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Project Report

A Service Based Evaluation of Compassion Focused Group Therapy Within a Community Mental Health Team Setting

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Abstract

The current paper explores the impact of Compassion Focused Therapy (CFT) when delivered in a group setting to people with a range of diagnoses presenting to a Community Mental Health Team. In total five groups of 14 to 18 sessions were run with an average of five participants completing each group. A range of self-report measures examining global psychological distress, self-criticism, depression, anxiety and stress, emotion regulation, social comparison, shame and compassionate attributes and skills were administered pre and post group. Results indicate overall reductions in psychological distress, depression, anxiety and stress and suggest improved emotion regulation and improved perception of social rank and how others may see them following completion of the group. In addition participants appeared to rate themselves as more compassionate towards themselves and more accepting of compassion from others following the group, according to the Compassionate Engagement and Action Scales. These results appear to be generally in keeping with the findings of other

similar studies examining the effectiveness of CFT groups with trans-diagnostic populations thus adding to the evidence base in this area, however larger, more robust trials including a control group for comparison would be beneficial.

Keywords
Compassion focused therapy; group; trans-diagnostic; mental health

1. Introduction

Compassion Focused Therapy (CFT) is an approach that has been shown to be helpful for people who have chronic and complex mental health problems that appear to have developed or are being maintained by feelings of shame and self-criticism [1, 2]. These feelings are common in a range of mental health problems and are often linked to neglectful or abusive backgrounds [3, 4]. CFT was developed to try to help people with high levels of shame and self-criticism who struggle with self-soothing, feelings of safeness and self-acceptance [5]. It is proposed that delivering this therapy in a group format could help target both external shame i.e. our thoughts and feelings about how we exist in the minds of others and internal shame i.e. self-directed attention and focus on the self as inadequate or bad and therefore prove beneficial to participants. It has also been found that people with high levels of shame and self-criticism may do poorly in traditional Cognitive Behavioural Therapy (CBT) [6]. CFT is a multimodal therapy that is rooted in evolutionary psychology and is based on growing evidence that affiliative emotions and motives can have a positive impact on well-being and affect regulation [7]. CFT encourages the development of compassionate motivation, attributes and skills and seeks to build feelings of safeness, contentment and connection in order to develop emotional balance, well-being and to manage the challenges of life.

CFT has a growing evidence-base and the first evidence for the value of CFT came from group-based work [5]. Group-based CFT is now showing promising effects for people with a diagnosis of personality disorder [8], for those in a high security psychiatric setting [9], for people with an acquired brain injury [10], those with eating disorders [11, 12], for people recovering from psychosis [13]; for people with heterogeneous mental health problems presenting to community mental health teams [14-16] and for patients in an acute inpatient setting with a range of diagnoses [17]. A systematic review by Leaviss and colleagues [18] concluded that CFT has promise for the treatment of mood disorders, particularly for those who are highly self-critical, but they suggest that additional, large-scale, high-quality studies are needed before it can be deemed evidence-based practice. A non-randomised controlled trial of a trans-diagnostic CFT group versus treatment as usual found significantly greater reductions in level of psychopathology for the CFT group compared with TAU [15]. Furthermore these reductions in psychopathology were found to be maintained at 2 month follow-up. Additionally a systematic review and meta-analysis suggested that self-compassion related therapies bring about improvements in self-compassion and psychopathology but the authors questioned whether this is over and above other interventions [19]. A more recent systematic review of the effectiveness and acceptability of CFT in clinical populations [20] examined 29 studies and concluded that CFT shows promise for treating a range of mental health problems, especially if delivered in a group setting for at least 12 sessions. They suggest that CFT leads to

increased self-compassion and reduced mental health symptoms across a range of presentations and appears to be equally effective or possibly more effective than other interventions. They also state that there is currently more evidence for group CFT than individual/self-help intervention.

Given the promising evidence-base for group-based CFT for a range of mental health problems we wished to develop a CFT group intervention for Community Mental Health Team (CMHT) patients locally within NHS Ayrshire and Arran. A CFT model was chosen because people with a variety of diagnoses referred for psychological intervention within our CMHTs often experience trans-diagnostic similarities such as low self-worth and high levels of shame and self-criticism, combined with a limited ability to self-soothe for which CFT has been developed to help [1]. While CFT was already being provided on an individual basis we were interested in the possible added benefits of de-shaming and validation which may arise from learning and sharing ideas and experiences with other group members. It was initially hoped that offering CFT in a group format may have health economic benefits and be a helpful waiting list initiative, however given the time commitment for facilitators and relatively small number of participants in each group it became apparent this may not be the case. In this paper we have included the data from all five CFT groups delivered within our service to date as the content of these groups was very similar and we wished to achieve a sufficient sample size. We had hoped to include the data from a subsequent CFT group which commenced in early 2020 but unfortunately this group had to be put on hold and then cancelled due to the Covid-19 pandemic.

NHS Ayrshire and Arran supported the group facilitators (five Clinical Psychologists, a Counselling Psychologist and a Nurse Consultant in Psychological Therapies) to complete training in Compassion Focused Therapy (CFT) as part of developing clinical skills within the service. We also recruited an Assistant Psychologist in preparation for and during the delivery and evaluation of the first two groups.

1.1 Aims

To explore the development, delivery and effectiveness, in relation to psychopathology, of a CFT group in a community mental health team setting for participants with a range of diagnoses.

2. Materials and Methods

2.1 Design and Procedure

This was an uncontrolled observational study with a pre and post intervention design. CFT groups were run as part of routine clinical practice in the Psychological Specialty within the Community Mental Health Teams across two localities in Ayrshire and Arran.

All patients referred to the Psychological Specialty within the CMHTs were routinely assessed and placed onto a treatment waiting list if identified as suitable for psychological intervention as usual. Patients on this waiting list who were identified to experience high levels of shame and self-criticism were invited to attend a further screening assessment appointment with one of the group facilitators to consider suitability and willingness to participate in the group therapy. Participants were selected predominantly on the basis of assessment/screening which highlighted significant issues with self-criticism and shame which appeared to be playing a key role in maintaining their distress/difficulties. The majority of participants had received previous psychological intervention,

however this was not a specific inclusion criteria and no data were recorded on participants` past treatment exposure. The CFT group was developed as a stand-alone psychological intervention. If those screened were considered unsuitable for this intervention or chose not to participate in the group they remained on the waiting list for individual treatment as usual. Eligible participants were offered a place in the group and commenced intervention. Data were collected by providing participants with self-report measures for completion prior to commencing the first group session and post intervention at the end of the final group session.

2.2 Participants

Inclusion criteria were: clear long-standing problems with intense shame and self-criticism. It was also emphasized that participants must be motivated, willing and able to attend the majority of sessions, to complete home practice between sessions and to talk about their difficulties in a group setting. Exclusion criteria were: severe depression where symptoms would impact on the ability to attend sessions, actively participate in the group and undertake homework tasks; significant risk (e.g. serious deliberate self-harm or suicidality); significant alcohol and substance misuse; active psychotic symptoms; severe literacy problems and marked interpersonal difficulties which would be likely to be difficult to manage in a group setting.

Thirty nine participants were offered a place in a CFT group. Twelve individuals did not attend or dropped out prior to completion. A total of 27 individuals completed the group (31% attrition). Data from two individuals was lost to follow-up, therefore, the final sample used for data analysis consisted of 25 participants all of who completed the group and had available pre and post outcome data for most measures.

Of these, 21 were female and four were male (age range 22-61 years, mean 43.04, SD 10.9). The predominant diagnoses, obtained from clinical records and referral information, were anxiety and/or depression (20 participants), two participants had a diagnosis of Bipolar Affective Disorder and three had a diagnosis of Borderline Personality Disorder. Many of the group participants reported having experienced significant trauma and/or neglect in childhood and all experienced ongoing difficulties with shame and self-criticism. There was no follow up data for those who did not attend or dropped out. All of those who dropped out were invited to make contact with the service to discuss on-going treatment options.

2.3 CFT Intervention

Each group was facilitated by two or three (group 2) psychological therapists each based within a CMHT in NHS Ayrshire and Arran and with experience of using CFT. All therapists had previously attended a minimum of a 3-day introductory workshop in CFT and several had also completed a 3-day advanced clinical skills in CFT training. The group facilitators sought external, expert supervision during the planning, delivery and review of the first two groups. This involved approximately one hour supervision fortnightly which allowed an opportunity to reflect on our experiences of facilitating the groups; developing and adjusting the content and pacing of sessions in accordance with participants' engagement and group dynamics; supporting our understanding and skills development of delivering CFT in a group format, anticipating and forward planning for potential challenges resulting from participants' engagement with CFT and considering how to evaluate the CFT groups. During delivery of the third and fourth groups fortnightly peer supervision was arranged

with the group facilitators and one of the therapists from the second group who is also an experienced supervisor.

The groups were delivered over 14 (group 1), 16 (group 2) to 18 (groups 3-5) sessions (weekly for approximately 2.5 hours with a break in the middle for tea and coffee) and were each completed within a 6-7 month period between October 2013 and March 2018. While the content of the group sessions was very similar, the number of sessions was increased to allow for more repetition based on feedback from group participants and our own reflections in supervision regarding appropriate pacing and content of group sessions. From cursory review of the data the majority of participants in group 1 and groups 2 to 5 appeared to have a similar pattern towards reduced severity in ratings according to key symptomatology outcome measures post-group and thus all 5 groups were included in the analysis. There was an average of five members per group.

The group content was developed from Paul Gilbert's materials and also from materials and experiences shared on the Compassionate Mind Foundation website and discussion forum. Individual group sessions were developed based on these resources and discussion in supervision and were adapted as necessary as each group progressed. The group-based format of CFT was highly experiential and task-focused. Group facilitators engaged in practices alongside the group wherever possible and shared our own feelings and experiences to try to promote the CFT principle of us all being vulnerable to the flow of life and its various challenges. Group participants were encouraged to practice skills between sessions and audio-recordings of all exercises were provided to assist with this along with handouts summarising the content of each session and with a reminder about any home tasks.

Content of the 18 CFT group sessions was broken down as follows:

- Sessions 1-5 – Introduction to compassion, the 'tricky brain', 3 systems model of emotion regulation and introducing mindfulness, soothing rhythm breathing, compassionate colour imagery and place of calm imagery.
- Sessions 6-10 – Developing the compassionate mind-set and practicing the 3 flows of compassion: compassionate memory, ideal compassionate other and compassionate self. Exploring and working through any blocks to compassion as they arise.
- Sessions 11-15 – Putting compassion to work – compassionate thought balancing, letter writing and multi-self.
- Sessions 16-18 – Exploring feelings about group ending, compassionate motivation, intention and commitment for the future, personal practice planning.

2.4 Measures

The following self-report measures were administered prior to and after completion of the CFT group:

2.4.1 Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM; [21])

The CORE is a 34-item self-report questionnaire developed for administration pre and post therapy. Questions ask the client about how they have been feeling over the past week according to a 5-point scale on which options range from 'not at all' to 'most or all of the time'. The items in the CORE cover four main areas: subjective well-being; problems/symptoms; life functioning; and

risk/harm. Scores on the CORE can be used to indicate level of current psychological global distress and range from 'healthy' to 'severe'.

2.4.2 Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS; [22])

This is a 22-item self-report scale developed to examine self-criticism and the ability to self-reassure. It looks at the different ways people think and feel about themselves when things go wrong for them. There are three types of questions: two which look at forms of self-criticism; inadequate self, which focuses on a sense of personal inadequacy (e.g. I am easily disappointed with myself), and hated self, which examines the desire to hurt or persecute the self (e.g. I have become so angry with myself that I want to hurt or injure myself), and one which looks at the ability to reassure self (e.g. I am able to remind myself of positive things about myself). Participants rate their responses according to a 5-point Likert scale which ranges from 0 = not at all like me, to 4 = extremely like me.

2.4.3 Depression, Anxiety and Stress Scale - 21 (DASS-21; [23])

This is a 21-item self-report scale which contains 3 sets of items designed to measure the emotional states of depression, anxiety and stress. There are 7 items per subscale which respondents are asked to rate from 0 (did not apply to me at all) to 3 (applied to me very much or most of the time) in relation to how they have been feeling over the past week. Scores for depression, anxiety and stress are calculated by summing the scores for the 7 items in each subscale. The DASS-21 scores are multiplied by 2 to obtain the clinical reference range and these are the scores our analysis was based on.

2.4.4 Difficulties in Emotion Regulation Scale (DERS; [24])

This is a 36-item self-report questionnaire developed to assess multiple aspects of emotional dysregulation. Items are rated from 1 = almost never to 5 = almost always. Greater difficulty with emotion regulation is indicated by higher scores on this measure. A total score (SUM) can be calculated and the scores can also be broken down into six sub-scales.

2.4.5 Social Comparison Scale (SCS; [25])

This 11-item self-report scale explores how a person views themselves in comparison to others. Items explore respondents' judgements about their rank, attractiveness and how well they think they 'fit in' with others. Low scores indicate a sense of low social rank perceptions about the self and sense of inferiority therefore this measure was included as a proxy measure of internal shame. Items consist of 11 bipolar constructs according to which participants are asked to make a global comparison of themselves in relation to other people and to rate themselves along a ten-point scale. Examples include: In relationship to others I feel: Incompetent 1 2 3 4 5 6 7 8 9 10 More competent.

2.4.6 Other as Shamer Scale (OAS; [26])

This measure was selected as a widely used measure of external shame. This is an 18-item self-report scale which examines how respondents think others see them. Items are rated on a scale

from 0 = Never to 4 = Almost Always. Total scores can range from 0 to 72 with higher scores reflecting a more negative perception of how respondents think others see them.

2.4.7 The Compassionate Engagement and Action Scales (CEAS; [27])

This measure was only available for use with groups two to five and is made up of 3 separate sets of self-report scales which measure perceptions of compassion for self, compassion to others and compassion from others. Each scale is broken down further into two parts: compassionate engagement and compassionate action. Items are rated from 1 = Never to 10 = Always. The scales can help to identify relations between these three flows of compassion.

The Local Research and Development Committee approved this as a service-based evaluation and therefore NHS research ethical approval was not required. No personally identifiable information was collected and data collected was part of routine clinical practice thus no formal consent to use data was obtained.

3. Results

3.1 Data Analysis

Data were analysed using SPSS 15.0 for Windows. The assumption of normal distribution for continuous data was explored using descriptive statistics (mean, 5% trimmed mean, median). Kolmogorov-Smirnov tests and skewness and kurtosis values were also calculated to formally assess normality. The majority of the data were normally distributed, with the exception of the Social Comparison Scale which was peaked (Kurtosis w 1.86), therefore a series of paired t-tests were used to examine the difference between pre and post scores. Group 1 (N = 4) had complete data for all measures apart from the CEAS which was unavailable at the time of delivering the group. Groups 2-5 (N = 21) had complete data for the SCS, N = 3 had missing CORE-OM data either pre or post group, N = 1 had missing DERS data pre group, N = 1 had missing FSCRS data pre group, N = 1 had missing OAS data pre-group and N = 1 had missing DASS-21 data pre group, therefore these participants scores were not included in the analysis for these particular measures (see Table 1 for the total N who completed each measure pre and post group and are therefore included in the analysis).

Reliable and clinically significant changes were also examined. The Reliable Change Index (RCI) was calculated for two key outcome measures (CORE-OM & DASS-21) according to Jacobson and Truax criteria [28]. For the DASS-21 the RCI was calculated using published Cronbach's alpha values from a similar population [29]. Given the current study's relatively small sample size, standard deviations were derived from a large outpatient clinical sample study [30]. RCI for the depression subscale was 5.33 (Cronbach's alpha = 0.97, SD, 11.10). The RCI for the anxiety subscale was 6.91 (Cronbach's alpha = 0.92, SD 8.82) and for the stress subscale the RCI was 6.20 (Cronbach's alpha = 0.95, SD 10.00). For the CORE-OM the RCI was calculated using the reliability coefficient (Cronbach's alpha = 0.93) and the standard deviation (0.75) based on a UK clinical sample [31], giving a RCI of 0.51.

3.1.1 Intervention Outcome

The paired t-tests examining pre and post group scores are presented in Table 1.

Table 1 Pre and Post Self-report Measures.

Measure	N	Pre Mean (SD)	Post Mean (SD)	t	p	Effect size (d)
CORE-34	22	65.45 (19.88)	46.97(27.11)	4.26	***	0.46
DASS-21 Depression	24	24.96 (9.90)	18.50 (13.98)	2.78	*	0.25
DASS-21 Anxiety	24	18.79 (11.35)	14.92 (10.04)	2.07	0.05	0.16
DASS-21 Stress	24	22.54 (9.34)	18.63 (10.7)	2.10	*	0.16
OAS	24	42.67 (14.28)	33.21 (17.6)	3.98	**	0.47
SCS	25	36.24 (17.07)	47.08 (16.9)	-3.39	**	0.32
DERS-Total	24	115.04 (30.52)	97.58 (31.5)	3.93	**	0.33
FSCRS-Inadequate	24	26.88 (6.07427)	21.2917 (8.28)	5.08	***	0.53
FSCRS-Reassure	24	9.96 (5.21)	17.04 (7.34)	-4.74	***	0.4
FSCRS-Hated	24	12.13 (5.77)	7.33 (4.73)	5.06	***	0.53
CEAS-Self Compassion engage	21	5.14 (1.2)	6.33 (1.35)	-4.79	***	0.53
CEAS-Self Compassion action	21	3.96 (1.8)	6.49 (1.69)	-7.09	***	0.71
CEAS-Compassion to Others engage	21	7.18 (1.69)	7.53 (1.32)	-1.12	0.28	0.06
CEAS-Compassion to Others action	21	7.49 (1.75)	7.77 (1.6)	-1.05	0.31	0.05
CEAS-Compassion from Others engage	21	5.27 (1.57)	6.18 (1.625)	-2.80	*	0.28
CEAS-Compassion from Others action	21	5.76 (1.7)	6.21 (1.66)	-1.04	0.31	0.05

Note. CORE-OM: Clinical Outcomes in Routine Evaluation - Outcome Measure; DASS-21: Depression, Anxiety & Stress Scale; OAS: Other as a Shamer Scale; SCS: Social Comparison Scale; DERS: Difficulties in Emotion Regulation Scale; FSCSR: Forms of Self-Criticising/Attacking and Self-Reassuring Scale; CEAS: The Compassion Engagement and Action Scales. *$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

Social Rank. Following group attendance, there was a significant increase in scores on the Social Comparison Scale, indicating that participants felt less inferior, unattractive and different from other people. There was also a significant decrease in scores on the Other as Shamer Scale of a large effect size following the group, indicating that participants experienced a reduction in external shame, thus perceiving that others viewed them less negatively.

Self-criticism. On the Forms of Self-Criticism Scale, there were significant decreases in both inadequate self-criticism and hated self-criticism after completion of the CFT group. Both of these changes were of large effect size.

Self-compassion. Scores on the self-compassion subscale of the of The Compassionate Engagement and Action Scales showed significant increases in both the engagement and actions subscales and these were of large effect size. Additionally significant increases, of large effect sizes,

were found on the reassure-self subscale of the Forms of Self-Criticising/Attacking and Self-Reassuring Scale, indicating positive changes in the ability to reassure oneself after a difficulty.

Compassion to others/from others. There was no change in participants' reported ability to engage with or alleviate other people's distress on the compassion to others subscales of The Compassionate Engagement and Action Scales. Regarding ability to receive compassion from others on this scale, there was a significant increase in engagement subscale scores, thus a sense that others were able to engage with their suffering and this was of large effect size. However, there was no change in action subscale scores, indicating no change to perceptions of others being able to take action to help to alleviate their suffering.

Symptomatology measures. A significant improvement was found on the CORE-OM overall scores and this was of large effect size. Significant reductions were also found following the group on overall DERS scores indicating improvement in perceptions of emotion regulation skills, again this was of a large effect size. There was also significant improvement in depression and stress symptoms on the DASS-21 following the group, with large effect sizes. Although the change in anxiety scores on the DASS-21 was not significant, the p value was approaching significance and scores decreased from the 'severe' clinical range pre-group to the 'moderate' clinical range for anxiety according to this measure following the group.

3.1.2 Reliable and Clinical Change

As shown in Table 2, results from the RCI analyses showed that 59% of participants demonstrated reliable improvement from pre- to post-intervention on the CORE-OM. Between 33% and 67% of participant's demonstrated reliable improvement from pre- to post-intervention on the DASS-21 subscales, with scores for depression showing the highest proportion of improvement (67%). A minority of participants demonstrated reliable deterioration on at least one DASS-21 subscale pre- to post-intervention. Five participants out of 24 (21%) demonstrated reliable deterioration on the depression subscale of the DASS-21. Three and four participants respectively showed reliable deterioration on the anxiety and stress subscales of the DASS-21.

Table 2 Percentage of participants who demonstrated reliable and clinical change.

Measure	% reliable improvement	% reliable deterioration	% clinically improved
CORE-OM	59%	0%	20%
DASS-21 Depression	67%	21%	30%
DASS-21 Anxiety	33%	12%	25%
DASS-21 Stress	46%	17%	33%

Note. CORE-OM: Clinical Outcomes in Routine Evaluation - Outcome Measure; DASS-21: The Depression, Anxiety & Stress Scale.

Clinical change scores were also calculated for measures with available clinical cut-offs (CORE-OM and DASS-21). The CORE-OM has a recommended clinical cut-off of 1.0 for the mean scores. Twenty out of 22 participants (90%) demonstrated scores above the clinical cut-off pre-intervention.

Of these, 20% had scores below the clinical cut-off post-intervention. On the DASS-21, 20 of the 24 participants (83%) had scores within the clinical range (moderate to extremely severe) pre-intervention for both depression and anxiety. Eighteen of the 24 participants (75%) scored in the clinical range for stress pre-intervention on the DASS-21. For depression, of those who scored in the clinical range pre intervention, 30% were in the non-clinical range (normal or mild) after the group intervention. 25% and 33% of participants that scored in the clinical range for anxiety and stress respectively scored below the clinical cut offs (normal or mild range) post group.

4. Discussion

We opted to develop a trans-diagnostic CFT group as there is a growing evidence base for the effectiveness of such groups [5, 14-16]. Also the clients seeking help from our CMHTs tend to present with very high levels of comorbidity, rather than one clear diagnosis, therefore we were keen to develop interventions that can be helpful trans-diagnostically. Our findings generally appear in keeping with similar studies in the area which examined the effectiveness of CFT groups with heterogeneous populations within a mental health setting. For example, Judge and colleagues [14] found significant reductions on measures of depression, anxiety, stress, self-criticism and shame post group. While our analysis did not show a significant reduction in anxiety according to the DASS-21 it is perhaps worth noting that the mean score fell in the 'moderate' range following the group compared to the 'severe' range pre-group. Reliable change analyses showed that 59% of participants demonstrated reliable improvement from pre- to post- intervention on the CORE-OM and between 33% and 67% of participants showed reliable improvement from pre- to post-intervention on the DASS-21 subscales, with the largest reliable change on this measure (67%) being for depression. Twenty percent of participants showed clinical improvement on the CORE-OM post intervention and between 25% and 33% of participants showed clinical improvement on the DASS-21 subscales. It was beyond the scope of this paper to explore and compare individual characteristics of participants such as specific presenting problems and severity on outcome, however this could be an important area for future research. Interestingly, while they used different outcome measures [32, 33], Judge et al. [14] also noted what appear to be large shifts for depression in particular, reporting that while the majority of their participants scored in the 'severe' range for depression pre-group, the most frequent classification for depression after the group was 'borderline'. They also carried out correlational analysis which they report suggested that high initial levels of anxiety may make it difficult for participants to generate self-soothing thoughts. Cuppage and colleagues [15] found significantly greater improvement on measures of psychopathology, fear of self-compassion and social safeness following a CFT group compared with TAU. Their analyses also showed improvements in self-criticism and shame for the CFT group but not the comparison TAU group. McManus and colleagues [16] found statistically significant improvements on all measures used post group, including the Forms of Self-Criticising/Attacking and Self-Reassuring Scale [22] and the Other As Shamer Scale [26] and we also found statistically significant improvements according to these measures.

We additionally used the Difficulties with Emotion Regulation Scale [24] pre and post group because significant emotion dysregulation is a common trans-diagnostic feature for many people presenting to our CMHTs, particularly given the high incidence of early experiences characterised by significant trauma and/or neglect. A systematic review by Inwood and Ferrari [34] examining the

mechanisms of change in the relationship between self-compassion, emotion regulation and mental health suggested emotion regulation being a possible mechanism of change in the relationship between self-compassion and mental health. Moreover, they suggested that self-compassion may be a helpful preliminary target for treatment for people who are avoidant of their emotional experience. Our results suggest that there was significant improvement in emotion regulation following completion of the CFT group according to the DERS.

In addition, The Compassionate Engagement and Action Scales [27] were used to explore changes in the three flows of compassion (compassion to self, compassion to others and receiving compassion from others) following the group. Scores for this measure indicated that participants were more motivated to be compassionate towards themselves, and that they thought others were more likely to be motivated to engage compassionately with their distress following the group. However, there were no significant changes in how likely participants felt others would be to help with their distress. It is possible that this could be due to a range of factors related to the social support network of group participants. Interestingly participants rated themselves fairly highly for compassion to others at the start of the group and these scores did not change significantly following the group. It seems possible that people who opted to participate in a group treatment (as opposed to individual therapy) may be more likely to be compassionate towards others to begin with. Similar to the suggestions of Irons and Heriot-Maitland [35], it was also noted that many group participants considered themselves "people pleasers", often putting others feelings and needs before their own and it may be that this affected their scores on this subscale.

There are a number of limitations to the current evaluation. First, this is a relatively small sample and there was no waitlist control or active therapy comparison group. Second, we did not gather information regarding the reasons/characteristics of the proportion of participants who dropped out nor examine individual characteristics such as diagnosis or severity for those participants who did not appear to benefit, or for the minority who experienced reliable deterioration according to subscales of the DASS-21. This information could be helpful in understanding who is likely to benefit most from this approach. We also did not collect data regarding previous psychological interventions received nor which individuals went on to require additional psychological intervention following the group. This would be interesting for future research, especially given the apparent lack of significant improvement in anxiety scores on the DASS-21 post-group. Third, the number of sessions for our groups increased from 14 to 18, in part based upon feedback from participants. Although we grouped the data together for the purpose of analysis, it may be that groups with a greater number of sessions were more effective. Administering outcome measures at more regular intervals may help us to assess optimum group length in future. There is a suggestion from Craig and colleagues [20] systematic review that similar changes were found for CFT interventions lasting at least 12 sessions (20-24 hours total) to those lasting 27+ hours which raises questions about the need for the additional group sessions which we added in later groups. In addition given that 21 out of the 25 group participants in this analysis were female it is possible this may have influenced the group dynamics and outcomes and the issue of whether gender impacts on outcomes would be interesting to explore in future. Furthermore we did not collect any follow-up data therefore it is not possible to determine if any gains were maintained. Finally the lack of a manualised, standard approach to delivering group based CFT at the time of delivering these groups makes it difficult to draw direct comparisons with other seemingly similar studies.

However given the promising initial findings we plan to repeat CFT groups on a rolling basis and now consider this part of routine provision of psychological therapies within our CMHTs. It will be important to continue to evaluate this intervention by repeating the aforementioned measures pre and post treatment to assess the clinical effectiveness of the group and to refine the most effective means to capture long-term and meaningful change for participants. We will also consider using selected measures at more regular intervals to evaluate change as the group progresses and to give a better indication of the optimum number of group sessions. Ideas for the future could involve longer-term follow-up of group participants so that we can assess whether any gains following group therapy are maintained and to refine our knowledge about the most suitable candidates for this approach. Ideas for future research may also include comparison with a control group if possible, or comparison of group CFT with individual CFT. Additionally a qualitative thematic analysis of participants' experiences of attending the group could be helpful for developing a more in-depth understanding of the group process.

5. Conclusions

The results of this service-based evaluation appear to further support the growing evidence base for trans-diagnostic CFT groups for adults with a range of mental health problems accessing treatment from community mental health services. The inclusion of the Difficulties in Emotion Regulation Scale (DERS) may lend itself to further exploration of the role of emotion regulation as a possible mediator between self-compassion and mental health. As with many other studies in this area, the lack of a control group means we are unable to ascertain if similar results could be obtained with a different intervention and there remains a need for more rigorous randomised controlled trials.

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Author Contributions

Becky Dafters and Sarah Mackintosh were group facilitators and contributed to the conceptualisation, data collection, data analysis and writing of the original draft. Chris Irons provided supervision for the first two groups and contributed to the conceptualisation and reviewing and editing the original draft.

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Competing Interests

The authors have declared that no competing interests exist.

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