing [23, 24].

2.5 The 'New Grief'

Recent trends in most industrialized countries have shown that people are generally living longer; however, the price of living longer is that people now live longer with more chronic medical

conditions. The frailty trajectory (sometimes referred to as 'the dwindling') is becoming increasingly common [25]. Families often lose older loved ones a piece at a time, over a long and arduous period of decreasing functionality, increased needs for care, and longer times of dependency. Grief often begins a long time before someone dies. Family members and professionals can become exhausted and feel like they are failing the individual as they traverse this trajectory of increasing frailty and decreased functionality. Okun and Nowinski [26] refer to this as the 'new grief' that has now become commonplace. In the past, people died from maladies that can now be prevented or stabilized due to good public health measures, enhanced medical technology, newer pharmaceuticals, and interventions that were unheard of even a generation ago. This trend has created a common scenario where those who offer care and support to an older loved one see less and less of the 'person' that they have known while there is a need to increase involvement and care of bodily functions and often, the need to adjust to the individual's cognitive decline as well [27]. The grief that starts before the person dies is significant and painful—and often completely unacknowledged because there is no physical death. Family members will often say that the person they knew as their loved one died a long time before the death of their body. Thus, grief can be viewed as a process that begins upon the start of decline and may continue in an exhausting and chronic way death occurs, when the physical loss of the person coincides with the psychological loss that occurred prior to death.

2.6 Summary About Grief

In summary, grief is a highly variable, but typically adaptive response to significant losses. These losses may be death or non-death in origin, and their impact and intensity are subjectively appraised by the individual who experiences them. The clinical issues that arise most commonly in grief therapy are the problematic medicalization and expectation of grief to be something to "treat" rather than to facilitate, the need for grieving individuals to be supported in their grief rather than rewarded for suppressing their grief, the need to make meaning and restore a sense of coherence in life after a significant loss, and social messaging that tends to create unrealistic expectations and shame for those whose grief falls outside of socially implicit norms. In addition, the enhanced use of medical intervention has allowed for increasing longevity for many, but at the cost of increased needs for care and often the loss of the individual person before their body dies. These are the primary areas where compassion-based approaches, and more specifically, Compassion Focused Therapy, may be beneficial as a modality.

3. Compassion Focused Therapy and Grief

It can be argued that compassion is a uniquely human experience that developed as the need for cooperation and kinship became paramount to survival [28]. Likewise, the formation of the attachment system and the bonds that developed as part of that system ensured the survival of humans. This system also influenced the response of humans when these kinship relationships ended though death. Thus, it could be said that the experience of grief has evolved with the human species. Compassion training can have a powerful impact upon grief therapy [29]. Many of the stories that are shared by grieving clients involve terrible situations of despair and pain, with intense feelings that are difficult for the client to process and for others to hear without being profoundly affected. Grieving individuals are accustomed to others being unable to tolerate their pain and

distress; many will blunt their emotions or suppress their grief because they see how difficult it is for others around them to engage with them [20, 24]. Most people who have experienced a significant loss are very familiar with admonitions by well-meaning others to help them suppress or deny their grief, usually through dismissive comments, distraction, or avoidance.

Clinicians who support grieving individuals must be able to mindfully embrace their clients' experiences and feelings, remaining fully present to the distress without jumping in with a "fix it" mentality, and be able to discern how to best journey alongside their clients in a way that allows the healthy facilitation of grief. Compassion training is uniquely suited to afford the grief therapist with the skills to effectively support clients who experience deep grief and pain. In this section, we will explore specific applications of Compassion-Focused Therapy to the support of grieving individuals.

3.1 Compassion Training for the Clinician

The motivation to relieve suffering is foundational to compassion. However, this motivation alone is not sustainable without the acquisition of the wisdom and skills necessary to support the enactment of compassion [30]. Compassionate action is composed of many elements that can result from specific types of training that encourage specific types of knowledge, skills, and competencies [2]. This training can take the form of focused work on a specific component, such as engaging in a mindfulness meditation program to enhance focus and develop the ability to regulate emotion [31]. Core components of compassion include mindful awareness, the ability to be fully present, and an awareness of the shared experience of common humanity. Engaging with each of these components is helpful for the clinician, who can, in turn, utilize practices related to each area with clients.

Of interest is that compassion is often confused with empathy, kindness, and sympathy. The main difference between compassion and these prosocial behaviors rests upon the focus on intention and motivation. Similar to empathy, compassion includes attunement and understanding of another's feeling state, but empathy does not necessarily involve a motivation to relieve pain or distress. Likewise, kindness and sympathy are also viewed as prosocial predispositions, but there is no expectation that being kind or sympathetic includes the intention of directly addressing the source of the suffering in order to alleviate the accompanying distress [7, 32]. Thus, the intention to transform suffering is one of the main features that distinguishes compassion from other prosocial inclinations [7]. C*ompassion fatigue* is an inaccurate description of what would more accurately be described as empathic overload or empathic distress fatigue. Neuroimaging studies with fMRI support the distinction between these experiences, with empathic overload typically showing up in the pain centers of the brain, while compassionate intention and responses observed in the reward centers of the brain [33, 34]. This type of overwhelm is more typically found in clinicians who are very empathetic but who do not have the foundational understandings that would emerge from training to foster discernment, insight, and dual awareness[2], which are developed through compassion training.

3.2 Emotion Regulation

In addition to providing a compassionate base from which to engage grieving individuals, CFT can

[2] Dual awareness refers to the ability to be fully engaged with the description or memory of something painful or disorienting that has occurred in the past while being firmly grounded in the present moment to prevent emotional overwhelm or overidentification with the distressing situation that is being recalled.

assist to enable better regulation of emotion for individuals. In addition, CFT may foster the ability to be open to receive compassion from others, which opens the door for the healing and support that may be offered by others during this time. There is a growing body of research that describes how training in compassion may have a corresponding physiological impact; more specifically, a positive effect upon the autonomic nervous system. For example, upon exposure to distressing situations, the heart rate typically increases. However, heart rate has been shown to slow down when compassion-based practices are implemented in these same situations [35]. This suggests that there may be an associated response between compassion and the parasympathetic nervous system. Other studies have explored the effects of compassion training on heart rate variability (HRV), where the use of compassion-based exercises has resulted in greater HRV. High HRV (relative to baseline) accompanies the activation of the parasympathetic (rest, soothe, and digest) nervous system [35].

A foundational tenet of CFT is that our brains have evolved in ways to support social connection, and our ability to regulate emotions is tied into social roles, which includes things such as social status, feeling a sense of belonging and affiliation, as well as the ability to cooperate and care about others [7]. Each component of the motivational system is directly tied into specific emotion states. The three dominant motives are identified as protection and harm avoidance (threat system), seeking resources and necessities for life (drive system), and the need for rest, digest, and repair (soothe system). None of these systems are more important than the other; they are meant to be in balance with each other, with each one serving important functions that are necessary for navigating everyday life and overall survival. The pictorial representation of these systems is often referred to as the 'Three Circles' model [28, 36]. The figure displayed here (see Figure 2) has adjusted the three circles to include processes associated with grief and how they might be mapped onto this model.

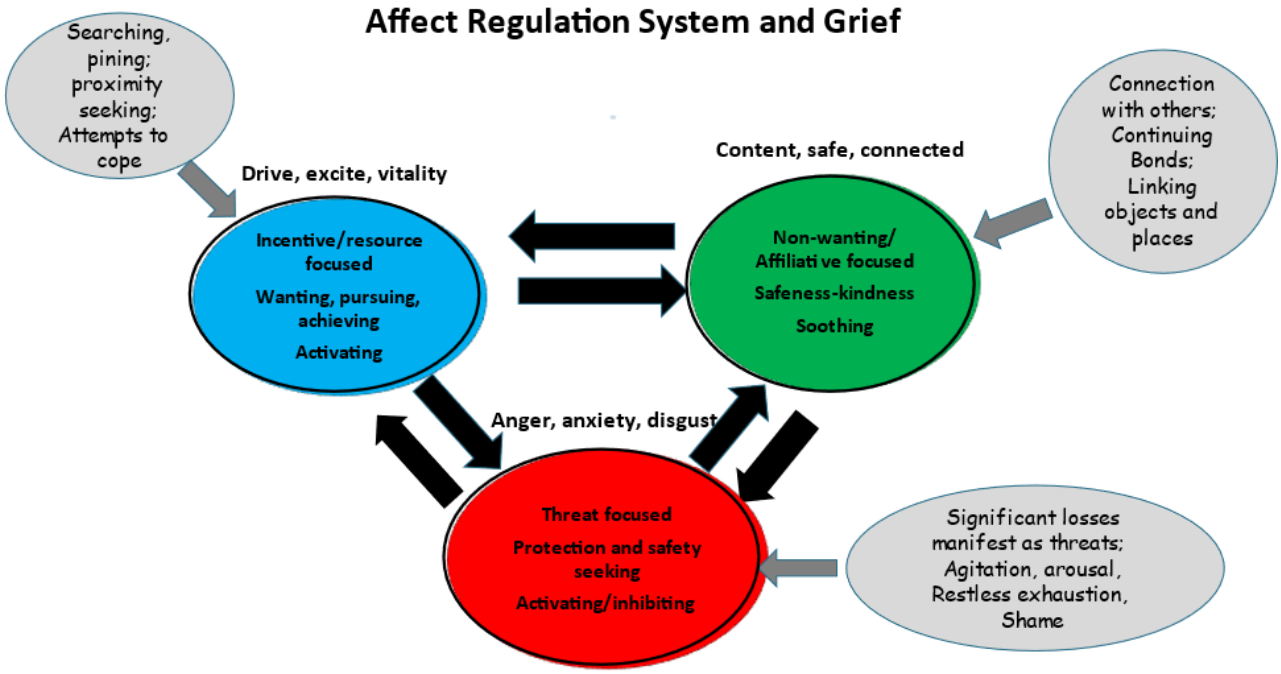

Figure 2 The Three Functions of Emotion in CFT Applied to Grief (Adapted from Gilbert, 2022) [36].

The threat system functions to protect us from harm. It may warn of impending danger or threat; common feelings that arise when this system is activated may be anger, anxiety, and disgust. This system is associated with fight/flight responses, but it might also involve responding with freezing (paralysis) and deactivation, which are associated with defeat, helplessness, and despair [7]. Over a longer period of time, the threat system can impede the ability to be open to possible avenues for healing by interfering with our ability to share pain and receive support from others. As stated earlier, significant losses threaten the assumptive world, highlighting a sense of vulnerability, which then can activate the threat system. The grieving process itself may also feel threatening, especially if it is accompanied by overwhelming emotions. In addition, individuals who are shamed for their grief because it violates implicit social rules may experience further activation of their threat system, as feeling judged, rejected, and/or left out of a desired social group could increase a sense of isolation and danger [24]. Other threats to our safety and security may also activate this system, such as threats to financial stability, health, and the ability to engage with supportive relationships, which are all common in non-death loss experiences.

The drive system ensures that we have the necessities of life and our well-being. This system is activated when there may be concerns about lacking something that is perceived to be essential or necessary [7]. This system engages energizing emotions and those linked to rewards, such as pleasure, excitement, and joy. The drive system may be present in grief through the common attachment-oriented behaviors of (often unconsciously) searching for the lost loved one in places where they have previously been found or being drawn to linking objects and reminders of the loved one. These types of behaviors are also commonly present in non-death losses. For example, an individual who has left their homeland may crave and seek out familiar foods or cultural symbols that are associated with their home country. It could also be argued that the drive system may fuel attempts to cope with grief, as well as some compulsive tendencies, including engagement with addictive behaviors in order to fill a void, provide a sense of reward, or to balance out a threat system that is creating chaos and intensity that can feel intolerable to the grieving individual. Indeed, some researchers have identified a particularly problematic form of grieving (Complicated Grief/Prolonged Grief Disorder) as a form of repetitive engagement in rewarding seeking behavior [37, 38]. This possibility has interesting implications when considered in the context of the drive system.

The soothing/affiliative system is sometimes referred to as the “rest and digest” system, and it is tied into the parasympathetic nervous system. This system was adapted through attachment that enabled the parent to have a calming and supportive relationship with the infant, which serves as the template for soothing and settling later in life. When this system is engaged, there is an opportunity to rest, reflect, and for restoration to occur [39]. The soothing system is considered to be the natural regulator of the threat and drive systems, providing relief from the intensely active states that these two systems may induce [39]. Engaging the soothing system provides the ability to connect with others and to reflect within ourselves. Engaging this system in grief can offer a much-needed reprieve from the threat and drive system activation that can occur alongside a significant loss. The clinician can act as a catalyst to the soothing system, functioning as a secure base that creates a place for social connection that feels safe, and for healing the wound that has been created by loss. In addition, just as grief often presents as a wound to the attachment system, the soothing system creates a space where there may be more openness to social connection and the support being offered by others [29]. For many grieving clients, learning how to access the soothing system

is a key part of therapy in CFT. In summary, each of the motivational systems has an important purpose, evolving over time to increase chances for survival. However, it is important to remember the need for balance between these systems in grief, especially when the threat and drive systems create exhaustion and inhibit the ability to receive necessary support from others.

3.3 Addressing Shame in Grief

Two key issues arise related to shame and grief. The first pertains to the social rules and expectations that are experienced by grieving individuals, as discussed earlier. These rules may apply to aspects of the loss itself that are disenfranchised, such as the death of a lover who is married, or they may relate to the unspoken but readily identified 'shoulds' about grief, such as how bereaved individuals are expected to grieve, or if their grief is falling within expected social and cultural norms [40]. Bereaved individuals experience many social pressures to conform to social grieving rules, even when adherence to these rules could prolong their personal suffering after a loss [20, 24]. Individuals who stray from accepted norms of behavior are often shamed by their social group for somehow not measuring up to the expectations of what their grief should look like [20, 41]. The second aspect of shame in grief relates to an internalized sense of self-deprecation, feelings of unworthiness to grieve, or that something is basically wrong with you because of your loss and/or your grief. Shame creates a need to withdraw, making it difficult to connect with others in a meaningful way at a crucial time when support is most needed [24, 42].

Recent research in self-compassion has explored the relationship between internalized negative messages about the self and grief. Vara and Thimm [5] discussed the link between low self-compassion and complicated grief symptoms. Their study found that stronger self-criticism and negative appraisals of self were related to more severe and debilitating grief reactions after loss. The conclusion was that low self-compassion is a potential variable that can lead to the development of complicated grief. In a study of ambiguous loss with families of long-term missing persons, Lenferink et al. [4] found associations between self-compassion and the degree of emotional distress that was present in these families. Participants with higher self-compassion scores demonstrated lower degrees of emotional distress than those with lower self-compassion. In a study of pet loss by Bussolari et al. [43], participants who were more self-compassionate reported less intense grief, fewer negative social interactions, higher psychosocial functioning, and were more able to create a comforting continuing bond that sustained them in their grief. These studies were based mostly upon self-compassion as it is described by Neff and not necessarily in line with how CFT describes the same concept. They are also mainly cross-sectional in their methodology; there are inferences about the relationship between self-compassion and self-criticism that are implied in their findings. It is of interest that in these studies of grieving individuals, attention is paid to the distress that was associated with the loss itself as well as the internal process of the grieving individual in relation to their view of themselves.

The clinician also models a compassionate approach to the client's process, re-framing messages of shame and self-disenfranchisement in ways that position grief within the broader context of the human experience. The messaging in the re-frame acknowledges the pain associated with significant losses and recognizes that the difficulties associated with the grief are understandable and appropriate in the situation. In short, the therapist is re-framing by pointing out what is 'right' (e.g., the grief response) in the midst of what is 'wrong' (e.g., feeling weak or having difficulties

functioning). Re-framing is not a simple exercise to try to get the client to think more "positively." Doing this simply reinforces the social messaging for grieving individuals to suppress their negative feelings. Rather, in the context of the therapeutic relationship, there is a gentle challenging of the ways that negative social messaging about grief, vulnerability, and emotions are typically viewed to allow the client space to understand their grief and be able to be fully present to it as it arises. Examples of this reframing may be found in Table 1.

Table 1 Compassionate Re-framing in Grief.

Client's Statement	Clinician's Compassionate Reframe
What is wrong with me?	Maybe let's focus on what is right about you in this situation.
I feel so weak and pathetic.	Grief makes us feel vulnerable, but that doesn't mean we are weak.
People around me are so disappointed that I'm not better yet.	It's hard for others to understand your grief, especially if they haven't experienced a profound loss themselves.
I can't think clearly; What happens if I'm like this forever?	Right now, it is important to listen to yourself and what you need. Grief takes a lot of attention and energy as you experience it.

3.4 Compassionate Imagery with Grief

CFT utilizes guided imagery to assist clients to help regulate emotion by offering a way to engage with the soothing system during a very painful or overwhelming experience, thus enhancing the client's ability to tolerate distress. This imagery can involve visualizing compassionate qualities and experiences across the three flows of compassion, and cultivating a compassionate motivation [44, 45]. Such imagery is thought to activate the soothing- affiliative system via the parasympathetic nervous system, as evidenced by increased heart rate variability and reduced cortisol levels [46]. The use of imagery has recently been further supported from a neurobiological basis with the use of functional magnetic resonance imaging [47] and other forms of physiological measures [48]. This research has clearly shown that the use of imagery activates many of the sensory/perceptual areas of the brain in ways that are similar to the directly experiencing these events. Indeed, these findings make sense from an experiential perspective; consider how we respond to having a very vivid bad dream. Our heart rate increases. We feel the anxiety, dread, and fear as if we were in the situation physically. Engaging this same mechanism, we can use specific forms of positive imagery to enhance access to our soothing system, activating a parasympathetic response of rest and downregulation rather than the sympathetic response of upregulation and vigilance [29, 48]. As stated earlier, significant loss experiences often activate the threat system, alerting us to potential danger after the death of a loved one, or the loss of something in our lives that holds significance for us. We can use different forms of imagery to help regulate the threat-based emotions that can accompany grief in these scenarios.

Compassion focused imagery may also be used to cultivate a connection with the shamed self or the grieving self, offering the ability to directly engage with these wounded parts of the self with kindness and wisdom [45]. Almost all imagery starts with awareness of and grounding in the body

through the breath, usually through an exercise such as soothing rhythm breathing.[3] Once there is familiarity with soothing rhythm breathing or another way to provide this sense of grounding, imagery exercises can be introduced. Common forms of imagery might include envisioning a safe place, imagining the compassionate self or a compassionate other, or enhancing ways to direct compassion to the self. These imagery exercises can readily be adapted to loss and grief.

3.4.1 Safe Place Imagery Exercise

In this exercise, the client is asked to bring to mind a place where they feel comforted, or where they have a sense of peace or grounding. During this exercise, it is important that the client not feel rushed, and that there is a sense of the therapist "walking alongside" by asking the client to describe what they see, hear, and sense in the imagined space. The client may be invited to engage with the imagery through descriptions of what they are imagining, engaging with their senses in the imaginal environment (what they see, hear, feel, touch, and even smell). Caution is advised if the therapist is considering inviting the deceased loved one to enter this guided imagery, as doing so may completely change the soothing-oriented dynamic that has been established. However, the client may choose to spontaneously include the deceased loved one in the scenario, and if so, the therapist should follow the client's lead.

3.4.2 Envisioning a Compassionate Being

In this exercise, the client may be asked to bring to mind someone or something that signifies compassion to them. The therapist then asks the client to identify the compassionate attributes that are present in this image, and how these compassionate ways of being might relate to them in this present moment. Many clients struggle with envisioning themselves as compassionate. They may also not have many experiences of others being compassionate towards them, so this imagery exercise may be difficult. Thus, it is important to take time to let the client find some form of compassionate representation that feels real and comforting to them. Many clients have pets that embody this sense of presence in their lives. In these instances, asking the client to imagine holding their pet, feeling the engaged response of their pet (such as purring against their chest or face, or burying their face in the animal's fur) may be helpful. As in the previous exercise, it might not be the best idea to have the client bring to mind the loved one who has died in this exercise, as there may be elements of grief that can hijack the soothing aspects of the imagining process.

3.4.3 Flows of Compassion

Another imagery exercise involves recalling a scenario with a loved one or someone close to them that might be hard for them, or that has created some angst. In this exercise, clients may choose to envision their deceased loved one, or a part of themselves that they have lost. Recalling that most grieving individuals form a continuing bond with their deceased loved ones, this bond can be used to address unfinished business or to address things in the relationship that need to be repaired. After the client settles into the scenario, the therapist gently guides the client to direct compassion for self, wishing themselves to be well, at peace, settled, and feeling loved. Once this is well established,

[3] An example of a soothing rhythm breathing script can be found at https://balancedminds.com/soothing-breathing-rhythm-1-script/

the therapist can then suggest that the client extend their circle of compassion to that individual, or to walk alongside that individual for a few moments. The client may be asked to consider what this individual needed, or how this individual was wounded. In the exercise, the client can be asked about what a truly compassionate being would offer to this individual, always followed by what a compassionate being would also offer to them as they share the imaginal space with this person. Note that expanding compassionate intention in this way is a very different process from forgiveness or not holding someone accountable for behavior that has caused harm. This particular form of imagery is best when other imagery exercises have been completed and the client reports finding them helpful.

3.5 Chronic Sorrow and Compassion

As mentioned earlier, with increasing life spans and advancing medical technology that extends life, often at the price of decreased functionality and increased care needs, grief often takes on a more chronic state that can continue alongside someone who is still alive for many years. This 'new grief' [26] is more aptly described as *chronic sorrow*, where the loss itself and the accompanying grief may coexist for years without a foreseeable end. This form of grief is more often manifest as anxiety and exhaustion rather than sadness. However, chronic sorrow is not only present in the frailty trajectory; it can be present in any situation of loss that requires ongoing accommodation and adjustment. For example, chronic pain, infertility and involuntary childlessness, degenerative conditions, and mental health conditions that repeatedly cycle through relapse and improvement may all lead to the grief that is chronic sorrow [6, 49]. The anxiety is a result of the ongoing uncertainty about what may (or may not) happen next, as well as the exhaustion (emotional, physical, and often financial) that accompany an intense experience that is drawn out over a long period of time.

The chronic grief that accompanies these experiences is certainly exhausting for the those affected by the loss; in addition, it can be very difficult for the individual's support system to tolerate the intensity and chronic grief over a long period of time. Thus, it is common for those experiencing nondeath losses to become isolated, as friends and family members tire of not seeing "progress" in the person's grief, or the loss is not one that they can see, comprehend, or even acknowledge. With the strong focus placed on diagnosis, intervention, and short-term, solution-oriented therapies (often driven by funding models for reimbursement of services), there is very little emphasis placed upon the essential act of being fully present to someone, bearing witness to another's experience and struggles, and of holding the intention to make a difference, even in the absence of being able to make things better or demonstrate a positive, measurable outcome [50].

In situations of chronic sorrow, it is important to be clear with expectations and to remain focused on compassion as an intention and motivation rather than setting specific endpoint goals to be achieved. In this context, intention is the underlying motivation for the therapeutic work. The intention and motivation to relieve suffering must be tempered with the reality that not all suffering can be relieved [49, 51]. For clinicians who have engaged in compassion training, this form of discernment is a key aspect of the training. The focus on intention relieves the expectation of a specific outcome. For example, if you were working with someone with a health condition that causes ongoing, chronic physical pain, it would be easy to try different ways to address the pain and to look for relief of the pain as your goal. But what if all the interventions that were tried to relieve

the pain were ineffective and the pain continues unremittingly? Most likely, the person who is struggling with the chronic pain has also endured being shuffled from one care provider to another, looking for relief. If the treatment goal is focused only on relieving the pain, then not being able to take away the pain is seen as failure, and the therapeutic relationship becomes centered around the clinician's sense of shame and avoidance.

Through compassion training, the clinician can adjust to a more realistic goal of accompanying the person who is in pain, without feeling the need to turn away or interpret what is happening as a personal failure. Whether or not there is lessening of the pain in response to interventions, the clinician is able to remain present to this individual's experience, without adding to the sense of isolation, shame, and failure that have probably become frequent companions to this hurting individual. It is these complicating factors to situations of chronic sorrow that create a great deal of the suffering, and these sources of suffering are readily amenable to compassionate presence and responding. Thinking, "I may not be able to take this pain away from this person, but I can ensure that they will not have to go through this pain alone" may help to reframe some of the expectations around the role of the clinician in similar contexts [52].

In a study of interventions in patients with chronic pain [53], one group of participants was assigned to a CFT oriented group intervention over a period of eight weeks. While the other groups that were assigned to other forms of support did not show any significant change related to the intervention to which they were assigned, most participants from the CFT group reported changes in how they viewed their situation, with greater freedom to make choices that could better accommodate their current needs. What is interesting to note in this study is that the participants in the CFT group reported overall improvement in their well-being, even while their reported pain levels did not change. If the only outcome being measured was level of pain, the study would have missed the actual perceived benefit of the CFT intervention. Similarly, a study by Maratos and Sheffield [54] investigated the impact of Compassion-Focused Imagery on coping with chronic pain. This study found that the use of CFI changed the degree of associated stress in coping with pain, providing participants with relief from the anxiety and vigilance associated with pain, even while the actual reported levels of pain did not change.

What is important to remember is that we cannot remove many of the causes of suffering that occur because of significant change and loss that can upend a person's world. Compassion must include insight and discernment, recognizing that while there is a desire to relieve suffering, it is impossible to relieve all the suffering that crosses our path. Far from being a passive process or a "soft and fluffy" superficial niceness, true compassion requires us to actively and courageously "be with" another individual when others may leave or get frustrated because they cannot "fix" things or make them "better" [49]. Compassion requires a great deal of inner strength and awareness, and it takes time and practice to cultivate the ability to remain grounded, focused, and fully present in such an engaged and open way, especially in the face of suffering that is not amenable to relief [51].

Clinicians cannot change the past, reverse a diagnosis, or restore what is permanently lost in the lives of their clients. By focusing on our presence and intention to accompany grieving clients through nonfinite losses and the chronic sorrow that defies conventional expectations of cure or resolution, it is possible to open opportunities for healing that are not contingent upon a specific outcome [49]. The chronic sorrow associated with losses that are ongoing in nature is often misunderstood and can be debilitating to experience. Supporting an individual over the long haul through chronic sorrow can be exhausting for those who care for and about that person. It is the

clinician's compassionate intention and presence that creates the foundation that will provide sustainability when working with people whose painful loss experiences may permeate the rest of their lives. To be a support for the long haul, it is important to have the wisdom to recognize what is and is not possible and be able to separate the desire to relieve suffering from any expectations or outcomes that may never happen. Because situations that lead to chronic sorrow have no real resolution or sense of closure, the grief can persist for an indeterminate amount of time [49, 50]. Taking a compassionate stance at the outset frees clients from potentially harmful expectations about their process, allowing them to engage in therapeutic work that will ultimately support their innate strengths and integration of the loss in their lives.

4. Conclusion

Compassion Focused Therapy offers specific, helpful ways to approach grieving individuals. The understanding of the physiological, psychological, and social response to significant losses forms the underpinning of compassionate support of individuals as they navigate their painful grief journey. The focus on emotion regulation, the experiential work of compassion-based practices, and the cultivation of wisdom and discernment regarding the nature of suffering provide a uniquely oriented way to journey alongside those who grieve losses of all types. Compassion is a choice that requires courage to turn toward the suffering rather than away from it. Discerning a response that is compassionate requires wisdom that is cultivated by reinforcement through everyday practice of navigating through complexities with mindful awareness and intentioned presence, both of which are fostered by compassion training. Compassion training enables the clinician to be grounded in their intention and motivation to relieve suffering.

Working from a compassionate stance in grief is not about doing as much as it is about intention and motivation. It is not possible to bring back a loved one who has died. Relationships that dissolve cannot be readily renewed. It is impossible to reverse a diagnosis that completely upends the life trajectories of those in our care. Supporting grieving individuals is not about fixing or finding solutions; rather, it is about journeying alongside people who are in considerable pain, relating to them, and helping them to relate to their pain in a way that still allows for potential healing. Compassion acknowledges the presence of suffering and the desire to relieve that suffering in whatever ways are possible. Grief reminds us that some wounds must be carefully tended, with a shared sense of presence amid tremendous pain. Both grief and compassion point toward healing and wholeness; the key is understanding that neither is about fixing or arriving at a specific endpoint.

Author Contributions

The author did all the research work of this study.

Competing Interests

The author declares no competing interest with this work.

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