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Research Article

Living Well with Illness: Evaluation of a Transdiagnostic Compassion-Focused Therapy Group for Long-Term Health Conditions

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Abstract

This study presents a mixed methods evaluation of a transdiagnostic Compassion Focused Therapy (CFT) group intervention, for adults with long-term health conditions (LTHCs). It aims to assess whether group completion was associated with improved outcomes in mood, overall well-being and the extent of LTHC interference in confidence for managing daily activities. Additionally, it examines the extent to which changes were related to processes targeted by CFT. The 'Living Well with Illness' group consisted of eleven weekly sessions, ten in group format and one individual formulation session at the course midpoint. Group participants were under the care of a medical consultant for their LTHC and were referred by a Psychology in Healthcare clinician. Outcome measurement data was collected from participants who attended groups conducted between January 2018 to January 2020. These measures assessed levels of anxiety, depression, overall well-being and confidence engaging in daily activities.

Processes targeted by CFT were also measured including self-compassion and self-criticism. Additionally, qualitative questionnaire feedback was collated and analysed using conventional content analysis. The current study revealed a significant reduction in scores of anxiety and depression. A significant improvement was observed for well-being and confidence for engaging in daily activities. Additionally, a significant improvement was seen in self-compassion and a concurrent reduction in levels of self-criticism. Qualitative findings provided support for changes in self-compassion, utility of compassion-focused strategies and the benefits of a transdiagnostic group format. The findings of this study suggest CFT is an effective therapeutic approach to improve psychological well-being in LTHCs and that this can be delivered in a transdiagnostic group format.

Keywords
Long-term health condition; self-compassion course; group intervention; mixed methods

1. Introduction

Long-term health conditions (LTHC) are illnesses for which there is currently no cure and are managed with drugs or other treatment. At present, approximately 15 million people in England are living with a LTHC which include but are not limited to: cancer, diabetes, chronic obstructive pulmonary disease, and arthritis [1, 2]. The Department of Health has also estimated that, in the longer-term, numbers are predicted to grow and the incidence of people living with multiple health conditions will rise. Thus, the development of improved treatment and management for LTHCs is the most important challenge facing the NHS [3]. There is significant demand and financial expenditure needed as the impact of LTHC typically involves more than just physical symptoms [4]. This has subsequently been reflected in the intentions of the NHS Long Term Plan which outlines 'upstream prevention' of illness exacerbations and better support for individuals and their carers in 'supported self-management' of LTHCs [5].

For the individuals affected, diagnosis of a LTHC involves significant processes of adjustment, both on an immediate basis such as initiation of pharmacological treatment or medical procedures, and ongoing changes such as the gradual loss of energy and adapting to lifestyle adjustments [6]. This multifaceted process involves a degree of acceptance, coping, and self-management as well as integration into an individual's identity [7]. Natural variation occurs across conditions, for example, in the burden of self-management and treatment adherence, and degree of visibility or progression of the condition [8]; however, research indicates important commonalities including burnout and reduced quality of life that can cause self-doubt and low self-esteem [9]. Moreover, further psychological difficulties can arise when there is significant self-blame, with perceived responsibility in causing or exacerbating the condition [10, 11].

It has been well documented that those with LTHCs have an increased risk of depression and anxiety, with up to 30% of individuals experiencing mental health co-morbidities [12]. National Institute for Clinical Excellence (NICE) guidelines [13] for co-morbid psychological difficulties within physical health conditions propose the use of Cognitive Behavioural Therapy (CBT); however, where there are significant difficulties in reducing self-criticism, individuals are less likely to benefit from

CBT [14] and are more likely to experience relapses following therapy [15]. In the context of LTHCs, this has substantial consequences including lower treatment adherence, poorer illness outcomes, and possible premature death [16-19]. Over the last decade there has been a mounting evidence base for additional psychological approaches that are crucial to improve well-being and prognoses [20].

One attribute proposed to help individuals accept and cope with the specific challenges of a LTHC is fostering compassion. Compassion-focused therapy (CFT) [21] is an integrative, multi-modal approach that aims to help individuals with high levels of shame and self-criticism, factors that have been linked to a range of psychological difficulties and present as transdiagnostic in nature [22, 23]. CFT holds roots in evolutionary psychology, attachment theory, and neurophysiological perspectives on well-being [24]. Additionally, it draws upon Buddhist teachings of mindfulness and compassion. Gilbert proposes the three systems model of affect regulation: the threat and self-protection system, the drive and resource-seeking system, and the soothing and connection system [25]. Difficulties are noted to arise when there is imbalance between these systems, namely an overactivation of the threat system and underdevelopment of the soothing system. As a result, compassion-focused interventions seek to increase an individual's felt sense of compassion and de-shame emotional difficulties, occurring partly due to the way our brains have evolved [26].

Existing evidence has demonstrated the value of CFT (including group-based formats) for a range of psychological difficulties such as eating disorders, depression, anxiety, personality disorder, psychosis, brain injury, substance misuse and PTSD [27]. Although the majority of research has focused on mental health difficulties in isolation, there is also promise for the incorporation of CFT interventions within physical health settings. Furthermore, a recent systemic review included 19 studies encompassing a variety of LTHCs [28]. The authors highlighted the prevalence of low self-compassion scores and their correlation with psychosocial outcomes such as depression, anxiety, stress, shame, resilience, and quality of life. Additionally, two included studies showed the positive impact of compassion-based interventions in condition management [29, 30]. Moving forward and expanding the evidence-base, the importance of multi-session CFT interventions has been highlighted to improve psychological outcomes for physical health populations [31].

1.1 Background and Rationale

This study describes the evaluation of a CFT group intervention within a tertiary care service and acute hospital setting. The Psychology in Healthcare service is based at the Royal Victoria Infirmary, Newcastle upon Tyne. The service provides therapy and support for people with a variety of psychological issues related to injury and illness on both an inpatient and outpatient basis. Primarily, psychological engagement takes place in a one-to-one format, and prior to the establishment of Living Well with Illness group, treatment pathways across the service did not contain any therapeutic groups. Nevertheless, clinicians were aware from individual therapy work that patients would like to connect with others in a similar position, to feel less alone in their difficulties of navigating healthcare systems and life with a LTHC. This was a key driver for the establishment of the group, to allow shared experiences and reduce isolation. It was proposed that the transdiagnostic nature of the group could be beneficial to allow integration across LTHCs and focus on shared processes and coping strategies.

1.2 Study Aims

This study aimed to evaluate the establishment of the Living Well with Illness group, exploring the acceptability and potential value of CFT as a group intervention across long-term health conditions. There were two primary objectives:

1. To assess whether attending the group was associated with improved outcomes in depression, anxiety, well-being and the extent to which LTHCs interfered with engagement in everyday activities.
2. To examine the extent to which the outcomes were associated with CFT. Specifically, whether there were changes in processes related to CFT, in terms of levels of self-compassion and self-criticism.

A secondary aim from qualitative analysis was to elicit participants' experiences of being part of a healthcare group.

2. Materials and Methods

2.1 Group Content

The Living Well with Illness group was designed to be delivered as a stand-alone treatment. It comprised eleven weekly sessions: ten in group format and one individual formulation session with a facilitator at the course midpoint. The inclusion of the formulation session afforded participants the opportunity to link course content to their individual circumstances. A follow-up session approximately one month after the group intervention then provided a review of course content and consolidation of learning. Groups were facilitated by two Clinical Psychologists specialising in working with a range of physical health conditions (TC and JC). Both facilitators had completed introductory training with the Compassionate Mind Foundation. The lead facilitator (TC) had also completed advanced training and compassion-focused therapy group training with the Compassionate Mind Foundation. This training formed the basis for the group content and was tailored specifically by facilitators to working with physical health conditions. Content included a mix of psycho-education, skills training, and experiential learning. The primary aims of the group were to facilitate the development of self-compassion and reduce self-criticism, learn to balance difficult emotions, develop an understanding of brain-body connections, and acquire skills for settling the mind and body. Although group reflections and discussions were encouraged throughout participants were asked to share only what they felt comfortable with. Table 1 below details the pre-determined course structure that was followed:

Table 1 Course content.

Session	Content
1	Defining compassion; fears, blocks, and resistances to compassion; soothing rhythm breathing
2	Emotion-regulation systems; calming imagery
3	Introduction to the 'tricky brain'; brain-body connections; introduction to mindfulness
4	Getting to know our tricky brains; developing mindfulness practice

5	Understanding protective strategies; how we are shaped by our experiences; receiving compassion
6	Individual CFT-based formulation sessions
7	Developing our compassionate self; compassion for others
8	Shame and self-criticism; compassion for self
9	Values; compassion in action
10	Understanding our "multiple selves"; compassionate letter-writing
11	Planning for setbacks; maintaining practice; compassionate kitbag [32]

2.2 Design

This study utilises a mixed-methods design, combining quantitative and qualitative methods to support group evaluation. The qualitative analysis provided an opportunity to explore emerging themes relating to what participants found useful about the group intervention, whilst the quantitative data charted the progress of the group with regard to the specific aims of the intervention; namely, to facilitate the development of self-compassion and reduce self-criticism towards living with a health condition.

2.3 Participants

A total of 45 participants took part across groups with age ranging from 29 to 84 years old.
To be eligible for the group, participants were required to:

- Be under the care of a medical consultant in adult services within The Newcastle upon Tyne Hospitals NHS Foundation Trust
- Be over 18 years of age
- Have been assessed by a clinical psychologist and willing to explore psychological approaches to living with a physical health condition
- Have a willingness to attend and participate in group format

The following exclusion criteria was also employed:

- Any untreated severe and enduring mental health problem likely to impact on group participation
- Current alcohol or substance misuse
- Imminent risk of self-harm or suicide
- Diagnosed learning disability

No restrictions were placed upon medical specialty, aiming to accommodate a variety of long-term health conditions. Prior assessment by a clinical psychologist was a prerequisite as some of the themes and practices and the group format could be challenging for anyone unfamiliar with psychological approaches to living with a physical health condition. Thus, all group members had received a degree of one-to-one input prior to commencing the course; however, this was not necessarily from a compassion-focused perspective and the group therefore provided participants with an appropriate introduction to the CFT model.

2.4 Data and Procedure

Questionnaire data was collected from all participants who attended the Living Well with Illness groups conducted between January 2018 to January 2020. During this time period, six groups took place (n = 45) with an average attendance of 7-8 participants per group. Outcome measures were administered to participants by group facilitators on week one and week 11 of the group. At week 11, participants were also asked to complete a qualitative feedback questionnaire designed by the facilitators. Participants provided written responses to thirteen open-ended questions. Figure 1 shows a procedural timeline from point of referral to discharge from the group.

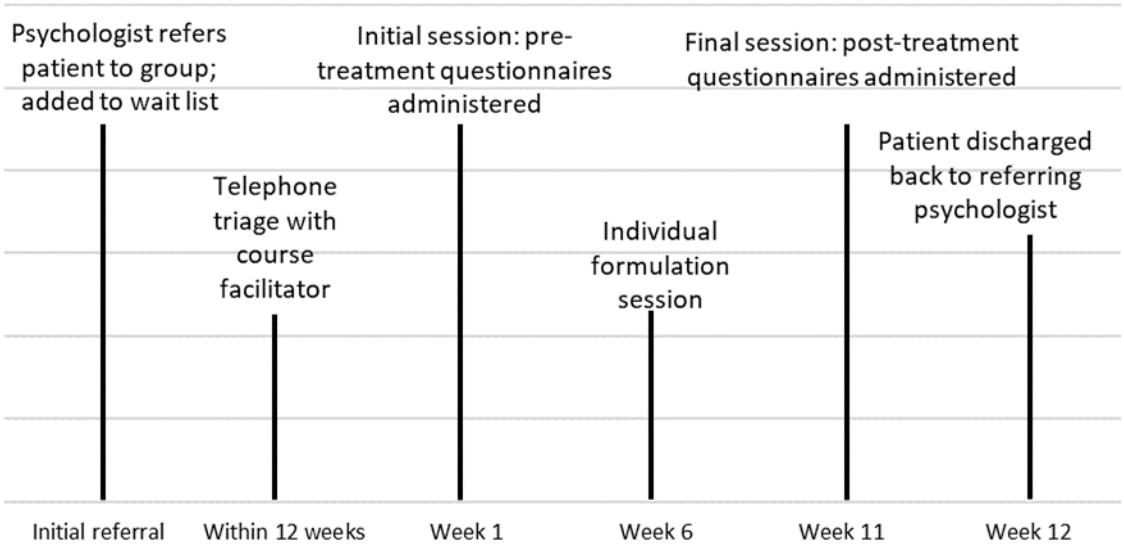

Figure 1 Treatment timeline for 'Living Well with Illness' group.

2.5 Measures

2.5.1 Participant Demographics

Categories of demographic data were collated from participants; gender, age and referring medical specialty (to ascertain spread of LTHCs). Please see Table 2 detailing demographic data of the participant sample.

Table 2 Participant characteristics.

	Group 1 (n = 1)	Group 2 (n = 5)	Group 3 (n = 5)	Group 4 (n = 7)	Group 6 (n = 5)	All Groups (n = 23)
Mean Age (years)	**62**	**54**	**44**	**44**	**54**	**49**
Gender (% female)	**100%**	**60%**	**80%**	**71%**	**80%**	**74%**
Medical Specialty of LTHC (n)	**Cardiology (1)**	**Cardiology (3)** **Dermatology (1)** **Pain (1)**	**Cardiology (3)** **Urology (1)** **Nephrology (1)**	**Pain (1)** **Gastroenterology (1)** **Dermatology (1)** **Infectious Diseases (1)** **Burns (1)** **Neurology (1)** **Colorectal (1)**	**Diabetes (1)** **Plastics (1)** **Pain (1)** **Gastroenterology (1)** **Infectious Diseases (1)**	**Cardiology (7)** **Pain (3)** **Dermatology (2)** **Infectious Diseases (2)** **Gastroenterology (2)** **Colorectal (1)** **Burns (1)** **Plastics (1)** **Urology (1)** **Nephrology (1)** **Neurology (1)** **Diabetes (1)**

Key: LTHC = Long-term health condition

Common LTHC Examples by Medical Specialty: Cardiology: Ischemic heart disease, Cardiac arrythmia; Colorectal: Inflammatory bowel diseases, Diverticular disease; Dermatology: Psoriasis; Nephrology: End stage renal failure; Pain: Complex regional pain syndrome, Sjögren's syndrome; Urology: Interstitial Cystitis (Painful Bladder Syndrome); Gastroenterology: Ulcerative colitis, Irritable bowel syndrome; Infectious Diseases: HIV, Hepatitis; Neurology: Fibrous dysplasia, Acquired brain injury.

2.5.2 Efficacy – Mood and Well-Being

Patient Health Questionnaire-4 (PHQ-4; [33]). The Patient Health Questionnaire-4 (PHQ-4) is a four-item screening tool for both depression and anxiety. It comprises two items derived from the original PHQ-9 alongside two items from the GAD-7. Participants are asked to rate items based on how they have felt over the past two weeks, from 0 (not at all) to 3 (nearly every day). Scores are rated as 'normal' (0-2), 'mild' (3-5), 'moderate' (6-8), and 'severe' (9-12). The internal reliability for the scale (Cronbach α) has been reported as good (>0.80; [34]).

Short Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS; [35]). This is a shortened version of the WEMWBS, designed to measure individuals' well-being. The seven items are positively worded in relation to an individuals' thoughts and feelings; rated on a five-point scale. Scores range from 7-35, with higher scores indicative of greater well-being. The SWEMWBS has demonstrated good content validity and discriminated between population groups in a way that is largely consistent with the results of other population surveys [35].

2.5.3 Efficacy – Self-Compassion and Self-Criticism

Self-Compassion Scale-Short From (SCS-SF; [36]). The SCS-SF assesses degree of self-compassion using 12-items comprising six factors: Self-kindness, self-judgement, common humanity, isolation mindfulness and over-identification. There are no clinical norms, however, Raes and colleagues consider scores of 1.0-2.49 to be low, 2.5-3.5 as moderate, and 3.51-5 as high. It has been demonstrated to have good internal consistency [37].

The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS; [38]). This 22-item scale measures self-criticism and the ability to self-reassure. It measures two forms of self-criticism – Inadequate Self (IS) and Hated Self (HS). Participants are asked to estimate how like them each statement is on a Likert scale, ranging from 0 (not at all like me) to 4 (extremely like me). An example of an item is 'I think I deserve my self-criticism'. There are three subscales: IS with 9 items focusing on feelings of personal inadequacy. Reassured Self (RS) with 8 items targeting ability to reassurance and support oneself. HS with 5 items focusing on desire to hurt or punish oneself.

2.5.4 Efficacy – Health Condition Self-Efficacy

Health Condition – Self-Efficacy Questionnaire (HC-SEQ). With the authors permission, an adapted version of the Pain Self-Efficacy Questionnaire (PSEQ; [39]) measured confidence in doing daily activities whilst living with a long-term health condition. Participants rate from 0 (not at all confident) to 6 (completely confident). Raw scores range from 0-60, where higher scores indicate greater levels of confidence. To the author's knowledge, the HC-SEQ has not been validated out-with persistent pain populations.

2.6 Analysis

2.6.1 Quantitative

Descriptive statistics are reported in Table 2 for each group that took place. Statistical analyses were carried out using SPSS-27. Tests of normality were conducted on complete sets of questionnaire data; outcome measures completed by participants both pre- and post-treatment. All group participants completed pre-treatment measures; however, completion rates dropped for post-treatment. Group 5 were issued with a different questionnaire pack with alternative outcome measures and were therefore excluded from analysis; however, for datasets that were complete there were no issues with missing responses. All questionnaires provided sufficient fit of normality, except the SWEMWBS and the reassured-self subscale of the FSCRS. Where data was normally distributed, paired samples t-tests were used to analyse the mean difference in scores pre- and post-intervention. In cases where normality was not met, the non-parametric equivalent test (Wilcoxon signed ranks test) was used.

2.6.2 Qualitative

Data was analysed using conventional content analysis [40] which presents a flexible method for analysing text data. Firstly, the qualitative responses were read repeatedly by the author and a group facilitator to gain a clear understanding of the dataset. The dataset was then "cleaned" by removing responses that did not contain usable feedback in relation to participant experience (for example "N/A" or "No comments"). Both researchers then independently highlighted words or phrases that appeared to capture key thoughts or concepts and notes were made of initial impressions and thoughts. Here, an inductive approach was adopted for the coding scheme to facilitate proximity to the data; therefore, codes were generated either directly from participant text or reflected one or more key thoughts. Once all responses had been coded, data under each code was re-examined collaboratively. The initial coding scheme was discussed and revised between researchers. Subsequently, codes were sorted into categories based on they were related and linked. These emergent categories provided a means of grouping codes into meaningful clusters [41, 42].

Ethical approval was obtained from the Newcastle upon Tyne Hospitals NHS Foundation Trust, Research and Design Department in August 2021. At the point of data collection, participants provided informed consent for the use of anonymised data in service evaluation. Participants were assigned a code and identifiable data was stored separately. Data utilised within this project was held on a password protected excel database within the Newcastle upon Tyne Hospitals Foundation Trust.

3. Results

3.1 Participant Demographics

In total, 91 people were invited to the 'Living Well with Illness' group from January 2018 to January 2020. Subsequently, 45 people then attended the 'Living with Illness' group for at least one session. From those who attended the group, 33 completed the course of 11 sessions (73%) and 23 provided full data sets (51%). Please see Figure 2 for the flow diagram of participant engagement across the study. Table 2 displays the characteristics of participants with complete data sets (n = 23)

and some examples of LTHC diagnoses across medical specialties. Differences on outcome measures between pre- and post-treatment are displayed in Table 3 and Table 4.

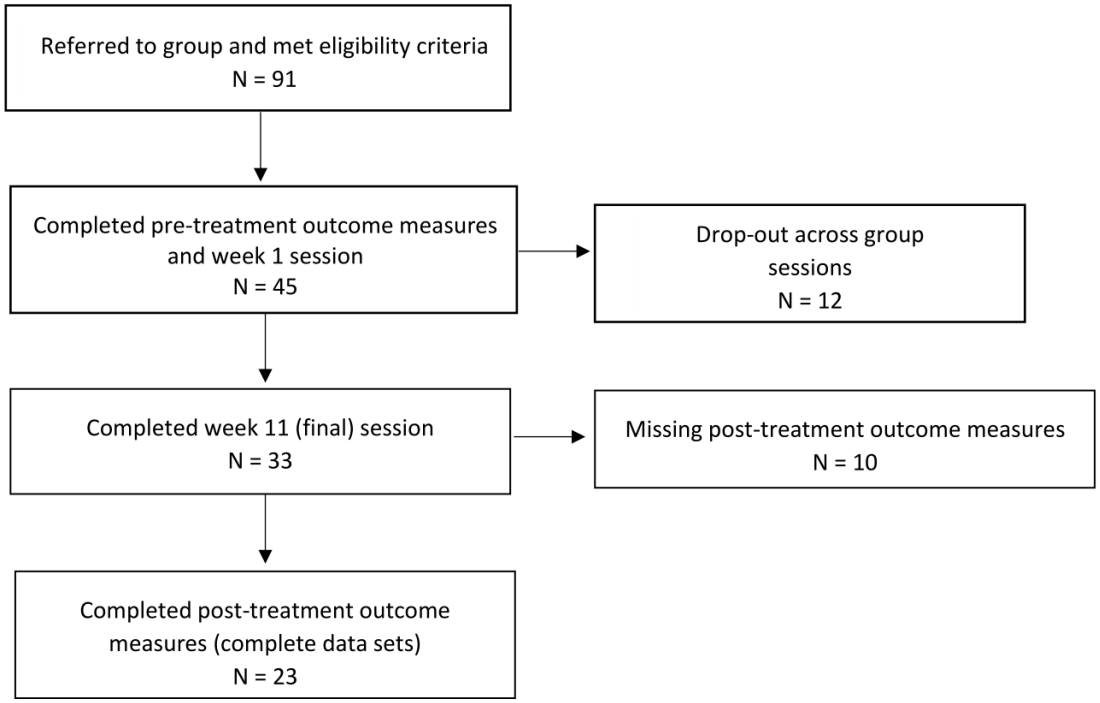

Figure 2 Flow diagram of participant completion rate.

Table 3 Means, standard deviations, and effect sizes pre- and post-treatment (parametric data).

Outcome Measure	Pre-Treatment *M* (SD)	Post-Treatment *M* (SD)	Effect Size *d (Descriptor)*
PHQ-4	***6.78*** **(3.36)**	***5.17*** **(2.48)**	***0.55 (Medium)***
HCSEQ	***27.91*** **(11.13)**	***34.13*** **(9.95)**	***0.59 (Medium)***
SCS-SF	***2.16*** **(0.68)**	***2.61*** **(0.78)**	***0.61 (Medium)***
FSCRS			
IS	***25.52*** **(6.08)**	***20.70*** **(7.52)**	***0.70 (Medium)***
HS	***7.48*** **(4.50)**	***5.48*** **(4.13)**	***0.46 (Small)***

Key: PHQ-4, Patient Health Questionnaire-4; HCSEQ, Health Condition Self-Efficacy Questionnaire; SCS-SF, Self-Compassion Scale-Short Form; FSCRS, Forms of Self-Criticising/Attacking and Self-Reassuring Scale; IS, Inadequate Self; HS, Hated Self; *M*, Mean; SD, Standard Deviation.

Table 4 Z statistics and effect sizes pre- and post-treatment (non-parametric data).

Outcome Measure	Z Statistic	Effect Size *r (Descriptor)*
SWEMWBS	**-2.63**	***0.55 (Large)***
FSCRS		

RS	**-2.45**	***0.51 (Large)***

Key: SWEMWBS, Shortened Warwick-Edinburgh Mental Well-Being Scale; FSCRS, Forms of Self-Criticising/Attacking and Self-Reassuring Scale RS, Reassured Self.

3.2 Mood and Well-Being

Paired-samples t-tests were conducted to compare scores on the PHQ-4 (depression and anxiety) at time 1 (T1; pre-intervention) and time 2 (T2; post-intervention). Results showed a significant improvement in depression and anxiety scores between T1 (M = 6.78, SD = 3.36) and T2 (M = 5.17, SD = 2.48); (t(22) = 2.45, p = 0.023) with a medium effect size (*d = 0.55).*

A Wilcoxon signed ranks test was conducted for comparison of SWEMWBS (well-being) scores. Results showed a significant improvement in well-being scores between T1 and T2 (Z = -2.63, p = 0.009) with a large effect size (r = 0.55).

3.3 Health Condition Self-Efficacy

Paired-samples t-tests were conducted to compare scores on the HCSEQ (ability to engage in everyday activities) at Time 1 (T1; pre-intervention) and Time 2 (T2; post-intervention). Results showed a significant improvement in scores between T1 (M = 27.91, SD = 11.13) and T2 (M = 34.13, SD = 9.95); (t(22) = -2.91, p = 0.008) with a medium effect size (d = 0.59).

3.4 Self-Compassion and Self-Criticism

Scores on the SCS-SF and normally distributed subscales of the FSCRS were also compared by conducting paired-samples t-tests. Results showed a significant improvement in self-compassion scores between T1 (M = 2.16, SD = 0.68) and T2 (M = 2.61, SD = 0.78); (t(22) = -3.68, p = 0.001) with a medium effect size (d = 0.61). For the FSCRS-IS subscale, results demonstrated a significant improvement in self-criticism scores between T1 (M = 25.52, SD = 6.08) and T2 (M = 20.70, SD = 7.52); (t(22) = 3.50, p = 0.002) with a medium effect size (d = 0.70). Similarly, for FSCRS-HS, results also showed a significant improvement in scores of self-criticism T1 (M = 7.48, SD = 4.50) and T2 (M = 5.48, SD = 4.13); (t(22) = 2.33, p = 0.029) with a small effect size (d = 0.46).

Furthermore, a Wilcoxon signed ranks test was conducted for comparison of FSCRS-RS subscale. Results showed a significant improvement in scores of self-reassurance between T1 and T2 (Z = -2.45, p = 0.014) with a large effect size (r = 0.51).

3.5 Qualitative Questionnaire Feedback

Participants' written responses to items on the feedback questionnaire were qualitatively analysed using conventional content analysis. In this section, the overall experience of participants' is discussed in relation to key themes which map onto the overall study aims. Two main themes were identified: 1) Experience of a Healthcare-Related Group 2) Impact of a Compassion-Focused Intervention. Please see Figure 3 for thematic map.

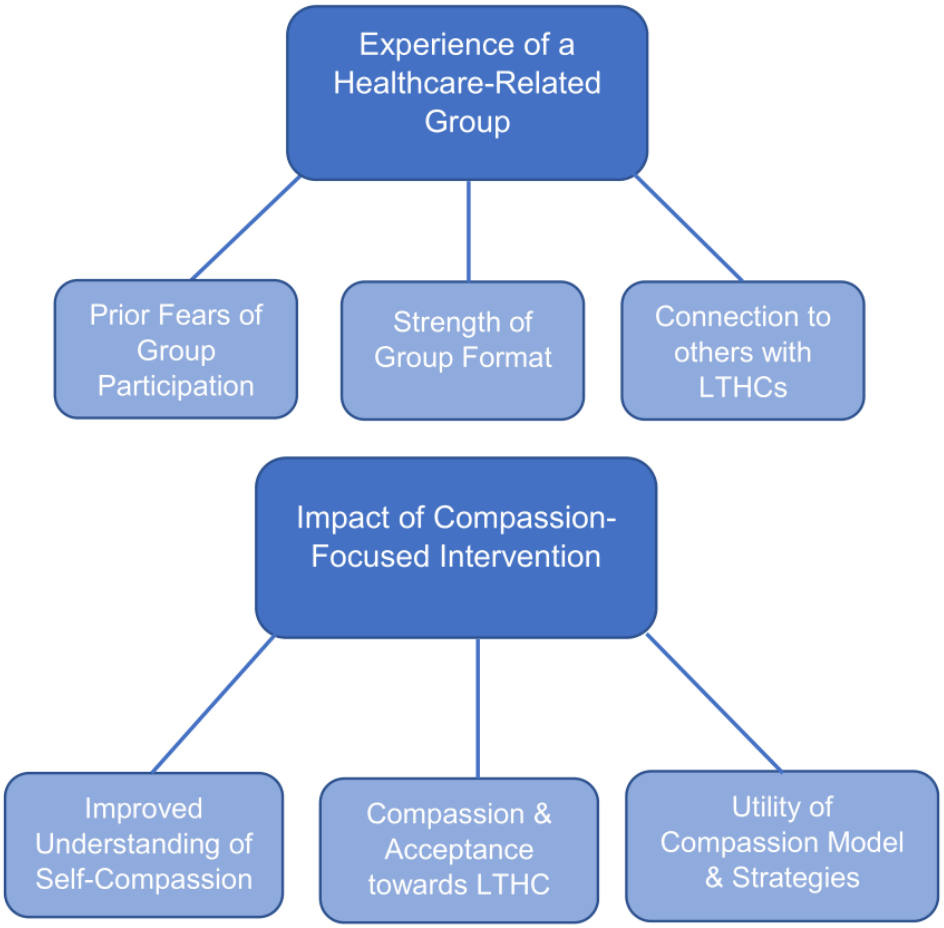

Figure 3 Thematic map.

3.5.1 Experience of a Healthcare-Related Group

Within this theme, three sub-themes were identified: 1) Prior Fears of Group Participation 2) Strength of the Group Format 3) Connection to others with LTHCs.

Prior Fears of Group Participation This subtheme captures the shared fears and anticipations, participants experienced prior to the group commencing. Across participants, it was apparent this was not a format they had experienced before and fears of entering the *"unknown"* were frequently described:

"I was worried about the unknown, the possible number of people and how far I would be pushed to disclose about me." (Participant 2C).

For some participants emphasis was placed on how they would generally be perceived by other group members, that *"people might judge me" (Participant 1A)* and worries of integrating into the group successfully:

"I was worried about fitting in, wanting to please everyone and frightened to be myself. I had lots of fears and didn't fully realise I had them." (Participant 4B).

Furthermore, some participants expressed specific fears of disclosure relating to the discussion of personal health experiences and possible risks of this within a group environment:

"There was trepidation of everyone discussing health conditions, having a situation of competition and 'mine is worse than yours' mentality…" (Participant 2E).

Encouragingly, following course completion, participants reflected how these fears did not translate into reality:

"I was also worried in case we had to talk about our health issues a lot but after finishing the course it has been completely different to how I expected." (Participant 3C).

Strength of the Group Format Here, it became evident that the group format was a positive experience across participants and how it facilitated engagement with its content:

"It was much easier than I imagined. I think the group brought a wider focus and seeing how it affected others made it easier to apply to myself." (Participant 6B).

Moreover, in comparison to one-to-one intervention, having varying perspectives, enhanced learning for some participants over the duration of the group:

"One-to-one can help focus on individual health issues but there were clear positives to being a group and being able to learn from others' experiences as well." (Participant 6E).

Connection to Others with LTHCs Within this subtheme, there was a strong sentiment of connection between group members. This was built on the commonalities of their physical health experiences, despite living with various LTHCs:

"I am more understanding that everyone here is going through or has felt similar things. Theoretically I knew this before, but actually doing the group work has proven this. The group has now become a safe place for me." (Participant 4A).

Additionally, one of the key drivers behind the group format was to reduce feelings of isolation that living with a LTHC can often create. Thus, it was encouraging to then see this reflected in qualitative responses:

"Being in a group with other people with similar health difficulties made me feel less ashamed and alone with my own problems." (Participant 6C).

3.5.2 Impact of a Compassion-Focused Intervention

For this key theme, a further three sub-themes were identified: 1) Improved Understanding of Self-Compassion 2) Compassion & Acceptance towards LTHC 3) Utility of Compassion Model and Strategies.

Improved Understanding of Self-Compassion Participants overwhelmingly expressed an improved understanding of self-compassion and its necessity as a result of course completion. This expanded awareness beyond simply compassion towards others:

"Previously I thought that you are compassionate to others but I never thought about being compassionate towards myself. Also, I've often been compassionate to others at the expense of myself and now I realise that I should think of how it's affecting me too." (Participant 5D).

Additionally, it was apparent that the group intervention was able to challenge preconceptions surrounding self-compassion, with participants often making an association of self-indulgence:

"I used to not really understand the meaning and I believed it was weak and indulgent." (Participant 3E).

Compassion & Acceptance towards LTHC In relation to physical health difficulties, participants reflected the subsequent benefits of increased self-compassion. They described an enhanced acceptance of their LTHCs and the vulnerabilities this can bring:

"I am more accepting that I haven't chosen my condition, therefore I'm able to be more compassionate to myself when things are going wrong." (Participant 4D).

Participants spoke about the compassion-focused intervention as forming part of their journey in finding new means of managing life alongside their LTHC rather than engaging in self-blame or criticism:

"I've stepped further into my path of acceptance of my physical health without it meaning I have given up. I am able to truly understand what self-soothing means and ways I can apply it to myself." (Participant 4C).

Utility of Compassion Model and Strategies This subtheme captures the components and techniques within the compassion-focused intervention that participants highlighted as particularly useful towards their psychological well-being. Awareness of the three systems of emotion regulation and acknowledging 'threat mode' were noted. Furthermore, mindfulness practice was frequently emphasised*:*

"I've used mindfulness on days when I've felt so unwell, I didn't think I could do things. For example, when I want to try and make some food but feel too rough, if I mindfully chop ingredients, it helps me get through." (Participant 4B).

The evolutionary psychology that underpins CFT, highlighting the problematic nature of the evolved human brain, also demonstrated value for this participant population: *"I've learnt there is a purpose of my self-critical voice. It's got me through bad times, maybe not in the most helpful way but I understand the biological and evolutionary purpose for this. Showing compassion towards the self-critical voice gives me hope that all is not lost!" (Participant 1B).*

4. Discussion

This study outlines an evaluation of a CFT-based group for adults living with LTHCs. It aimed to assess whether group completion was associated with improved outcomes in mood, overall well-being, and the extent of LTHC interference in everyday activities. Additionally, it sought to examine the extent to which changes were related to processes targeted by CFT. Finally, participants' experiences of being in a healthcare group were explored using qualitative analysis. To the authors knowledge it also presents as the first study to assess group CFT intervention for a population of transdiagnostic LTHCs.

The results of the current study demonstrated a significant reduction in scores of anxiety and depression on the PHQ-4, with mean scores falling in the 'moderate' range pre-treatment and the 'mild' range post-treatment. Participants' well-being as measured by the SWEMWBS also saw a significant improvement following intervention, moving from the 'probable depression' category to 'average well-being'. Furthermore, a significant increase in confidence for engaging in daily activities was observed from the HCSEQ; however, average post-treatment scores remained below 40. This cut-off has been previously identified in the literature for probable maintenance of functional gains, whilst lower scores are thought to predict less sustainability in this regard [43].

Additionally, the current study demonstrated support for observed improvements arising from processes targeted by CFT. Specifically, a significant increase was seen in scores of self-compassion

on the SCS-SF and reduction in self-criticism as measured by the FSCRS. Thus, a significant reduction in the 'hated self' alongside improvement in the 'reassured self' measure suggests a shift for participants in their level of self-loathing, towards an enhanced capacity to self-soothe and reassure. An increase in self-compassion and reduced self-criticism was also in line with the study's qualitative findings. Here it became clear that participants' awareness had expanded beyond compassion for others as they reflected a subsequent understanding for the necessity of compassion to self. Furthermore, the utility of a compassion-focused model and techniques was noted by participants; namely, mindfulness exercises and psychoeducation regarding evolutionary and neuropsychological underpinnings of CFT. At this stage however, it is difficult to pinpoint specific aspects of the programme that could have led to changes in compassion-targeted processes. To address this, a helpful next step for the service would involve in-depth qualitative exploration such as focus groups or individual interviews following intervention. Although this option would be more time intensive than the written feedback questionnaire, it would facilitate collation of rich detailed data regarding development and experience of self-compassion in LTHCs.

4.1 Strengths and Limitations

The current study was strengthened by adopting a mixed-methods approach which facilitated a more comprehensive evaluation of group intervention and participant experience. A further clear strength of the study was the transdiagnostic approach to the group. In clinical health settings, psychological services are typically organised by medical specialty. This often limits opportunity for group intervention in terms of both clinician capacity and pool of participants. Thus, having a transdiagnostic approach increased throughput from the group and allowed for more efficient use of psychology time and resources. At the outset, the transdiagnostic set-up was hypothesised to facilitate integration with focus on shared processes and coping strategies for living with a LTHC. An important aspect of conducting a group in this way is balancing the parameters for inclusion alongside the condition-specific features of LTHCs. Across conditions, different challenges can exist around sources of illness-related distress or perceptions of illness-related beliefs [44]. Too much variability can risk polarisation of participants and unhelpful group dynamics [45]; however, in the current study, qualitative findings demonstrated high levels of treatment acceptability for the transdiagnostic approach within a physical health setting. Overwhelmingly, participants echoed the helpful connection that existed between group members. Shared experiences of living with a LTHC were cited as instrumental in allowing participants to feel more understood and less isolated. Furthermore, this corroborates and adds to existing findings within the compassion-focused literature for LTHCs. A recent study by Lathren and colleagues implemented an 8-week mindful self-compassion intervention for young adult cancer survivors [46]. Similarly, despite having different cancer types and courses of treatment, participants were validated by the group's shared understandings and expressed comfort in knowing others had relatable experiences.

It is equally important to note limitations to the current study when interpreting results. The primary limitation was that there was no active treatment comparison. Therefore, future studies would benefit from a control arm such as a wait-list control, to increase certainty and internal validity of findings. Additionally, the current methodology placed considerable reliance was on completion of patient-reported outcome measures. These have well cited disadvantages such as respondent fatigue and susceptibility to socially desirable responding [47, 48].

For the current participant sample, diagnostic thresholds or categories surrounding anxiety and depression were not grounds for exclusion for group participation. Subsequently, baseline levels of psychological distress varied across participants with some reporting sub-clinical levels of anxiety and depression. Nevertheless, this context of low baseline distress did not present as a barrier to significant reductions in anxiety and depression. Furthermore, this approach to participant diagnostic thresholds is consistent with the organisation of many NHS health psychology settings, thus supporting the generalisability of these findings. Also, the age range of the current sample is worth highlighting given that average participant age was 49 years across groups. This is helpful to note when considering generalisability to young adult or adolescent LTHC populations, and further research would be needed to compare compassion-focused intervention across these groups.

4.2 Implications & Recommendations

Considering the aforementioned strengths and weaknesses, there are some useful recommendations that can be made at a local service level. Participants who provided qualitative feedback found great value in the group and it was clear it offered something novel towards management of their LTHC. To extend findings, it would be beneficial to conduct longer-term follow-up of participants, either issuing outcome measures at a third timepoint or collating detailed qualitative feedback at this stage. As it stands, the response rate for outcome measures at week 11 would benefit from improvement in order to demonstrate effectiveness. Moreover, it may be that completion of any additional outcomes would be problematic in obtaining a sufficient response rate. A higher proportion of participants within the current sample provided qualitative feedback, hence, focus on further qualitative analysis such as a focus group could be a useful future direction.

In this study, all participants had received a degree of one-to-one psychological input prior to commencing the group. From a service perspective, this criterion was adopted to support participants' understanding of therapeutic content and consider a psychological approach to managing the impact of living with a LTHC. Excluding those who had no previous experience of the psychology service was hypothesised to reduce the need for additional input following the Living Well with Illness course. Thus, going forward, it would also be useful to establish rates of re-referral to health psychology after group completion, and whether a relationship exists between outcomes and amount of prior therapeutic input received.

As gatekeepers for referrals, referring psychologists informed participants' consultant teams when the course was completed. Additionally, the group course was promoted at Trust level with posters and presentations to keep referrers up to date. Subsequently, this aimed to create some degree of awareness amongst medical staff, that the group was an option for those referred to the wider Psychology in Healthcare service. Nonetheless, further promotion and dissemination of these findings is required to inform healthcare professionals across the Trust that this is an option for patients with a variety of LTHCs, especially those high on shame and self-criticism. Ultimately, it is hoped that this shared knowledge will encourage further research and improve longer-term outcomes for individuals living with LTHCs.

5. Conclusions

In summary, this evaluation demonstrated the benefits of a compassion-focused group intervention across a range of LTHCs. The group experience was well-received by participants and

results showed improvements across outcomes of mood, well-being, and engagement in everyday activities. Additionally, findings provide support for observed improvements arising from processes targeted by CFT. The wider field of CFT for LTHCs and its available evidence remains in its infancy; however, these results demonstrate the utility of a transdiagnostic approach and provide recommendations that can be employed to expand findings in the future.

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Author Contributions

TC and JC collaboratively devised and recruited for the 'Living Well with Illness' groups. RS conceived and designed parameters of the group evaluation. RS collated and analysed both quantitative and qualitative study data. Data coding was completed by RS and JC. RS independently drafted the manuscript which was then revised collaboratively (RS and TC). TC supervised all stages of this research project.

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Competing Interests

The authors have declared that no competing interests exist.

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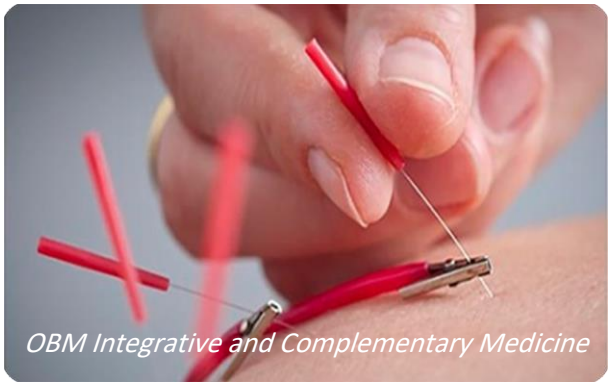

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