An Evaluation of Compassion Focused Group Psychotherapy for those at the 'edge of therapeutic opportunity'

by

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Abstract

The research aimed to evaluate an exploratory Compassion Focused Group Psychotherapy Program and the impact on participants' experiences of self-criticism, usage of services and general wellbeing. Participants included patients with a history of complex Attachment and Relational Trauma (A&RT), who might attract a diagnosis of personality disorder.

This study utilised a quasi – experimental non-randomised within subject controlled design for the evaluation of the efficacy of Compassion Focused Group Psychotherapy (CFGP). In addition, a qualitative study explored the participants' experience of this treatment.

Participants were recruited from secondary care and tertiary care services to facilitate a comparison of the two interventions. One Cohort was offered a 12-week Preparation and Engagement intervention (PEG) followed by a 40-week Compassion Focused Trauma Group intervention (CFTG), whilst the other Cohort was offered a 12-week Preparation and Engagement intervention (PEG) and Treatment As Usual (TAU) for 40 weeks. Both Cohorts were followed up after 12 months during which period they received TAU.

A comprehensive selection of self-report measures were administered for completion at various points within the therapeutic process and following completion of the group interventions. The data from these measures were analysed and presented along with the qualitative data.

A sub-sample from the PEG + CFTG Cohort only were invited to participate in a semi structured interview following completion of their treatment. The qualitative data from these interviews was analysed according to a Thematic Analysis protocol.

The results of the research showed that the provision of a long term, slow paced, Compassion Focused Group Psychotherapy intervention, enabled participants to make significant changes across all measures which were maintained at 12 month follow up. These data were supported by a significant reduction in service usage and a significant increase in engagement in employment and education. Coupled with key messages from the qualitative analysis about the importance of safeness, structure and space to return to early trauma as a mechanism for change and psychological growth.

In contrast, participants who received a short-term version of the intervention, initially made dramatic gains but these were not maintained over time.

Dedication

This thesis is humbly dedicated to all my patients, co-travellers and fellow conspirators, whose compassionate courage, wisdom and strength has made this work possible. I am indebted to you all.

Acknowledgements

I am most grateful to my supervisors, Dr. Chris Jones and Prof. Alex Copello who have advised, counselled and at times pulled me out of a number of holes. Chris' attention to detail has been a source of joy, humour and ultimately learning (often the hard way). Alex's gentle approach has provided a consistent source of soothing, often just when I needed it most.

My husband Dion has supported, cajoled, challenged and ultimately proof read all my work, without him not only would this not have been possible, it would not have been nearly so much fun. My children Affi and Tane have given me space to work when I needed and stopped me from taking this thesis or myself too seriously.

Graham Mackay and Susie Taylor have, with me, coaxed Compassion Focused Group Psychotherapy into life and often been the rather noisy voice of my conscience. I am grateful.

Professor Paul Gilbert has inspired, supported, questioned and provoked me to make Compassion Focused Group Psychotherapy accessible to those who are truly at the 'edge of therapeutic opportunity'. It is his unwavering support and dedication to CFT that has made all this possible.

Finally, I am thankful to rock climbing and all those who climb with me. It makes everything else possible.

"Everyone wants to live on top of the mountain, but all the happiness and growth occur while you are climbing it" (Andy Rooney)

Papers and Conferences

During the course of study at University of Birmingham, School of Psychology, the following articles were published or accepted for publication and conference abstracts were accepted and presented. All co-authors and co-presenters received training and guidance on the Compassion Focused Group Psychotherapy model from the author. Graham Mackay was involved in the development of the intervention and was the co-facilitator for the duration of the study.

Publications prior to the Study

The following publication was the result of a pilot study of CFT for people with a diagnosis of personality disorder which was developed and delivered by the author. N, Corten who was a research assistant working in the same department and supported with data collection and analysis. The paper was written entirely by the author with support from Professor Paul Gilbert (Compassionate Mind Foundation).

The evaluation of this small-scale intervention was the initial step in the process of developing the study presented within this Thesis. In that the encouraging data prompted the author to develop Compassion Focused Group Psychotherapy with support and supervision from Professor Paul Gilbert.

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.

Publications

Lucre, K. (in press). Compassion Focused Group Psychotherapy for people who could attract a diagnosis of personality disorder. In *Compassion Focused Therapy: Clinical practice and applications*. Routledge/Taylor & Francis Group.

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Conference presentations

CMF: Compassionate Mind Foundation, October 2016

Lucre , K: Compassion Focused Group Psychotherapy – Working at the Edge of Therapeutic Opportunity

Clinical Psychology Division, October 2015

Lucre, K: Compassion Focussed Group Psychotherapy for older adults with complex needs

Institute of Group Analysis, April 2018

Lucre, K. Mackay, G. Compassion Focused Group Psychotherapy – Working at the Edge of Therapeutic Opportunity

One Day Conference, Feb 2020

Lucre, K: Compassion Focused Group Psychotherapy for People with Attachment and Relational Trauma

CMF: Compassionate Mind Foundation, October 2020

Symposium: Compassion Focused therapy in Groups

Lucre, K: Compassion Focused Group Psychotherapy – Working at the Edge of Therapeutic Opportunity

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List of Abbreviations

Abbreviation	Definition
ANOVA	Analysis of variance
C1: PEG+CFTG	Cohort 1 who received the whole CFGP program
C2: PEG+TAU	Cohort 2 who received PEG and 40 weeks of TAU
ETO	Edge of Therapeutic Opportunity
ITT	Intention to Treat
PwD	People with Dementia
TAU	Treatment as usual
PD	Personality Disorder
A&RT	Attachment and Relational Trauma
PEG	Preparation and Engagement Group
CFTG	Compassion Focused Trauma Group
CFGP	Compassion Focused Group Psychotherapy

Chapter 1: Working compassionately at the 'edge of therapeutic opportunity'

This chapter will introduce the idea that there are those, whose significant 'early relational trauma' and consequent identity disturbance, places them at the 'edge of therapeutic opportunity' (ETO). This group will often attract a diagnosis of personality disorder (PD) and with it the negative and often pejorative associations. Initially, this chapter will challenge this diagnosis and suggest an alternative view from an evolutionary psychology conceptual framework.

Early relational trauma often manifests in complex and self-defeating patterns of relating to others, therefore making access to appropriate psychological therapy difficult and challenging. The nature of the particular relational and complex trauma issues will be explored as a rationale for the use of Compassion Focused Therapy (CFT). Therefore, the neuroscientific and evolutionary basis of CFT will be examined in the context of the relevance for those with relational trauma.

This section will conclude with a summary of the focal points for the comprehensive quality review of the literature.

Understanding the limitations of the Personality Disorder diagnosis

"Personality Disorder appears to be an enduring pejorative judgement rather than a clinical diagnosis. It is proposed that the concept be abandoned" (Lewis & Appleby, 1988, p.44).

Lewis and Appleby (1988) made this claim over 30 years ago, despite this Chartonas, Kyratsous, Dracass and Lee (2017) reported similar findings more recently regarding negative attitudes towards people with that diagnosis. This has been followed by repeated and numerous calls for change, not least during the years that preceded the publication of Diagnostic and Statistical Manual 5 (Kinderman, Read, Moncrieff & Bentall, 2013; Kling, 2014). These ranged from a suggested shift to a dimensional categorisation with a greater level of gradient between 'order and disorder' (Hopwood et al., 2018; Tyrer et al. 2011),

through to calls to *"drop the language of disorder"* altogether to enable problems to be recognised validated and explained in the context of extreme life events (Kinderman et al., 2013, p.1).

Despite this the following definition is offered by the International Classification of Diseases (ICD 11, 2018) "nomenclature for Personality Disorders focuses on the impairment of self and interpersonal personality functioning, which may be classified according to degree of severity".

From the 1980's onwards there has been debate, discussion and scientific enquiry into the aetiology of personality disorder, with a specific and often binary focus on Borderline Personality Disorder (BPD). These studies have generally reported a causal link between the early attachment and relational trauma, which include psychological maltreatment and the symptomatology of BPD (Herman et al. 1989; Fonagy, Campbell & Luyten, 2018; Terr, 1991; Wildschut, Swart, Langland, Smit & Draijer, 2018; Zaleski, Johnson & Klein, 2016).

Currently the diagnosis of personality disorder across the nine categories has been described by some as *"a failure to achieve adaptive solutions to life tasks"* (Livesey et al., 1994). The pejorative nature of the language, *"manipulative, resistant, self-defeating and attention seeking"* (Terr, 1991, p. 23) and strong implications that there is something 'wrong', as Becker puts it, *"a consequence of character",* has remained unchanged for decades (Becker, 2000, p.422).

Therefore, to conceptualise this group of patients, the complexity associated with the term personality disorder and the implications of homogeneity emerges. This complexity is deepened by many recognised therapeutic interventions such as Dialectical Behaviour Therapy (DBT) and Mentalisation Based Therapy (MBT) being offered specifically and solely for BPD (Bateman & Fonagy, 2014; Linehan, 2014). The concern with this strategy which is also reflected in the specific BPD focus of the National Institute for Clinical Excellence guidelines is that those whose presentations are more mixed may not be catered for by the current psychological treatment pathway for personality disorder. Additionally, it is understood that most people with a diagnosis of personality disorder meet the criteria for more than one of the nine categories (Bornstein, 1998; Lilienfeld, Waldman, & Israel, 1994).

Returning back to Lewis and Appleby (1988), the current system does not adequately support accurate diagnosis, in that the majority of people presenting with difficulties in

emotional regulation, interpersonal, relational and engagement difficulties are classified as BPD. Although there are eight other categories these are often overlooked, as is the necessary attention to underlying adverse childhood experiences which are highly prevalent for this group of patients (Brune, 2015; Herman & Perry, 1989; Lucre & Clapton, 2020, Lucre, 2020 in press; Sabo, 1997). It is widely understood and recognised that whichever diagnostic category of personality disorder a person may be labelled with, there is likely to be stigma associated with this (Bowen, 2019; Sheehan, Nieweglowski & Corrigan, 2016).

Reworking the diagnosis through an evolutionary lens

"Why do we stigmatise people if evolution is perfecting the work, scanning our needs and adjusting the responses?" (Ali, 2015, p. 4).

Ali's (2015) rhetorical question poses a useful starting point to consider the concepts of *maladaptive behaviours*, *dysfunctional beliefs* and *disordered relating* which are common terms in describing people with a diagnosis of personality disorder. However, if it can be accepted that in most cases those who have been given or would meet the criteria for a diagnosis of personality disorder actually have experienced Attachment and Relational Trauma (A&RT), then these concepts can be reviewed as adaptive and understandable responses to the extraordinary circumstances of trauma (Brune, 2015; Molina et al., 2009).

Another lens through which sense can be made of seemingly problematic behavioural manifestations are *"complex adaptations to early adversity"* which therefore have an important function to regulate stress (Brune, 2015, p.61). Given the often dangerous and unpracticable nature of the early environment, these 'adaptations' were functional. However, in the absence of new learning, these strategies remain fixed and appear 'dysfunctional' in a seemingly less hostile environment (Ali, 2015; Brune, 2015; Molina et al. 2009).

An alternative definition may be that proposed by Van de Kolk which appears to capture not only the broad range of caregiver behaviours, but also the impact on the child, *"when caregivers are extraordinarily inconsistent, frustrating, violent, intrusive, or neglectful, children are likely to become intolerably distressed, without a sense that the external environment will provide relief"* (Van der Kolk, 2003, p. 296). It is of course of note that this maltreatment can also take a psychological and less visible form.

In recent times there have also been a number of proposals for a developmental and attachment-based model of understanding personality disturbance which could support the development of more effective treatment interventions (Buckeim & Diamond, 2018; Liotti & Gilbert, 2011; Lyddon & Sherry, 2001).

So, in the interests of inclusion there is a need to look beyond diagnosis and National Institute of Clinical Excellence (NICE) guidelines for BPD to offer interventions to all those whose ruptured early attachments have interrupted the developmental flow and capacity for compassion.

Meeting the needs of Attachment and Relational Trauma

This group of patients, whose needs are complex and challenging, present a significant challenge to service providers, commissioners and therapists (Crawford, Price, Rutter & Moran, 2008). These patients will often be repeat presenters to mental health services with high risk aggressive and/or antagonistic patterns of relating to service providers which often results in these patients being offered either very little in the way of active interventions or a wide range of interventions without a clear rationale or a clear treatment pathway (Lucre & Corten, 2013; McMurran & Ward, 2010).

The underlying reasons for the often challenging and confrontation behaviour displayed by this group of patients can be understood in the context of traumatised early attachment relationships characterised by intrusive, abusive or absent attachment relationships which compromise an individual's capacity to feel connected and socially safe (Kelly & Dupasquier, 2016), seek appropriate care and support, and self-soothe (Sloman & Taylor, 2016; Gallop, 2002), and a multitude of shame-based difficulties (Andrews, 1998; Feiring & Taska, 2005; Karan et al., 2014). These are many of the capacities required to engage in psychotherapeutic interventions, thus creating a significant barrier to engaging with and making use of such interventions (Bateman & Fonagy, 2014). As a consequence of toxic early attachment experiences, these patients are often more likely to suffer with excessive shame and self-criticism (Gilbert, 2011, 2017).

Shame proneness has been linked with increased self-criticism and consequently poorer quality of life (Rusch et al., 2007). These difficulties have been identified as particularly

prevalent in women with a diagnosis of BPD compared with socially phobic or healthy subjects (Rusch, 2007).

Liotti (2000) further links the early disruption of primary caregiver relationships, with an increased propensity for serious trauma and BPD vulnerability. Allen (2008) also identified that the early experience of intrusive, abusive or absent primary care givers are common for people with a diagnosis of BPD, which is also associated with the impairment in emotional regulation systems. These early attachment ruptures often give rise to negative or critical schematic representations of the self as unacceptable and perhaps to blame for the abuse, coupled with an avoidant attachment style which often means that these self-beliefs are perpetuated remain unchallenged in adulthood (Allen, Fonagy and Bateman, 2008; Gilbert, 2011, 2017). Gilbert and Iron (2004) also link the experience of critical self to self relating with reports of harsh or rejecting parental narratives.

There is a link between disorganised attachment experiences and relational trauma in that the primary attachment object for the infant can also represent the source of threat and fear, thus creating an *approach – avoidance dilemma* (Holmes, 2001; Main, 1995). This situation has been observed when the infant in distress instinctively turns to the primary care giver for comfort but is confused by the parent being also the source of threat and "*no consistent behavioural strategy will resolve the threat"* (Holmes, 2007, p.182). This can be understood as an understandable and adaptive response to an impossible situation, rather than a pathological disturbance or disorder (Gilbert, 2011; Holmes, 2017; Liotti et al. 2000). This attachment style is also described as 'unresolved' by Main (1995), thereby the manifestations in adult behaviour often replicate the early attachment relationship patterns which have been disturbing. Bateman et al. (2014) asserts that the disorganisation in the attachment system results in fragmentation in the sense of self so that making sense of the feeling states of self and others and regulating emotional states becomes problematic.

The 'edge of therapeutic opportunity' (ETO) therefore describes those for whom the nature and complexity of the interpersonal difficulty and attachment trauma mean the very care that is needed to heal the wounds is often out of reach due the manifestations of such trauma.

Working at the edge of therapeutic opportunity often necessitates the need to explicitly work creatively at the deeper emotional and body-focused, sensory-motor level, as we move

beyond the diagnosis of personality disorder and understand the difficulties in the context of attachment trauma (Fay, 2017; Ogden, & Fisher, 2015; Payne, Levine & Crane-Godreau, 2015; Van der Kolk, 2015).

Compassion Focused Therapy – Bringing Compassion to the 'edge of therapeutic opportunity'

There has been considerable work in recent years to devise psychotherapeutic interventions which can address directly some of the issues which interfere with the capacity to engage in psychotherapeutic work (Gilbert, 2009; McMurran, 2012; Crawford, 2009; Linehan, 2014; Bateman & Fonagy, 2014). Compassion Focused Group Psychotherapy (CFGP) is one such intervention and has been devised according to the evolutionary psychology model and neuroscience based psychotherapeutic intervention of Compassion Focussed Therapy (CFT) developed by Prof. Paul Gilbert (2009, 2010, 2014). CFT is an integrative, motivational switching therapy and was designed to address issues with the shame and self-criticism that is manifest in a broad range of psychological and emotional difficulty. As such this therapeutic intervention offers a potential opportunity for those at the edge of therapeutic opportunity (ETO). CFT was developed for people who for a variety of reasons are prone to experiencing excessive shame and self-criticism (Gilbert, 2000, 2010a).

Essentially CFT proposes that different systems have evolved as a threat calming and soothing system in the context of attachment and affiliative relationships (Depue & Morrone-Strupinsky, 2005). CFT is based on an evolutionary (Gilbert, 1989; 2000, 2010a, 2010b) and neuroscience model of emotional regulation and motivational systems (Depue & Morrone-Strupinsky, 2005; Panksepp, 1998). Our social motives, such as finding and making use of attachments, developing intimate and reproductive relationships, and being part of groups and seeking status, evolved over millions of years and these are regulated by three specific affect regulation systems. First are those that detect and respond to threats (e.g., with defensive emotions such as anxiety and anger and behaviours such fight, flight, avoidance, and submission (LeDoux, 1998). There are secondly those systems that detect and respond to rewards (e.g., with feelings of pleasure, excitement drive, and motivated behaviours). The drive system promotes seeking and exploratory behaviour and is associated with feelings of activation in the context of goal orientated behaviours. Third are those that detect sufficiency and safeness and give rise to feelings of contentment, soothing, and affiliation, associated

with consolidation of relief from distress and promotes bonding with affiliates (Gilbert, 2017).

CFT suggests that during the early stages of child development these three systems or circles become structured and patterned in specific ways. Considerable research evidence based on the attachment model (Bowlby, 1980; Mikulincer & Shaver, 2007) has demonstrated that children raised in the context of caring and stable relationships, will have been soothed by care givers when distressed. It is posited that this repeated affiliative experience enables the development of positive internal models or representations of self as capable, others as caring and distress as tolerable (Mikulincer & Shaver, 2007). The activation of the soothing and safeness system via interpersonal interactions is therefore key to the regulation of the threat system and to some extent the drive system (Cozolino, 2008). Humans have evolved to be emotionally regulated within relationships and have particular neurophysiological systems, especially those linked to oxytocin, that enable affiliation to regulate threat (Depue & Morrone-Strupinsky, 2005).

CFT posits that some mental health difficulties arise because affect regulation systems become imbalanced, resulting in the activation and dominance of a particular system over others. This imbalance can become particularly problematic when the threat system becomes overactive and poorly regulated (Gilbert, 1993, 2010a). There are many complex and interconnected ways of understanding how this poor regulation can arise, be accentuated and maintained. For many the neurophysiological consequences of ruptured or absent early attachment relationships can result in unprocessed traumatic memories, which are maintained and experienced as threatening through rumination or by living in hostile critical environments. These factors combine to create a ‘toxic cocktail’ of biological, neurological and cognitive bias toward threat-based processing of all experiences.

CFT as a response to Shame based trauma

This model also proposes that pathological shame can arise out of ‘misattunnments’ that occur in attachment failures which halt emotional progress and capacity to regulate feelings (Lawrence & Lee, 2014: Gilbert, 2010). This sense of internal shame can become a ‘*dark internal mirror’* by which we view ourselves whereas external shame relates to negative way we may consequently believe that we live in the mind of the other (Gilbert, 2011).

"*unbearable shame is generated through the incongruity of having one's humanity negated exactly when one is legitimately expecting to be cherished*" (Bateman & Fonagy, 2004, p.97).

There are a number of complex interrelated associations between shame and early trauma which link to the meaning made of the early trauma coupled with the impact on the self to self-relationship, in that those prone to self-attribution are more vulnerable to psychological difficulty (Feiring et al., 2002; Irons et al., 2006; Tangney & Dearing, 2003). For many, self-criticism is the manifestation of shame as a *safety strategy* to manage the experience of others and the world as inherently threatening and hostile (Gilbert, 2009; Kaufman, 1989; Andrews, 1998; Shore, 1998).

However, CFT also suggests one of the most common ways in which the threat system can become overly sensitive, accentuated and be maintained in a state of activation is when the internal, self to self-relationship, how we relate to and experience ourselves, is critical and shame prone. This can result in the individual developing a sense of being of low social rank in relation to others. Gilbert (2009) describes a process of dual focusing on the self and others, coupled with a need to suppress any expressions of anger to more highly ranked individuals. Self-criticism is a common automatic response when individuals experience setbacks. A functional magnetic resonance imaging (fMRI) study found that self-criticism, in contrast to self-reassurance, activates quite different (more threat focused) brain systems (Longe et al., 2010). Shame and self-criticism are major pathogenic processes for a wide range of psychopathologies (Gilbert & Irons, 2005; Zuroff, Santor, & Mongrain, 2005) and vulnerability to shame-based self-criticism is commonly rooted in emotional memories of the self being rejected, criticized, shamed, and abused (Andrews, 1998; Kaufman, 1989; Schore, 1998).

Research into treatment responses have highlighted that self-critics tend to do less well in controlled trials (Rector, Bagley, Zegal, Joffe, & Levitt, 2000). One way of managing difficulties associated with self-criticism is to give clear de-shaming explanations of why people can have difficulties with emotional regulation and traumatic memory. Locating these difficulties within an evolutionary and 'survival strategies model' can be helpful in addressing the implicit self-blame that is often a key aspect of shame prone clients.

Developing the competencies of compassion

Compassion has a number of defined competencies which can be developed or cultivated within the context of developing what is known as the flows of compassion (Gilbert 2010, 2011). The core competencies are courage, wisdom, strength and commitment which have been linked to the capacity to tolerate as well as approach and engage with suffering and then be motivated to alleviate and prevent it in the future (Gilbert 2017). Implicit and explicit attention to the cultivation of the three flows of compassion underpins the work within CFT but conversely presents the greatest challenge to the therapeutic process (Gilbert, 2011). Those at the edge of therapeutic opportunity are likely to find developing the flows of compassion particularly challenging and as a consequence experience high levels of fear and emotional activation (Gilbert & Proctor, 2006; Lucre & Corten, 2013). Gilbert (2010) has offered an attachment perspective in that the therapeutic process and compassion from the group is likely to trigger the attachment system where emotional memories of early intrusion and abuse are coded (Bowlby, 1973, 1980). Gilbert (2010) goes on to describe the group therapeutic process, the experience of compassion from others and the invitation to cultivate self-compassion as a potential trigger for grief and rage as clients come to an understanding of the nurturing that was missing from their early life.

Compassion Focused Therapy for Attachment and Relational Trauma – A case for group interventions

This emotion focused therapeutic intervention has been developed specially to address the difficulties which are complex, multifaceted and interfere with the psychotherapeutic process, namely shame based trauma memories and defensive self-criticism. Creating the conditions for the cultivation of compassion explicitly across the three flows will require specific interventions designed to reduce threat and create an affiliative space for growth and change. Group therapy has been identified as an opportunity for the resolution of shame, through the experience of others as affiliative and caring (Rathbone, 2012). Yalom (1995) identifies eleven therapeutic factors which can enable growth, change within the medium of group therapy. The processing of early trauma through the corrective reliving of early family dynamics, within a containing framework where information is imparted and hope instilled, coupled with a deep affiliative connection with others who are suffering. Interestingly Yalom (1995) also identified the equal significance of the therapist and group members' impact on

the therapeutic process, indicating the importance of creating a framework for group members to relate to one another. Working with those at the edge of therapeutic opportunity will require the therapeutic process to have a strong relational component, in that the trauma is rooted in the emotional memories of abusive and ruptured early attachment relationships (Haigh, 2004; Campling, 1994, Gilbert, 2011; Hobson, 2013). The group therapy process also offers an opportunity for explicit and implicit cultivation and practice of compassion across the three flows, giving compassion to group members in the context of listening and engaging with the suffering, receiving compassion from others and by attending to the group process compassionate motivation to self is implicitly developed.

If the group is a possible arena for the resolution of shame and shame-based trauma, then this would seem to be a useful medium to consider for those at the edge of therapeutic opportunity whose experience of the authority of the individual therapist may be unbearable (Gilbert, 2011; Rathbone, 2010).

Discussion

Redefining personality disorder as understandable survival strategies as an evolved means of adapting to hostile early rearing experiences, offers an opportunity to validate the interpersonal difficulties that generally accompany this cluster of presentations.

The use of Attachment and Relational Trauma (A&RT) as a means of describing this group provides a more accurate and less stigmatising way forward.

CFT with the emphasis on the provision of safeness and attention to the manifestations of shame-based trauma offers a trauma sensitive and informed response to this group. CFT posits that developing a capacity for affiliative relating is key to cultivating compassion, the group is therefore an ideal medium for members to explore, understand and make sense of early trauma and create new meanings.

There will follow a review of the current literature for Compassion Focused Therapy in a group-based format to establish the efficacy of such interventions.

Chapter 2: A Review of Outcome Studies for Group Based CFT Interventions

Introduction

The previous chapter offered an introduction to Compassion Focused Therapy with a particular focus on meeting the psychotherapeutic needs of people with attachment, relational trauma who present challenges to service providers. The challenges are associated with the manifestations of early trauma in the patient's capacity to make use of standard therapies such as CBT and psychodynamic psychotherapy.

The key elements of the model which could specifically address the attachment ruptures and consequent identity disturbance are presented with a rationale for the use of group therapy.

This chapter will provide a systematic review of all group-based CFT interventions, using the Down and Blacks Quality Review Protocol (1998) and according the Inclusion / iexclusion criteria in Table 2.2, p.13.

The following review of the clinical trial literature will examine the efficacy of group based CFT within mental health settings. This review will focus on mental health related outcomes (such as the frequency and severity of distressing symptoms) as well as cognitive and behavioural expressions of global self-evaluation.

Search strategy

A systematic search of the literature was conducted using PsychINFO, PubMed and Web of Science databases between the dates from 1980 to Feb 2017 (Psychinfo and Pubmed) and 1990 to Feb 2017 (Web of Science). The aim of the search was to obtain a comprehensive overview of the outcome literature evaluating the effectiveness of group-based Compassion Focused Therapy (CFT). This search was examined with reference to a recent literature review of all CFT interventions (Leviss et al., 2015).

The search terms that were used to identify these two areas (CFT and Compassionate Mind Training CMT), which were then combined and are outlined in Table 2-1 below.

The Compassionate Mind Foundation www.Compassionatemindfoundation.co.uk website was also searched as new papers relevant to CFT are often available on this site.

The aim of this search was to develop a comprehensive list of all the group based CFT interventions. A recent metanalysis by Kirby et al. (2017) identified an array of interventions which are compassion based, however this study will be exploring the efficacy of group based CFT interventions for recipients of mental health services only.

Table 2-1: Search Strategy

Construct	Free Text Search Terms	Method of Search	Limits
Compassion Focused Therapy	"Compassion Focused Therap*" "compassion focused psychotherapy" "CFT" "compassion*" "therap*"	Free search terms All search terms combined with *OR*	Peer reviewed articles 1967-March 2018
Compassionate Mind Training	"compassion*"		
Compassion focused therapy Group	"Compassion focused therapy* group*"		
Group compassion focused therapy	"Group compassion focused therap*"		
CFT and compassion	"CFT and compassion"		

Inclusion/exclusion criteria

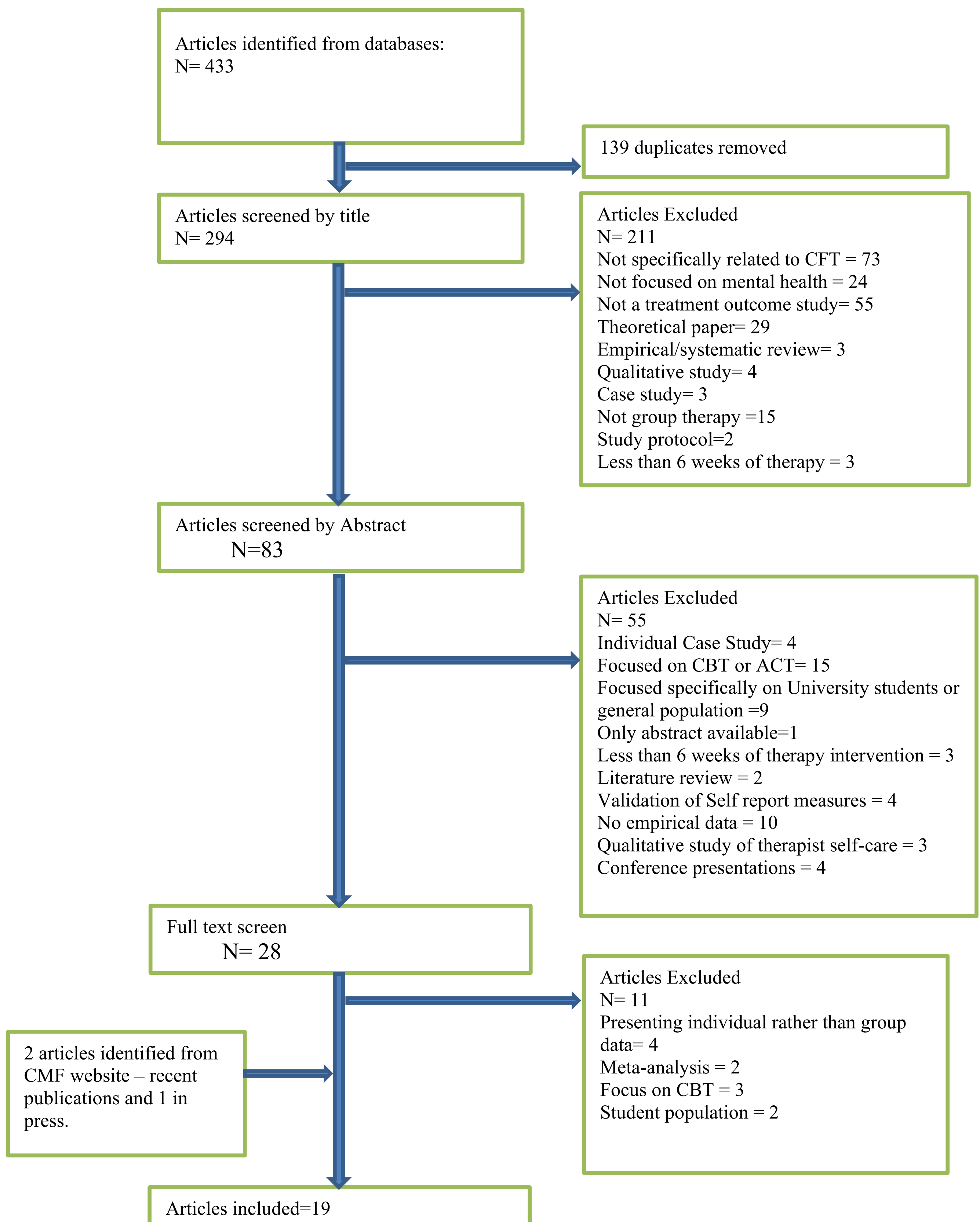
Full inclusion/exclusion criteria are described in Table 2-2, below. In order to gain an overview of the effectiveness of group based CFT the criteria were kept quite broad. CFT is relatively new intervention and as such has not been subject to extensive evaluation. Therefore, the main search criteria were any group based controlled study of at least 6 weeks duration within a mental health setting. There was a minimum cohort size to ensure sufficient power to calculate an effect.

Table 2-2: Inclusion and Exclusion criteria

Inclusion criteria	**Justification**
Nature of CFT intervention: Controlled trials of group based CFT/CMT interventions on at least 6 weeks duration.	There are many published studies which have incorporated CMT practices into a different therapeutic intervention. This review is focusing on CFT / CMT interventions specifically. This type of review has not yet been conducted.
The intervention needs to be delivered face-to-face, rather than by telephone or online.	This is to reflect the diversity of the presenting populations and differing elements of treatment that are included with different client groups. For instance, many studies include family involvement and/ or things such as pain education. Combination with other therapeutic elements will be accounted for in the quality criteria.
Participant focus: Studies that target interventions at adults within mental health settings, rather than general adult populations.	The review of literature pertaining to mental health populations also replicates the population group of the research group.
Participant Characteristics: University/College general populations will not be included.	This group do not represent the presenting difficulties of those who are currently been seen by mental health services and it is the impact of CFT/CMT on recipients of mental health services which is to be reviewed.

As presented in Figure 2-1 below, the systematic search yielded 433 articles once duplicates were removed (n= 294). These articles were screened using the inclusion / exclusion criteria using the study titles and abstract. The three most common reasons for exclusion were: not being specifically related to CFT (n= 73), not focused on mental health population i.e. general public, including using a university sample (n=24) and not being a treatment outcome study i.e. review of literature or study protocol (n= 55). The remaining 83 articles were then reviewed in more detail against the inclusion / exclusion criteria. 19 articles met the full inclusion/exclusion criteria.

Figure 2-1: PRISMA Chart



Down and Blacks Quality Review Protocol (1998)

Nineteen studies were identified as meeting the criteria for the Quality Review. These studies have been described in further detail in the following table. The key characteristics of the studies included such as, sample size, presenting problem and details about the intervention are presented in Table *2-4*.

Assessment of risk of bias

A set of quality criteria were developed to assess any risk of bias within this literature. The quality criteria were derived from the Down and Blacks (1998) framework. The framework assessed risk of bias in five domains: Reporting, External Validity, Bias, Confounding and Power. The detailed criteria for each domain are described below in Table 2-3. A number of key variables were added to articulate the criteria considered to be of importance to CFT interventions and therapeutic interventions in general.

Table 2-3: Domains of bias in primary studies

Domain	Details	Risk of Bias
Reporting	This category provides an assessment of whether the details of the study provided by the paper were sufficient to enable an unbiased overview of the outcome of the study (Down and Black 1998). What is the study design and the type of control used within the study? Has the intervention and aims been clearly described	High risk – Limited or missing study details including aims, participant demographics and possible adverse impact of study Unclear risk - Some descriptive data regarding the study Low risk – clear descriptions of aims of study, interventions to be used patient demographics, possible adverse impact of study Intention to treat data included
External Validity	External validity (3 items)—which addressed the extent to which the findings from the study could be generalised to the population from which the study subjects were derived (Down and Blacks 1998:) Were patients representative of the population they were drawn from? Were the study premises appropriate	High Risk – study participants and venue for treatment were not representative Unclear Risk – information regarding the sampling methods were not clear, details of venue not explicit Low Risk – Patient group highly representative and venue as per usual treatment

Domain	Details	Risk of Bias
Bias	(7 items)—which addressed biases in the measurement of the intervention and the outcome (Down and Blacks 1998) If using randomisation, have they described the method of allocation clearly? Has this allowed for the production of comparable groups? Is the outcome measure valid and appropriate for the group being studied? Have they used a CFT specific outcome measure? Was treatment fidelity addressed? Were follow up measures taken?	High Risk- Only reported un-validated outcome measure, or bespoke measures of outcome, no outcome measures. Lack of a robust and coherent treatment plan. Unclear Risk- No report of an CFT specific outcome measure, unclear use of outcome measures Low Risk- Reliable and valid outcome measures and a CFT specific measure is used. Patients and researchers blind to intervention arms with follow up data.
Confounding	Confounding (6 items)—which addressed bias in the selection of study subjects (Down and Blacks 1998:) Is there intention to treat data been included in the study?	High risk – no randomisation or control group with inadequate description of reasons for sample attrition. Unclear Risk – Inadequate or unclear descriptions of randomisation process Low risk – Blind randomised control trial
Power	(1 item)—which attempted to assess whether the negative findings from a study could be due to chance (Down and Blacks 1998) Small <20 per arm of the study Adequate > 20 per arm of the study	High risk – Small sample with or without idiosyncratic feature (<20 per group). Unclear risk - Sufficient sample for generalisation but with some idiosyncratic feature (> 20 per group). Low risk- Sufficient sample for generalisation and representative of target population (>20 per group)

Each of the nineteen studies have been rigorously examined utilising the Down and Blacks (1998) protocol. A summary of each domain has been presented in Figure 2-3, and the sum of these ratings provides an overall rating for each domain. The risk of bias for each domain has consequently been rated as either, high, unclear or low risk with corresponding colour coding of red, amber and green. The ratings for each study are presented in Figure 2-2 below.

Study	Reporting	External Validity	Bias	Confounding	Power
Braehler, Gumley, Harper, Wallace, Norrie & Gilbert(2013)					
Kelly, Allison, Wisniewski, Martin-Wagar, Hoffman (2012)					
Cuppage, Baird, Gibson, Booth, Hevey (2016)					
Beaumont Durkin, McAndrew, Martin (2016					
Gilbert & Proctor (2006)					
Judge, Cleghorn, McEwan & Gilbert (2012)					
Laithwaite, O'Hanlon, Collins, Doyle, Abraham & Porter & Gumley (2009)					
Lucre &Corten 2012)					
Andersen &Rasmussen (2017)					
Bartels-Velthuis, Schroevers, van der Ploeg, Koster, Fleer, van den Brink (2016)					
Clapton, Williams, Friffith & Jones (20116)					
Gale, Gilbert, Read and Goss 2014					
Collins, Gilligan, Poz (2017)					
Graser, Hofling, Weblau, Mendes, Stangier (2016)					
Pennington (2018)					
Fox, Cattani, Burlingame (2020)					
Mullen, Dowling, Doyle & Reilly (2019)					
Navab, Dehghani, Salehi (2019)					
Grodin, Clark, Kolts & Lovejoy (2019)					

Figure 2-2: Ratings of the five areas of risk of bias for each of the included studies

Thirteen of the nineteen studies reviewed were based in the UK with two in Europe, 1 in Canada, 1 in Iran and 2 in the USA indicating the popularity and spread of CFT at this time which seems to be predominantly in the UK, which is where CFT was developed. All nineteen studies were evaluating the impact of short term CFT closed group interventions of between six and twenty weeks in duration. Fifteen of the nineteen group programmes took place within an outpatient psychiatric setting, which catered for service users with a range of psychiatric difficulties including personality disorders, eating disorders, post-traumatic stress disorder (PTSD), chronic depression, problematic anger and anxiety, schizophrenia spectrum disorders, mood disorders and dementia. Two studies took place in private psychiatric clinics, one in a maximum-security hospital setting and one within a local fire department.

There were five studies with a between group study design, with only two implementing a Randomised Controlled Trial (RCT), in both cases the control condition was treatment as usual (TAU). One of the Between Group studies had an alternative therapy group as a comparison condition, all other had a TAU condition. Of the five Between Group

studies, only two utilised CFT specific measures which when analysed demonstrated significant changes. The measures were social rank, capacity for self-compassion and fear of compassion coupled with process-based measures of the intervention. The other three studies had a mixture of symptom specific measures coupled with qualitative based feedback which was positive but indicated a need for a longer intervention. A semi-structured interview was developed for one study which was utilised to measure pre and post capacity for compassion coupled with key correlations which were made between compassion and decrease in depression.

Of the remaining fourteen studies, nine utilised a naturalistic study design, which involved gathering routine clinical data from a number of CFT groups which took place as part of routine service provision, over a period of time. Seven of those seven studies utilised CFT specific measures which ranged in number from one to six (6 being the most CFT specific measures used in any of the studies under review) and five also used a mixed methods design of quantitative measures coupled with a formal qualitative analysis. Of the seven studies utilising CFT specific measures all reported significant changes across the CFT measures with varying effective sizes. The further three studies reported significant changes on measures of depression, quality of life and ED specific symptom measures.

The remaining four studies were single case designs which measured the impact of a single group intervention within a fixed time period. Similarly, all studies utilised CFT specific measures, the number of these specific measures varied with some studies utilising up to five measures whereas others used only one. All also reported significant improvements in social rank and corresponding reductions in depression, anxiety symptomatology, coupled with an increased capacity for compassion to self, to others and from others.

Reporting

Overall, the reporting domain has the lowest risk of bias and contained largely clear descriptions of the intended intervention, coupled with clear aims of the study. These ranged from evaluating the development of a new iteration of a CFT intervention (Bartels-Velthuis et al., 2016; Fox et al., 2020; Gilbert et al., 2006; Grodin et al., 2019; Lucre & Corten, 2013) to the addition of CFT to an established therapeutic protocol (Beaumont et al., 2016; Gale et al., 2010; Kelly et al., 2012) and the implementation of CFT with a new client group (Braehler et al., 2013; Clapton et al., 2016; Collins et al., 2017; Navab et al., 2019).

Six studies were assessed to have an unclear risk of bias but the consequences of this bias were unclear, this translated to an amber rating which for the most part linked to an inadequate description of patients who dropped out of the study and a paucity of information describing the patients in the study (Beaumont et al., 2016; Gale et al., 2014; Graser et al. 2016; Judge et al. 2012, Laithwaite et al., 2009; Pennington, 2018).

There were a number of other issues in the reporting domain which were present across all studies. None of the studies provided details of the possible adverse impact of the intervention on the intended population. Any form of psychological therapy can result in decompensation and a worsening of the individual's symptoms, however this was absent from the reporting. Also missing was a description of the factors which could result in an imbalance within the group to be evaluated. Many of the groups were predominantly female, however this was not treated as a potential confounding factor within the studies themselves (Bratels-Velthuis, 2016; Gale et al., 2014; Lucre & Corten, 2012; Pennington, 2018).

External validity

Overall the studies under review demonstrated a high level of external validity measured by the descriptions provided of the recruitment strategy and environment where the intervention took place, which were both consistent with and indicated a high level of representation of the population group. These papers gave a robust description of the intended population, and their key characteristics were presented in a clear and transparent format. There were three notable exception where the information provided either indicated the patients recruited were not representative or the information was not made available within the paper (Gale et al., 2014; Graser et al., 2016; Judge et al., 2012;).

In the case of Graser et al. (2016) there was no information provided about the participants or venue where the treatment took place, therefore it was not possible to evaluate how representative they were of the population group. In Judge et al. (2012) and Gale et al. (2014) there was no information about the participant recruitment strategy, therefore the appropriateness of this to ensure a representative sample could not be established.

Internal Validity – bias

The studies showed quite high levels of internal bias within the study designs and implementation, with seven of the nineteen studies scoring an unclear risk of bias or bias with

unknown consequences and three with an identified risk or bias. All nineteen studies had not included a recorded attempt to blind the participants and or researchers to the component parts of the study. This factor linked to the context of many of the studies and the naturalistic data collection methodology.

Eight of the nineteen studies were limited by a lack of follow up data following completion of the intervention, which could offer an indication of maintenance or otherwise of therapy gains (Anderson et al., 2017; Bartels-Velthuis et al. 2016; Beaumont et al., 2016; Collins et al., 2017; Gale et al. 2014; Judge et al.. 2012; Kelly et al., 2012; Pennington, 2018). Although these studies were all examining the impact of a CFT intervention, five of the studies did not include any CFT specific measures, which could have utilised to explore the target areas for the intervention i.e. flows of compassion and fear of compassion (Beaumont et al., 2016; Collins et al., 2017; Gale et al., 2014; Kelly et al., 2012; Pennington 2018).

Issues of treatment fidelity and treatment protocol compliance were measured in a number of ways with reference to the material reported. Eight studies provided a session by session plan detailing the structure and content of the fixed session protocols (Anderson et al., 2017; Bartels-Velthuis et al., 2016; Cuppage et al., 2016; Clapton et al., 2016; Gale et al., 2014; Gilbert et al., 2009; Laithwaite et al., 2012; Pennington, 2018). Collins et al. (2017) and Lucre et al. (2013) provided an overview of the treatment protocol only and an overview of the structure.

The level of training of the therapists and the supervision arrangements designed to maintain treatment fidelity were explored to establish a baseline of competence which in the case of CFT would be completion of the Three Day CFT Introductory Training. Twelve out of the nineteen studies indicated the training level of the therapists, which was either the three day only or the three day followed by more advanced training available through the Compassionate Mind Foundation (The charitable organisation which holds responsibility for national training in CFT (Bartels-Velthuis et al., 2016; Braehler et al., 2013; Collins et al., 2017; Cuppage et al., 2016; Clapton et al., 2016; Laithwaite et al., 2012; Lucre et al., 2013; Gilbert et al., 2006). Seven of these studies also offered detailed information regarding the supervision arrangements for therapists delivering the interventions, which provides further evidence of fidelity to the model (Bartels-Velthuis et al., 2016; Braehler et al., 2013; Collins

et al., 2017; Cuppage et al., 2016; Clapton et al., 2016; Fox, Cattani & Burlingame, 2020; Lucre & Corten, 2013).

Internal validity – selection bias confounding

This domain demonstrated the highest level of bias and lowest level of internal validity, with seven of the studies scoring unclear risk and eleven with clear risk of bias on the framework. The only study which scored a low risk was Braehler et al. (2012) which was the only fully randomised controlled trial with attempts made to blind participants to the intervention and a full account of sample attrition. The main reason for this level of bias relates to the weaknesses in the methodology for most of the studies, in that many were cohort studies conducting a service evaluation of routinely gathered data, or a design which supported the development of a programme within a naturalistic setting (Anderson et al., 2016; Bartels-Velthuis et al., 2016; Clapton et al., 2016; Graser et al., 2016; Gilbert et al., 2006; Gale et al., 2014; Judge et al., 2016; Lucre & Corten, 2012; Pennington , 2018).

Another factor which reduced the internal validity of the study related to concurrent or recently completed therapy. Four studies involved participants who were currently receiving another form of therapy or had just completed which confounds the impact of the study intervention (Bartels-Velthuis et al., 2016; Kelly et al., 2012; Gale et al., 2014; Gilbert et al., 2009;).

None of the studies explicitly referenced the inclusion of intention to treat (ITT) data. The failure to use an ITT analysis is a serious methodological flaw, as completer only analysis tends to over-estimate treatment efficacy. Calculations were made from the data presented which indicated that data completion rates range from 35% to 100%, scores were spread evenly across this spectrum indicating that the larger sample sizes tended to have higher attrition rates. An analysis of each data set was made to develop an attrition bias index. The initial sample size as reported for each group was looked at in relation to the end data number and this was calculated as a percentage to establish the attrition present in each data set.

Eight of the studies followed a design of repeated measures, in that participants were recruited and offered the intervention over a period of time which reduced the validity of the study and introduced another possible area of bias in the sampling method (Anderson et al.,

2017; Braehler et al., 2013; Bartels-Velthuis et al., 2016; Cuppage et al., 2016; Gale et al., 2014; Pennington, 2018; Collins et al., 2017; Judge et al., 2016;).

Power

In order to evaluate the power of the studies included in the review, criteria of more than 20 participants in each sample size were set. Nine of the studies had sample sizes of less than 20 which scored them as high risk and therefore insufficient power to produce a clinically important effect (Beaumont et al., 2016; Gilbert et al., 2006; Laithwaite et al., 2009; Lucre & Corten, 2012; Anderson et al., 2017; Clapton et al., 2016; Graser et al., 2016; Pennington, 2018; Mullen et al., 2019). A further three studies became high risk of being under powered when the attrition rate in data completion was accounted for (Grodin et al., 2019; Kelly et al., 2012; Navab et al., 2019). Of the underpowered studies the actual sample ranged from 6 to 19 participants which reduced to 17 when the attrition rate for data collection was accounted for.

Eight studies were therefore identified as having more than 20 participants and therefore sufficient power. Four of those studies, due to attrition, dropped to below 20 by the end of the study period (Cuppage et al., 2014; Braehler et al., 2013; Judge et al., 2012; Bartels-Velthuis et al., 2016).

Summary of Outcomes

A description of the key methodological characteristics and principal findings of the nineteen primary studies is given in Table 2-44.

Table 2-4: Study characteristics

Study	Sample Size	Age (range and mean)	% Female	Presenting problem	Country	Design	Follow up data	Setting	Type of control	Intervention length	CFT specific measures	Data completion rate	Qual / quant	Outcome data
Braehler, Gumley, Harper, Wallace, Norrie &Gilbert(2013)	40	43.2	42%	Schizophrenia spectrum disorder	Scotland	BG	N	Community Mental Health Team	Randomised TAU	16 sessions 2 hrs	NRS	35 (87%)	Narrative recovery style scale (Qual) Non CFT measures	BDi sig reduction NRSS – comparisons with TAU and CFT – CFT group ass. Decrease in avoidance and increase in sense of control of illness. Compassion sig ass. With decrease in depression
Kelly, Allison, Wisniewski, Martin-Wagar, Hoffman (2012)	22	31.9 mean	95%	Eating disorders EDNOS AN BN	Canada	BG	N	Eating Disorders programme	TAU	12 weeks (90 mins)	SCS (Neff) FCS ESC	73%	SRM Feedback form (bespoke)	Feedback – highly acceptable but not enough time. Reduced ED pathology SCS, FCS, sig change compared to TAU
Cuppage, Baird, Gibson, Booth, Hevey (2016)	58	18-69 yrs 42 yrs	69%	Range of psychiatric disorders	Ireland	BG	Y	Independent Psychiatric hospital	TAU	14 sessions 3 hrs	Functions of SC Scale FCS (self comp) OAS SS&Pleasure	57%	Quant SRM Mechanisms of change	Sig change across all measures in comparison to TAU. Change maintained at fup Mechanisms of change analysis, Fear of self-comp, self-persecution and self-correction corelated with change
Beaumont , Durkin, McAndrew, Martin (2016	17	27-55 41.3	24%	PTSD	England	BG	N	Fire Service Department	Non-randomised CBT	12 sessions 1.5 hrs	SCS (short)	100%	SRM (Quant)	CFT grp – greater change on measures SC. PTSD measures sig on both groups. No sig change for CFT grp
Gilbert & Proctor (2006)	9 (6)	39-51 yrs	65%	Severe long term complex difficulties	England	WG	Y	Day Treatment service NHS	none	12 sessions 2 hours	OAS FSCRS SocCS SBSFSCS Diaries	100%	Quant SRM	Sig change across all measures with a smaller magnitude of change for self-criticism

Study	Sample Size	Age (range and mean)	% Female	Presenting problem	Country	Design	Follow up data	Setting	Type of control	Intervention length	CFT specific measures	Data completion rate	Qual / quant	Outcome data
Judge, Cleghorn, McEwan & Gilbert (2012)	42	20-58 38.34 mean	67%	Depression and anxiety (54%) Other psy illness	Scotland	WG	N	Community Mental Health Team	None	14 weeks	OAS FSCRS SocCS FSCS ISS SBS Diaries	64%	SRM Feedback (qual)	Sig change across ISS, OAS, SCS, SBS, SRSA, Non sig change in self-criticism. Reduced anxiety corelates with increase soothing thoughts
Laithwaite, O'Hanlon, Collins, Doyle, Abraham & Porter & gumley (2009)	19	36.9 mean	0%	Schizophreni a Schizo-affective disorder Bipolar	Scotland	WG	Y	Maximum Security hospital	None	20 sessions over 10 weeks 2 hrs	SocCS OAS SCS (neff) RSE	95%	SRM Structure d interview s	Sig improvement SocCS, BDi,(lrg) OAS(small),SES(lrg) Maintained at fup
Lucre &Corten 2012)	10	18-54 yrs	78%	Personality disorder	England	WG	Yes 1 year	Psychotherap y OP service	None	16 weeks 2 hrs	OAS FSCRS SocCS FSCS SBS	80%	SRM Qualitativ e data	Sig change OAS, SCS, Dep, stress, Hated self, reassured self Non sig Anx, SBS, inadequate self Qualitative: importance of not being only one, FBRs to self compassion
Andersen &Rasmussen (2017)	102	20-69	84%	Not specified Range of psychiatric disorders	Denmark	WG	N	Private psychiatric practice	None	10 sessions (weekly)	SES	57 (55%)	SRM	Sig change in depression, anxiety SES sig improvement
Bartels-Velthuis, Schroevers, van der Ploeg, Koster, Fleer, van den Brink (2016)	62	23-65 48yrs	82%	Mood Anxiety Other disorders	Netherlands	WG	N	Outpatient community Outpatients	None	9 sessions (1.5 hrs)	SCS	33 (50%)	SRM	BDi and SCS (Neff) Sig change. Non sig change anxiety
Clapton, Williams, Friffith &Jones (20116)	6	38.5yrs	67%	Mild ID (IQ between 51-69)	Wales	WG	Y	Community ID Service	None	6 sessions	SCS (short) Soc Comp S (adapted)	100%	Focus Group (qual) SRM	Small grp – Wilcoxon SCS, SCS(Neff) self compassion sig change on adapted measures

Study	Sample Size	Age (range and mean)	% Female	Presenting problem	Country	Design	Follow up data	Setting	Type of control	Intervention length	CFT specific measures	Data completion rate	Qual / quant	Outcome data
														Qual feedback not alone, and FBR to self-compassion
Gale, Gilbert, Read and Goss 2014	139	17-62 years 28.01 yrs	96%	EDNOS Anorexia nervosa Bulimia nervosa	England	WG	N	Community ED Service	None	20 sessions (2 hrs)	None	99 (71%)	Quant (SRM)	73% improvements of ED measures (Bulimic group)
Collins, Gilligan, Poz (2017)	64 (less in data set)	74.12	37%	Diagnosis of Dementia in last 6/12	England	WG	N	Community Older Adults Service4	none	6 sessions 2 hrs	None	RR(Respiratory rate) (43%) HADS (73%) ProQual (70%)	Feedback on helpful (qual) SRM Respirato ry rate	Sig change dep, RR non sig change anx. Carers: sig change RR, non sig change in dep and anx. Positive feedback no analysis
Graser, Hofling, Weblau, Mendes, Stangier (2016)	11	46.6yrs	36%	Chronic Depression	Germany	WG	Y	Outpatient Psychiatric Clinic	None	12 weeks	SCS (Neff) SES	100%	SRM	Sig change HRSD , BDi, comp love scale Non sig change SCS, SES
Pennington (2018)	83	18-66	76%	Persistent pain	England	WG	N	Pain Management clinic	none	8 weeks (2hrs)	None	70%	SRM Qualitativ e data (thematic Analysis)	GHQ2 sig change
Fox, Cattani, Burlingame, (2019)	75	18-29	73.5 %	Depression 28% Perfectionism 20% Anxiety 11% Interpersonal 9%	USA	WG	N	Univeristy Counselling centre	None	12 weeks (1.5 hrs)	FCS CAES FSCSR DES TOSCA	61%	Quant (SRM)	Sig change on all measures with medium ot large magnitude of change on Cohen's d
Navab, Dehghani, & Saehi (2019)	20	30.65	100 %	Carer of child with ADHD	Iran	BG	N	Health Center	Wait List	8 weeks	None	Not known	Quant (SRM)	DASS Sig reduction on depression and anxiety, non sig on stress in TG. No sig change in WLC

Study	Sample Size	Age (range and mean)	% Female	Presenting problem	Country	Design	Follow up data	Setting	Type of control	Intervention length	CFT specific measures	Data completion rate	Qual / quant	Outcome data
Mullen, Dowling, Doyle & O'Reilly, (2019)	13	19-58 (33.92)	77%	ED	Ireland	WG	N	Private MH Hospital	None	6 months	None Qual only	9/13	Qual only	Themes: key memories, identity, evaluation, power, arousal, recovery (thematic analysis)
Grodin, Calrk, Kolts & Lovejoy (2019)	22	52.6	4%	Problematic anger	USA	WG	N	VA Medical Center	None	12 weeks	FCS	72%	Quant (SRM)	Sig reduction in RC and ECS, Expressing compassion to others - not sig

Note: RCT= Randomised Control Trial; BG= Between-group; WG= Within-group; CO= Clinical Outpatient; CI= Clinical Inpatient; G= Group; TAU= Treatment as Usual; WLC= Waitlist Control; CBT= Cognitive-Behavioural Therapy; N= No; Y= Yes, SRM = Self report measures, TG= Treatment Group, ED = Eating Disorder

Findings from included studies

All studies measured outcomes from a CFT group-based intervention of at least six weeks in duration, administered to patients receiving services from mental health services providers across the spectrum of inpatient, outpatient and secure services. There were two studies offering CFT to patients presenting with difficulties across the spectrum of mental disorder and such could be described as ‘transdiagnostic’ (Cuppage et al., 2016; Anderson et al., 2017). The majority of studies offered the intervention to disorder specific populations, including eating, personality, anxiety disorder and psychosis. The reported findings of these studies indicated that CFT was generally experienced as an acceptable and useful intervention in addressing shame and self-criticism within general adult mental health populations, whilst reducing symptoms of anxiety, depression and stress across a variety of different measures.

The attrition rates across the group programmes were generally cited to be quite low from 15% to 20% (Lucre & Corten, 2012; Kelly et al., 2012; Braehler et al., 2013; Cuppage et al., 2016; Gilbert et al., 2006; Beaumont et al., 2016; Graser et al., 2016).

Two studies also examined the possible mechanism of change and found some broadly similar processes. These mechanisms appear to link to the core psychological constructs of shame and self-criticism and our propensity for shame proneness and consequent self-critical strategies which unpin CFT as a bio social model of human behaviour. Cuppage et al. (2016) found that reductions in self-criticism and fears of self-compassion significantly predicted improvements in psychopathology and that increased experience of social safeness also correlated with improvements in psychopathology. Similarly, Braehler et al. (2013) found that the practice of self-compassion and compassion to others through the group process reduced the experience of social exclusion, inferiority and shame.

The outcome measures utilised by the nineteen studies were largely CFT related with only two studies using no CFT specific measures (Gale et al., 2014; Collins et al., 2017). Both studies reported diagnosis and symptoms specific measures, which demonstrated some shifts in anxiety and depression symptomatology, coupled with reductions in Eating Disorder symptoms in the case of Gale et al. (2014) and improvements in respiratory rate in the case of people with dementia (PwD) and their spouses in Collins et al. (2017). Collins et al. (2017)

found that the evolutionary psychology model of CFT was difficult for some PwD to access, similarly Clapton et al. (2016) found that the complexity of some of the concepts within the psychoeducation process were problematic for people with intellectual disabilities. This raises questions about what might be needed to ensure that this model is accessible across the spectrum of capacity and intellectual ability.

Within the remaining thirteen studies which utilised CFT specific measures, there was very little conformity across the battery of measures used. Six studies used Self Compassion Scale (Neff 2009) scale and all found significant improvements in levels of self-compassion following the intervention (Laithewaite et al., 200; Kelly et al., 2012; Graser et al., 2016; Clapton et al., 2016; Beaumont et al., 2016; Bartels-Velthuis et al., 2016). However, there were a number of key findings which combined symptom and process variables, in that the conclusions presented regarding the efficacy of the intervention drew on both measures. A number of studies found correlations between increased capacity for compassion measured by the experience of compassion to self, to others and from others and decreases in reported depressive symptoms (Braehler et al., 2012; Cuppage et al., 2016; Clapton et al., 2016).

Three studies also noted that there appeared to be a correlation within the Forms of Self-Criticising/Attacking & Self-Reassuring Scale (2014) between the significant reduction in the hated self and the increase in reassured self-subscales. Whilst the changes on the inadequate self subscale were not significant and a number of studies hypothesised that this slower rate of change on the inadequate self may link to the need for behavioural activation explicitly within the therapy process to enable participants to ‘put their compassionate selves to work’ in a more explicit way (Gilbert et al., 2006; Lucre & Corten, 2013; Judge et al., 2016).

Six studies provided follow up data following completion of the group intervention. The reliable change measured and indicated at the end of treatment was maintained at follow up, which was between two and twelve months after intervention completion (Clapton et al., 2016; Graser et al., 2016; Laithwaite et al., 2009; Lucre & Corten, 2013; Cuppage et al., 2016; Gilbert et al., 2006). Two studies noted further non-significant improvements at the follow up point (Lucre & Corten, 2013; Cuppage et al., 2016,),

Laithwaite et al. (2009), Judge et al (2012), Lucre et al. (2012) and Cuppage et al. (2016) utilised a similar battery of CFT specific process measures which can be broadly described as social ranking, shame and self-criticism / self-reassurance measures. Significant improvement across some of the social ranking measures, in particular *Other as Shamer* and *Social Comparison Scale* were attributed tentatively to the impact of the group process. This was also supported by qualitative feedback from group members who described the importance of the other group members in the therapeutic process (Gilbert et al., 2005; Cuppage et al., 2016; Lucre & Corten , 2013; Clapton et al., 2016). This finding is also supported by group therapy research more broadly (Bateman & Fonagy, 2004; Yalom, 1995).

Eight out of the nineteen also used qualitative measures and feedback, which ranged from informal gathering of feedback from participants regarding the acceptability and accessibility of the intervention to formal Content and Discourse analysis of the semi structured interviews carried out following the completion of the intervention. Some key themes have emerged from this qualitative literature which appear quite consistently across the studies. A number of studies reported that participants had found the model helpful but the duration of the intervention had been insufficient to enable the model to be embedded fully (Lucre & Corten, 2013; Kelly et al., 201; Clapton et al., 2016; Gilbert et al,. 2006). A further theme related to the fears, blocks and resistance to the flows of compassion, in particular the practice of self-compassion. Feedback from the informal qualitative data gathered or the formal analysis identified the common anxiety about the explicit compassionate self-practices designed to cultivate the capacity for affiliative self to self to relating. These were viewed as a potential barrier to acceptability of the model but feedback also indicated that the group provided an experience of social safeness with others which addressed this issue directly (Gilbert et al,. 2009; Judge et al., 2014; Cuppage et al., 2017; Kelly et al., 2012; Lucre & Corten, 2013).

Gilbert et al. (2009), Judge et al. (2014), and Cuppage et al. (2017) also found that there was a non-significant reduction in the experience of self-criticism which was coupled with the qualitative feedback about the group members feeling fearful of giving up self-criticism as it was linked with making mistakes and deeper identity issues i.e. being defined by the self-criticism. This finding was shared by a number of studies and therefore constitutes a finding of interest which could be part of a future study to explore this further. These findings

have also been the basis of the development of further CFT self-report measures (Gilbert et al., 2017).

There were a few findings of note that were shared by a number of studies, Judge et al. (2016), Clapton et al. (2016) and Lucre et al. (2012) all reported the from the qualitative semi-structured interviews that many patients shared the view that they did not deserve compassion and that this interfered with the therapeutic process. These studies also reported an important shared experience which was associated with a positive feeling of not being alone within the group process.

Discussion

In conclusion, despite the methodological limitations and potential flaws within the existent literature, this review of the evidence in relation to group based CFT interventions indicates that this intervention was acceptable and clinically useful across a broad spectrum of psychological difficulties. This review also indicates that CFT has demonstrates a consistent benefit to address the difficulties associated with shame-based trauma and self-criticism.

The level of bias present in the studies reviewed was very mixed with a high level of variance in the risk of bias. There was only one study which had a low risk of bias across all domains (Braehler et al., 2013). There were particularly high levels of bias across all studies in sampling, study design and sample size, with lower levels of bias in reporting of study aims, objectives and measurement of outcome.

It is of particular note that none of the studies conducted an intention to treat analysis or made any specific reference to those who dropped out of the treatment interventions. Without information regarding dropout rates it is not possible to gauge the acceptability of treatment programmes. Similarly, analysis based on only those who compete the group, provides information on the benefits of therapy but only for those people with sufficient resilience to tolerate the ardours of the therapeutic process. Therefore, it is difficult to gauge the probability of a successful clinical outcome at the point of referral as failing to control for

attrition masks the influence of such factors as compliance, engagement and acceptability of treatment on the outcome of therapy.

Those studies that completed a post treatment intervention follow-up, found that for the most part change was maintained and there was some limited evidence that further change had occurred. Despite the methodological flaws of this outcome research, there is some support for the use of this intervention across the spectrum of mental health difficulties. These findings are consistent with the recent literature review of all CFT interventions and also the meta-analysis of compassion interventions more broadly (Leviss et al., 2018; Kirby et al., 2017).

These results offer some early indication that group-based CFT has some benefit for people with Attachment and Relational Trauma (A&RT). The body of literature, however, regarding effective interventions for this group recommend longer interventions with greater attention to the process of therapy, what happens between the patients in the room, over the content or material presented to patients (Arlo, 2017; Bateman & Fonagy, 2016; Flores & Porges, 2017; Fonagy, Campbell & Bateman, 2017).

But there is a need to further investigate and evaluate the efficacy of this model with those with A&RT, particularly regarding offering a CFT group intervention over a longer time period.

Specifically, the review of the existent literature supports the following questions for the development of therapies for people with A&RT.

1. Does Compassion Focused Group Psychotherapy show efficacy in the treatment of patients with mixed presentations of complex relational trauma and personality disorder and high levels of shame and self-criticism?
2. Are there particular factors which can be associated with positive and/or negative patient experiences of the treatment process?
3. Does a more intensive longer-term treatment programme show significant advantages in outcomes compared to a shorter-term intervention?

In order to address the questions identified from the literature review, a long-term Compassion Focused Group Psychotherapy (CFGP) program was devised. Chapter 3

describes the development of a mixed quantitative and qualitative evaluation of the CFGP program, the specific methodology and set up of the study.

Chapter 3: Overview of the research methodology with focus on quantitative outcomes

The 12-month Compassion Focused Group Psychotherapy (CFGP) program has been developed in response to clinical observations, client feedback and a thorough review of the literature relating to group psychotherapy for patients with complex needs and relational trauma. The research aimed to evaluate an extended exploratory 12-month Compassion Focused Group Psychotherapy program and the impact on the experience of self-criticism, usage of services and general wellbeing in a group of patients with a history of complex trauma and relational difficulties.

It is of note that this trial took place within a naturalistic clinical setting, offering a variety of different psychotherapeutic interventions. The current treatment evaluation was originally conceived as a randomised controlled trial. Unfortunately, a randomised controlled trial could not be achieved within the operational parameters of the existing clinical service. The length of the study period (2 years) precluded an RCT at this point as funding was not available for this study and patients considered suitable for the study within the service would need to be offered an intervention in a more timely manner. Accordingly, this study has utilised a non-randomised mixed between and within subject controlled design with a qualitative evaluation of the process of change and the patient experience of the treatment. There has been 5 years of data collection during which time a total of 68 participants have progressed through the two Cohort groups. An application to the local Ethics committee and receipt of a favourable response, enabled recruitment of participants (see Appendix A).

The overall design of the study

The research trial included two Cohorts of participants. Cohort 1 were obtained from referrals to an NHS tertiary Specialist Psychotherapy Service who had been assessed as suitable for a 12-month CFGP program. In comparison, Cohort 2 were recruited from a number of Community Mental Health Teams within the same NHS Trust. These participants were referred by their mental health providers with the offer of an assessment to engage in a research trial, involving a 12-week Preparation and Engagement Group (PEG) intervention

(see Appendix C for Referral Criteria). Following the initial screening process (see Appendix B), those from both Cohorts who met the criteria were given a participant information leaflet and invited to consider taking part in the study (see Appendix F). A follow up meeting was then offered, at which point participants were invited if they wished to take part in the study, to sign a consent form (see Appendix E).

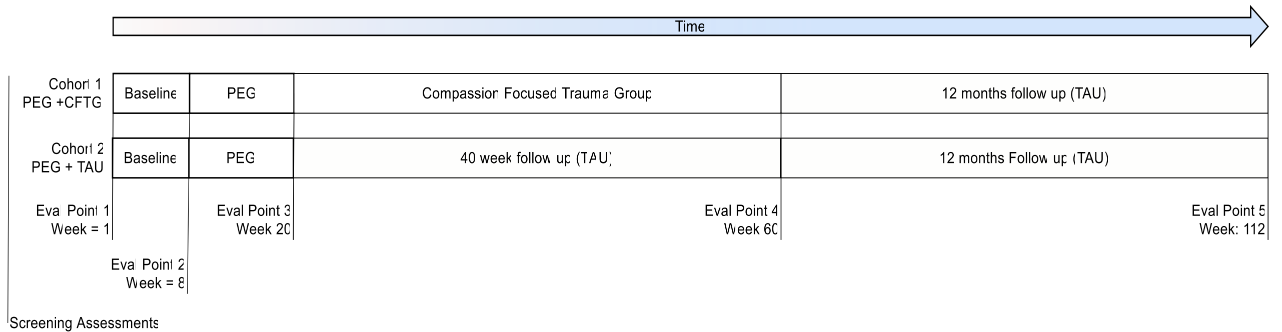


Figure 3-1::Research methodology

Figure 3-1 depicts the entire progression of the Cohort 1 and Cohort 2 participants through the PEG, through 40 weeks of Compassion Focused Trauma Group (CFTG) or treatment as usual (TAU) and finally the assessment of long-term outcomes after 12 months of TAU.

Cohort 1 undertook initial screening measures and an 8-week baselining period to assess the stability of the outcome measures (evaluation point 1 to evaluation point 2). They then undertook a 12-week Preparation and Engagement Group (i.e. evaluation point 2 to a valuation point 3), followed by a 40-week Compassion Focused Group Psychotherapy Program (i.e., evaluation 3 to evaluation point 4) and then long-term outcome data was assessed after 12-months treatment as usual (i.e., evaluation point 4 to evaluation point 5).

Like Cohort 1, Cohort 2 undertook initial screening measures, an 8-week baselining period (evaluation point 1 to evaluation point 2) and then undertook the 12-week Preparation and Engagement Group (i.e. evaluation point 2 to a valuation point 3). However, this Cohort did not progress onto Compassion Focused Group Psychotherapy Program but instead were monitored through 40 week of TAU, followed by a further 12 months of TAU (i.e. evaluation point 3 to evaluation point 5).

There were three evaluations detailed below, namely the 'Preparation and Engagement' phase, the Compassion Focused Trauma Group and the long-term follow-up.

Participants

Participants meeting the screening criteria were recruited from a mental health setting in a large city within the UK. Some referrals came from a specialist service (cohort 1) and others from a community mental health team (cohort 2).

The Initial Screening

The screening form which measures self-attacking, self-reassuring and self-hating attitudes was used to ensure that patients referred to the study met the criteria of having high levels of this type of psychopathology (See Appendix B).

Cohort 1: The screening form was administered at the point where the participants had been identified as potentially appropriate for CFT and was sent out with the initial appointment letter, in accordance with standard CFT service protocol. The scores were looked at in accordance with the rule. To meet the criteria for the group scores on the screening form must have at least 3 scores of 4 on the inadequate self and hated self subscales and 3 scores of 0 on the reassured self subscale). The Forms of Self Reassuring and Self Attacking Scale was used as this measure has been specifically designed for CFT interventions and also that it explores three keys areas of self to self-relating, namely experience of self as ‘inadequate’, ‘hated’ and ‘reassured’. This measure was therefore selected as the most appropriate, brief and robust measure to identify those who would likely require a CFT intervention.

Cohort 2: Clinicians asked participants if they would like to complete a screening form to be considered for participation in a research study. Consent was not requested until screening had been completed to avoid any unnecessary disruption for those who did not meet the criteria for inclusion in the study.

Recruitment

Cohort 1 participants were recruited from referrals to a specialist tertiary psychotherapy service who were considered by the allocations meeting to be potentially appropriate for CFT, which means that referrals were taken from all secondary care services.

Cohort 2 participants were recruited from a community mental health team located in the same city. The Chief Investigator (CI) attended team and allocation meetings at the CMHT base and advised clinicians about the study and gave the referral criteria (see Appendix C).

Measures

Eleven measures were administered at each of the five evaluation points (see Appendix D – Self report Measures). The measures are as follows:

(1) Forms of Self-Criticising/Attacking & Self-Reassuring Scale (FSCSRS). This was developed by Gilbert et al. (2004). It is made up of 22 items to measure the forms and styles of people's critical and self-reassuring self-evaluative responses to a disappointment. An example of an item is; ' I think I deserve my self-criticism'. Participants are asked to rate their estimated frequency on a Likert scale, ranging from 0 (not at all like me) to 4 (extremely like me). Paula Castilho, José Pinto-Gouveia and Joana Duarte (2015) the reported test/retest reliability was good for the subscales inadequate self (r= 0.72), hated self (r= 0.78) and reassured self (r=0.65) and varied from r =0.31 to r =0.86 for the FSCRS items.

(2) Social Comparison Scale (SCS). The social comparison scale was developed by Allan and Gilbert (1995). Participants make a social comparison of themselves in relation to others on 11 bipolar constructs, rated 1-10.

(3) The "Other as Shamer" Scale. The OAS scale is an 18-item scale developed Goss, Gilbert and Allan (1994). Participants respond to statements such as 'I feel other people see me as not good enough' on a five-point Likert scale ranging from 0 (never) to 4 (almost always).

(4) Submissive Behaviour Scale (SBS). The submissive behaviour scale was developed by Allan & Gilbert (1997). It is made up of 16-items such as 'I am not able to tell my friends when I am angry with them'. Participants are asked to rate their estimated frequency of these behaviours on a five-point Likert scale, ranging from 0 (never) to 4 (always).

(5) Depression, Anxiety and Stress Scales (DASS-21). DASS was developed by Lovibond & Lovibond (1995). It is made up of 21 items such as 'I felt that life

was meaningless'. Participants are asked to rate their estimated frequency on a Likert scale, ranging from 0 (Did not apply to me at all) to 3 (Applied to me very much, or most of the time). DASS is routinely being used in all up and coming CFT studies so there will be a growing body of evidence using this form. Also, it measures depression, anxiety, and stress in one form so reducing the paperwork for participants.

(6) Fear of Compassion Scales This scale generated a series of items based on various fears of compassion for each of these scales. Many of these items were inspired by PGs discussions with patients, ideas generated in the psychotherapy literature (e.g. Arieti & Bemporad, 1980) and in the attachment literature (Bowlby, 1969, 1973, 1980).

(7) Clinical Outcomes in Routine Evaluation (CORE) – CORE was designed in the UK for use in psychotherapy, psychological therapies and counselling. CORE is the first standardised public domain approach to audit, evaluation and outcome measure for psychological therapies, including psychotherapy. CORE was developed by The Psychological Research Centre at the University of Leeds (1998).

(8) Impact of Event Scale is a point Likert scale, ranging from (o-not at all to 4 extremely) and measures the level of distress associated with responses to stressful life events, with separate subscales for level of intrusion of traumatic memories and level of avoidance. In the 30 years of use it is widely used as a useful measure of stress reactions after a range of traumatic events.

(9) The Work and Social Adjustment Scale. The WSAS is a simple, reliable and valid measure of impaired functioning, with satisfactory levels of validity and test retest reliability. (Mundt et al. 2002).

(10) Internal Shame Scale. This measure evaluates the extent to which the negative affect of shame becomes magnified and internalized. The internal reliability and test-retest reliability of the ISS has been found to be sufficient (Cook 1994).

(11) A service utilisation questionnaire, this measure was adapted from a standard measure utilised within the psychotherapy service to gather information regarding general and psychiatric service usage, employment status and benefit status.

The evaluation of the Preparation and Engagement phase

The evaluation of the PEG phase is reported in Chapter Four. Both Cohorts 1 and 2 received an 8-week baseline period followed by a 12-week PEG. Within subject changes in outcome measures across the 12-week group were assessed relative to the change observed during the “no treatment” baseline period. Outcome data was analysed for completers only and on an intention-to-treat (ITT) basis. Change at the level of individual participants is presented as a histogram of participant level reliable change indices.

The evaluation of the Compassion Focused Trauma Group Program

The evaluation of the CFTG is reported in Chapter Five. Cohort 1 progressed from the PEG into a 40-week CFTG, whereas Cohort 2 progress from the PEG group into a 40-week period of TAU. Changes in outcome measures from the start (evaluation point 3) to the end (evaluation point 4) of the 40-week period were compared for the CFTG (i.e., Cohort 1) and the treatment as usual group (i.e., Cohort 2). Outcome data will be analysed for completers only and on an intention-to-treat basis. Change at the level of individual participants is presented as a histogram of participant level reliable change indices.

The evaluation of the long-term follow-up

The evaluation of the long-term follow-up is presented in Chapter 6. The change in outcomes were compared for Cohort 1 and 2 from the start of the intervention (evaluation point 2) to end of the PEG (evaluation point 3) to the end of CFTG for Cohort 1 and treatment as usual for Cohort 2 (evaluation point 4), across the final 12 month treatment as usual phase for both Cohorts (evaluation point 5).

This analysis addressed the progression of the participants through the Preparatory and Engagement Group (PEG), through forty weeks of Compassion Focused Trauma Group (CFTG) or treatment as usual (TAU) and finally the assessment of long term outcomes after a twelve month period of treatment as usual for both Cohorts. Accordingly, we assessed the long-term outcomes of the PEG with and without the CFTG. These outcomes will be discussed in the context of the trajectories of the two Cohorts across the entire period of the

evaluation and addresses the questions relating to (a) durability of therapeutic gains from the preparation and engagement phase, (b) the additional therapeutic gains that could be attributed to of the 40 week CFTG, and (c) the durability of therapeutic gains from the CFTG.

The change in outcomes was compared for Cohort 1 and 2 from the start of the intervention (evaluation point 2) to end of the preparation and Engagement Group (evaluation point 3) to the end of Compassion Focused Trauma Group for Cohort 1 and treatment as usual for Cohort 2 (evaluation point 4), across the final 12 month treatment as usual phase for both Cohorts (evaluation point 5). Rates of attrition, and level of service utilisation and quality of life measures are also considered in this chapter.

The presentation of the analysis for the study will commence with an overview of the pertinent literature supporting long-term psychotherapeutic interventions with a focus on the 12-week Preparation and Engagement Phase. The comparative data for both Cohorts will be presented in accordance with the format outlined above.

Chapter 4: The Efficacy of the Preparation and Engagement Group

In the previous chapters it was concluded that although there are methodological weaknesses which compromised the quality of the current body of evidence for the efficacy of CFT in a group format, the existing literature affords some hope that this intervention can be worthwhile in a variety of clinical populations. With the exception of one very small study with a number of methodological issues (Lucre & Corten, 2013), this model has not been systematically tested with a population with Attachment and Relational Trauma (A&RT).

This chapter describes the evaluation of the 12-week Preparation and Engagement Group (PEG), which is the initial stage in the 12-month Compassion Focused Group Psychotherapy Program. It is the intention of this chapter to explore the differences between two Cohorts of participants who received the PEG and a) evaluate the change in symptom outcome measures during the period of the PEG; b) to examine the association between change in outcome measures with change in measures of therapeutic process; and c) to identify reliable change at the level of the individual participants. Both an 'intention to treat' analysis and a 'completer only' analysis will be conducted for each Cohort.

Introduction

Compassion Focused Group Psychotherapy

"The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery therefore is based upon empowerment of the survivor and the creation of new connections." (Herman, 2002, p.s98)

Chapter One has described the significant challenge associated with meeting the therapeutic needs of people with A&RT who could be given a diagnosis of Personality Disorder (PD). The term A&RT will be used to describe the participants recruited for this study.

Lucre and Corten (2013) made a tentative proposal for a group based CFT intervention for people with a diagnosis of personality disorder, this model has been adapted and extended according to emerging literature supporting interventions for this patient population. It is also recognised that there are still few studies evaluating and demonstrating the effectiveness of long-term dynamic group interventions for people with a diagnosis of personality disorder (Fjeldstad & Hϕglend, 2016). This chapter will introduce the essential elements of this program with specific reference to the PEG phase of the intervention.

The main emphasis for a program for people with A&RT, is to provide *"a corrective emotional experience for individuals to facilitate the development of adaptive ways of relating with others"* (Capone, Schroder, Clarke & Braham, 2016, p. 4)

There is a growing body of evidence supporting the development of longer-term programs which combine structured components with more traditional psychodynamic theories and practice (Bateman & Fonagy 2016; Fonagy, Campbell & Bateman, 2017). Flores and Porges (2017) propose a model combining attachment theory and polyvagal principles in group psychotherapy, while many programs are now proposing DBT combined with psychodynamic principles (Arlo, 2017; Leiderman, 2016; Wehle, 2016). Therapeutic communities (TCs) are multi-modal programs often offering more process driven group, where there is an emphasis on understanding the complex interactions between participants and therapists and the links with experiences in the past, rather than interventions that focus on the content, what is said and delivered in the room. These programs have a structured format with a focus on democratic decision making and empowerment for group members. Sadly, the lack of robust evaluations of this model has resulted in most TCs in the UK losing funding (Capone, Schroder, Clarke, & Braham, 2016). The rationale for multi-model therapeutic programs is linked to a need to provide a consistent, predictable structured intervention which can support people whose ruptured early attachment systems make connecting with others problematic (as described in Chapter 1). The structure provides a framework for participants to feel a sense of safeness with others in the room, from which to start the work of exploring and creating new meaning from traumatic early life experiences (Lucre, 2020 in press; Lucre & Clapton, 2020; Yalom, 2006).

Compassion Focused Group Psychotherapy (CFGP) has followed a similar principle of combining a process driven slow open group psychotherapy format with more structured

components (Arlo 2017; Capone, Schroder, Clarke & Braham 2016; Kalleklev & Karterud, 2018; Yalom & Leczez, 2006). The therapeutic program is 'rolling', following a slow open format, in that group members join at different points in the program but everyone completes 12 months. This model is compassion focused therapy (Gilbert 2017; Lucre & Corten, 2013), with elements of group analytic theory and practice (Dalal 1998), delivered through a medium of action methods and psychodrama (Tomasulo 1998; White, 2002). Action Methods describes the use of visual, tactile and role based psychological interventions which were derived from psychodrama to support perspective taking, conflict resolution and the development of new meaning to past events (White, 2002). On a very basic level people with A&RT often experience somatic memories of early trauma which are triggered by being in group settings, the combination of Compassionate Mind Training practices, with movement and play based activities is designed to offer participants practical ways to feel safe and contained in the group space. In doing so, the program was developed as a model to rebuild some of the functions of attachment such as 'safe-relating' as a secure base and safe haven. These being primary functions of the early attachment system to enable a process of growth and development (Holmes, 2017; Music, 2018).

Table 4.1 below describes the progressive elements of the program and purpose, which will be outlined in detail below.

Table 4-1: The Phases of Compassion Focused Group Psychotherapy

Program element	Format	Function
Phase One: Assessment and formulation process	Three, individual sessions with one of the Psychotherapists from group program	Initial engagement with patient Establishing trust Commencement of narrative based formulating and sense making process Containment for the therapeutic work Commencement of psychoeducation phase of treatment
Phase Two: Preparation and Engagement Phase Group (PEG)	12 weekly sessions Two hours in duration (no break) Slow paced, experiential, play based group intervention Facilitated by 2 highly trained Compassion Focused Psychotherapists	Introduction of compassionate mind training practices and rationale Early exposure to CFGP model and the experience of compassion across the three flows Continuing development of safe haven and secure base function
Phase Three: Compassion Focused Trauma Group (CFTG)	40 weekly sessions 2 hours (no break) 'putting compassion to work' Facilitated by the same two highly trained Compassion Focused Psychotherapists	Using the capacity for compassion developed in the PEG to turn back towards early ruptured attachment relationships Using the group as a secure base to begin to explore past and present relationships Bringing compassion to shame based trauma memories Using the group process to develop new attachment relationships Working with conflict (external and within the group) Support to manage the ending and associated grief
Phase Four: Moving On Group	Peer Led support group Monthly meetings Online Facebook Group Informal social meetings	Moving towards a process of individuation, internalising the therapy and 'moving on' Practicing flows of compassion through peer led support

Phase One - Assessment and Formulation

The important task of building the therapeutic alliance and preparing for the psychotherapeutic process begins with the assessment (Bateman & Fonagy 2004; Bannerjee

et al., 2012; Gilbert, 2003; Gunderson & Links, 2014; Kamphuis and Finn 2018). The assessment therefore requires a number of sessions which are spaced out over a period of time to allow time for a therapeutic alliance to be established, some initial understanding and trust to be developed (Gilbert, 2010; Mace, 1995; Kamphuis & Finn 2018). De Saeger (2014) found that an extended assessment improved therapeutic alliance, perceptions of progress towards treatment and raised outcome expectancies, compared with a goal focused pre-treatment intervention. Langley and Klopper (2005) reported from a qualitative study of patients and clinicians that trust is also integral to the development of a therapeutic alliance.

An initial, tentative and collaborative formulation process starts at this stage, but it is then a template to return to within the psychotherapeutic process, rather than a concrete representation of patient's pathology (Bateman & Fonagy, 2006; Lee, 2015; Lucre, 2020 in press). This formulation is then included within the summary which is written explicitly to the patient and not about them to aid the process of collaboration and ensure that the language and format are accessible for the patient, using a shared language which has been developed during the sessions (Kamphuis & Finn, 2018).

The assessment process also introduces the patient to the dynamic administration process, which is the setting and holding of the therapeutic frame. This begins at the outset of the treatment process (Van De Kleij, 2013). Bear and Hearst (2008) describes the important of setting out what can be negotiated and perhaps more importantly what is fixed i.e. the time and place of the group at an early stage which offers containment through direct and honest interaction.

Phase Two – The Preparation and Engagement Group

The 12-week preparation and engagement group (PEG) was developed to specifically address the difficulty with high attrition rates in psychotherapy, which are on average 37% for people with a diagnosis of personality disorder (McMurran et al., 2010; Huband & Overton, 2010). Those who drop out tend to have poorer social outcomes, than those who do complete therapeutic interventions (McMurran, 2012; Birtle et al. 2007). Various studies have identified that psycho-educative, preparatory interventions can reduce the dropout rate substantially (Barnicot et al. 2011; Chiesa et al. 2003; McMurran, 2012; Pearce & Haigh, 2020; Webb & McMurran, 2009).

An additional measure was implemented to address the problems with drop out. Specifically, participants whose attendance was causing concern or who were struggling at any stage of the process were given the opportunity to take a break from the therapy and either restart the program or re-join at an agreed time. This aspect of the program was designed to foster engagement with and attachment to the group, through offering autonomy and choice, as these issues have also been linked to drop out within similar programs (McMurran, 2020, Campling, 2001).

During the 12-week PEG three modules are introduced to begin the first two phases of the treatment, the psychoeducation and Compassionate Mind Training (CMT). The group has an open format in that participants joined at specified time points within a rolling continuous 12 weeks cycle. This would mean that participants would all spend 12 weeks in the PEG group but would receive the sessions in a different order to other participants (see Figure 4.1). This means in practice that participants are invited to join a group, usually in pairs, which is already 'running'. This aspect of the model is intended to promote a process whereby new group members are supported by existing 'senior' members to begin to make sense of the process and content of the groups, thereby encouraging the sense of cohesion between the group members (Burlingame, 2020; Haigh, 2013; Yalom & Leszcz, 2005). Lorentzen, Strauss and Altmann (2018) identified the importance of developing cohesion in short term group interventions through the psycho- educative component.

Senior group members, in explaining the basic model to new members can rehearse and explore their own learning, reflect on their journey in self-compassion, whilst being empowered by the opportunity to support those at the commencement of their journey (Campling, 2001; Haigh, 2013; Yalom & Leszcz, 2005) This group structure, content and process has been designed to cultivate compassion in the participants across the three flows explicitly through teaching participants about the meaning of the compassion and implicitly through the design of the program which encourages turn taking and mutual support. Thus developing the capacity of group members to experience compassion from others, offer compassion to others and to begin to practice giving compassion to themselves (Gilbert, 2011; Kolts, 2016).

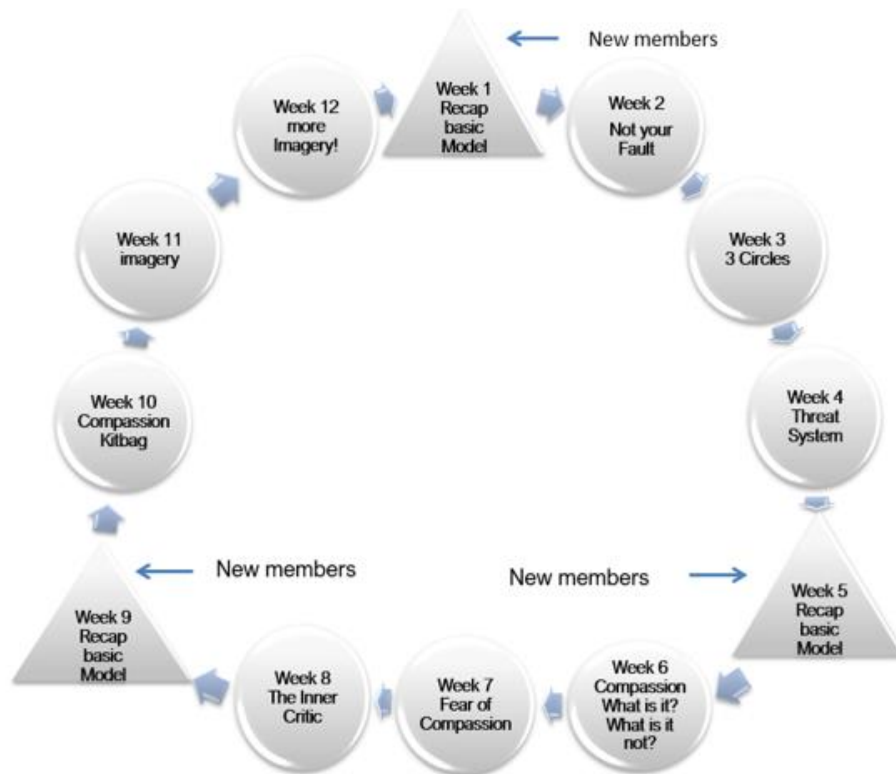


Figure 4-1 Format of the 12-Week Preparation and Engagement Group

The Structured Components of the PEG

The 'triangle' sessions depicted in Figure 4.1 above represent the session in the 12-week PEG when new participants to join the program. These sessions have a particular structure designed to introduce the new participants and explain how the groups will be run. An essential component of this 'joining session' is the 'safe space agreement' which is a group based behavioural contract which everyone agrees to abide by. This is reviewed each time new members join, thus ensuring the key principles of the therapy contract are held in mind by each member (Lucre, 2020 in press).

There appears to be a consensus within the literature that providing a structure to the therapeutic intervention, can be helpful to those whose early attachment relationships have been ruptured or absent (Arlo 2017; Gilbert, 2009; Haigh, 2013; Tomasulo, 1998; Yalom & Leszcz, 2005). The therapy in the early stages is predictable and reliable, which is generally a contrast to participants' experiences of parental figures who have often been absent and or abusive. The structure that is introduced during the 'triangle' joining week is then followed for every subsequent session. The practice is introduced during the first session of every

intake to the psychotherapeutic process with a detailed rationale for the practice to ensure that the purpose is understood.

Each group commences with a guided soothing breathing rhythm practice (SBR), designed to create a predictable consistent starting point for the group and an opportunity for group members to settle into the group space at the outset (Arlo, 2019; Bo et al, 2019; Lucre & Corten, 2013). This practice is consistent with Porges (2011) polyvagal theory, an emphasis is placed on an increased postural awareness, straight slightly concave back, grounded upright posture, gentle facial expression and warm friendly inner voice tone as this can facilitate the activation of the vagal nerve. This is associated with the activation of the social engagement system and the neuro biological benefits of co-regulation in groups (Porges, 2011; Geller & Porges, 2014; Flores & Porges, 2017). It is also helpful to anticipate the likely adverse reactions which often accompany the practices. This is linked to the invitation to slow down and be still in a group context whihccan be experienced as threatening, in particular by those who are prone to emotional dysregulation because these individuals have often not learned or more importantly not been taught how to regulate their emotions (Austin & Porges, 2007; Bateman & Fonagy, 2011; Mizen, 2014). Austin and Porges (2007) found that patients with a diagnosis of Borderline Personality Disorder had no spontaneous activation of the social engagement system. They suggested that this was linked to the experimental conditions whereby the presence of the experimenter in the room prevented the Parasympathetic Nervous System (PSNS) arousal and instead triggered the Sympathetic Nervous System (SNS), indicating that others were a source of threat and not soothing. This is a significant finding and lends weight to the need for explicit practices which stimulate the PSNS and associated social engagement processes.

Group members are also invited at this stage to make use of objects which are available in the group room as a sensory focus and also as a gift from the group (Gilbert & Proctor, 2006; Lucre & Corten, 2013; Lucre & Clapton, 2020).

Feedback is paramount for each group member after each breathing practice, to ensure that the common misunderstanding of the practice and the inevitable critical dialogues can be explored and understood. The social skills acquisition component of the group, enabled through turn taking and expectations regarding contribution, are designed to teach and encourage mentalising capacity, altruism through listening to others and the reparative

experience of other's curiosity and connection (Arlo, 2017; Bateman & Fonagy, 2006; Lucre & Corten, 2013; Yalom & Lesczc, 2006). Following this, each member is invited to take turns to offer a short check in about their week and current situation. The purpose of this is to support and develop basic social skills training in turn taking and sharing the space (Gabbard, 2000; Haigh, 2013; Yalom & Leczez, 2006). Over time group members are encouraged to take responsibility for time keeping the, check in, and supporting each other to manage the time boundary. See Table 4.2 Structure of the weekly group session.

Table 4-2: Structure of the weekly group session – Preparation and Engagement Group

Component	Purpose
Soothing Breathing Rhythm Practice	Creating predictable ritual for group Introducing Compassionate Mind Training and self-practice Creating a Safe Haven and Secure Base in the therapy room
Feedback from the Breathing Practice	Turn taking Social skills training Informal teaching and validation around Soothing Breathing Rhythm (SBR)
Check in with participants	Turn taking Social skills training Gathering information for taught components
Introduction of Module specific topic using participant examples from the check in	Delivery of basic Compassion Focused Therapy model Opportunities for group discussion / engagement Normalising and validating emotional distress

The introduction of the basic evolutionary psychology model takes place gradually with shared discussions, games and pairs work. This experiential learning is designed with careful attention to the development of the capacity of group members to tolerate the shared group space/processes (Bateman & Fonagy, 2011; Gilbert, 2009; Flores & Porges, 2017). The evolutionary psychology model is introduced in the 12-week PEG in three distinct modules see Table 4.3 below.

The Modules

Three modules are introduced over these 12 weeks of the PEG, see Table 4.3 below. There is an emphasis on collaborative psychoeducation and compassionate mind training. The development of those modules has been informed by the now substantial published work on CFT as a modular short term intervention (Leviss & Uttley 2015; Kirby et al. 2017).

The key components of the psychoeducation are integrated into issues that the group members share about their current difficulties, rather than delivering the materials in a more traditional didactic teaching format. In practice group members are invited to talk a little about their week and it is this material that is used to explain the basic model.

Table 4-3: Overview of the Preparation and Engagement Group Modules

Module Title	Material covered
Module 1 **The brain, how it works and our threat systems**	An introduction to the neuroscientific complexity of underlying everyday human experience and emotional difficulties, the inevitable nature of suffering coupled with a predisposition to threat based emotional processing, is offered to normalise and validate difficulties (Lucre & Corten, 2013; Gilbert 2017; Irons & Beaumont, 2018).
Module 2 **Compassion. What it is.. What it isn't .. and Why we might need it**	The second module introduces the concept of compassion in greater depth, although the understanding of compassion is discussed explicitly during every group. Time is spent exploring what compassion is, more importantly perhaps what it is not and why we might need it. This translates into an exploration of the fears of compassion and an introduction to the concept of internal critical self to self-shame based dialogues (Lee, 2012; Lucre & Corten, 2013; Gilbert, McEwan, Irons, Bhundia, Christie, Broomhead & Rockliff, 2010).
Module 3 **The Compassionate Kitbag**	The third module formalises the Compassionate Mind Training which has been gradually introduced through the preceding weeks. The focus of this module is the development of the sensory and imaginal Compassionate Kitbag (see below). including harnessing diverse sensory objects and items that can be powerful and rapid non-verbal ways of stimulating compassionate processes of both self-soothing and courage innervation (Lucre & Clapton, 2020).

Following discussion and the introduction of key ideas, the group are encouraged to use creative means to explore the personal connections and associations to the ideas presented. These activities could take the form of movement-based activities and games (White, 2006; Arlo 2017), using art materials to externalise an aspect of the self to allow for emotional distance and an alternative perspective (Lucre & Corten 2013).

The Compassionate Kitbag

A key component of the preparation stage of the therapeutic work is the development of a 'Compassionate Kitbag', which is a novel multi-sensory based means of helping draw together the various elements of Compassionate Mind Training (CMT) and processes within the therapeutic work, to help participants to cultivate and facilitate their capacities for compassion (Lucre & Clapton, 2020). This is a concrete practical collection of objects which

patients are invited to gather together, share with each other and utilise in the explicit stimulation of the drive and soothing systems. Objects are also given by therapists to support the psychotherapeutic work and in such cases these objects can also become transitional objects (Arthern & Madill, 2002; Lucre & Corten, 2013). This concept focuses on the development of a compassionate motivation and compassionate self identity, rather than just symptomatic relief, the latter being the usage of toolkits, first aid kids and self soothe boxes, which are common in mental health and therapeutic settings (Sokmen & Watters, 2016, Linehan, 2014).

The Compassionate Kitbag's potential therapeutic value lies in offering multifarious creative and tangible means of accessing compassion to a wide range of individuals who are typically fearful of, blocked and/or resistant to compassion.

The importance and centrality of Play

Central to CFGP, and the successful facilitation of therapeutic processes and tasks, is the ability of the therapist to be playful and thus facilitate *playfulness* in the client. Play is essential to human learning and growth. Play has been proposed as a neural exercise that engages evolved social engagement systems (Porges, 2015; Panksepp, 2004) that allows us to cooperatively explore, experiment, learn, and experience joyful connection to others (Durand & Schank, 2015).

Play can only truly occur when one feels safe enough to do so, which maybe first achieved through the expression of compassion from the therapist in the form of therapeutic presence (Geller & Porges, 2014). This can then skilfully be extended to the use of humour as a means of 'joining' (Panichelli, 2013) and further promoting playful interactions that facilitate emotional learning and that are intrinsically rewarding (Panksepp, 2004).

A specific technique to develop the capacity for playing and playfulness while supporting the expanding the utility of the 'compassionate kitbag' is 'role taking'. This technique has been adapted from Jacob Moreno's concept of role theory (Blatner, 1991). This was designed as a means of exploring, expanding and strengthening the more functioning aspects of self, via an explicit intentional process (Blatner, 1991; Lucre, 2020 in press; Lucre & Clapton, 2020).

During the early stages of the PEG this therapeutic technique is introduced as a means of deepening the emotional connections to the 'objects' from the kitbag, to explore meaning and significance. This technique also offers an opportunity to creatively stimulate the flow of compassion to self through imagery, gently exposing the member to the care giving and care receiving mentalities. See Appendix G - Case example of Role Taking.

Aims and hypotheses

This current chapter builds upon the findings of the existent literature and will describe the operation and outcome of the 12 weeks Preparation and Engagement Group (PEG) conducted prior to the 40-week Compassion Focused Trauma Group (CFTG).

From the review of the existent evidence it is clear that there is need of a preparation and engagement phase in the treatment of persons presenting with A&RT who may be given a diagnosis of personality disorder. The following specific hypothesise are posited

1. For those completing the preparation and engagement group there will be a reliable and meaningful improvement in symptom level, adjustment level and process level outcomes across the 12-week period of the group.
2. Any reliable and meaningful improvement will be maintained when the outcome is evaluated on an intention to treat basis.
3. There will be a clinically meaningful associations between symptom level change and process level change during the preparation and engagement group.
4. That there will not be any significant differences between control and treatment group outcomes.

Method

All participants recruited to this study received the 12-week PEG. These data were obtained from two separate cohorts in different locations. The first cohort consisted of forty-one patients who had been referred to a tertiary level Specialist Psychotherapy service (Cohort 1: PEG + CFTG) and the second group consisted of twenty-seven participants who had been offered the preparation and engagement group as part of their psychiatric treatment

for a secondary care community mental health team (Cohort 2: PEG + TAU), both groups were being seen within an NHS Mental Health Trust (TAU = Treatment As Usual).

Changes in outcomes relating to mental health assessed during the eight-week period without intervention (see figure 4.2 below, Overview of Research, evaluation points 2 and 3) in both Cohorts will be compared to the change scores during the period of the preparation and engagement group (see figure 4.2, evaluation points 3 and 4).

This non treatment period of at least 8 weeks in duration, during this time all participants received treatment as usual from their referring Community Mental Health Teams. This would usually comprise of a mixture of outpatient appointments with Psychiatrist, supportive input from Care Coordinators in the form of meetings or phone contact and access to the emergency duty phone support system. This period of time following completion of assessment and acceptance into the study will be described as the baseline phase.

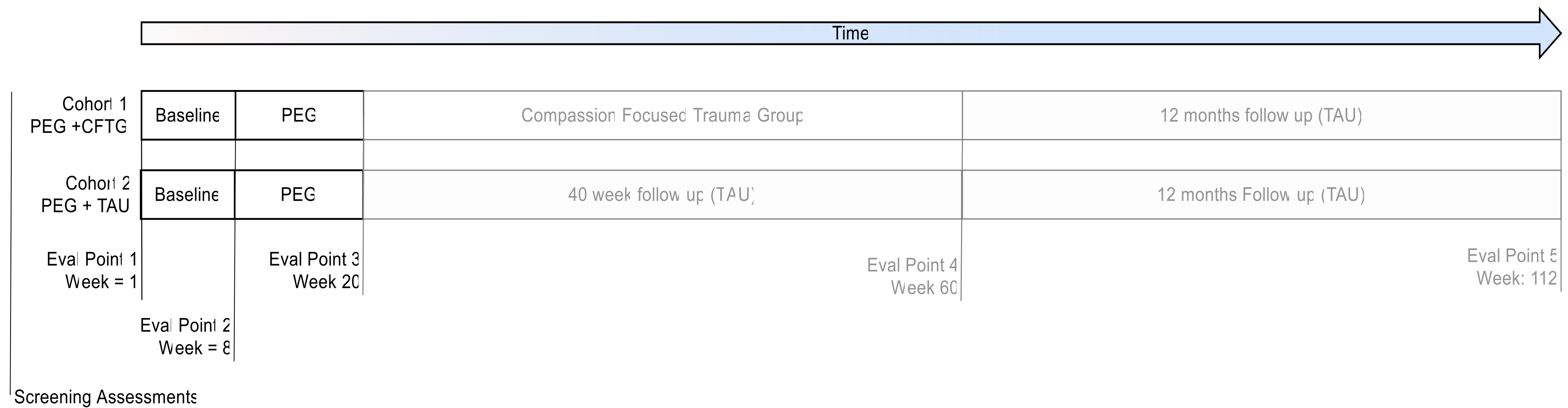


Figure 4-2 Overview of Research

The evaluation of the Preparation and Engagement phase is shown in Figure 4.2. In this phase both Cohorts 1 and 2 receive the Preparation and Engagement Group (PEG). A within and between-subjects ANOVA will be used to differentiate the change across the baseline treatment as usual phase (weeks 1 to 8) from change during the period of the Preparation and Engagement group (week 8 to 20). The difference between the two Cohorts will also be assessed.

Prior to the onset of the PEG each participant had a minimum of eight weeks treatment as usual baseline period. Each participant was assessed at the beginning of the baseline period and then again after eight weeks. This period of treatment as usual acted as the within subjects control condition to evaluate change across the 12-week preparation and engagement group.

Participant characteristics

There was a total of 68 participants in the study, 50 women and 18 men. There were 27 participants who went forward into Cohort 2 and 41 who went forward into the Cohort 1. All 68 participants received the PEG.

The age of the participants ranged from 23 years to 66 years; mean age 54 years. 80% of the Cohort had a primary diagnosis of personality disorder, it is of note that all of Cohort 1 had a diagnosis of personality disorder whereas only 50% of Cohort 2. This discrepancy in diagnosis between the two conditions can be understood in the context of the referral streams. Cohort 1 were referred from a specialist personality disorder service whereas the Cohort 2 were referred from a Community Mental Health Team.

Eighty percent of the Cohort had been given a Health Of the Nation Scale (HONOS) cluster of 7 or 8, indicating high levels of complex needs and severe distress, these clusters are linked with F60 diagnostic categories relating to the disorders of personality (NHS England 2017). This scale is used to measure the objective experience of distress and disability as a consequence of the disorder that the participant has been diagnosed with.

A summary the baseline demographics and clinical characterises of the participants is provided in Table 4.4 below. Chi Square test was performed on the demographic data and the only significant differences were between the diagnostic categories, with more participants in Cohort 1 being diagnosed with one of the nine categories of personality disorder.

Table 4-4 Participant characteristics by location

	Cohort 2 n = 27	Cohort 1 n=41	Total n=68	X^2	p
Age					
> 25 yrs	0	1(2%)	1(1%)	1.435	0.839
25- 35 yrs	7(26%)	8(19%)	15(22%)		
36-45 yrs	6(22%)	12(29%)	18(27%)		
46 - 55yrs	11(41%)	13(32%)	24(36%)		
56+ yrs	3(11%)	7(18%)	10(14%)		
Gender n(%)					
Male	5 (18%)	13 (32%)	18(27%)	1.454	0.228
Female	22 (82%)	28 (68%)	50(73%)		
Marital Status n (%)					
Single	16 (57%)	20 (50%)	36(54%)	4.149	0.246
Cohabiting / civil partnership	3 (13%)	11 (27%)	14(21%)		
Divorced /separated	5 (16%)	3 (8%)	8 (12%)		
Married	3 (14%)	6 (15%)	9 (13%)		
Ethnicity n (%)					
White British	17 (64%)	31 (76%)	48(71%)	2.2786	0.685
Mixed Race	4 (15%)	6 (15%)	10 (15%)		
Asian	2 (7%)	4 (9%)	6 (8%)		
White Other	2 (7%)	0	2 (3%)		
Ethnic Other	2 (7%)	0	2 (3%)		
Primary Diagnosis n (%)					
EUPD	10 (37%)	25 (61%)	36(54%)	32.2448	0.0002
PD not specified	1 (7%)	4 (10%)	6 (9%)		
PD Avoidant	0	7 (17%)	7 (10%)		
PD Paranoid	0	2 (5%)	2 (3)		
PD Dependent	0	1 (2%)	1 (1%)		
PD Narcissistic	0	2(5%)	2 (3%)		
Bipolar	6 (22%)	0	5 (7%)		
Depressive illness	6 (22%)	0	6 (9%)		
Psychosis	2 (6%)	0	2(3%)		
Schizoaffective	1 (3%)	0	1(1%)		
Obsessive Compulsive Disorder	1(3%)	0	1(1%)		
Documented Early Attachment Trauma (%)	27 (100%)	41 (100%)			
Employment Status n (%)					
Employed	7 (25%)	6 (8%)	13 (19%)	1.946	0.746
PT Employed	2 (7%)	2 (5%)	4 (6%)		
Voluntary	0	0	0		
Education	1 (3%)	1 (2%)	2 (3%)		
Unable to work (sick)	17 (65%)	32 (85%)	49(73%)		
Honos Cluster					
Cluster 4	2 (8%	6 (13%)	8 (12%)	6.223	0.183
Cluster 7	7 (26%)	11 (28%)	18(26%)		
Cluster 8	12 (45%)	24 (59%)	36(54%)		
Cluster 11	1 (4%)	0	1(1%)		
Cluster 12	5 (16%)	0	5(7%)		

Measures

The following self-report scales were administered to measure symptoms of mental distress, process and adjustment, see chapter 3, p.2 for a full description of their psychometric properties.

Symptom Measures

The symptom level measures report outcome at the level of mental health symptoms.

1. Depression, Anxiety and Stress Scales (DASS-21). DASS was developed by Lovibond & Lovibond (1995).
2. Clinical Outcomes in Routine Evaluation. CORE was developed by The Psychological Research Centre at the University of Leeds (1998).

Therapeutic Process Measures

The therapeutic process measures quantify the purported therapeutic processes within the preparation and engagement group.

1. Forms of Self-Criticising/Attacking & Self-Reassuring Scale (FSCSRS) Gilbert et al. (2004).
2. Social Comparison Scale (SCS). The social comparison scale was developed by Allan and Gilbert (1995).
3. The Other as Shamer Scale. The OAS scale is an 18-item scale developed Goss, Gilbert and Allan (1994).
4. Submissive Behaviour Scale (SBS). The submissive behaviour scale was developed by Allan & Gilbert (1997).
5. Fear of Compassion Scales (Gilbert et al. 2014).
6. Internal Shame Scale (Cook 1994).

Adjustment Measures

The adjustment measures provide assessment of functional adjustment and

1. The work and Social Adjustment Scale (Mundt et al. 2002).
2. Impact of Event Scale (IES) developed by Horrowitz, M., Wilner, N., & Alvarez (1976)

Procedure

Following recruitment measures of mental health symptoms, therapeutic process and social adjustment were taken at baseline, at the start of the group and at the end of the group. There was a minimum of 8 weeks and maximum of 20 weeks between baseline and the start of group and a twelve-week period between the start and the end of the intervention group. The variance in the time spent between baseline and start of intervention related to the availability of places in the rolling group program.

Cohorts 1 and 2 received the PEG intervention at separate locations and although the intervention was provided in the same way, by the same therapists, there were key areas of difference at outset of the PEG. Specifically the participants were aware of the two arms of the study (PEG+ 40 week TAU and PEG + 40 week CFTG), which may have resulted in differences in response to the intervention.

Analysis strategy

The means and SDs for the symptom and process measures are presented below. A repeated measures ANOVA compared the means of the measures at the baseline, start and end of intervention and the Greenhouse Gleissier adjusted F and significance values are reported. If a significant F was observed, then post hoc t-tests were undertaken to assess change between the (1) baseline and the start of the intervention and (2) the start and end of the intervention.

In order to show clinically or statistically meaningful change at the level of the individual participant within each Cohort, the 66% CI and the 95% CI for Reliable Change was calculated for each of the symptom and process measures using the procedures described by Jacobson and Truax (1991).

Participant scores at the start of the PEG and at the end of the PEG were then plotted and the bands for clinically meaningful change (66% CI) highlighted in red and statistically reliable change (95% CI) were highlighted in black.

There was no more than 5% missing data for most of the measures. However, this figure rose to 15% for IES and 24% for CORE. In the case of significant results from the

ANOVA tests, an Intention to Treat Analysis (ITT) was undertaken to enable an estimation of the treatment effect size controlling for participants who were lost to attrition, either due to drop out from the study or failure to complete the end of 12-week therapy measures. A "null result" was calculated for those participants who were lost to attrition by calculating the average of the lowest tenth percentile of scores on that outcome measure. The ANOVAs for the start and end of PEG intervention were then recalculated with the average "null result" substituted for any missing data.

Within the first 12 weeks of the intervention 4 people from Cohort 2 and 1 participant from Cohort 1 dropped out or did not complete end measures, resulting in a non-completion of 7%. The ITT data was therefore calculated for these 5 participants. It is of note that a further 8 patients who commenced the treatment group attended less than 4 sessions, did not consent to be in the research and did not complete any measures. Their data are not included in this study; however, the non-completer rate rises to 19% if these patients are included.

Results

Data for both Cohorts are presented in single charts with blue to present Cohort 1 and red to represent Cohort 2. This format will be followed throughout the following chapters. All significant results in tables will be highlighted in yellow.

Attendance Rates

The 12-week Preparation and Engagement group program for Cohort 1 commenced September 2014 and data was gathered from this group until May 2018 when the final research participants completed the 12-week group. Overall attendance was 81% for the 12-week PEG, with 12% Did Not Attend (no contact with the service) and 7% sending apologies. These data were calculated on a session by session basis and cross referenced with electronic databases for recording session attendance. The 12-week group for the Cohort 2 ran from April 2016 until May 2017. See figure 4.5 below, for details of attendance by Cohort. Both groups were run on a slow open rolling format with fixed entry and exit points. Participants entered the program on at the beginning of each module, represented by the triangles in Figure 4.1, p. 47.

Table 4-5 Attendance Rates by % for Cohort 1 (2014-2018) and Cohort 2 (2016-18)

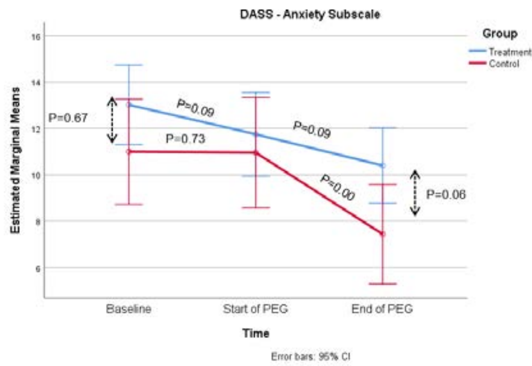
Cohort	Attended	Did Not Attend	Apologies
Cohort 1	83%	10%	7%
Cohort 2	78%	14%	8%

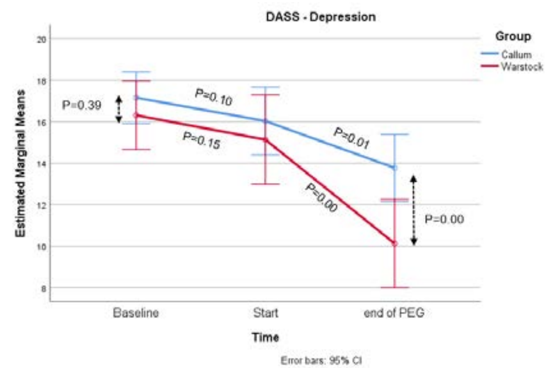
Changes in Symptom Measures

Depression Anxiety and Stress Scale

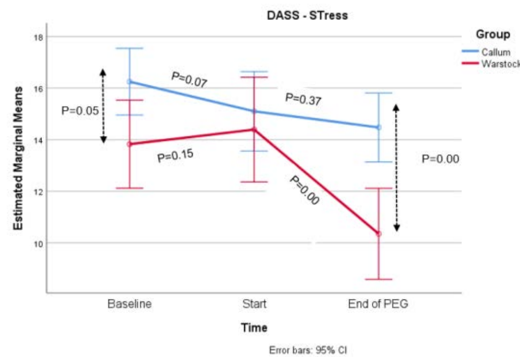
A repeat measure ANOVA compared the means of the measures at the baseline, start and end of intervention for both Cohorts. There was a significant Greenhouse Gleissier adjusted F for change over time for Anxiety (f=14.59, p=0.00), Depression (f=29.229, p=0.00) and Stress (f=14.59, p=0.00).

The means and 95% confidence intervals for both Cohorts at each of the time measurement points are shown in Figure 4.3. Figure 4.3 charts A to C show a significant improvement on all the DASS subscales for Cohort 2 (PEG + TAU) across the duration of the 12-week PEG, whereas Cohort 1 (PEG + CFTG) showed significant improvement for Depression only. The difference between Cohort 1 and Cohort 2 scores at the end of the intervention was statistically significant for Depression and Stress subscales only.





A: DASS - Anxiety B: DASS - Depression

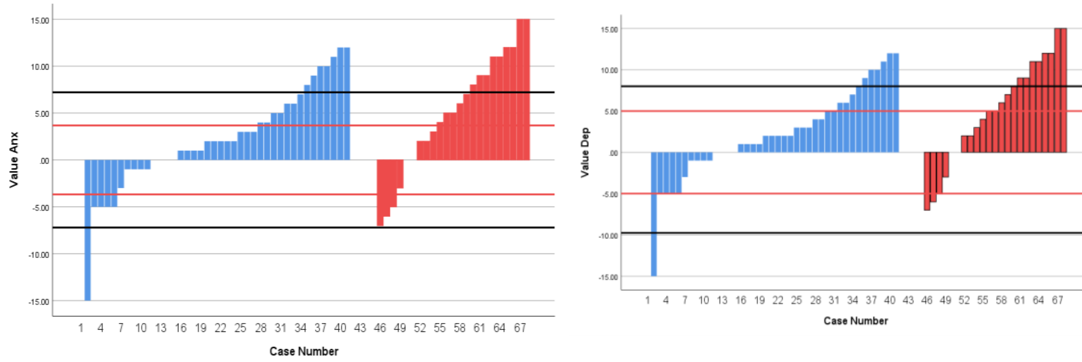


C: DASS - Stress

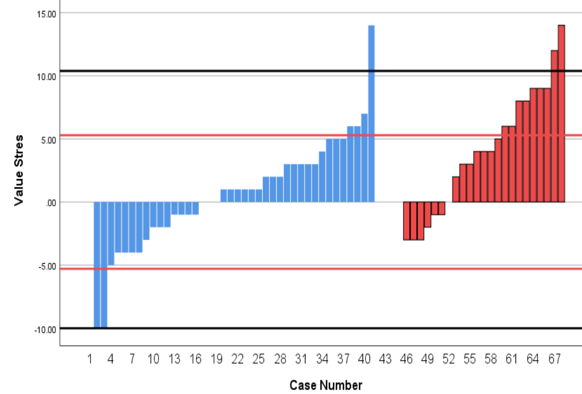
Figure 4-3 Plot of DASS subscale means and 95% confidence intervals for interaction effect. Cohort 1 (PEG + CFTG) is depicted as a blue line and Cohort 2 (PEG + TAU) is depicted as a red line.

When these tests were recalculated on an intention to treat basis over the period of the intervention, the significant improvements were maintained, for Depression (C1: f=16.698, p=0.01; Cohort 2: f=11.866, p=0.00) and in Cohort 2 only for Anxiety (C2: f=19.499, p=0.00) and Stress (C2: f=14.909, p=0.00).

In order to explore participant level change, the Reliable Change Index was calculated for each participant, see Figure 4-4 below (Jacobson & Truax, 1991).



A: DASS - Anxiety B: DASS – Depression



A: DASS – Stress

Figure 4-4 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the Cohort 1 and Cohort 2 reaching the criteria for clinical and statistical improvement or deterioration is shown in Table *4-6*. These data show a clear difference in the level of improvement and deterioration between the Cohorts, but the difference in the levels of deterioration are less evident.

Table 4-6 Percent of the two Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the DASS subscales

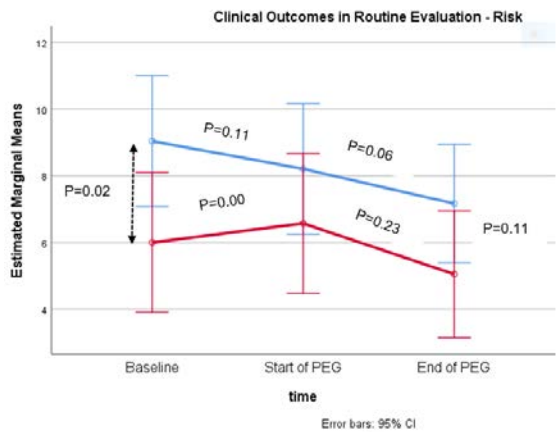
	Anxiety		**Depression**		**Stress**	
	C1:	C2:	C1:	C2:	C1:	C2:
Statistically reliable improvement	17%	33%	15%	35%	2%	9%
Clinically meaningful improvement	34%	52%	25%	48%	10%	39%
Clinically meaningful deterioration	12%	15%	2%	9%	5%	0%
Statistically reliable deterioration	2%	0%	2%	0%	0%	0%

Clinical Outcomes in Routine Evaluation Measure

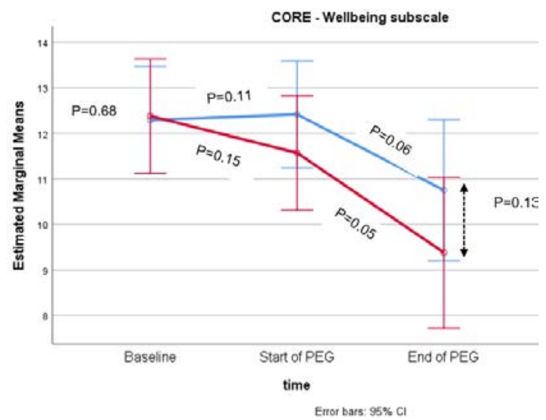
A repeat measure ANOVA compared the means of the measures at the baseline, start and end of intervention for both cohorts. There was a significant Greenhouse Gleissier adjusted F for change over time for Risk (f=3.50, p=0.03), Wellbeing (f=11.50, p=0.00), Functioning (f=9.10, p=0.00) and Problems (f=10.92, p=0.00).

The means and 95% confidence intervals for both Cohorts at each of the time measurement points are shown in Figure *4-5* below. Figure *4-5* charts A to C show a significant improvement on the Functioning and Wellbeing subscales only for Cohort 2 across the duration of the 12-week PEG. The difference between the Cohort 1 and Cohort 2 scores at the end of the intervention was statistically significant for Functioning and Problems subscales.

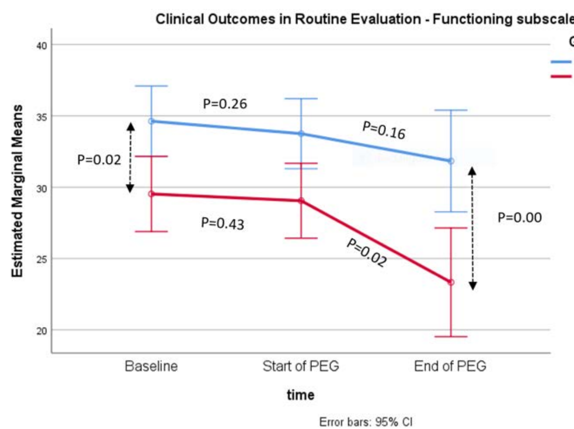
There was a significant difference between the two Cohorts at baseline for Functioning and Risk and a significant increase during the baseline phase for Risk, coupled with a significant improvement for Problems in Cohort 2.



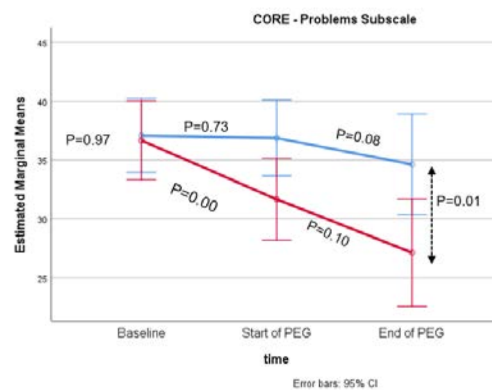
A: CORE - Risk



B: CORE - Wellbeing



A: CORE – Functioning



B: CORE – Problems

Figure 4-5 Plot of DASS subscale means and 95% confidence intervals for interaction effect. Cohort 1 (PEG+CFTG) is depicted as a blue line and Cohort 2 (PEG+TAU) is depicted as a red line.

When the significant scores were recalculated on an intention to treat basis over the period of the intervention for Cohort 2, both Wellbeing (C2: f=1.840, p=0.18) and Functioning (C2: f= 2.074, p=0.16) dropped below significance.

In order to explore participant level change, the reliable change index was calculated for each participant in Figure *4-6* below (Jacobson & Truax, 1991).

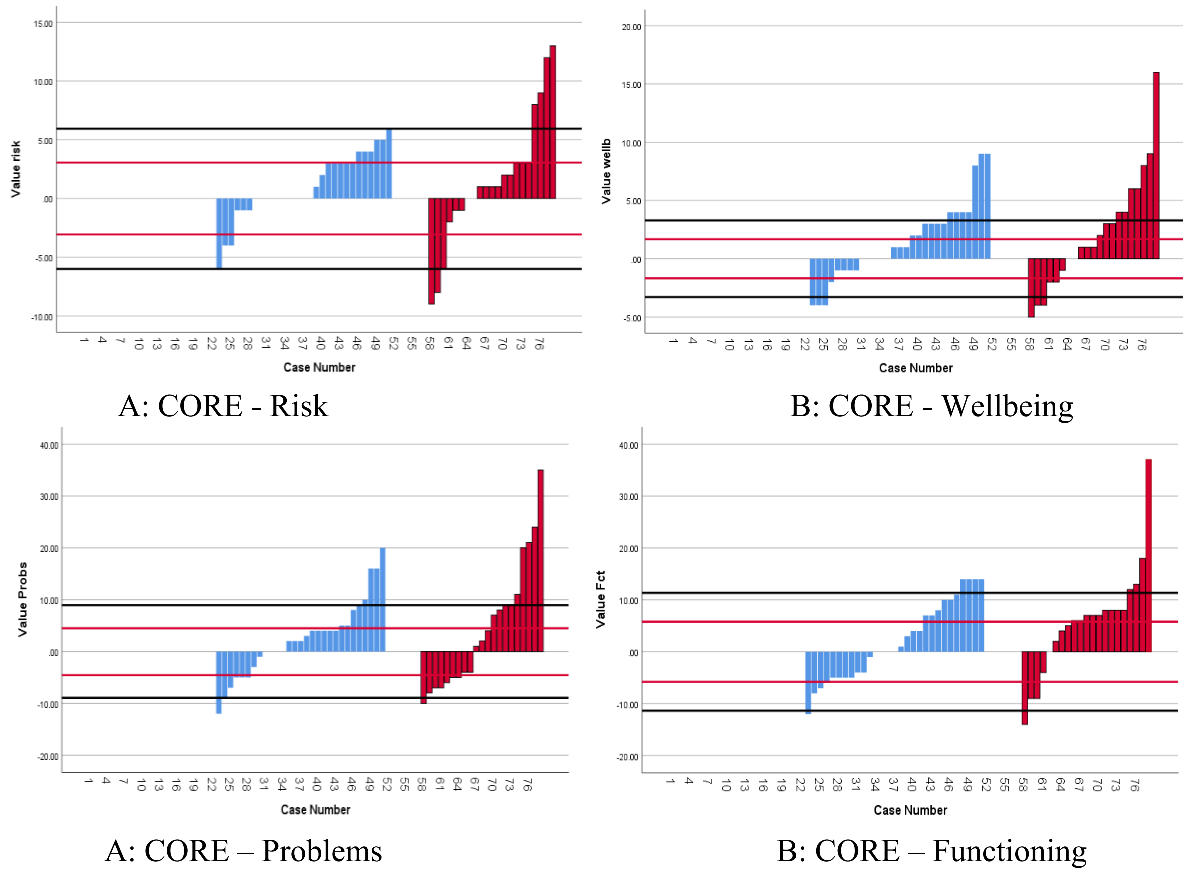


Figure 4-6 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the Cohort 1 and Cohort 2 reaching the criteria for clinical and statistical improvement or deterioration is shown in Table *4-7* below. These data show Risk and Wellbeing in Cohort 1 had a higher percentage of clinically meaningful improvement than Cohort 2.

Table 4-7 Percent of the Cohort 1 (CFTG) and Cohort 2 (TAU) Cohort reaching the criteria for clinical and statistical improvement or deterioration on the CORE subscales

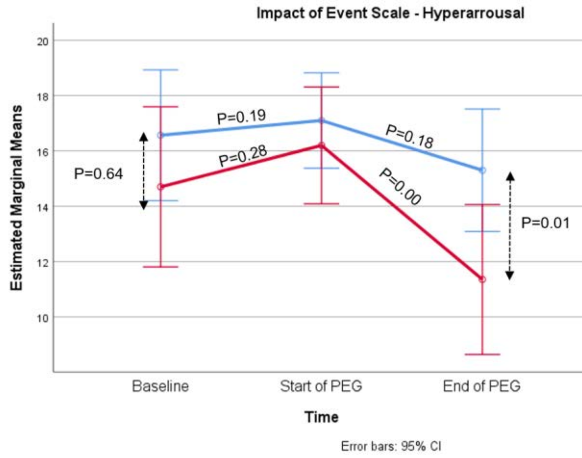
	Risk		**Wellbeing**		**Functioning**		**Problems**	
	C1:CFTG	C2:TAU	C1:CFTG	C2:TAU	C1:CFTG	C2:TAU	C1:CFTG	C2:TAU
Statistically reliable improvement	0%	19%	29%	33%	17%	14%	17%	24%
Clinically meaningful improvement	25%	19%	54%	48%	42%	53%	33%	43%
Clinically meaningful deterioration	12%	14%	17%	24%	13%	13%	13%	33%
Statistically reliable deterioration	0%	5%	12%	14%	0%	4%	2%	5%

Impact of Event Scale

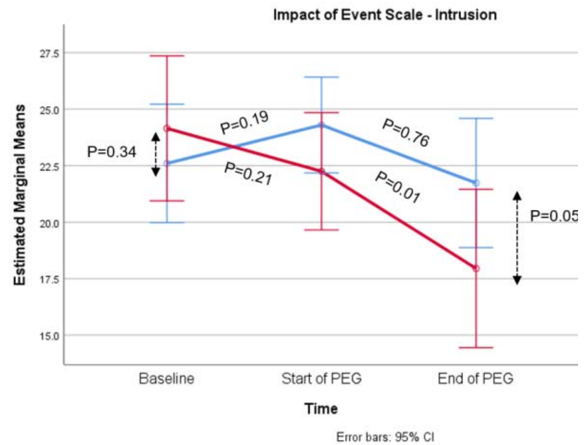
A repeat measure ANOVA compared the means of the measures at the baseline, start and end of intervention. There was a significant Greenhouse Gleissier adjusted F for change over time for Hyperarousal (f=6.792, p=0.00), Intrusion (f=7.07, p=0.01) and Avoidance (f=12.28, p=0.00).

The means and 95% confidence intervals for both Cohorts at each of the time measurement points are shown in Figure 4-7 below. Figure 4-7 charts A to C show a significant improvement on the all subscale for Cohort 2 only across the duration of the 12-week PEG. The difference between the Cohort 1 and Cohort 2 scores at the end of the intervention was statistically significant for all subscales.

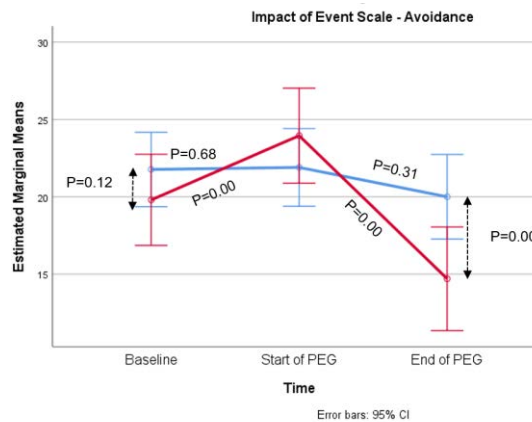
There was no significant difference between the two Cohorts for all subscales and a significant deterioration over time during the baseline phase for Avoidance for Cohort 2.



A: IES – Hyperarousal



B: IES – Intrusion

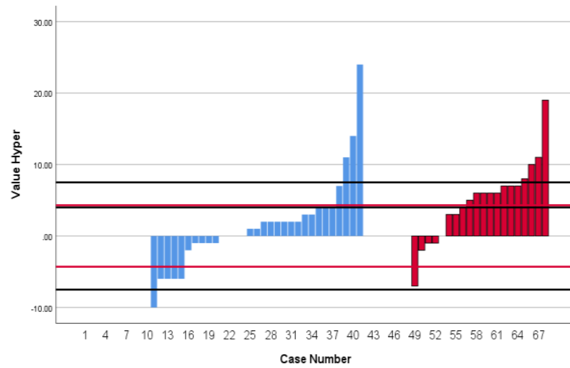


C: IES – Avoidance

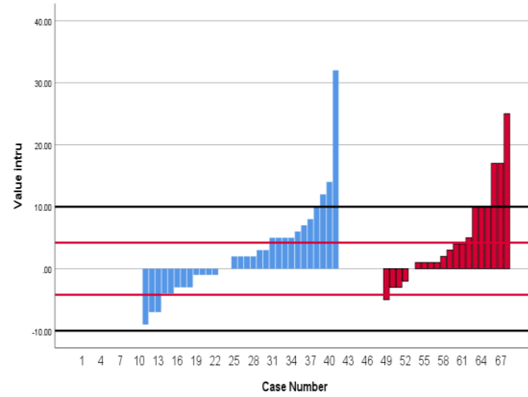
Figure 4-7 Plot of IES subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two is depicted as a red line.

When the significant scores for Cohort 2 were recalculated on an ITT basis over the period of the intervention, all remained significant, Hyperarousal (C2: f=10.436, p=0.00), Intrusion (C2: f=3.975, p=0.05) and Avoidance (C2: f=11.988, p=0.00).

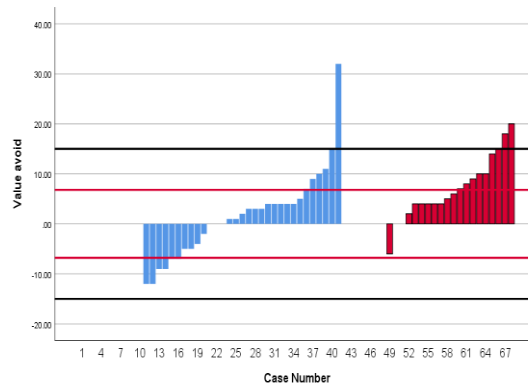
In order to explore participant level change, the reliable change index was calculated for each participant, see Figure *4-8* (Jacobson & Truax, 1991).



A: IES – Hyperarousal



B: IES – Intrusion



C: IES – Avoidance

Figure 4-8 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentages of Cohort 1 and Cohort 2 reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 4-8. These data show Cohort 1 had a higher % of clinically meaningful improvement than Cohort 2 for Intrusion.

Table 4-8 Percent of the C1 (PEG+CFTG) and the C2 (PEG+TAU) Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the IES subscales

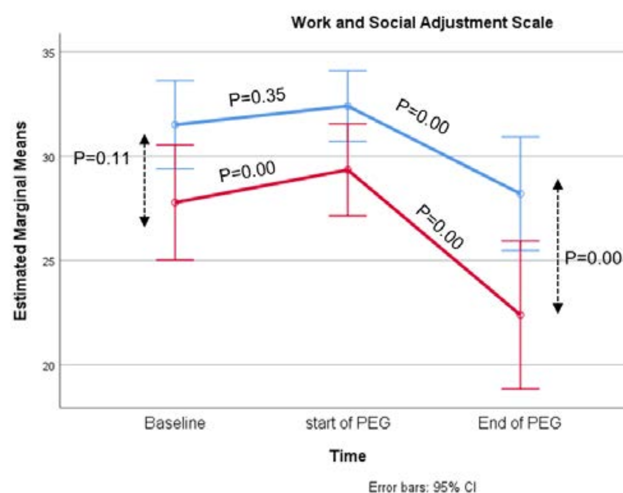
	Hyperarousal		**Intrusion**		**Avoidance**	
	C1:	C2:	C1:	C2:	C1:	C2:
Statistically reliable improvement	12%	20%	12%	10%	4%	10%
Clinically meaningful improvement	16%	40%	45%	35%	25%	38%
Clinically meaningful deterioration	17%	20%	10%	5%	17%	0%
Statistically reliable deterioration	2%	0%	0%	0%	0%	0%

Work and Social Adjustment Scale

A repeat measure ANOVA compared the means of the measures at the baseline, start and end of intervention. There was a significant Greenhouse Gleissier adjusted F for change over time (f=23.53, p=0.00).

The means and 95% confidence intervals for both Cohorts at each of the time measurement points are shown in Figure 4-9. Figure 4-9 chart A show a significant improvement on both the Cohorts only across the duration of the 12-week PEG. The difference between the Cohort 1 and Cohort 2 scores at the end of the intervention was statistically significant.

There was no significant difference between the two Cohorts and a significant deterioration over time during the baseline phase for Cohort 2.

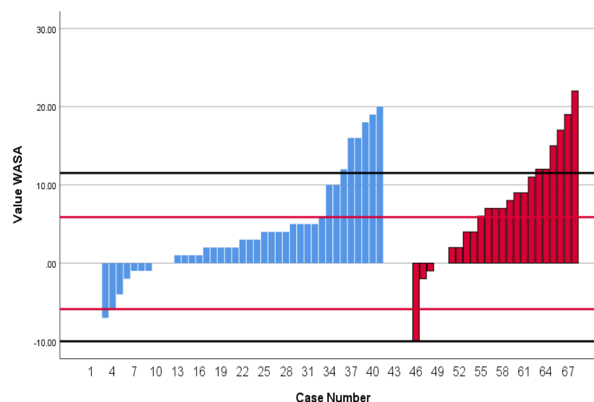


A: WASA

Figure 4-9 Plot of WASA subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two is depicted as a red line.

When these tests were recalculated on an intention to treat basis over the period of the intervention, the significant improvements were maintained for both Cohorts at (C1: f=17.464, p=0.00; C2: f=24.398, p=0.00).

In order to explore participant level change, the reliable change index was calculated for each participant, Figure 4-10 (Jacobson & Truax, 1991).



A: WASA

Figure 4-10 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the Cohort 1 and Cohort 2 reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 4.9. These data show Cohort 2 had a higher % of clinically meaningful improvement than Cohort 1.

Table 4-9 Percent of the C1 (PEG +CFTG) and the C2 (PEG +TAU) Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the CORE subscales

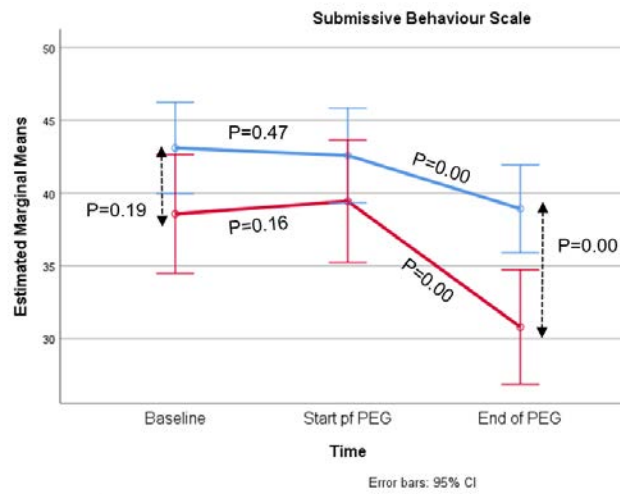
	WASA	
	C1:	C2:
Statistically reliable improvement	15%	26%
Clinically meaningful improvement	21%	57%
Clinically meaningful deterioration	2%	4%
Statistically reliable deterioration	0%	0%

Process Measures

Submissive Behaviour Scale

A repeat measure ANOVA compared the means of the measures at the baseline, start and end of intervention. There was a significant Greenhouse Gleissier adjusted F for change over time (f=28.43, p=0.00).

The means and 95% confidence intervals for the two Cohorts at each of the time measurement points are shown in Figure 4.11 below. There was no significant difference, at the start, between the two Cohorts. Over the period of the intervention there was a significant improvement in both treatment and control Cohorts.

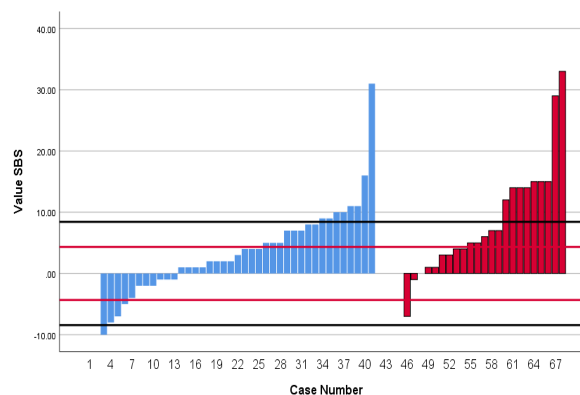


A: SBS

Figure 4-11 Plot of SBS subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two is depicted as a red line.

When these tests were recalculated on an intention to treat basis over the period of the intervention, the significant improvements were maintained for both Cohorts at (C1: f=8.782, p=0.00; C2 f=21.073, p=0.00).

In order to explore participant level change, the reliable change index was calculated for each participant, Figure 4-12 (Jacobson & Truax, 1991).



A: SBS

Figure 4-12 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the Cohort 1 and Cohort 2 reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 4-10. These data show that Cohort

2 had a higher % of clinically meaningful and statistically reliable improvement than Cohort 1.

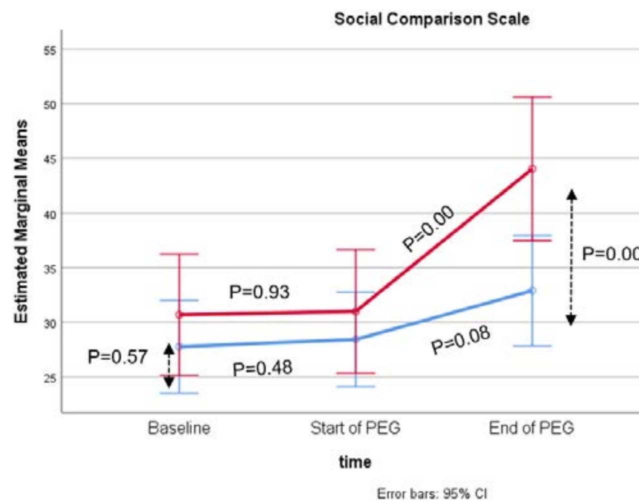
Table 4-10 Percent of the C1 (PEG+CFTG) and the C2 (PEG+TAU) Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the SBS subscales.

	SBS	
	C1:	C2:
Statistically reliable improvement	20%	39%
Clinically meaningful improvement	40%	61%
Clinically meaningful deterioration	10%	4%
Statistically reliable deterioration	2%	0%

Social Comparison Scale

A repeat measure ANOVA compared the means of the measures at the baseline, start and end of intervention. There was a significant Greenhouse Gleissier adjusted F for change over time (f=17.88, p=0.00).

The means and 95% confidence intervals for the two Cohorts at each of the time measurement points are shown in Figure 4-13. There was no significant difference between the two Cohorts. Over the period of the intervention there was a significant improvement in Cohort 2 only.

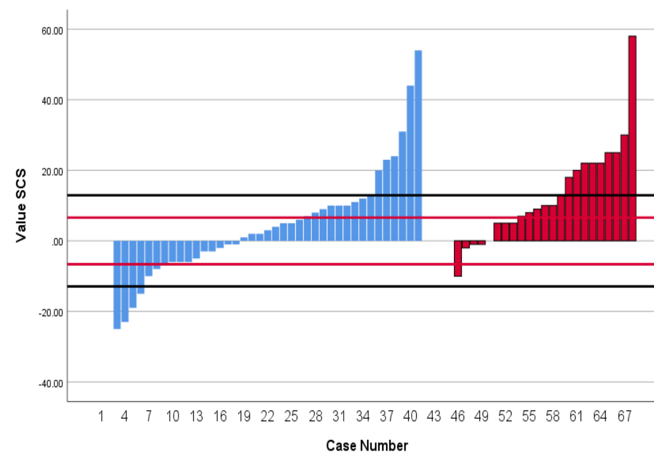


A - SCS

Figure 4-13 Plot of SCS subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two is depicted as a red line.

When these tests were recalculated on an intention to treat basis over the period of the intervention, the significant improvements were maintained for Cohort 2 at (C2: f=13.934, p=0.00).

In order to explore participant level change, the reliable change index was calculated for each participant, Figure 4-14 (Jacobson & Truax, 1991).



A - SCS

Figure 4-14 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the Cohort 1 and Cohort 2 reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 4-11. These data matched the outcomes for the other social rank measures.

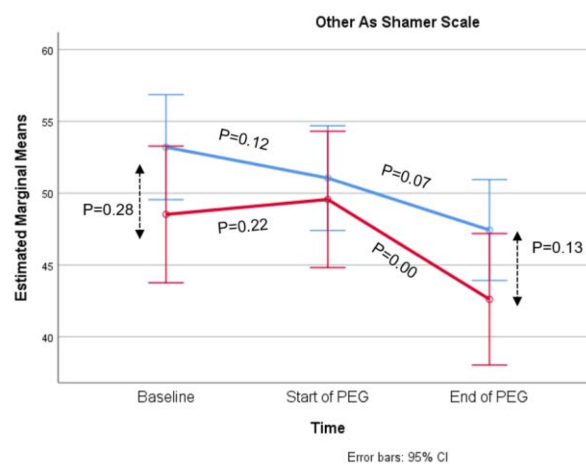
Table 4-11 Percent of the C1 (PEG + CFTG) and the C2 (PEG +TAU) Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the SBS subscales

	SCS	
	C1:	C2:
Statistically reliable improvement	15%	39%
Clinically meaningful improvement	36%	61%
Clinically meaningful deterioration	15%	4%
Statistically reliable deterioration	10%	0%

Other as Shamer Scale

A repeat measure ANOVA compared the means of the measures at the baseline, start and end of intervention. There was a significant Greenhouse Gleissier adjusted F for change over time (f=17.88, p=0.00).

The means and 95% confidence intervals for the two Cohorts at each of the time measurement points are shown in Figure 4-15. There was no significant difference between the two Cohorts. Over the period of the 12 week PEG intervention there was a significant improvement in Cohort 2 only.

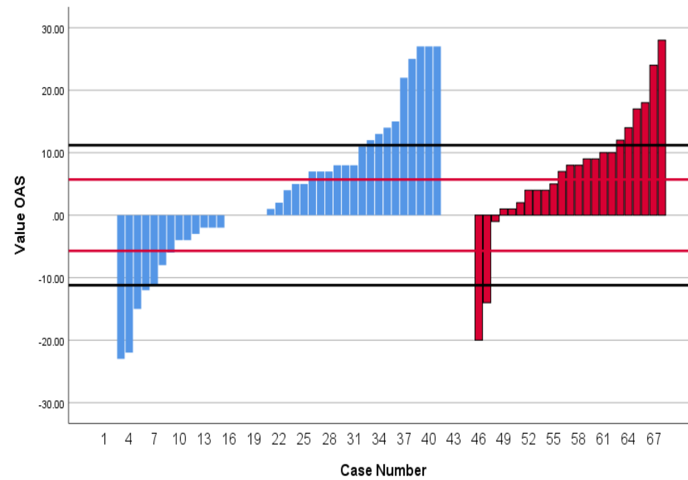


A - OAS

Figure 4-15 Plot of OAS subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two is depicted as a red line.

When these tests were recalculated on an intention to treat basis over the period of the intervention, the significant improvements were maintained for Cohort 2 at (C2: f=10.141, p=0.00).

In order to explore participant level change, the reliable change index was calculated for each participant, Figure 4-16 (Jacobson & Truax, 1991).



A – OAS

Figure 4-16 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the Cohort 1 and Cohort 2 reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 4-12 below. These data show that Cohort 2 had a higher % of clinically meaningful improvement than Cohort 1.

Table 4-12 Percent of the C1 (PEG + CFTG) and the C2 (PEG + TAU) Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the SBS subscales

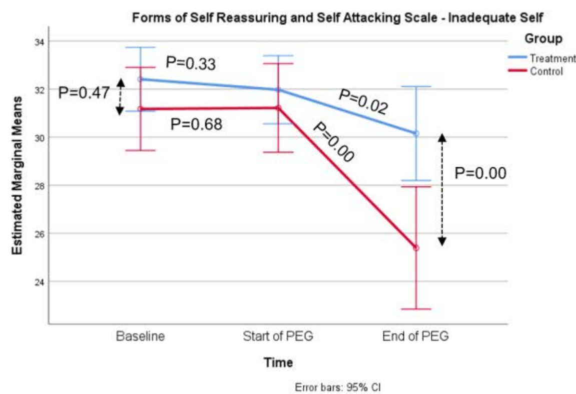
	OAS	
	CFTG	TAU
Statistically reliable improvement	23%	26%
Clinically meaningful improvement	41%	57%
Clinically meaningful deterioration	15%	9%
Statistically reliable deterioration	10%	0%

Forms of Self Reassuring and Self Attacking Scale

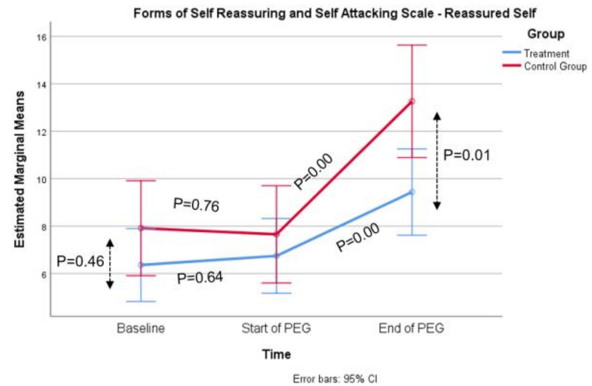
A repeat measure ANOVA compared the means of the measures at the baseline, start and end of intervention. There was a significant Greenhouse Gleissier adjusted F for change over time for Inadequate Self (f=23.34, p=0.00), Reassured Self (f=28.76, p=0.00) and Hated Self (f=18.46, p=0.00).

The means and 95% confidence intervals for the two Cohorts at each of the time measurement points are shown in Figure 4-17. There was no significant difference between the two Cohorts in any of the three subscales, at the commencement of the intervention and

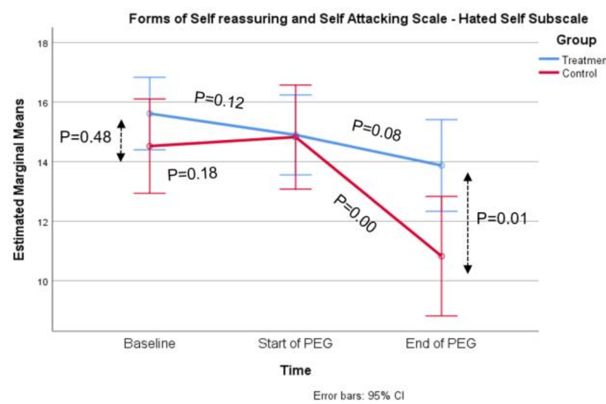
no significant changes during the baseline period. Over the period of the 12 week PEG intervention both Cohorts achieved significant improvement with the exception of Cohort 1 in the Hated Self subscale.



A: FSRSA – Inadequate Self



B: FSRSA – Reassured Self



C: FSRSA – Hated Self

Figure 4-17 Plot of IES subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort 2 is depicted as a red line.

When these tests were recalculated on an intention to treat basis over the period of the intervention, the significant improvements were maintained for both Cohorts for Inadequate Self (C1: f=5.074, p=0.03; C2: f=13.179, p=0.00) and Reassured Self (C1: f=10.833, p=0.00; and C2: f=12.737, p=0.00). For Hated Self Cohort 2 remained significant at (C2: f=9.759, p=0.00).

In order to explore participant level change, the reliable change index was calculated for each participant, Figure 4-18 (Jacobson & Truax, 1991).

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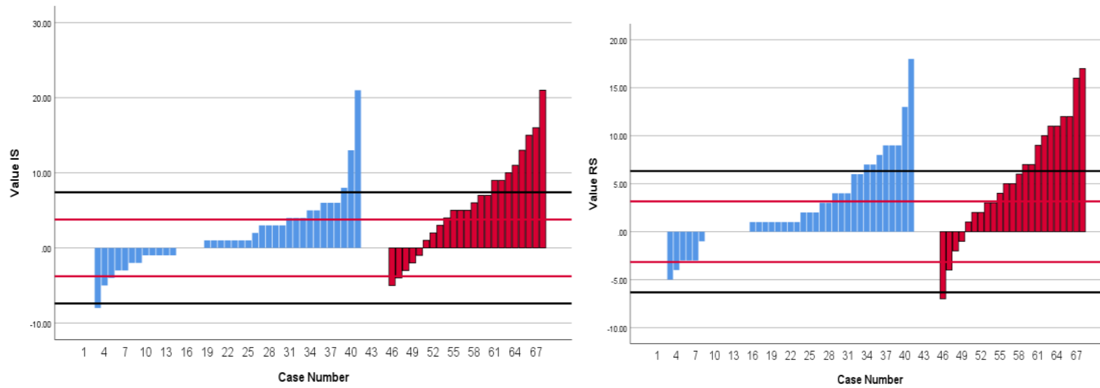
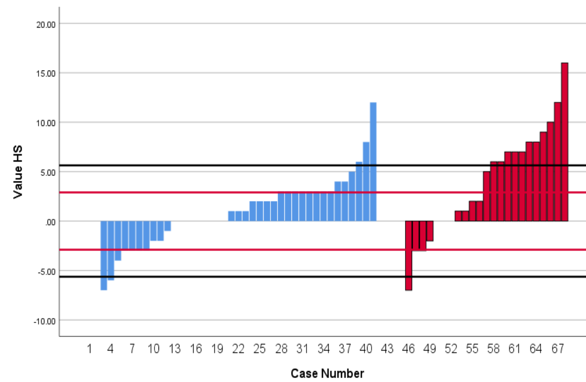


A: FSRSA – Inadequate Self B: FSRSA – Reassured Self



C: FSRSA – Hated Self

Figure 4-18 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the Cohort 1 and Cohort 2 reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 4-13.

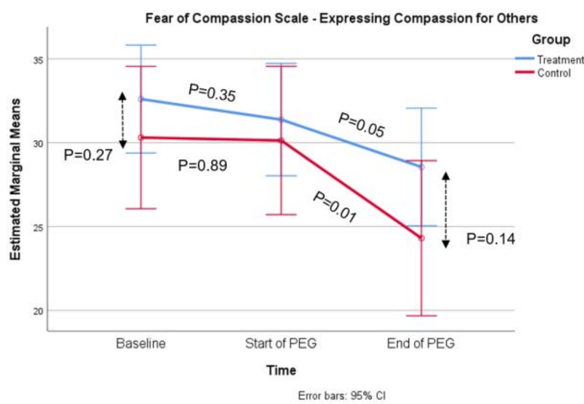
Table 4-13 Percent of the C1 (PEG + CFTG) and the C2 (PEG +TAU) Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the FSRSA subscales

	Inadequate Self		**Reassured Self**		**Hated Self**	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Statistically reliable improvement	8%	35%	21%	39%	8%	42%
Clinically meaningful improvement	21%	61%	33%	51%	15%	48%
Clinically meaningful deterioration	5%	9%	5%	9%	8%	4%
Statistically reliable deterioration	2%	0%	0%	4%	5%	4%

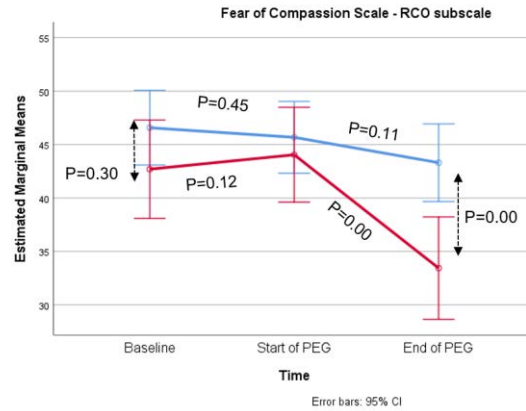
Fear of Compassion Scale

A repeat measure ANOVA compared the means of the measures at the baseline, start and end of intervention. There was a significant Greenhouse Gleissier adjusted F for change over time for Expressing Compassion for Others (f=9.87, p=0.00), Responding to the Expression of Compassion from Others (f=17.20, p=0.00) Expressing Compassion to Self (f=26.48, p=0.00).

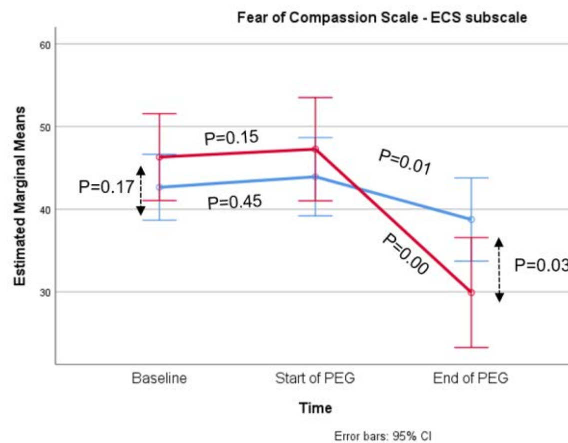
The means and 95% confidence intervals for the two Cohorts at each of the time measurement points are shown in Figure 4-19 below. There was no significant difference between the two Cohorts in any of the three subscales, at the commencement of the intervention and no significant changes during the baseline period. Over the period of the 12-week PEG intervention all Cohorts achieved significant improvement with the exception of Cohort 1 in the RCO subscale.



A: FCS – ECO



B: FCS - RCO

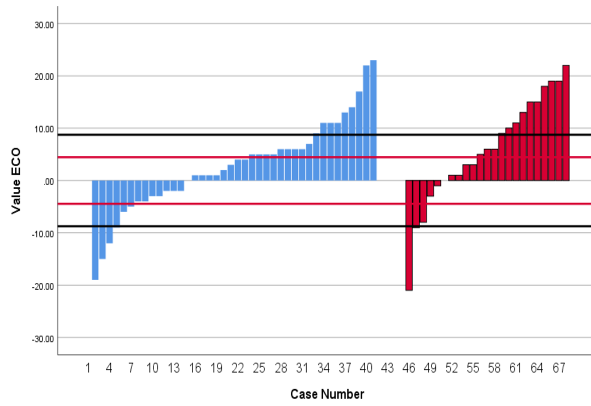


C: FCS - ECS

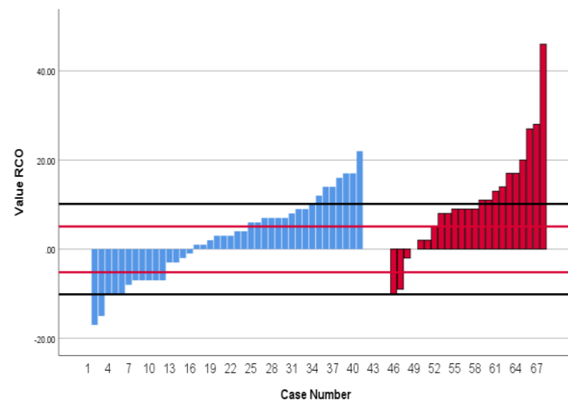
Figure 4-19 Plot of IES subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort 2 is depicted as a red line.

When these tests were recalculated on an intention to treat basis over the period of the intervention, the significant improvements were maintained for Cohort 2 for Responding to Compassion from Others (C2: f=20.207, p=0.00) and Expressing Compassion to Self (C2: f=19.119, p=0.00). All other subscales dropped to below significance Expressing Compassion to Others (C1 f=2.859, p=0.09; C2: f=2.484, p=0.12) and Expressing Compassion for Self (C2: 6.180, p=0.17).

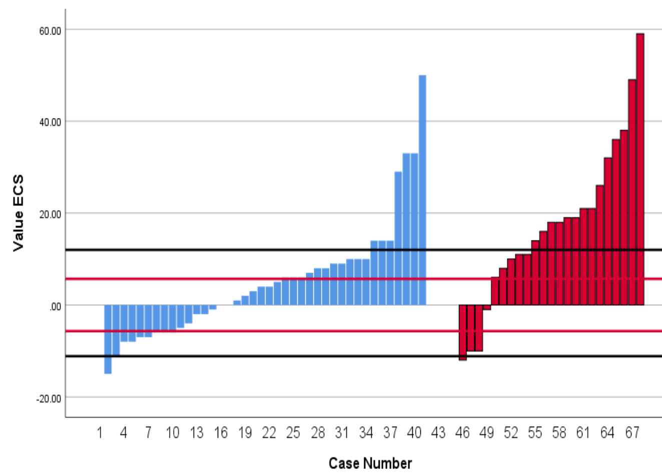
In order to explore participant level change, the reliable change index was calculated for each participant, Figure 4-20 (Jacobson & Truax, 1991).



A: FCS – ECO



B: FCS - RCO



C: FCS - ECS

Figure 4-20 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the Cohort 1 and Cohort 2 reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 4-14. In the case of ECO the % of deterioration was higher in Cohort 2.

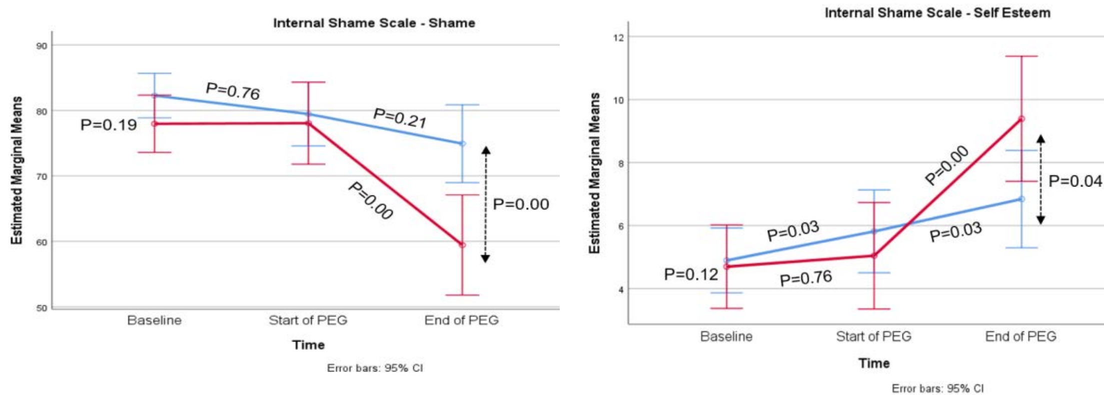
Table 4-14 Percent of the C1 (PEG + CFTG) and the C2 (PEG +TAU) Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the FC subscales

	ECO		**RCO**		**ECS**	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Statistically reliable improvement	20	39	18	43	18	61
Clinically meaningful improvement	45	57	43	67	38	78
Clinically meaningful deterioration	7	13	30	9	15	13
Statistically reliable deterioration	7	14	5	0	2	4

Internal Shame Scale – Shame

A repeat measure ANOVA compared the means of the measures at the baseline, start and end of intervention. There was a significant Greenhouse Gleissier adjusted F for change over time for Shame (f=18.79, p=0.00) and Self Esteem (f=16.88, p=0.00).

The means and 95% confidence intervals for the two Cohorts at each of the time measurement points are shown in Figure 4-21. There was no significant difference between the two Cohorts in either subscale, at the commencement of the intervention and no significant changes during the baseline period. Over the period of the 12-week PEG intervention all Cohorts achieved significant improvement with the exception of Cohort 1 in the Shame subscale.

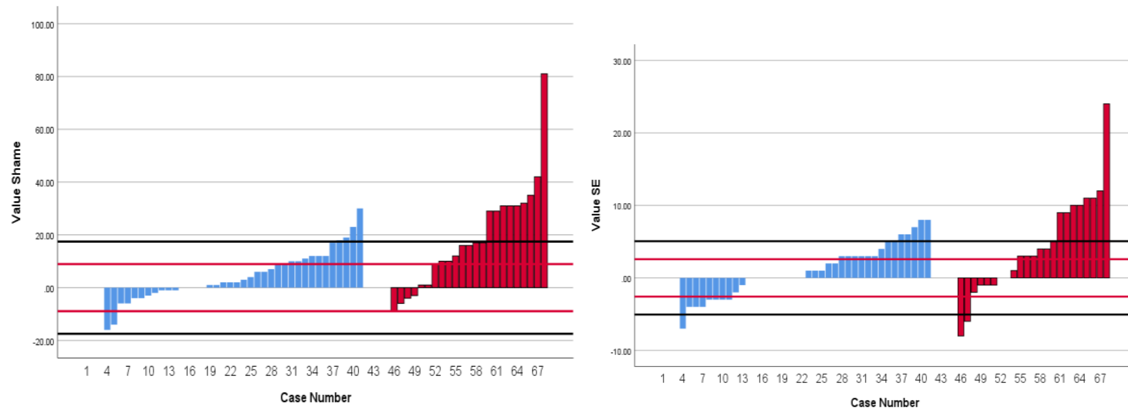


A: ISS – Shame B: ISS – Self Esteem

Figure 4-21 Plot of IES subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two is depicted as a red line.

When these tests were recalculated on an intention to treat basis over the period of the intervention, the significant improvements were maintained for Cohort in both subscales, Shame (C2: f=21.219, p=0.00) and Self Esteem (C2: f=7.74, p= 0.01. Whereas for Cohort 1 the Self Esteem subscale dropped below significance at (C1: f=3.510, p=0.06).

In order to explore participant level change, the reliable change index was calculated for each participant (Figure 4.-22).



A: ISS – Shame B: ISS – Self Esteem

Figure 4-22 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the Cohort 1 and Cohort 2 reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 4-15.

Table 4-15 Percent of the C1 (PEG +CFTG) and the C2 (PEG +TAU) Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the FC subscales

	Shame		Self Esteem	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Statistically reliable improvement	8	43	20	35
Clinically meaningful improvement	28	70	36	61
Clinically meaningful deterioration	5	0	10	9
Statistically reliable deterioration	0	0	2	9

The association between the outcome variables and the therapy process

In order to assess the association between the symptoms/outcome variables and the therapy process variables, a correlational table of change scores for symptom measures and change scores from process measures were calculated. This correlation matrix is shown in Table 4-16.

The change scores for each subscale were calculated for the whole data set, cohort 1 and cohort 2, followed by a Pearson's correlation to establish the significance of the corelations. The same analysis was conducted for the start scores and this revealed no significant corelations, therefore it can be concluded that Table 4-16 shows the correlations which are a result of the intervention.

Table 4-16 Correlational Table of Outcome scores for therapy process and outcome

	Internal Shame Scale (Shame)	Internal Shame Scale (Self Esteem)	Other As Shamer Scale	Submissive Behaviour Scale	Social Comparison Scale	The Forms of Self Criticising / attacking and self Reassuring (Inadequate Self)	The Forms of Self Criticising / attacking and self Reassuring (Reassured Self)	The Forms of Self Criticising / attacking and self Reassuring (Hated Self)	Fear of Compassion Scale (Expressing compassion for Others)	Fear of Compassion Scale (Responding to compassion from others)	Fear of Compassion Scale (Expressing compassion for self)
problems	.402**					.383**	.320*				
Functioning	.449**	.307*	.318*	.362*	.341*	.312*	.315*	.422**		.327*	
wellbeing			.411**		.366*	.376**	.396**	.380**		.331*	
risk	.349*		.324*				.347*				
WSAS	.357**	.310*	.387**			.575**	.481**	.441**		.470**	.394**
avoidance	.456**		.286*			.367**	.348*	.427**		.475**	.389**
intrusion	.370**									.305*	.342*
hyper	.523**					.379**	.378**	.399**		.504**	.406**
stress	.394**		.479**	.396**	.338**	.431**	.500**	.426**		.362**	.330**
Depression	.460**	.282*	.460**	.421**	.520**	.597**	.531**	.543**		.516**	
Anxiety	.358**		.521**	.573**	-.268*		.335**	.436**		.425**	.278*

Key to colour coding - darker red = great size of correlation

Social Rank Measures

Internal Shame Scale

This measure has two subscales and measures the subjective experience of internal shame and self-esteem. Shame is highly positively correlated with all the symptom measures with the exception of wellbeing, in that high shame scores link with high symptom of distress, PTSD, depression, anxiety and stress.

Other as Shamer Scale

This measure was developed to evaluate the responders experience of external shame. The measure is most strongly correlated with symptoms Anxiety, followed by Stress, Depression and struggling with Wellbeing. Less strongly correlated was issues of risk, functioning, avoidance and managing the activities of daily living.

Submissive Behaviour Scale

This scale measures the behavioural frequency of submissive behaviour. This scale also corelated very strongly with symptoms of Anxiety, Depression and Stress, with a weaker association with perceived Functioning difficulty. This measure was not associated with any other symptom measures and subscales.

Social Comparison Scale

This scale measures self-perceptions of social rank and relative social standing. This scale was very strongly corelated with Depression and slightly less so with Stress. There was weaker but still significant to (>0.05) correlations with Functioning and Stress.

Self to Self-relating Measures

The Forms of Self Criticising / Attacking and Self Reassuring Scale

This scale was developed to measure self-criticism and the ability to self-reassure. The Inadequate Self subscale was most strongly correlated with Depression and Work and Social Adjustment, followed by Stress, Hyper Arousal, Avoidance, difficulties with Wellbeing. There were weaker correlations with Problems and Functioning, significant at >0.05.

The Reassured Self subscale is reversed scored was most strongly negatively correlated with Stress, Depression and struggle with activities of daily living, followed by Anxiety, Hyperarousal, and wellbeing. There was a slightly lower level of significant correlation (>0.05) observed for functioning, problems and risk.

The Hated Self subscale was again highly correlated with Depression, Anxiety, Stress, Avoidance, Functioning, struggle with activities of daily living and Avoidance with a slightly lower level of correlation with Wellbeing and Hyperarousal.

Fear of Compassion Scale

This scale measures responders experience of fearful feelings and thoughts about compassion across three areas, fear of compassion for self, for others and from others.

The Fear of Expressing to Others was the only process measure not to have any significant correlations with the symptom measures.

The Fear of Responding to Compassion from others was strongly correlated with Depression, Hyperarousal, followed by Anxiety, Avoidance and Difficulties with activities of daily living. There was slightly weaker correlation (>0.05) with Intrusion, Wellbeing and Functioning.

The Fear of Expressing Compassion to self was quite highly correlated with Hyperarousal Stress, Avoidance and Difficulties with activities of daily living and less strongly corelated (>0.05) with Intrusion and Anxiety.

Discussion and conclusions

Symptom and Adjustment Measures Summary

In the case of Cohort 2 (PEG+TAU) all symptom and process measures, with the exception of Risk (CORE) and Problems (CORE), were significantly improved at the end of PEG intervention. This was maintained following the ITT analysis with the exception of Wellbeing (CORE) and Functioning (CORE). It is possible that as CORE is a generic

measures may be less sensitive to change, coupled with the lower levels of completion of this measure (24% of missing data).

Within Cohort 1 (PEG+CFTG) significant change was reached in only Work and Social Adjustment, and Depression (DASS), both significant scores were maintained following ITT, indicating a significant difference in response to the 12-week PEG on a symptomatic level.

The Reliable Change, individual scores analysis supported these data with most participants showing "clinically meaningful" improvement in Cohort 2 (PEG+TAU), with the exception of Risk (CORE). Interestingly the individual level deterioration in Cohort 2 was also higher for Problems, Wellbeing (CORE), Hyperarousal (IES) and Work and Social Adjustment Scales. This result suggests that the mean calculations for Cohort 2 mask some individual deterioration across a spectrum of symptomatic change (Appendix .

Process Measures Summary

Similarly, all process measure changes for the Cohort 2 were significant in both the completer only and intention to treat analyses. The exception to this was Expressing Compassion for Others (FCS) which dropped below significance after the ITT, indicating a lower magnitude of change in the experience of fear associated with expressing compassion to others.

Cohort 1 achieved significant level change in SBS, Inadequate Self, Reassured Self (FSRSA), Expressing Compassion for Others (FCS), Expressing Compassion to Self (FCS) and Self Esteem (ISS). Following the ITT analysis only Submissive Behaviour Scale, Inadequate Self and Reassured Self (FSRSA) maintained significance.

The Reliable Change Analysis supports the findings from the comparative analysis of the two Cohorts, with most of Cohort 2 participants demonstrating clinically meaningful improvement. Inadequate Self and Hated Self (FSRSA) measures reached a much lower level of improvement in Cohort 1. Indicating that the level of self-criticism and self-hatred remained relatively high at the end of 12-week PEG. It may be that this data can be explained by the differences in diagnosis coupled with the strong corelations between a personality

disorder diagnosis and the experience of self-criticism and associated self-hatred (Donald & Lawrence, 2019; Feli-Sola et al., 2019; Kopala- Sibley et al., 2012; Warren 2015).

When observing the results as a whole there is generally a greater level of improvement in the process than the symptoms measures, particularly with regard to the individual change analysis. This is an interesting finding given that the PEG is designed to stabilise participants to facilitate engagement in more exploratory work in the Phase Three (CFTG) of the treatment. Given the participant group and the prevalence of adjustment difficulties linked to early trauma demonstrated by high baseline scores on all measures of distress and disturbance, it is reasonable to expect deterioration and decompensation at the commencement of therapy for some participants (Leibovich, 1975; Yalom 2010). The diagnostic differences may be of relevance here in understanding the differential responses to the 12-week PEG. See Appendix G for a summary of key RCI findings.

Symptom and Process Measure Correlations

Overall, the analysis demonstrated a significant association between change in most symptom and process variables, with a particular correlation between the Depression, Anxiety and Stress (DASS) measures and all process variables. Indicating that the process of PEG overall, which directly addressed issues of social rank (SBS, SCS, OAS), self criticism and Shame (FSRSA and ISS) and capacity for compassion (FCS), had a particular positive effect on symptoms of general mental health. These data support the findings of two studies which have explored the specific mechanisms of change in CFT (Cuppage et al., 2017; Fox et al., 2020).

The notable exception to this was the lack of any significant correlations between Expressing Compassion to Others (FCS) and all symptom measures. In that it seems that a reduction in the fear of ECO did not connect with symptomatic improvement. It is also of note that change on the ECO subscale was not robust to an ITT analysis. However, it is also possible that increased capacity for ECO may have been less ‘valued’ by the participants, given the propensity for self-criticism in both cohorts and therefore not linked in a meaningful way to symptomatic improvement. Further research will be required to explore this hypothesis.

Overall conclusions

The 12-week PEG demonstrated highly significant improvement across all process and symptom measures following analysis of the data set as a whole. As a result of significant differences in diagnostic category between the two Cohorts, the data were also analysed separately. The Cohort specific analysis showed a significant difference in many scales between the two Cohorts, with Cohort 2 (PEG + TAU) showing significant early gains, which in many cases were not matched by Cohort 1 (PEG + CFTG).

The level of variance in the data and response to the initial 12-week PEG intervention could be explained, at least in part, by the significant difference in the diagnostic categories of the two cohorts. The method of delivery, however, is specifically geared towards those whose interpersonal difficulties make trust and exploration within psychotherapy problematic (cf Chapter 1 - Introduction). This upbeat, light-hearted, play based approach to the model delivery may result in patients with an underlying psychotic illness becoming overstimulated by the therapeutic process which could in turn lead to an overreporting of improvements.

Another potential confound was that Cohort 2 were aware that they were only receiving a 12-week intervention and Cohort 1 were aware that they were going to receive a further 40 weeks of treatment. It is likely that the awareness of subsequent treatment plans set up different expectations of therapy and contributed to the different patterns of outcome.

It is of note that the concept of ‘early gains’ is well documented in the literature and refers to the potential for some patients engaging in short term therapeutic interventions. In these cases, the gains are maintained and an indicator of therapeutic capacity on the part of the patient (Clerkin et al. 2008; Norton et al. 2010). In the case of Cohort 2, this could be linked to an observed phenomenon for people with a diagnosed psychotic illness related to the experience of 'inter-personal validation’, the importance of social connection and the capacity to make use of this. This could provide another explanation for the early improvements in the context of group therapy (Heriot-Maitland et al., 2012).

Chapter 5: Effects of 40-Week Compassion Focused Group Trauma Group compared with Cohort 2 Treatment as Usual Group

The previous chapter examined the efficacy of the 12-week PEG programme across the two Cohorts. The analysis of these data showed a generally high level of significant changes across all symptom, process and adjustment measures. However, in many cases there were differences in the way in which the two Cohorts responded to the 12-week programme (with significantly greater gains in symptom and process level reduction being achieved by Cohort 2). The previous chapter discussed some of the possible explanations for the differences between Cohort 2 (PEG+TAU) and Cohort 1 (PEG+CFTG), in particular the concept of early gains was explored as a means of explaining the differential responses to the PEG.

In the absence of any marked difference in the treatment program the differential outcomes from the Preparation and Engagement (PEG) phase remains something of a conundrum.

This chapter will develop upon the outcomes from the PEG (observed in the previous chapter) by looking at the long-term trajectory of the PEG phase in those participants that received treatment as usual compared with those participants who went on to receive an additional 40 weeks of exploratory Compassion Focused Trauma Group (CFTG).

Introduction

Chapter 4 introduced the Compassion Focused Group Psychotherapy (CFGP) program with a focus on the Assessment and Preparation and Engagement (PEG) Phase (see Table 4.1 Chapter 4). This chapter will first introduce the key components of the 40-week Compassion Focused Trauma Group (CFTG) with reference to the current available literature on group-based interventions for people with Attachment and Relational Trauma (A&RT).

The structure of the 40-Week Compassion Focused Trauma Group (CFTG)

The 12-week PEG phase is viewed as preparation for the 40-week CFTG phase. Therefore, participants are invited to join the 40-week CFTG, immediately following completion of the PEG. This transition into the 40-week CFTG is made with the participant or participants who commenced the programme at the same time as described in Chapter 4. This element of the programme is designed to aid the transition between the two aspects of the group program by providing participants with a source of support.

The slow open format as described in Chapter Four can be helpful in that participants are invited to join a programme which is already 'running' and thereby have access to support from existing group members who can normalise anxieties about the group.

The transition into the CFTG group phase can also be unsettling for participants, as they may have become accustomed to the membership of the 12-week PEG and disruption is experienced when they join the new group. This can link with a sensitivity to instability and change common among participants who have experienced early A&RT (Yalom & Leszcz, 2005; Van de Kleji, 2013). The experience of emotional tension in group also has an interdependent connection with group cohesion in that each of these group processes supports the development of the other (Yalom & Leszcz, 2005). Thereby the difficulties associated with managing the move from the PEG to the CFTG, once navigated can serve to deepen the bonds and connections between the participants in the programme.

However, the basic elements of the group program remain the same as the 12-week PEG, to enable participants to have some sense of familiarity in the midst of the change of group (see Table 5-1 below).

Table 5-1 Basic elements of the weekly group session - CFTG

Component	Purpose
Soothing Breathing Rhythm Practice (SBR)	Creating predictable ritual for group
	Introducing Compassionate Mind Training and self-practice
	Creating a Safe Haven and Secure Base function
Feedback from the SBR Breathing Practice	Turn taking
	Social skills training
	Informal teaching and validation around SBR
Check in with participants	Turn taking
	Social skills training
	Gathering information for trauma work
Compassion Focused Trauma Work	Putting the developed capacity for compassion to 'work'
	Compassionate Transformation work, resolving early trauma

These same elements can also present significant challenges for many, in particular those whose early attachments ruptures and trauma have resulted in coping strategies or defences which can manifest in seeming contempt and / or disregard for the group.

Some examples of this may be consistent timekeeping issues, struggling with 'turn-taking', altering the layout of the chairs. These can be understood and formulated in the context of understandable fears associated with the sense of connection and belonging to the group and the activation of the attachment system which inevitably accompanies this experience. One participant who insisted on moving his chair every week so that it was not line with the others, noted that his need to move the chair lessened as the weeks passed and he was more able to tolerate the sense of belonging to the group and compassion for fellow group members. This example demonstrates in a small way, how the slow-paced consistency of the group programme is enabling patients to create new attachment relationships with peers and therapists (Flores & Porges, 2017; Millar-Bottome et al., 2019).

The key area of difference in the CFTG program structure is the shift from the introduction of the basic evolutionary psychology model in the modules, designed to lay a foundation of shared understanding of the principles and practice of compassion (cf chapter 4) to the Compassion Focused Trauma work.

Phase Three - Compassion Focused Trauma Group (CFTG)

There are also a number of explicit therapeutic techniques coupled with a general therapeutic style, which is slow paced and supportive (Flores & Porges, 2017) designed to cultivate and then maintain a sense of safeness for patients undertaking compassion focused trauma work. Much of this relates to the need to ensure that patients feel in control of the process (Herman, 2002). For example, there is an explicit invitation for participants if needed to withdraw from the circle whilst remaining in the room, knowing that this will be understood and not challenged or questioned (Kipper, 1986). Group members can continue to participate in the group from this place or step out of the group process altogether, knowing that the therapists will inquire after them but that there will be no compulsion to participate or even respond.

The 'Compassion Focused Trauma Work' draws on key elements of Action Methods, whereby participants are invited to work through early traumatic memories, often with the use of objects or props (e.g. buttons, pebbles, scarfs and cubes) to represent people and places (Tomasulo, 1998; White, 2006). This process of symbolising can enable participants to achieve emotional distance from a particular memory or experience which reduces the risk of the memory triggering post-traumatic stress symptoms of reliving, overwhelming feelings and dissociation (Tomasulo, 1998). The memory is then transformed or put simply the ending changed, thus offering an opportunity for reattribution or new understanding to be made of the experience (Lee & James, 2012; Lucre, in press, 2020). Often the compassionate transformation will involve the participant coming to a realisation that what happened to them was not their fault and this is often follows hearing the view of the other group members.

The explicit focus on bringing the Compassionate Self or Compassionate Other to the situation is designed to build on the CMT training from the PEG phase of the group program. This intervention is designed to enabled participants to engage in 'motivational switching' which involves the explicit movement from a competitive threat focused orientation into a caring orientation. In other words, if therapies can help individuals shift from a competitive and potentially persecuting view of the world to more caring and cooperative one this will have a range of impacts on physiological systems (Gilbert, 2020). Over time this work is also

designed to offer the opportunity for a new internal perspective about the early trauma memory to be developed (Gilbert, 2019; 2020; Lee & James, 2012). This work is also designed to enable emotional processing and resolution of the trauma memories with the introduction of the compassionate perspective.

One way of explicitly inviting group members to support each other in the trauma work is through the request for members of the group to hold the place of the different aspects of the self or others who are being worked through and act as an auxiliary (Tomasulo, 1998). This work is designed explicitly and implicitly to support participants to cultivate their capacity for giving compassion to others, which is a key component of the therapy work.

This function offers the participant who is engaging in compassion focused trauma work to quite literally step out and observe the scene they are working with a degree of emotional distance (Kipper, 1986). Kipper (1986) identifies the benefits for the auxiliaries and observing members as it offers an opportunity for identification with the participant or vicarious modelling. Again, the idea of motivational switching is relevant here to develop the capacity of participants to move from one motivational state or orientation to another. These concepts are particularly pertinent for CFTG as members of the group are selected on the basis of their tendency towards self-criticism and experience of shame-based trauma (Gilbert & Proctor, 2006; Lucre & Corten, 2013). See Appendix H for a detailed case example of the Compassion Focused Trauma work.

Working with Conflict

"[In therapy] early familial conflicts are relived, but they are relived correctively."
(Yalom & Lesczc, 2005, p.86)

As the intensity of the group intervention increases there is often more conflict between the group members and difficulties arise in the transference with the therapists (Arlo, 2017; Bateman & Fonagy, 2016; Gilbert, 2003; Leiderman, 2020; Van de Kleij, 1983). Much has been written about the importance of understanding the 'enactments' in the room and finding ways to work with the material that is emerging in the room but also attending to the links with past relationships which may be unresolved Arlo, 2017; Bateman & Fonagy, 2016; Gilbert, 2003; Leiderman, 2020; Van de Kleij, 1983). Strauss, et al. (2006). Found that

stronger alliances supported working through the rupture and repair and resulted in improvement in symptoms of personality disorder. Safran, Muran, and Eubanks-Carter, (2011) explore the impact of rupture and repair on therapeutic outcome and concluded similarly that therapeutic alliance can improved outcomes.

Within the CFTG programme conflicts represent opportunities for participants to experience rupture-repair and reaffiliation processes that have often been starkly absent from their attachment relationships (Flores & Porges, 2017; Yalom & Leszcz, 2005). Much of the CFTG structure and process is geared around having created sufficient safeness in the room to allow for disagreements, challenging of authority and protesting at feeling treated unfairly/misunderstood (Flores & Porges, 2017) to occur and be compassionately worked through. Such in-session safeness (i.e. attachment security) is associated with higher levels of rupture resolution (Miller-Bottome et al., 2019).

The CFTG programme addresses the inevitable difficulties with rupture at this stage of the group process by the explicit cultivation of the Compassionate Self, which is then accessed and used to provide an alternative perspective and way of moving forward from difficult interactions. Often this can be successfully achieved with the use of extra chairs to facilitate the separation of the Threat Mind from the Compassionate (Wise) Mind. The use of role-taking as articulated in the previous section can also be used to invite group members who may be in conflict with one another to ‘role take ’each other and have a conversation. This exercise is designed to train and develop the capacity for mentalizing, holding other’s minds in mind, within a playful medium. These techniques and processes are all opportunities to exercise the vagal brake that down-regulates the intensity of threat-based defensive reactions to remain socially engaged long enough to repair/resolve ruptures (Flores & Porges, 2017).

Role of the Therapist

During the more discursive aspects of the group programme, particular attention to paid to the therapist’s stance and style. Stone (2017) suggest that the concept of self-psychology can be helpful to guide the therapeutic process particularly for those with A&RT. In that the empathic attuned response of the therapist can support the group members becoming more

able to more able to give / receive feedback and act as agents for change for each other, within an atmosphere of safeness and mutual respect (Stone, 2017; Yalom, 2006). The role of group facilitator is thus akin to that of a conductor (Dalal, 1998), guiding rather than instructing the orchestra how to play and when they are playing 'stepping back', allowing the process to unfold.

Within the CFTG programmes therapists are required to engage in their own self practice in compassion, which mirrors the CMT process (Kolts et al. 2016). This enables therapist to learn about compassion from the inside out, rather than on a purely theoretical basis. Additionally, this also supports the work of therapists in attending to their own responses within the therapeutic work (Kolts et al., 2016; Rihacek & Roubal, 2017; Stone, 2017). There is an implicit shift within the CFTG from a more vertical transference stance, where participants relate to the therapists in a more parental, authoritarian way to invite a more horizontal transference relationship, which is more sibling focused, in the group for both therapists and patients (Lorentzen, 2013; Yalom & Leszcz, 2005). This in practice means that the therapists work to flatten the hierarchy, leaving the group to perform tasks together to develop group cohesion, inviting group members in more explicit way to support, engage in sense making and resolve conflicts for each other (Burlingame et al., 2016; Haigh, 2013; Stone, 2017; Yalom & Leszcz, 2006; Van Der Kleij, 1985).

'Bookending' the Compassion Focused Trauma Work

Managing the impact on participants of engaging in this challenging and demanding psychotherapeutic work, has required specific interventions to be made a part of the group protocol to offer a source of containment (Cooke, 2014; White, 2006; Yalom, 2006). Following the conclusion of the explicit compassion focused trauma work, participants are invited to return to the circle of chairs, bringing an ending to the sharing aspect of the work and the group are invited to join up together for a period of reflection (White, 2006).

At this time participants are often explicitly reminded that the group is coming to close and space is given for a discussion about the experience of the work that has taken place. This is an opportunity for all participants to reflect on their experience of either observing or engaging in the CFTW. This closing component of the group is an opportunity to process

some of the emerging feelings (Tomasulo, 1998), explicitly reinforce the examples of compassionate behaviours across all three flows (Gilbert, 2017), and create a sense of affiliative connection between the group members by highlighting the shared experiences (Cooke, 2017; Wehle, 2017).

If, however, the level of emotional arousal has been particularly high, there may be occasions when this closing section of the group requires more active interventions. In this context the model offers the opportunity for spontaneous play focused activities (White, 2006). These games are contextualised to what is required by the group to either leave difficult unresolved feelings behind, increase the emotional energy in the room, reducing tension in the room. *"to promote spontaneity in a culture of play and to promote trust and communication between group members"* (Cooke, 2017, p.1).

Managing Endings

Managing endings in the context of group therapy has been a source of much focus in clinical research and commentary (Bernard et al. 2008; Dalal, 1998; White, 2006; Yalom & Leszcz, 2005). In the context of the ending for CFTG a specific protocol has been developed to facilitate the consolidation of the compassionate mind training work, integration of the affiliative experience of the group, saying goodbye and allowing for a process of grieving. The date of ending is planned from the outset and clearly articulated to the group. The rolling programme format means that group members will leave at different times and therefore each group member is invited to make choices about their ending process (Bernard et al. 2008). The regular experience of ending rituals in the CFTG programme is designed to habituate the group members to the reality of ending and also hopefully model tolerating the process.

Over time a group-based ritual has emerged which most participants have opted to take part in, which can create a sense of safeness and predictability around the ending stage of the group. The group member who is leaving chooses a cake or sweet treat which is then prepared by the group therapist which is intended to provide a reparative experience of marking significant events, in that many participants will have had the experience of birthdays and special occasions either being ignored or marred by trauma. The group starts in the usual way with the breath and check in, maintaining consistency for group. The therapists

will then make drinks for the group members which offers a further opportunity for the flattening of the hierarchy, in that the therapists explicitly move out of the tradition therapist role (Pearce & Haigh, 2008).

A gift giving exercise follows, in that the members who are leaving write a message for the group which is contained in a book and each remaining member will write to the person leaving with a message of encouragement and compassion for the next stage of their journey. These cards are given to the member leaving who is invited to either read them, have them read by the group members or to take them away from the group.

The ending phase of the group process involves the integration of therapy experience and tolerating the internalising of the care and understanding from the other members of the group. Acknowledging and practicing compassion for the self as the movement towards ending and individuation from the group. This involves a process of grieving for the loss of the group and the participants acknowledging the impact of the therapeutic process and future planning (Mangione et al, 2007; Schlesinger, 2013; Yalom & Leszcz, 2006;). It is anticipated that this therapeutic intervention will redress the experience of shame-based trauma, self-criticism, internal and external shame and improve general symptoms and activities of daily living.

Phase Four – the Moving On Group

The invitation for participants to continue to engage in 'peer led' support following the completion of the therapeutic intervention was designed to support a process of 'individuation' or separation from the therapists and the group whilst still receiving support from peers.

The development, structure and format of this group was developed by the participants and also included access to a private Facebook page, 'The 3 Circles Group'. At the point of ending, participants were given the contact details of the peer coordinator of the Moving On Group and invited to make contact if they wished to take part in the group. This element of the program was not evaluated as it was not part of the formal therapeutic process.

Aims and hypotheses

From the review of the current literature it is clear that there is a case for longer term treatment interventions for those presenting with attachment and relational trauma. The following specific hypotheses are posited

1. For those completing the 40-week CFTG group there will be a reliable and meaningful improvement in symptom level, adjustment level and process level outcomes. These improvements will be maintained when individual scores are examined.
2. There will be a significant difference between the 40-week CFTG Cohort and the treatment as usual Cohort.
3. Any reliable and meaningful improvement will be maintained when the outcome is evaluated on an intention to treat basis.

Method

Design

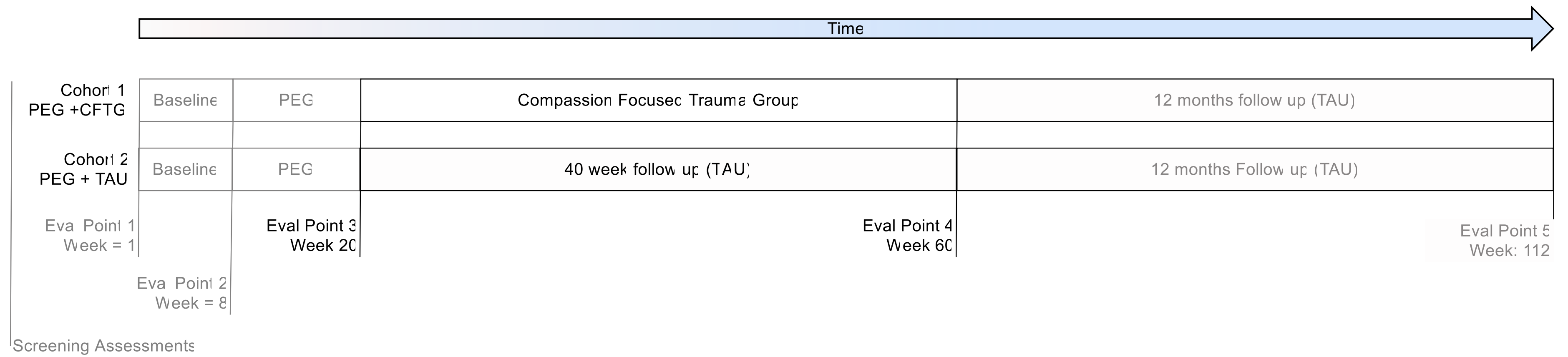


Figure 5-1 Overview of Research

The evaluation of the Compassion Focused Psychotherapy phase is shown in Figure 5.1. A mixed between and within subjects ANOVA will be used to differentiate the change from the start of the intervention (week 20) to end of the intervention (week 60) across the treatment as usual phase (Cohort 2) from the change in the compassion focused psychotherapy programme (Cohort 1).

Measures

The following self-report scales were administered to measure symptoms of mental distress, process, and adjustment. Further details of the psychometric properties of these measures is provided in chapter 3.

Symptom Measures

The symptom level measures report outcome at the level of mental health symptoms.

1. Depression, Anxiety and Stress Scales (DASS-21). DASS was developed by Lovibond & Lovibond (1995).
2. Clinical Outcomes in Routine Evaluation. CORE was developed by The Psychological Research Centre at the University of Leeds (1998).

Therapeutic Process Measures

The therapeutic process measures quantify the purported therapeutic processes within the 40 week CFTG.

1. Forms of Self-Criticising/Attacking & Self-Reassuring Scale (FSCSRS) Gilbert et al. (2004).
2. Social Comparison Scale (SCS). The social comparison scale was developed by Allan and Gilbert (1995).
3. The Other as Shamer Scale. The OAS scale is an 18-item scale developed Goss, Gilbert and Allan (1994).
4. Submissive Behaviour Scale (SBS). The submissive behaviour scale was developed by Allan & Gilbert (1997).
5. Fear of Compassion Scales (Gilbert et al. 2014).
6. Internal Shame Scale (Cook 1994).

Adjustment Measures

The adjustment measures provide assessment of functional adjustment

1. The work and Social Adjustment Scale (Mundt et al. 2002).

2. Impact of Event Scale (IES) developed by Horrowitz, M., Wilner, N., & Alvarez (1976)

Procedure

Following completion of the 12-week PEG all participants were invited to complete the end of 12-week therapy measures, either at the end of the last group programme or if needed to be taken home and returned. These measures form the baseline evaluation for this chapter. At this point participants in Cohort 1 were invited to join the 40-week CFTG component of the programme whereas Cohort 2 reverted to treatment as usual after the completion of the Preparation and Engagement Group.

The end of programme measures were completed either on the final session of the 40-week Compassion Focused Trauma Group programme (CFTG) for Cohort 1 or measures were administered after 40 weeks of Treatment as Usual (TAU) for the Cohort 2. To manage the potential for attrition in the Cohort 2, the researcher offered to make home or Community Mental Health Team base visits to support with the completion of the forms. Participants were also supported by their mental health care teams to complete the measures where needed.

Analysis strategy

The pre and post intervention means, SDs and N for the treatment and Cohort 2 condition are shown in Tables 5-2 – 5-20. A repeat measures ANOVA compared the means of the measures at the start and end of intervention and the Greenhouse Glessier adjusted F and significance values are reported in Tables 5-2 – 5-20 along with the Greenhouse Glessier F and statistical significance for the interaction between group (Cohort 1 Vs Cohort 2 Participants) and Time (Pre Versus Post intervention). There were 40 participants in Cohort 1, (40-week CFTG treatment intervention), 1 participant having dropped out in the 12-week PEG intervention and 23 participants in Cohort 2 group (40 week Treatment as Usual) , 4 having dropped out in the 12-week PEG intervention. The difference in the number of participants in each arm of the study relates to the difficulty in recruiting patients to the Cohort 2 (12-week PEG only).

In order to identify the individual participants who had shown clinically or statistically meaningful change in comparison with the Cohort 2, the 65% CI and the 95% CI was calculated for each of the symptom and process measures using the procedures described by Jacobson and Truax (1991). Start and End of intervention scores were then plotted and the bands for clinically meaningful change (66% CI) highlighted in red and statistically reliable change (95% CI) were highlighted in black. These Reliable change graphs were recorded for each measure subscale to demonstrate individual scores for both Cohorts of the study.

An Intention to Treat Analysis (ITT) was also undertaken to enable an estimation of the treatment effect size for participants who were lost to attrition, either due to drop out from the study or failure to complete the measures. A "null result" was calculated for those participants who were lost to attrition by calculating the average of the lowest tenth percentile of scores on that outcome measure. The ANOVAs were then recalculated with the average "null result" substituted for any missing data. The ITT analysis was undertaken separately for both Cohort 1 and Cohort 2.

Results

Attendance Rates

During the 40-week CFTG intervention 8 participants dropped out and 2 participants dropped out of the Cohort 2. All of the 8 who dropped out of the 40-week CFTG did so in the first 8 weeks of the programme, many who dropped out at that stage cited the transition from the 12-week PEG into the 40-week CFTG as part of the reason for drop out. These conclusions have not been tested and should be treated with caution. Overall, the drop out from the both arms of the study were 22% collectively with 21% dropping out of Cohort 1 and 21% dropping out of the Cohort 2. The ITT was therefore calculated for these participants.

It is of note that there are missing data for CORE and IES in both 40-week CFTG intervention group and the Cohort 2 TAU group. Cohort 1 had 13% and 51% for CORE and IES missing respectively and the Cohort 2 had 10% and 13% missing. The missing data for IES for the treatment intervention is quite striking, a number of participants had written on

the forms that they did not know how to answer the questions, but had completed the IES measure at the end of the 12-week PEG.

The 40-week CFTG intervention commenced in December 2014 and data was gathered from the participants in this group until March 2019 when the last participants completed the programme.

Overall attendance was 85% for the 40-week CFTG intervention, with 8% Did Not Attends (no contact with the service) and 6% sending apologies. These data were calculated on a session by session basis and cross referenced with electronic databases for recording session attendance.

Changes in Symptom Measures

Clinical Outcomes in Routine Evaluation Measure (CORE)

Table 5-2 reports the pre and post intervention scores on the CORE subscales for Cohort 1 (CFTG) and Cohort 2 (TAU) participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement. As can be seen from Table 5-2, there was a significant interaction between Cohort and time of outcome measurement on each of the Risk, Wellbeing, Functioning and Problems subscales.

Table 5-2 Pre and post intervention scores on the CORE subscales for Cohort 1 (Compassion Focused Trauma Group) and Cohort 2 (treatment as usual) participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement.

Symptom Measures		**Pre-Intervention**			**Post Intervention**				
	Group	Mean	SD	N	Mean	SD	N	Greenhouse Geisser F	Sig
CORE – Risk	Cohort 1	6.89	4.81	28	3.07	3.39	27		
	Cohort 2	4.84	4.00	19	5.00	4.24	19	10.067	0.002
	Cohort 1	10.57	3.20	28	7.21	3.29	28		
CORE - Wellbeing	Cohort 2	9.63	3.76	19	10.8	3.07	19	21.31	<0.001
CORE – Functioning	Cohort 1	30.9	7.44	28	19.6	9.47	28		
	Cohort 2	24.4	8.58	19	28.3	8.28	19	21.18	<0.001
	Cohort 1	33.5	8.50	28	21.7	11.13	28		
CORE – Problems	Cohort 2	28.2	11.1	19	33.4	8.02	19	36.23	<0.001

The significant interactions between Cohort and time of outcome measurement are explored as mean plots with 95% confidence intervals in Figure 5-2.

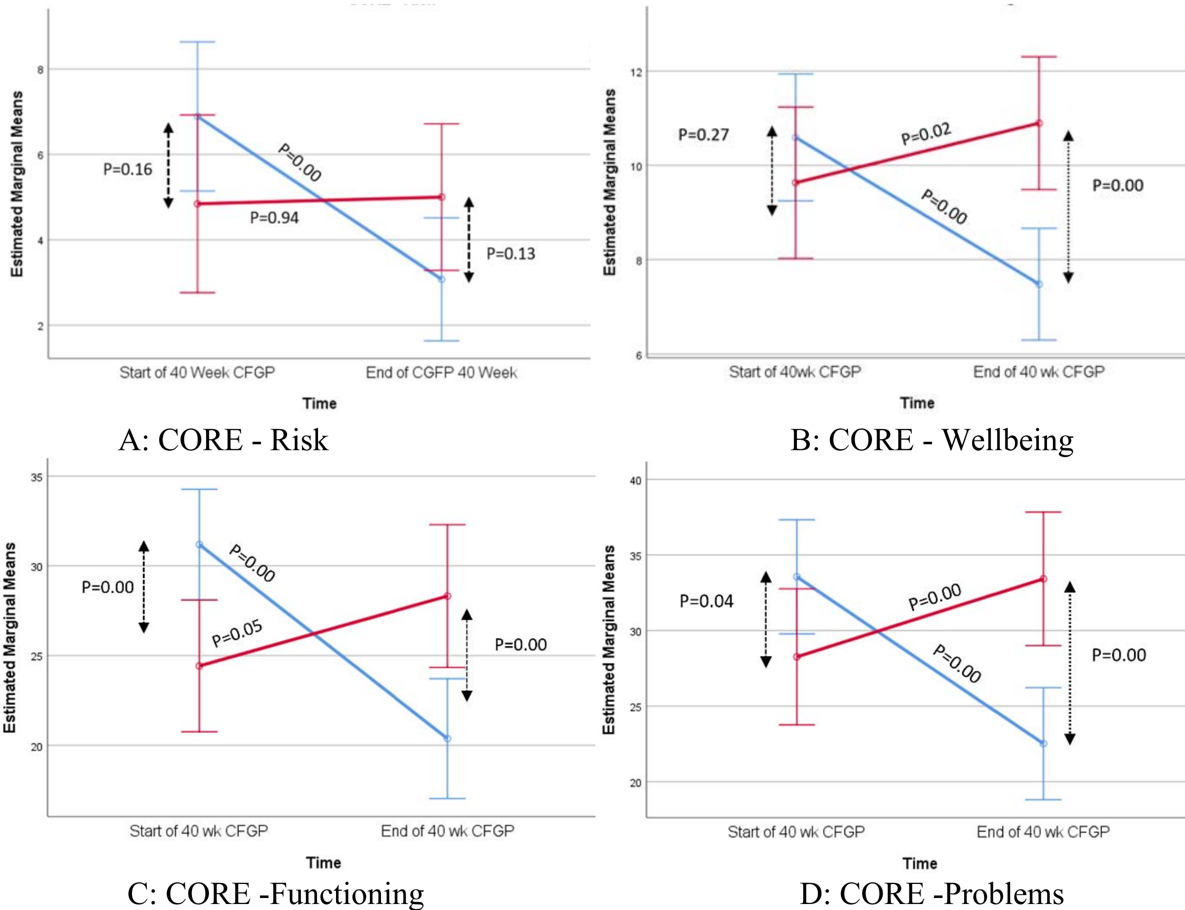


Figure 5-2 Plot of CORE subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two (TAU) is depicted as a red line.

Figure 5-2, charts A to D show a significant improvement across all of the CORE subscales for Cohort 1 over the duration of the intervention, whereas the Cohort 2 participants show a deterioration across all measures except the Risk subscale. The difference between the Cohort scores at the end of the intervention was statistically significant for all subscales with the exception of Risk.

An Intention to Treat (ITT) analysis for Cohort 1 was undertaken to correct for missing data, significance was maintained across all subscales: Risk (F=20.59, Sig=<0.01), Wellbeing (F=33.90, Sig=<0.01), Functioning (F=36.85, Sig=<0.01) and Problems (F=42.18, Sig=<0.01).

However, the evaluation of overall group change may mask the character and level of change at the level of the participants. In order to explore participant level change, the reliable change index was calculated for each participant (see Figure 5-3).

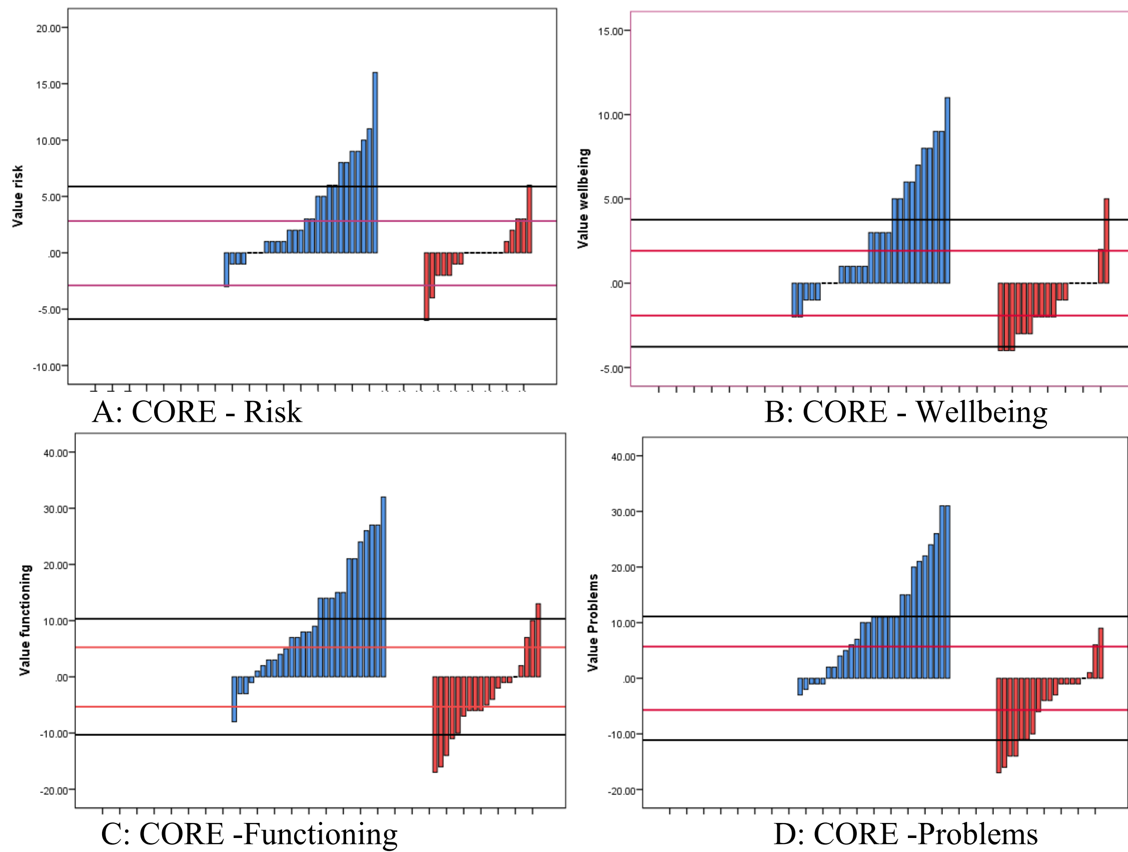


Figure 5-3 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 5-3.

Table 5-3 Percent of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the CORE subscales

	Risk		Wellbeing		Functioning		Problems	
	CFTG	TAU	CFTG	TAU	CFTG	TAU	CFTG	TAU
Statistically reliable improvement	32%	5%	35%	5%	43%	5%	54%	5%
Clinically meaningful improvement	46%	21%	50%	10%	63%	33%	63%	10%
Clinically meaningful deterioration	4%	11%	7%	53%	4%	53%	0%	42%
Statistically reliable deterioration	0%	5%	0%	16%	0%	26%	0%	31%

Depression, Anxiety and Stress Scale

Table 5-3 reports the pre and post intervention scores on the DASS subscales for both Cohorts and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement. As can be seen from Table-4, there was a significant interaction between Cohort and time of outcome measurement on each of the Anxiety, Depression and Stress subscales.

Table 5-4 Pre and post intervention scores on the DASS for Cohort 1 (Compassion Focused Trauma Group) and Cohort 2 (treatment as usual) participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement.

Symptom Measures		**Pre-Intervention**			**Post Intervention**				
	Group	Mean	SD	N	Mean	SD	N	Greenhouse Geisser F	Sig
	Cohort 1	10.1	5.63	32	6.4	4.77	32		
DASS – Anxiety	Cohort 2	7.48	4.50	21	11.9	4.66	21	41.46	.000
	Cohort 1	13.9	4041	32	9.1	5.19	32		
DASS - Depression	Cohort 2	9.9	5.59	21	12.62	5.25	21	34.07	.000
	Cohort 1	14.6	4.37	32	9.3	5.30	32		
DASS - Stress	Cohort 2	10.1	4.27	21	13.7	3.72	21	36.29	.000

The significant interactions between Cohort and time of outcome measurement are explored as mean plots with 95% confidence intervals in Figure 5-4.

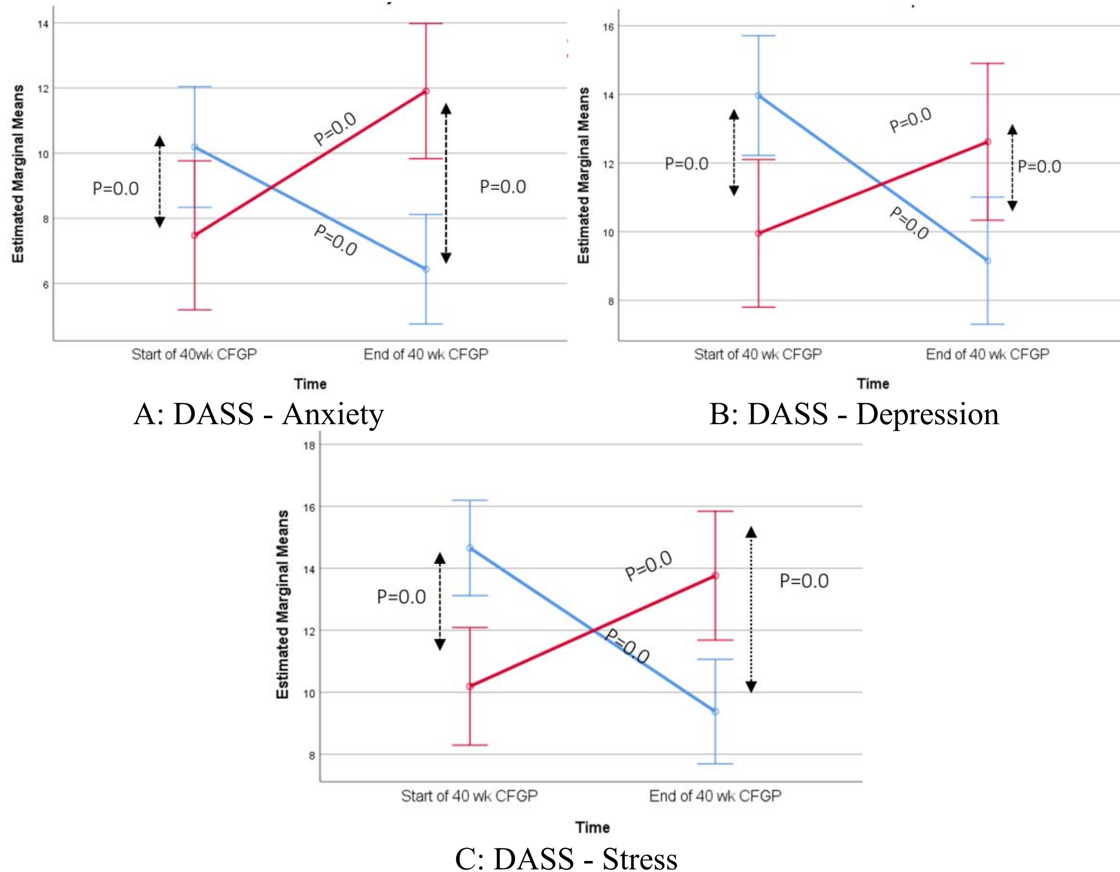


Figure 5-4 Plot of DASS subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two (TAU) is depicted as a red line.

Figure 5-4 above, charts A to C show a significant improvement on the DASS subscales across the duration of the intervention in the 40-week CFTG Cohort scores, whereas the Cohort 2 participants show a significant deterioration across all measures. The difference between the Cohort 2 and Cohort 1 scores at the end of the intervention was statistically significant for all subscales. It should be noted that Cohort 2 started the 40-week period with significantly lower scores on the Depression and Stress subscales than the CFTG Cohort and that this was reversed by the end of the 40 week period.

For Cohort 1 the statistically significant interaction between Cohort and time of outcome measurement remained following an intention to treat correction for missing data; Anxiety (F=8.30, Sig=<0.01), Depression (F=12.30, Sig=<0.01), Stress (F=11.04, Sig=<0.01).

In order to explore participant level change, the reliable change index was calculated for each participant (Figure 5-5 below).

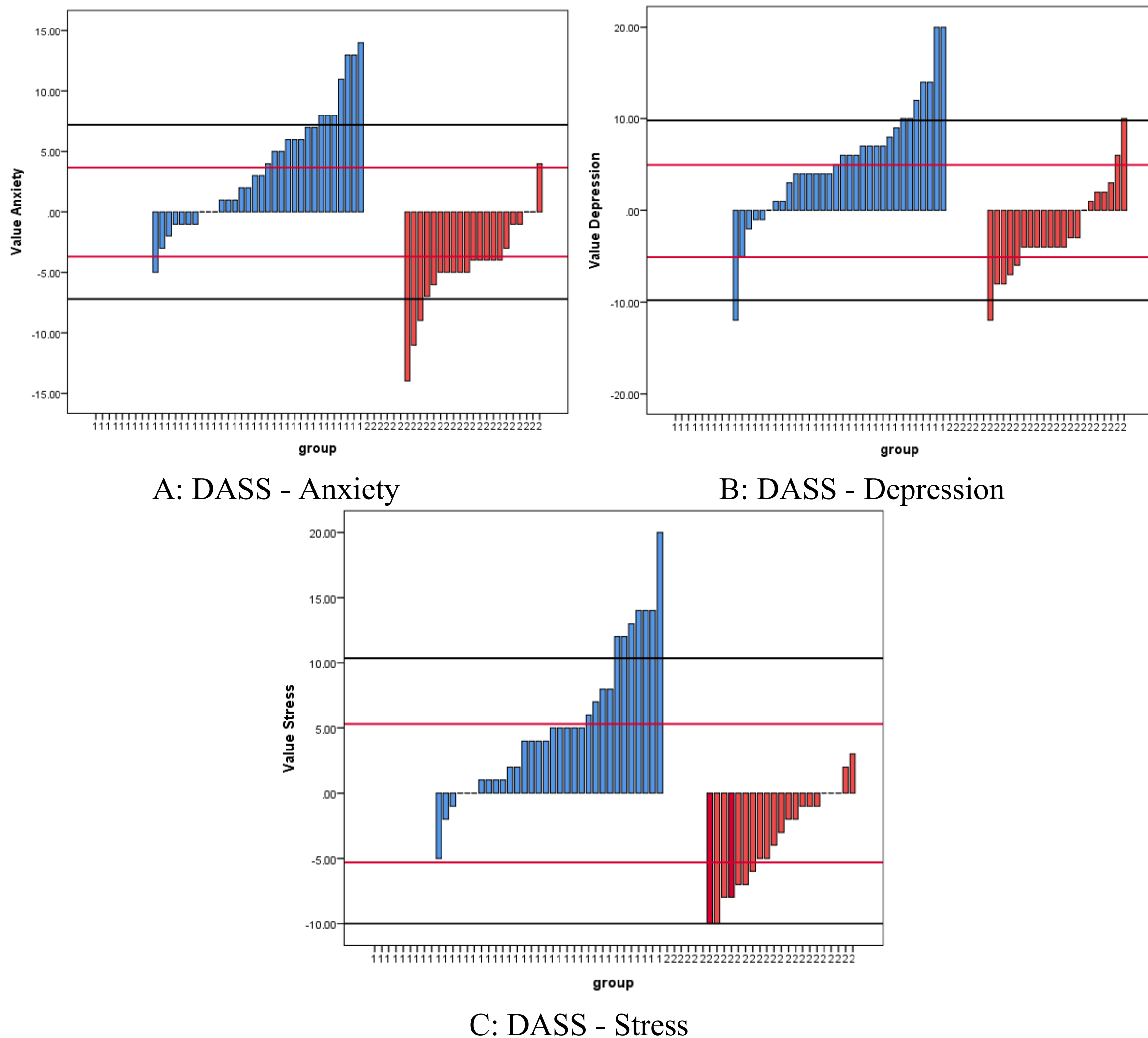


Figure 5-5 Participant level reliable change scores for Cohort 1: CFTG (blue) and Cohort 2:TAU (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/ deterioration is shown as a black line.

When changed was assessed at the level of the individual participant, there is a clear advantage for the Cohort 1 both in terms of increased percentage of participants showing improvement and a marked reduction in the percentage of participants showing a deterioration across the 40 week period.

Table 5-5 Percent of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the DASS subscales

	Anxiety		Depression		Stress	
	CFTG	TAU	CFTG	TAU	CFTG	TAU
Statistically reliable improvement	21	0	25	5	21	0
Clinically meaningful improvement	54	5	39	11	53	0
Clinically meaningful deterioration	4	71	4	73	0	24
Statistically reliable deterioration	0	14	4	5	0	0

Therapeutic Process Measures

Forms of Self Reassuring and Self-Attacking Scale

Table 5-6 reports the pre and post intervention scores on the FSRSA subscales for both Cohorts participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement. As can be seen from Table 5-6, there was a significant interaction between Cohort and time of outcome measurement on each of the Inadequate Self, Reassured Self and Hated Self subscales.

Table 5-6 Pre and post intervention scores on the Therapeutic Process Measures for Cohort 1 (Compassion Focused Trauma Group) and Cohort 2 (treatment as usual) participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement.

Therapeutic Process Measures		**Pre-Intervention**			**Post-Intervention**				
	Group	Mean	SD	N	Mean	SD	N	Greenhouse Geisser F	Sig
	Cohort 1	30.2	4.19	31	23.8	7.43	31		
FSRSA – Inadequate	Cohort 2	24.8	7.97	21	28.5	6.84	21	33.90	.000
	Cohort 1	8.5	5.44	31	12.6	6.09	31		
FSRSA – Reassured	Cohort 2	13.7	5.83	21	9.52	5.64	21	26.25	.000
	Cohort 1	13.8	4.22	31	9.2	5.56	31		
FSRSA – Hated Self	Cohort 2	10.2	5.23	21	12.3	5.65	21	28.53	.000

Note: FSRSA = Forms of Self Reassuring and Self-Attacking Scale

The significant interactions between Cohort and time of outcome measurement on the Forms of Self Reassuring and Self-Attacking Scale are explored as mean plots with 95% confidence intervals in Figure 5-6.

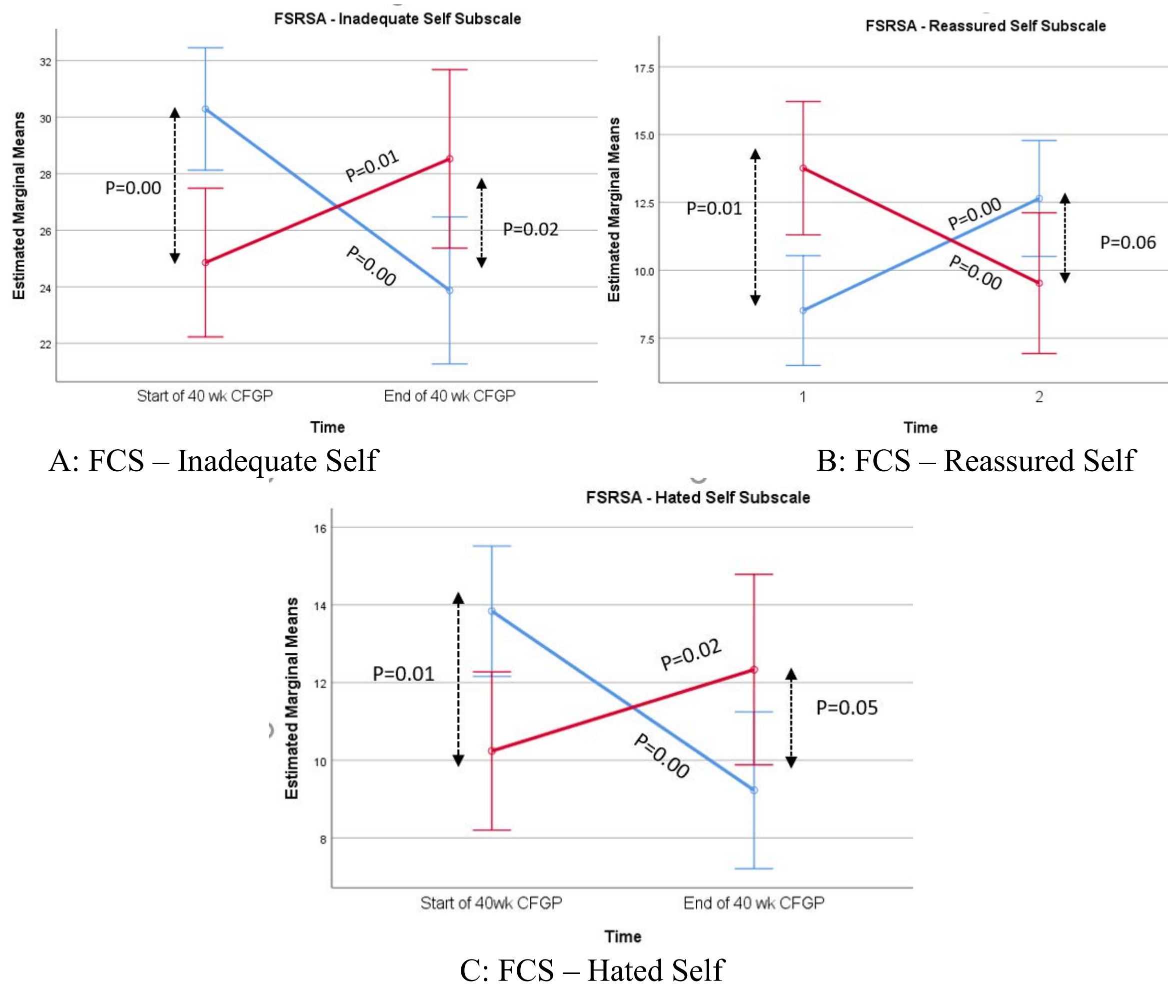
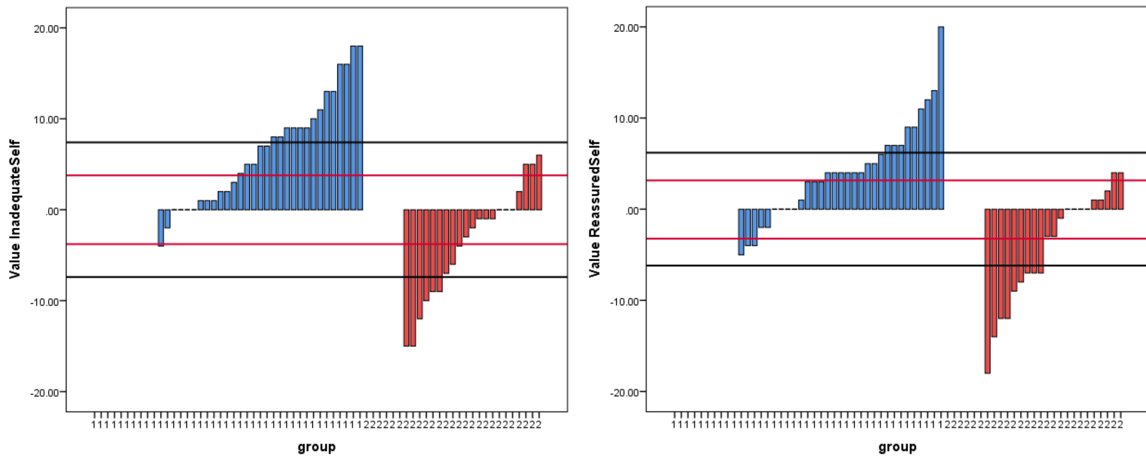


Figure 5-6 Plot of FSRSA subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two (TAU) is depicted as a red line.

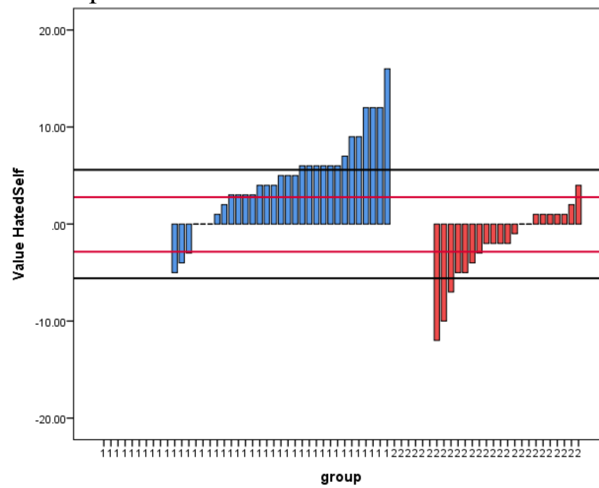
Figure 5-6, charts A to C show a significant improvement on the FSRSA subscales across the duration of the intervention in Cohort 1, whereas the Cohort 2 participants show a significant deterioration across all measures. The difference between the Cohort scores at the end of the intervention was statistically significant for the Inadequate Self only.

The statistically significant interaction between Cohort and time of outcome measurement for Cohort 1 remained following an intention to treat correction for missing data; Inadequate Self (C1: F=7.63, Sig=<0.01), Reassured Self (C1: F=2.67, Sig=<0.01), Hated Self (C1: F=20.83, Sig=<0.01).

In order to explore participant level change, the reliable change index was calculated for each participant (see Figure 5.7).



A: FSRSA – Inadequate Self B: FSRSA – Reassured Self



B: FCS – Hated Self

Figure 5-7 Participant level reliable change scores for Cohort1: CFTG (blue) and Cohort 2:TAU (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/5.4deterioration is shown as a black line.

When changed was assessed at the level of the individual participant (see Table 5-7 below), there is a clear advantage for the Cohort 1 both in terms of increased percentage of participants showing improvement and a marked reduction in the percentage of participants showing a deterioration across the 40 week period.

Table 5-7 Percent of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the DASS subscales

	Inadequate		Reassured		Hated	
	CFTG	TAU	CFTG	TAU	CFTG	TAU
Statistically reliable improvement	45	0	29	0	42	0
Clinically meaningful improvement	61	14	68	9	71	5
Clinically meaningful deterioration	3	67	9	57	10	57
Statistically reliable deterioration	0	29	0	43	0	14

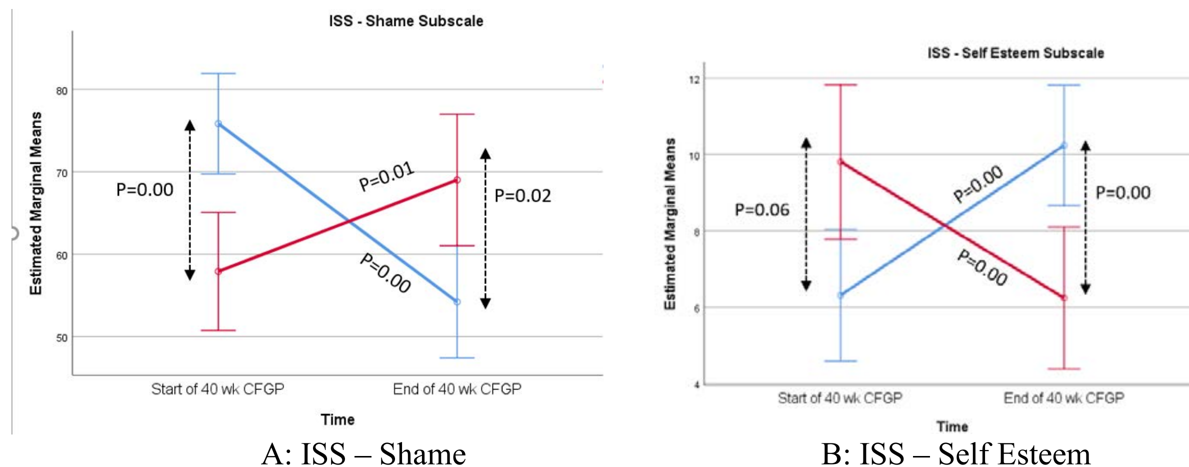
Internal Shame Scale

Table 5-8 reports the pre and post intervention scores on the ISS subscales for both cohorts and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement. There was a significant interaction between Cohort and time of outcome measurement on each of the shame and self-esteem subscales.

Table 5-8 Pre and post intervention scores on the Internal Shame Scale subscales for Cohort 1 (Compassion Focused Trauma Group) and Cohort 2 (treatment as usual) participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement.

		Pre-Intervention		Post-Intervention					
	Group	Mean	SD	N	Mean	SD	N	Greenhouse Geisser F	Sig
	Cohort 1	73.3	18.49	30	54.8	19.05	30		
ISS – Shame	Cohort 2	57.9	20.5	21	69.0	16.79	21	24.47	.000
	Cohort 1	6.1	3.74	30	10.1	4.26	30		
ISS – Self Esteem	Cohort 2	9.8	5.73	21	6.24	4.13	21	44.75	.000

The significant interactions between Cohort and time of outcome measurement on the Internal Shame Scale are explored as mean plots with 95% confidence intervals in Figure 5-9.



A: ISS – Shame B: ISS – Self Esteem

Figure 5-8 Plot of ISS subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two (TAU) is depicted as a red line.

Figure 5-9, charts A & B show a significant improvement on the ISS subscales across the duration of the intervention in Cohort 1, whereas the Cohort 2 participants show a significant deterioration across both subscales. The difference between the Cohort scores at

the end of the intervention was statistically significant for both Cohorts. The trend towards a reversal in the Cohort scores during the intervention period was demonstrated for ISS.

The statistically significant interaction between Cohort and time of outcome measurement remained for Cohort 1 following an intention to treat correction for missing data: Shame (C1: F=10.63, Sig=<0.01), Self Esteem (F=5.80, Sig=0.02). In order to explore participant level change, the reliable change index was calculated for each participant (see Figure 5-10).

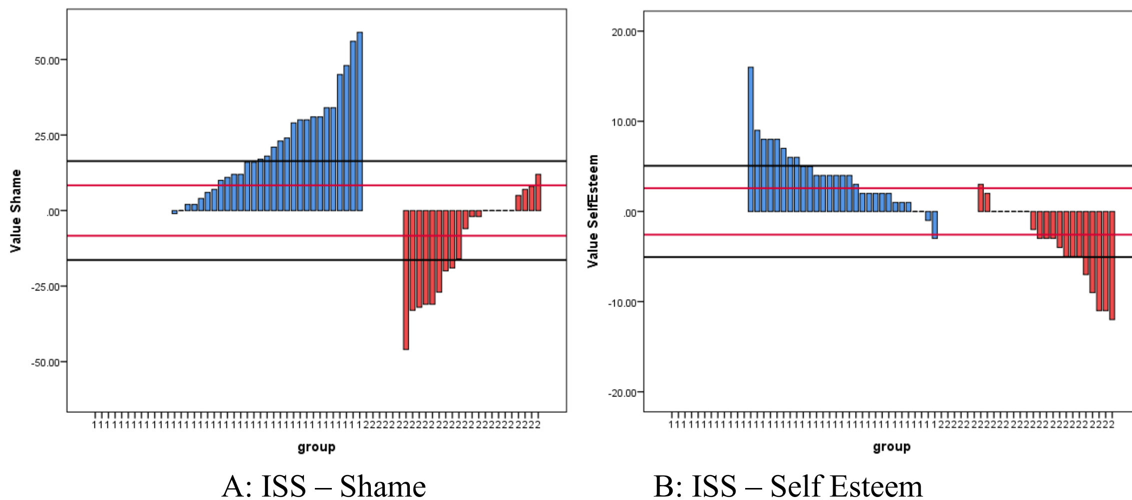


Figure 5-9 Participant level reliable change scores for Cohort 1: CFTG (blue) and Cohort 2: TAU (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement deterioration is shown as a black line.

The percentage of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 5-9. When change was assessed at the level of the individual participants (see Figure 5-9), there is a clear advantage for the CFTG Cohort 1 both in terms of increased percentage of participants showing improvement and a marked reduction in the percentage of participants showing a deterioration across the 40-week period.

Table 5-9 Percent of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the DASS subscales

	Shame		**Self Esteem**	
	CFTG	TAU	CFTG	TAU
Statistically reliable improvement	60	0	29	0
Clinically meaningful improvement	77	2	55	0
Clinically meaningful deterioration	0	57	3	57
Statistically reliable deterioration	0	48	0	23

Other as Shamer Scale

Table 5-10 reports the pre and post intervention scores on the OAS subscales for both Cohorts and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement. There was a significant interaction between Cohort and time of outcome measurement.

Table 5-10 Pre and post intervention scores on the OAS subscales for Cohort 1 (compassion focused group psychotherapy) and Cohort 2 (treatment as usual) participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement.

		Pre-Intervention			**Post Intervention**				
Process Measures	Group	Mean	SD	N	Mean	SD	N	Greenhouse Geisser F	Sig
OAS	Cohort 1	46.3	12.77	31	37.2	13.13	31	21.16	.000
	Cohort 2	42.1	9.17	19	47.4	12.2	19		

The significant interactions between Cohort and time of outcome measurement are explored as mean plots with 95% confidence intervals in Figure *5-11*

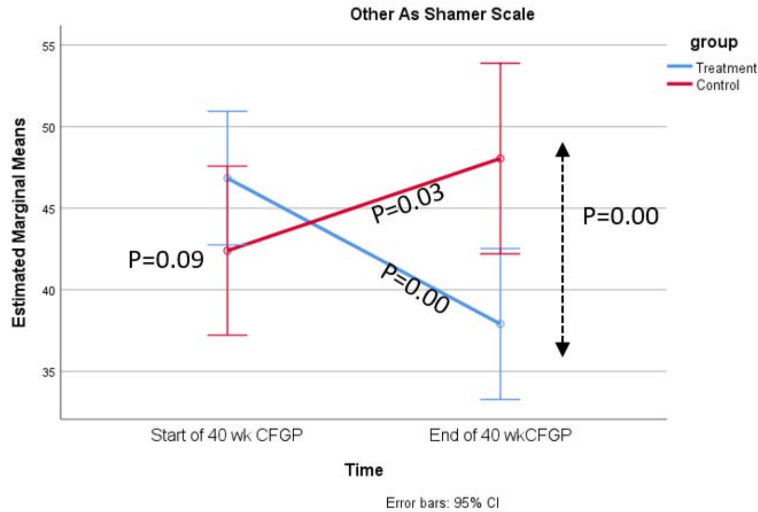


Figure 5-10 Plot of OAS subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two (TAU) is depicted as a red line.

Figure 5-10 Matched the previous measures with significant improvement for Cohort 1 and significant deterioration for Cohort 2. The improvement for Cohort 1was maintained following the ITT analysis OAS (F=8.194, Sig=<0.01).

In order to explore participant level change, the reliable change index was calculated for each participant (see Figure 5-11).

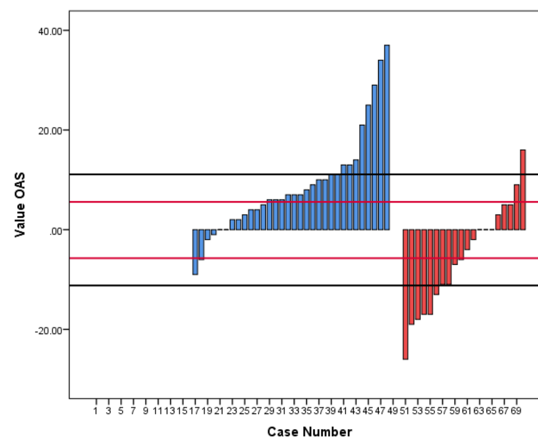


Figure 5-11 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/ deterioration is shown as a black line.

The percentage of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 5-11. The data again mirrors the group level analysis.

Table 5-11 Percent of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the OAS subscales

	OAS	
	CFTG	**TAU**
Statistically reliable improvement	26%	5%
Clinically meaningful improvement	65%	10%
Clinically meaningful deterioration	6%	53%
Statistically reliable deterioration	0%	42%

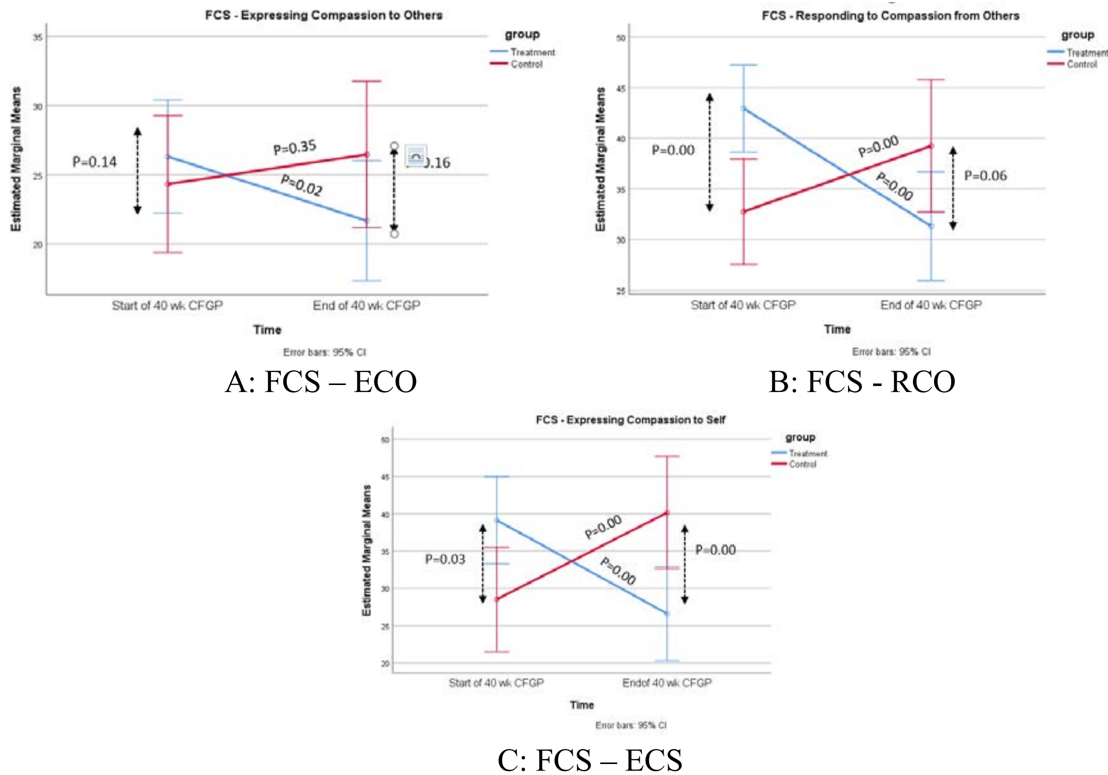
Fear of Compassion Scale

Table 5-12 reports the pre and post intervention scores on the FCS subscales for Cohorts 1 and 2 and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement. As can be seen from Table 5-12, there was a significant interaction between Cohort and time of outcome measurement on the RCO and ECS subscales, with a non-significant effect for ECO subscale.

Table 5-12 Pre and post intervention scores on the FCS subscales for Cohort 1 (compassion focused group psychotherapy) and Cohort 2 (treatment as usual) participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement

Process Measures	**Pre-Intervention**				**Post Intervention**				
	Group	**Mean**	**SD**	**N**	**Mean**	**SD**	**N**	**Greenhouse Geisser F**	**Sig**
FCS - ECO	Cohort 1	26.3	12.05	31	21.6	12.81	31	5.19	0.27
	Cohort2	24.3	10.05	21	26.4	10.7	21		
FCS - RCO	Cohort 1	42.9	12.87	31	31.3	15.9	31	30.69	.000
	Cohort 2	32.7	10.17	21	39.2	13.1	21		
FCS - ECS	Cohort 1	39.1	14.38	31	26.6	15.37	31	38.88	.000
	Cohort 2	28.5	17.99	21	40.1	19.56	21		

The significant interactions between Cohort and time of outcome measurement on the FCS are explored as mean plots with 95% confidence intervals in Figure 5-12.



A: FCS – ECO B: FCS - RCO

C: FCS – ECS

Figure 5-12 Plot of FCS subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two (TAU) is depicted as a red line.

Figure 5-12, charts A to C show a significant improvement across all of the FCS subscales, for Cohort 1, whereas the Cohort 2 participants show a significant deterioration across all measures except ECO subscale. Indicating that the experience of fear associated with Expressing Compassion to Others did not rise to the same degree as other measures for Cohort 2 during the TAU period. The difference between the Cohort scores at the end of the intervention was statistically significant for ECS only.

The ITT analysis for Cohort 1 resulted in the significance of the improvement being maintained: ECO (F=6.82, Sig=0.01), RCO (F=8.31, Sig=<0.01), ECS (F=10.20, Sig=<0.01).

In order to explore participant level change, the reliable change index was calculated for each participant (see Figure 5-13).

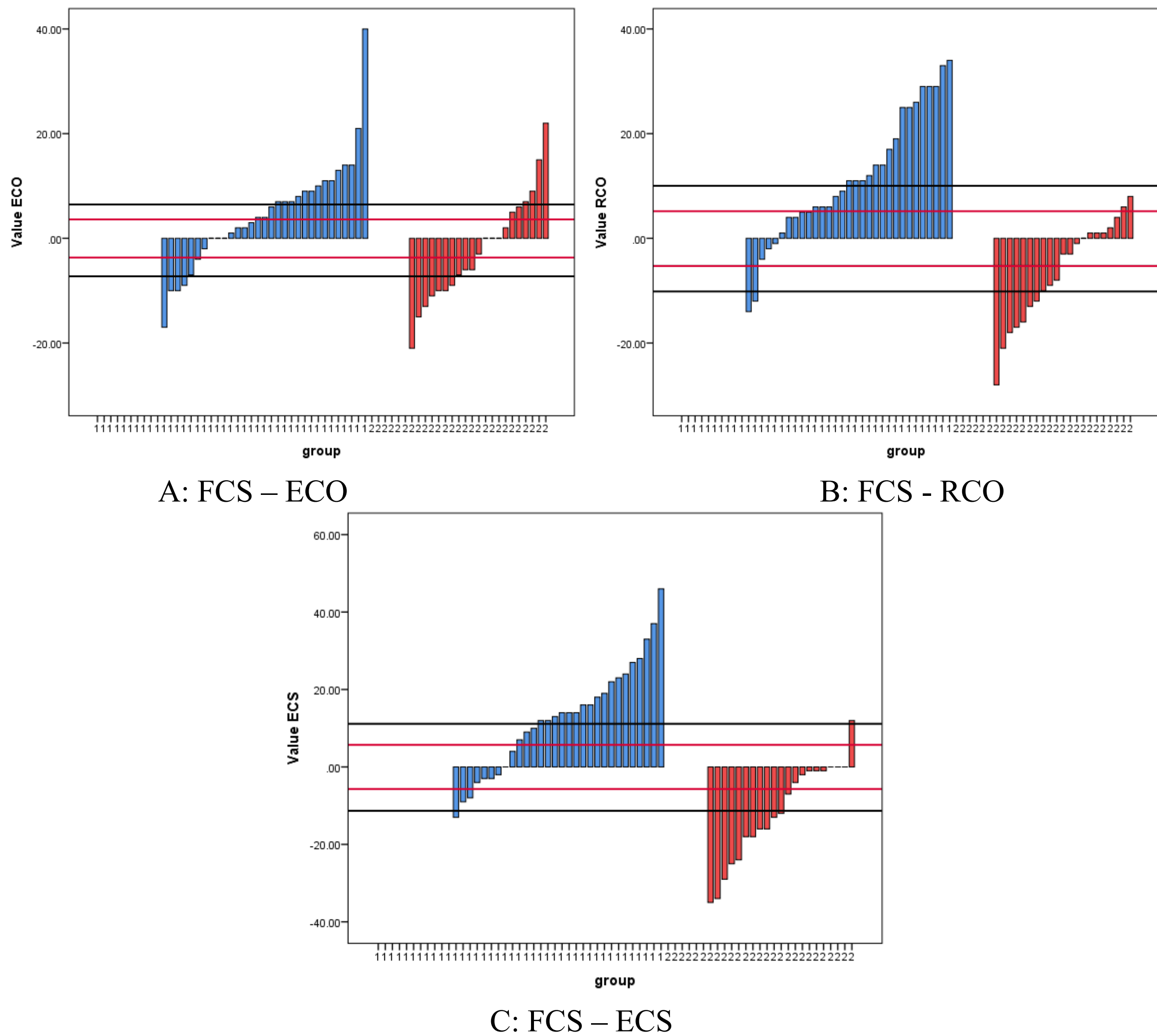


Figure 5-13 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 5-13. There is a clear advantage for the Cohort 1 both in terms of increased percentage of participants showing improvement and a marked reduction in the percentage of participants showing a deterioration across the 40-week period.

Table 5-13 Percent of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the FCS subscales

	ECO		RCO		ECS	
	CFTG	**TAU**	**CFTG**	**TAU**	**CFTG**	**TAU**
Statistically reliable improvement	45%	19%	51%	0%	58%	3%
Clinically meaningful improvement	55%	29%	74%	9%	71%	3%
Clinically meaningful deterioration	19%	48%	6%	48%	9%	57%
Statistically reliable deterioration	16%	33%	3%	52%	3%	52%

Social Comparison Scale

Table 5-14 reports the pre and post intervention scores on the SCS subscales for both Cohorts and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement. There was a significant interaction between Cohort and time of outcome measurement.

Table 5-14 Pre and post intervention scores on the SBS subscales for Cohort 1 (compassion focused group psychotherapy) and Cohort 2 (treatment as usual) participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement.

Symptom Measures		**Pre-Intervention**			**Post Intervention**				
	Group	**Mean**	**SD**	**N**	**Mean**	**SD**	**N**	**Greenhouse Geisser F**	**Sig**
Social Comparison Scale	Cohort 1	30.4	13.85	31	42.5	13.62	31		
	Cohort 2	45.0	16.27	21	36.7	13.34	21	34.53	.000

The significant interactions between Cohort and time of outcome measurement are explored as mean plots with 95% confidence intervals in Figure 5-14.

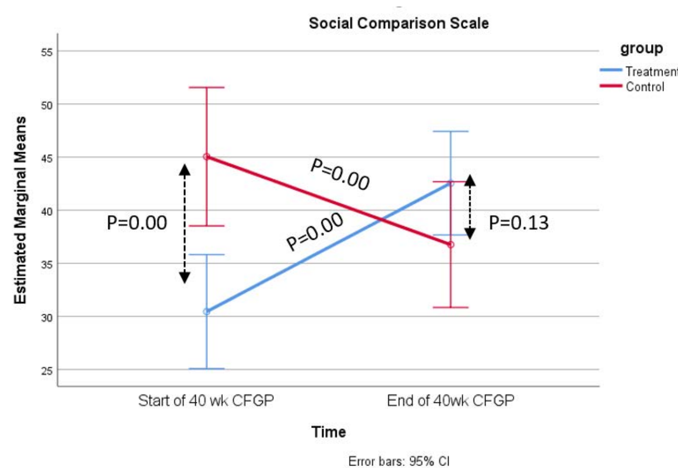


Figure 5-14 Plot of SCS subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two (TAU) is depicted as a red line.

Figure 5-14, show a significant improvement across the duration of the intervention in Cohort 1, whereas the Cohort 2 participants show a significant deterioration. The difference between the Cohort scores at the end of the intervention was non-significant.

The statistically significant interaction between Cohort and time of outcome measurement for Cohort 1 remained following an ITT correction for missing data (F=4.13, Sig=0.04).

The reliable change index was calculated for each participant, in order to explore participant level change (see Figure 5-15).

Figure 5-15 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 5-15, with over 30% reaching statistically reliable improvement in Cohort 1 and over 30% deterioration in Cohort 2.

Table 5-15 Percent of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the SCS subscales

	SCS	
	CFTG	**TAU**
Statistically reliable improvement	42%	3%
Clinically meaningful improvement	61%	9%
Clinically meaningful deterioration	3%	62%
Statistically reliable deterioration	0%	33%

Submissive Behaviour Scale

Table 5-16 reports the pre and post intervention scores on the SBS subscales for Cohort 1 and Cohort 2 participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement. As can be seen from Table 5-16, there was a significant interaction between Cohort and time of outcome measurement.

Table 5-16 Pre and post intervention scores on the SBS subscales for Cohort 1 (compassion focused group psychotherapy) and Cohort 2 (treatment as usual) participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement.

Therapeutic Process Measures		**Pre-Intervention**			**Post-Intervention**				
	Group	Mean	SD	N	Mean	SD	N	Greenhouse Geisser F	Sig
Social Comparison	Cohort 1	30.4	13.85	31	42.5	13.62	31		
Scale	Cohort 2	45.0	16.27	21	36.7	13.34	21	34.53	.000

The significant interactions between Cohort and time of outcome measurement on the SBS are explored as mean plots with 95% confidence intervals in Figure 5-16.

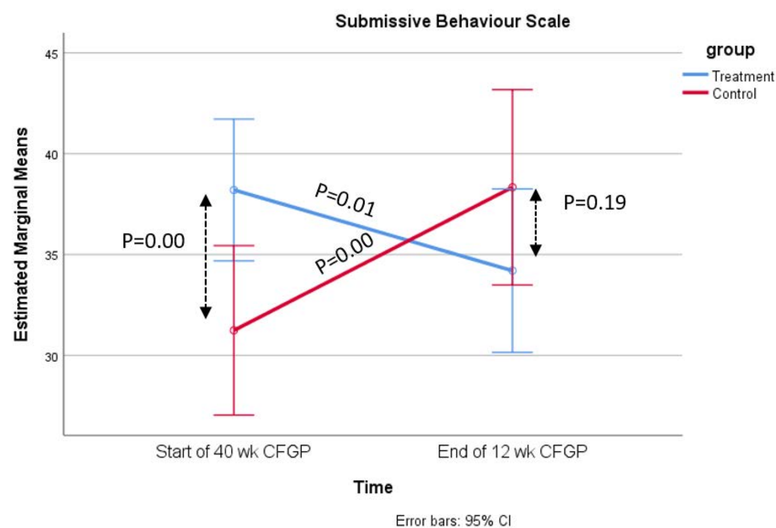


Figure 5-16 Plot of SBS subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two (TAU) is depicted as a red line.

Figure 5-16 shows a significant improvement across the duration of the intervention in the 40-week CFTG Cohort 1 scores whereas the Cohort 2 participants show a significant deterioration. The difference between the Cohort scores at the end of the intervention was non-significant.

The statistically significant interaction between Cohort and time of outcome measurement for Cohort 1 was not maintained following an intention to treat correction for missing data; (F=0.85, Sig=0.36).

In order to explore participant level change, the reliable change index was calculated for each participant (see Figure 5-17).

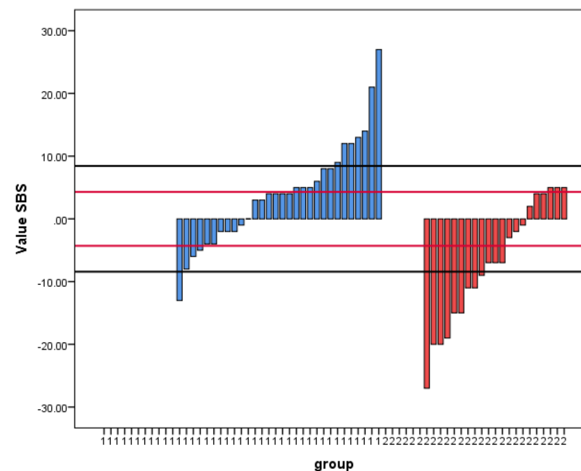


Figure 5-17 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 5-17. There is a clear advantage for the CFTG Cohort both in terms of increased percentage of participants showing improvement and a marked reduction in the percentage of participants showing a deterioration across the 40-week period.

Table 5-17 Percent of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the SBS subscales

	SBS	
	CFTG	**TAU**
Statistically reliable improvement	23%	5%
Clinically meaningful improvement	42%	14%
Clinically meaningful deterioration	12%	57%
Statistically reliable deterioration	3%	38%

Adjustment Measures

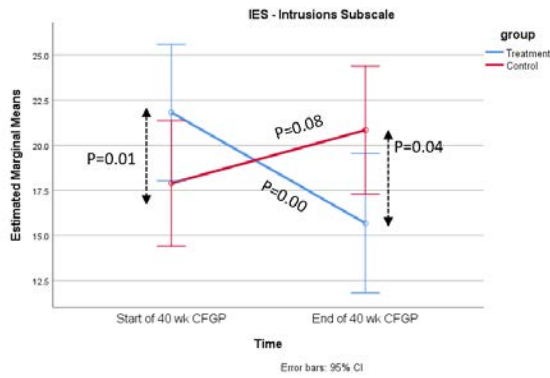
Impact of Event Scale

Table 5-18 reports the pre and post intervention scores on the IES subscales for both Cohorts and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement. There was a significant interaction between Cohort and time of outcome measurement on each of the subscales.

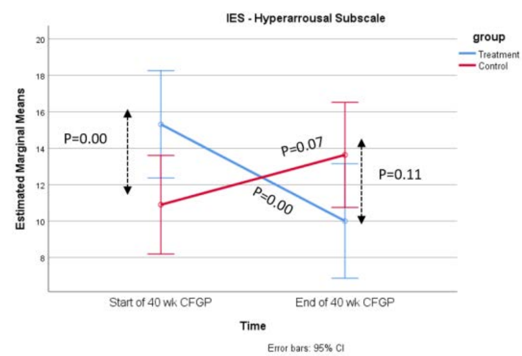
Table 5-18 Pre and post intervention scores on the IES for Cohort 1 (Compassion Focused Trauma Group) and Cohort 2 (treatment as usual) participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement.

Adjustment Measures		**Pre Intervention**			**Post Intervention**				
	Group	Mean	SD	N	Mean	SD	N	Greenhouse Geisser F	Sig
IES - Hypervigilance	Cohort 1	15.3	4.82	16	10.0	5.59	16	15.75	.000
	Cohort 2	10.8	6.50	19	13.6	6.66	19		
IES - Intrusion	Cohort 1	21.8	6.47	16	15.5	7.29	16	15.78	.000
	Cohort 2	17.8	8.14	19	20.8	7.80	19		
IES - Avoidance	Cohort 1	20.4	6.38	16	13.5	6.60	16	18.44	.000
	Cohort 2	14.0	7.51	19	16.7	5.95	19		

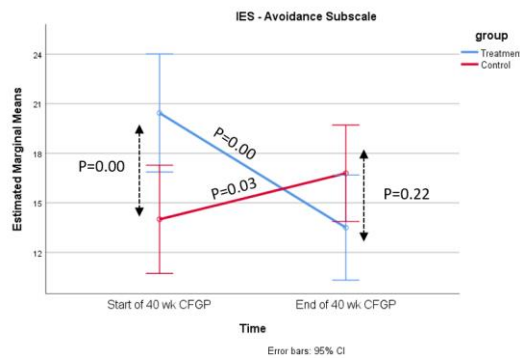
The significant interactions between Cohort and time of outcome measurement on the Impact of Event Scale are explored as mean plots with 95% confidence intervals in Figure 5-19.



A: IES - Intrusions



B: IES – Hyperarousal



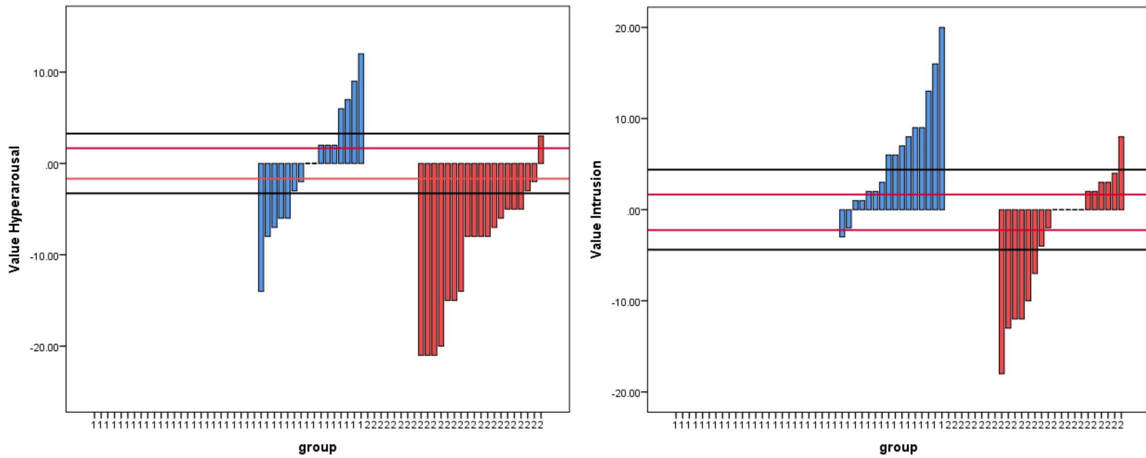
C: IES - Avoidance

Figure 5-18 Plot of IES subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two (TAU) is depicted as a red line.

Figure 5-18, charts A to C show a significant improvement across all of the IES subscales across the duration of the intervention in the 40-week CFTG Cohort scores whereas the Cohort 2 (TAU) participants show a significant deterioration for Avoidance and non-significant for Hyperarousal and Intrusions subscales. The difference between the Cohort scores at the end of the intervention was statistically significant for the Intrusions subscale only.

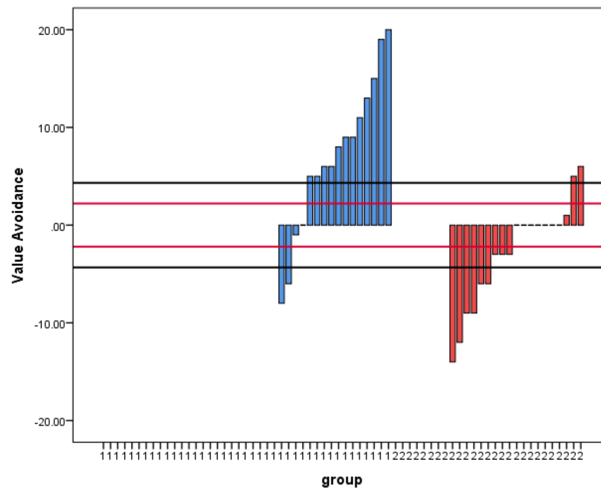
The statistically significant interaction between Cohort and time of outcome measurement for Cohort 1 remained following an intention to treat correction for missing data; Intrusion (F=10.01, Sig=<0.01), Hyperarousal F=5.64, Sig=0.02) and Avoidance (F=18.80, Sig=<0.01).

However, the evaluation of overall group change may mask the character and level of change at the level of the participants. In order to explore participant level change, the reliable change index was calculated for each participant (see Figure 5-19).



A: IES - Hyperarousal

B: IES – Intrusions



C: IES - Avoidance

Figure 5-19 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

The percentage of the Cohorts 1 and 2 reaching the criteria for clinical and statistical improvement or deterioration is shown in Table 5-19. There is a clear advantage for the CFTG Cohort both in terms of increased percentage of participants showing improvement and a marked reduction in the percentage of participants showing a deterioration across the 40 week period.

Table 5-19 Percent of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the IES subscales

	Intrusions		Hyperarousal		Avoidance	
	CFTG	TAU	CFTG	TAU	CFTG	TAU
Statistically reliable improvement	75%	0%	43%	5%	75%	10%
Clinically meaningful improvement	56%	25%	25%	5%	75%	10%
Clinically meaningful deterioration	6%	37%	43%	94%	12%	47%
Statistically reliable deterioration	0%	31%	25%	84%	0%	31%

Work and Social Adjustment Scale

Table 5-20 reports the pre and post intervention scores on the WASA for both Cohorts and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement. There was a significant interaction between Cohort and time of outcome measurement.

Table 5-20 Pre and post intervention scores on the IES for Cohort 1 (Compassion Focused Trauma Group) and Cohort 2 (treatment as usual) participants and Greenhouse-Geisser corrected F scores of the interaction between Cohort and time of outcome measurement.

Adjustment Measures		**Pre-Intervention**			**Post Intervention**				
	Group	Mean	SD	N	Mean	SD	N	Greenhouse Geisser F	Sig
WASA	Cohort 1	30.1	7.76	31	21.1	8.58	31		
	Cohort 2	21.9	8.16	21	26.8	6.80	21	41.98	.000

The significant interactions between Cohort and time of outcome measurement on the WASA Scale explored as mean plots with 95% confidence intervals in Figure 5-20.

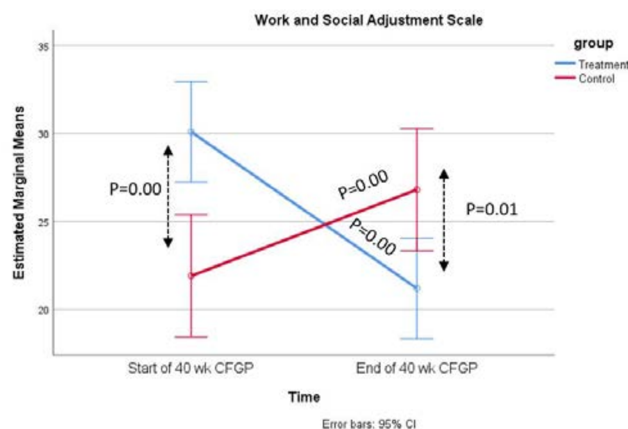


Figure 5-20 Plot of WASA subscale means and 95% confidence intervals for interaction effect. Cohort 1 (CFTG) is depicted as a blue line and Cohort two (TAU) is depicted as a red line.

Figure 5-20 shows a significant improvement across the duration of the intervention in the 40-week CFTG Cohort scores whereas the Cohort 2 (TAU) participants show a significant deterioration. The difference between the Cohort scores at the end of the intervention was also significant.

The statistically significant interaction between Cohort and time of outcome measurement for Cohort 1 remained following an intention to treat correction for missing data; (F=7.07, Sig=0.01).

However, the evaluation of overall group change may mask the character and level of change at the level of the participants. In order to explore participant level change, the reliable change index was calculated for each participant (see Figure 5-21).

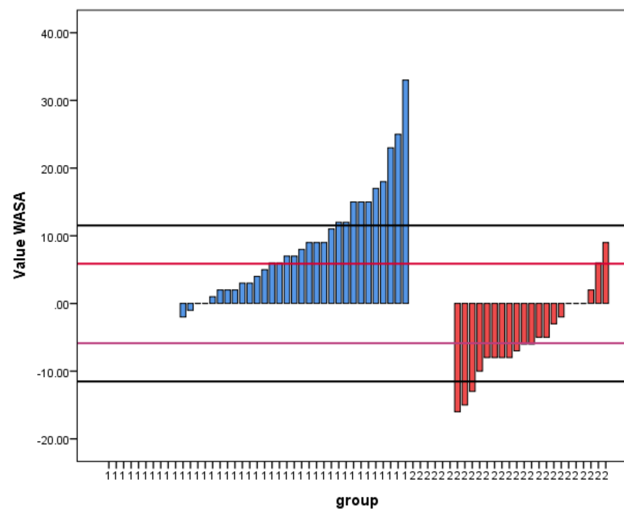


Figure 5-21 Participant level reliable change scores for Cohort 1 (blue) and Cohort 2 (red). The cut off for clinical level (66% CI) improvement/ deterioration is shown as a red line and statistical (95% CI) improvement/deterioration is shown as a black line.

As can be seen in Table 5-21, there is a clear advantage for the CFTG Cohort both in terms of increased percentage of participants showing improvement and a marked reduction in the percentage of participants showing a deterioration across the 40 week period.

Table 5-21 Percent of the CFTG and the TAU Cohorts reaching the criteria for clinical and statistical improvement or deterioration on the WASA subscales

	WASA	
	CFTG	TAU
Statistically reliable improvement	35%	0%
Clinically meaningful improvement	61%	9%
Clinically meaningful deterioration	0%	52%
Statistically reliable deterioration	0%	14%

Discussion

The dropout rate of 21% in Cohort 1 was substantially lower than the average drop out for this population, which stands at between 30%- 60% according to a recent meta-analyses. (Barnicot et al., 2012; McMurran, 2012; Webb & McMurran, 2009). The attendance rates were maintained at 85% for Cohort 1 which again are substantially higher than reported averages for this patient group (McMurran, 2012).

There was a high level of missing data for Cohort 1, IES end of CFTG, in that 50% of the data was missing. For 80% of these participants there had been some indication on the forms that they were not sure how to complete this measure or that this did not apply, but had completed the measure at the start point of the intervention. Although these ideas must be treated with extreme caution, it is possible that at least some of these participants were no longer identifying themselves as having suffered a significant event. The IES data for Cohort 1, should nonetheless be treated with caution given the level of missing data.

Summary of Process and Symptom Level Change

Cohort 2 had a highly significant improvement response to the PEG intervention creating a significant difference in the starting scores for the CFTG condition, with the exception of Risk, Wellbeing (CORE), Other As Shamer and Expressing Compassion for Others. Cohort 1, therefore commenced the CFTG with much lower starting scores across all measures, which could be described as Cohort 1 starting at a distinct disadvantage.

The trend towards significantly lower scores for Cohort 1 was reversed by the end of Phase Three – CFTG with all measures reaching highly significant improvement which were

maintained following the Intention to Treat Analysis, with the exception of the Submissive Behaviour Scale.

Conversely, for Cohort 2 during the same 40-week TAU condition, there was a significant level of deterioration across all process and symptom measures with the exception of Expressing Compassion to Others (FCS), Risk (CORE), Intrusion and Hyperarousal (IES). The smaller number of participants in Cohort 2 coupled with the high level of missing data in CORE and IES may have contributed to the non-significant deterioration in these subscales. A possible explanation for the non-significant deterioration in the ECO measure may be linked to the slightly lower baseline levels for this measure which could indicate less severe difficulty with Expressing Compassion to Others in Cohort 2 at the commencement of the study.

The magnitude of difference between the end scores of the two Cohorts was such that it reached significance in most measures with the exception of two of the social rank measures, Social Comparison Scale and Submissive Behaviour, Hyperarousal , Avoidance (IES), Reassured Self (FSRSA), Expressing Compassion to Others and Responding to Compassion from Others (FCS). In all cases there was either high levels of missing data (CORE and IES), or a much greater magnitude of difference between the start scores. See Appendix J for a summary of RCI scores.

Chapter 4 explored the possible explanations for the significant differences in the response to the PEG condition. The 'cross over' effect which has been observed within the CFTG versus TAU condition raises interesting questions about the capacity of Cohort 2 to consolidate and develop upon the initial improvements. These data can be understood in the context of Cohort 2 receiving a 'sub-therapeutic dose' of the intervention which therefore was not maintained over time. These findings can be used to warn against the over interpretation of early therapeutic gains and supports the notion that longer-term therapeutic contact with this client group is imperative for change to be maintained.

A further explanation for this stark difference in response to the (PEG) between the two cohorts is the concept of 'flight into health'. This concept has been largely commented upon with the psychoanalytic literature and seems to reflect a sudden improvement in symptoms

which is not accompanied by insight level change, i.e. an understanding of the mechanisms of the improvement without applying on a personal level (Frick, 1999).

The process driven nature of the CFGP program, where there is an emphasis on understanding the complex interactions between participants and therapists and the links with experiences in the past, rather than interventions that focus on the content, what is said and delivered in the room, may be helpful in explaining this dynamic further. It is understood that insight level change requires slow paced discursive interventions (Frick, 1999).

Linked to the 'flight into health' dynamic is the fact that Cohort 2 were aware that their arm of the study had only 12 weeks, whereas the other arm had 12 months. This could also account for the disparity in the rates of improvement, in that Cohort 2 were quite literally taking flight with the awareness of the short nature of the intervention.

This leads to a number of questions about maintenance of improvements over time and the impact that this change has had on service utilisation for both groups. Furthermore, analysis of data from the complete program will be required to establish if the current trend in the change process between and within the Cohorts is maintained after a 12 month period of TAU for both Cohorts.

These conjectures are explored more thoroughly in Chapter 6, when the overall trajectory of change is considered across the entire two-year period.

Chapter 6: The Maintenance of Change and Service Usage

This chapter explores the maintenance of clinical outcomes, service utilisation and employment status following the completion of the 12-week PEG and the 40-week CFTG intervention periods. For Cohort 2: PEG + TAU this would represent 24-month TAU follow-up data for the Preparation and Engagement group. Whereas for Cohort 1: PEG + CFTG these data would constitute a 12-month follow up following completion of the Compassion Focused Group Psychotherapy program.

Data from the service utilisation and employment status questionnaires will be presented with some analysis of the differences between the Cohorts. Also, the outcome data from the whole intervention and some exploration of the possible links between service utilisation, employment status and the CFGP intervention.

Introduction

As described in Chapter One, undertaking psychological therapy with clients who have Attachment and Relational Trauma (A&RT) can be exceedingly challenging for both client and therapist. This often results in such individuals being found unsuitable for psychological therapy, repeating a familiar pattern of rejection and disappointment (Pearlman & Courtois, 2005). Equally, many such individuals are unable to engage in and complete therapeutic interventions and dropout rates remain high (McMurran et al, 2010). It is possible to link the complex and often confusing presentation of this group with the prevalence of childhood maltreatment, often in the form of intrusive or abusive caregivers and ruptured or absent early attachment relationships (Lucre & Clapton, 2020; Lucre, 2020 in press; Schore, 2020).

Service Utilisation

It is well documented in the literature that people who would meet the criteria for personality disorder, will often have a high usage of health and social care services (Bender, et al. 2001; Crawford, 2009; Dolan et al. 2018; Meuldijk et al., 2017). Indeed Twomey et al. (2015) found that a diagnosis of personality disorder was highly correlated with and therefore a predictor of High Health Service Utilisation (HSU).

Meuldijk et al. (2017) conducted a systematic review of key studies looking at service utilisation before and after intensive psychotherapeutic interventions, which revealed a general cost offset and consequent economic benefit for all of the 29 psychological interventions examined.

It is of note that all of the studies reported in the previous section relate specifically to interventions and outcomes for people with a diagnosis of Borderline Personality Disorder, see chapter 1 for a discussion of the difficulties associated with a narrow focus on this diagnosis. Crawford et al. (2009) called for interventions to be targeted within this homogenous group to men and those with other diagnoses than BPD. The broad inclusion criteria for this study was designed to address this deficit in the literature.

It is also widely acknowledged that in order to evaluate the effectiveness of psychological interventions for people with Attachment and Relational Trauma (A&RT) who may also attract the diagnosis of Personality Disorder (PD), long term follow is needed (Bateman & Fonagy, 2000; 2018; Bateman, Gunderson & Mulder, 2015). It is understood that there is a scarcity of published studies with long term follow up, it is interesting to note that many of the published studies are over 15 years old (Chiesa, Fonagy, Holmes, 2006; Davis & Campling, 2003; Maeres & Stevenson, 1992).

In order to understand the possible long-term impact of the intervention on more general level of functioning, service utilisation and employment data was gathered from the two Cohorts at Baseline, end of 40-week CFTG and at 12 months follow up. This was coupled with a repeat of the symptom, process and adjustment self-report measures.

Method

Design

Figure 6-1 depicts the entire progression of the Cohort 1 and Cohort 2 participants through the Preparatory and Engagement Group (PEG), through forty weeks of Compassion Focused Trauma Group (CFTG) or Treatment As Usual (TAU) and finally the assessment of long term outcomes after a 12 months of TAU for both Cohorts, see Figure 6-1.

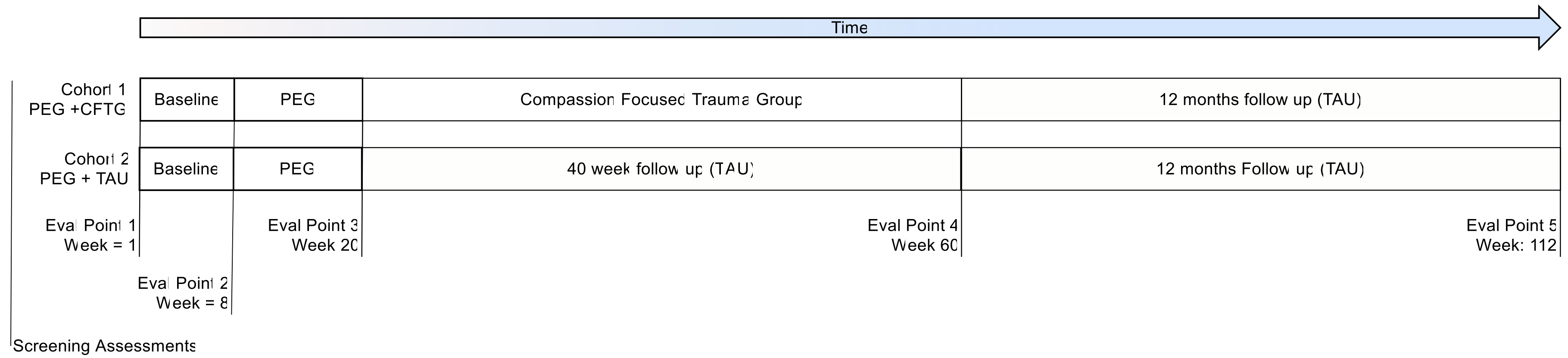


Figure 6-1 The entire progression of the participants through the preparatory and engagement phase, through forty weeks of compassion focused trauma group or treatment as usual and finally the assessment of long term outcomes after a twelve month period of treatment as usual for both Cohort s

Measures

The following self-report scales were administered to measure symptoms of mental distress, process, and adjustment. Further details of the psychometric properties of these measures is provided in Chapter 3.

Symptom Measures

The symptom level measures report outcome at the level of mental health symptoms.

1. Depression, Anxiety and Stress Scales (DASS-21). DASS was developed by Lovibond & Lovibond (1995).
2. Clinical Outcomes in Routine Evaluation. CORE was developed by The Psychological Research Centre at the University of Leeds (1998).

Therapeutic Process Measures

The therapeutic process measures quantify the purported therapeutic processes within the 40-week CFTG.

1. Forms of Self-Criticising/Attacking & Self-Reassuring Scale (FSCSRS) Gilbert et al. (2004).
2. Social Comparison Scale (SCS). The social comparison scale was developed by Allan and Gilbert (1995).
3. The Other as Shamer Scale. The OAS scale is an 18-item scale developed Goss, Gilbert and Allan (1994).
4. Submissive Behaviour Scale (SBS). The submissive behaviour scale was developed by Allan & Gilbert (1997).
5. Fear of Compassion Scales (Gilbert et al. 2014).
6. Internal Shame Scale (Cook 1994).

Adjustment Measures

The adjustment measures provide assessment of functional adjustment

1. The Work and Social Adjustment Scale (Mundt et al. 2002).
2. Impact of Event Scale (IES) developed by Horrowitz, M., Wilner, N., & Alvarez (1976).

Procedure

Participants recruited to Cohort 1 as part of a routine assessment, within a dedicated psychotherapy service, were invited to participate in the research as a part of the therapeutic intervention. The intervention being 12 weeks of PEG immediately followed by a 40 week of CFTG which together formed the therapeutic program. Participation involved the anonymised use of routinely gathered self-report measures for the purpose of the evaluation and the request for consent to be interviewed post intervention about the experience.

Cohort 2 were recruited from a local Community Mental Health Team (CMHT) to take part in a 12-week PEG intervention, followed by 40 weeks of TAU. Participation involved the anonymised use of routinely gathered self-report measures for the purpose of the evaluation and the request for consent to be interviewed post intervention about the experience.

All participants were contacted 12 months after the end of the either the 40-week CFTG for Cohort 1 and or the 40-week TAU for the Cohort 2. In order to ensure the completion of measures, all participants were offered an opportunity to either have a home visit or attend the local CMHT or psychotherapy unit to meet with the researcher to complete the measures.

All participants who did not respond to this initial invitation received a follow up phone call, with a further offer of support to complete the measures.

Analysis Strategy

A mixed between and within subjects ANOVA will be used to differentiate the change from the start of the intervention (week 8) to end of the PEG (week 20) to the end of Compassion Focused Trauma Group - CFTG for Cohort 1 and TAU for Cohort 2 (week 60), across the TAU phase for both Cohorts (week 112).

Please note that the stated aim is to evaluate the long-term outcomes in the context of the trajectories of the two Cohorts across the entire period of the evaluation. All significant results are highlighted on charts with either Yellow (between Cohort difference), Blue (Cohort 1 significant change) or Red (Cohort 2 significant change).

Results

Introduction

Although this chapter is focused on the evaluation of the 12-month follow-up period, it was decided to present the process and symptom outcome measures across the entire period of evaluation in order to clarify the overall trajectory of the two Cohorts. As this intervention was of 12 months duration with two separate groups (PEG and CFTG).

Symptom Measures

Clinical Outcomes in Routine Evaluation Scale

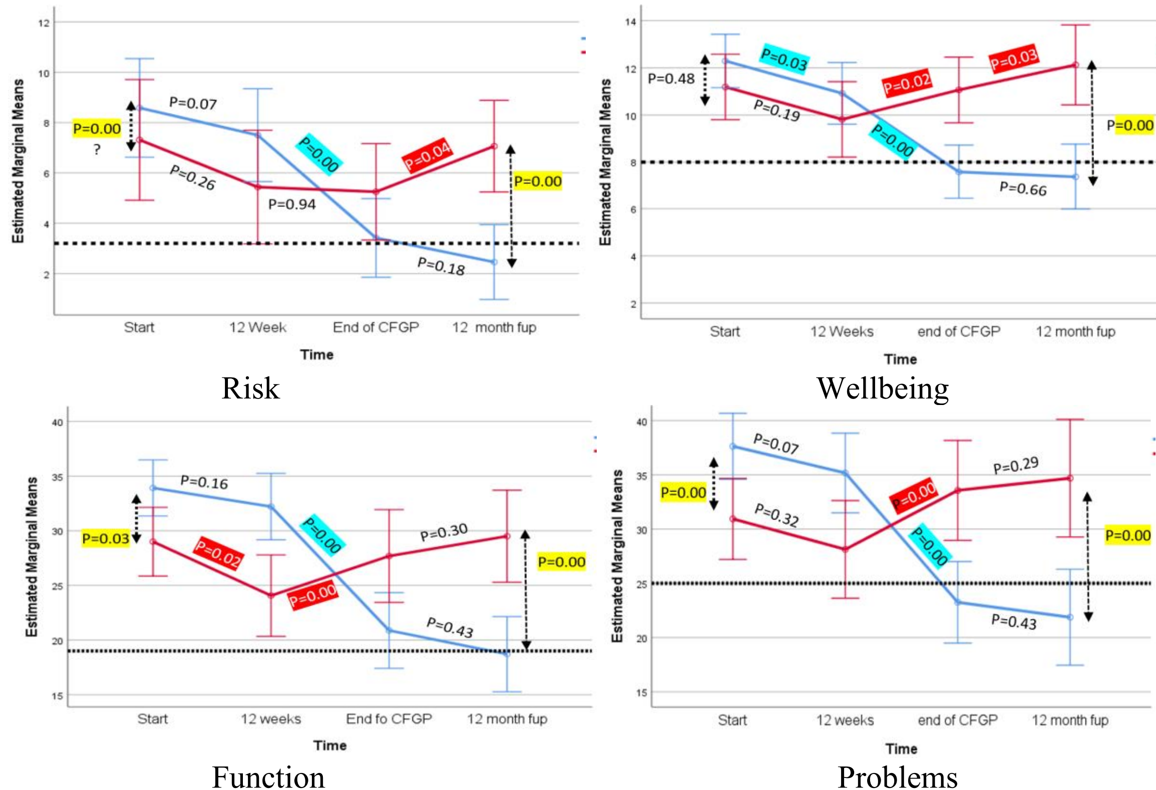


Figure 6-2 Outcomes across the entire period of evaluation for the CORE Cohort 1: PEG+CFTG is depicted as a blue line and Cohort 2: PEG+TAU is depicted as a red line. 95% confidence interval of the mean is provided for each Cohort at each time point and significance tests (independent t-test) are shown for the start of the baseline period and at the end of the 12-month follow-up. The dotted black line indicates clinical cut off according to …

A similar pattern was observed for each of the subscales of the CORE. At the beginning of the 12 week Preparation and Engagement Group Cohort 2: PEG+TAU showed lower scores on the CORE subscales and in three of the four scales (i.e., Risk, Functioning and Problems) this difference was statistically significance. Both Cohort 1: PEG+CFTG and Cohort 2: PEG+TAU showed benefits during the twelve-week period of PEG, with the Cohort 2 achieving statically greater benefit than the Cohort 1 participants on the Functioning Subscale. However, as reported in Chapter 5, a cross-over was observed during the 40-week period in which those receiving the Compassion Focused Trauma Group (CFTG) continued to make statistically significant therapeutic gains whereas the participants that received TAU showed a return to baseline levels of functioning on all of the subscales of the CORE. The differences in therapeutic benefit between the two Cohorts was further emphasised over the

period of the 12 month follow-up with the Cohort 2 participants making no further benefit whilst the Cohort 1 participants continued to make improvements on the CORE subscales (showing statistically significance on the Risk and Wellbeing subscales). By the end of the 24-month follow-up period all of the Core subscales showed a statistically significant advantage for the Cohort 1 participants.

Depression, Anxiety and Stress Scale

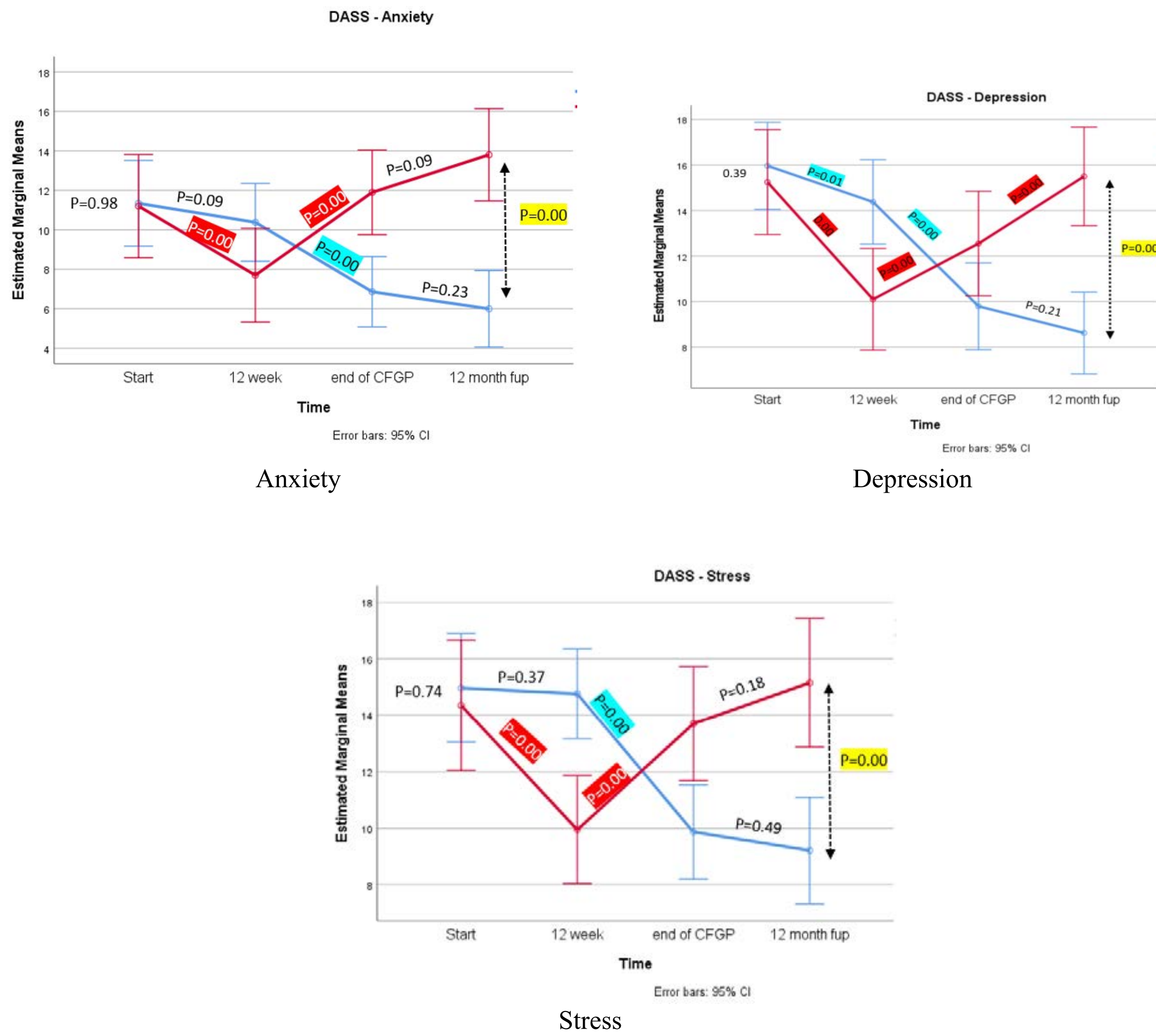


Figure 6-3 Outcomes across the entire period of evaluation for the DASS Cohort 1: PEG+CFTG is depicted as a blue line and Cohort 2: PEG+TAU is depicted as a red line. 95% confidence interval of the mean is provided for each Cohort at each time point and significance tests (independent t-test) are shown for the start of the baseline period and at the end of the 12-month follow-up.

Figure 6-3 shows Cohort 2 made significant improvement in all three subscales during the 12-week PEG, as did Cohort 1 for the Depression subscale only. This trend toward improvement was reversed during the 40-week CFTW condition with significant levels of

improvement for Cohort 1 and significant deterioration for the Cohort 2 across all three the subscales. During the 12-month TAU period, there was a continued non-significant improvement for Cohort 1 and a non-significant deterioration for Cohort 2, which reached significance for the Depression subscale only, for cohort 1.

Adjustment Measures

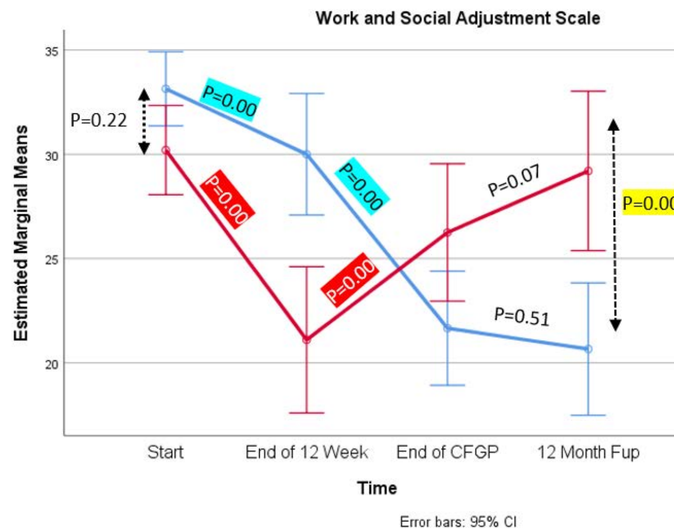


Figure 6-4 Outcomes across the entire period of evaluation for the WASA Cohort 1: PEG+CFTG is depicted as a blue line and Cohort 2: PEG+TAU is depicted as a red line. 95% confidence interval of the mean is provided for each Cohort at each time point and significance tests (independent t-test) are shown for the start of the baseline period and at the end of the 12 month follow-up.

Both Cohorts reached a significant level improvement during the 12-week PEG, followed by a further significant improvement for the Cohort 1 corresponding with a significant deterioration in Cohort 2 during the 40-week CFTG period. During the 12-month TAU, Cohort 1 continued to improve at a non-significant level which matched the continued non-significant deterioration in Cohort 2, Figure 6-4 above.

Impact of Event Scale

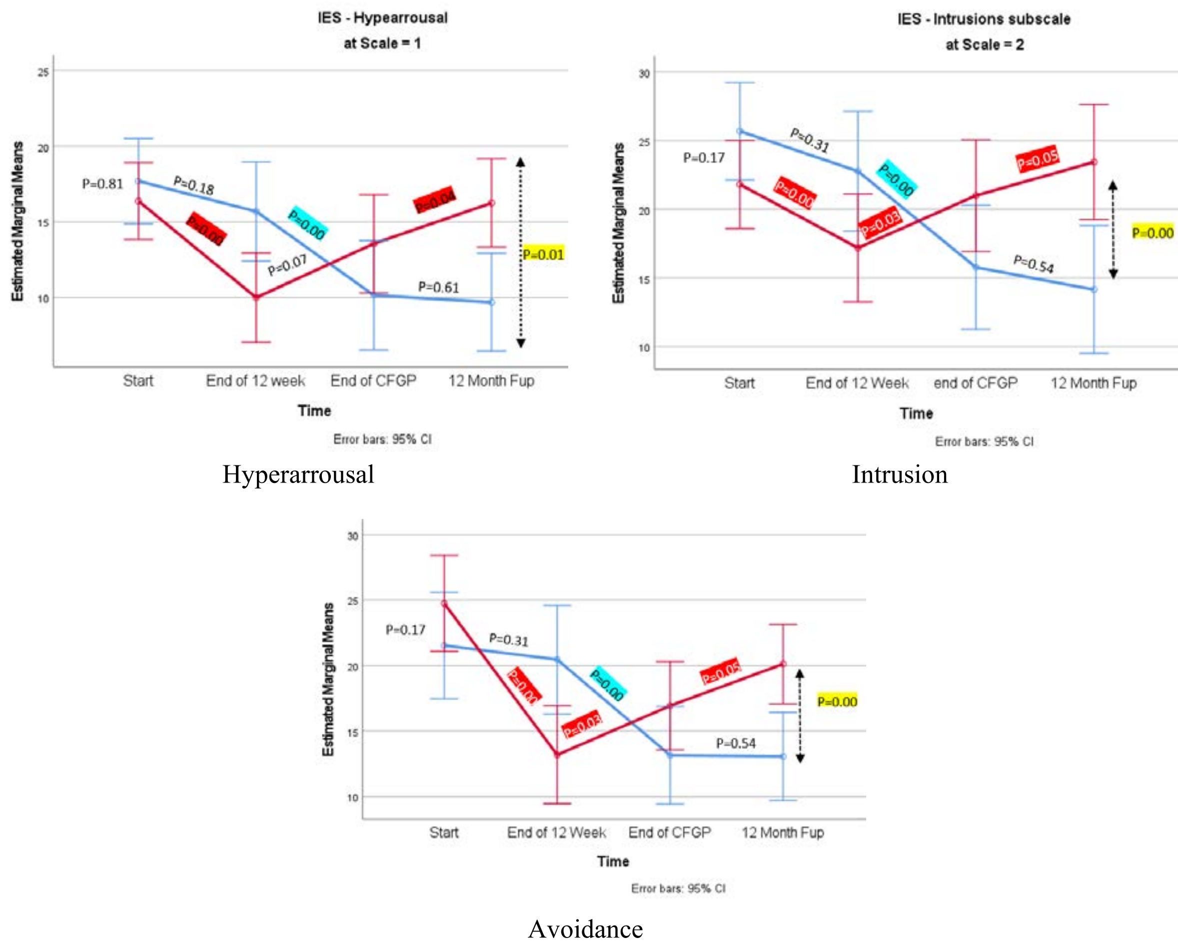
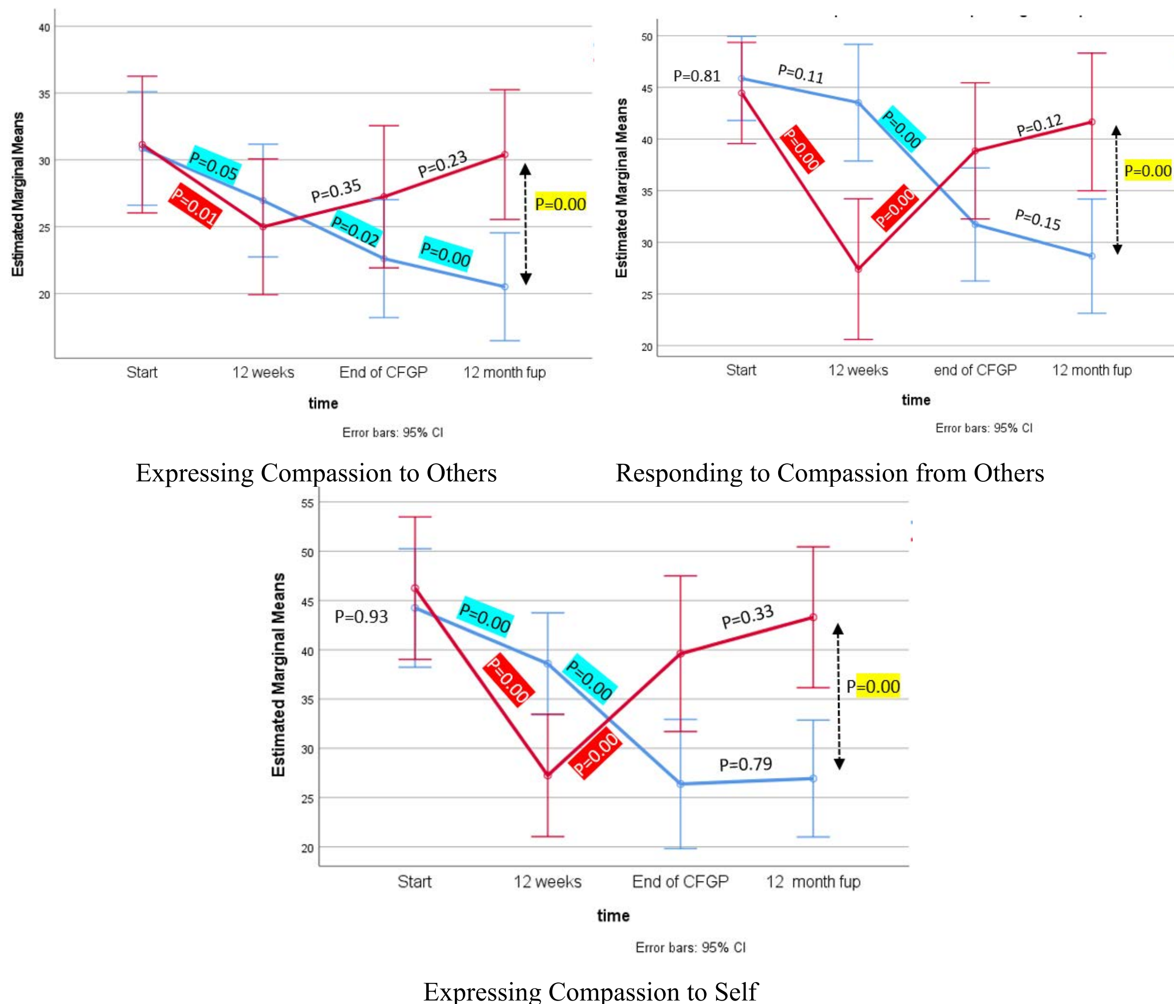


Figure 6-5 Outcomes across the entire period of evaluation for the IES Cohort 1: PEG+CFTG is depicted as a blue line and Cohort 2: PEG+TAU is depicted as a red line. 95% confidence interval of the mean is provided for each Cohort at each time point and significance tests (independent t-test) are shown for the start of the baseline period and at the end of the 12 month follow-up.

There was a highly significant improvement across all three subscales for Cohort 2 during the 12-week PEG, whereas there was a very minor improvement for Cohort 1 (Figure 6-5). The level of improvement for the Cohort 1 for the 40 week CFTG, was highly significant, whereas Cohort 2 deteriorated, significantly for Avoidance. During the 12-month TAU period, Cohort 2 continued to deteriorate at a significant level for Avoidance and Hyperarousal, whereas in Cohort 1 the non-significant improvement was maintained for all three subscales. At the conclusion of the study there was a significant difference between the two Cohorts.

Process measures

Fear of Compassion Scale



Expressing Compassion to Others

Responding to Compassion from Others

Expressing Compassion to Self

Figure 6-6 Outcomes across the entire period of evaluation for the FCS Cohort 1: PEG+CFTG is depicted as a blue line and Cohort 2: PEG+TAU is depicted as a red line. 95% confidence interval of the mean is provided for each Cohort at each time point and significance tests (independent t-test) are shown for the start of the baseline period and at the end of the 12 month follow-up.

During the 12-week PEG period both Cohorts showed improvement in the experience of Fear of Compassion across all three subscales with the exception of RCO, which showed significant improvement in Cohort 2 only. During the 40-week CFTG, Cohort 2 significantly deteriorated in two subscales with the exception of ECO which did not reach significance, whereas Cohort 1 improved to a significant level in all subscales. During the 12-month TAU the Cohort trajectories of improvement and deterioration respectively continued with the exception of significant improvement for ECO. At the conclusion of the study there as a significant difference between the two Cohorts (see Figure 6-6 above).

Forms of Self Reassuring and Self Attacking Scale

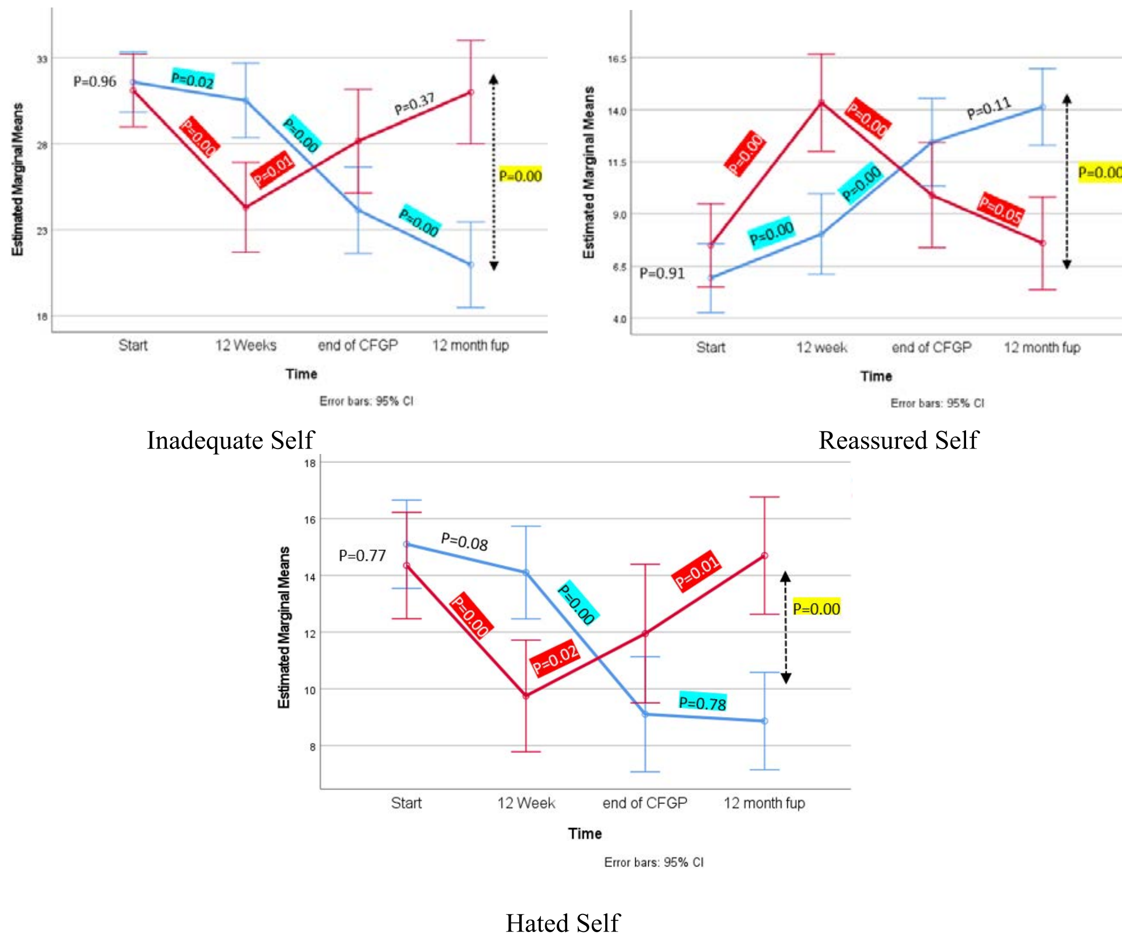


Figure 6-7 Outcomes across the entire period of evaluation for the FSRSA Cohort 1: PEG+CFTG is depicted as a blue line and Cohort 2: PEG+TAU is depicted as a red line. 95% confidence interval of the mean is provided for each Cohort at each time point and significance tests (independent t-test) are shown for the start of the baseline period and at the end of the 12-month follow-up.

Figure 6-7 show during the initial 12-week PEG only the Reassured Self subscale improved significantly for the Cohort 1, whereas all three subscales showed significant improvement for the Cohort 2. For all three subscales, Cohort 1 showed significant improvement and Cohort 2 showed significant deterioration during the 40-week CFTG. Following the 12-month TAU period the deterioration in Hated Self and Reassured Self remained significant for Cohort 2 and the improvement for Cohort 1 in Inadequate Self was also significant. As with the other measures the end of study scores were significantly different for the Cohorts.

Social rank Measures

Submissive Behaviour Scale

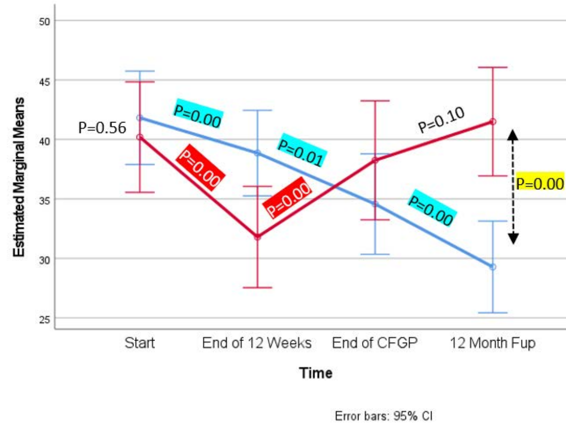


Figure 6-8 Outcomes across the entire period of evaluation for the SBS Cohort 1: PEG+CFTG is depicted as a blue line and Cohort 2: PEG+TAU is depicted as a red line. 95% confidence interval of the mean is provided for each Cohort at each time point and significance tests (independent t-test) are shown for the start of the baseline period and at the end of the 12 month follow-up.

The trend for Cohort 1 demonstrates a steady significant improvement over the course of the study period. Whereas Cohort 2 showed significant improvement in the first 12 week PEG, followed by a significant deterioration over the 40-week CFTG period, this was followed by a non-significant continuation in the trend of deterioration during the 12 month TAU period.

Social Comparison Scale

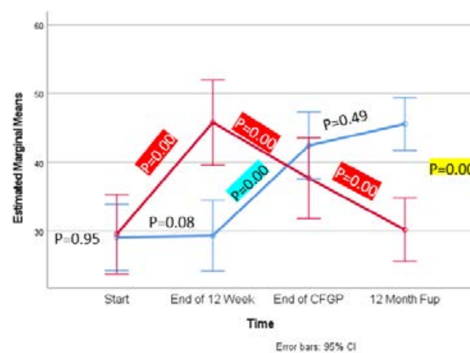


Figure 6-9 Outcomes across the entire period of evaluation for the SCS Cohort 1: PEG+CFTG is depicted as a blue line and Cohort 2: PEG+TAU is depicted as a red line. 95% confidence interval of the mean is provided for each Cohort at each time point and significance tests (independent t-test) are shown for the start of the baseline period and at the end of the 12 month follow-up.

The magnitude of change in Cohort 2 during the first 12 week of PEG was not only highly significant but also in stark contrast to the lack of change in Cohort 1 during the same time period. Cohort 2 deteriorated significantly during the CFTG 40-week period in contrast with the significant improvement in Cohort 1. The deterioration for Cohort 2 continued to be significant during the 12-month TAU period, whereas Cohort 1 maintained a non-significant improvement. But the end of the study Cohort 2 scores has returned to the baseline level (see figure 6-9 above).

Other as Shamer Scale

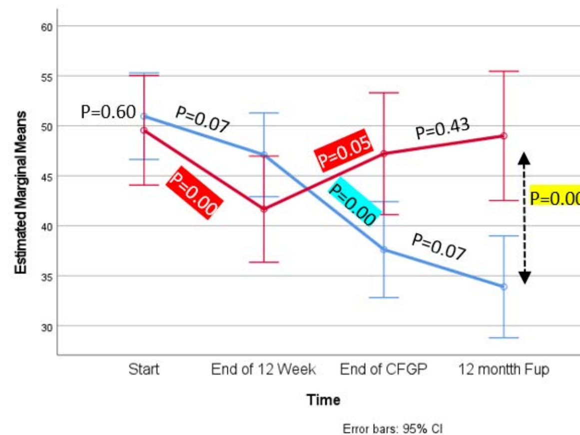
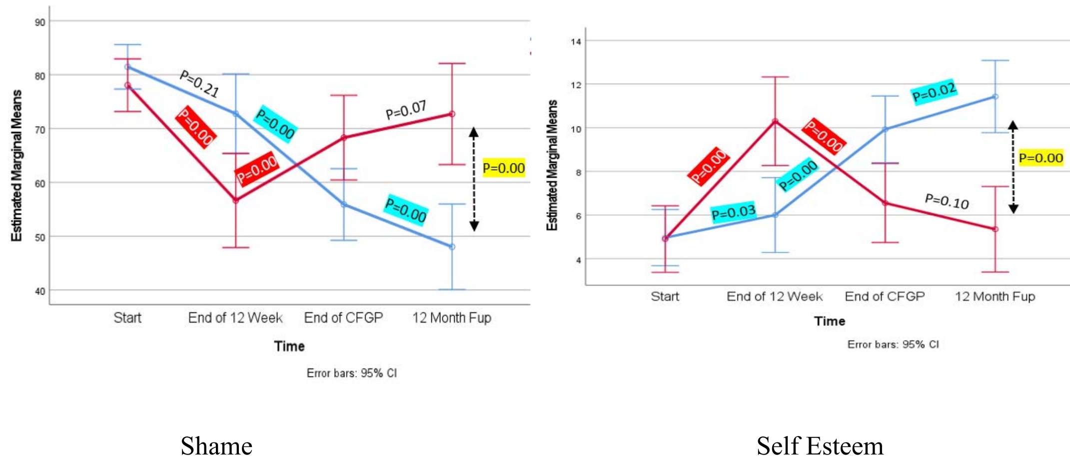


Figure 6-10 Outcomes across the entire period of evaluation for the OAS Cohort 1: PEG+CFTG is depicted as a blue line and Cohort 2: PEG+TAU is depicted as a red line. 95% confidence interval of the mean is provided for each Cohort at each time point and significance tests (independent t-test) are shown for the start of the baseline period and at the end of the 12 month follow-up.

Cohort 2 made significant improvements in the first 12 weeks of PEG whereas Cohort 1 did not reach significance. Cohort 2 reached a significant level of deterioration while Cohort 1 reached significance in improvement. Both Cohort s continued with the trend towards non-significant deterioration and improvement respectively (see Figure 6-10 above).

Internal Shame Scale



Shame Self Esteem

Figure 6-11 Outcomes across the entire period of evaluation for the ISS Cohort 1: PEG+CFTG is depicted as a blue line and Cohort 2: PEG+TAU is depicted as a red line. 95% confidence interval of the mean is provided for each Cohort at each time point and significance tests (independent t-test) are shown for the start of the baseline period and at the end of the 12-month follow-up

Cohort 1 improved at a significant level in the Shame subscale across the three time periods of the intervention. Cohort 2 similarly improved to a significant level during the 12-week PEG, however the trend reversed to demonstrate a significant deterioration during the CFTG, which continued at a non-significant level during the 12 month TAU period.

Dropout

From Cohort 1: PEG+CFTG, 1 participant refused the follow up meeting / home visit and also decided not to complete the measures and 1 participant took their own life 9 months after the end of the therapy intervention. All participants in Cohort 2 either completed the measures independently or agreed to a meeting. Therefore, follow up data was gathered for 29 participants in Cohort 1 and 21 in Cohort 2.

Service Utilisation

The frequency of usage of basic health, social care and specific mental health services for both Cohorts was obtained for the twelve months prior to the study (baseline - A), for the twelve-month period of the treatment programs (i.e., the period inclusive of the Preparation and Engagement Group and the Compassion Focused Trauma Group - B), and for the twelve-month follow-up period – C). Therefore, the evaluation points mark the beginning, end of

therapy and end of the one-year follow-up. It is of note that this data was based on self-report measures and should therefore be treated with some caution.

Self-report data were gathered regarding the frequency of GP attendances, emergency GP attendances and emergency CPN attendances and Psychiatrist attendances in the 12 months prior to the joining the study. These data were reported with the percentage of each Cohort who attended an appointment during each period of evaluation, and the average number of attendances for each Cohort at each time point.

GP Attendance

Table 6-1 The number and percentage of persons attending GP appointments during the baseline, period of therapy and 12 month follow-up and Fisher's exact p values for pairwise differences

	12-month prior therapy A	12-month period of therapy B	12-month Follow-up C	p(A Vs B)	p(B Vs C)	p(A Vs C)
Cohort 1: PEG-CFTG	97.5% (40/41)	93.%% (29/31)	77.4% (24/31)	0.57	0.1466	0.0176
Cohort 2: PEG-TAU	96.5% (26/27)	90.4% (19/21)	95.2% (20/21)	0.573	>0.999	>0.999
p(Cohort 1 Vs Cohort 2)	>0.999	>0.999	0.1225			

Table 6-1 shows a Fishers Exact test of the differences in the number of persons attending GP appointments in Cohort 1 and Cohort 2 did not show any significant differences between the Cohorts in the baseline 8 week period (A) the 12 month intervention period (B) and the 12 month follow-up period (C) However, Cohort 1 showed a significant reduction in GP visits when the 12 month follow up period was compared with the 12 month period prior to therapy (Fishers exact p = 0.0176).

Table 6-2 The mean and standard deviation of the number of GP appointments during the baseline, period of therapy, and 12 month follow-up. Independent t-test P values for pairwise comparisons are provided.

	12-month prior therapy A	12-month period of therapy B	12-month Follow-up C	p(A Vs B)	p(B Vs C)	p(A Vs C)
Cohort 1: PEG-CFTG	Mean = 10.80 (SD) 6.225 N= 41	Mean = 4.419 (SD) 3.253 N = 31	Mean = 3.3 (SD) 3.174 N = 30	<0.001	0.267	<0.001
Cohort 2: PEG-TAU	Mean = 10.33 (SD) 9.494 N= 27	Mean = 7.857 (SD) 5.19 N= 21	Mean = 7.75 (SD) 4.586 N= 20	0.289	0.945	0.269
p(Cohort 1 Vs Cohort 2)	0.806	0.005	<0.001			

The mean and SDs were calculated for each time point, followed by an independent T-test to establish the pairwise comparisons. The range in the individual number of attendances for Cohort 1 was 0-30 and for Cohort 2 was 0-50. In the 12-month intervention period (B) and the 12-month follow-up period (C), there were significant differences between the two Cohort s (p=0.00; p=<0.001) with a reduction in frequency of appointments for Cohort 1. Only Cohort showed a significant difference between A and B (p=<0.01) and A and C (<0.001). See Table 6-2 above.

Service utilisation and activity measures

Emergency GP Appointments

Table 6-3 The number and percentage of persons attending emergency GP appointments during the baseline, period of therapy and 12-month follow-up and Fisher's exact p values for pairwise differences

	12-month prior therapy A	12-month period of therapy B	12-month Follow-up C	p(A Vs B)	p(B Vs C)	p(A Vs C)
Cohort 1: PEG-CFTG	68% (28/41)	21%% (7/31)	14% (4/31)	<0.001	0.507	<0.001
Cohort 2: PEG-TAU	52% (14/27)	64% (13/21)	54% (15/21)	0.564	0.744	0.236
P (Cohort 1 Vs Cohort 2)	0.2076	0.0086	<0.001			

A Fishers Exact test of the differences in the number of persons attending emergency GP appointments in Cohort 1 and Cohort 2 did not show any significant differences between the Cohort s in the baseline 8-week period (A). In the 12-month intervention period (B) and the 12-month follow-up period (C), there were significant differences between the two Cohort s (p=0.00; p=<0.001) with a reduction in frequency of appointments for Cohort 1.

Cohort 1 showed a significant reduction in emergency GP appointments when the 12 months prior to intervention period was compared to the 12-month period of the intervention (p=<0.001) and when the 12 months follow up period was compared with the 12-month period prior to therapy (Fishers exact p = <0.001).

Table 6-4 The mean and standard deviation of the number of Emergency GP appointments during the baseline, period of therapy, and 12 month follow-up. Independent t-test P values for pairwise comparisons are provided.

	12-month prior therapy A	**12-month period of therapy B**	**12-month Follow-up C**	**p(A Vs B)**	**p(B Vs C)**	**p(A Vs C)**
Cohort 1: PEG-CFTG	Mean = 2.146 (SD) 1.837 N= 41	Mean = 0.548 (SD) 1.150 N = 31	Mean = 0.166 (SD) 0.461 N = 30	<0.001	0.096	<0.001
Cohort 2: PEG-TAU	Mean = 2.076 (SD) 4.204 N= 27	Mean = 1.095 (SD) 1.044 N= 21	Mean = 0.85 (SD) 0.875 N= 20	0.303	0.422	0.207
p(Cohort 1 Vs Cohort 2)	0.925	0.087	<0.001			

The mean and SDs were calculated for each time point, followed by an independent T-test to establish the pairwise comparisons. At baseline, participants in Cohort 1 made more emergency GP appts, which did not reach significance. The variance in the number of appointments for Cohort 1 was (0-6), whereas for Cohort 2 (0-20). The within group comparisons for Cohort 1 show a significant reduction between time point A and B (p=0.035) and between A and C (p=0.016), indicating the level of change was most significant during the intervention period. The between group difference was significant at the 12-month follow up (C) only (p=0.005).

Emergency CPN Appointments

Table 6-5 The number and percentage of persons attending emergency CPN / Psychiatrist appointments during the baseline, period of therapy and 12-month follow-up and Fisher's exact p values for pairwise differences

	12-month prior therapy A	**12-month period of therapy B**	**12-month Follow-up C**	**p(A Vs B)**	**p(B Vs C)**	**p(A Vs C)**
Cohort 1: PEG-CFTG	45% (18/41)	16% (5/31)	10% (3/31)	0.026	0.707	0.001
Cohort 2: PEG-TAU	67% (18/27)	38% (8/21)	48% (10/21)	0.583	0.755	1.000
p(Cohort 1 Vs Cohort 2)	0.165	0.1048	0.004			

A Fishers Exact test of the differences in the number of persons attending emergency CPN / Psychiatrist appointments in Cohort 1 and Cohort 2 did not show any significant differences between the Cohort s in the baseline 8-week period (A). In the 12-month follow-up period (C), there was a significant difference between the two Cohort s (p=0.004) with a reduction in frequency of appointments for Cohort 1. Cohort 1 showed a significant reduction in emergency GP appointments when the 12 month prior to intervention period was compared to the 12 month period of the intervention (p=0.026) and when the 12 month prior to intervention period was compared with the 12 month follow up period was compared with the 12 month period prior to therapy (Fishers exact p = 0.001).

Table 6-6 The mean and standard deviation of the number of Emergency CPN / Psychiatric appointments during the baseline, period of therapy, and 12-month follow-up. Independent t-test P values for pairwise comparisons are provided.

	12-month prior therapy A	**12-month period of therapy B**	**12-month Follow-up C**	**p(A Vs B)**	**p(B Vs C)**	**p(A Vs C)**
Cohort 1: PEG-CFTG	Mean = 3.658 (SD) 7.663 N= 41	Mean = 0.645 (SD) 1.1623 N = 31	Mean = 0.02 (SD) 0.644 N = 30	0.032	0.01	0.012
Cohort 2: PEG-TAU	Mean = 1.269 (SD) 2.089 N= 27	Mean = 1.523 (SD) 3.010 N= 21	Mean = 1.55 (SD) 0.1512 N= 20	0.723	0.968	0.552
p(Cohort 1 Vs Cohort 2)	0.119	0.146	<0.001			

The mean and SDs were calculated for each time point, followed by an independent T-test to establish the pairwise comparisons. At baseline, participants in Cohort 1 made more emergency CPN Psychiatric appts, which did not reach significance. The variance in the number of appointments for Cohort 1 was 0-30, whereas for Cohort 2 was 0-9. The within group comparisons for Cohort 1 show a significant reduction in mean number of appointments between all three time points. The between group difference was significant at the 12-month follow up (C) only (p=<0.001).

Employment Data

Table 6-7 the number and percentage of persons unemployed due to ill health by Cohort during the baseline, period of therapy and 12 month follow-up and Fisher's exact p values for pairwise differences

	12-month prior therapy A	12-month period of therapy B	12-month Follow-up C	p(A Vs B)	p(B Vs C)	p(A Vs C)
Cohort 1: PEG-CFTG	80% (33/41)	54% (17/31)	29% (9/31)	0.045	0.470	0.000
Cohort 2: PEG-TAU	66% (18/27)	70% (15/21)	70% (15/21)	0.763	1.000	0.763
p(Cohort 1 Vs Cohort 2)	0.400	0.2600	0.0043			

A Fishers Exact test of the differences in the number of persons unemployed due to ill health in Cohort 1 and Cohort 2 did not show any significant differences between the Cohorts in the baseline 8-week period (A). In the 12-month follow-up period (C), there was a significant difference between the two Cohorts (p=0.004) with a reduction in number of persons being unable to work due to ill health for Cohort 1. Cohort 1 showed a significant reduction in the number of people when the 12 month prior to intervention period was compared to the 12 month period of the intervention (p=0.045) and when the 12 month prior to intervention period was compared with the 12 month follow up period was compared with the 12 month period prior to therapy (Fishers exact p = <0.001).

The % of participants in Cohort 1 unemployed due to sickness reduced by 24% during the CFTG treatment intervention and again by 24% in the 12-month follow-up period. Whereas Cohort 2 increased by 5% and then remained at 70% at the 12 months follow up.

Table 6-8 The employment status of participants prior to intervention and at 12-month follow-up (whole data set)

Cohort	Employed	Part Time Employed	Education	Voluntary	Retired	Carer	Unable to work due to sickness	Not Known
Cohort 1 -12 month prior to intervention (A)	3/41 (8%)	1/41 (2%)	1/41 (2%)	1/41 (2%)	1/41 (2%)	1/41 (2%)	33/41 (80%)	0/41 (0%)
Cohort 1 – 12 month post intervention follow up (C)	8/41 (19%)	6/41 (14%)	0/41 (0%)	7/41 (17%)	1/41 (2%)	1/41 (2%)	13/41 (31%)	5/41 (12%)
Significance of difference in proportion	0.09	0.15		0.003	0.5	0.5	<0.001	
Cohort 2 – 12 month prior to intervention (A)	4/27 (14%)	2/27 (7%)	1/27 (3%)	2/27 (7%)			18/27 (66%)	0/27 (0%)
Cohort 2 - 12 month post intervention follow up (C)	3/27 (11%)	1/27 (3%)	0/27 (0%)	0/27 (0%)			18/27 (66%)	5/27 (18%)
Significance of difference in proportion	0.32	0.20					0.50	

Table 6-8 represents the whole data set regarding employment status, as it was possible to gather employment status at follow up for those who had dropped out of the study. This analysis showed a significant difference in Cohort 1 for the Voluntary work category, which increased and Unable to Work due to Sickness which reduced.

Table 6-9 Mean and standard deviation of the number of days lost to sickness during the baseline, period of therapy, and 12-month follow-up. Independent t-test P values for pairwise comparisons are provided.

	12-month prior therapy A	**12-month period of therapy B**	**12-month Follow-up C**	**p(A Vs B)**	**p(B Vs C)**	**p(A Vs C)**
Cohort 1: PEG-CFTG	Mean = 297.51 (SD) 138.90 N= 41	Mean = 202.25 (SD) 182.39 N = 31	Mean = 161.33 (SD) 181.25 N = 30	0.014	0.383	<0.001
Cohort 2: PEG-TAU	Mean = 271.42 (SD) 157.52 N= 27	Mean = 246.71 (SD) 171.54 N= 21	Mean = 272.5 (SD) 159.09 N= 20	0.607	0.621	0.982
p(Cohort 1 Vs Cohort 2)	0.475	0.381	0.031			

The mean and SDs for the number of days lost to sickness were calculated for each time point, followed by an independent T-test to establish the pairwise comparisons, shown in Table 6-9. Those who stated that they were unable to work were given a score of 365 days. The within group comparisons for Cohort 1 show a significant reduction in the number of days lost to sickness which corelates with the increase in employment and educational activity between time point A and B (p=0.014) and between A and C (p=<0.001), indicating

the level of change was most significant during the intervention period. The between group difference was significant at the 12-month follow up (C) only (p=0.031).

Table 6-10 The number and percentage of persons claiming unemployment benefit by Cohort during the baseline, period of therapy and 12-month follow-up and Fisher's exact p values for pairwise differences

	12-month prior therapy A	12-month period of therapy B	12-month Follow-up C	p(A Vs B)	p(B Vs C)	p(A Vs C)
Cohort 1: PEG-CFTG	76% (31/41)	65% (20/31)	44% (13/31)	0.432	0.126	0.006
Cohort 2: PEG-TAU	56% (15/27)	50% (10/21)	70% (14/20)	0.771	0.208	0.373
p(Cohort 1 Vs Cohort 2)	0.1135	0.2633	0.084			

A Fishers Exact test of the differences in the number of persons claiming unemployment benefit in Cohort 1 and Cohort 2 did not show any significant differences between the Cohorts, Table 6-10 above. Cohort 1 showed a significant reduction in the number of people claiming unemployment benefit when the 12 months prior to intervention period (A) was compared to the 12-month follow up period (C) (p=0.006).

The percentage of participants in Cohort 1 unemployed due to sickness reduced by 24% during the CFTG treatment intervention and again by 24% in the 12-month follow-up period. Whereas Cohort 2 increased by 5% and then remained at 70% at the 12 months follow up.

Table 6-11 The mean and standard deviation of the number of benefit payments claimed by participants during the baseline, period of therapy, and 12 month follow-up. Independent t-test P values for pairwise comparisons are provided

	12-month prior therapy A	12-month period of therapy B	12-month Follow-up C	p(A Vs B)	p(B Vs C)	p(A Vs C)
Cohort 1: PEG-CFTG	Mean = 2.146 (SD) 1.388 N= 41	Mean = 1.387 (SD) 1.406 N = 31	Mean = 1.366 (SD) 1.473 N = 30	0.025	0.955	0.026
Cohort 2: PEG-TAU	Mean = 1.576 (SD) 1.629 N= 27	Mean = 1.476 (SD) 1.569 N= 21	Mean = 2.2 (SD) 1.609 N= 20	0.831	0.152	0.198
p(Cohort 1 Vs Cohort 2)	0.127	0.831	0.065			

The mean and SDs for the number of benefit payments claimed by participants were calculated for each time point, followed by an independent T-test to establish the pairwise comparisons, Table 6-11 above. The within group comparisons for Cohort 1 show a significant reduction in the number of benefits claimed by participants which corelates with

the increase in employment and educational activity and reduction in levels of sickness between time point A and B (p=0.025) and between A and C (p=0.026), indicating again that the level of change was most significant during the intervention period.

Table 6-12 The number and percentage of persons discharged from Mental Health Services by Cohort at the 12-month follow-up and Fisher's exact p values for pairwise differences

	12-month Follow-up
Cohort 1: PEG-CFTG	43% (13/30)
Cohort 2: PEG-TAU	3% (1/20)
p(Cohort 1 Vs Cohort 2)	P<0.001

A Fishers Exact test of the differences in the number of persons who had been discharged from Mental Services at 12 months follow up, Table 6-12 above. There was a highly significant difference with Cohort 1 having a significant larger number of discharges. It is of note that the reasons for discharge were not available, however the data were examined regarding potential correlations with employment status. Table 6.13 below shows that the majority of this group who were discharged during the 1 year Follow up TAU period had also returned to some form of work or education.

Table 6-13 The employment status of participants in Cohort 1 who had been discharged from Mental Health Services at 12-month follow-up

Cohort	**Employed**	**Part Time Employed**	**Education**	**Voluntary**	**Retired**	**Carer**	**Unable to work due to sickness**	**Not Known**
Cohort 1 – baseline (A)	3/13 (23%)	1/13 (8%)					9/13 (69%)	
Cohort 1 – 12 month follow up (C)	7/13 (54%)			3/13 (23%)			3/13 (23%)	

Discussion

The examination of the data set as a whole over the course of the study from baseline to end of follow up has revealed some consistent patterns which are evident in the process, symptom and adjustment measures.

At the commencement of the study there were some significant differences between the Cohorts with Cohort 1 reporting higher levels of disturbance in some symptom measures; Risk, Wellbeing and Functioning. In essence meaning that Cohort 1 were starting from a position of disadvantage symptomatically. During the PEG intervention, there was a marked

improvement across all measures for Cohort 2, reaching significance in most cases, with the exception of Wellbeing, Risk and Problems (CORE). This could possibly be explained by the high level of missing data for CORE across both Cohorts. This improvement possibly represented an 'early gains' phenomena as described in Chapter 4. These gains were not maintained for Cohort 2, in the 40 week TAU, who showed significant deterioration across all measures, with the exception of Hyperarousal, Intrusion (IES), Risk (CORE) and Expressing Compassion to Others (FCS). During the 12-month TAU period the trend towards deterioration continued for Cohort 2, which reached significance for over half of the process, symptom and adjustment subscales.

This trend was initially followed to a less significant level with Cohort 1 data demonstrating significant improvements during the 12-week PEG for only eight out of the twenty-two subscales (Depression, WASA, Reassured Self, Wellbeing, SBS, Shame, Expressing Compassion for Others and Expressing Compassion for Self). The level of improvement, however, increased to highly significant for all subscales during the 40 CFTG which is represented by the 'cross over' effect with the Cohort 2 deteriorating and Cohort 1 improving to a similar degree. This cross over period demonstrates the impact of continued intensive therapy for Cohort 1 compared with TAU for Cohort 2. This data perhaps indicates that the 12-week PEG was an insufficient 'dose' of therapy to support lasting change. During the 12-month TAU period for Cohort 1 the level of improvement continued but at a more modest rate with only Expressing Compassion for Others, Inadequate Self, SBS, ISS reaching significance. The therapeutic gains from the intervention period were however, maintained across all subscales.

The difference between the two Cohorts was highly significant for all of the outcome measures at the conclusion of the study, demonstrating the magnitude of change that can be attributed to the 40-week CFTG.

The analysis of the service utilisation and employment data revealed patterns which appear to match the quantitative data. The reduction in number and frequency of GP appointments, emergency GP, CPN and Psychiatrist appointments reached significance for Cohort 1 during the intervention 12-month period and also from the baseline to end of 12 month TAU, indicating that service utilisation reduced for Cohort 1, whereas the changes for

Cohort 2 did not reach significance. The difference in the averages for the two Cohorts were significant for all the service usage categories at the 12-month TAU follow up, with Cohort 2 showing very little change in number of appointments and frequency of service usage.

There are of course multiple variables which could impact on service usage, however it is of note that the differences in the Cohorts are highly significant matching the significant differences in the Cohort's symptoms of distress, social rank, capacity for compassion, self-care and activities of daily living at the conclusion of the study.

The data relating to employment and meaningful activity matched the service usage with significant changes in number of people being unable to work due to sickness, number of days lost to sickness and number of people claiming unemployment benefit. These changes followed the same pattern with Cohort 1 reporting significant reductions in the 12-month intervention period and also the 12-month TAU. The differences between the Cohorts were also significant at the end of the 12-month TAU period with little or no change observed in the Cohort 2 data.

At the conclusion of the study nearly half of Cohort 1 had been discharged from Mental Health Services, representing a significant reduction in service usage, in contrast with 3% of Cohort 2. It is also significant that 77% of this discharged group were in some form of education, employment, or voluntary work at the 12-month follow-up time point.

This combined data provides some evidence that the CFGP program, made up of 12 week PEG followed by 40 week CFTG supports symptom, process and adjustment level change which is maintained at 12 month follow and is also associated with reduction in service usage, including discharge from MH services and increase in employment and meaningful activity. This trend is reversed for those who had the 12-week PEG only with no further therapeutic intervention. The deterioration continued during the 12 months follow up period with some subscales reaching significance, coupled with no significant change in service usage and capacity for work.

These service usage and quantitative data will now be contextualised by the exploration of the participant experience. This next chapter will offer an analysis of the semi-structured interviews of a selection of participants.

Chapter 7: The Participant Experience

The previous chapter explored the impact of the therapeutic intervention on service utilisation and employment status. The data demonstrated a significant difference between the end of program status of the two Cohorts, with higher numbers in the Cohort 1 engaged in employment or employment-based activities at the 12 month follow up. Whereas for Cohort 2 there was either no change or a small increase in service utilisation and number of participants claiming sickness benefit due to being unable to work.

Tentative links can be made with the treatment intervention and the reduction in service utilisation, however consideration must be given to some of the differences between the two Cohorts regarding diagnosis.

Introduction

This chapter will explore the patient's views of perceived key components of the group for participants who attended the 12-month Compassion Focused Group Psychotherapy Program. The aim of the qualitative component was to develop an in depth understanding of "what it is like" to be in the group, in this case the Compassion Focused Group Psychotherapy Program (CFGP) for 12 months (Willig, 2013, p.8).

The method of analysis chosen was Thematic Analysis (Braun & Clark, 2016) and the chapter presents a number of main themes which emerged from the thematic analysis of interview data. Thematic Analysis was chosen as the method is broadly understood to provide generic skills applicable to all areas of qualitative analysis but within a flexible format, *"which can potentially provide a rich and detailed yet complex account of data"* (Braun & Clark, 2006, p.78). Given the need to explore and identify recurring themes across participants, Thematic Analysis offers an opportunity to capture this diversity without the need for predefined hypothesis or constructs (Braun & Clark, 2006; Roulson, 2001). Given the paucity of published qualitative research on the impact of Compassion Focused Therapy on participants and therefore no established theoretical framework, the data formed the basis of the analysis (Braun & Clark, 2006).

Aims of Present Study

To date there have been two published qualitative studies of CFT (Lawrence & Lee, 2014: Ashfield, Chan & Lee, 2020). The Lawrence and Lee (2014) study followed an Interpretative Phenomenological Analysis format exploring in detail the experience of five participants from a CFT for trauma group, whereas Ashfield et al. (2020) utilised a Grounded Theory analysis to develop a theoretical framework to describe the change process. It is of note that the Ashfield et al. (2020) study made certain assumptions that participants would experience change as result of the therapeutic intervention.

Both published studies above explored a similar intervention to that delivered in the current study, however there were also key differences including, length of intervention (12 weeks versus 12 months), the number of participants interviewed (five versus nine in the current study), the presenting difficulties of the participants. Furthermore, all participants in the current study had Attachment and Relational Trauma (A&RT) and had a diagnosis of Personality Disorder (PD), which crossed over with some of the participants in the Lawrence and Lee (2014) and Ashfield et al. (2020) studies but not exclusively. These key factors as well as the need to focus on perceived components across participants rather than individual's experience informed the decision to use a Thematic Analysis method to explore and establish the presence of repeating patterns related to how participants made sense of their experience of the therapeutic intervention (Braun & Clark, 2006).

Methods

Design

A qualitative semi-structured interview study of the perceptions of key components of the twelve-month Compassion Focused Group Psychotherapy program arm.

Procedure

At the commencement of the study and as part of the recruitment process, all participants were interviewed and given information about the full study (cf Chapter 3).

Participants were then invited to consent to be involved in the study, which included the possibility of a post therapy interview about their experience. The qualitative data used for the analysis reported in this chapter was collected from Cohort 1 (PEG + CFTG) who were all exposed to the intervention over a 12-month period. Participants who consented to this element of the study were separated into five small groups which represented the informal clusters of participants who had completed the programme during approximately the same time period and had therefore received their treatment together. Two participants were selected at random from each small group with the aim of offering a broad spread of opinion about the programme over the five-year time period.

The selected participants were then invited to attend the Psychotherapy Service to take part in the interview about their experience of the therapy. It is of note that all participants approached to be interviewed agreed and were subsequently interviewed. Interviews were conducted by an independent research assistant not familiar with the CFT model or the research protocols. This was to ensure impartiality and curiosity in the mind of the interviewer (Lyons & Coyle, 2007). She had attended two one day training events for post graduate researchers at the University of Birmingham engaging in qualitative research.

A set of semi structured interview questions were developed by the author, in consultation with the literature (Lyons & Coyle, 2007) and academic supervisors. Following this the research assistant conducting the interviews was provided with training that included guidance about the best way to elicit information about the participant experience (See Appendix I - Interview schedule). The semi structured questions also had prompts for additional information if needed. An early draft of the interview schedule was altered slightly following the first interview, following feedback from the participant and interviewer. An extra question and prompts were added about any goals that the participant might have had for the intervention prior to commencing the program.

Each participant was offered an opportunity to withdraw their data from the study at any time and also a payment of £10 to cover travel and their time. All contact regarding the interview process was with the research assistant and not the author to ensure that the participants experienced the process as impartial (Lyons & Coyle, 2007).

All interviews were recorded and subsequently transcribed by the author towards the end of the data collection period to avoid the researcher risk of contamination of the therapy model with the feedback from participants about their experience being seen prior to the end of the group program. However it is noted that as the author also developed the group CFGP protocol, there was a high level of investment in the qualitative study which will have introduced bias to the data analysis process. In order to reduce the level of bias, sample transcripts with coding were reviewed by academic supervisor to check validity of codes and themes. It is also of note that the author discovered novel themes which are not within the current CFT literature.

In total there were ten participant interviews, there was a technical problem with one of the tapes and it was not possible to transcribe the material, therefore the final data set included nine interviews transcribed and analysed for the purposes of the research.

The transcripts were analysed according to a Thematic Analysis method, used for the *"identifying and interpreting patterns in qualitative data"* (Lyons & Coyle, 2007, p. 12). This method is recursive in that movement is required between the stages, rather than a linear process of exploring the data (Braun & Clark, 2006).

Analysis

The analysis followed the Clarke and Braun (2006) six stage process which is concerned with the development of observable themes which can be used to interpret the data and extrapolate meaning. The first phase of analysis involved *familiarisation with the data,* including transcription of the interviews. As the interviews were not conducted by the Chief Investigator, this offered an opportunity to begin to engage with and immerse in the data. The transcripts were then re-read and some initial notes made regarding the observations providing a useful way to track the emerging themes (Braun & Clarke 2006). The second phase involved *generating initial codes,* which emerged from re-reading the transcripts and notes. This involved manually summarising extracts of data, which were of interest for the author and recording them by making notes and highlighting extracts of text. Phase three involved *searching for themes and consisted of* beginning to describe the codes collectively and drawing together different codes across the data set, to develop some overarching

themes. These themes were drawn together in a diagram demonstrating seven overarching themes and the interactions between the themes (See Figure 7-1, p.164 below). Phase four and five *Reviewing Themes* involved returning to the code to ensure that they matched the generated themes and to connect the themes with quotes from the data. This is also an opportunity to review the themes and refine as necessary. Phase Five *Defining and Naming Themes*, ensured that the analysis included the *"essence"* of the theme in each case with the supporting evidence and quotations (Braun & Clarke, 2006, p.92). This element of the analysis also involved generating subthemes within each category, for example for the Theme: The Experience of connection, specific reoccurring words to describe the experience of connection were drawn together in Table 7-2 below.

The aim of this analysis was to explore in depth the participant's perceived important elements of the group therapy from their perspective and hence try to explore and elucidate some of the possible mechanisms of change.

Results

Participant sample: From the original sample of 41 participants who started the group, 30 participants completed the 12-month programme and it was this cohort that was split into 5 small groups. Two participants were selected at random from each small group to create the qualitative study participant sample. Descriptive characteristics of these patients are presented in Table 7-1.

Table 7-1 Table of participant's descriptive characteristics

Anonymised participant identifiers	Age category	Diagnostic category	HONOS cluster**	Gender	Ethnicity	% of sessions attended (of 52)
DJ	56+	PD* Avoidant	7	Female	White	74%
ED	46-55	PD Unspecified	7	male	White	88%
HM	56+	PD Avoidant	7	Male	White	96%
AJ	46-55	PD Unspecified	8	Male	Mixed race	79%
KA	25-35	Emotionally Unstable PD	4	Female	White	93%
WA	36-45	Emotionally Unstable PD	8	Female	Mixed race	72%
AC	36-45	Emotionally Unstable PD	8	Male	White	70%
HD	46-55	Emotionally Unstable PD	8	Male	Mixed race	70%
TS	36-45	Emotionally Unstable PD	4	Female	White	88%

* PD is used to describe the diagnostic category of Personality Disorder
** HONOS stands for Health Of the Nation and is a numerical scale indicating level of severity of presenting difficulties. It is note that there is a correlation between Cluster 7 and 8 and a diagnosis of Personality Disorder.

Thematic analysis results

The following sections present the overall results of the thematic analysis in terms of themes and sub-themes, each with illustrative verbatim quotes from participants. The overall results are displayed in diagrammatic form in Figure 7-1. The name of each participant was anonymised to ensure confidentiality and participant identifiers are represented in Table 7-1 and at the end of each quote. The presentation of results will be followed by an exploration and discussion of each theme and the connections between the themes.

The aim of this section is to offer a coherent narrative which emerged from the data which mark the key elements of change in the participant's journey through the CFGP 12-month therapeutic intervention.

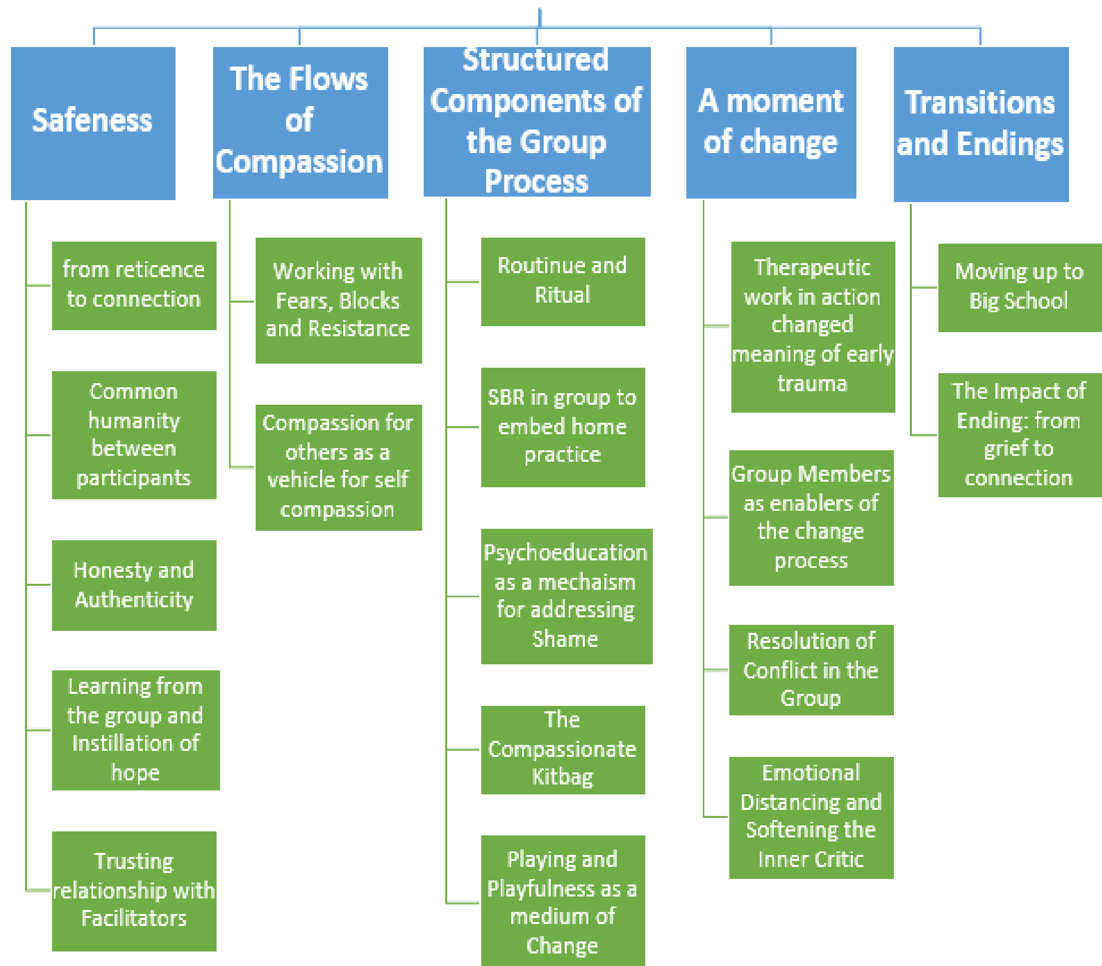


Figure 7-1 Tree Diagram of Themes and Subthemes

Theme One: The experience of safeness

This main superordinate theme emerged from the data which was shared by all participants and describes the experience of the overall therapeutic journey. Participants described different ways that the experience of being part of the group and being with the other groups members and the group facilitators enabled them to engage fully in the therapeutic intervention. Five subthemes emerged to describe the different ways that participants experienced the phenomena of connection and the links which were made to the mechanisms of change.

Subtheme One -From reticence to connection

Many participants described a particular process or journey which started with reticence to be with and share with others and ended with a deep sense of connection.

> *"At first I hated being in the group .. But then I started to rely on the group and wanted to be part to it sharing things .. Emotional .. Hurtful thing and the group became very important definitely"* (AC)

> *"We gained a bond I'd bonded different with all the people in the group … when one group member went into hospital we all felt it" (*HM)

Similarly this participant expressed surprise that she was able to make connections with other participants and tolerate the group process as it unfolded.

> *"I was thinking I don't know how I was going to be in a group but I was able to tolerate others.. also I ended up bonding with people as well over a year and seeing them in a way... tolerate more I suppose"* (WA)

Subtheme Two –Common humanity between participants creating safeness

Predominantly participants described that the process of being treated within a group setting with others who had similar difficulties created a sense of safeness,

> *"Something just shifts and you make a connection"* (DJ)

> *"Everyone in this group is here for the same reasons .. we are all equal and was how we treated each other"* (HM)

> *"Enforced exposure to other human being that made me realise that we are all in the soup we are all swimming in the soup erm and because I realised that it wasn't just me in the soup on my own"* (TS)

> *"Some people would say things that .. struck a chord with you.."* (KA*)*

> *"It's seeing your experience mirrored back… reflected in everyone else's experience.. Understanding we are all suffering"* (TS)

Subtheme Three –Honesty and authenticity as a mechanism of change

For some participants there seemed to be a focus on where members were invited to be authentic and honest with each other and themselves.

> *"The emphasis was really on .. on .. the safe space and this was a place where you could come and you could .. I used to refer to it as the no bullshit zone.. you know you come here and you can drop your mask"* (ED)

> *"I think I just found that just opening up and being honest I think that was really powerful" (ED)*

Another strand to this subtheme was the idea that group participants supported each other with acceptance and offered *"safe challenges"* (AJ) to stuck patterns of responding, as a means to facilitating connection to feelings of vulnerability and ultimately to change.

> *"You had to be honest with yourself and that opens you up and when you open up it shows who you truly are and it's very difficult .. the openness within the group.. there were times when I'd draw back or other people would draw back but people in the group would challenge and that was part of then therapy trying to get you drawn out"* (AJ)

> *"You can present yourself warts and all people will go yeah ok.. something great about being able to realise this stuff .. and for that to be acknowledged not sort of automatically forgiven .. challenging as well but that you could work it through safely .."(ED)*

> *"The first time in my life where I've had a family .. it's ok you're accepted and you kind of have your hand held"* (TS)

Subtheme Four – Learning from the Group and the instillation of hope

Linked closely to the previous subtheme was the experience that participants reported of learning from each other through being connected, trusting and mutual support.

> *"Everyone brought something to the table I learned something from each individual member of that group and hopefully I gave them something too yeah" (CA)*

"One person we had to bring out because they got really stuck and had gone into a space and couldn't get themselves out and that was good" (MH)

"it was emphasised that this was a safe space and it can't work without it is an essential part" (ED)

The implicit learning from observing group members make changes and try new things acted as a catalyst for participants and instilled hope.

"When you see other people embrace what's happened and come further and further it helps yourself as well.. if they're brave enough to do it then you know I've got to be brave enough and it happened over and over in the group" (HM)

"Seeing people change in small ways that gives you a lot of hope … maybe this could happen for me .. and making bonds with people" (AC)

<u>*Subtheme Five – Trusting relationship with facilitators*</u>

The impact of the facilitators on therapeutic process was referred to explicitly by every participant, the experience of the participants can be clustered into a number of interacting ideas. Initially there were a number of comments indicating the participant's perception of a compassionate motivation and intention of the facilitators towards the group.

"I got a strong impression that they weren't just coasting they were serious about this .. they were serious about helping this group" (ED).

"….they were very compassionate people and very sneaky (laugh) they were able to see through the bullshit and draw out the real side of things .. being lighthearted in stressful moments but also having the understanding and care that they have .. don't change" (AJ).

Another participant spoke about the experience of the facilitators as attuned and the impact that this had on undermining the internal critic.

"Things were said made me realise that they were paying attention .. that means a lot if you have a negative self image .. when somebody pays attention 2 or 3 months later and they remember something you said.. that is worth a lot" (HD).

Participants spoke of similar experiences of developing a bond with the facilitators and that this was the foundation to change.

"I had to tell him that he had been the most significant male figure in my life ever .. because I grew a bond" (AC).

*It was trust .. it was trust.. I build a relationship with this lady who was sat next to me .. and I trusted that.. she was gonna sit there with me until I felt OK to make a decision (*TS*).*

The differences between the way and style of engaging in the therapy was also found by some to be important.

"[he - facilitator] *was a bit more challenging .. provocative whereas [she – facilitator] had a more gentle approach not too gentle the contrast was empathic .. I liked the combination they were just different and it worked"* (WA)

Table 7-2. illustrates words frequently used by participants to describe the experience within the group which linked to 'safeness'.

Table 7-2 Frequency of word usage

Words used by participants to describe the Theme of 'Safeness'	Number of participants using this term or derivatives	Frequency of occurrence of word in data set as a whole by participants (related to group process)
"Belonging"	3	5
"Sharing"	7	34
"*Bond"*	6	19
"Tribe"	3	5
"*Family"*	5	14
"*Connection"*	7	23
"Caring for and from the group"	8	17
"Acceptance"	7	11
"Trust"	5	16
"Honest"	8	33
"Safe"	7	35

Theme Two – The Flows of Compassion

Many participants identified and made reference to the implicit and explicit focus on developing the three flows of compassion (to others, from others and to the self) and how this enabled the development of an internal compassionate motivational system. The explicit

focus on the teaching about compassion and exploring myths and misunderstandings and the implicit compassion focus in the group structure and process. Participants also made reference to the impact of the group process in experiencing and developing a capacity for giving compassion to others, receiving compassion from others and giving compassion to the self, coupled with an acknowledgement of the significant emotional challenge associated with the therapeutic work. Two closely linked subthemes emerged from the data connecting the teaching and the group experience in blocks to and developing flow of compassion.

Subtheme One – Working with the Fears, Blocks and Resistance to Compassion

A number of participants spoke of the initial reticence and suspicion that they had about the concept of compassion and how the experience in the group enabled them to learn a new way of thinking about compassion.

> "*I realised that compassion isn't necessarily all about fluffy kind of.. Of yeah you know we love ourselves, it's not like that it was quite tough, a tough kind of passion" (AW)*

> *"I didn't think I would ever feel compassion for anybody because I was so bitter and angry with the world.. but then something shifts and you make a connection .. " (DJ)*

> *"I am focused on compassion and the need for it and how essential it is.. It's just that it is difficult.." (AC)*

Participants also spoke of developing an intuitive understanding of their own compassionate competencies and the ongoing challenges associated with this.

> *"Getting more assertive.. I didn't see that as looking after myself and being compassionate to myself but by actually doing that it made such a difference" (WA)*

> *"I'm getting better at taking compassion from others .. but if people are too compassionate to me I'm obviously going to burst into tears.. " (HM)*

Subtheme Two – compassion for others as a vehicle for self compassion

There were a number of explicit references to the ways in which experiencing compassion in one area supported the development in another. Participants spoke of the experience of feeling compassion for others as a precursor for beginning to acknowledge the need to practice it for the self.

> *"It was a natural response of compassion sympathy empathy and wanting to sort of reach out.. Then the penny dropped that it was time to do it for myself" (HD)*

> *"I started feeling it [compassion] with them I'd get upset for other people and the realise .. well hang on they've just said something that is really identical to you" (AC)*

> *"CFT gives you the tools to be able to understand yourself .. understand what's happened .. what's gone on and gives you the tools to actually deal with it and move forward you know .. the compassion you can feel for others you can actually start to feel for yourself" (AJ)*

Other participants described the experience of giving and receiving compassion within the group process as a significant, but also linking with subtheme One regarding the challenges.

> *"Compassion was an alien concept .. scared the crap out of me.. but feeling compassion for everybody understanding that it was compassion for everybody and that they were feeling compassion towards me without any strong without any other motives .. it was very very strange.. you were with a group you were asking for help and they're asking for help and you were helping each other .. asking for help in the beginning was hard" (AJ)*

> *"One of the things a lot of people think is erm .. namby pamby touchy feely therapy .. it's nothing like that .. when you come to something like this you've got to understand that it is hard work and it knackers you out because of the emotional work" (AJ)*

Theme Three - The Impact of the Structured Elements of CFGP on the participant's engagement with the program

A number of key themes emerged from the data and the participants observations about the aspects of the structured programme and the impact that this had on their therapeutic journey and experience of change.

<u>*Subtheme One – Routine and ritual*</u>

This Soothing Breathing Rhythm practice (SBR) at the commencement of each session, followed by a 'check in' session was referred to by every participant, with a general theme emerging about the significance of this as a regular predictable element of the programme and the consequent experience of safeness in the room as a result. The check in was also identified by many as key to learning 'turn taking' and structured ways to begin to engage with each other.

> *"then the breathe .. it was almost like a trigger for the group that's when the work started " (AJ)*

> *"the breathing practice to get everyone in the flow of the group session … and gather yourself in really … then we'd do a check in.. then you'd pass it on to someone else and it's a way of bonding aswell and you also got to learn people's names" (AC)*

> *"I say relaxation it's actually no it's bringing yourself into the moment so it's the breathe .. Helps you sit back and gather yourself in really.. Then the group share that was really important" (AJ)*

> *"The stuff that happened that was good … happened in the round the room check in" (HD)*

The experience of trust and containment in the room was also linked by participants to the explicit development of a 'Safe Space Agreement', a group based collaborative behavioural contract which everyone agrees to abide by (cf Chapter 4, p. 47).

> *"It's the people that you respect and trust and all the rest of it and because the ground rules stay the ground rules and they are the ground rules we came up with and all that trust and shared history is still there (JA)*

"so you could actually remove yourself from the group but still be part of the group and go and calm yourself and then come back" (AJ)

"there was a safe chair .. you could put yourself and sit there until you felt comfortable enough to come back.." (HM)

<u>Subtheme Two – SBR in group to embed home practice</u>

This interconnected theme, explicitly linked the 'breathe' practice in the group with the development of regular home practice and the value of this.

I do many breathes throughout the day if I start feeling.. So I'm mindful of where I am .. And just go .. Take a moment .. And sometimes you can catch it and sometimes you can't" (ED)

I now practice that [SBR] at home was sparked off by doing it in the group .. slowly day by day.. (KA)

" it's like the breathe we did once a week and everybody practiced it at home.. and that just became natural .. it formed a habit.. it's like the critical part of me.. it's building blocks as long as I don't let things slip I can only improve on it" (HM)

Table 7-3 Participant words to describe the Soothing Breathing Rhythm Practice and their frequency

words used by participants to describe Theme	**Number of participants using this term or derivatives**	**Frequency of occurrence of word in data set as a whole by participants (related to group process)**
Breathe, Breather, breath	9	89
Settling	4	18

Table 7.3 demonstrates the significance of the SBR practice for all group members as it was named by every participant and the word occurred frequently in the text. See Appendix J for a 'word cloud' image of all the main words used by participants and their frequency.

Subtheme Three – Psychoeducation as a mechanism for addressing Shame

The teaching of the evolutionary psychology model was linked to a greater understanding by participants of their emotional experience. The 'normalising' seems to have been key to reduction in the experience of shame related to their difficulties.

> *"It's like being afraid and ashamed of your own humanity.. But the compassionate mind set.. in a way you are being realistic about human frailty and the kind of problems we all have .. It really did address shame you know" (ED)*

> *"Before I'd think I'm an idiot there's somit wrong with me but it (the old brain new brain teaching) got rid of that and the feeling of helplessness" (AC)*

> *"it wasn't just go there and pour your heart out.. it was educational which you need because without understanding how can even begin really on that path without understanding"* (AC)

Subtheme Four – The Compassionate Kitbag

The significance of the use of objects in the therapeutic work was referred to by every participant and the meaning associated with being given gifts from the group. Links were made with the helpfulness of the stones, beanbags and buttons in the context of a sensory focus in the SBR. But perhaps most significantly participants described the use of the stones as a way of connecting with and reminding of the group and the therapeutic work (cf Chapter 4, p.50).

> *"It's a virtual kitbag you might keep the breathe exercise in there and for me it was the little stones.. A picture .. A smell .. That calms and reminds you of the group" (AC)*

> *"The stones that can help you focus ..you have that visual form that is great to go back to .. refresh it for yourself … something physical there that . brings you back to the group in a way" (ED)*

> *" I've still got my stone it's got a little nick in it … and every now and then if I feel stressed I'll pick it up and do a breathe with it"* (HM)

"One of the tools is the stone it's the first stone I had.. but for me it's a reminder of what I wanted out of the group which was to be a more whole person to understand my emotions to understand erm the threat system.. to understand that I'm not alone" (JA)

<u>*Subtheme Five – Playing and Playfulness as a medium of change*</u>

The theme of playfulness was present in many of the participants feedback about what enabled them to engage with the therapeutic work. This seemed to be particularly connected with how playfulness was woven into the structure of the programme.

"There was a great sense of humour .. we all started being silly and the pressure is relieved.. there was space to do that without it being like you know no this is serious therapy .. you can't laugh" (DH)

"The togetherness it's the whole group .. not feeling self-conscious about a playing a silly game… it was good" (DJ)

"so we'd play each other up by jumping in their chairs .. general tomfoolery .. then we'd get the breathe going" (AJ)

"before I was pacing along the road looking out for dangers .. listening out for dangers causing issues .. now I'm looking around for fun.. looking to play up … looking to have a laugh so I actually get to live life now whereas before I couldn't do it" (WA)

Theme Four – A Moment of Change

This theme brings together a number of themes around the 'Action Methods' or work in action element of the Compassion Focused Trauma Group (CFTG). All participants made reference to either observing and or taking part in chair work, compassionate tranformation and group-based activities. A number of interwoven subthemes also emerged regarding the particular mechanisms of change. Participants described the experience of working in action, addressing early trauma, becoming upset and overwhelmed but that this was accepted and not judged.

Subtheme one- Therapeutic work in action changed the meaning of early trauma

Many participants spoke of a sudden and immediate moment of change, building on the foundation of early work in creating a sense of safeness.

> *"And it was a sudden understanding shit that's me I've drawn me and wanting comfort.. comfort and strength it's just like shit because that is something I never received"* (AJ)

> *"Wow that's quite difficult to answer what was best .. it being a group and running for a long time and getting off my chest some things .. the best bit was that I was waiting for 30 years to get that off my chest" (AC)*

> *"I spoke about it as an epiphany and it is one of those moments when you realise you've changed from that to .. this and you don't know where the middle has gone but you know it was a sudden understanding" (JA)*

> *"things come up which I wasn't expecting it wasn't like I could think about it cognitively.. like I am gonna talk about this when I am sitting there ..it's just things really emotional came from a different part of me.. quite challenging and important aswell.."*

> *"It is the first time I was upset without being angry and part of that was because I felt safe"* (AJ)

Subtheme Two – Group members as enablers of the change process

All participants described the significance of the other group members in supporting, challenging and facilitating working through early shame based trauma memories.

> *"they'd be like well [participant name] you've never done that before and I'd be like you're right actually .. you're right because I wouldn't see that but others do and the group can help you see what you can't or don't want to"* (AC)

> *"The verbal beating was just echoes of things said erm in an overly expectant impatient father and that was a denial of legitimacy you or your feelings are wrong or you have no right to feel them .. then the group allowed you to unpick it because*

you're not trying to constantly shove it down.. it just allows .. it is just who I am" (DH)

"I was showing emotion I was getting upset.. I was embarrassed I was frightened because of the understanding that I was crying but afterwards it made me realise actually this is a good place because you can bring that out and you won't be criticised " (AJ)

There was also an acknowledgment that observing the trauma work taking place also impacted on the therapeutic journey.

"the impact on other people in the room, it changed things for them it wasn't just the person at the front in the chairs it was everybody" (WA*)*

"so I began to realise that what happened to me was just a normal response to trauma" (DJ)

In addition to the impact of group members, many participants also identified the impact of the facilitators in this change process.

That was a turning point.. I felt like that trigger… my need to escape when things got tough didn't feel active anymore.. I could walk a middle path now.. Because I had built a relationship with this lady [facilitator] and I trusted her" (TS)

He [facilitator] said to me.. you felt that your love wasn't good enough.. It flipped a switch in me.. The years… the inadequacy just fell away and made me realise.. The love I have is ok (HD)

<u>*Subtheme Three - Resolution of conflict in the group*</u>

This theme emerged for some participants around developing new ways of dealing with conflict through the group experience where a resolution was possible. Participants also spoke of this as a contrast to the early experiences of unresolved conflicts and how this reinforces the importance of the group work programme.

“There was a big who ha… doors were slammed…then she came back and said I felt like and you made me feel like this and you know people apologise and actually she became quite a part of the group.. I guess again it’s a testimony to the effectiveness if you know for those people who kept at it.. it bears fruit” (HD)

One participant described meeting with a group member outside of the group, which was generally discouraged as this kind of situation generally disrupts the group’s sense of safeness.

“ I met him outside the group .. it did change things for me in the group.. I felt bad.. but then I asserted my boundaries and said no to him .. so then I brought it up in the group like in a confessional ..I’ve gone against the rules .. I’m glad I got it off my chest.. it changed things for me .. being more assertive and practicing in group “ (WA)

“he [participant] said something to me which I found offensive .. previously I would have sat there and boiled or I’ve would’ve lost my temper .. but I made eye contact with him and said your behaviour made me feel uncomfortable .. he apologised … it was a turning point..” (TS)

Subtheme Four – Emotional distancing and softening the Inner Critic

All participants made either specific reference to an ‘internal critic’ or described the experience of a disparaging self to self dialogue, which through the course of the therapeutic work was softened through different mechanisms. In particular many participants described the significance to creating emotional distance from the voice as a means to bringing a level of understanding.

“we were all struggling with the inner critic.. so they said give it a physical form.. I went for plasticine and made this little gremlin thing .. it was really useful you could put your inner critic on the table over there and just separate from it for a second.. and it wasn’t about squashing it or anything …over time I could then explain it.. my monster is being a pain in the butt today.. and over time not such a screaming voice in my head..” (AK)

“this internal monologue very critical merciless .. you’re useless.. you will fail..that has largely stopped .. quite dramatic really” (HD)

“you know that kind of negative dialogue.. I’d sit there and compare and think they definitely don’t like me.. I can actually now challenge those negative thoughts .. before they were just automatic and take you off into a tail spin now I can challenge more more often” (ED)

“They didn’t drum it into you but the whole mind set is don’t be so hard on yourself and it’s about reinforcing the idea .. every week so .. over time you kind of gradually .. the voice get a bit quieter” (AK)

Theme Five – The challenge of managing transitions and endings

The final theme generated from the data was built around the experience that participants described transitioning between different stages of the group programme and of the ending. All participants made reference to the challenging nature of these elements of the programme with a focus on understanding the function and impact on their therapy journey.

<u>*Subtheme One – ‘Moving up to Big School’*</u>

The transition from the preparation and engagement group (PEG) to the Compassion Focused Trauma Group (CFTG) element of the program, was cited by all group members as a significant source of anxiety with many initially questioning the structure.

“a safety almost in that group identity which and some people were just starting to open up and somebody new come and they close up again so then they have to sort of go through that process again” (HD)

“*it was difficult to be honest because the 12 week group I’d settled in.. then all of sudden it was flipped on it’s head coz I was going to the afternoon group .. but then when you get in there that all changes because it was the same as the morning group..”* (AC)

For others the value of a rolling programme and the consequent changes were more clear in relation to the impact that this had on the participants move from being a 'junior' group member to a senior' and all the conferred advantages that this brought.

"so having that rolling program is a great benefit if we had all started on the same day … a room full of frightened silent people wouldn't have been of great benefit but where some had been there for months and were ready to move on .. seeing people at different stages of development that kind of gave me hope". (TS)

"The older ones showed us the ropes .. Then you look after the newbies you just take on that role and I don't know it naturally shifts ." .(AK)

<u>*Subtheme Two – The impact of ending: from grief to connection*</u>

All participants made explicit reference to the strong feelings of loss and sadness associated with the ending of the programme. This linked to a therapeutic experience which was of value and connections made with other group members

"I do remember as I was coming to the end 3 or 4 people that I considered my group all graduated and left me behind.. I felt the broken connection .. that was a little stumble …and it made me realise that we had built up quite a bond" (TS)

Many participants simultaneously connected to the underlying therapeutic journey and recognised the ending as an important mechanism of the change process.

I suppose it's not grieving it's actually quite positive but you still feel upset that I wasted most of my life being the person that I was when I am actually beginning to like who I am .. that makes a massive difference (JA)

It's changed my life really even though it's small it's still changed my life.. I'm a different person now for the good .. so I think it's essential it's essential it's the best and hardest thing I've ever done in that sense .. (CA)

It has changed my idea of therapy so yeah it was physically hard mental, hard .. and .. but it works.. even though you may not think it when you go through it (laughter) (JA)

"If you plant a tree and then every day you go and pull it up and if the roots are any bigger. you have to believe and just let it do it's thing" (HD)

Finally, explicit reference was made to the self-directed 'Moving On' or maintenance grou' which was developed by participants following completion of the program (cf Chapter 5, p.94). A theme emerged for some about the way that looking forward to and engaging with this group, enabled the work from the group to be continued and the grief associated with the ending to diluted.

"a lot of people including myself felt fear coming to towards the end .. but you don't have that loss because you know there something else .. all that trust and shared history is still there" (AJ)

"although at the end I could feel the immeasurable difference I had a feeling that you hadn't completed a journey and you felt like you were doing really well and all of sudden it stopped .. and there was nothing else.. which is why we decided to start the social group" (DJ)

*"we talk about check in and stuff you know strengthening what we are going through but like I said self-compassion is a work in progress so we help each other" (*HM)

Discussion

This chapter reported the results of qualitative analysis of participants' interviews aiming to understand the key ingredients of the group as perceived by the participants who attended the 12-month CFGP program. Qualitative methodology provided a user perspective. The findings contribute to the area and the literature and add to previous similar studies (Ashfield et al. 2020; Lawrence & Lee, 2012) already discussed. Thematic analysis revealed five key overall themes with associated sub-themes that were present in most participant interviews. The overall themes included participants reporting a feeling of 'safeness' in the group; 'compassion flows'; specific aspects of 'psychoeducational components'; 'change moments' and 'transitions and endings'. Each theme is discussed below in relation to the

existing literature. Later in the thesis (Chapter 8), qualitative and quantitative findings are considered together.

One of the key outcomes from this Thematic Analysis of the interview data was the importance of the cultivation of a space of safeness and connection within the group and between the participants, including the experience of containment from the therapists. This is supported by the body of literature about the importance establishing safeness for psychological work with this patient group (Gilbert, 2017; Music, 2018; Smith et al. 2006; Yalom & Leszcz, 2006). This overarching theme was a strand which emerged in each of the other subordinate themes and seems to have been the foundational internal construct which facilitated the necessary therapeutic engagement and mechanism of change. This is consistent with the findings of the other three qualitative studies of CFT; Lucre and Corten (2013, p.9) reported "*the comfort of shared group experiences",* Ashfield et al. (2020, p.8) described "*the group as a key mechanism of change"* and Lawrence and Lee (2014, p.501) reported the *"emotional experience of therapy".* This is also consistent with key research findings regarding the significant change factors in group therapy, Yalom & Leszcz (2006) found that group members reported that the impact of group members was as significant if not more so than the impact of the facilitators on creating the conditions for change.

The data supports the view that from this foundational construct, participants were able engage with the cultivation of the three flows of compassion which emerged as the second main theme, again with the group process as a significant medium for this work. In keeping with much of the published literature reporting CFT interventions, the initial experience of Fears, Blocks Resistances to compassion were reported by all participants (Ashfield et al., 2020; Bratt, et al., 2010; Clapton et al., 2016; Lawrence & Lee., 2014; Lucre & Corten, 2013; Pauley & McPherson, 2010). In addition to this a novel subtheme emerged which has not been reported elsewhere in the literature, 'compassion for others as a vehicle for developing compassion for self'. It is of note that this study is the first reporting a long-term intervention and it is possible that this process of repeatedly being exposed to the feelings of sympathy and empathy for others and the consequent development and tolerance of similar feelings for the self, requires time to emerge.

The structured components of the group process were identified as a further main theme, which included a number of subthemes identifying the function, specific elements and key emotional experiences associated with the psychoeducation and compassionate mind training. Some elements of this intervention are consistent with other published studies and specifically, the significance of the 'not your fault' message in addressing shame was evident in most published CFT studies (Ashfield et al., 2020; Bratt, et al., 2010; Clapton et al., 2016; Lawrence & Lee., 2014; Lucre & Corten, 2013). The unique components of this intervention, in particular the compassionate kitbag and the use of playfulness as a medium for delivery of the structured components were identified by most participants as key to the experience of change in the group (Arlo, 2019; Lucre & Clapton, 2020; Lucre, 2020, in press; Flores & Porges, 2017).

A further unique component of the CFGP programme was Compassion Focused Trauma work which was identified by all group members as the main theme, 'a moment of change', whereby this work in the group triggered a shift in perspective, compassionate capacity and meaning associated with early traumas. These ideas are supported by the wider trauma focused psychotherapeutic literature (Arlo, 2017; Bateman & Fonagy, 2006; Critchfield & Benjamin, 2006; Herman, 1998). The subthemes captured the ways in which participants were able to use the group as a medium of change (Yalom & Leszcz, 2006), change the meaning of their early traumatic experiences (Herman, 1992; 2002) and soften the internal critic dialogue through emotional distancing (Lucre & Corten, 2013).

Participants also identified a sub-theme of 'Grief to connection' in the context of the ending of the program, this manifest in participants bringing a compassionate response to the grief associated with the ending and a capacity to utilise the therapeutic change process to accept the ending of therapy and focus on the positive impact of the experience. This is supported by the substantial literature on the importance of managing endings and transitions within psychotherapy and supporting patients to grieve for the loss of the therapy and plan for moving on (Bernard, et al., 2008; Mangione, et al. 2007; Yalom & Leszcz, 2006).

The key message from this analysis would seem to be the significance of the group based nature of this intervention in that participants used the group process and affiliative connections with fellow participants to develop the capacity and competencies in compassion

to put these ‘to work’ in the context of reworking attachment traumas from early life. Therefore, developing a sense of ‘Safeness’ in the room and with each other, coupled with the implicit and explicit cultivation of ‘Flows of Compassion’, with the ‘Structured components of the model’ enabled participants to use the group as a Safe Haven and Secure Base to undertake the exploratory therapy identified by the ‘Moments of Change’ and finally to manage ‘Transitions and Endings’. Further connections with the quantitative data will be explored in the following Chapter 8.

Chapter 8: Overall Discussion, concluding thoughts and reflections

Introduction

This study has mapped the therapeutic experience of two Cohorts of participants recruited to join a Compassion Focused Group Psychotherapy program. These two Cohorts had differential therapeutic experiences, Cohort 1 (PEG + CFTG) and Cohort 2 (PEG + TAU). The analysis across the two years of the study identified significant differences in the response to the initial PEG intervention which were coupled with differences in the diagnostic categories of the Cohorts.

Quantitative and service utilisation data was gathered at various time points during the two-year study period for both Cohorts, coupled with qualitative data gathered for Cohort 1 only following completion of PEG + CFTG. This chapter will highlight the significant results, links between the data sets and connections with the current body of research in this area. This chapter will be guided by the response to the research questions posed at the end of the review of the existent literature (Chapter 2). Each component of the study has been reported and discussed in previous chapters. This final chapter aims to discuss the full set of findings, and identify conclusions.

Does Compassion Focused Group Psychotherapy have efficacy in the treatment of patients with complex attachment and relational trauma?

An examination of Cohort 1 data indicates that participants who engaged with the CFGP (PEG + CFTG) made significant improvements in all symptom and process measures which were maintained at 12 months post therapy follow up, with some evidence of further non-significant improvement during this TAU period. The process measures were explicitly

exploring the experience of shame and self-criticism, coupled with the experience of fear associated with giving and receiving compassion.

Engagement with the intervention was also encouraging, in that only 21% of participants dropped out of Cohort 1, coupled with an 85% session attendance rate that was consistent across the duration of therapy. This attrition rate was lower than that of published literature reviews of treatment interventions for people with a diagnosis of personality disorder which indicated a mean of 37% non-completion (McMurran et al., 2010). This study and others have also recommended the use of preparation and engagement interventions to improve completion rates (Barnicot et al. 2011; Chiesa et al. 2003; McMurran et al., 2010; McMurran, 2012; Webb & McMurran, 2009; Pearce et al. 2017). The inclusion of the PEG component therefore supports the current body of evidence for the efficacy of these types of interventions.

This quantitative data was coupled with a significant reduction in usage of mental health specific and general medical services, in particular a reduction in emergency appointments. In addition, nearly half the Cohort had been discharged from mental health services at one year follow up, the majority (70%) of those discharged were engaging in education or employment-based activities and no longer claiming sickness benefit. It is possible that this data provides some tentative evidence of a reversal of the reported link between attrition rates in group psychotherapy and poorer social outcomes (Birtle et al., 2007; Chiesa, 2003; McMurran et al., 2010; McMurran, 2012; Tomko et al., 2014).

Are there particular factors which can be associated with positive and/or negative patient experiences of the treatment process?

The qualitative analysis from a selection of interviews conducted with nine participants, from Cohort 1 who completed the 12-month CFGP program, revealed the experience of a sequential therapeutic process, with a number of key components.

Feedback from patients indicated that the group-based nature of the intervention was an important component of the change process, which links to the substantial body of evidence for group cohesion as a key therapeutic factor (Burlingame et al., 2011; Crowe & Grenyer,

2020; Lucre, 2020 (in press); Yalom & Lesczc, 2006). The unique components of CFGP which emerged alongside this concept was the development of a shared sense of 'safeness' within and between group members including the therapists, which was supported and facilitated by the 'structured components of the model' and enabled the cultivation of 'flows of compassion'. This enabled the participants to use the group as a 'safe haven' and 'secure base', through the explicit cultivation of the 'flows of compassion' and to use this capacity for compassion to undertake the exploratory therapy identified by the 'Moments of Change' and finally to manage 'Transitions and Endings'.

It is also possible to see links between the main themes from the Thematic Analysis and findings from the quantitative data. The main superordinate theme from the whole study related the experience of safeness as a key mechanism in the change process. Safeness has been identified as a key mechanism in ameliorating the experience of psychosocial suffering and is linked to the experience of closeness with others (Kelly et al., 2012). There is also a clear link between the experience of social safeness and capacity to give and receive compassion, which is dependent on the quality of early attachment relationships (Kelly & Dupasquier, 2016; Silva et al., 2019). The significant reduction in the Fear of Compassion Scale across all three subscales is an indication of the increased capacity of participants in Cohort 1 to give and receive compassion in the context of increased social safeness and feelings of connection with the group. Coupled with this, the significant improvements in the reported symptoms of social ranking, Social Comparison Scale, Submissive Behaviour Scale and Other as Shamer may also have facilitated the social safeness dynamic and increased connection with other group members and facilitators.

Qualitative feedback indicated that safeness and connection within the group was facilitated and maintained by the 'Structured Components of the Model', which in turn enabled participants to learn and develop the capacity to give and receive compassion, through the 'Flows of Compassion'. This is again supported by the literature outlining the importance of structured interventions to promote safeness and group cohesion (Arlo, 2017; Haigh, 2013; Lucre & Corten, 2013; Lucre, 2020 (in press). This in turn enabled participants to engage in Compassion Focused Trauma Work (CFTW) bringing a compassionate transformation to early attachment and relational trauma memories (Ashfield et al., 2020; Lee & Lawrence, 2013). The supporting evidence from the quantitative data is the significant

reduction in the reporting of symptoms of Post-Traumatic Stress measured by the Impact of Event Scale (IES). It is of note that many patients did not complete the IES at one year follow up and indicated on the form that they did not feel that any of the questions related to symptoms of Avoidance, Hyperarousal and Intrusion were of relevance to them. The Internal Shame Scale also had significant reductions which links to the literature which connects the experience of shame to early attachment and relational trauma memories (Ashfield et al., 2020; Lee, 2012; Lawrence & Lee, 2013).

The maintenance of change and the positive associations that participants made to the ending of therapy process, is supported by the quantitative reports which demonstrated that change was maintained across all symptom and process measures at the one year follow up, particular the Work and Social Adjustment Scale. The number of participants who had moved into employment, training or education also supports the qualitative data in that there was perhaps a process of 'internalising' the therapy experience to enable engagement with meaningful activity beyond the therapeutic process. The Moving On Group was also cited by many as key to the managing of the ending process and resolving the grief at the loss of connection. Although post therapy support and maintenance groups have been a part of the therapeutic community movement for decades, very little has been written evaluating the effectiveness of such interventions.

This process of recovery which is supported by the qualitative and quantitative data supports and reinforces the observation of Herman (2002 p. s98) that

> *"Recovery unfolds in three stages. The central task of the first stage is the establishment of safety. The central task of the second stage is remembrance and mourning. The central focus of the third stage is reconnection with ordinary life."*

Does a more intensive longer-term therapeutic program show significant advantages in outcomes compared to a shorter-term intervention?

The study protocol offered a 12-week Preparation and Engagement Group (PEG) to both Cohort 1 and Cohort 2, to test the growing body of evidence which supports the use of

short term CFT (Cuppage et al., 2016; Lucre & Corten, 2013; Kirby et al., 2017). Cohort 1 then continued on to receive a further 40 weeks of Compassion Focused Trauma Group (CFTG), while Cohort 2 received Treatment As Usual (TAU) for the same time period.

Following PEG, significant differences between the Cohorts were observed with Cohort 2 showing marked ‘early gains’ and much greater levels of improvement than Cohort 1. In many measures this improvement was significantly higher in Cohort 2 than 1. This was an unexpected finding which may require further research to explore and explain. It is possible that the significant differences in the Cohort diagnostic categories (personality disorder vs mixed bipolar, depressive illnesses) may account for the differential response (Heriot-Maitland et al., 2012).

These ‘early gains’ for Cohort 2 were not maintained during the 40-week TAU period and the deterioration for most of the symptom and process measures reached significance, returning to near baseline by the end of the TAU period. This was conversely matched by a significant improvement across all measures for Cohort 1, resulting in a ‘cross over effect’ of improvement and deterioration. This study therefore strongly indicates that there are significant advantages to longer term therapeutic interventions in contrast with the gains which were not sustained following the shorter-term intervention. This phenomenon has not been documented in the literature and represents a unique finding which would merit further investigation.

Clinical implications

Despite the clear guidance from the NICE Guidance for Treatment and Management of Borderline Personality Disorder (2009) recommending longer term interventions psychological interventions (of more than 12 weeks duration) and research indicating the need for such interventions (Arlo 2017; Leiderman, 2016; Wehle 2016), there has continued to be a significant level of short-term interventions being offered to patients with A&RT, 40% of Cohort 1 had been previously offered therapy of less than 24 weeks duration, mostly 12 weeks of Cognitive Behavioural Therapy, with no follow up.

A recent review of short-term interventions for BPD identified that it is not clear that these interventions are useful, and the studies suffered from a paucity of follow up or attrition data (Spong et al., 2020). This study adds weight to this review with the clear message that offering a short-term intervention to this group is likely to produce a '*Hare and Tortoise'* dynamic. In that those receiving a short-term intervention may make significant and substantial gains but over time these diminished, followed by a sustained period of deterioration, only to be 'overtaken' by those receiving longer interventions.

The provision of interventions of adequate duration (12 months or more) are likely to produce not only sustained change in symptom, process and adjustment measures, but also to result in a reduction in usage of psychiatric and general medical services, coupled with an increase in employment and education (Bateman & Fonagy, 2010; Crawford et al., 2009; Davies & Campling, 2003).

Presenting the evidence for longer term interventions is one strategy to persuade commissions and service providers to invest in such programs. Coupled with this it could also be helpful to introduce decision makers to the science of compassion and invite such groups to consider compassion as a way of managing the rigours of their own work and home lives. Thus, offering a more personal and compelling introduction to the rationale for investing on long term attachment focused interventions.

Limitations

There were several limitations which have to be considered when interpreting the findings. The naturalistic setting of this study, although to some extent a strength, meant that it was not possible for participants to be randomised to the different arms of the study and further there was no control group.

An explanation for the rationale for this protocol relates to the difficulty associated with inviting participants who had been assessed as meeting the requirements for the intervention to wait for two years before receiving treatment. This raises significant ethical concerns and issues relating to the risk of participants becoming unwell and overwhelmed, which is often an issue for this patient group.

The constitution of the two Cohorts was dictated by referral pathways, and therefore location, rather than a more robust randomised process. In addition, the participants in each of the Cohorts were aware of the intervention (and differences thereof) being received by the other Cohort. It is also of note that a number of participants in Cohort 2 expressed concern that they were not getting the ‘full’ treatment. Furthermore, 44% (12/27) of Cohort 2 were referred for further long-term therapy following completion of the study, of this group (8/27) went on to engage with the full CFGP program.

There was also a significant therapist impact on study, as the therapist was also chief investigator and responsible for all data collection. Therefore, the high levels of post therapy response to the study may be linked to the attachment relationship formed with therapist. This was also reported anecdotally by a number of participants, in that they had responded to the request to meet and complete the 12 months follow up forms as a means to maintaining connection with the therapist.

The potential for bias within the study was mediated by the involvement of an independent researcher to conduct the semi structured qualitative interviews, to ensure that the researcher/therapist was not involved in any aspect of the interview process.

The analysis of the data from the PEG revealed that there were significant differences between the two Cohorts with regard to diagnostic category. This difference may have impacted on the significant variance in the intervention response which were observed between the two Cohorts.

Whilst the above limitations are noted and should be considered, the naturalistic setting of the intervention that was delivered within clinical routine services with robust attempts to seek participant views can also be considered a strength of the study

Areas for Future Research

Given the positive outcomes from the current study, the next stage for research would be to undertake a more rigorous evaluation of this intervention, preferably in the form of a Randomised Controlled Trial. However, given the ethical considerations, the length of the intervention and TAU period, this will need careful management.

There was a high level of significance attributed to the experience of safeness as a mechanism for change and undertaking psychological work. It would, therefore, be helpful to measure this explicitly in future research. Therefore, using the Early Memories of Warmth and Social Safeness Scale is recommended to explore the experience of participants of their social world as safe or otherwise (Capinha et al., 2020). This would enable a more thorough exploration of participants' experience of safeness in the context of therapeutic experience coupled with a further test of the qualitative findings.

The study focused on the provision of a psychotherapeutic intervention for patients who had suffered Attachment and Relational Trauma (A&RT)and had consequent difficulties in managing relationships, it is suggested that future research also utilise the Adverse Childhood Experiences Scale (Ford et al., 2014). This would enable a more accurate picture of the early life experiences of the group, rather than relying on the redundant personality disorder diagnostic categories.

The significant difference in the responses to the PEG may be linked to the differences in the diagnostic categories of the two Cohorts, and would merit further investigation. A further study could compare the response to Compassion Focused Therapy for patients with an established psychotic illness and those with A&RT. This study could test if the differential results are replicated by a more robust and comprehensive methodology.

This study made some tentative claims about the possible positive impact of CFGP on service usage and meaningful daily activity. There are clear limitations associated with the methodological flaws in the data collection protocols which meant that all data relating to service usage was self-reported. In addition, no financial calculations were made which could demonstrate the potential for CFGP to be a cost saving initiative. It is therefore recommended that a full economic analysis be undertaken (i.e., inclusive of the impact of treatment on the use of other social and health care resources), particularly as there is a paucity of published data on the economic impact of long term psychotherapy on this patient group (Meuldjik et al., 2017).

Conclusions

This study has offered an alternative way of describing patients diagnosed with a personality disorder, as those 'at the edge of therapeutic opportunity' (ETO) because of their Attachment and Relational Trauma (A&RT). This redefining aims to offer a more robust understanding of causes of the difficulties, i.e. early attachment ruptures, rather than a categorisation of the behaviour which often accompanies these early experiences. The reworking of this diagnosis through an evolutionary lens aims to offer a de-shaming perspective on this cluster of interpersonal, emotional, cognitive and indeed neurobiological difficulties, which often attract stigma, denigration and exclusion from therapeutic provision (Ali, 2015; Brune, 2015).

The Compassion Focused Group Psychotherapy Program was developed to provide therapeutic opportunity to this group and this study evaluated CFGP using mixed quantitative and qualitative methodology and measures. The results of the study supported the original hypothesis that effective treatments for people with A&RT need to be of longer duration, slower paced with greater flexibility within a structured model to manage the inevitable ruptures associated with this work. This study identified a therapeutic process of establishing group-based safeness as a necessary precursor to cultivating compassion and reworking early shame-based trauma memories.

This study will conclude with the insightful and profound words of Judith Herman,

> "***Recovery can only take place only within the context of relationships; it cannot occur in isolation***"
>
> (Herman 1992, p.s98).

Appendices

Appendix A: Ethics Approval Letter

Health Research Authority

West Midlands - The Black Country Research Ethics Committee
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839435
Fax:0115 8839294

06 November 2015

Dr. Chris Jones
Clinical Psychologist
Birmingham University
Edgbaston
Birmingham
B15 2TT

Dear Dr. Jones

Study title:	**An Evaluation of Compassion Focussed Group Psychotherapy**
REC reference:	**15/WM/0387**
IRAS project ID:	**160319**

The Research Ethics Committee reviewed the above application at the meeting held on 26 October 2015. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager Miss Georgia Copeland , nrescommittee.westmidlandsblackcountry@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below. .

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

1. The following changes/revisions must be made to the Participant Information Sheet for group A.
   a) The word 'deal' must be added to the second sentence under the heading, 'What is the purpose of the study?' so that it states: 'Although there has been a great deal of research into how these exercises can stimulate particular parts of our brain…'

2. The following changes/revisions must be made to the Participant Information Sheet for group B.
   a) The word 'deal' must be added to the second sentence under the heading, 'What is the purpose of the study?' so that it states: 'Although there has been a great deal of research into how these exercises can stimulate particular parts of our brain…'
   b) The last sentence under the heading, 'What is the purpose of the study?' must be amended to state: The purpose of the study is to evaluate the effectiveness of the 12 week group and compare it to the 40 week group.
   c) Number sequencing must be checked and amended throughout the document.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non NHS sites

The Committee has not yet completed any site-specific assessment(s) (SSA) for the non NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. I will write to you again as soon as an SSA application(s) has been reviewed. In the meantime no study procedures should be initiated at non-NHS sites.

Summary of discussion at the meeting

Social or scientific value; scientific design and conduct of the study

The Committee asked the applicant to explain the methodology and the way in which the study had been set out. *The applicant explained that as her role as a psychotherapist in the NHS she had been helping to develop Compassion Focussed Therapy (CFT) for years. The applicant added the purpose of the study was to evaluate what she was already doing within the confines of her role. The applicant stated the research team had put something together to try and evaluate it the best they could with the tools they have. The applicants explained that one of the services they had initially intended to use had been closed and stated that as things within the trust were not*

currently stable the research team would have to work with what they had got. The Committee asked the applicant to elaborate further. *The applicant stated the research team would have ideally liked to conduct a randomised controlled trial (RCT) with the idea to try 12 months. The applicant added that the plan would have been to randomise to either CFT for 12 months or treatment as usual.* The Committee asked the applicant what would be treatment as usual. *The applicant stated treatment as usual would be care from the community meatal healthcare team. The applicant added that such services were shrunk and patients may actually just receive an out patients psychiatric service.* The Committee stated that treatment as usual could therefore mean very little treatment at all. *The applicant confirmed that was the case.*

The Committee discussed the study end points and asked the applicant whether they would be incorporated into the assessment outcomes. *The applicant stated that the 40 weeks program would add some benefit. The applicant stated that the 12 weeks program would add some benefit for Group A and Group B participants but also explained that the research team would hope that Group A participants will have made some further and more lasting improvements upon particular issues such as shame, self-assessment and self-soothing following the 40 week program. The applicant stated Assessment at 12and 14 months would show what improvements were experienced and which lasted.*

Recruitment arrangements and access to health information, and fair participant selection

The Committee noted there would be two different groups in the study and asked the applicant to clarify where participants for each group would be recruited from. *The applicant clarified that group A would be recruited via a referral service and group B would be recruited from the community healthcare team. The applicant added that participants in group A would be from right across the city.*

Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity

The Committee stated their understanding after having read through the application was that the group receiving 12 week program would have a semi-structured interview at that point but would not be assessed after. The Committee asked the applicant to clarify further. *The applicant clarified that both groups would follow the exact same trajectory.* The Committee informed the applicant her statement was not consistent with what was written in the study protocol, as that stated a semi structured interview would take place after the 12 week program for group B rather than at 40 weeks. The Committee stated the groups could not be following the same program as they were being assessed at different time points and asked how the research team would therefore be able to make a comparison between the two groups. The Committee reiterated that it appeared as though group A would be assessed with different things and different times. *The applicant stated the IPA's would be looking at the experience of the 12 week group and added that the same questions would be used for group B. The applicant stated that evaluation points would be the same for both study groups and explained that whilst interviews would take place at different points the assessments or both groups would be the same.*

Informed consent process and the adequacy and completeness of participant information

The Committee informed the applicant that the statement, 'The purpose of the study is to evaluate the effectiveness of the 12 week group and compare it to a longer group' within the participant information sheet for group B was too vague. The Committee agreed the sentence under the heading, 'What is the purpose of the study?' should be amended to instead state that the 12 week group would be compared with the 40 week group. *The applicant agreed to make the change to the document.*

The Committee informed the applicant there was an omission of the word 'deal' from the second sentence of the paragraph under the heading, 'What is the purpose of the study?' in the participant information sheets for groups A and B. *The applicant agreed to amend the document.*

The Committee pointed out that the number sequencing on the participant information sheets for group B needed correcting as some numbers had been repeated whilst others were missing. *The applicant agreed to make the changes to the both documents.*

Suitability of supporting information

In private discussion the Committee commented on the presentation of the study application and agreed the applicant should be informed that though the study posed no major issues the application was highly technical and quite confusing. The Committee stated that future applications should be presented to a higher quality.

Other general comments

The Committee asked the applicant out of interest what her modality was. *The applicants stated it was cognitive therapy.*

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		07 October 2015
GP/consultant information sheets or letters	Version 1.0	07 October 2015
Interview schedules or topic guides for participants	version 1.0	07 October 2015
Interview schedules or topic guides for participants	version 1.0	07 October 2015
IRAS Checklist XML [Checklist_07102015]		07 October 2015
IRAS Checklist XML [Checklist_26102015]		26 October 2015
Letter from sponsor		07 October 2015
Letter from statistician		07 October 2015
Other [codes for evaluation]		
Participant consent form	Version 1.0	07 October 2015

Participant consent form	version 1.0	07 October 2015
Participant information sheet (PIS)	Version 1.0	07 October 2015
REC Application Form [REC_Form_07102015]		07 October 2015
Referee's report or other scientific critique report		07 October 2015
Research protocol or project proposal [Project Proposal]	version 1.0	07 October 2015
Summary CV for Chief Investigator (CI)		07 October 2015
Summary CV for student [KL CV]		07 October 2015
Summary CV for supervisor (student research)		07 October 2015
Summary, synopsis or diagram (flowchart) of protocol in non technical language	version1.0	07 October 2015
Validated questionnaire	version 1.0	07 October 2015
Validated questionnaire		

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

<u>Reporting requirements</u>

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
  Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-thehra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/WM/0387	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

Dr Hilary Paniagua Chair

E-mail: nrescommittee.westmidlands-blackcountry@nhs.net

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

"After ethical review – guidance for researchers"

Copy to: *Dr. Sean Jennings*
Ms Emma Patterson , Birmingham and Solihull Mental Health Foundation Trust

West Midlands - The Black Country Research Ethics Committee
Attendance at Committee meeting on 26 October 2015

Committee Members:

Name	*Profession*	*Present*	*Notes*
Dr Joseph Arumainayagam	Consultant and Honorary Senior Clinical Lecturer in HIV and GUM	No	
Mrs Chris Bell	Lay Member	Yes	
Dr Nicola Erb	Consultant Rheumatologist	No	
Dr. Brendan Laverty (co-opted member)		Yes	
Dr Hilary Paniagua	Senior Lecturer	Yes	
Mrs Bernadette Roberts (co-opted member)	Retired Finance Manager	Yes	
Mr Nanak Singh Sarhadi	Consultant Plastic Surgeon	Yes	
Dr Julian Sonksen	Consultant in Anaesthesia and Critical Care	No	
Reverend Mark Stobert	Hospital Chaplain	Yes	
Dr David Vallance	Clinical Biochemist	Yes	
Mrs Jennifer Walton	Retired Research Nurse	No	
Dr Tony Zalin	Expert Member	No	

Also in attendance:

Name	*Position (or reason for attending)*
Georgia Copeland	REC Manager

Appendix B: Screening Form

SELF ATTACKING & SELF REASSURING

When things go wrong in our lives or don't work out as we hoped, and we feel we could have done better, we sometimes have *negative and self-critical thoughts and feelings*. These may take the form of feeling worthless, useless or inferior, etc. However, people can also try to be supportive of themselves. Below are series of thoughts and feelings that people sometimes have. Read each statement carefully and circle the number that best describes how much each statement is true for you.

Not at all like me	A little bit like me	Moderately like me	Quite a bit like me	Extremely like me
0	1	2	3	4

When things go wrong for me:

1. I am easily disappointed with myself.	0	1	2	3	4
2. There is a part of me that puts me down.	0	1	2	3	4
3. I am able to remind myself of positive things about myself.	0	1	2	3	4
4. I find it difficult to control my anger and frustration. at myself.	0	1	2	3	4
5. I find it easy to forgive myself.	0	1	2	3	4
6. There is a part of me that feels I am not good enough.	0	1	2	3	4
7. I feel beaten down by my own self-critical thoughts.	0	1	2	3	4
8. I still like being me.	0	1	2	3	4
9. I have become so angry with myself that I want to hurt or injure myself.	0	1	2	3	4
10. I have a sense of disgust with myself.	0	1	2	3	4
11. I can still feel lovable and acceptable.	0	1	2	3	4
12. I stop caring about myself.	0	1	2	3	4
13. I find it easy to like myself.	0	1	2	3	4
14. I remember and dwell on my failings.	0	1	2	3	4
15. I call myself names.	0	1	2	3	4
16. I am gently and supportive with myself.	0	1	2	3	4
17. I can't accept failures and setbacks without feeling inadequate.	0	1	2	3	4
18. I think I deserve my self-criticism.	0	1	2	3	4
19. I am able to care and look after myself.	0	1	2	3	4
20. There is a part of me that wants to get rid of the bits I don't like.	0	1	2	3	4
21. I encourage myself for the future.	0	1	2	3	4
22. I do not like being me.	0	1	2	3	4

Appendix C: Referral Criteria

Compassion Focused Group Psychotherapy(CFGP) has been developed specifically for people who are highly shame prone and who experience high levels of self criticism or self attack. Although it is hypothesised that this approach can and indeed has had positive effects on many different aspects of client's lives, for example assertiveness, deliberate self harm, harmful use of alcohol/ substances.

It would be helpful if considering CFGP to establish if clients meet these criteria

- An enduring pattern of complex needs which could be understood in terms of Personality Disorder, although a diagnosis would not be required for consideration for the group.

- This group has been developed to offer an outpatient psychotherapeutic intervention for tier two /tier three clients (CF Commissioning for Complexity 2009).

- Client would need to engage in some form of self criticism or self attacking, although they may not describe it in those terms. This often takes the form of a critical / negative dialogue, many clients describe a 'voice' which adds a negative and critical commentary to their daily lives. This would need to be a prominent aspect of their presentation for the group to be useful. Although their presenting issue may be the way that they respond to or cope with this experience. Anger also seems to be a common response to the experience of shame particularly for the men that we have assessed and treated recently.

- Clients would need to have some awareness of themselves as self critical to get the most out of the group. Clients who are most likely to benefit from the group will likely be presenting with high levels of shame and so might not immediately volunteer information about this difficulty / way of relating to themselves.

- Because of the nature of the group and duration clients would need to have some awareness of the negative impact of the self criticism on their lives and relationships. This process can be further established through the assessment and clinical formulation process. But at the same time it is recognised that clients will often present with fear of change and this can be worked through and addressed directly through the group.

- Clients will need to have some capacity to tolerate exploring past abuse issues.

- Clients would also need to have some motivation to make changes to their current ways of coping. Those who are much invested are likely to drop out and feel attacked by the process of therapy.

The reasons for these criteria relate mostly to the duration of the group, at this stage being 12 months and previous groups have illustrated that clients who were not ready to address these issues found the group process very attacking which compounded their difficulties.

Shame and self-criticism are associated with a range of psychological difficulties, including depression, social anxiety, eating disorders, various personality disorders, and post-traumatic stress disorder.

For a variety of different reasons, many of us find that we develop a negative, self-critical part of our thinking. This can often be in response to harsh critical treatment from important people in our lives or a sense that receiving care is dependent on personal achievement.

It nags and tells us that we are no good, worthless beings that deserve very little in life and over the course of time this inevitably becomes the overwhelming way we feel about ourselves. It lowers self-esteem, and possibly contributes to anxious and depressive thoughts and feelings.

This then becomes a familiar well-worn path that is easy to access and probably underpins how we live our lives. In these situations it becomes very difficult to soothe ourselves and might lead to feeling under threat from others, as our experience of others has often been quite abusive. The self-attack pre-empts what we might believe to be inevitable rejection from others.

For many self-attack is something, which is 'felt' rather than 'thought'. Despite the efforts of others to persuade that we do have strengths and positive qualities, we may accept the objective truth of what they are saying, but just don't believe it. This is referred to as the 'head heart lag'. It is for this reason that work on self criticism or self-attacking focuses on the feelings rather than the thoughts.

The task in working with self-criticism can focus on the value of compassion, kindness and nurturing to the self and in turn developing a 'compassionate mind'. This process can involve a number of different therapeutic techniques, including imagery (developing and practicing a compassionate image or 'perfect nurturer' to soothe), reframing thoughts using a compassionate focus, writing a compassionate letter to focus on being kind to oneself and helping identify the source of the criticism.

Starting to work compassionately may involve encouragement to focus attention 'in the moment' and recognise accomplishments without looking into the past or future for possible failures. Sometimes it can be as simple as validating distress, rather than 'why didn't you…' 'it must have been very difficult to try and do this, perhaps we can think together about what you would need to have to get this job done.'

It is unlikely that we will be able to fight the internal critic as we have become 'expert' at putting ourselves down, instead focus may be on support to feel kindness, forgiveness and acceptance for ourselves. This is based on the work of Paul Gilbert, for more information, please see http://www.compassionatemind.co.uk/

Appendix D: Process, Symptom and Adjustment Self Report Measures

We would now like to ask you about services you may have used within the last 12 months

So, within the last 12 months have you..... **please indicate by circling answer**

1. Seen your GP?	YES	if so number of times		NO
2. Had to make an **emergency appointment** to see your GP?	YES	if so number of times		NO
3. Called for an emergency ambulance for yourself?	YES	if so number of times		NO
4. Attended an Accident and Emergency department?	YES	if so number of times		NO
5. Had any overnight admissions to general hospital?	YES	if so number of admissions		NO
		AND total number of days		
6. Had any overnight admissions to psychiatric hospital? admissions	YES	if so number of		NO
		AND total number of days		
7. Had any contact with Home Treatment? days	YES	if so total number of		NO
8. Had contact with social worker benefits or housing worker?	YES	if so number of times		NO
9. Had an unplanned contact with a psychiatrist, community psychiatric nurse (CPN), or psychologist? times	YES	if so number of		NO
10. Lost time from work due to ill health? lost	YES	if so number of days		No unable to work
11. Had contact with the police?	YES	if so number of times		NO
12. You been arrested?	YES	if so number of times		NO
13. Been charged with an offence?	YES	if so number of times		NO
14. Have you been on any kind of benefits (DLA, incapacity, housing)?	YES	if so how many?		NO

DASS21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all.
1 Applied to me to some degree, or some of the time.
2 Applied to me to a considerable degree, or a good part of time.
3 Applied to me very much, or most of the time.

1. I found it hard to wind down 0123
2. I was aware of dryness of my mouth. 0123
3. I couldn't seem to experience any positive feeling at all. 0123
4. I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion). 0123
5. I found it difficult to work up the initiative to do things. 0123
6. I tended to over-react to situations. 0123
7. I experienced trembling (e.g. in the hands). 0123
8. I felt that I was using a lot of nervous energy. 0123
9. I was worried about situations in which I might panic and make a fool of myself. 0123
10. I felt that I had nothing to look forward to. 0123
11. I found myself getting agitated. 0123
12. I found it difficult to relax. 0123
13. I felt down-hearted and blue. 0123
14. I was intolerant of anything that kept me from getting on with what I was doing. 0123
15. I felt I was close to panic. 0123
16. I was unable to become enthusiastic about anything. 0123
17. I felt I wasn't worth much as a person. 0123
18. I felt that I was rather touchy. 0123
19. I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat). 0123

20. I felt scared without good reason. 0123

21. I felt that life was meaningless. 0123

SOCIAL COMPARISON RATING SCALE

Please place a mark on each line at a point which best describes the way in which you see yourself in comparison to others.

***In relationship to others I feel:**

Inferior 1	2	3	4	5	6	7	7	9	10	Superior
Incompetent1	2	3	4	5	6	7	8	9	10	More Competent
Unlikeable1	2	3	4	5	6	7	8	9	10	More Likeable
Left out1	2	3	4	5	6	7	8	9	10	Accepted
Different1	2	3	4	5	6	7	8	9	10	Same
Untalented1	2	3	4	5	6	7	8	9	10	More Talented
Weaker1	2	3	4	5	6	7	8	9	10	Stronger
Unconfident1	2	3	4	5	6	7	8	9	10	More Confident
Undesirable1	2	3	4	5	6	7	8	9	10	More Desirable
Unattractive1	2	3	4	5	6	7	8	9	10	More Attractive
An outsider1	2	3	4	5	6	7	8	9	10	An insider

SUBMISSIVE BEHAVIOUR SCALE

Below are a series of statements which describe how people act and feel about social situations.
Circle the number to the right of the statements which best describes the degree to which a statement
is true for you.

Please use the following scale:

0 = NEVER 1 = RARELY 2 = SOMETIMES 3 = MOSTLY 4 = ALWAYS

1. I agree that I am wrong even though I know I'm not.	0	1	2	3	4
2. I do things because other people are doing them, rather than because I want to.	0	1	2	3	4
3. I would walk out of shop without questioning, knowing that I had been short-changed.	0	1	2	3	4
4. I let others criticise me or put me down without defending myself.	0	1	2	3	4
5. I do what is expected of me even when I don't want to.	0	1	2	3	4
6. If I try to speak and others continue, I shut up.	0	1	2	3	4
7. I continue to apologise for minor mistakes.	0	1	2	3	4
8. I listen quietly if people in authority say unpleasant things about me.	0	1	2	3	4
9. I am not able to tell my friends when I am angry with them	0	1	2	3	4
10. At meetings and gatherings, I let others monopolise the Conversation.	0	1	2	3	4
11. I don't like people to look straight at me when they are talking.	0	1	2	3	4
12. I say 'thank you' enthusiastically and repeatedly when someone does a small favour for me.	0	1	2	3	4
13. I avoid direct eye contact	0	1	2	3	4
14. I avoid starting conversations at social gatherings.	0	1	2	3	4
15. I blush when people stare at me.	0	1	2	3	4
16. I pretend I am ill when declining an invitation.	0	1	2	3	4

OAS SCALE

We are interested in how people think others see them. Below is a list of statements describing feelings or experiences about how you may feel other people see you.

Read each statements and circle the number to the right of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below.

0 = NEVER 1 = SELDOM 2 = SOMETIMES 3 = FREQUENTLY 4 = ALMOST ALWAYS

1.	I feel other people see me as not good enough.	0	1	2	3	
2.	I think that other people look down on me.	0	1	2	3	4
3.	Other people put me down a lot.	0	1	2	3	4
4.	I feel insecure about others opinions of me.	0	1	2	3	4
5.	Other people see me as not measuring up to them.	0	1	2	3	4
6.	Other people see me as small and insignificant.	0	1	2	3	4
7.	Other people see me as somehow defective as a person.	0	1	2	3	4
8.	People see me as unimportant compared to others.	0	1	2	3	4
9.	Other people look for my faults.	0	1	2	3	4
10.	People see me as striving for perfection but being unable to reach my own standards.	0	1	2	3	4
11.	I think others are able to see my defects.	0	1	2	3	4
12.	Others are critical or punishing when I make a mistake.	0	1	2	3	4
13.	People distance themselves from me when I make mistakes.	0	1	2	3	4
14.	Other people always remember my mistakes.	0	1	2	3	4
15.	Others see me as fragile.	0	1	2	3	4
16.	Others see me as empty and unfulfilled.	0	1	2	3	4
17.	Others think there is something missing in me.	0	1	2	3	4
18.	Other people think I have lost control over my body and feelings.	0	1	2	3	4

SELF ATTACKING & SELF REASSURING

When things go wrong in our lives or don't work out as we hoped, and we feel we could have done better, we sometimes have *negative and self-critical thoughts and feelings*. These may take the form of feeling worthless, useless or inferior, etc. However, people can also try to be supportive of themselves. Below are series of thoughts and feelings that people sometimes have. Read each statement carefully and circle the number that best describes how much each statement is true for you.

Not at all like me	A little bit like me	Moderately like me	Quite a bit like me	Extremely like me
0	1	2	3	4

When things go wrong for me:

1. I am easily disappointed with myself.	0	1	2	3	4
2. There is a part of me that puts me down.	0	1	2	3	4
3. I am able to remind myself of positive things about myself.	0	1	2	3	4
4. I find it difficult to control my anger and frustration. at myself	0	1	2	3	4
5. I find it easy to forgive myself.	0	1	2	3	4
6. There is a part of me that feels I am not good enough.	0	1	2	3	4
7. I feel beaten down by my own self-critical thoughts.	0	1	2	3	4
8. I still like being me.	0	1	2	3	4
9. I have become so angry with myself that I want to hurt or injure myself.	0	1	2	3	4
10. I have a sense of disgust with myself.	0	1	2	3	4
11. I can still feel lovable and acceptable.	0	1	2	3	4
12. I stop caring about myself.	0	1	2	3	4
13. I find it easy to like myself.	0	1	2	3	4
14. I remember and dwell on my failings.	0	1	2	3	4
15. I call myself names.	0	1	2	3	4
16. I am gently and supportive with myself.	0	1	2	3	4
17. I can't accept failures and setbacks without feeling inadequate.	0	1	2	3	4
18. I think I deserve my self-criticism.	0	1	2	3	4
19. I am able to care and look after myself.	0	1	2	3	4
20. There is a part of me that wants to get rid of the bits I don't like.	0	1	2	3	4
21. I encourage myself for the future.	0	1	2	3	4
22. I do not like being me.	0	1	2	3	4

FEARS OF COMPASSION SCALES

Below are a series of statements that we would like you to think carefully about and then circle the number that best describes how each statement fits you.

SCALE

Don't agree at all	0	1	2	3	4	5	Completely agree
			Somewhat agree				

Please use this scale to rate the extent that you agree with each statement

Scale 1: Expressing compassion for others

1. People will take advantage of me if they see me as too compassionate0 1 2 3 4 5
2. Being compassionate towards people who have done bad things is letting them off the hook 0 1 2 3 4 5
3. There are some people in life who don't deserve compassion 0 1 2 3 4 5
4. I fear that being too compassionate makes people an easy target 0 1 2 3 4 5
5. People will take advantage of you if you are too forgiving and compassionate 0 1 2 3 4 5
6. I worry that if I am compassionate, vulnerable people can be drawn to me and drain my emotional resources 0 1 2 3 4 5
7. People need to help themselves rather than waiting for others to help them 0 1 2 3 4 5
8. I fear that if I am compassionate, some people will become too dependent upon me 0 1 2 3 4 5
9. Being too compassionate makes people soft and easy to take advantage of 0 1 2 3 4 5
10. For some people, I think discipline and proper punishments are more helpful than being compassionate to them 0 1 2 3 4 5

Scale 2: Responding to the expression of compassion from others

1. Wanting others to be kind to oneself is a weakness 0 1 2 3 4 5
2. I fear that when I need people to be kind and understanding they won't be 0 1 2 3 4 5
3. I'm fearful of becoming dependent on the care from others because they0 1 2 3 4 5 might not always be available or willing to give it

4. I often wonder whether displays of warmth and kindness from others are genuine 0 1 2 3 4 5

5. Feelings of kindness from others are somehow frightening 0 1 2 3 4 5
6. When people are kind and compassionate towards me I feel anxious or embarrassed 0 1 2 3 4 5

7. If people are friendly and kind I worry they will find out something bad about me that will change their mind 0 1 2 3 4 5

8. I worry that people are only kind and compassionate if they want something from me 0 1 2 3 4 5

9. When people are kind and compassionate towards me I feel empty and sad 0 1 2 3 4 5

10. If people are kind I feel they are getting too close 0 1 2 3 4 5

11. Even though other people are kind to me, I have rarely felt warmth from my relationships with others 0 1 2 3 4 5

12. I try to keep my distance from others even if I know they are kind 0 1 2 3 4 5

13. If I think someone is being kind and caring towards me, I 'put up a barrier' 0 1 2 3 4 5

Scale 3: Expressing kindness and compassion towards yourself

1. I feel that I don't deserve to be kind and forgiving to myself 0 1 2 3 4 5

2. If I really think about being kind and gentle with myself it makes me sad 0 1 2 3 4 5

3. Getting on in life is about being tough rather than compassionate 0 1 2 3 4 5

4. I would rather not know what being 'kind and compassionate to myself' feels like 0 1 2 3 4 5

5. When I try and feel kind and warm to myself I just feel kind of empty 0 1 2 3 4 5

6. I fear that if I start to feel compassion and warmth for myself, I will feel overcome with a sense of loss/grief 0 1 2 3 4 5

7. I fear that if I become kinder and less self-critical to myself then my standards will drop 0 1 2 3 4 5

8. I fear that if I am more self-compassionate I will become a weak person 0 1 2 3 4 5

9. I have never felt compassion for myself, so I would not know where to begin to develop these feelings 0 1 2 3 4 5

10. I worry that if I start to develop compassion for myself I will become dependent on it 0 1 2 3 4 5

11. I fear that if I become too compassionate to myself I will lose my self-criticism and my flaws will show 0 1 2 3 4 5

12. I fear that if I develop compassion for myself, I will become someone I do not want to be 0 1 2 3 4 5

13. I fear that if I become too compassionate to myself others will reject me 0 1 2 3 4 5

14. I find it easier to be critical towards myself rather than compassionate 0 1 2 3 4 5

15. I fear that if I am too compassionate towards myself, bad things will happen 0 1 2 3 4 5

Work and Social Adjustment Scale

Rate each of the following questions on a 0 to 8 scale: 0 indicates no impairment at all and 8 indicates very severe impairment.

1 Because of my problem, my ability to work is impaired.

0 1 2 3 4 5 6 7 8
Not at all slightly definitely markedly very severely

I cannot work

2 Because of my problem, my home management (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired

0 1 2 3 4 5 6 7 8
Not at all slightly definitely markedly very severely

I cannot do it

3 Because of my problem, my social leisure activities (with other people, such as parties, bars, clubs, outings, visits, dating, home entertainment)

0 1 2 3 4 5 6 7 8
Not at all slightly definitely markedly very severely

I never do these

4 Because of my problem, my private leisure activities (done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired

0 1 2 3 4 5 6 7 8
Not at all slightly definitely markedly very severely

I never do these

5 Because of my problem, my ability to form and maintain close relationships with others, including those I live with, is impaired.

0 1 2 3 4 5 6 7 8
Not at all slightly definitely markedly very severely

I never have these

Impact of Event Scale – Revised

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to ___________________________, which occurred on ______________. How much were you distressed or bothered by these difficulties?

Not at all	A little bit	Moderately	Quite a bit	Extremely
0	1	2	3	4

Item					
1. Any reminder brought back feelings about it.	0	1	2	3	4
2. I had trouble staying asleep.	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry.	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3	4
6. I thought about it when I didn't mean to.	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders of it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on-guard.	0	1	2	3	4
22. I tried not to talk about it._	0	1	2	3	

I.S.S. SCALE

DIRECTIONS: Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had them for a long time. Most of these statements describe feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have many of these feelings. Everyone has had some of these feelings at some time, but if you find that these statements describe the way that you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and circle the number to the left of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below.
DO NOT OMIT ANY ITEM. SCALE

0 = NEVER 1 = SELDOM 2 = SOMETIMES 3 = FREQUENTLY 4 = ALMOST ALWAYS

0 1 2 3 4 1. I feel like I am never quite good enough

0 1 2 3 4 2. I feel somehow left out

0 1 2 3 4 3. I think other people look down on me

0 1 2 3 4 4. All in all, I am inclined to feel that I am a success

0 1 2 3 4 5. I scold myself and put myself down

0 1 2 3 4 6. I feel insecure about others opinions of me

0 1 2 3 4 7. Compared to other people, I feel like I somehow never measure up

0 1 2 3 4 8. I see myself as being very small and insignificant

0 1 2 3 4 9. I feel I have much to be proud of

0 1 2 3 4 10. I feel intensely inadequate and full of self-doubt

0 1 2 3 4 11. I feel as if I am somehow defective as a person, like there is something basically wrong with me

0 1 2 3 4 12. When I compare myself to others I am just not as important

0 1 2 3 4 13. I have an overpowering dread that my faults revealed in front of others

0 1 2 3 4 14. I have a number of good qualities

0 1 2 3 4 15. I see myself striving for perfection only to continually fall short

0 1 2 3 4 16. I think others are able to see my defects

0 1 2 3 4 17. I could beat myself over the head with a club when make a mistake

0 1 2 3 4 18. On the whole, I am satisfied with myself

0 1 2 3 4 19. I would like to shrink away when I make a mistake

0 1 2 3 4 20. I replay painful events over and over in my mind until I am overwhelmed

0 1 2 3 4 21. I feel I am a person of worth at least on an equal plane with others

0 1 2 3 4 22. At times I feel like I will break into a thousand pieces

0 = NEVER 1 = SELDOM 2 = SOMETIMES 3 = FREQUENTLY 4 = ALMOST ALWAYS

0 1 2 3 4 23. I feel as if I have lost control over my body functions and feelings

0 1 2 3 4 24. Sometimes I feel no bigger than a pea

0 1 2 3 4 25. At times I feel so exposed that I wish the earth would open up and swallow me

0 1 2 3 4 26. I have this painful gap within me that I have not been able to fill

0 1 2 3 4 27. I feel empty and unfulfilled

0 1 2 3 4 28. I take a positive attitude toward myself

0 1 2 3 4 29. My loneliness is more like emptiness

0 1 2 3 4 30. I always feel there is something missing

Appendix E: Consent Form

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: **An Evaluation of Group based Compassion Focussed Psychotherapy**

Name of Researcher: **Katherine Lucre**

Please initial box

1. I confirm that I have read the information sheet dated 23rd March 2015 Version 1for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from Birmingham and Solihull Mental health Foundation Trust , from regulatory authorities or where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐
4. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
5. I agree to my General Practitioner being informed of my participation in the study. ☐
6. I agree to be contacted to take part in a semi structured interview following the end of my Treatment. ☐
7. I understand that any direct quotes from the interview data may be used and will be made non-identifiable in the write up of the study ☐
8. I agree to take part in the above study. ☐

________________	________________	________________
Name of Participant	Date	Signature
________________	________________	________________
Name of Person taking consent	Date	Signature

Appendix F: Patient Information Sheets

Client Participant Information Sheet – Cohort One

Study Title: An Evaluation of Group-based Compassion Focussed Psychotherapy

Part One

1. **Invitation Paragraph** At the Specialist Psychotherapies Service we provide a range of different 'talking therapies', the Compassion focused psychotherapy group is just one of these.

Compassion Focussed Psychotherapy has been offered as a brief therapy for many years and many of our clients tell us that the groups need to be longer. Therefore in response to this we have developed a 12 month programme. In order to continue to provide an effective service to service users it is important that we evaluate the therapies that we provide.

As someone who is being assessed for a compassion focussed psychotherapy group, you are being invited to take part in an evaluation study. This information sheet details the how's and why's of this evaluation. Please take the time to read the following information carefully and contact me if there is anything you are unsure of or if you would like more information

2. What is the purpose of the study?

Compassion Focussed Psychotherapy is a relatively new form of psychotherapy which draws from scientific research into how our minds work and the benefits of particular imagery exercises on our physical and emotional wellbeing. Although there has been a great deal of research into how these exercises can stimulate particular parts of our brain, to help us feel soothed and also improve our physical health, there has been little research into how this can work as a therapy intervention.

Therefore the purpose of the study is to evaluate the effectiveness of a 12 month compassion focused psychotherapy group.

3. Why have I been chosen?You have been selected as you are currently being assessed for the compassion focused psychotherapy group at Devon House .

4. Do I have to take part?

No, it is up to you to decide whether or not to take part. If you decide not to take part you will continue through the assessment process for the compassion focused psychotherapy programme as usual.

5. What will happen to me if I take part?

You will be asked to sign two consent forms (a copy for you and a copy for the researcher). Involvement in the study will mean that the information that you provide in the questionnaires before starting the group will be anonymously collected and looked at in relation to the information in the questionnaires that you will be asked to complete at the midpoint, end of therapy and at 1 and 12 month intervals following the end of the therapy.

At the end of the group programme there will be a semi structured interview which you are being asked to consent to take part in. This will be a member of the research team to gather information about your experience of the group and your views about what was helpful / unhelpful. Not everyone who consents to be interviewed will be contacted. If you chose not to consent to the interview or having your data used in the study this will not have any impact on your therapy.

6.What are the possible disadvantages and risks of taking part?

There are not thought to be any major risks or disadvantages to taking part in this study. Questions in the interview after the group could trigger distressing thoughts, if this happens you will have access to a clinician to discuss this. Participation in the study is completely independent of your treatment with SPS.

7. What are the benefits of taking part?
There are no direct benefits. However, examining the data will enable us to better understand the experience of participants and their views of the therapy. With the intention to make improvements to the therapy based on this information.

8. Will my taking part in this study be kept confidential?

All information you provide to us will be kept confidential. Only members of the research team will have access to it. All data collection, storage and processing will comply with the principles of the Data Protection Act 1998 and the EU Directive 95/46 on Data Protection. Under no circumstances will identifiable responses be provided to any other third party. Your name will not be placed on the questionnaires, however your assigned number on our secure online database will be places on the questionnaire.

9. Who is organising and funding the research?
The research is being conducted as part of a PhD in Psychology at the University of Birmingham. The funding required for the research will be paid by the Specialist Psychotherapies Service (BSMHFT).

Part two

10. What will happen if I don't want to carry on with the study?

You are free to withdraw your participation in the study including collation of any data from questionnaires up until the point of analysis which will occur at the end of therapy.

11. What will happen to the results of the research study?

All information provided by you will be stored anonymously on a NHS password secured computer with analysis of the information obtained undertaken by the research team based Specialist Psychotherapies Service. The results from this analysis will be available in one or more of the following sources; scientific papers in peer reviewed academic journals; presentations at a regional conference; local seminars. The findings will also be available via the thesis for this project, stored in the Birmingham University library.

12.What do I do if I have a complaint?
If you have a complaint you can contact;
Patient Advice and Liaison Service (PALS) on 0800 953 0045 or email pals@bsmhft.nhs.uk (8am – 8pm Monday to Friday)

13. If you would like to contact me to ask any further questions before signing the consent form. Kate Lucre [redacted] or email: [redacted] or my Supervisor Dr. Chris Jones [redacted]

You may keep this information sheet and will be given a copy of the signed consent form should you choose to participate. Thank you for taking the time to read this information sheet

Client Participant Information Sheet – Cohort Two

Study Title: An Evaluation of Group-based Compassion Focussed Psychotherapy

Part One

1. Invitation Paragraph

At the Specialist Psychotherapies Service we provide a range of different 'talking therapies', the Compassion focused psychotherapy group is just one of these.

This study is evaluating a 12 week compassion focussed psychotherapy group which will be running at Warstock Lane CMHT. This information sheet details the how's and why's of this evaluation. Please take the time to read the following information carefully and contact me if there is anything you are unsure of or if you would like more information

2. What is the purpose of the study?

Compassion Focussed Psychotherapy is a relatively new form of psychotherapy which draws from scientific research into how our minds work and the benefits of particular imagery exercises on our physical and emotional wellbeing. Although there has been a great deal of research into how these exercises can stimulate particular parts of our brain, to help us feel soothed and also improve our physical health, there has been very little research into how this can work as a therapy intervention.

The purpose of the study is to evaluate the effectiveness of the 12 week group and compare it to a 40 week group.

3. Why have I been chosen?

You have been selected as your clinical team have felt that a compassion focused approach may be of interest to you considering your difficulties.

4. Do I have to take part?

No, it is up to you to decide whether or not to take part. If you decide not to take part we will not take your assessment for the group any further and will not contact you again. If you do decide to take part you will be given this information sheet to keep and be asked to sign two consent forms.

5. What will happen to me if I take part?

You will be asked to sign two consent forms (a copy for you and a copy for the researcher). You will then be assessed for the group and if you are accepted for the group, you will join the study. The information that you provide prior to attending the group, in the form of a number of different questionnaires will be anonymously collected and looked at in relation to the information in the questionnaires that you will be asked to complete at the end of therapy and again 9 months, 12 months and 24 months after the therapy has ended.
At the end of the group programme there will be a semi structured interview which you are being asked to consent to take part in. This will be a member of the research team to gather information about your experience of the group and your views about what was helpful / unhelpful. If you chose not to consent to the interview or having your data used in the study this will not have any impact on your therapy. Not everyone who consents to be interviewed will be contacted.

6. What are the possible disadvantages and risks of taking part?

There are not thought to be any major risks or disadvantages to taking part in this study. Completing the questionnaires and participating in the group could trigger distressing thoughts and feelings. If this happens be sure to raise this with the clinicians involved in the group. Questions in the interview after the group could trigger distressing thoughts, if this happens you will have access to a clinician to discuss this.

7. What are the benefits of taking part?
If you agree to take part in this study you will have an opportunity to be assessed for and possibly to be offered a 12 week psychotherapy group, which could be of benefit to your emotional wellbeing and health.

8. Will my taking part in this study be kept confidential?

All information you provide to us will be kept confidential. Only members of the research team will have access to it. All data collection, storage and processing will comply with the principles of the Data Protection Act 1998 and the EU Directive 95/46 on Data Protection. Under no circumstances will identifiable responses be provided to any other third party. Your name will not be placed on the questionnaires, however your assigned number on our secure online database will be places on the questionnaire.

9. Who is organising and funding the research?
The research is being conducted as part of a PhD in Psychology at the University of Birmingham. The funding required for the research will be paid by the Specialist Psychotherapies Service (BSMHFT).

Part Two

10. What will happen if I don't want to carry on with the study?

You are free to withdraw your participation in the study including collation of any data from questionnaires up until the point of analysis which will occur at the end of therapy. Prior to commencing the group withdrawing from the study will also mean withdrawing from the group. If you chose to withdraw from the study once the group has started you can remain in the group for the duration of the 12 week programme.

11. What will happen to the results of the research study?

All information provided by you will be stored anonymously on a NHS password secured computer with analysis of the information obtained undertaken by the research team based Specialist Psychotherapies Service. The results from this analysis will be available in one or more of the following sources; scientific papers in peer reviewed academic journals; presentations at a regional conference; local seminars. The findings will also be available via the thesis for this project, stored in the Birmingham University library.

12. What do I do if I have a complaint?
If you have a complaint you can contact;
Patient Advice and Liaison Service (PALS) on
0800 953 0045 or email pals@bsmhft.nhs.uk (8am – 8pm Monday to Friday)

13. If you would like to contact me to ask any further questions before signing the consent form. Kate Lucre [redacted] or email: [redacted] or my Supervisor Dr. Chris Jones [redacted]

You may keep this information sheet and will be given a copy of the signed consent form should you choose to participate. Thank you for taking the time to read this information sheet.

Appendix G – Reliable Change Summary Chapter 4

CORE	**Risk**		**Wellbeing**		**Functioning**		**Problems**	
	C1:CFTG	**C2:TAU**	**C1:CFTG**	**C2:TAU**	**C1:CFTG**	**C2:TAU**	**C1:CFTG**	**C2:TAU**
Clinically meaningful improvement	25%	19%	54%	48%	42%	53%	33%	43%
Clinically meaningful deterioration	12%	14%	17%	24%	13%	13%	13%	33%
DASS	**Anxiety**		**Depression**		**Stress**			
Clinically meaningful improvement	34%	52%	25%	48%	10%	39%		
Clinically meaningful deterioration	12%	15%	2%	9%	5%	0%		
IES	**Hyperarrousal**		**Intrusion**		**Avoidance**			
Clinically meaningful improvement	16%	40%	45%	35%	25%	38%		
Clinically meaningful deterioration	17%	20%	10%	5%	17%	0%		
Social Rank Measures	**SCS**		**OAS**		**SBS**		**WASA**	
Clinically meaningful improvement	36%	61%	41%	57%	40%	61%	21%	57%
Clinically meaningful deterioration	15%	4%	15%	9%	10%	4%	2%	4%
FSRSA	**Inadequate Self**		**Reassured Self**		**Hated Self**			
Clinically meaningful improvement	21%	61%	33%	51%	15%	48%		
Clinically meaningful deterioration	5%	9%	5%	9%	8%	4%		
FCS	**ECO**		**RCO**		**ECS**			
Clinically meaningful improvement	45%	57%	43%	67%	38%	78%		
Clinically meaningful deterioration	7%	13%	30%	9%	15%	13%		
ISS	**Shame**		**Self Esteem**					
Clinically meaningful improvement	28%	70%	36%	61%				
Clinically meaningful deterioration	5%	0%	10%	9%				

Appendix H: Role Taking Case Illustration

Jon was a member of a CFGP Program and had been invited to bring objects from home which had significant meaning and could become part of his compassionate Kitbag. Jon had been reluctant to engage in this aspect of group and had stated that he did not have anything that helped him feel calm or courageous.

In this context, he had shared with the group that as a child there had been an abundance of toys around the home but they remained in their boxes and were not allowed to be played with. He described a feeling of terror associated with the idea of playing and resisted exercises which involved playing such as using art materials and compassion focused games.

Jon quite unexpectedly came to group with a bag which he said contained something that 'might do as a compassionate object'. Very tentatively he shared a brightly coloured elephant which had been a gift from his teacher, early in his education. He had kept the elephant in a box in a cupboard which he rarely looked at. As it was passed around the group he spoke of feeling very fearful and anxious that that the elephant would be damaged.

Jon agreed to take the role of the elephant which he called 'Bruce', but only with the agreement that he could stop the exercise if it became too much. He was invited to hold the elephant and stand up and then as he sat down he took on the role of Bruce. After an initial introduction he was asked about how long he had been in Jon's life and the sort of situations which Jon might think of him. He (as Bruce) described with tears in his eyes that Jon would often think of him when he felt alone and despairing. Bruce reminded Jon that the teacher who had made the gift had cared very much for him and had seen his strengths and ability. When asked, Bruce (through Jon) spoke of feeling very warm towards Jon, coupled with a motivation to help him see the things that he struggles to hold in mind, that people have cared about him and that he is strong (like Bruce). At the end of the process, Bruce was invited to give a message to Jon: "*you are stronger than you know and you need to take me out of the box because I am an elephant and I can remember this for you."* He stood up to step out of role and sat again to step back into being Jon.

The following sharing session enabled Jon to settle with the things that he had learned from being Bruce, he resolved to take him out of the box and place him by his bed so he could be

reminded more often. This exercise enabled Jon to connect with the unconscious meaning associated with the elephant and the connections with his early life which he was repeating by denying himself access to opportunities for soothing. (Taken from Lucre, in press, with permission)

Appendix I: Compassionate Transformation Case Illustration

Saran, is a group member in Phase 4 of the program. She had chosen to use the group to work on an early abuse memory that had taken place within her family home. The aim of this piece of work was a compassionate transforming of her relationship with the memory. First a 'stage' was created in the room, by pushing the chairs into a semicircle with a space at the front for the work to take place. This separation allowed for some emotional distance and if needed, Saran could return to her place in the group leaving the stage and the memories encountered there.

Saran was invited to use objects from the room to represent the different people who had been present during the abuse, this scene was clearly marked out using scarfs, ensuring that the scene was contained. Saran talked through her choices of objects to present the different characters and placed them within the boundary marked by the scarfs. During this time the therapist stayed close to and mirroring the actions of Saran to provide an experience of affiliative safeness.

At the point where the scene had been set, Saran was invited to use an object to represent herself. She choose a pebble which had been a gift from the group and as such was imbibed with the group's belief in her. The pace and tone of the process was slowed at this point to allow for some space for Saran to observe the scene and settle with the emotional connection. Saran noticed at this point that her young self in this scene was much younger than she remembered and this connected to a compassionate wisdom and realisation that she could not have prevented this abuse. She was invited to focus on the soothing rhythm of the breath to help ground herself and bring her compassionate self to this scene. Some time was spent utilising a standing guided imagery practice to support Saran to connect with and embody the qualities of strength, wisdom and courage.

The therapist then invited Saran to turn back to the scene and consider what this very young Saran needed and her response was to be rescued from the scene by her adult compassionate self. A request was made for volunteers to hold the place of Saran's child self, holding the object that had represented her in the scene and also another to hold the place of Saran's compassionate self.

Saran was then invited to gently direct her fellow group members who had volunteered to ensure that body postures, words, emotional meaning and actions fitted for her. She then stepped out of the scene, to allow the scene to be replayed by the volunteer group members with the compassionately transformed ending. Once it had been established that Saran was satisfied with the scene, time was taken to ensure that the group members who had held places in Saran's scene had 'de-roled' and were not left holding any of the trauma material worked through in the scene. Saran was guided to 'de-role' the objects and put away the props that had been used.

The group then returned to the circle to reflect on personal responses to the experience. This was an opportunity for validation and reinforcement of the courage and connection for all group members. Group members spoke of being deeply affected by the experience and a strong sense of connection with their own experience of early abuse and intrusion. Time was taken for this to be discussed, explored with a commitment from others to use the group in a similar way. (Taken from Lucre, in press, with permission)

Appendix J Reliable Change Index Summary Chapter 5

CORE	**Risk**		**Wellbeing**		**Functioning**		**Problems**	
	C1:CFTG	**C2:TAU**	**C1:CFTG**	**C2:TAU**	**C1:CFTG**	**C2:TAU**	**C1:CFTG**	**C2:TAU**
Clinically meaningful improvement	46%	21%	50%	10%	63%	33%	63%	10%
Clinically meaningful deterioration	4%	11%	7%	53%	4%	53%	0%	42%
DASS	**Anxiety**		Depression		Stress			
Clinically meaningful improvement	54	5	39	11	53	0		
Clinically meaningful deterioration	4	71	4	73	0	24		
IES	**Hyperarrousal**		**Intrusion**		**Avoidance**			
Clinically meaningful improvement	56%	25%	25%	5%	75%	10%		
Clinically meaningful deterioration	6%	37%	43%	94%	12%	47%		
Social Rank Measures	**SCS**		**OAS**		**SBS**		**WASA**	
Clinically meaningful improvement	61%	9%	65%	10%	42%	14%	61%	9%
Clinically meaningful deterioration	3%	62%	6%	53%	12%	57%	0%	52%
FSRSA	**Inadequate Self**		**Reassured Self**		**Hated Self**			
Clinically meaningful improvement	61	14	68	9	71	5		
Clinically meaningful deterioration	3	67	9	57	10	57		
FCS	**ECO**		**RCO**		**ECS**			
Clinically meaningful improvement	55%	29%	74%	9%	71%	3%		
Clinically meaningful deterioration	19%	48%	6%	48%	9%	57%		
ISS	**Shame**		**Self Esteem**					
Clinically meaningful improvement	77	2	55	0				
Clinically meaningful deterioration	0	57	3	57				

Appendix K: Semi Structured Interview Questions and Proforma

1. What led you to be referred to the CFT group ?

   Prompts
   - *Were there particular difficulties that you felt that the group might have been helpful with?*

2. Can you say a little about what your goals were at the beginning of therapy?

3. How do you feel you have changed since being in the group?

Prompts
- *If yes…. What why and how*
- *If no…. what why and how*

4. Could you describe and talk me through a typical group session ?

   prompts
   - *Structure*
   - *Format*
   - *Interventions*
   - *Duration*
   - *What were each of these components like helpful / unhelpful?*

5. Tell me about your experience of the group therapy?

Prompts
- *Helpful …What and why?*
- *Unhelpful … what and why?*
- *Rolling programme ?*
- *The different parts .. 12 week / 40 week*
- *Facilitators*
- *Group members*
- *Environment – to and from / time of day?*
- *The activities that were used in the group*

6. Can you tell me if you experienced any change throughout the time of the group and if so what with specifically?

Prompts
- *How and why*
- *How did this change affect your goals for therapy ?*
-

7. What advice would you give us about running this group in the future?

Prompts
- *How could we make it better?*
- *What was best/worst and why?*

Appendix L: Word Cloud of Participant words

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