

Research Article

A Compassionate Mind: A Qualitative Evaluation of Compassion Focused Group Therapy for Complex Interpersonal Trauma

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Abstract

A significant percentage of the population attending local adult psychology services have experienced variable forms of maltreatment from a young age and by a close attachment figure. For those who do not present with post-traumatic stress disorder symptoms, they may be misunderstood and offered a phase-based approach to their care. Although a stepped care approach to complex trauma is in keeping with current guidelines this often includes lengthy periods of group-based psychoeducation and skills development that often fails to address core transdiagnostic features of such experiences, such as self-criticism, self-attack and shame. This can lead to prolonged care journeys, repeated episodes of care or even exclusion from mental health services. This paper presents a qualitative evaluation of our Compassion Focused Group Therapy programme that integrates both compassionate mind training and formulation driven experiential practices aiming to address self-criticism and shame. This study was a qualitative service evaluation project which used a self-report survey to capture experiences of group members who had completed the 16-session group programme consisting of two pre-group sessions to orientate to model and formulate, 12 weekly 2.5-hour group sessions and two review sessions – an individual session post group and group review at 3-months post group. Group would consist of up to eight patients and



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two CFT trained facilitators. Eleven questions were listed with supplementary prompts to be used if needed. A thematic analysis was then conducted to identify key themes and sub-themes. Multiple factors were found to be of central importance for group members journey in and through the programme, which supported identification of key areas of improvement. This included the importance of a slower paced approach, the roles of therapists and the need for longer term therapeutic work. Thematic analysis uncovered four main overarching themes, with two themes having sub-themes. Group members found the programme transformative in comparison to previous experiences of psychotherapy. Key to these changes were the role of the group therapists and use compassion focused practices, however all group members indicated a need for longer group therapy input.

Keywords

CFT; group therapy; complex trauma; service evaluation; qualitative evaluation

1. Introduction

For those whose early years have been characterised by maltreatment, either in the form of abusive and critical, or absent and inconsistent attachment figures, these experiences can have profound difficulties in later life [1]. A latent vulnerability [1] that insidiously cultivates complex and enduring disturbances in the abilities to self-organise can present a real challenge to mental health services [2], in terms of providing an efficacious intervention. As a result, this population may experience repeated episodes of therapy, prolonged journeys through multi-modal therapies or even labelled un-treatable [3].

The diagnostic term “personality disorder” is often used when talking about those whose difficulties have emerged because of traumatic life experiences. A societal shift to think through an increasingly trauma informed lens has made way for the term ‘complex trauma’, a softer and more contextual term as a way to understand and conceptualise those who have experienced such childhood trauma. Complex trauma can be defined as “the syndrome that follows upon prolonged, repeated trauma” ([4], p. 115). Diagnostically this can be expanded to detail core symptoms of post-traumatic stress disorder but also ‘disturbances in self-organisation’, which include affect dysregulation, negative self-concept, relational difficulties, dissociation, somatic symptoms and cognitive difficulties. It is here where the distinction of complex can be made [5] and not simply an experience of repeated traumatic events in childhood. Where attachment and relational trauma may differ is within its role as a transdiagnostic and dimensional factor that can be linked to many mental health problems in adults, not just simply PTSD or Complex PTSD [6]. Although evolving from this perception the term ‘complex trauma’ is still divisive, often mischaracterised and used interchangeably with Complex Post-traumatic Stress Disorder (cPTSD). Critically this can fail to capture the nature of the multifaceted and pervasive problems attachment and relational trauma may cause, which mislead professionals in identifying treatment options.

The nature of these early experiences can cause understandable adaptations within the individuals that promote immediate survival in childhood but then have unintended consequences

later into adulthood [7]. As adaptive as this population can be, they equally can pose a significant challenge to the caring therapist who may experience a foray of suspicion, criticism, aggression, but also an intense drive for connection marked by a longing for attention, care, and responsiveness. This often can be understood as a repeat of early attachment experiences and thereby quite resistant to the psychotherapeutic suggestion of change, especially within traditional individual therapies. For this population whose challenges are in attachment and relational trauma [8, 9] it is only through attachments and relationships can the work begin [10].

1.1 Compassion Focused Group Psychotherapy Model

Compassion Focused Therapy (CFT) is an integrative evolutionary informed psychotherapy that aims to understand our evolved minds and motivational systems [11]. These motivations organise and serve us in three distinct and different ways; to defend, to resource seek and to rest. The primary focus of CFT is making use of the evolved psychophysiological systems that allow us to care. CFT understands the function and motivation to care and be cared for is an evolved capacity or simply put, humans have evolved to be regulated by relationships [12]. This makes CFT ideal as a group therapy.

It is routine for services in the NHS to offer psychoeducational and skills training groups, such as Compassionate Mind Training Groups (CMT) [13]. These are typically 12 sessions or modules which are structured and manualised [14-16].

A further development to CMT groups, is the CFGP (Compassion Focused Group Psychotherapy; Lucre et al., [9]). This is a five-phase model encompassing assessment and formulation, waiting list group, preparation and engagement group, compassion focused trauma group and moving on group. This model builds on elements of compassionate mind training with what they describe as “a process-driven group psychotherapy format with more structured components to foster a sense of social safety and safeness, a secure base and safe haven between group members” [12]. This group psychotherapy model was specifically developed to address the needs of those who have experienced attachment and relational trauma. Lucre and colleagues use the group process as the container from which to explore fears, blocks and resistances to the flow of compassion (see Lucre [17], for further details of 5 phase model group structure). An analysis of CFGP found to provide significant improvement on subscales including shame, which was sustained at 12 month follow up [17].

1.2 Service Evaluation

During a period of service redesign the interest in therapeutically driven groups increased in response to growing referrals and clinical demand. To meet the requirements of the service and with an opportunity to implement a novel approach into local psychological therapy services a proposal was made to implement Compassion Focused Group Psychotherapy. A small-scale test of change [18] was approved where a quality improvement approach to implementation and evaluation was authorised. In principle, this would encompass phases one, three and five (with adaptation) of Lucre’s five-phase model. This paper aims to present the evaluation of this work and its role in further service development. The paper uses qualitative feedback from patients who have attended the group.

2. Method

2.1 Design

A working group was devised to develop a CFT Group within an adult psychological therapies service within the NHS. This was first envisioned as a 'Compassionate Mind Training' (CMT) group, that ideally would combine elements of both a psycho-education informed skills-based approach and a formulation driven group psychotherapy. Working within the literature and service remit this was devised as an initial conjoint session to assess suitability and where appropriate this would be followed by three individual and thirteen group session closed group programme that was separated into three parts – orientation, group therapy, moving on (Figure 1).

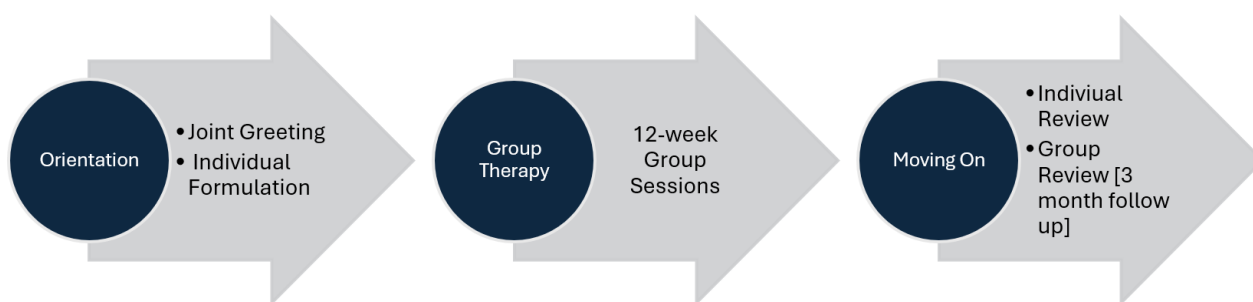


Figure 1 Visual Model.

2.2 Procedure and Intervention

Groups were always facilitated by two senior therapists (Band 7 and above), who had been trained via the Compassionate Mind Foundation both in Compassion Focused Therapy (>3 days) and Compassion Focused Group Psychotherapy (>3 days) and attend monthly group CFT supervision.

Referrals for the group were sought from within the department where group was initially populated by existing patients who had either completed a piece of therapy but had continued difficulties within self-organisation or were making limited progress within individual therapy. The group programme was, therefore, initially used by the department as a means of supporting people through endings or where self-criticism and shame acted as blocks to individual therapy. Due to service demands and structural changes by the third group most patients entering the programme were new to service, however most reported a history of previous psychological therapy or mental health treatment.

Orientation comprised of two sessions, one of which was focused on an initial meeting with the therapists facilitating the group and one focused on the beginnings of an individual threat-focused formulation. The orientation sessions were thought of as a 'dry run' offering patients an opportunity to meet and ask the therapists questions, travel to and be within the group room and for therapists to begin collecting psychometric data and early assessment information on compassionate motivation and capacity. The patients would also be allocated a key worker, who was a member of the clinical team that they could approach with questions between sessions, with the aim to offer a safe base if it was difficult to raise issues in the larger group. This design was in keeping with the principles of trauma informed practice [19, 20].

If patients were felt to be appropriate for the group, each patient received an individual session with one of the therapists, their “key worker”, to develop their formulation. This would start the psycho-educational element but also establish individualised understanding of their difficulties within the compassionate framework. This would allow the therapists insights into how they can adapt the group sessions to individual patient needs and promote a sense of direction and goals for the group members to hold in mind whilst in group. This also helped the group facilitators identify common themes and shared experiences amongst group members, but also potential conflicts.

The group would consist of between 6-9 members and was closed (i.e. the same people in each session). The format was 12 sessions, punctuated by an individual review session after session 6. Appendix 1 provides a brief outline of each session. Sessions were delivered dynamically and responsive to what group members reported on each week. It was not uncommon that while being sensitive and attentive to themes emerging from the group, that session content would be moved around, therefore adding to the active and need focused aspect of the therapy programme. When themes emerged in group, the facilitators would follow the lead of the group, whilst at the same time relating it and interweaving key messages and underpinning theory of CFT. Session 6 would formally mark the end of the more content and psychoeducational sessions. Each group member received an individual session to re-check psychometric data and further develop their formulation. This, ideally, identified further fears, blocks and resistances that would be elaborated on and reviewed within group sessions.

The final 6 sessions offered the opportunity for, within the limitations of the 12-group sessions format, with boundaries to safely engage with exploratory work into self-criticism, shame and the compassionate kitbag [21]. Chair-work was lightly explored during this part of the programme, for example as a useful object to collect the qualities of the group compassionate other, for role-taking items from group members compassionate kitbags or for therapist delivered role playing of the group’s inner critic or multiple self (sad, angry, anxious and compassionate parts). This decision was informed by the progress, capacity and need of each group, therefore each group required and/or could tolerate different work. However transitional work always remained the same and from session 7 the awareness of endings was never far from the group room, with dedicated time given to this in the latter sessions.

On completion of session twelve each member had a individual session where psychometrics were repeated reflecting on the progress that was had. This provided a space to digest the previous weeks but also consider next steps, whether this was discharge from the service or onto further psychological work. A final group session was provided three months after this session where psychometrics were taken for a final time and the group were supported in final queries, questions and transitions. The three-month break was envisioned to give group members time away from the service, to apply and consolidate learning, while knowing that should they require contact with therapists/key workers this was possible, or that they could raise issues at the final group session. This provides a continued line to the safe base group had developed across time.

2.3 Data Collection and Ethical Statement

A qualitative evaluation was devised as part of the projects broader evaluation and felt essential in understanding the individual experiences of group an 11-item, open questioned

survey was developed and provided to the NHS board's local research and development department and information governance department. As this was deemed service evaluation and not research, ethical approval was not indicated by the research and development department [22]. As our objective was to qualitatively evaluate a service there were no requirements for ethics approval. Advice was provided from Information Governance. Due to clinical restrictions, of central importance the evaluation being conducted primarily by two NHS therapists co-ordinating the programme, in time and resource an electronic survey was chosen as the method of information gathering which was thought to be ecologically valid [23]. Appendix 2 provides the 11-item questionnaire that was used.

2.4 Participants

A total of 27 members, who had completed the group programme, across five group intakes were contacted via email by one of the group co-ordinators with 3 patients being excluded due to outdated or unavailable email addresses. Attrition rate across the five groups have been consistently low as detailed in the Table 1. Reasons for drop out were linked to group members opting out due to living circumstances or struggled with the group format. On at least two occasions therapists supported group member to leave the group due to challenges within compassionate capacity for self and others.

Table 1 Group Attendance and Attrition.

Group	Total Group Members	Attrition Percentage
One	6	16.7% (1)
Two	8	12.5% (1)
Three	9	22.2% (2)
Four	8	12.5% (1)
Five	8	25% (2)

These group members had a range of historical and current psychiatric diagnoses, for example PTSD, Borderline Personality Disorder, Complex PTSD, Depression, Autism Spectrum Disorder. However, each member had experienced at least one rupture during childhood within a care-giving relationship that was central the individuals form of self-criticism and self-attack. The survey was live for 31 days with a further prompt email sent at the halfway point. A total of 9 responses were received where a thematic analysis was conducted [24, 25] by one of the group co-ordinators and a nurse psychotherapist employed by the same department but external to all compassion focused group therapy work. Both independently familiarised themselves with the survey responses prior to identifying codes for theme development. Themes were then constructed together through discussion and exploration of individual codes, with quotes being used to support theme development and areas of further improvement.

3. Results

The thematic analysis provided four main themes. Two of main themes had two subordinate themes – Therapist Role, Structure, An Opportunity for Connection, Therapeutic Play. Each theme,

and relevant subordinate themes, will be explored including the links between them. The name of each participant has been anonymised to respect confidentiality.

3.1 Theme One–Therapist Role

The dominant theme emerging from the qualitative data that was described across all participants was the role therapists played within the group setting, which was distinguished into two subordinate themes.

3.1.1 Subtheme One–Therapist Qualities

Many respondents spoke to therapists' demonstration of compassion, during the early orientation and formulation sessions:

"They were both very welcoming, warm, understanding and approachable."

"First of all, it was very daunting thing to do, after only seconds of meeting both X & X I felt comfortable enough to remove my armour and pour my heart out quite literally."

This was also extended to group sessions, in-between sessions and beyond:

"X is knowledgeable and skilled in X field, with a great balance of empathy, humour, enthusiasm and professionalism."

"...I really appreciated the calls I had when I had a rupture occurred and the care from X I felt".

"It was like I've had these stabilisers on for all these weeks, what if I need them again a year down the line or something...so yeah I think it was important to me."

Importantly there was a respondent noting to a sense of inauthenticity from a therapist, which contributed to early resistance:

"I felt a bit patronised and condescended to by X, as if X wasn't being genuine somehow which put me further on edge."

3.1.2 Subtheme Two–Competency

Respondents made references to therapist facilitation and co-facilitation:

"X and X did well at including everyone though, so it didn't feel like a 1:1 session with just me and would pull it back to group yet making my point or question valid."

"The team was amazing and seemed to work really well together."

"The first few weeks were heavy going and the facilitators were amazing at guiding us through the lulls."

The expertise of delivering the therapeutic model and adapting the psychotherapeutic material:

"The way it was spoken to us too, none of that textbook lingo. It was brought down to a level where we could all understand and use it to our own advantage. It wasn't fast so it was easy to absorb."

"The content was admittedly one of my favourites, every session there was something new and it was customised to ourselves and needs..."

Participants of the survey also referred to how therapists managed group dynamics,

“It seemed like some people weren’t ready and had to leave eventually and things were much better when they had because we could move at a less slow pace.”

3.2 Theme Two–Structure

Structure was the second overarching theme across all respondents’ surveys, with particular focus on how group members entered and exited the programme but also how group sessions were organised.

3.2.1 Subtheme One–Beginnings & Endings

What was highlighted across the responses was the importance of being prepared and ready for the group programme through early opportunities for containment:

“I was given every bit of preparation I needed. Understandably I was very anxious so my questions were probably very far stretched at times but anytime I reached out before during and after, I was met with an answer.”

“This was very reassuring. I was sceptical about the group aspect of the therapy and having tried various other therapies previously, I wasn’t confident that this would be anymore useful.”

“The first session could possibly be handled differently. We were asked to wait in a different room while the facilitators finished setting up and that was quite an uncomfortable experience because we all knew why we were there, but didn’t know each other yet so it was difficult to know what to say.”

“The explanation and details about what to expect and how we needed to behave was most reassuring as the group made the rules.”

However, what was repeatedly reflected upon was the importance of having endings equally as containing and supportive, including recognising the readiness to, and the need for further group work:

“The moving on group is a great idea. I’ve only made it to 1 or 2 because of work commitments, but it’s definitely supportive.”

“I loved seeing where I started, and how it finished. Was a real boost especially when you feel like some days there is no progress at all.”

“It would have been helpful to have the option to continue with the same group into a 25-week one for those that needed it and wanted to stay together.”

“I felt we were just starting to get into the work when the 12-week group ended.”

“Wish there could have been more to ease out of what was a life altering and intense few weeks.”

“Make the course run longer over more sessions...maybe even 3, one month apart. You take in so much information and it felt a bit like “what do I do with it all”. Extra 1-2-1s were most helpful in getting to a conclusion as to what I wanted to do next and the spacing was good as I had time to really process and reflect.”

3.2.2 Subtheme Two–Session Organisation

How group sessions were organised was also an important structural component, that contributed to theme three, which had impact across pacing, individual goals, and dynamic administration:

“Didn’t always have enough time for each of the topics we were covering.”

“A gentle informal introduction to everyone in the group, we were all terrified I think but soon as we did an outdoor session it opened up more conversation.”

“Content was not really clear. Apprehension heightened as a result, probably.”

“Extremely helpful. The group gave me tools to deal with my thoughts and emotions, all the interactions were very kind and helpful.”

“It would be good to have all sessions running without any breaks.”

“The number of people was good. It meant that if people couldn’t make all the sessions the room didn’t feel empty or too much focus on individuals. Also, small enough that all could contribute if they wanted to.”

“Room was often too hot. Not really set up for people to get up and move about.”

“The explanation and details about what to expect and how we needed to behave was most reassuring as the group made the rules.”

3.3 Theme Three–An Opportunity for Connection

What became evident for most people was the opportunities created within the group programme for individuals to experience compassionate flow – to others, from others and to themselves – which provided each member an opportunity for connection:

“I loved the support and care towards each other, there was a gentleness, and it felt so safe.”

“The group element was integral to this as I gained such a raw insight into different people’s perspectives.”

“There was no judgement... ever. Purely support from everyone. There was no expectation to share pieces of yourself should you want to hold back.”

For some there was descriptions that moved beyond opportunities for connection but the actual experiences of connectedness:

“A sense of camaraderie. Of belonging. Being able to ask group members for their thoughts on what I was experiencing.”

“It was the most in-depth thing I’ve ever done, but from a safe place. Safety was my main concern, it was something I was really not doing well within in life, and this solid 12 weeks of having that net was just what I needed.”

3.4 Theme Four–Therapeutic Play

Finally, what was reflected was the therapeutic methods applied to fears, blocks and resistances to compassion during the programme demonstrated through descriptions of the practical and play-based work completed.

“The meditation has been a tool I’ve used more than anything. Initially I thought I can’t do it or it won’t work for me...for various reasons but I’ve stuck with it and it has been a saviour even after group has ended.”

“I had tried to get through much of this for a long time in my life, so when I had the time in any chair regarding therapy or work on myself, I took it and ran with it.”

“We were given things away (things I’ve kept) as a reminder that even if I don’t use them everyday or need them.”

“Loved the sessions where we were all connected (with the) ball of wool etc.”

But also descriptions shared of personal experiences of the group therapeutic work that mobilised change for them.

“The facts of my life haven’t suddenly changed, and painful memories haven’t been erased, but this therapy has helped me see things differently. It has allowed me to make peace with the past and have confidence in myself going forward. I can calmly stand up for myself now, without doubting myself or feeling guilty.”

4. Discussion

This thematic analysis identified four core themes across the patient feedback: *Therapist Role, Structure, An Opportunity for Connection, and Therapeutic Play*. These themes reflect important components of group-based therapeutic work, particularly within the context of Compassion-Focused Group Psychotherapy (CFGP) and are consistent with existing research into compassion-focused and group interventions [17, 26, 27].

The theme *Therapist Role* underscored the importance of the therapists’ warmth, compassion, and expertise within the model. Participants described facilitators as emotionally attuned and approachable, particularly during the early orientation and formulation sessions. These qualities are central to CFGP, which places significant emphasis on the cultivation of a compassionate interpersonal dynamic as a foundation for psychological safety and social safeness [28-31]. Therapist competence, including the ability to adapt material and manage group processes, also emerged as important. This aligns with recent findings that underscore the importance of skilled facilitation in delivering CFT in a group setting [32].

Notably, one participant raised concerns about a therapist’s perceived inauthenticity, which may suggest the need for ongoing therapist self-reflection but also openness to exploring the posed perception in terms of projections and transference. While compassion is crucial, it must be balanced with genuine presence and emotional congruence. Yalom and Leszcz [33] suggest that authenticity in therapist–patient relationships are key to establishing trust, and a perceived lack of it can impact engagement. This highlights the importance of the provision of a supervisory space that can provide space to explore potential for transference and projections onto the therapist, but also the therapists’ feelings in the room and counter transferences.

The theme *Structure* focused on how the format and design of the group influenced participants’ experiences. Pre-group preparation and transparency were seen as critical for containment, which the literature on the importance of careful orientation and pacing in group work can support [34]. Participants also valued the structure of beginnings and endings, though several expressed a desire for more time and/or transitional support at the conclusion of the programme. This echoes calls from compassion-focused researchers for extended or follow-up

support to aid integration of therapeutic material beyond the group and NHS services into third sector and voluntary agencies [17, 26].

The second structural subtheme, *Session Organisation*, reflected mixed feedback. While many appreciated the clarity and accessibility of content, others noted issues with time allocation, group size, and environmental factors. These findings highlight the importance of flexible and responsive group facilitation, particularly in adapting therapeutic content to the emerging needs of the group [32].

The theme *An Opportunity for Connection* revealed that many participants experienced strong group cohesion and mutual support, which contributed to increased self-acceptance and a sense of belonging. This aligns with one of the core aims of CFGP: to foster compassionate relational experiences in a group context that challenge shame and promote safeness [27, 29]. Group cohesion is widely acknowledged as a key factor in therapeutic change [33], and participants' descriptions of camaraderie and safety suggest this was achieved. They may demonstrate the work of active experiences of compassionate flows from self, to self and to others. The utility of group-work can allow space for explicit compassionate flow work, which is integral in addressing self-criticism and shame [35].

Finally, the theme *Therapeutic Play* captured the personal and psychological changes experienced during the programme through modes of play, chair-work and experiential exercises. These changes included increased emotional regulation, shifts in self-perception, and the development of compassionate coping tools. Participants referred to practical elements such as metaphor-based exercises and sensory aids drawn from the Compassionate Kitbag [17], which were used to anchor therapeutic concepts in daily life. These interventions are designed to build emotional resilience through embodied compassion practices, and their integration appears to have enhanced the effectiveness of the programme.

Overall, the findings suggest that the group was effective in delivering core components of CFGP, including emotional safety, psychoeducation, and compassionate relational experiences. While largely consistent with previous research, several areas—such as the desire for longer engagement or extended endings—point to future improvements where further psychological work is needed to address such attachment trauma. Balancing structure and flexibility, ensuring therapeutic authenticity, exploring the therapist role and experiences of delivering group and incorporating extended support mechanisms may enhance the delivery of compassion-based group interventions going forward.

4.1 Limitations

Despite the valuable insights generated through this thematic analysis, several limitations must be acknowledged. Firstly, the small number of participants limits the findings, as the sample may not fully represent the diversity of experiences within similar therapeutic groups. We can only speculate as to why 9 out of 27 invited attendees completed the survey but may be representative of the impact group had on them. Secondly, the data was collected via an open-ended survey response rather than in-depth interviews, which may have restricted the depth and nuance of group member reflections. The absence of any follow-up querying also limits the ability to clarify or expand on ambiguous or complex statements. Additionally, the analysis was conducted without the use of inter-rater reliability procedures, which introduces potential bias and limits the

credibility and consistency of theme development. One therapist was heavily involved in both the group development and delivery and the thematic analysis, which may introduce further bias. The study also lacked inclusion of demographic information requests within the survey therefore limiting specificity on experiences relating to gender, age, diagnosis or previous experiences of therapy. Furthermore, there was no long-term follow-up data to assess the sustainability of perceived benefits over time, nor was there information available regarding whether participants re-engaged with services or pursued further therapeutic input following discharge. However, it is notable that six participants transitioned into a 25-week Compassion Focused Group (phase 4 of Lucre approach), reflecting both the complexity of their difficulties and the assessed need for continued integrative therapeutic work. This acted as a continuation of care where members from various 12-week groups were brought together to form a new group focusing on 'putting the compassionate mind to work'. It should also be recognised that, while this programme may offer meaningful therapeutic benefit, it may not fully resolve the enduring and multifaceted difficulties associated with attachment trauma, which often require longer-term interventions.

5. Conclusion

The above analysis highlights the value of Compassion-Focused Group Psychotherapy (CFGP), particularly its Assessment and Formulation phase and the Preparation and Engagement Group, in fostering safety, connection, and compassionate change. Participants consistently emphasised the importance of skilled and authentic facilitation, the balance between structure and flexibility, and the transformative impact of compassionate relational experiences.

While these findings align with the existing evidence base, participants' calls for a longer programme, more gradual endings, and ongoing support underscore the need for an extended pathway for individuals with enduring, complex attachment-related difficulties. CFGP may address the various needs in a way standard form of CFT groups may not. This evaluation has informed local decision-making and supported the trial of a 25-week Phase 4 Compassion-Focused Trauma Group for those who require continued psychological work after completing the Preparation and Engagement Group. This brings the programme more in line with Lucre's model, where the current evidence for Compassion-Focused Group Psychotherapy is strongest, and makes attempts to respect the need for more extended group programmes for those presenting with pervasive attachment-related difficulties.

Despite methodological limitations, the results suggest that CFGT delivered in isolation—specifically phases 1 and 3 of CFGP—offers a meaningful therapeutic pathway. However, further refinement and improved integration across the service are needed, particularly in supporting the transfer between therapeutic phases and groups, and in managing transitions both out of therapy and out of the service.

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Author Contributions

Graeme Tainsh: Methodology, conceptualization, writing – original draft, formal analysis, writing – review and editing. Katherine Baughan: Methodology, conceptualization, writing – review and editing. All authors have read and approved the published version of the manuscript.

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Competing Interests

The authors have declared that no competing interests exist.

AI-Assisted Technologies Statement

Artificial intelligence (AI) tools were used solely for constructing our final reference list. Specifically, OpenAI's ChatGPT was employed to collate and format references into the correct style and list. All scientific content, data interpretation, and conclusions were developed independently by the author. The authors have thoroughly reviewed and edited the AI-assisted reference list to ensure its accuracy and accept full responsibility for the content of the manuscript.

Additional Materials

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

1. Appendix 1: 12-week CFGT Programme.
2. Appendix 2: 11-item survey for patients.

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