

Original Research

An Exploration of the Experiences of Group Compassion Focused Therapy for Hospital Outpatients with Long-Term Mental Health Difficulties

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Abstract

There is now good evidence for the efficacy of Compassion Focused Therapy (CFT) for a variety of mental health difficulties. To deepen understanding of the processes underpinning CFT's effectiveness, this service evaluation explored the experiences and reflections of individuals with long-term mental health difficulties who had previously received therapy and attended an 11-week CFT group. Ten clients were invited to the group; one withdrew before the group started because of work and personal commitments and another attended five sessions, improved, was able to obtain employment and left. Eight participants attended eleven 2-hour sessions of group CFT. Five of the participants attended the first focus group at the end of the therapy and three of these participants also attended the second focus group 3 months after



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the group had ended. Focus groups were analysed using Reflexive Thematic Analysis. Participants highlighted the value of understanding the distinctions between safety and safeness, how to create social safeness between themselves and its link with compassion. These participants' efforts enabled feelings of grounding, interconnectedness, openness and were de-shaming in ways they had not experienced before. They reflected on how they had benefitted from psychoeducation on the evolved functions of mind, their biopsychosocial properties and the nature of brain states. They had also gained new understandings into the nature of compassion, in particular the distinction between processes of empathic *engagement* and *actions* in response to distress. This enabled them to apply different components and processes of compassion flexibly and in relevant ways to their mental health difficulties and everyday life. CFT's focus on evolution, tricky brain concepts and how compassion can change brain states was experienced as new and different from previous therapies. One participant described CFT as 'life changing'. Although we did not set out to explore the impact on employment, five participants began to seek employment during the course of the group. While there is good evidence that CFT is a well-accepted and effective psychotherapy, this service evaluation adds to insights on some of the core micro-processes participants identify as central CFT themes, which were felt to be unique and important to their progress.

Keywords

Compassion focused therapy; psychotherapy; safeness; service evaluation

1. Introduction

The first group therapy study of CFT for people with complex mental health difficulties was conducted over 20 years ago [1]. Since then, CFT has grown and developed rapidly in terms of incorporating the developments in biopsychosocial sciences that guide CFT [2-8] and the therapeutic processes of delivery [3, 9-15]. This service evaluation builds on these further by exploring the experiences of people with chronic and long-term mental health difficulties who received group-based compassion focused therapy (CFT), which was grounded in helping participants create experiences of social safeness and compassionate sharing. CFT integrates a range of evidence-based therapeutic interventions from different schools of therapy and continues to evolve in line with emerging research [6]. CFT highlights that any intervention will have a greater impact when in the context of compassionate brain states, partly due to their role in regulating threat states [11, 16]. Hence, this study utilised some of the recent developments of CFT [11], including a specific focus on the distinction between safety and safeness and the importance of practising compassionate behaviours for this client group.

A major meta-analysis consisting of clinical and non-clinical samples, with data from 7,875 participants, found that "CFT was effective in reducing overall negative mental health outcomes ($k = 32$, $g = 0.72$, $p < 0.0001$), depression ($k = 23$, $g = 0.49$, $p < 0.0001$), self-criticism ($k = 17$, $g = 0.40$, $p < 0.0001$) and in improving compassion for self and others ($k = 24$, $g = 0.51$, $p < 0.0001$)" ([17], p. 230). CFT is now used for a range of group-based interventions [14, 18]. Group delivered CFT has

been shown to be helpful for many mental health difficulties including those that are complex and difficult to treat, such as: complex PTSD [19-21]; complex attachment trauma [13, 22, 23]; trauma and relational problems in veterans [24, 25]; treatment-resistant OCD [26]; voice-hearing [27]; chronic depression [28] and bipolar disorder [29] and has also been shown to impact heart rate variability (HRV) [29]. Group-based CFT has also been helpful for people with physical health difficulties such as chronic pain [30, 31] and irritable bowel syndrome [32].

In general, group psychotherapy provides a socially supportive learning environment that enables participants to explore their own minds as well as those of others, share their stories, hopes and fears and experience 'common humanity' with validating and empathic caring interactions that facilitate growth and change [33-35]. These processes are central to CFT and are contextualised within an evolution-informed, biopsychosocial approach to mental functioning and mental health difficulties [6, 11, 36-39]. CFT integrates a range of evidence-based therapeutic interventions that guide people in how to create brain states that support the biopsychosocial processes of compassion [6, 36, 37, 39, 40]. This is because care and compassion focused motives evolved with specific biopsychosocial processes for regulating threat and resource (reward) seeking systems and promoting social affiliation, thereby generating the potential for positive relationships with self and others [11, 39, 41-43].

1.1 Social Mentalities and CFT

CFT outlines how different social and non-social motivational and emotional systems evolved to pursue different functions. These include harm avoidance, resource gathering, social competition and cooperation, reproduction, and infant and conspecific caring [6, 16, 44]. Social mentalities co-evolved enabling *reciprocal, dynamic interactions* that are role sensitive and psychophysiological regulating [6, 40, 45-47]. For example, for caring to evolve, brain mechanisms in both providers and recipients, that can send signals as well as appropriately respond to caring, needed to co-evolve. The co-evolution of 'sender and recipient' is similar for other social motives such as for sex and for dominant-submissive interactions. Hence, social motives (that differ from non-social motives) have been referred to as *social mentalities* because they are the foundation for reciprocal, dynamic, role-appropriate interpersonal interactions, and are dependent on specialist processing systems that are role specific and 'social signal sensitive' with profound impacts on multiple physiological systems [6, 42, 43, 46, 48]. Hence, when two or more individuals are exchanging signals of care, affection and support, they co-regulate their psychophysiological states because they both have brain mechanisms for sending and responding to care signals [43]. The psychophysiological states that are activated in caring will therefore be very different than those activated during conflict or argument [6, 36, 38, 39, 49-52]. Social relationships can therefore be in or out of physiological synchrony [53]. The physiological mediators of empathy are stimulated differently if the target is somebody we identify with or like than somebody we do not [54]. We empathise differently when in a caring versus a competitive social mentality [55]. Hence, social mentalities co-regulate psychophysiological states of interacting individuals [6, 49, 56]. Importantly, whether others are critical of us, or we are being self-critical, the same threat-based physiological systems are stimulated [57, 58]. Self-criticism and self-compassion create very different patterns of neurophysiological activation [57, 58].

Most approaches to compassion view it as a care-focused motive [6, 41, 59] which can be seen as a social mentality; that is, a motive with social signal sensitivity for ways of engaging in dynamic reciprocal interactions [6, 48, 60]. As for all motives and social mentalities, CFT suggests compassion is operated via a “if A, then do B” stimulus detection-response algorithm and defined as a *sensitivity to suffering in self and others (stimulus) with a commitment to try to alleviate and prevent it (response)* (37). CFT argues that it is very important to distinguish the stimulus sensitivity (e.g. detection of, and engagement with, distress and needs) from the response functions of compassion, because they require different skills [6, 16, 38, 61]. Someone can have one without the other. For example, individuals who are sensitive to distress but do not know what to do can become overwhelmed or feel helpless and thereby disengage or avoid painful states. Indeed, sensitivity to distress without knowledge or abilities to take action can increase vulnerability to anxiety and depression [62]. Hence, both stimulus engagement *and* taking action require (different types of) courage and wisdom and operate through different psychophysiological systems [6, 61]. Without wisdom, compassion can be well-meaning but reckless and harmful. Without courage, people can know what to do but are too indifferent, fearful or avoidant to do it; for example, standing up against injustice to others or self, addressing trauma, learning self-assertion, working through feared or non-conscious rage and grief [11, 63, 64]. In addition, group therapy participants may be sensitive to the distress of others but not engage with it. They may feel they have too many problems of their own to engage with them, believe that because they do not know how to help themselves, they do not know how to help others, and devalue their possible contributions. They may fear their efforts at helpfulness will be unhelpful or rejected, or believe helping is not their responsibility but that of the group leader. These can be part of what are called basic compassion inhibitors linked to fears, blocks and resistances (FBRs) to compassion (and the therapeutic process) [63, 64].

1.1.1 Safety vs Safeness

Crucial to all forms of life are the motives and abilities to address the three major tasks of life: 1. detecting threats, preventing harm and seeking safety, 2. acquiring resources needed to survive, flourish and reproduce, and 3. utilising opportunities for settling physiological systems, returning to homeostasis and physiological patterns conducive to health and safeness [6, 43]. The evolution of caring and affiliation created forms of relationships that powerfully impact physiological systems conducive to health and forms of positive affect. In regard to the evolution of caring and its physiological impacts, attachment theory showed that parents provide offspring with three core safeness-creating contexts for growing and learning [50, 65-67]. These are: 1. proximity maintenance, whereby the infant has regular access to a caring other (parent); 2. a secure base, where the parent protects, rescues *and* provides resources for the infant, enabling and encouraging them to learn and adapt to their environments; 3. a safe haven, where the parent regulates the infant’s emotional state such as with soothing and calming when distressed. Textured through these interactions are experiences of positive emotions of affection, caring and warmth [43, 68, 69].

These functions can be distinguished between those of *safety*, where safety is defined as the absence or prevention of harm, and *safeness*, as indicated by the presence of helpful, caring others [39, 44, 46, 70]. Social safety is regulated through the threat system involving the amygdala, hypothalamic pituitary adrenal axis and sympathetic arousal [71, 72], whereas social safeness operates through circuits that evolved for social trust and attachment [67, 73]. Numerous studies

have found that attachment-security priming impacts and attenuates threat processing via different pathways and systems such as the amygdala [74, 75]. We may feel free from being threatened by others, but that does not necessarily mean we feel they will help us if they need to give up time, energy and resources to do so. These are crucial distinctions in group therapy experience.

Importantly, people's experiences of shame can create anticipations that when they are emotionally needy or distressed, others are unlikely to be helpful and may not see them as *worthy* of being helped [44, 50, 76]. Nearly a century ago, Adler and Wolfe [77], argued that people compete for recognition and strive to avoid inferiority because they fear others will reject them if they fail [78, 79]. One of the drivers for some forms of perfectionism is the belief that others will not help them if they make mistakes, which Dunkley et al. [80, 81] called *evaluative concerns*. Dunkley et al. [80] suggested that self-critical perfectionists experience chronic dysphoria "... because they experience minor hassles in catastrophic terms and perceive others as condemning, unwilling, or unavailable to help them in times of stress" (p. 235). Crucially, however, this is not only the case for perfectionists, but for many people who have mental health difficulties. Hence, this is an especially important dynamic to explore in group CFT because addressing 'evaluative concerns' and learning how to stimulate social safeness processing systems can generate expectancies that others will be helpful rather than rejecting [6, 11].

1.2 Social Mentalities in Group Therapy

Different social mentalities (e.g. competitive-dominating versus fearful-submissive; socially trusting versus distrusting, caring versus indifferent or callous) can become activated within group therapy, influencing relating styles and how connected individuals feel with each other and the leaders of the group. The social mentalities that are activated (e.g. trust vs distrust; caring versus competitive) in relational episodes, play important roles in the activation of different psychophysiological states that can facilitate or inhibit therapeutic change [6, 20, 82]. CFT therapists guide a client's attention to these relational and psychophysiological effects and to the advantages of practising and deliberately stimulating care-compassion motivational processing systems that will impact styles of social and self-relating. CFT explores how compassionate brain states generate ways of paying attention, thinking, feeling and acting and can be recruited to engage with complex, distressed states. This makes CFT ideally suited to group psychotherapy because group psychotherapy is specifically focused on improving social relating [83].

While many group therapies highlight the importance of developing a secure base and safe haven to facilitate therapeutic alliance, and the tasks of the group [34, 84], CFT also guides participants to explore the differences between safety (freedom from threat) and safeness (social trust and the availability of helpful support) and how these can be created between them. Participants explore how they would like to contribute to the group's safety and safeness. As part of this, participants are introduced to the idea of empathic listening (listening without overly focusing on what to say), empathic reflections, the importance of non-verbal communication such as voice tones and facial expressions and various other social skills [11]. Included are the use of Socratic dialogues, guiding clients to ask questions of each other (e.g. Sam asks Jane: "What was going through your mind?", "What were you hoping for?", "What were you worried about?", "What do you think could help you/him/her?", "What can the group do to help you/him/her?"). Clients can reflect on the value of *validating* and reflecting back that they try to understand how 'John' or 'Jane' feels and share stories.

Also important are mentalising explorations with each other; e.g. “When you say X what do you think ‘John/Jane’ will feel or think? Why might that be? What would be your intention for them to feel/think?” [85]. These intersect with social skills training, which can include assertiveness, empathy and conflict resolution skills [86], and functional analysis in behaviour therapy [87].

Biopsychosocial processes for caring, social affiliative behaviour and the ‘social brain’ evolved with multiple adaptations to genetic and biological processes [42, 43, 50, 59, 88-90]. CFT suggests these motivational biopsychosocial processing systems need to be recruited into the psychotherapeutic process because they evolved to facilitate emotion regulation (threat-processing) and build confidence and positive affect linked to affiliation and social safeness [40, 44, 46]. While most therapies see the therapeutic relationship as a means for the client to experience caring [34], CFT also focuses on cultivating this motivation system using the three flows of compassion: compassion for self, compassion for others and being open to compassion from others. Many clients struggle with stimulating compassionate motives and feelings for themselves, and being open to and trusting compassion from others [36, 39, 63, 64]. They can be fearful of these behaviours from others because they can activate memories of aversive attachment experiences. Indeed, there is now considerable evidence that FBRs to compassion are significantly linked to a range of mental health difficulties [63, 64], including repression and avoidance of rage and grief [11]. Group therapies provide opportunities for people to explore these together and work through them. Hence, group CFT offers a format to engage in the three flows of compassion. The reality of the inhibitors of compassion highlights the fact that a lot of the central processes of CFT are to address the FBRs to compassion. As people can begin to generate and experience the three flows of compassion, they are on their way to change [11, 39].

1.3 Service Evaluation

This service evaluation explored the impact of group CFT for clients who had long-term mental health difficulties and had been on waiting lists, with a focus on distinguishing safeness from safety [44] and guiding participants to explore how they can create a secure base and safe haven between and within themselves.

2. Materials and Methods

2.1 Design

This service evaluation originally used a mixed-methods design. However, in regard to the self-report measures, some participants felt they did not have the time to fill them in, others misplaced them and some were only partially completed. Due to insufficient data, and although some participants showed positive changes on many of the scales they did complete, we have chosen to focus this report on exploring participants’ experiences using the reflections from the two focus groups. The first group took place one week after the therapy had ended and the second three months later.

While the second author and principal therapist (DG) for this group had over 20 years of experience leading general process psychotherapy groups [2-5] and over ten years of experience researching and applying CFT to group psychotherapy (including being involved in a clinical trial at his university; Fox et al. [91]), this particular group experience was unique from any other in which

he had been involved. More specifically, the guide used for this particular group was written by the primary author (and founder of CFT). Further, DG and his co-leaders consulted regularly and received weekly supervision from the first author (PG) whilst leading this group. Given this unique experience, DG kept detailed notes of what occurred in each session with the hopes of offering insights to other practicing clinicians about ways this group differed from any other group formats he had previously used. These observations and reflections are included in the results section below.

2.2 Ethics Statement

As service evaluations are excluded from ethical review in the United Kingdom (UK), we consulted the UK-based Health Research Authority [92] online decision-making tool, which confirmed that ethical review was not required. This project was also approved as a service evaluation by the NHS Trust involved. Informed consent was obtained from participants to publish this data.

2.3 Participants

The first author approached the local Derbyshire Healthcare National Health Service (NHS) Trust with the opportunity for a therapist (second author), who was on a training sabbatical with the Compassionate Mind Foundation, to run a CFT group with NHS therapists for NHS clients. All participants had been referred for therapy to the Derbyshire Healthcare NHS Trust. They were identified from waiting lists and their suitability for the CFT group was assessed by their treating clinicians. Inclusion criteria included those who: were over 18 years old; currently under the Trust's care; had a recognised mental health difficulty for which they were having or seeking treatment; were identified as potential participants for the CFT group by treating clinicians; understood the purpose of the service evaluation and were interested in taking part; understood verbal and written English; and understood the nature of and were likely to benefit from group therapy. Exclusion criteria included: problems that would likely interfere with engagement in a group intervention (i.e. other major mental health issues, such as psychosis or significant dissociative problems; evidence of schizoid and disengaged personality disorder; major substance use; organic complications that would interfere with memory and processing; lack of commitment or interest; issues with interpersonal engagement; acute suicide risk and evidence of anti-social traits/presentation that would pose a problem for the group).

Ten clients were invited to the group. One client withdrew before the group started because of work and personal commitments and another had to leave the group after the 7th session because their improvement helped them obtain employment. Eight participants attended the majority of sessions including the final session. The group began with one male and eight females, who were all over the age of 18. While there was a gender imbalance, the group's focus on here-and-now processing allowed for participants to address this by discussing how it was for the women in the group to have only one man, and what it was like for this man to be the only male in the group. As noted, five participants attended the first focus group and three of these participants also attended the second focus group.

All participants had a long history of complex mental health difficulties of various forms and included people seeking treatment for depression and anxiety disorders, many of which were textured by trauma history, e.g. verbal, physical or emotional abuse and/or neglect. Beyond the

reported information above, therapists recorded self-descriptions of mental health concerns that participants noted (see below). Participants voluntarily provided this information during the group process, noting they felt safe enough to share them.

- 1 participant self-reported that they had been diagnosed with severe obsessive compulsive disorder (OCD; which was evidenced during the group sessions by their reassurance-seeking behaviours).
- 1 participant self-reported having been diagnosed with autism.
- 2 participants self-reported being diagnosed with borderline personality disorder.
- 1 participant self-reported being diagnosed with bipolar disorder.
- 2 participants reported being assessed for attention deficit hyperactivity disorder (ADHD).
- Several participants reported early life adverse events.

Two participants revealed that they were actively experiencing paranoia and had previously been involuntarily sectioned. One acknowledged experiencing auditory hallucinations during the course of the group. These issues were only brought to light during group discussions (during times of processing with one another) and not at the recruitment stage despite the exclusion criteria including current mental health difficulties related to psychosis. However, these participants wanted to and felt able to stay part of the group. Importantly too, all participants had a long history of different types of psychological and pharmacological interventions. Hence, this was a heterogenous group of outpatients with complex psychiatric comorbidities which was representative of 'real world' mental health community samples and services.

2.4 Procedure and Intervention

The second author who was on a training sabbatical from Brigham Young University in Utah was the principal therapist, supported by three NHS therapists (one clinical psychologist and two clinical psychology trainees). Partly due to the time of the principal therapist's stay, the group ran for 11 sessions over 13 weeks (including two breaks of one week between sessions 3 and 4 and sessions 9 and 10). Participants suggested the two breaks were helpful for letting them consolidate and practise the interventions they had been covering in the modules. Our experience of delivering CFT with clients with a diagnosis of bipolar disorder [1, 29] suggested that running all sessions sequentially may not give participants enough time to settle into practice.

Each session lasted two hours and included a 10–15-minute tea break provided about midway through. Drinks and snacks were provided each week by the therapists. CFT encourages tea/coffee breaks to enable participants to socialise between themselves and talk to the therapists.

The first author and second author (principal therapist) met each week to review the process and progress of the group and to refine the modules for each session. The first author also offered supervision to the therapy team each week. A brief outline of the modules is available in the supplementary materials [Table S1](#). A detailed description of all sessions is currently being prepared for publication. We tried to keep the sessions participant-led so it is important to note that the module content may take more than one session depending on participants' needs.

At the start of each therapy session, the principal therapist and his co-leaders began with a soothing rhythm breathing (SRB) exercise, then invited participants to check-in to reflect on how things had been going for them regarding the group and their progress, and how they were finding their personal CMT practices. A considerable amount of time during check-ins was spent exploring

their FBRs. There was an emphasis on de-shaming and trying to approach difficulties with curiosity rather than self-criticism. Examples of difficulties include participants forgetting the content of the group, struggling to do some of the exercises, believing they were not doing very well, or feeling they had dealt with a life event poorly. Hence, during check-ins, therapists helped participants re-focus their attention and views and invited reflection on possible negative bias and ways they were connecting with one another. During these encounters, participants also were able to focus on helpful and supportive interactions they had with each other when they were struggling.

CFT offers a range of different types of psychoeducation in relation to the nature and working of mental processes. We usually provided this psychoeducation after participants had checked in. That being said, psychoeducation was consistently interweaved throughout the process of the therapy. As psychoeducation developed through the course of therapy, concepts were used to help participants formulate difficulties. For example, we helped participants conceptualise certain difficulties in relationship to their 'multimind' or 'tricky brain', or how easy it is to lose a sense of mindfulness.

After each session, the principal therapist sent an email to all participants containing one short and one long summary to serve as a recap. These were provided to help participants with different attentional and memory abilities. Participants reportedly found this very useful and described this as a journal of their unfolding process. These emails included recordings of the practices done in session for participants to listen to in their own time.

2.5 Data Collection

All participants provided written informed consent for the evaluation of the group which included completing pre and post outcome measures and participating in semi-structured focus-group interviews. Participants were advised that if they did not wish to participate in the service evaluation or wanted to withdraw, they would still receive all treatment as per normal practice. Participants were informed that all data would be anonymised to protect confidentiality. During the first and final sessions, participants were provided with a questionnaire pack containing five validated scales measuring various indicators of mental health, affect and trauma, and six single-item questions. They were asked to complete these and return them to the therapists. As mentioned, several participants did not return the questionnaires for the reasons listed above and given that there was a substantial amount of missing data, the quantitative data we obtained was not complete enough to be used in the evaluation. Thus, we focus on the information gathered via the focus groups.

2.6 Focus Groups

Participants took part in two semi-structured focus groups immediately after the end of the therapy and at three months' follow-up to explore their experiences of the intervention. These focus groups were recorded and transcribed using transcription software. Transcripts were manually checked to ensure they were verbatim. All participants were given pseudonyms to preserve confidentiality.

Both focus groups were led by the same interviewer, who was not involved in the therapy group, transcription or analysis. Table 1 summarises the questions that were asked in the first focus group.

Table 1 Focus group 1 questions.

Focus	Question
1. Participant views of the group	Looking back, did you have any thoughts, hopes or worries about what this group might be about or like?
2. CFT group experience as a whole	What was it like being a member of a compassion focused group?
3. Experience and impact of the CFT model	What did you think about CFT and the model around the tricky brain?
4. Impact of CFT exercises	How did you find the practices and exercises?
5. Experiences of and changes in self-criticism and self-compassion	What was your journey like in coming to understand your self-criticism and trying to use self-compassion with yourself?
6. Future use of CFT outside of the group in everyday life	How do you plan or hope to use CFT for the rest of your life?

The second focus group took place three months after the end of the therapy course. However, only three participants were able to attend. Those who could not attend gave different reasons for this, such as physical illness, work and family commitments. The questions focused on similar themes and explored participants' experiences during the three months following the therapy. There were changes in the wording of the questions to reflect that this was three months post-therapy, rather than shortly after.

2.7 Data Analysis

2.7.1 Focus Group

Data analysis was conducted using Reflexive Thematic Analysis (RTA; Braun & Clarke [93, 94]), which is a stepped analytical method appropriate for focus group research. This involves careful reading of the narrative content to familiarise the researcher with core themes, and then creating codes representing these themes. The six phases of RTA, as developed by Braun and Clarke, are: 1. 'familiarising yourself with data'; 2. 'generating initial codes'; 3. 'searching for themes'; 4. 'reviewing themes'; 5. 'defining and naming themes'; and 6. 'producing the report'. This was a deductive analysis using the CFT framework as guidance. Additionally, the reflexive process was used to reduce the risk of bias through conscious awareness of any assumptions surrounding CFT.

3. Results

Five participants took part in the first focus group and three in the second. One of the reasons for the lower attendance was because some of the participants gained employment over the course of the therapy and were not available, and some experienced physical illness (e.g. flu).

3.1 Focus Group 1

From the first focus group, four main themes emerged: 'from threat to safeness'; 'psychoeducation'; 'experiential practices', and 'on becoming compassionate.' These and their subthemes are discussed below.

3.1.1 Theme 1: From Threat to Safeness

As is common in beginning group therapy, participants acknowledged feeling daunted and worried about participating. These fears typically centre around those of social anxiety, feeling overwhelmed, socially intimidated and being misunderstood [35, 95]. Given that it is so common for participants to be anxious, worried, and afraid of attending group therapy, this group spent the first few sessions specifically addressing these issues through the lens of differences between safety and safeness and spent time exploring how to create social safeness [44, 70]. It is illuminating how participants perceived these discussions on safety vs safeness and how quickly their initial anxieties about attending group therapy settled with being able to talk about their needs for safeness as well as safety.

Yasmin. *The speed that the group got together... it wasn't long before we were talking and sharing ideas and supporting each other.*

Samantha. *I thought it would be a bit awkward in terms of me being shy... [but] we felt at ease so quickly.*

Eliza. *I was very worried about the group and if it would actually help... I felt very welcomed in... I fitted in quite quickly, um, and I almost straight away gained that trust with everybody that I could say what I felt.*

Tom. *I found it quite, you know, daunting... but uh pretty much straight away from seeing [therapists]... I felt calmer and more relaxed in my thoughts and was able to express myself, you know, and not be sort of overly anxious or paranoid... I was a bit apprehensive about starting it... but um I can say it's been a very positive experience.*

Participants reflected that a sense of safeness emerged from how the group was contextualised and the discussion of the differences between safety and safeness, and that sharing and creating a sense of connectedness counteracted their sense of aloneness:

Samantha. *I think actually it was the first session, [therapist] sort of said 'right, this is a safe space, you can say and be what you want to be,' kind of thing, um, and it was that, like, instant realisation... I didn't understand the term 'safe space' until I was in it and I just felt like I can say and be who I am without judgement... [that] was the biggest thing... because we're all having similar... experiences and to and to be able to talk to other people about those experiences and not feel judged.*

Safety and safeness emerged from feeling free to speak without judgement or expectation.

Samantha. *the feeling that I felt that first day when I was like, 'oh my god... I can be myself'... straight away that we're safe, there's no judgement.*

Eliza. *feeling of the trust and feeling comfortable and feeling safe and not feeling judged comes first and... [then] I was able to take on board everything that was said in group. Um, so if, for someone from an outside point of view, first I wouldn't say 'right, okay, I want you to know that there's threat, drive, soothe', I would say 'I want you to know that this is a safe place and you can, you can say how you feel and you won't be judged and...you're with similar people'.*

Part of creating a sense of safety and safeness is feeling listened to and validated. Hence, the therapists helped participants explore compassionate listening through an exercise in which they paired off and one participant listened to another talk for a few minutes about a small life difficulty without responding verbally. After they listened, the participant was asked to reflect what they heard. Then the dyad switched roles. Some participants found practising these skills difficult.

Yasmin. *That [compassionate listening] was really awkward in that we, not that we didn't want to talk to each other, it was kind of like 'right, I don't know what to say now' ... the majority of us came back to the group and went 'oh, that was a bit weird, didn't like that'.*

Samantha. *That [exercise] could have been... a bit more beneficial if it had been a bit later down the line. [in the therapy course]*

As part of the therapy, participants would 'check in' with each other at the beginning of each session where they exchanged stories about how things have been going for them and how the practices of compassion were during the previous week.

Eliza. *I think we were compassionate when we listened during the check-in.*

As participants began to develop their compassionate ways of relating to themselves and others, this had a major impact on their experiences of feeling safe in the group.

Alice. *I wasn't sure that it was the right group for me, I was that anxious, I felt so um self-centred... but as the weeks have gone by, I've become uh I think less anxious and um, yeah, the compassion, yeah, I've taken it on board... I felt supported and I wanted to support, um, everybody else and even if I, uh, couldn't articulate myself very well... I still benefitted from it.*

Therapist Presence.

Appropriate therapist self-disclosure and personal sharing contributed to a sense of safeness, connectedness and was de-shaming.

Samantha. *For them [the therapists] to join in and show that actually we, we [the therapists] do have our own, um, things going on and that we can be just as, um, self-critical and that sort of thing, it, it just made us feel more human.*

Yasmin. *I want to say thank you to you [therapists]... the fact that you have been part of it rather than being somebody that sits on the outside um and shared experiences that are real... it has been very genuine.*

Participants felt their views and opinions were respected, valued and accepted by the therapists and were actively involved in the group decisions as noted by Yasmin.

Samantha. *They [therapists] made us feel like we, we mattered.*

Tom. *It wasn't like a lecture, it was more like a get-together, a social gathering, you know... There was a genuine connection between us.*

Yasmin. *I've felt like I'm really part of something... we came up with our own sort of boundaries about what we would accept as a group and not accept, um, and that was nice... it was us [participants] that were saying 'this is how I want it to go'.*

Safeness and Playfulness.

The creation of an experience of interpersonal safeness is central to CFT group therapy. To facilitate this, therapists can bring in a texture of gentle playfulness and humour. These are brain states that are conducive to open exploration and can help settle the threat system and create a sense of secure base [96, 97].

Samantha. (addressing Therapist) *I'm just laughing at last week's story about your... thing (group laughs) so we know that's real.*

Yasmin. *It was okay that we had a laugh.*

3.1.2 Theme 2: Psychoeducation

Participants were not familiar with the model prior to the CFT group. CFT discusses the fact that our brains are built *for us* (by DNA) not *by us*. As such, brains come ready made with potentials for all kinds of helpful but also difficult motives and emotions. For example, no-one chooses to have panic attacks, become depressed or have rages. When triggered, these brain states can take over attention, thinking, behavioural impulses and what is happening in our brains and body – even against our will. To cope, we can learn to work with our brain states rather than blame or shame ourselves for them. This is called 'tricky brain', highlighting the fact that these tricky potentials can at times be harmful to us and others through no fault of our own. This discussion about our inherent genetics and tricky brain is to de-centre, defuse and de-shame, whilst also to facilitate empathic mindfulness of triggered brain states, and to generate commitments to work with our tricky brains compassionately; that is to live to be helpful not harmful. Participants responded to this psychoeducation by sharing how they found these ideas useful.

Eliza. *I thought that was really helpful... to label it as something, as a tricky brain... For so long, you think almost it can't be helped... like 'I've been like this for so long.' Um but then it's fine, you've just got a tricky brain. And then it's just like coming to terms with it and it's like, okay then, I have got a tricky brain, it's how I'm going to now work with it, um and especially the threat, the drive and the soothe, um, I think talking through it helped and then outside of here, in certain situations, I'm like, right, I'm in threat (laughs) I need to go to soothe.*

Yasmin. *I live in a threat system, my whole life has been that, um, my brain never shuts up and whatever situation I'm in, straight away I go into the worst-case scenario... but I think because it [the model] was explained, like you said, it wasn't that 'it's your fault, why can't you, why can't you do better? Mindfulness bleh'... because it's been explained in a different way in terms of, um, that 'okay your mind is in threat now and you are in that state of mind'... I understood... it's a good model.*

3.1.3 Theme 3: Experiential Practices

CFT utilises *compassionate mind training*. These specific exercises are designed to be practised over time to stimulate compassionate brain states. Participants found the body focused exercises such as soothing rhythm breathing, and use of body posture and facial expressions, very helpful. There is good evidence that these have powerful psychophysiological effects [98, 99] and are used for this purpose in CFT [45, 100].

Samantha. I felt like Speedy Gonzales running into a room and then sitting down and then doing this exercise [soothing rhythm breathing] where it slows you down and makes you become mindful, and I just felt like I could like come to a screeching halt, but in a good way, like 'oh my god, like, so much has been going off and now my brain can slow down, it can breathe and it can relax' and it had that effect, but it also had a follow-on effect with my body as well... I love the breathing... I always tend to arrive anxious... so the breathing for me helps just bring me back down.

Eliza. I found that [soothing rhythm breathing] really helpful to then use that outside of this group because of the repetitiveness of the words that was being spoken during that few minutes, I can almost tell you now what [therapist] was saying.

Working with Challenges with Imagery.

CFT invites participants to use various imagery practices, for example of a safe place, being compassionate to self and others and receiving compassion. CFT seeks to help participants change brain states and 'bring online' compassionate forms of attention, thinking, emotion, body experiences and behaviours. However, it can take people a while to understand what imagery is and is not and to work through various blocks and connect physiologically to their images. CFT encourages practice and recognises that increased practice will result in increased competence. Once a person feels more competent, they are also more likely to continue with the practices.

Tom. I [had] sort of mixed, you know, success with the exercises. Sometimes I could think and focus on it properly and sometimes I couldn't... there's all these different elements all coming together at the same time when you're trying to do these exercises and it's challenging, you know, it's hard work uh but it's also incredibly helpful.

Yasmin. I'd said 'oh, I can't do that visualisation, there's no way I can do it', it, it was acknowledged and it, it [therapists] kind of was like, 'well think about it in this way instead then and try and look at it like that'... I didn't go straight into what I would normally have gone into: 'oh my god, you're ridiculous, everybody else in the room can do that and you can't', instead I was kind of like 'well, you know, you can't do it but look at it in a different way.'

Eliza. In the soothing rhythm [breathing], I remember Yasmin saying 'but it's not comfortable when you're sat like this' and [therapist] took that on board and actually said 'no, obviously do it in a way that's comfortable for you' and that really helped.

Other than some participants finding the imagery practices challenging (as well as the compassionate listening practices addressed earlier), when asked if there was anything they would have changed about the therapy, they only offered positive feedback.

3.1.4 Theme 4: On Becoming Compassionate

As the therapy progressed, from around the halfway stage, participants reported that they noticed changes in their thoughts, behaviours and mental health, an increase in all three flows of compassion; for self, for others and in receiving compassion from others (especially in the group). They reported that these became automatic for them, bringing an increase in confidence.

Eliza. About halfway through I noticed that I was actually being compassionate to myself.

Samantha. Since joining the group... I've learned that I can be more compassionate... in the first couple of sessions, even though I felt the safe space thing, I still thought 'well, I'm not getting much else from it', like yeah it's usually negative thoughts, isn't it, telling you the opposite so you can do a runner um but... in like week five or six... I explained [to my mum] that I had this moment at work where I was like 'I've made a mistake but you know what, you've made a mistake, it's fine' and it was only when I was like sort of verbalising it to my mum that my brain went 'hello, you've been compassionate'... I'm actually getting something subconsciously, I didn't even realise I'd started doing that... I can be compassionate towards myself if I put my mind to it.

Yasmin. From being a child, I've always been made to feel like 'I'm lazy, I'm stupid, I can't do this, I can't do that'... I criticise everything that I do and straight away, everybody else matters but me... being a part of this [group] has made me think, well actually you know, you do matter.

Eliza explained that from the group experience, she recognised she can receive compassion and be compassionate to others.

Eliza. Quite quickly, we learned that we could be compassionate to others... before this, I was very much like 'I don't think I can be compassionate to myself, I don't think I can be compassionate to others and I don't think I can receive compassion', whereas when... you're just having conversations and... [noticing] I received compassion and noticing that actually I can be compassionate to somebody else, then like 'right, so if I can be compassionate to somebody else, why am I not giving myself that same compassion?'

Participants observed an increase in their compassion for those within the therapy group. For example, Alice explained that she shifted from feeling 'self-centred' at the start of the group to wanting 'to support' the group participants over the therapy course.

Alice. I wasn't sure that it was the right group for me, I was that anxious, I felt so um self-centred... but as the weeks have gone by, I've become uh I think less anxious and um, the compassion, yeah, I've taken it on board... I felt supported and I wanted to support, um, everybody else and even if I, uh, couldn't articulate myself very well... I still benefitted from it.

Samantha. I've always had family around me, I've always had friends around me and then as I started to have struggles, relationships became strained and then there were times when I felt like I'm completely on my own... coming here, and only knowing these guys for um a number of weeks... it was a new experience for me to start to realise that I actually care... about these people and I think it's because I know their pain... I can empathise... I can care for other humans that aren't family or friends.

Samantha also reflected on a number of experiences of being compassionate. One example was empathising and being compassionate with another participant who was experiencing anxiety.

Samantha felt able to reassure her, to show common humanity and that she (her peer) was not being judged.

Samantha. We know how crap it is to feel the way we do... I wouldn't want you to feel that pain, so if this is helping and you're saying that it's helping, then we're happy for you.

This increase in compassion, for others and for self, extended to relationships outside of the therapy group such as relatives and strangers. For example, Eliza and Tom learned compassionate ways of approaching social situations. Alice became able to disclose more honestly about her mental health to close family members. Samantha developed assertiveness and started prioritising her own needs and not accepting poor treatment from others.

Samantha. I have noticed a big thing very, very more recently... [I've] struggled with relationships and how people have treated me um and but basically that's knocked my confidence in six feet under... I find myself, in particular since I've started here funnily enough, um, putting myself first, uh, in terms of, um, relationships... I've been a bit more sort of 'no, I'm not accepting that behaviour anymore'... I've made myself number one, which I don't think I've ever done. So, I think that's, taking it forward, that's the big thing that I see myself, um, using it for.

Tom. It's a journey, you know, it's an experience that you can constantly build on and improve on. Uh and you learn things, you know, through life experience that test your compassionate side and you'll deal with it in the best way you can. But there's sort of a big difference in my behaviours, uh, and [my] body language towards people, especially strangers, um has changed quite dramatically, so yeah, I'm very lucky to have been part of this group.

Alice. She'll [relative] ask me how I am... I've just learnt not, you know, to say 'I'm fine'... things are better that way, you know, things have been better between us.

Eliza. It has been very helpful for me um I did say to [therapist] I am quite amazed at how, at the difference I can see in myself over the past 11 weeks. Um, just in situations where I've been able to be compassionate to myself but also recognise other people, sometimes I can struggle judging how other people are feeling in the situation which could potentially make me quite confrontational... doing this [group CFT], I've learned how to approach certain situations, certain conversations, which has helped me massively.

Life-Changing and Hopeful.

Overall, participants felt the group CFT was a transformative experience. They observed changes in themselves and other group participants, including increased courage and confidence, throughout the therapy course. One participant expressed that they had been more outgoing and noticed improvements to their mental health, describing the experience as 'life-changing.'

Samantha. [Fellow participant] was very quiet when we first started but then [they're] more involved and been talking a lot more and it were nice to see.

Tom. I was suffering from a lot of anxiety which led to depression and coming to this group, I've noticed a massive, you know, improvement in my mental health, I'm able to do so much more things now, you know, than before the group. So, for me, it's been a life-changing experience, quite genuinely.

Participants reported that they will use CFT techniques in their everyday lives. This was related to gaining insight, recognising the value of compassionate brain states and how to generate and practise them. Participants explained they will prioritise their mental health more in the future by using the compassion skills they developed over the therapy.

Tom. *I've learned some really useful tools and techniques in Compassion Focused Therapy which I look forward to, you know, expanding on and using in my, sort of, daily life.*

Yasmin. *I'm not saying that I won't lapse, I'm not saying that I'll still not sit there sometime and go, you know 'your crap, what's up with you?' Um, but I also, I'm quite hopeful that I'll be able to take some of what I've done and see myself in a different light.*

Samantha. *I'm making progress but it is going to be a long journey.*

3.2 Focus Group 2

Given the small sample and that the themes of the second group substantially overlapped with those of the first, we provide only a short summary of the second follow-up focus group. This group was held three months' after the end of the therapy group and was attended by three participants.

Participants shared that their lives post-therapy group had been 'up and down' for reasons such as difficult family relationships, physical health difficulties and time of year (winter). Despite these challenges, one participant (Tom) reported that this CFT group had transformed his life: '[I'm] living life better than I ever have'. Observable, positive changes in participants' lives were reported, including a decrease in suicidal ideation and an increase in independence, confidence, self-assertion and self-compassion.

Examples from Alice include:

Alice. *When I started the course, um, the suicidal thoughts were terrible and they've more or less diminished.*

Alice. *I think I have [been less critical of myself].*

Examples from Tom:

Tom. *It's [the group's] changed my life in a very positive way and, uh, I'm able now to sort of, uh, be independent, you know, in my activities, in my life, and that's a really positive thing so that's good progress... I haven't been taking care of myself as well in the past. But nowadays I'm taking care of myself, you know, um, doing the washing up, you know, cleaning the house and all those normal things on a regular basis and I'm, I'm sort of living life better than I ever have, really.*

Tom. *At Christmas, actually, I feel very sort of isolated and not really knowing that anyone really understands me, but I've grown to learn that that's not the case, people do actually understand me and how, how I am and the way I think, and, and that's and that's okay. And, and that's been a really positive attribute that I've learned through the group.*

Tom. *It's um, given me a new lease on life.*

Tom. *Probably the main thing I've learned from it is that sort of, to stay in that compassionate mindset and not to get too upset when people say things that might upset you, family, or friends, or whatever, and rise above that and think in a sort of logical way.*

Tom. *Learning new skills, you know, and new sorts of abilities I didn't really know I had, and that's all been an absolutely incredible experience.*

Examples from Yasmin:

Yasmin. *I've been sticking up for myself a bit more than I probably did before.*

Yasmin. *I'm a lot better at being able to say, that 'no, you, you, you know, this, it's not you, you can't help your health conditions, you can't help all the things that are happening, it's not your fault.' Um, so I have got better at that. But like I said, I've still got a long way to go. But, the fact that I can actually do that now is a, is a massive positive.*

Yasmin. *The fact that I can actually say 'now Yasmin it's not your fault.' That's, that's a massive thing for me. But, but I think I got more, I got quite a lot out of this course when, because I felt a part of it.*

Yasmin. *I love the breathing stuff, I've done that, I do that, I try and do that regularly.*

Yasmin. *I've been able to step back a little bit from that and think: 'um, it's not me, it's not, there's not something wrong with you.'*

Yasmin. *sometimes I feel really useless, but I'm also now able to look at it in a different way, um, and, and kind of challenge the fact that, so like that, like with my mum saying, 'you know, you do know you're going to lose your job', it were like, I, I sat there and rather than me go, 'yeah, it is my fault, I am going to lose my job, aren't I, that's because I'm useless', it was like, 'thanks for that mum, thanks for that, that's really helped me feel good about myself. I'm going to ignore you.'*

Yasmin. *I've been able to change it, change it from straight away going into that, that 'me, it's my fault', to be able to go, 'well actually it's not'.*

They reported that they practised compassion to self and receiving compassion from others post-therapy. Participants talked about the benefits of writing compassionate letters to oneself. Tom explained that re-reading their compassionate letter since the therapy ended was 'revealing' and 'helpful' and that this was the 'best' exercise. They had also continued practising the SRB exercise. Regarding the therapist emails, the provision of both long and short summaries from each session was given high praise for accommodating various attention spans. Participants were provided with physical CFT booklets containing all email summaries at this three-month follow-up. They expressed that they were pleased to receive these booklets and said they would use them in the future. Yasmin advocated for more regular socialising with the WhatsApp group (created by the participants during the CFT group).

3.3 Therapist Observation and Reflections

We would like to offer some general observations that seemed to be particularly important for this group. Many participants in this group had been unemployed for some time, but five participants developed the confidence to seek employment during the 11-week therapy. One participant reported being offered a job, which although he or she did not take up for practical reasons, this gave them a major "boost". Another participant had to leave the group after the 7th session because of the demands of their new job but sent the group an email expressing their warm wishes, their desire that the group know they cared about them, and thanks for what the group had provided for them. The group seemed to be moved by this email.

In terms of connection and the concept of 'holding in mind', we asked the group if they would like for this participant to hear about the continued work of the group and the weekly summary emails we sent. The group enthusiastically expressed feelings that this was a good idea and would

like for this participant to know that she was being held in mind and remembered. Subsequently, we wrote her the following email in Figure 1.



From: [Redacted]
Sent: [Redacted]
To: [Redacted]

Dear X

Thanks so much for letting us know about your situation. We let the group know that you won't be able to continue attending. As you might imagine, they were sad that they won't get to interact with you in person and they were also very understanding of your situation. They wanted to make sure we sent along their best wishes for you and their hopes that you're doing well.

We asked the group what they thought about continuing to send along summaries from our group each week and they all said that they were totally fine with that. Is this something that you would like? If so, please let us know and we'll continue to send the summaries along. Even though you won't be in the group physically with us, we'll be thinking about you and holding you in the group in spirit. If circumstances switch on any given week and you are able to join, please know that you are very welcome to attend (even if it can't be consistent).

Thank you again for reaching out.
Compassionate Wishes,
Therapist 1, 2, 3 and 4

Figure 1 Example of email to participant who could no longer attend.

For those who continued, given the long-term complexity of the participants' mental health concerns, it was heartening that they never missed a session without letting the group know. They offered sentiments such as "I wish I could be there with you next week" or "I'll miss you and will be excited to see you again," indicating a strong sense of connectedness and wanting to convey a sense of valuing the support and contributions of the group. In CFT, it is important to generate a sense of connectedness in which participants can feel 'held in mind', even when unable to be physically present. It was a heartening experience to see how the group generated this connectedness.

We spent time addressing a repeated theme of: "I almost didn't come to group today because..." (e.g. 'I didn't complete the measures,' or 'I didn't know if I was contributing anything,' or 'I didn't want to ruin the group with my negativity,' or 'I can't do the visualisations like you all can'). They followed these types of statements quickly with, "But then I came because..." 'I just really like being here with you all,' or 'this is the one place I feel safe,' or 'I just thought I'd come and listen but not say anything,' or 'I didn't want to miss out'. Importantly, they came to talk about the group in ways that indicated they viewed it as both a secure base and *safe haven* and that this was one of the primary reasons for attending, not at first necessarily believing CFT would help them. Hearing these self-reported difficulties made it even more impressive that so many improved in the ways that they did (especially with several participants gaining employment). More specific therapist reflections organized into themes are presented in the supplementary materials [Table S2](#), which we hope will be useful to practicing clinicians.

4. Discussion

This paper reflects on the processes of an 11-week CFT group for people with various chronic mental health difficulties, who had therapy previously and were on hospital outpatient waiting lists for further help. Although there were fewer participants than hoped for in each of the focus groups due to other demands like getting a job and also illness, those who did attend provided a wealth of information about their experiences of CFT. Reflexive thematic analysis [93, 94] identified several themes. First, participants reported that understanding and then creating a sense of safety *and* safeness increased their ability to connect with each other and the group facilitators. Over time it helped them feel comfortable enough to share aspects of themselves they may not have shared before. Such sharing is both de-shaming (safety) and enables feelings of connectedness (safeness). Second, providing information about the *evolved* functions and social constructions of our minds, how we have ‘minds that have been built for us, not by us’, with guided discovery practices of how thoughts and imagination can influence the body and the brain, was revelatory. Participants reported that coming to understand that evolution has not built brains for happiness but to survive and reproduce, and are ‘tricky to handle’ and that different emotions like panic or depression can be triggered against our will, was de-shaming, reduced hostile self-criticism, and increased self-acceptance. They began to recognise that, rather than thinking that there was something wrong with them, it was more helpful to recognise that there are patterns in our minds (brain states) which, through no fault of our own, can be easily triggered, unhelpful, generate distress and suffering and, at times, be harmful. The concepts of ‘it is not my fault to have a brain like this’ and how to take responsibility to enable oneself to be helpful and not harmful were also experienced as revelatory. They facilitate ‘standing back’ and becoming more mindful and observant rather than being shaming and blaming of the ups and downs of their mind. This also helped reduce the self-attacking criticisms. Participants reported they were gradually able to move into taking a compassionate approach with themselves and others, suggesting changes in all three flows of compassion.

Third, over time, participants identified a number of benefits from creating and activating compassionate brain states. These included ways of being helpful in coping with stress, working with harsh self-criticism, becoming more assertive, being helpful to others and being more trusting and open to receiving compassion from others. They recognised that these were skills they could continue to develop as their lives unfolded, and they had notes, write ups, and practices they could repeatedly return to. The World Health Organisation [101] points out that ‘mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community’. We were heartened therefore to see how CFT had enabled five participants to seek employment after being unemployed. Moreover, participants’ quality of life improved over the course of the therapy, for example by improving relationships with others and increasing confidence in daily life. In terms of group processes, participants consistently discussed feeling connected with one another and that this sense of connectedness helped them to engage in therapy in meaningful ways.

Taken together, this service evaluation indicates important themes within CFT that people found helpful. These include the importance of creating a sense of safety *and* safeness early on in the therapy via helping participants understand the differences between these two processes, which became the basis for the sharing of hopes and fears and how to be supportive and understanding of each other. CFT psychoeducation gives an evolution informed framework for contextualising how

we can understand and work with our tricky minds. Shame and negative self-evaluation are such major themes for those struggling with mental health difficulties that finding new ways to address them is imperative. Overall, it is important to help people understand that cultivating compassion is a biopsychosocial process, and the value of paying attention to physiology and 'body experiences', mental states of thoughts and feelings, and also social behaviours. All of these components support the process of CFT.

4.1 Limitations

As this service evaluation explored how CFT can help people with chronic difficulties within a mental health service, we did not set out to identify particular diagnostic groups or people with particular mental health difficulties. Therefore, we cannot suggest any changes were linked to particular mental health difficulties and CFT, only that a relatively short CFT intervention was helpful for most. The sample comprised mostly of women, therefore exploring men's experiences of a safeness-focused group CFT would be of interest. Furthermore, the quantitative data was too incomplete to be usable (as discussed earlier). In a future service evaluation, reducing the number of self-report scales administered or using shortened versions such as the short-form FSCRS [102] may help the completion rate. For participants with long-term mental health problems and those who have trauma in their background, 11 sessions can seem rather short and longer therapies may be beneficial. However, studies have shown that short, group-based CFT can build resilience and help people process trauma even without engaging with details of trauma memory [20]. As people learn how to generate the processes of compassion within themselves, many have felt able to soften shame, self-blame and harsh self-judgments, and compassionately approach their life difficulties.

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Author Contributions

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writing – original draft; writing – review and editing. Yoram Giglio: Investigation; resources; writing – original draft; writing – review and editing. Corinne Gale: Investigation; methodology; writing – original draft; writing – review and editing.

Competing Interests

The authors have declared that no competing interests exist.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Additional Materials

The following additional supplementary materials are uploaded at the page of this paper.

1. [Table S1](#): Brief module outline.
2. [Table S2](#): Therapist Reflections (DG).

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