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Compassion-Focused Therapy Groups in Secondary Care Adult Mental Health Services: A Service Evaluation

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Abstract

Preliminary research highlights the potential benefits of compassion-focused therapy (CFT) groups for individuals with severe and enduring mental health difficulties (MHD) and high levels of self-criticism. This service evaluation aimed to assess whether attendance at CFT groups run by two adult community mental health teams (CMHTs) was associated with improvements in compassion, depression, anxiety, and self-esteem. A mixed-method design was employed. Quantitative and qualitative patient-reported routine outcome measures (PROMs) and experience feedback were obtained from 12 service users and analyzed using a reliable change index clinically significant change metrics, and frequency and content analyses. The most common, significant improvements indicated were found for self-compassion and self-kindness, and, to a lesser extent, in levels of anxiety and depression. Service users described the groups as enjoyable and useful, and valued the relational safety of the group and specific CFT techniques and concepts, requesting more sessions and visual materials. This service evaluation found that CFT group interventions can represent an acceptable alternative to individual treatment, though results need to be interpreted with caution due to the small sample size and use of different measures at each site.

Keywords Compassion-focused therapy · CFT · Compassion · Mental health · Psychological therapy · Psychotherapy

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Introduction

Compassion-focused therapy (CFT) is an increasingly popular psychological therapy that targets difficulties with self-criticism and shame (Gilbert, 2010). Numerous studies have linked self-criticism and shame with mental health difficulties (MHD), such as psychosis (Gilbert & Irons, 2005), personality difficulties (Lucre & Corten, 2013), trauma (Gilbert, 2010), depression and anxiety (Gilbert & Procter, 2006). Although often considered part of the third wave of cognitive-behavioural therapies, CFT also incorporates elements of attachment models, evolutionary theory, neuroscience and a conceptualisation of compassion typical of Buddhist philosophies (McManus et al., 2018). CFT proposes an affect-regulation model with three emotion-regulation systems: a drive and resource-seeking system to encourage and stimulate us to find resources needed to survive and prosper; a soothing and connection system to regulate feelings of safeness and restore emotional balance; and a threat and protection system to detect and respond to threats promptly (Gilbert, 2009, 2010). Within CFT, MHD are conceptualised as an imbalance of these three systems, particularly when the threat system is over-stimulated and the soothing system is under-stimulated (Gilbert, 2010). CFT interventions aim to de-shame and de-pathologise difficulties through an evolutionary lens, re-establishing the balance between the affect-regulation systems and enhancing self-compassion (Gilbert, 2009, 2010).

As a relatively new psychological therapy, CFT has not yet accrued a strong evidence base (McManus et al., 2018). However, a number of studies and small randomised controlled trials (RCTs) involving people with severe and enduring MHD have supported its efficacy as a transdiagnostic psychological treatment (McManus et al., 2018). A study involving 27 participants with complex MHD receiving support from CMHTs found that group-based CFT was associated with significant improvements in depression, anxiety, stress, shame, self-criticism, submissive behaviour and social comparison on self-report questionnaires (Judge et al., 2012). In a study involving eight participants with a diagnosis of personality disorder, Lucre and Corten (2013) reported that, following 16 weekly sessions of group therapy based on CFT, participants showed significant reductions in shame and self-hate, and improvements in self-reassurance, stress, depression and social comparison. McManus et al. (2018) evaluated a transdiagnostic CFT group intervention involving 13 clients experiencing severe and enduring MHD from 6 CMHTs, using quantitative and qualitative data. Results showed statistically significant improvements on all outcome measures and qualitative feedback confirmed clients found attending the group a positive experience (McManus et al., 2018). A systematic review of 29 studies with 914 participants found that CFT had positive effects on service users with a range of MHD, including eating disorders and personality difficulties (Craig et al., 2020). Another systematic review of 14 studies, three of which were RCTs, concluded that CFT is a promising therapeutic approach for mood difficulties, particularly in individuals with high levels of self-criticism (Leaviss & Uttley, 2015).

Recent research has highlighted possible mechanisms of action for the effectiveness of CFT in people experiencing severe and enduring MHD. Lucre and

Corten (2013) hypothesised that CFT helps to reduce shame and self-criticism by increasing awareness of negative self-perception and how other people view us. Alongside other authors, they stressed the importance of socialisation to the CFT model in promoting de-shaming processes (Cuppage et al., 2018; Lucre & Corten, 2013). Moreover, there is tentative evidence showing that group CFT creates a sense of relational safeness, which has been linked to a reduction in psychopathology, specifically through recognition of threat-based stimuli and engagement in soothing cognitive, emotional and behavioural processes (Cuppage et al., 2018; Gilbert, 2009; Lowens, 2010).

Being a relatively novel psychotherapeutic approach, and proposing a focus on targeting transdiagnostic mechanisms rather than condition-specific symptoms, has meant that the deployment of CFT in community settings is often secondary to first-line psychological treatments, such as CBT, which is recommended by most clinical guidelines for severe MHD (Cuppage et al., 2018; Lucre & Corten, 2013; McManus et al., 2018).

Given the volume of referrals to clinical psychology within CMHTs, group treatments can represent an effective alternative to individual therapy when they are supported by clinical decisions and consistent with clients' goals (McManus et al., 2018). Group interventions are particularly relevant to CFT as they can promote a relational understanding and implementation of its key affective components, such as developing compassion for ourselves and others, and the desire to connect with other people (Cuppage et al., 2018; Gilbert, 2010).

Service Evaluation Aims and Questions

Public mental health services in England are managed by the National Health Service (NHS), which aims to improve outcomes in clinical populations, and target inequalities in access and experience of care (NHS England, 2019). This is in line with national policies and guidelines, such as the NHS Long Term Plan and the national framework for action on improvement and leadership development in NHS-funded services (NHS England, 2019; NHS Improvement, 2019). NHS commissioning is based on a number of indicators and metrics which monitor and improve care provision (NHS England, 2023; NHS Improvement, 2019). NHS services and organisations rely greatly on the guidelines issued by the National Institute for Health and Care Excellence (NICE) when making decisions about clinical practices and treatments (NICE, 2013). NICE is a publicly funded body that sets quality standards for care provision based on research and clinical evidence (NICE, 2013).

Service evaluations are key contributions to the provision of healthcare in England, helping to determine the effectiveness and quality of services provided by publicly funded healthcare systems, including the NHS (Department of Health, 2010; Moule et al., 2016). Service evaluations aim to review care provision to assess quality and rigour, in turn highlighting potential improvements for healthcare services to address (Moule et al., 2016). In addition to contributing to research evidence, local service evaluations also permit careful investigation of the experiences and benefits associated with psychological interventions, such as CFT, for service users.

This project evaluated two CFT groups run by adult CMHTs in the East of England. Rather than attempting to generalise its findings, this service evaluation aimed to provide recommendations to improve future CFT-based group interventions for service users experiencing chronic and complex MHD. More specifically, it addressed the following questions:

1. Was CFT group attendance associated with improved clinical outcomes for service users experiencing severe and enduring MHD linked with high levels of shame and self-criticism?
2. What did feedback questionnaire responses indicate regarding aspects of the group valued by service users and suggestions to improve patient outcomes and experience?
3. What improvements, if any, could be made to the routine evaluation of this group intervention?

Method

Design

Given the project questions, a mixed-method design was employed to address the following aims:

1. A repeated measure design was used to evaluate change over time on PROMS (NHS Institute for Innovation and Improvement, 2005)
2. Frequent and content analyses (NQB, 2016; NICE, 2011) were utilised to evaluate patients' feedback and experiences
3. Relevant recommendations were made to improve the routine evaluation of CFT group interventions

Participants

The participants were service users from two adult CMHTs attending an eight-week CFT group. Data from 12 service users were available, six each from two CMHTs within the same NHS Trust. As a transdiagnostic group, participation did not require specific diagnoses. Instead, service users were referred to the groups if they experienced high levels of self-criticism and shame associated with their MHD, identified by the professionals involved in their care through clinical assessment.

Measures

PROMs were completed before and after delivery of the CFT groups to assess depression, anxiety, self-esteem and levels of compassion. The Patient Health Questionnaire-9 (PHQ-9) and the Generalized Anxiety Disorder-7 (GAD-7) were used to

measure symptoms of depression and anxiety as these have been found to be valid and reliable in adults (Kroenke et al., 2001, 2010; Spitzer et al., 2006). In this population, they have high internal reliability, with Cronbach's alpha values of 0.89 for the PHQ-9 (Kroenke et al., 2001) and 0.92 for the GAD-7 (Spitzer et al., 2006). The original validation study of the PHQ-9 (Kroenke et al., 2001) provides normative data (mean PHQ-9 score, 17.1; SD, 6.1) needed for comparisons with other groups. Similarly, the original validation study of the GAD-7 (Spitzer et al., 2006) provides normative data needed for comparisons with other populations (mean GAD-7 score, 14.4; SD, 4.7).

The Rosenberg Self-Esteem Scale (RSE, Rosenberg, 1965) was employed to measure self-esteem as this has high reliability and validity in adults (Blascovich & Tomaka, 1991; Torrey et al., 2000). A study involving adults with severe and enduring MHD found a coefficient alpha of 0.87, confirming high internal reliability, and a mean score of 22.8 (SD, 5.6) at baseline (Torrey et al. 2000).

A number of self-report measures of compassion were also employed. The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS) is a reliable and robust measure of self-criticism and self-reassurance in adults (Baião et al., 2015; Gilbert et al., 2017). The questionnaire measures three main domains: reassured-self, inadequate-self and hated-self. The original validation study provides Cronbach's alpha values of 0.91 for the inadequate self, 0.87 for the hated-self and 0.85 for reassured-self, and the normative data for comparisons with clinical populations (Baião et al., 2015). The Compassionate Engagement and Action Scales (CEAS, Gilbert et al., 2017) are a set of self-report tools that measure self-compassion, compassion for others and compassion from others. Each scale generates scores on the 'engagement' and 'actions' domains. The scales have good validity and reliability. The original validation study provides Cronbach's alpha scores for the subscales ranging from 0.72 to 0.94, means and standard deviation values for comparisons with other populations (Gilbert et al., 2017). The Self-Compassion Scale (SCS) is a psychometrically valid and reliable tool that measures self-compassion (Neff, 2003, 2016). A recent study (Neff et al., 2017), examining the factor structure of the SCS in four distinct populations, provides Cronbach's alpha values for the subscales ranging from 0.7 to 0.8, means and standard deviation values for potential comparisons.

Both teams used the same PROMS, with the exception of the measures of compassion, as one CMHT used the CEAS and the SCS, and the other used the FSCRS.

Feedback Forms

Service user feedback was collected at the end of the group interventions using a feedback form with four closed-ended and three open-ended questions (see Appendix 1).

Ethical Considerations

This project was approved as a service evaluation by the NHS Trust involved and the Faculty of Medicine and Health Sciences at the University of East Anglia.

Service users provided informed consent to complete PROMs for the purpose of service evaluation. They were informed that they could withdraw from the group intervention at any time if they wished to do so.

In line with the General Data Protection Regulation and the Data Protection Act (BPS, 2018), confidentiality was maintained by fully anonymising the data.

Procedure

After suitability for the group intervention was established and consent obtained, service users were invited to attend an eight-week closed CFT group. Baseline measures were completed during the screening sessions, within two weeks of the beginning of the group. Post-treatment measures and feedback forms were completed during the last group session. All measures were administered by the group facilitators.

CFT Group Intervention

Both CFT groups used the same format and structure. One group was facilitated by a clinical psychologist, an advanced nurse practitioner and an assistant psychologist, and another by a clinical psychologist and a trainee clinical psychologist. The lead facilitators of the groups were clinical psychologists who received clinical training on how to deliver CFT interventions. Each session lasted 90–120 minutes. The same materials were used to deliver both groups and included information on CFT and experiential exercises. Session content focussed on transdiagnostic principles rather than specific diagnoses. Prior to delivering the groups, the psychologists involved met twice with the local Lived Experience Advisory Group (LEAG) to obtain feedback on the implementation, content and structure of the group. Each session included a review of the key concepts and techniques covered in the previous session, an introduction to a new skill or technique, an experiential exercise, and a homework task. Each session had a key theme (Table 1).

Table 1 CFT Ggroup Session Titles and Key Themes

Session Number	Session Title and Key Theme
1	Introduction
2	The Three Systems
3	The Brain and Using Imagery
4	Feeling the Self-soothing System
5	The Compassionate Companion
6	Self-criticism and Focussing the Compassionate Self on Yourself
7	Compassionate Behaviour
8	Bringing It All Together

Data Analysis

Demographic data, including gender, age, ethnicity and diagnosis, were summarised using descriptive statistics to characterise the service users who attended the groups.

Reliable Change Index and Clinically Significant Change

Due to the small sample size and use of different measures of compassion across teams, group-level comparisons were not attempted. Instead, reliable change index and clinically significant change analyses were used to evaluate individual change in PROMS over time.

Clinically significant change (CSC) is defined as moving from the dysfunctional population and entering the functional population following treatment (Jacobson & Truax, 1991). In this project, CSC was evaluated using a threshold score for the clinical population and determining whether scores crossed this threshold, moving to a greater probability of falling within the range of the functional population (Evans et al., 1998; Jacobson & Truax, 1991). A cut-off score of 10 (or above) for the PHQ-9 and GAD-7 was used, as this has good sensitivity (88% for the PHQ-9 and 89% for the GAD-7) and specificity (88% for the PHQ-9 and 82% for the GAD-7) for detecting major depression and generalised anxiety in adults (Kroenke et al., 2001; Kroenke et al., 2010; Spitzer et al., 2006). No clinical cut-off scores were identified for the RSE, FSCRS, CEAS, and SCS in the relevant literature. These were calculated using the means and standard deviations of clinical (MEANclin, SDclin) and reference group data (MEANnorm, SDnorm), using the following equation (Evans et al., 1998):

$$\text{Clinical cut} - \text{off score} : \frac{(\text{MEANclin x SDnorm}) + (\text{MEANnorm x SDclin})}{\text{SDnorm} + \text{SDclin}}$$

Reliable change is defined as a statistically reliable change rather than change due to variability of measurement. Pre-intervention score (X1), post-intervention score (X2) and the standard error of the difference score (SE_{diff}) were used to calculate the reliable change index (RCI, Jacobson & Truax, 1991):

$$\text{RCI} : \frac{X2 - X1}{\text{SEdiff}}$$

The SEdiff value was calculated by using the following equation:

$$\text{SEdiff} = \sqrt{2}(SEm)$$

The SEm value represents the standard error of the measurement, which was calculated by using the following equation:

$$\text{SEm} = \text{SDb}\sqrt{1} - r$$

The *r* value represents Cronbach's alpha coefficient and *SDb* is the standard deviation value of the normative population used for the comparison. An index score (RCI score) greater than 1.96 was considered reliable change (Jacobson & Truax, 1991). A further classification of cut-off scores reflecting various degrees of reliable change is recommended by Wise (2004), including recovery (RCI = + 1.96, confidence levels = 95%), improvement (RCI = + 0.84, confidence levels = 80%), no reliable change (RCI = − 0.84 to + 0.84), mild deterioration (RCI = − 0.84, confidence levels = 80%), or deterioration (RCI = − 1.96, confidence levels = 95%).

Reference group data for the RCI and CSC analyses were found for the PHQ-9 (Kroenke et al., 2001), GAD-7 (Spitzer et al., 2006), RSE (Torrey et al. 2000), FSCRS (Baião et al., 2015), CEAS (Gilbert et al., 2017), and SCS (Neff et al., 2017).

Frequency and Content Analyses

Responses to closed-ended questions were summarised using frequency analysis. Content analysis (Kleinheksel et al., 2020) was used to analyse responses to the open-ended questions as it is particularly suitable for data lacking rich and nuanced detail, whose meaning is manifest and can be taken at face value (Kleinheksel et al., 2020). The analytical process began with the identification of units of meaning in the text, which typically took the form of short sentences or phrases (Kleinheksel et al., 2020). More complex meaning units were condensed into shorter phrases that retained the core meaning to facilitate the analytical process. Condensation did not require interpretation as its aim was to shorten units of meaning while retaining the original message (Erlingsson & Brysiewicz, 2017; Kleinheksel et al., 2020; Srnka & Koeszegi, 2007). Units were then coded and appropriate categories were generated, leading to the identification of main themes (Kleinheksel et al., 2020). To increase the rigour and credibility of the analytical process, and counter researcher bias, the lead researcher discussed the preliminary data analysis and subsequent findings with their research supervisor, who conducted a validation check of the codes, categories and themes generated.

Results

Demographic information and diagnoses are summarised in Table 2. Service users were White British, predominantly female, with a mean age of 53. Depressive disorders were the most prevalent diagnoses.

Reliable and Clinically Significant Change

The results of the combined RCI and CSC analysis on each subscale of the measures are summarised in Table 3. Reliable and clinically significant change was the most prevalent outcome on the CEAS 'self-compassion actions' and SCS 'self-kindness' subscales (66.67% of service users). On the CEAS 'self-compassion engagement'

Table 2 Demographic Information and Clinical Diagnoses

Demographic Characteristic	N (%)
Gender	
Female	9 (75%)
Male	3 (25%)
Age Range	28–65
Mean Age	53.25
Ethnicity	
White British	12 (100%)
All other	0 (0%)
Diagnosis*	
Depressive Disorders	8 (66.67%)
Adjustment Disorder	2 (16.67%)
Bipolar Affective Disorder	2 (16.67%)
Agoraphobia	1 (8.33%)
Mixed Anxiety and Depressive Disorder	1 (8.33%)
Social Phobia	1 (8.33%)
Obsessive–Compulsive Disorder	1 (8.33%)
Bulimia Nervosa	1 (8.33%)
Other Anxiety Disorder (unspecified)	1 (8.33%)

*Some service users were given more than one diagnosis

and SCS 'over-identification' subscales reliable and clinically significant change was found in half of the service users. Rates of deterioration across measures did not exceed 16.67%.

The results of separate RCI and CSC analyses are summarised in Tables 4 and 5. Over two-thirds of service users showed reliable and clinically significant reductions in self-criticism expressing inadequacy and increases in self-reassurance, on the FSCRS. At least half no longer met the identified threshold for a clinically low level of compassion or continued not to meet the clinical threshold on all three FSCRS subscales. None showed reliable change or improvement in self-criticism expressing self-hatred, however. At least one-third of service users showed reliable change or improvement on the three CEAS 'self-compassion' subscales, and at least half no longer met the clinical threshold or continued not to meet the clinical threshold. A third of service users showed reliable change or clinically significant improvement on both 'compassion for others' subscales of the CEAS, with at least a third no longer meeting the clinical threshold, or continuing not to meet the clinical threshold on these subscales. There was little reliable change or improvement in the two CEAS 'compassion from others' subscales (up to 16.67% of service users), although at least two-thirds of service users no longer met the clinical threshold or continued not to meet the clinical threshold. Between a third and a half of service users showed reliable deterioration on the two CEAS 'compassion for others' subscales.

There were indications of reliable change and improvement in self-kindness, common humanity and mindfulness on the SCS, and at least a third of service users no longer met the clinical threshold or continued not to meet the clinical

Table 3 Combined RCI and CSC Results for all Measures

Participant ID	PHQ9	GAD7	RSE scale	FSCRS inadequate self	FSCRS reassured self	FSCRS hated self	CEAS compassion for others engagement	CEAS compassion for others actions	CEAS compassion from others engagement	CEAS compassion from others actions	CEAS self-compassion sensitivity	CEAS self-compassion engagement	CEAS self-compassion actions	SCS self-kindness	SCS self-judgement	SCS common humanity	SCS isolation	SCS mindfulness	SCS over-identified
1	R	NC	NC	NC	NC	NC													
2	NC	NC	NC	NC	R	NC													
3	NC	NC	NC	R	NC	NC													
4	NC	NC	NC	NC	D	D													
5	NC	NC	NC	NC	NC	NC													
6	R	NC	D	R	NC	NC													
7	NC	NC	R				R	NC	NC	NC	NC	NC	R	NC	NC	NC	NC	NC	NC
8	NC	NC	NC				NC	NC	NC	NC	NC	R	R	NC	NC	R	NC	R	NC
9	NC	NC	NC				NC	NC	NC	NC	D	R	R	R	R	NC	R	NC	R
10	R	NC	NC				NC	NC	NC	NC	NC	NC	NC	R	NC	D	R	NC	R
11	R	R	NC				NC	NC	NC	D	R	R	R	R	R	NC	D	NC	R
12	NC	NC	NC				NC	D	NC	R	NC	NC	NC	R	NC	R	NC	NC	NC

R recovered, *NC* No Change, *D* Deteriorated, *PHQ-9* Patient Health Questionnaire-9, *GAD-7* Generalised Anxiety Disorder-7, *RSE* The Rosenberg Self-Esteem Scale, *FSCRS* The Forms of Self-Criticising/Attacking and Self-Reassuring Scale, *CEAS* The Compassionate Engagement and Action Scales, *SCS* The Self-Compassion Scale

*Total $N = 6$ for FSCRS, CEAS and SCS as these measures were completed by only one of the two CFT groups

Table 4 RCI Frequencies* and Percentages for all Measures

	Recovered		Improved		No Reliable Change		Mildly Deteriorated		Deteriorated	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
PHQ-9	3	25	3	25	6	50	0	0	0	0
GAD-7	3	25	3	25	6	50	0	0	0	0
RSE	2	16.67	3	25	3	25	3	25	1	8.33
FSCRS (inadequate self)	2	33.33	2	33.33	2	33.33	0	0	0	0
FSCRS (reassured self)	2	33.33	3	50	0	0	0	0	1	16.67
FSCRS (hated self)	0	0	0	0	4	66.67	2	33.33	0	0
CEAS (compassion for others engagement)	0	0	2	33.33	2	33.33	1	16.67	1	16.67
CEAS (compassion for others actions)	0	0	2	33.33	1	16.67	1	16.67	2	33.33
CEAS (compassion from others engagement)	0	0	0	0	4	66.67	0	0	2	33.33
CEAS (compassion from others actions)	0	0	1	16.67	3	50	1	16.67	1	16.67
CEAS (self-compassion sensitivity)	0	0	2	33.33	3	50	1	16.67	0	0
CEAS (self-compassion engagement)	1	16.67	3	50	2	33.33	0	0	0	0
CEAS (self-compassion actions)	4	66.67	0	0	2	33.33	0	0	0	0
SCS (self-kindness)	4	66.67	1	16.67	1	16.67	0	0	0	0
SCS (self-judgement)	0	0	4	66.67	2	33.33	0	0	0	0
SCS (common humanity)	1	16.67	1	16.67	3	50	0	0	1	16.67
SCS (isolation)	1	16.67	4	66.67	0	0	1	16.67	0	0
SCS (mindfulness)	0	0	2	33.33	3	50	1	16.67	0	0
SCS (over-identified)	1	16.67	3	50	2	33.33	0	0	0	0

PHQ-9 Patient Health Questionnaire-9, *GAD-7* Generalised Anxiety Disorder-7, *RSE* The Rosenberg Self-Esteem Scale, *FSCRS* The Forms of Self-Criticising/Attacking and Self-Reassuring Scale, *CEAS* The Compassionate Engagement and Action Scales, *SCS* The Self-Compassion Scale

*Total $N = 6$ for FSCRS, CEAS and SCS as these measures were completed by only one of the two CFT groups

threshold. These improvements were most prevalent on the self-kindness subscale. At least two-thirds of service users showed reliable change and improvement on the 'self-judgement', 'isolation' and 'over-identification' subscales of the SCS and no longer met the clinical threshold or continued not to meet the clinical threshold.

The separate RCI and CSC analyses also indicated improvements in depression, anxiety, and self-esteem. Half of the service users showed reliable recovery or improvement in depression or anxiety on the PHQ-9 and GAD-7, with almost half no longer meeting the clinical threshold or continuing not to meet it. Almost half of the service users showed reliable change or improvement in self-esteem on the RSE, with half no longer meeting the clinical threshold, or continuing not to meet it. Up to a third of service users showed reliable deterioration in self-esteem on the RSE, but none in depression and anxiety on the PHQ-9 or GAD-7.

Table 5 CSC Frequencies* and Percentages for all Measures

	Recovered		No Change (still meeting threshold)		No Change (still not meeting threshold)		Deteriorated	
	n	%	*n*	%	*n*	%	*n*	%
PHQ-9	4	33.33	6	50	2	16.67	0	0
GAD-7	1	8.33	7	58.33	4	33.33	0	0
RSE	1	8.33	5	41.67	5	41.67	1	8.33
FSCRS (inadequate self)	2	33.33	2	33.33	2	33.33	0	0
FSCRS (reassured self)	1	16.67	2	33.33	2	33.33	1	16.67
FSCRS (hated self)	0	0	2	33.33	3	50	1	16.67
CEAS (compassion for others engagement)	1	16.67	3	50	2	33.33	0	0
CEAS (compassion for others actions)	0	0	3	50	2	33.33	1	16.67
CEAS (compassion from others engagement)	0	0	1	16.67	5	83.33	0	0
CEAS (compassion from others actions)	1	16.67	1	16.67	3	50	1	16.67
CEAS (self-compassion sensitivity)	1	16.67	2	33.33	2	33.33	1	16.67
CEAS (self-compassion engagement)	3	50	1	16.67	2	33.33	0	0
CEAS (self-compassion actions)	4	66.67	1	16.67	1	16.67	0	0
SCS (self-kindness)	4	66.67	0	0	2	33.33	0	0
SCS (self-judgement)	2	33.33	2	33.33	2	33.33	0	0
SCS (common humanity)	2	33.33	1	16.67	1	16.67	2	33.33
SCS (isolation)	2	33.33	1	16.67	2	33.33	1	16.67
SCS (mindfulness)	1	16.67	4	66.67	1	16.67	0	0
SCS (over-identified)	3	50	1	16.67	2	33.33	0	0

PHQ-9 Patient Health Questionnaire-9, *GAD-7* Generalised Anxiety Disorder-7, *RSE* The Rosenberg Self-Esteem Scale, *FSCRS* The Forms of Self-Criticising/Attacking and Self-Reassuring Scale, *CEAS* The Compassionate Engagement and Action Scales, *SCS* The Self-Compassion Scale

*Total $N=6$ for FSCRS, CEAS and SCS as these measures were completed by only one of the two CFT groups

Frequency and Content Analyses

As shown in Table 6, service user responses were very positive. The frequency analysis highlighted that most service users found the group enjoyable and useful. Two-thirds of the service users found that their difficulties somewhat improved as a result of the group intervention, and more than half of the service users felt confident that they would continue to use the techniques and tools learnt in the future.

The content analysis of the responses to open-ended feedback questions (Kleinheksel et al., 2020) is illustrated in Fig. 1. Feedback did not always address the specific questions, so responses to the three open questions were analysed together. Two main themes were generated: 'perception and awareness of the benefits of the CFT group' and 'patient feedback aiming to shape future CFT groups'.

Table 6 Frequency Analysis of Participants' Responses to the Closed-ended Questions

Responses to Closed-ended Questions	*Not at all*		*Somewhat*		*Quite a lot*	
	Occurrence (*N*)	%	Occurrence (*N*)	%	Occurrence (*N*)	%
To what extent did you enjoy the group?	0	0%	1	8.33%	11	91.67%
To what extent did you find the group useful?	0	0%	3	25%	9	75%
To what extent do you feel that your difficulties have improved as a result of the group?	1	8.33%	8	66.67%	3	25%
To what extent do you feel as though you will continue with things that you have learned within the group?	0	0%	5	41.67%	7	58.33%

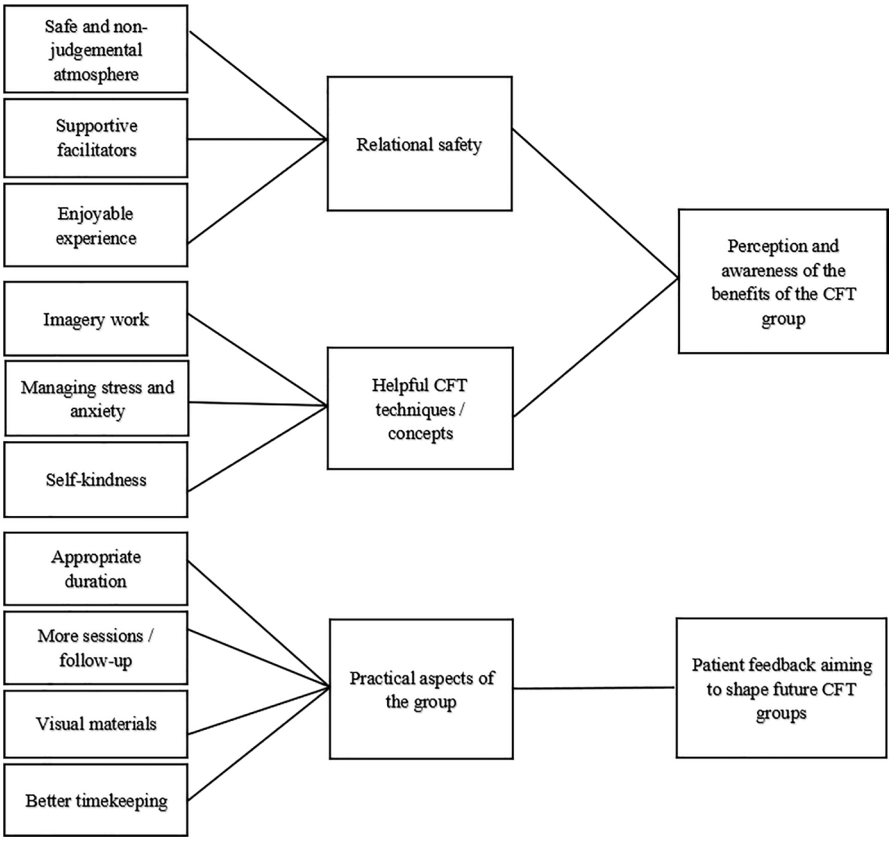

Fig. 1 Content Analysis of Participants' Responses to the Open-ended Questions

The first theme highlighted the benefits of the group, particularly in relation to two categories: experiencing 'relational safety' and the use of 'helpful CFT techniques/concepts'. Service users found attending the group an enjoyable experience. The safe and non-judgemental nature of the group was the most valued aspect of the intervention. This sense of safety was enhanced by the facilitators, who were perceived as supportive, friendly and compassionate. Service users also valued learning about specific techniques and concepts within the group, such as using imagery-based techniques, strategies to deal with stress and anxiety, and developing self-kindness.

The second theme emerged from the category 'practical aspects of the group', highlighting how service users hoped to shape future CFT groups. The duration of the group (90–120 minutes) was perceived as appropriate. Service users would have liked additional sessions or follow-up sessions, visual materials (e.g., video clips and large diagrams) and consistent time and duration of the sessions.

Discussion

This service evaluation assessed whether CFT group attendance was associated with increased compassion and reduced self-criticism in adult CMHT service users. Its main aim was to provide relevant recommendations to enhance future CFT-based group interventions, rather than generalising its findings.

Despite the limited sample size, the single-arm pilot, non-blind study design and associated statistical challenges, there was evidence of increased compassion at the individual level following group attendance. The most significant and prevalent improvements, indicated by combined and separate RCI and CSC analyses, were in self-compassion and self-kindness, evidenced by high recovery rates on the CEAS 'self-compassion actions' and the SCS 'self-kindness' subscales. These results are similar to those of Judge et al. (2012) and Gilbert and Procter (2006), suggesting that CFT groups can reduce self-criticism and shame in individuals experiencing complex MHD. Shame plays a key role in the development and maintenance of self-criticism (Gilbert, 2009, 2010), therefore it is possible that the process of sharing and reflecting on adverse life experiences while encouraging self-kindness and self-compassion helped to reduce distressing feelings and normalise difficulties (Judge et al., 2012). As Lucre and Corten (2013) suggest, this focus on the relationship with the self is particularly important as it is problematic to encourage clients to view others as kind, supportive and compassionate, given the tendency for this group to experience unhelpful and damaging relationships, and, more generally, the uncertainty surrounding other people's behaviour and responses.

We found a deterioration in subscales measuring 'compassion for others' and relatively little reliable change and improvement on subscales measuring 'compassion from others' and self-hatred. This was surprising, given the strong relational element of the intervention and its focus on targeting self-criticism. These findings contrast with prior research (Gilbert, 2009, 2010) and the qualitative feedback provided by the service users of this service evaluation. It may be that service users worked harder on identifying and relieving distress stemming from critical beliefs about the self, rather than others, which tends to be particularly challenging in individuals experiencing severe and long-lasting MHD (Lucre & Corten, 2013). Equally, as others have highlighted (Gilbert & Procter, 2006), this client group has been found to hold positive beliefs about self-criticism, such as perceiving it as a drive to improve themselves, which might have hindered their ability to target self-hatred.

When RCI and CSC were analysed separately, clinical outcomes at the individual level indicated improvements in depression, anxiety, and self-esteem. These findings are particularly important, given that depression, anxiety and low self-esteem were not the primary targets of the intervention. This mirrors the findings of Gilbert and Procter (2006) and Laithwaite et al. (2009), who found that group CFT can be effective in reducing depression, anxiety and low self-esteem in individuals with chronic and complex MHD. Depression and anxiety have both been linked to self-criticism, which is maintained through attention-focusing, attention-biasing and rumination (Gilbert, 2009). Similarly, self-criticism and self-attack have been associated with low self-esteem (Laithwaite et al., 2009). Therefore, it is possible that learning ways

to foster compassion towards oneself and others can lead to a reduction of anxiety and low mood, and improved self-esteem. This can be achieved through reduced attention to undesirable and distressing cognitions, and the ability to self-soothe when distress does occur (Gilbert, 2010). Some reliable deterioration was found in service user levels of self-esteem. As the group does not focus on targeting self-esteem, it is unclear whether this deterioration is related to the groups.

These findings are in line with existing theory and literature on the effects of group CFT on psychopathology, which highlights the role of increased awareness, engagement in de-shaming processes, and activation of soothing strategies, particularly relational, in relieving distress associated with chronic and complex MHD (Cuppage et al., 2018; Gilbert, 2009; Lowens, 2010; Lucre & Corten, 2013). As others have suggested (Cuppage et al., 2018; Gilbert, 2009; McManus et al., 2018), this service evaluation confirmed that group CFT can be used to treat a wide range of MHD in adult populations, which further stresses its transdiagnostic nature and applicability.

Future research could aim to employ larger samples and carry out group-level analyses of change over time to further investigate these processes and increase generalisability of findings (Cuppage et al., 2018; Lucre & Corten, 2013). In addition to measuring change in psychometric measures, future clinical trials evaluating the effectiveness of CFT in community settings should also focus on capturing the extent to which clinical improvements lead to progress in social and day-to-day functioning. This can be assessed, for example, by measuring recovery-related goals and dependency on mental health services (McManus et al., 2018).

Service users described attending the groups as an enjoyable and useful experience, and felt confident they would be able to use the techniques learnt in the future. Content analysis highlighted that the relational safety and the non-judgmental and supportive nature of the group were the most valued aspects of the intervention. This is consistent with the results of the quantitative analyses. One of the key elements of CFT is the recognition that people with high levels of shame and self-criticism can find it very difficult to feel safe in their relationships with others, therefore promoting relational safety is particularly beneficial for this group (Gilbert, 2009, 2010).

Service user feedback also highlighted the benefits of the groups and possible improvements. Service users commented on the benefits of specific CFT techniques, such as the use of imagery and strategies for dealing with stress and anxiety. Research shows that these techniques have been linked to favourable patient outcomes (Leaviss & Uttley, 2015). While service users felt that the duration of each session was appropriate, they would have liked to have more than eight sessions. Service user feedback also included having more and better visual materials. Longer CFT groups, ranging from 12 to 16 weekly sessions, have been shown to offer significant benefits to this client group (Gilbert & Procter, 2006; Judge et al., 2012; Lucre & Corten, 2013), and therefore this is something that could be considered for future CFT group interventions.

As a result of this evaluation, it was recommended to record attendance and drop-out rates, adopt consistent PROMs across the two CMHTs, add a quality-of-life measure, and address the improvements suggested by the service users.

Strengths and Limitations

One of the strengths of this evaluation is the use of mixed methods, including patient feedback, to inform quality improvement (NHS Improvement, 2018; NHS Institute for Innovation and Improvement, 2005). The inclusion of service users' feedback and experiences makes this service evaluation unique in its contribution to the current literature on CFT interventions, which has historically focussed on treatment outcomes (Craig et al., 2020; Leaviss and Uttley, 2015). Despite a lack of ethnic diversity, this project involved service users with an extensive range of mental health diagnoses and a wide age range. Finally, this project informs an area of research that currently has limited evidence (McManus et al., 2018), and it is hoped that it will encourage further interest in evaluating the effectiveness of CFT group interventions for this clinical population.

Several limitations should be acknowledged, however. This evaluation involves small numbers of service users, limiting options for statistical analysis. Although the use of RCI measures changes occurring anywhere in the scoring range, overcoming measurement error when assessing individual change (Wolpert et al., 2015), it does not detect small changes that may still be clinically meaningful to clients and does not consider regression to the mean, thus functioning less well with extreme scores at baseline (Hageman & Arrindell, 1993; Wise, 2004). The CSC method provides a useful classification to operationalise recovery in a relatively objective and unbiased way (Jacobson & Truax, 1991). However, operationalising clinical significance in relation to recovery can be problematic, particularly when working with severe and enduring MHD, due to the chronicity and high levels of comorbidity of this clinical group (Gilbert, 2010; Jacobson & Truax, 1991). Moreover, the CSC method relies on the identification of normative data for functional and dysfunctional populations, whose absence hinders the development of standardised clinical thresholds (Jacobson & Truax, 1991). Therefore, the clinical cut-offs used in this project may differ from those employed in other studies. The use of different compassion measures at different sites weakened the statistical analyses carried out. It is therefore recommended that the use of the PROMs be standardised across sites. Finally, it was not possible to assess whether change was maintained over time due to a lack of follow-up data.

Conclusions

This service evaluation shows evidence of reliable and clinically significant improvements at the individual level in adult CMHT service users' levels of self-compassion and self-kindness following attendance of CFT groups. Improvements were also found in anxiety, depression and self-esteem. Patient feedback highlighted that most service users found the group enjoyable and useful, valued the relational safety of the group, and found the CFT techniques helpful. It

highlighted possible improvements through offering more sessions and better visual materials. While offering CFT group interventions could represent an alternative to individual treatment, more research, such as high-quality trials and large-scale RCTs, is needed to further assess their clinical effectiveness.

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Declarations

Competing Interests The authors declare that they have no competing interests.

References

Baião, R., Gilbert, P., McEwan, K., & Carvalho, S. (2015). Forms of Self-Criticising/Attacking & Self-Reassuring Scale: Psychometric properties and normative study. *Psychology and Psychotherapy: Theory, Research and Practice, 88*(4), 438–452.

Blascovich, J., & Tomaka, J. (1991). Measures of self-esteem. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes* (pp. 115–160). Academic Press.

Craig, C., Hiskey, S., & Spector, A. (2020). Compassion focused therapy: A systematic review of its effectiveness and acceptability in clinical populations. *Expert Review of Neurotherapeutics, 20*(4), 385–400.

Cuppage, J., Baird, K., Gibson, J., Booth, R., & Hevey, D. (2018). Compassion focused therapy: Exploring the effectiveness with a transdiagnostic group and potential processes of change. *British Journal of Clinical Psychology, 57*, 240–254. https://pubmed.ncbi.nlm.nih.gov/29044607/

Department of Health. (2010). *Equity and excellence: liberating the NHS.* Retrieved June 18, 2024, from https://assets.publishing.service.gov.uk/media/5a7c5299e5274a2041cf33af/dh_117794.pdf

Erlingsson, C., & Brysiewicz, P. (2017). A hands-on guide to doing content analysis. *African Journal of Emergency Medicine, 7*, 93–99.

Evans, C., Margison, F., & Barkham, M. (1998). The contribution of reliable and clinically significant change methods to evidence-based mental health. *Evidence-Based Mental Health, 1*(3), 70–72.

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment, 15*(3), 199–208. https://doi.org/10.1192/apt.bp.107.005264

Gilbert, P. (2010). *Compassion focused therapy: The CBT distinctive features series*. Routledge.

Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 263–325). Routledge.

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: A pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy, 13*, 353–379.

Gilbert, P., Catarino, F., Duarte, C., Matos, M., Kolts, R., Stubbs, J., ... Basran, J. (2017). The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care, 4*(1), 4.

Hageman, W. L., & Arrindell, W. A. (1993). A further refinement of the reliable change index by improving the pre-post-difference score: Introducing the RCID. *Behaviour Research and Therapy, 51*, 693–700.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12–19.

Judge, L., Cleghorn, A., McEwan, K., & Gilbert, P. (2012). An exploration of group-based compassion focused therapy for a heterogeneous range of clients presenting to a community mental health team. *International Journal of Cognitive Therapy, 5*, 420–429.

Kleinheksel, A., Rockich-Winston, N., Tawfik, H., & Wyatt, T. R. (2020). Demystifying content analysis. *American Journal of Pharmaceutical Education, 84*(1), 7113.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613.

Kroenke, K., Spitzer, R. L., Williams, J. B. W., & Löwe, B. (2010). The patient health questionnaire somatic, anxiety, and depressive symptom scales: A systematic review. *General Hospital Psychiatry, 32*(4), 345–359.

Laithwaite, H., O'Hanlon, M., Collins, P., & Doyle, P. (2009). Recovery after psychosis (RAP): A compassion focused programme for individuals residing in high security. *Behavioural and Cognitive Psychotherapy, 37*, 511–526.

Leaviss, J., & Uttley, L. (2015). Psychotherapeutic benefits of compassion-focused therapy: An early systematic review. *Psychological Medicine, 45*, 927–945.

Lowens, I. (2010). Compassion focused therapy for people with bipolar disorder. *International Journal of Cognitive Therapy, 3*, 172–185.

Lucre, K. M., & Corten, N. (2013). An exploration of group compassion-focused therapy for personality disorder. *Psychology and Psychotherapy: Theory, Research and Practice, 86*(4), 387–400.

McManus, J., Tsivos, Z., Woodward, S., Fraser, J., & Hartwell, R. (2018). Compassion focused therapy groups: Evidence from routine clinical practice. *Behaviour Change, 35*(3), 167–173.

Moule, P., Armoogum, J., Dodd, E., Donskoy, A.-L., Douglass, E., Taylor, J., & Turton, P. (2016). Practical guidance on undertaking a service evaluation. *Nursing Standard, 30*(45), 46–51. https://doi.org/10.7748/ns.2016.e10277

National Institute for Health and Care Excellence. (2011). *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services* (Clinical Guideline 136). Retrieved June 18, 2024, from https://www.nice.org.uk/guidance/cg136

National Institute for Health and Care Excellence. (2013). *Contributing to clinical guidelines—a guide for patients and carers.* National Institute for Health and Care Excellence. 2013. Retrieved June 11, 2024, from https://www.nice.org.uk/media/default/About/NICE-Communities/Public-involvement/Developing-NICE-guidance/Factsheet-1-contribute-to-developing-clinical-guidelines.pdf

National Quality Board. (2016). *Shared commitment to quality from the National Quality Board.* Retrieved July 14, 2024, from https://www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmwrk.pdf

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity, 2*(3), 223–250.

Neff, K. D. (2016). The Self-Compassion Scale is a valid and theoretically coherent measure of self-compassion. *Mindfulness, 7*, 264–274.

Neff, K. D., Whittaker, T. A., & Karl, A. (2017). Examining the factor structure of the Self-Compassion Scale in four distinct populations: Is the use of a total scale score justified? *Journal of Personality Assessment, 99*(6), 596–607.

NHS England. (2019). *The NHS long term plan.* NHS England. Retrieved July 16, 2024, from www.longtermplan.nhs.uk/publication/nhs-long-term-plan

NHS England. (2023). *Commissioning for quality and innovation (CQUIN): 2023/2024 Guidance.* NHS England. Retrieved July 15, 2024, from https://www.england.nhs.uk/publication/cquin-2023-24-guidance/

NHS Improvement. (2018). *Patient experience improvement framework*. Retrieved July 2, 2024, from https://www.england.nhs.uk/wp-content/uploads/2021/04/nhsi-patient-experience-improvement-framework.pdf

NHS Improvement. (2019). *Developing people – improving care: a national framework for action on improvement and leadership development in NHS-funded services*. NHS Improvement. Retrieved June 25, 2024, from https://improvement.nhs.uk/resources/developing-people-improving-care/

NHS Institute for Innovation and Improvement. (2005). *Improvement leaders' guide: evaluating improvement. General improvement skills.* Retrieved July 8, 2024, from https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-1.5-Evaluating-Improvement.pdf

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton University Press.

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*(10), 1092–1097.

Srnka, K. J., & Koeszegi, S. T. (2007). From words to numbers: How to transform qualitative data into meaningful quantitative results. *Schmalenbach Business Review, 59*, 29–57.

The British Psychological Society. (2018). *data protection regulation: Guidance for researchers*. The British Psychological Society.

Torrey, W. C., Mueser, K., McHugo, G. H., & Drake, R. E. (2000). Self-esteem as an outcome measure in studies of vocational rehabilitation for adults with severe mental illness. *Psychiatric Services, 51*, 229–233.

Wise, E. A. (2004). Methods for analyzing psychotherapy outcomes: A review of clinical significance, reliable change, and recommendations for future directions. *Journal of Personality Assessment, 82*, 50–59.

Wolpert, M., Görzig, A., Deighton, J., Fugard, A. J., Newman, R., & Ford, T. (2015). Comparison of indices of clinically meaningful change in child and adolescent mental health services: Difference scores, reliable change, crossing clinical thresholds and 'added value'–an exploration using parent rated scores on the SDQ. *Child and Adolescent Mental Health, 20*(2), 94–101.