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Case Report

Compassion Focused Therapy for an Older Adult with Complex Emotional Needs: A Case Study and Considerations for Practice

Melissa Stock [1, 2], Catriona Craig [2, *]

1. Oxford Institute of Clinical Psychology Training and Research, Medical Sciences Division, University of Oxford, Oxford, UK; E-Mail: Melissa.Stock@hmc.ox.ac.uk
2. Buckinghamshire Older People's Psychological Services, Oxford Health NHS Foundation Trust, Saffron House, High Wycombe, UK; E-Mail: Catriona.Craig@oxfordhealth.nhs.uk

* **Correspondence:** Catriona Craig; E-Mail: Catriona.craig@oxfordhealth.nhs.uk

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Abstract

'Personality disorders' (referred to as complex emotional needs in this report) are common in older adults. Yet they are often under-recognised which impacts access to appropriate care pathways. Once in services, older adults lack the same access to specialist mental health care as adults, and the evidence base in older adults with complex emotional needs is sparse. Compassion Focused Therapy (CFT) is an approach that has shown promise for those with complex emotional needs. This case report presents a 12-session CFT intervention, delivered to an older adult female with complex emotional needs, in an NHS mental health setting. Post-intervention, small improvements in self-compassion were found. However, there were no reliable changes in anxiety or mood, and functioning declined. CFT has the potential to be an effective intervention for treating complex emotional needs in older adults, but further research is needed to build on the preliminary findings observed in this report.

Keywords

Compassion focused therapy; complex emotional needs; older adults; self-compassion

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1. Introduction

The National Health Service (NHS) Long-Term Plan and The Community Mental Health Framework (CMHF) [1, 2] outlines a commitment to developing trauma-informed care for individuals with severe mental health problems. 'Personality disorders' are classified as severe mental health problems and are an area of focus within the CMHF. There are 10 distinct subtypes of a 'personality disorder'. Individuals with a 'personality disorder' are associated as having difficulties relating to self and others, leading to impairments in functioning [3]. Over the years, the term 'personality disorder' has raised questions and debates within the field and can be seen as a stigmatizing label by many clinicians, service users, and carers [4, 5]. Both research and clinical experience from service users, carers, and clinicians report associated harm as a result of the term 'personality disorder', including stigmatization and exclusion from services [6, 7]. Holding such experiences in mind, this report uses the working term 'complex emotional needs' to refer to individuals who are likely to be diagnosed with a 'personality disorder' or have similar needs, and experience higher rates of mortality and co-morbidity [8, 9]. However, 'personality disorder' may at points be referenced in this report as data is still collated using this term. Coined through consultation and collaboration with service users [8] the term complex emotional needs is more frequently used in research, with NHS services beginning to rename 'personality disorder' pathways to complex emotional needs services. Despite this report identifying more recent research with complex emotional needs, previous research using the term 'personality disorder' may too be useful to review.

Individuals with complex emotional needs experience long-term difficulties in ability to function emotionally, and in their relationships [6, 10]. In adults, clinical presentations include impulsive behaviors, low mood, instability of interpersonal relationships, and suicidal ideation [11], but presentations can vary markedly in older adults [10]. It is estimated complex emotional needs occurs in 10.6-14.5% of older adults [12] yet is rarely recognized in this population [13]. While this might reduce related stigma, it raises the issue of unacknowledged needs or the appropriate pathway of care [13]. Childhood neglect, abuse, and/or adversity are risk factors for complex emotional needs [14], with patterns of behavior normally beginning in early adulthood [15]. However, in some older adults, complex emotional needs can develop later in life [6]. For these individuals they may be supported emotionally, and relationally, throughout their lives by established support systems, up until difficulties, commonly seen in older adults, including bereavement, retirement, or poor physical health, unsettle support systems enough for the distress to necessitate support [6]. Complex emotional needs have substantial impacts on public health and individual well-being, including the extensive use of healthcare resources, higher suicide rates, and decreased life expectancy [16]. Despite 44% of completed suicides being older adults with complex emotional needs [6], individuals are not receiving evidence-based and consistent care as defined by the National Institute for Health and Care Excellence (NICE) guidelines [17] or have equal access to dedicated services [16]. This is despite a diagnosis of 'personality disorder' no longer being an exclusion criterion for mental health services [18]. Furthermore, older adults do not have the same access to specialist mental health care as working-age adults [19]. One explanation for this is age discrimination. Negative beliefs and attitudes towards older adults are becoming increasingly

prevalent [20]. Such attitudes influence commissioning and service-related decisions, leading to diminished psychological well-being and poorer physical health outcomes in older adults [19]. It is therefore vital, when older adults do access support, they receive appropriate treatment.

NICE recommend individuals with severe mental health problems have access to evidence-based psychological therapies [21]. Due to complexity, clinicians should consider the presentation, and needs of the individual, to provide a flexible approach [22]. NICE guidelines for complex emotional needs (termed 'borderline personality disorder' in guidelines) are outdated and need reviewing [11]. However, NHS England [21] recommend several therapies including Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and Mentalization Based Therapy (MBT). There is also no evidence to suggest such psychological interventions are unsuitable for older adults [6].

Despite the prevalence of mental health difficulties older adults are frequently excluded in many areas of healthcare research and there are limited funding opportunities in this population [23]. Therefore, when it comes to reviewing literature in older adults, the evidence is scarce, and researchers resort to evaluating working-age adult outcomes. Several reviews have investigated the effectiveness of psychological interventions for individuals with complex emotional needs, yielding mixed results. One review found schema therapy, MBT, and DBT were all associated with large effect sizes in complex emotional needs presentations, across treatment settings [24]. Whereas, in community settings, aside from one review finding DBT most effective [25], results across interventions were similar, with no specific psychological interventions for complex emotional needs recommended [26, 27]. Whilst there is evidence individuals with complex emotional needs can be supported by psychological interventions, the evidence-base is poor and requires further development to ensure care is effective [6].

Over the years, advances in neurobiology have challenged the more traditional talking therapies, and other forms of psychological therapy have become popular among researchers and practitioners. Founded by Paul Gilbert [28] Compassion Focused Therapy (CFT) is an evolution-informed biopsychosocial model and treatment, developed for individuals struggling to generate kind, and compassionate inner voices, aiming to encourage development of compassion towards themselves, and others [29]. Whilst the definition of compassion is still out for debate, Gilbert [30-32] sees compassion as functionally different from kindness, sympathy, and empathy. Rather compassion is a *motive*, developed from early childhood experiences, with having the *courage* and *wisdom* to alleviate and prevent suffering at the core of compassion. Gilbert [29], describes compassion in three flows: giving compassion to others, receiving compassion from others, and having compassion for oneself.

Derived from Gilbert's model of affect regulation [33, 34], CFT draws on evolution, attachment theory, and neuroscience. Central to CFT, Gilbert proposes three main evolved functions of emotions: (1) the threat system alerts individuals to perceived and/or actual internal/external threats and activates defensive strategies; (2) the drive system alerts people to opportunities for pursuing goals and resources and linked with experiences of pleasure when goals are achieved; and (3) the soothing system provides information on safeness, and links with feelings of being calm, peaceful, and content [29]. It is when these systems become dysregulated difficulties in emotions and behaviors can occur [35]. In individuals who have experienced trauma, the nervous system can become oversensitive. In turn individuals might see the world, and others as more threatening, dangerous, or unsafe and individuals are more likely to be frightened of their own experiences, especially if their attachment figures have not provided responsive and loving parenting [36, 37].

The link between internal bodily sensations and external signals can be explained by neuroception [38] which is closely tied to the Polyvagal Theory [39]. A subconscious process, neuroception occurs through the interaction of our autonomic nervous system (the sympathetic and parasympathetic systems) and various sensory pathways, to detect cues for threat and/or danger [38, 39]. As the soothing system is not based on activation, but rather on feeling safe and content, the soothing system is likely to lay dormant, leaving the threat and drive systems in override. Learning to nurture one's soothing system through mindfulness, and other compassionate-based strategies can cultivate compassion. Thus, helping the three systems to operate at equilibrium [35].

Based on a transdiagnostic approach, CFT focuses on addressing shame and self-criticism, which can promote mental and emotional healing [40]. Using a combination of psychoeducation and compassion-based strategies, CFT seeks to develop the compassionate self to engage with individual difficulties and distress [29]. Based on the formulation, clinicians work through the core CFT components including psychoeducation on the concept of compassion, the 'tricky brain' – how the human brain has evolved over millions of years and its advantages and disadvantages (to de-shame at times confusing bodily and emotional responses), the affect regulation system (see above); alongside Compassionate Mind Training (CMT) [41] to build compassionate capacities using imagery, breathing, and writing exercises. More recently, researchers have published comprehensive CFT treatment protocols working transdiagnostically with individuals or in group settings [42] and with complex emotional needs [43].

Individuals with complex emotional needs report high levels of shame and guilt [44] and experience difficulties, termed Fears, Blocks, and Resistances (FBRs) in CFT, to compassion [45, 46]. Researchers too have posed being self-critical may feel safer rather than questioning childhood experiences [47]. In older adults this could mean spending a significant number of years caught in a vicious negative cycle of relating to oneself and others. Some older adults too may have cohort beliefs about themselves or others and hold a 'just get on with it', disconnected stance to emotions [48]. Thus, with no first line recommended psychological intervention for complex emotional needs in older adults a transdiagnostic, CFT approach might be beneficial in this population.

Literature evaluating the effectiveness of CFT for individuals with complex emotional needs is limited and results are mixed. Whilst one group CFT intervention for individuals with 'personality disorders' found no significant changes post-CFT (but improvements in self-critical beliefs at follow-up [49]), another short compassion meditation program, aimed at cultivating loving-kindness, found improvements in 'personality disorder' symptoms, self-criticism and kindness after three weeks [50]. Other research has found significant reductions in shame, social comparison, feelings of self-hatred, depression, and anxiety post-CFT intervention for individuals with complex emotional needs [51]. In addition, a long term, slow-paced CFT-based psychotherapy group for individuals with complex attachment and emotional trauma has been found to significantly improve measured symptoms including depression, wellbeing, self-esteem and shame [5]. However, results from a thematic analysis found individuals face barriers such as weak imagery ability, fear of compassion, and a lack of compassionate experiences [52]. Further research is needed in this population as sample sizes in studies are small, and CFT is yet to be directly compared to other psychological interventions in this population.

Currently research evaluating psychological interventions in complex emotional needs is mixed, with no clear first line evidence-based treatment recommended. Furthermore, research including older adults is scarce and there is currently no research examining the use of CFT in older adults

with complex emotional needs. As such, this case report examines the utility of an individually delivered CFT intervention for an older adult with complex emotional needs.

The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the British Association of Behavioral and Cognitive Therapies and the British Psychological Society. The treatment ran as part of routine clinical cases within a Community Mental Health Service in the UK. Individual consent was obtained for the study, and names/ages/family structure have been changed to preserve confidentiality.

2. Introduction to the Case

Helen (pseudonym) is a white-British woman in her 70s, referred to an Older Adult Community Mental Health team (OACMHT) by her general practitioner (GP), asking for support with increased anxiety. Helen had a history of anxiety, depression, and was prescribed medication to help reduce agitation. Helen was subsequently discharged from OACMHT and referred to primary care services. However, a referral to the crisis team soon witnessed Helen re-referred to the OACMHT, prescribed further medication, and referred, with Helen's consent, to psychological services for individual therapy. Whilst in the OACMHT, Helen received a diagnosis of Emotionally Unstable Personality Disorder (EUPD).

2.1 Assessment

Assessment was completed over two face-to-face, one-hour sessions with a trainee clinical psychologist.

2.1.1 Background

Despite reporting a 'normal childhood' in a middle-class family as the youngest of three, Helen cited the shame of being neglected as a child, often 'left downstairs to cry' and not having her emotional needs met. Helen's father projected high academic expectations onto his children, and despite studying at a prestigious university at a time when women rarely achieved this [53] she felt ashamed that she never lived up to her father's expectations. Helen recalled 'feeling different' from an early age, wanting to 'fit in' but often 'feeling the odd one out'. Aged 18, Helen's middle sister was tragically killed in a car accident, leaving Helen feeling more isolated due to their tight bond.

Helen subsequently married and had three children. She described her 36-year marriage as unhappy, with her ex-husband lacking encouragement and being critical towards her, mirroring the relationship she had with her father. Since the divorce, Helen's two further relationships (spanning three years and then six months) ended with Helen describing herself as not being supported emotionally. Before retiring in 2014, Helen held several jobs including counselling, pastoral and charity work. Since retirement, Helen had started volunteering, supporting her church, gardening, and exploring nature through her love of walking. Helen was very self-critical of lacking ability, and motivation, to engage with these activities.

Aged 40, Helen first received psychological input for anxiety and depression around the time her mother was dying from cancer. From this counselling, Helen recalled acknowledging she is 'worthy of being loved', but still felt quite self-critical. Helen was later sexually assaulted by 'someone in authority' and had an informal mental health admission. Towards the end of her marriage, Helen

engaged with Cognitive Analytic Therapy and Psychodynamic Psychotherapy. When asked about her experiences of therapy, Helen struggled to reflect on them.

2.1.2 Presenting Difficulties

Helen's main concern was increased anxiety over the last few months, in particular a recent development of uncontrollable grunting noises, which left her feeling frustrated. She cited the impact of lockdown isolation, and financial concerns, leading to acute anxiety. Helen felt ashamed to be living in a home, owned by her son, which required substantial upkeep. Being retired, and the current 'cost of living crisis', contributed to increased anxiety. Helen described how her anxiety quickly became paralyzing; she struggled to leave her house, engage with social activities, or even get dressed. Helen became increasingly worried she was losing her identity, and consumed by her thoughts, was left feeling low in mood, exhausted and self-critical.

From meeting with Helen, her background, in particular her early childhood experiences appeared to impact her relationship to help [54], ability to regulate emotions and build and maintain relationships with others. To be seen and not forgotten, Helen appeared to voice isolation and increased suicidal thoughts as a way of communicating her distress. Over the years, Helen's relationships with her children, other family members and friends had become fraught. Friends and her children, who happened to live abroad, were trying to support Helen throughout her difficulties, but Helen could only see fault in others, and failed to acknowledge her role in the breakdown of the relationships.

2.1.3 Risk

At assessment, Helen rated her mood as 5/10. She was experiencing thoughts such as 'it would be better if I were to finish it all' and considered taking an overdose during those moments. Helen stated she felt 7/10 (10 being the most) confident that she could keep herself safe. There was no risk to others. She identified her grandchildren as protective factors and cited calling on her friends helpful when in distress. A risk assessment was already completed within OACMHT and crisis numbers were given. Helen's presentation declined significantly after three sessions, leading to the development of a further safety plan.

2.1.4 Goals

Helen was skeptical on setting goals for therapy, citing previous negative experiences of this. Describing why goals are used, and set, helped Helen to identify three general goals.

1. To gain coping skills to help with anxiety.
2. To increase my compassion.
3. When I am well, start volunteering in a museum or read to children.

2.2 Psychological Formulation

In line with her goals, Helen's difficulties were conceptualized using the CFT framework [55] (see Figure 1), with the aim to model, and develop, a compassionate, collaborative understanding of her experiences. Although not shared with Helen, a longitudinal CBT formulation for older adults [56]

was devised to help further understand age-related concerns within the context of Helen's presentation (see Figure 2).

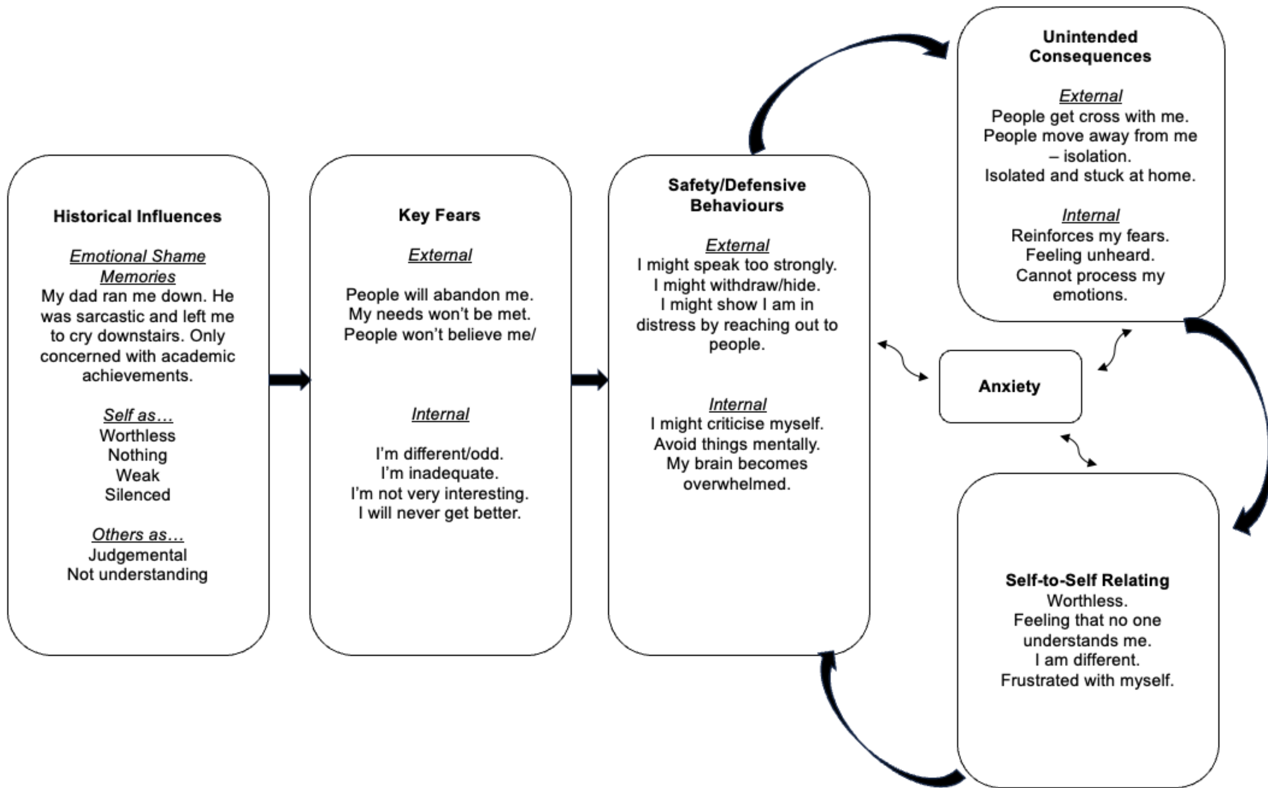

Figure 1 Helen's CFT Formulation.

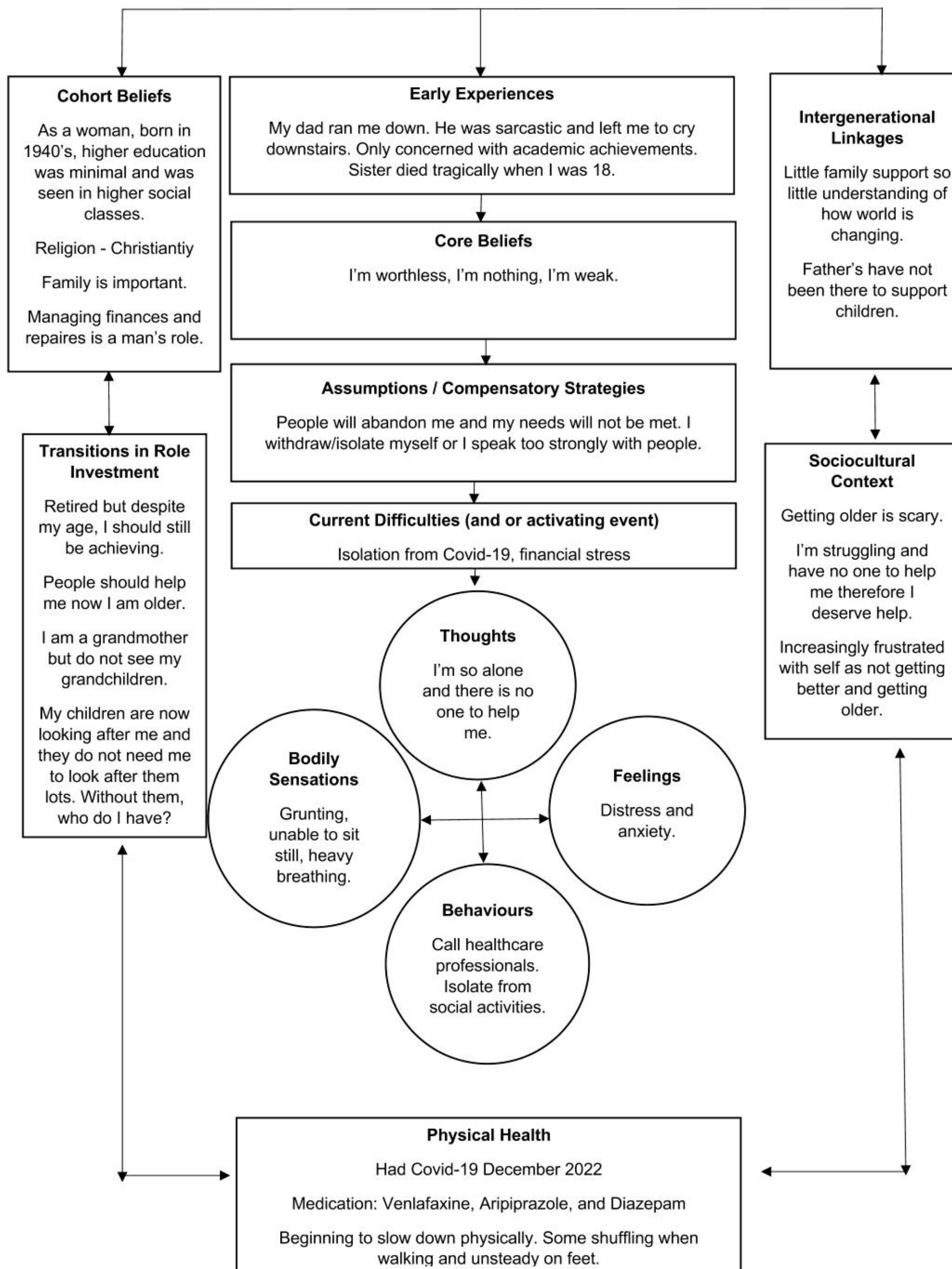

Figure 2 Helen's Longitudinal Formulation.

From Helen's perspective, her father's lack of care and love, highlighted by remembering being 'left to cry downstairs', his sarcasm, and high academic expectations, were early experiences of being shamed and criticized. Such experiences led her to internalize feelings of shame and self-criticism, and developing a survival strategy to criticize others first, before perhaps being criticized herself. Helen developed a sense of herself as 'nothing', 'worthless', 'weak' and consistently felt pressure to prove herself. Her 'worth' consisted of academic achievement and middle-class status, yet this rarely alleviated her pressure. Helen saw others as judgmental, indifferent, or uncomprehending. Firstly, her parents and now her children and friends, are for Helen, unable to sufficiently care for her, nor able to meet her needs. These perceptions have led to key fears about herself and others. She believed 'people will abandon me', and would disbelieve her, and thus

became sources of threat. Helen did not wish to speak of her sister's death, but it is hypothesized the trauma of losing her sister further strengthened her sense that others cannot be trusted or relied upon. Internally, Helen feared that she was 'inadequate', 'different/odd', and would never get better.

Over time, Helen's fears led to a vicious cycle to avoid anxiety. Helen herself, alongside friends and children were not seen as a source of comfort and/or safeness, but as threatening. She developed survival strategies in attempt to protect herself from key fears, including withdrawal and self-isolation, criticizing others before she could be criticized, or became agitated and annoyed. Internally, she criticized herself in an understandable attempt to self-protect and to evoke the care she needed from others. Unfortunately, such safety strategies had unintended consequences that maintained or exacerbated Helen's difficulties. Consequently, externally Helen acknowledged people retreating and/or becoming annoyed with her, which only increased her isolation and anxiety. Her children had moved to live abroad, and friends began retreating from supporting her which confirmed her belief people abandoned her and could not provide the physical connection Helen so wished for. When speaking about her children Helen voiced irritation at their lack of understanding and support. She struggled to hear an alternative perspective, one whereby she might be caught in a negative cycle caused by early childhood experiences. Over time it seemed her children became defeated in not knowing how to help Helen and became frustrated with her. Helen would often speak of friends and children showing reduced interest and/or avoiding contact with her. Internally, Helen felt increasingly isolated, anxious, unheard, and struggled to process her overwhelming emotions.

Helen was caught in an overwhelming, and despairing, vicious cycle of worthlessness, and frustration with herself. When Helen presented for therapy, she was relating to herself with high self-criticism and deep feelings of shame, given the way she was unable to get her needs met effectively, thereby maintaining the anxiety. Helen was relating to others as if no one understood her, no one cared for her or was willing to give her the support she needed. The only coping strategies Helen had were to revert to old survival strategies.

2.3 Assessment Measures

Assessment measures were collected at the beginning and end of therapy to help assess risk, gather further information, and analyze the intervention's effectiveness.

- *Work and Social Adjustment Scale (WSAS)* [57]: This is a 5-item, self-report measure administered at the beginning and end of therapy. The measure assesses the impact of a person's mental health difficulties on their ability to function in terms of work, home management, social leisure activities, private leisure activities, and family/relationships. Each item is scored on an 8-point scale ('not at all' (0) to 'very severely' (8)). Scores are summed to derive a total ranging from 0 to 40, with higher scores representing increased functional impairment. Scores below 10 appear to be associated with subclinical populations. The WSAS has been shown to be a simple, reliable, and valid measure of impaired functioning.
- *Hospital Anxiety and Depression Scale (HADS)* [58]: This is a 14-item, self-report measure administered at the beginning and end of therapy. The measure assesses the severity of anxiety and depression, each forming a subscale. Each subscale has 7 items, scored on a 3-point scale (0-3). The maximum score for each individual subscale is 21, with higher scores

indicating greater psychological distress. Clinical threshold is a score of 8 and above. The measure is validated and recommended to assess psychological distress among a general population aged 65-80 years.

- *Self-Compassion Scale Short Form (SCS-SF)* [59]: This a 12-item, self-report measure administered at the beginning and end of therapy. The measure assesses the compassion a person has for themselves. Each item is scored on a 5-point scale (‘almost never’ (1) to ‘almost always’ (5)). The scale has six subscales (each containing 2 items): self-kindness, self-judgement, common humanity, isolation, mindfulness, and over-identification. Items within the self-judgment, isolation, and over-identification subscales are reverse scored (6 items in total). Items within the subscales are scored by finding the mean (between 1 and 5). The mean is then taken from each subscale to compute a total mean (the average of the six subscale means). Lower mean scores represent lower levels of self-compassion. The measure has demonstrated adequate internal consistency and near-perfect correlation with the long form self-compassion scale, however, in an older adult population, reliability and validity results are mixed. The SCS-SF was administered rather than the Fears of Compassion Scale [60] as this aligned with Helen’s goals for therapy.

2.4 Intervention

Therapy consisted of 12 one-hour sessions, delivered face-to-face. Prior to starting therapy, Helen had been prescribed antidepressant and antipsychotic medication.

From assessment and supervision, CBT and CFT were identified as potential approaches which felt best aligned with Helen’s presentation and goals. Both interventions were described, and further information provided, allowing Helen to make an informed choice on her treatment. Shared decision making is known to empower individuals to make decisions about their care and is included in several healthcare guidelines [61, 62]. From this, Helen wished to work on increasing self-compassion and receiving compassion from others, and opted for CFT. To achieve this, through formulation work, the first few sessions aimed to develop Helen’s understanding of how she relates to herself and to others, and develop compassion for her early experiences, survival strategies, and their unintended consequences. Later on, sessions aimed to engage Helen with CFT practices to cultivate her soothing system (self-compassion and openness to receiving care from others). Sessions are summarized below.

2.4.1 Sessions 1-2

The first two sessions were dedicated to discussing the concept of compassion in order to develop a collaborative understanding and start practicing compassionate mind training (CMT). It was important, throughout sessions, to model compassion to help Helen feel heard and valued. CMT skills were introduced, and practiced, during these sessions to provide Helen with coping strategies to manage her overwhelming anxiety. Helen physiologically responded well to these exercises but expressed her frustration at the lack of focus on others and how they should be supporting her. It was hypothesized when Helen felt threatened, she believed it was only others who could support her, thus not considering self-compassion. This makes sense given her early childhood experiences, not being supported by her parents or shown helpful coping strategies to support herself in times of distress. The clinician explained the rationale for providing coping

strategies and Helen did agree to incorporate the techniques over the weeks. Technique scripts (e.g., body scanning) and videos (e.g., soothing rhythm breathing) were sent to Helen to aid facilitation.

2.4.2 Sessions 3-6

The purpose of these sessions was to help Helen develop awareness, and understanding, around how the human brain has evolved (e.g., ‘our tricky brain’) and the implications ‘new brain’ competencies can have for anxiety. Initially Helen was uncertain as to how this would help with her difficulties. However, incorporating the ‘three circles model of emotions’ to describe how Helen’s adverse early experiences may have led to an imbalance between the threat, drive, and soothing systems enabled Helen to identify with the concept. It was hypothesized formulating Helen’s childhood events into the model validated her experiences, allowing her to accept compassion from the clinician. Helen identified an overuse of her threat and drive systems, acknowledging utilizing the drive system (e.g., ‘I must keep busy’) to reduce any threat only provides short-term relief, and avoidance (e.g., not going out) inadvertently results in an increase of threat and anxiety.

2.4.3 Sessions 7-9

These sessions drew on Helen’s FBRs to compassion. Helen was able to describe feeling a loss of her identity and resisted compassion. Helen felt ashamed and believed she did not deserve self-compassion. This linked to her now reduced income, social economic status, and inability to achieve her goals. It became apparent Helen’s adverse early experiences presented challenges in her experience of compassion, in turn becoming a source of distress and anxiety. Helen became increasingly agitated and angry towards the clinician and her wider healthcare team. It appeared compassion was triggering painful emotions, therefore small steps (e.g., acknowledging moments of kindness) were encouraged. However, Helen was adamant the trainee was failing to understand her difficulties and was not sufficient for her needs, and she asked for a more senior clinician. Despite feeling hurt and unsatisfactory in her role as a therapist, the trainee accepted Helen’s feelings and empathized with her situation, as well as her early experiences and spent time validating and understanding Helen’s perspective. Time was taken to explore the therapeutic rupture, including age and ability of trainee in the context of her formulation, thus Helen agreed to attend further sessions. Helen was able to identify similar patterns in previous relationships, both romantic and parental. In the moment this appeared to regulate Helen’s distress, and Helen reflected how she felt heard at the end of the session. Although not discussed with Helen, it was hypothesized the age difference and ‘trainee status’ triggered Helen’s feelings of shame, inadequacy and worthlessness.

2.4.4 Session 10

As Helen was having difficulty receiving compassion from others, time was taken to explore qualities of a compassionate other. She was orientated to memories of being cared for, aiming to enable her to connect with physiological experiences of compassion. Helen had difficulty understanding the concept of developing an image of a compassionate other, rejecting the idea and clinging on to receiving physical contact and compassion from her friends and children. It was hypothesized Helen internalized this as a source of threat and struggled to connect with previous

times of receiving compassion. Psychoeducation was given on how our brain and body can respond to the image of a caring and compassionate other in a similar way to a real person, but Helen still had difficulties engaging with this exercise. These practices were not imposed on Helen further as she became increasingly angry and distressed.

2.4.5 Sessions 11-12

Following the previous session, the continuation or ending of therapy was discussed at length. Helen strongly believed therapy *'was not working'* and was making her more unwell. Alongside wider discussions within the multidisciplinary team, Helen and the clinician decided to end therapy. Elements of psychoeducation on anxiety, our tricky brain and three circles model of emotions were reinforced. A compassionate therapeutic letter was read to Helen to enable discussion around the formulation and therapeutic relationship, but this was met with defense and anger. Again, the clinician heard Helen's distress and offered to stop reading the letter. However, Helen asked the clinician to continue. It seemed her survival strategy of criticizing others when she felt criticized was being triggered, yet she desperately still wanted to be understood and shown care. Helen did not attend her last scheduled session.

3. Results

At the beginning of treatment, Helen's WSAS was 12, indicating impairment in her functioning. At the end of treatment, the WSAS increased to 15, suggesting increased impairment in functioning across treatment (see Figure 3).

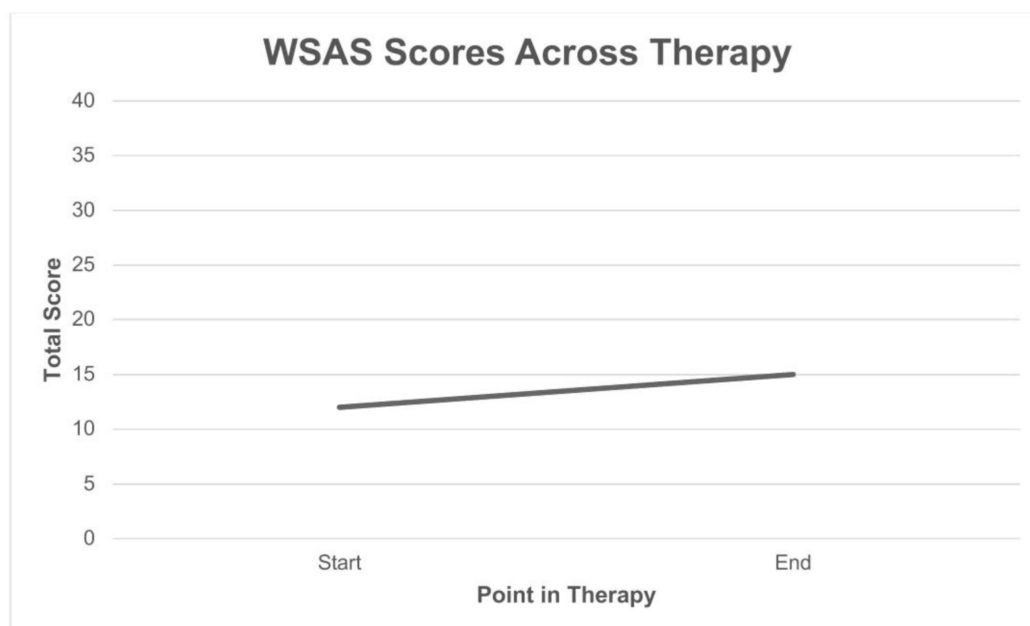

Figure 3 Change in WSAS scores across treatment.

On the HADS, Helen scored 11/21 on anxiety and 13/21 on depression, indicating clinical caseness for both anxiety and depression. At the end of treatment, Helen scored 10 on anxiety, moving to borderline caseness, although this is unlikely to be reliable change. HADS depression score remained at 13 suggesting Helen's mood did not improve (see Figure 4).

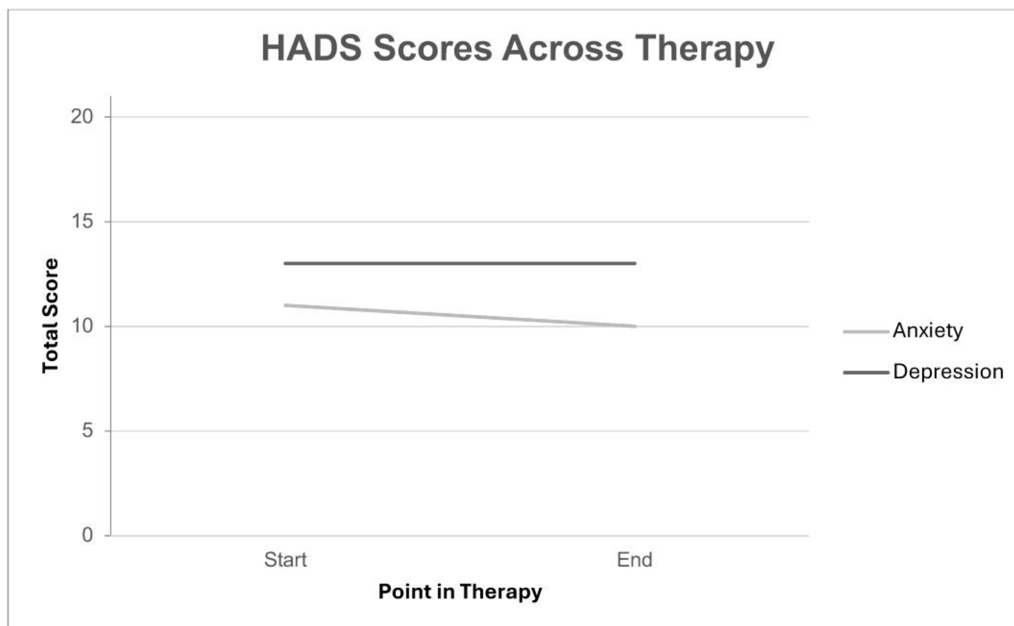

Figure 4 Change in HADS scores across treatment.

Helen's self-compassion at the beginning of treatment was 2.5, indicating a moderate level of self-compassion. At the end of treatment, SCS-SF increased to 3, suggesting a moderate, increased level in Helen's self-compassion (see Figure 5), which was in line with one of Helen's goals of improving compassion. Of the subscales, Helen made improvements in her self-judgment and common humanity.

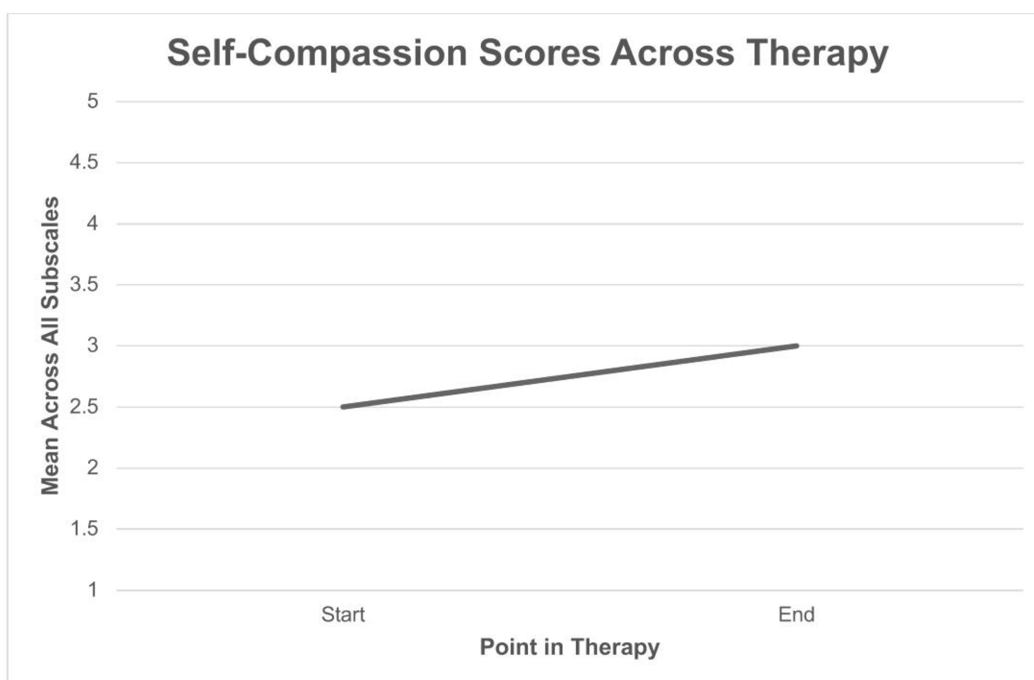

Figure 5 Change in SCS-SF scores across treatment.

Of the other goals, Helen was provided with several coping strategies to manage her anxiety. However, she mentioned they were not helpful as they only decreased her anxiety for a short space

of time. Helen had yet to engage with volunteering work, but on reflection, because of her level of distress, this may be a longer-term goal.

4. Discussion

This case report examined the utility of a CFT intervention for an older adult with complex emotional needs. Overall, measures and feedback are mixed, with slight improvement in Helen's self-compassion, but no reliable changes in anxiety, mood, or functioning. There are several possible explanations for these results.

Societal identity and religion appeared important in Helen's formulation, and she seemed to hold shame around self-identifying now as working-class. Shame around religion and mental health is complex [63] and research suggests income, education, and occupation, determine social class [64], of which Helen lacked or perceived as not good enough. Therefore, discussing social graces [65] might have been helpful in reducing shame and self-criticism.

When understanding Helen's early experiences of feeling critizied and shamed, it is not surprising that Helen became distressed in several therapy sessions. In line with her goals for treatment, Helen was introduced to self-compassion first, before moving onto 'compassionate other' exercises. Yet Helen became self-critical and projected anger, frustration, and criticizm towards professionals from the beginning. Several hypotheses related to FBRs were discussed, holding interpersonal trauma and attachment insecurity in mind. The age difference between Helen and the therapist, in addition to being a trainee, may have fed into Helen's internal fear of feeling inadequate. Age, however, is not found as a predictor of early growth in the therapeutic relationship [66]. Furthermore, Helen's negative opinions of professionals may have been a way of protecting herself, engaging in survival strategies, because being vulnerable and needing care was too painful. Alternatively, Helen's struggle to know how to get her needs met might have been more easily expressed in articulating anger. Research has found therapists' uses of empathy and common humanity can have an indirect impact on patient compassion [67]. Although no causation can be inferred, since hearing the clinician's reflections, post-therapy Helen had begun engaging with her care plan and adopting healthy coping strategies.

Despite desperately wanting care from others, Helen did not appear to be able to tolerate compassion and seemed to find it threatening. Thus, receiving compassion may have been unfamiliar and more a source of threat for Helen. Not feeling supported emotionally was a consistent theme throughout the sessions, with Helen identifying this experience in previous romantic, and parental relationships. It seemed this interpersonal pattern repeated itself in the therapeutic relationship. Therapeutic relationship and client motivation are consistently linked with positive outcomes and reduction in symptoms [68, 69]. Whilst destabilization and therapeutic ruptures are common, repairing the rupture, in vivo, is a major part of the work and provides space to navigate interpersonal issues [70]. Ruptures occur for a variety of reasons including therapist attachment [71] and interpersonal problems of the patient [72] and are to be expected when working with individuals who have experienced complex trauma and ruptured attachment systems [73]. Despite various methods to acknowledge and understand Helen's frustration and although Helen's survival strategy of criticizing others first was formulated as such, this of course triggered feelings in the therapist, including frustration and sadness, and potentially evoked a 'punitive other'. Research has found individuals with complex emotional needs find sessions aversive and individuals

require persistent, titrated exposure and desensitization to overcome such FBRs [45, 46]. Thus, understanding individuals' FBRs to compassion is vital for therapy success [74]. CFT is designed in particular to work with FBRs and has frameworks for doing so safely [74, 75]. Thus, it is important clinicians are trained sufficiently in CFT, working with FBRs, and rupture-repair work [76, 77], particularly in this clinical population. Although the concepts of FBRs to compassion were introduced, it is possible more could have been done to address the dynamic, as part of therapeutic work. For example, the repeated pattern of relating with the therapist was not directly named or wondered about with Helen to help her make sense of her reactions. This could have been a powerful intervention to help Helen become more aware of her interpersonal patterns of relating, and why care and compassion felt so threatening.

Limitations should be considered when interpreting the findings of this case study. Firstly, the nature of single case studies hinders any generalization of findings, as does the lack of comparisons with alternative treatments, and no follow-up data. Additionally, the flows of compassion may be experienced differently by individuals [52]. Thus, applying, and attending, to a more comprehensive measure on the flows of compassion (e.g., Fears of Compassion Scales [60]), may have provided further information about Helen's interpersonal relationships, alongside measuring any changes. In addition, Helen was prescribed Venlafaxine, Aripiprazole, and Diazepam in combination. Polypharmacy is a critical and growing public health issue [78] and is more common in older adults [79]. The interaction between multiple medications can lead to an increased risk of falls, frailty, and increased mortality [80]. Specifically, Helen's combined prescription is cited as increasing the risk of hyponatremia, cardiac disease, and metabolic disturbances [81]. In line with Helen's self-report of symptoms, such issues can cause lethargy, agitation, grunting, and poor concentration. It could be that the interaction of medications may have explained some of Helen's increased agitation and distress. However, Helen was not taking the medication as prescribed, which may have invertedly contributed to her distressed presentation. The advantage of multi-disciplinary teams is having professional expertise within the service. Despite this, service and systemic barriers impede clinicians from accessing trauma-informed care, offering training opportunities and long-term interventions in complex emotional needs [82], in turn impacting patient care [13, 83].

Helen might have benefitted further from psychological therapy if not discharged, without intervention, from the first GP referral. Standards for inclusion of complex emotional needs in older adults are outlined and should be implemented across services [13]. NHS England, in particular the NHS Long Term Plan [1] acknowledges the importance of early identification and intervention in older adults and predicts that, without action, by 2037, one third of over 65's will have mental health difficulties. Considering the lifespan complexities in older adults, getting the right care for those with complex emotional needs, at the right time, is key. This case also highlights the potential pitfalls of time-limited interventions for an older person with complex emotional needs within a service context that may not fit the needs of the patient. For example, trainees in the early stages of their carers may not be equipped to work with this level of complexity whilst also having time-limited placements. These are important implications, that we avoid unintentional iatrogenic harm to those with complex emotional needs [82].

5. Conclusions

Overall, this case study shows very limited results for the utility of CFT in an older adult with complex emotional needs. It however highlights the importance of developing a shared formulation and working with FBRs to compassion in the context of the therapeutic relationship, with a well-trained and skilled therapist in CFT and working with early trauma and complexity. It emphasizes the life experiences older adults bring to psychological services and the need to provide appropriate, and accessible interventions. Whilst it would have been positive to present significant outcomes, it is clinically important to report limited findings for both effective dissemination and to reduce publication bias. Further research is needed to explore whether CFT is an acceptable and beneficial treatment for older people with complex emotional needs.

6. Considerations for Practice

- Every service user with complex emotional needs should have access to evidence-based psychological therapies if/when they indicate interest in engaging in psychological therapy.
- Psychological professionals must conduct a thorough assessment and develop a comprehensive formulation that considers service users' Social Graces, physical health needs and lifespan stage, in addition to core assessment competencies.
- CFT is a treatment option for older people with complex emotional needs. Developing a compassion formulation that identifies early shame memories, key fears, and survival strategies can be a useful map for therapy and can be used to reflect on what is triggered in the client and between the client and therapist.
- Resistance and blocks to compassion is likely to be a barrier in CFT in older people with complex emotional needs, so should be anticipated and time given to work through them.
- When working with older adults in particular, clinicians must consider lifecycle issues, any cognitive changes, sensory deficits, location of sessions, and beliefs around ageing. It is more common in this population to be working across agencies, so experience of multiagency working is helpful.
- Use the experience within the services multi-disciplinary team.
- Clinicians must be competent to deliver psychological therapies as set out in competence frameworks for complex emotional needs https://www.ucl.ac.uk/clinical-psychology/competency-maps/pd-map.html.
- Clinicians must engage with clinical supervision throughout the intervention in order to reflect on progress and/or any therapeutic ruptures that may occur in particular with this clinical population.
- Clinicians should consider when it might be appropriate to end therapy prematurely if the client appears to be becoming more distressed by the intervention. The impact on the client of ending therapy prematurely should be considered, such as feelings of abandonment and rejection, and so communicated with care and concern for their wellbeing.

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The first author worked with Helen and wrote the case report. This author contributed significantly more to this work. The second author supervised the case and supported the write up of the case report.

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Competing Interests

The authors have declared that no competing interests exist.

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