Client Experience of Compassion Focused Therapy (CFT) & Compassion Following Therapy

By

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Thesis Overview

This thesis is submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology (ClinPsyD) at the University of Birmingham.

Chapter 1: Client experiences of Compassion-Focused Therapy (CFT) Interventions: A Meta-Ethnography. This chapter comprises a qualitative ethnography of the current literature base surrounding experience of CFT.

Chapter 2: Experiences of compassion in people with attachment and relational trauma 5-7 years after completing a long-term compassion-focused therapy (CFT) group: An IPA study. This chapter comprises the empirical paper focusing on the experiences of compassion in a group of adults up to 7 years after CFT.

Chapter 3: The final chapter is a press release document providing overview of the papers contained in chapters 1 and 2.

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Dedications

I dedicate this thesis to my incredible family and friends. Mom, Dad, Liam and all my lovely friends. Your unwavering support and belief in me even when I really couldn't see it

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Client experiences of Compassion-Focused Therapy (CFT) Interventions: A Meta-Ethnography

Abstract

Introduction: This meta-ethnography aimed to synthesise the existing literature surrounding participant experiences of Compassion-Focused Therapy (CFT) interventions. This was to address a gap in the literature and bring together the emerging qualitative studies concerned with CFT.

Method: A combination of a systematic literature search and additional search strategies was used to identify the existing qualitative studies. Four databases were searched covering a range of healthcare disciplines. A meta-ethnography was conducted according to the 7 stages outlined by Noblit and Hare (1988) and these are outlined along with details about how this was carried out by the researcher.

Results: 3 overarching themes and 7 subthemes were identified. These related to 'psychological safeness', CFT active ingredients' and 'processes of change'. Within the themes, the role of the therapist, the group experience, resonance of the model, practice of skills and barriers to compassion are explored. Participants recognised the changes they experienced during CFT and their implications for their future.

Discussion: The results are discussed in the context of the broader processes of change literature and the common experiences of individuals who have experienced CFT. The results have particular implications also for the broader therapy literature around group processes. Potential limitations are also discussed.

Introduction

Exploring client experience

Exploring client experiences of therapy contributes to understanding processes of change and has implications for predicting outcomes for clients (Elliot, 2008). In an early meta-synthesis of qualitative research on client experiences of therapy, Elliot and James (1989) highlighted the unique value of a client's perspective, or their "privileged access" (p.445) to aspects of the therapeutic experience. Asking participants to retrospectively comment on their experience of an entire course of therapy also has value in identifying key aspects of the therapeutic relationship and any helpful aspects of the therapy (Elliot & James, 1989). Given that therapy seeks to bring about change in the client's experience (Elliot & James, 1989), research that directly explores client experience can contribute to an understanding of the changes it may have produced in a move away from focusing only on therapeutic outcomes (Wyatt et al, 2014).

In research seeking to understand the experience of treatment, qualitative methods have become increasingly popular, particularly when exploring experience of psychotherapy approaches (McPherson et al, 2020). Randomised-control trials (RCTs), which are often considered the gold standard methodology for efficacy research (Hariton & Locascio, 2018) are recognised as poorly equipped to provide sufficient detail on the process, context and personal experience (McPherson et al., 2020). There is a growing number of qualitative studies that have identified the value of capturing the "quality of people's lived experience" (Allen et al., 2009, p. 414) to contribute to clinical practice and the development of therapies and interventions (Wyatt et al., 2014).

Compassion-focused therapy

Compassion-focused therapy (CFT) is an integrated, biopsychosocial model of psychotherapy developed by Paul Gilbert (2000). Building upon the understanding that compassion is an integral component of a therapeutic relationship, CFT combines its roots in Buddhist practices with scientific practices from neuroscience and evolutionary theory (Gilbert, 2009). CFT refers to the application of the model in psychotherapy, whereas Compassionate Mind Training (CMT) refers to the specific skills development activities that aim to develop compassion (Gilbert, 2009). These activities are often then featured within a CFT intervention. Henceforth 'CFT' will be used to encapsulate both CFT and CMT interventions based upon the work of Gilbert.

The theoretical underpinning of CFT draws on evolutionary principles, attachment theory and social mentality theory (Gilbert, 2014; Kirby et al., 2017). Although other models refer to compassion, CFT is clear in its definition that compassion is: *'a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it'* (Gilbert, 2014, p.19). Gilbert (2014) stipulates that both psychologies or facets of compassion need to be present and are integral to CFT.

CFT was developed in response to several observations, the first of which was the challenge faced by those with high levels of shame and self-criticism to show compassion and kindness toward themselves (Gilbert, 2000). Secondly, Gilbert recognised that difficulties with shame and self-criticism were often rooted in traumatic experiences of abuse and neglect giving rise to an increased sense of threat both internally and in their external world. Gilbert also stipulates that in CFT, the role of the therapist or trainer is to demonstrate to and instil in the client the skills and attributes of compassion (Gilbert, 2009).

CFT recognises compassion as flowing in three directions: compassion can be felt for others, compassion can be felt from others to ourselves and finally compassion we direct to the self (Gilbert, 2014). These flows are recognised by Gilbert (2014) as human, affiliative

processes and therefore CFT, when applied therapeutically is transdiagnostic (Gilbert, 2000, Craig et al, 2020). Gilbert and Proctor (2006) identify shame and self-criticism as factors that may contribute to or have a maintaining effect on several mental health difficulties. Transdiagnostic applicability of CFT provides rationale for looking at experience of CFT therapy across a range of clinical and non-clinical samples. CFT, unlike other compassion-based interventions is not manualised and therefore possible to be tailored to the particular case/formulation led and therefore more widely applicable and applicable (Kirby et al, 2017).

Influenced by neurobiology and evolutionary theory, CFT emphasises the evolutionary function of human affiliative emotions and their role in social communication and regulation with others (Gilbert, 2014). The three emotion-system approach or 'three circles' model central to CFT is underpinned by earlier findings from neuroscience (Gilbert, 2014) that identify a combination of affiliative and motivational systems (Depue & Morrone-Strupinsky, 2005) and the presence of a threat-based system (LeDoux, 1998). Gilbert (2009) describes these three distinct emotional regulation systems; threat system, motivated to protect, the drive system, concerned with resource and excitement seeking and finally the soothe system, which promotes content and safeness.

CFT interventions are concerned with the balance between these systems (Gilbert, 2010). The aim of CFT as an intervention is to normalise and de-shame emotional experiences that are a product of our evolutionary brain development and tendencies to respond from our threat system (Cuppage et al, 2018). CFT approaches use various compassion focused exercises to cultivate compassionate wisdom and promote the affiliative/soothing system as a means to regulate and rebalance the drive and threat systems (Gilbert, 2010, 2014).

In striving for balance between the three circles and moving towards giving and receiving compassion, blocks, fears, and resistances to compassion are also recognised

(Matos et al., 2022). Matos et al (2022) identify that often fears to compassion are the result of fears or avoidance rather than an inability to connect with compassion. Fear of compassion can be present in all flows of compassion (Matos et al., 2022) and derived from beliefs about the compassionate experience, e.g., feeling underserving of compassion, concerned that they/others may become too overwhelmed or that compassion indicates self-indulgence or weakness (Gilbert & Mascaro., 2017). Gilbert (2020) recognises that these fears to compassion can be understood from an attachment lens where fears can be rooted in earlier experiences, e.g., experiences of shame or a lack of safeness/emotional warmth in early life (Matos et al., 2017). Studies have shown that clinically, there is a high prevalence of such fears and these in turn may interfere with interventions and therapy (Kelly et al, 2021, Pauley & McPherson., 2010). Kirby et al (2019) identified that fear of compassion was strongly associated with depression, shame, and self-criticism. Therefore, research that focuses on understanding what it is like to partake in CFT interventions has value in terms of contributing to the existing literature base around fears and barriers.

Efficacy evidence base

There is a growing evidence base for the efficacy of CFT across several clinical populations. To date three meta-analyses have been conducted reviewing the efficacy of CFT as a psychological therapy across a range of clinical populations including those experiencing depression, psychosis, eating disorders, trauma related difficulties, social anxiety, prolonged grief and borderline personality disorder (Leaviss & Uttley, 2015, Craig et al, 2020 & Millard et al, 2023). When compared to wait list control groups CFT significantly improves on specific compassion outcomes such as self-compassion, self-reassurance alongside reductions to self-criticism and fear of self-compassion (Craig et al., 2020 & Millard et al., 2023). CFT has also been found to reduce clinical symptomology such as depression symptomology

compared to wait-list control (Millard et al., 2023). Although there have been some promising findings comparing CFT with other interventions in some populations such as traditional CBT (Leaviss & Uttely, 2015), Millard and colleagues (2023) concluded that currently there is insufficient data to conclude whether CFT performs above other psychological interventions due to small numbers of RCTs. Similarly, most of the findings to date focus on baseline and post-intervention comparisons so conclusions at follow-up are inconclusive (Millard et al., 2023).

The applicability of CFT in non-clinical settings has also been considered. In a study exploring CFT in an educational setting, participants experienced significant increases in self-compassion and decreases in self-criticism (Maratos et al, 2019). In a sample of healthcare professions, the integration of CFT practice into supervision was found to cultivate self-compassion and reduce self-criticism (Bell et al, 2016). In a study of general population adults with low to moderate levels of wellbeing, Sommers-Spijkerman et al (2018a) found that guided CFT self-help improved measures of well-being compared to a waiting list control group.

Less is known about how CFT brings about these reported changes. The CFT theoretical model identifies four potential mechanisms of change: 'cultivating self-reassurance', 'disengaging from self-critical thoughts', 'stimulating attention for and processing of positive affect' and 'improving distress tolerance and decreasing negative affect' (Gilbert, 2014). In an RCT comparing a CFT intervention to waitlist controls in a non-clinical sample, Sommers-Spijkerman et al. (2018b) reported that changes in wellbeing and anxiety / depressive symptoms were mediated by self-reassurance and self-criticism, while regulating positive and negative affect mediated anxiety and depressive symptoms respectively. Matos et al. (2021) examined RCT data reporting that, following a CMT intervention, increased compassion towards the self, receiving compassion from others and

decreases in fears of compassion, mediated reductions in shame and self-criticism when compared to pre-intervention data. Despite their contributions to understanding of the mechanisms of change in CFT, both papers highlight the need to build upon these preliminary results.

The current ethnography and rationale

Exploring accounts of those who have engaged in CFT may provide some insights into what CFT is like to experience and contribute to understanding of these distinctive features of CFT as a model of therapy and ascertain if there are similarities across those individual experiences. Exploring the experience of CFT interventions has implications for intervention development, as noted by Sommers-Spijkerman et al (2018) who recognise that with an increase in understanding mechanisms of change comes the improvement and development of future interventions and good clinical practice. As captured by Elliot and James (1989), clients who have experienced a particular therapy are a unique resource in understanding the acceptability and helpfulness of an intervention.

Qualitative research that explores common psychological processes in CFT can contribute to a richer understanding of mechanisms of change within therapy (Wyatt et al., 2014). McPherson and colleagues (2020) synthesised client experiences of depression treatments highlighting the importance of the client voice in making decisions about interventions and the need for treatments to be tailored to an individual's needs. The authors note the value in synthesis papers such as these in providing a client voice which can inform future practice and the delivery of services (McPherson et al, 2020) and this may be of particular value for relatively new interventions with a rapidly emerging evidence base where questions remain about their acceptability and potential barriers for clients.

To date there is no published paper synthesising what is know about client experience of CFT. France et al (2016) recognise the benefit of synthesis, particularly in health care practice, which is where a majority of CFT studies lie. A meta-synthesis is described by Finfgeld (2003) as "a new and integrative interpretation of findings that is more substantive than those resulting from individual investigations" (p. 894). Timulak (2008) highlight the value in this offering a systematic and rigorous secondary analysis of a range of initial qualitative findings. By integrating across, qualitative syntheses can help to make sense of complex phenomena and build upon conceptual and theoretical understanding (France et al., 2016).

Aims of this meta-ethnography

This aim of this meta-ethnography is to systematically identify, appraise and synthesise the current qualitative literature on the experience of individuals who have received a CFT based intervention. This ethnography aims to develop a comprehensive understanding of participant experiences across participant groups and modalities of CFT therapy.

Methodology

Meta-ethnography

A meta-ethnography, devised by Noblit and Hare (1988) is one methodology that synthesises qualitative studies. Meta-ethnography is a type of qualitative synthesis which are concerned with pooling together the findings of qualitative studies and provide a systematic interpretation to convey meaning of the gathered studies (Bearman et al, 2013). The meta-ethnography methodology aims to provide an interpretive approach to synthesizing

qualitative studies which combines systematic identification and quality appraisal of all relevant papers with an interpretive synthesis of the available data (Noblit & Hare, 1988, France et al, 2016, Sattar et al, 2021). It is described by Noblit and Hare as sharing the same goal of a meta-analysis in that it aims to "put together" all of the research on a topic that is available. A meta-ethnography is intended to provide more interpretive literature reviews, critical examination of multiple accounts, systematic comparison to draw conclusions and provide a way of talking about qualitative data and compare it to the work of others (Noblit & Hare, 1988). Meta-ethnography is a suitable methodology when the research question is concerned with the theoretical or conceptual understanding of a phenomenon (Sattar et al, 2021), in this case, participant experience of CFT.

Noblit and Hare (1988) propose that the meta-ethnography methodology is comprised of seven phases or stages (see table 1.1 below). Although these appear in a linear and systematic order, the authors note that these phases may overlap or run in parallel and the unique contribution of a meta-ethnography is the translations (Noblit & Hare, 1988, Satter et al, 2021).

Table 1.1: Seven phases of meta-ethnography propose by Noblit and Hare (1988).

Phase/stage	What is involved	Steps carried out
Phase 1: Getting started	Identifying an intellectual area of interest. (Noblit & Hare, 1988, p.26)	Discussions in supervision Establishing need for meta-ethnography and what its contribution would be to growing CFT literature base.
Phase 2: Deciding	Effort is made to develop an exhaustive list of the	Discussion and decision making about scope of focus e.g. whether to include non-clinical samples, mixed method

what is relevant to the initial interest	available papers, including development of inclusion/exclusion criteria, systematic search. (Noblit & Hare, 1988, p.27)	studies to ensure suitable spread of papers but not large quantity to synthesise. Consultation with University library services about systematic literature searches and development of search terms. Inclusion and exclusion criteria identified and discussed in supervision. Systematic search of multiple databases. Exploration of existing quality appraisal frameworks for qualitative papers.
Phase 3: Reading the studies	Meta-ethnography involves the synthesising of texts therefore awareness of the content and detail is important. (Noblit & Hare, 1988, p.28).	Multiple read throughs of the papers with particular attention to the results sections. Entire results data extracted to include only the qualitative results from mixed method papers. Separate study characteristics table developed and completed for each study. Quality appraisal framework applied to all papers.
Phase 4: Determining how the studies are related	Determine what is the relationship between the studies. (Noblit & Hare, 1988, p.28).	On the extraction table, themes and patterns were identified. This was carried out on a spreadsheet and data extraction table was also printed so that highlighting and tracking of patterns could be carried out.
Phase 5: Translating the studies	Comparing metaphors and concepts across papers that balances between protecting the	On printed extraction table translations were added with coloured highlighters. Translations and patterns discussed with supervisor.

into one another	specifics but enabling comparisons between papers. (Noblit & Hare, 1988, p.28).	
Phase 6: Synthesizing translations	Making the whole into something more than the parts and translating interpretations. (Noblit & Hare, 1988, p.28)	Translations compiled into groups/themes. Discussions had between researcher and supervisor in developing interpretations and grouping of translations into themes.
Phase 7: Expressing the synthesis	How is the synthesis best expressed and in what form. (Noblit & Hare, 1988, p.29).	PRISMA diagram compiled of stages Number of papers that contribute to each theme identified and reported. Key quotes identified for each theme. Narrative about how the translations fit together, including divergences discussed in supervision and informed writing of results.

Initial scoping search (phase 1)

An initial search of the existing CFT literature was conducted, identifying the current systematic reviews, meta-analyses and meta-syntheses. This initial scoping search identified an existing literature base concerned with the efficacy of CFT. During the scoping search several qualitative papers were identified, spanning a range of clinical and non-clinical populations and in some instances qualitative data was reported alongside quantitative data as part of a mixed method study. The aim of a scoping search was to identify whether there was

a body of qualitative literature to synthesise (Sattar et al, 2021). The scoping search confirmed that there was no existing synthesis of literature concerned with client experience of CFT. The absence of an existing review and the growing CFT literature base contributed to the development of the research question.

Systematic literature search (phase 2)

Search strategy

The development of search terms related to the topic area is required for effective searching of bibliographic databases (Barroso et al 2003), particularly accounting for the specificity and sensitivity required. Search terms related to the research question were developed by reviewing the search terms of key relevant papers, discussing the terms with supervisor and consulting a university librarian, which is recognised as good practice for qualitative searches (Satter et al, 2021). Barroso and colleagues (2003) highlight the difficulties with indexing of qualitative studies which was discussed with the librarian. It is recognised that searches including qualitative papers can produce large numbers of papers (Satter et al, 2021) therefore it is recommended that the resources available are considered at point of developing search terms (Satter et al, 2021). Without including the 'qualitative' search term, the search retrieved large numbers of irrelevant papers that were unmanageable and beyond the scope of the project.

The final search terms with truncations (indicated with *) are presented in table 1.2 below.

Table 1.2: Search terms used in systematic search

Constructs	**Compassion (keyword)**		**Therapy (keyword)**		**Method (subject heading/keyword)**
Search terms	Compassion*	AND	Intervention* OR Training OR Treatment* OR Therap* OR Program*	AND	Qualitative

Four databases were searched to cover a range of healthcare disciplines. 'PsycINFO' was selected for its coverage of the psychological literature, 'CINAHL' for its coverage of nursing literature and 'Embase' and 'Medline' for coverage of medical literature. The search was conducted in August 2022. After free-text search terms were used, all retrieved papers were refined using pre-programmed database limiters to ensure that only papers available in English language were included in the retrieved papers.

Following the systematic searches, additional non-systematic searches were also conducted. This was particularly relevant given that qualitative papers are not well indexed (Barosso et al, 2013). Following the systematic search, a Google Scholar search was conducted. The reference lists of key papers were also screened by the researcher. The researcher also consulted an expert in the field of CFT as part of the additional searches.

Inclusion & exclusion criteria

Inclusion and exclusion criteria were devised in conjunction with the wider research team. See Table 1.3 for the criteria used to screen the papers. The only criteria in relation to

the population was the stipulation that papers exploring the experience of adults only were included. Due to the emerging evidence base for CFT and its transdiagnostic applicability (Gilbert, 2010), the decision was made to include both clinical and non-clinical samples. The theoretical underpinning of CFT is concerned with the human struggle (Gilbert, 2010) and the focus on experience in the research question indicated the inclusion of both clinical and non-clinical samples. Given that the research question concerned with CFT based interventions, this includes both individual and group intervention delivery. The research question aimed to synthesise the experience of CFT as an intervention, therefore discrimination between mode of delivery was not required but details about this was included in the table of study characteristics.

Table 1.3: Inclusion and exclusion criteria

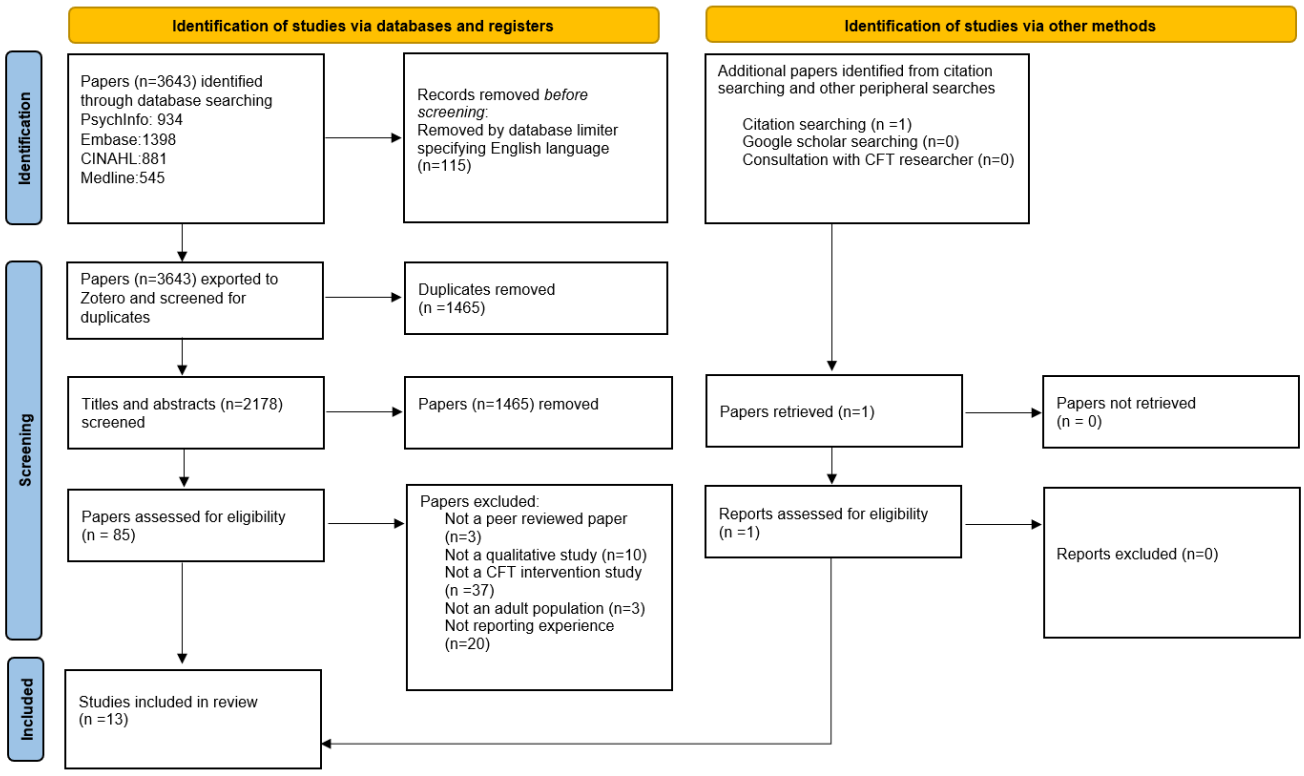
Inclusion criteria	Exclusion criteria	Justification
Paper available in English language	Paper not available in English language.	No funds available for the translation of studies not available in English.
Paper is a peer reviewed article that reports original data	Paper is not peer reviewed, e.g. dissertation, unpublished article, conference poster, theory articles, review papers.	Peer reviewed articles have already been through robust quality appraisal processes. Original data is also required to synthesise.
Paper reports qualitative data and quotes as part of qualitative or mixed methods study	Paper reports quantitative data only.	Noblit and Hare (1988) refer to qualitative to mean "approaches within the interpretative paradigm that includes ethnography, case study research, intensive interview studies and discourse analysis" (p.13).

Paper reports an intervention that is Compassion-Focused Therapy (CFT) or Compassionate Mind Training (CMT) interventions based upon Paul Gilbert framework	Either no exposure to an intervention reported or where an intervention is reported, this refers to other compassion-focused intervention not underpinned by CFT.	Scoping searches identified a broad scope of interventions that could be grouped under broader umbrella of 'compassion-based interventions'. These have a different theoretical underpinning to CFT.
Papers that focus on adults	Papers that focus on children or adolescents	Research question is concerned with adult population.
Paper reports data related to the participants' experience of CFT intervention	Paper did not report data about participants' experience of the intervention	Research question is concerned with experience of CFT interventions therefore commentary about the intervention is required.

Systematic screening

The Preferred Reporting Items for Systematic Review and Meta-analyses (PRISMA) model (Page et al, 2021) was utilised for the systematic selection of papers to include in the synthesis. Below is a PRISMA diagram outlining the number of papers included and excluded at each stage of the process. At each step, queries about whether a paper met the inclusion criteria were resolved through discussion with my supervisor.

Figure 1.1: PRISMA diagram (Page et al, 2021) to show systematic screening process.



Quality appraisal

As part of stage 2, existing quality appraisal frameworks were researched. There is currently a lack of agreement in the qualitative field about the application of quality appraisal frameworks (Satter et al, 2021, Toye et al, 2013) and it is argued that appraising quality relies on subjective judgment (Dixon-Woods et al, 2007). Satter et al (2021) recognise the importance of some quality appraisal so that the researcher can draw conclusions about the credibility of studies included in a synthesis. They go on to highlight the potential benefit of utilising appraisal frameworks or checklists as part of the quality appraisal process (Satter et al, 2021), therefore the NICE 'Quality appraisal checklist- qualitative studies' was utilised

(NICE, 2012). This comprehensive checklist covered many of the necessary domains for qualitative studies. An additional criterion related to the quality of reporting about the study intervention was added for the purposes of this ethnography and research question.

The framework was applied to each study during stage 3 of the methodology. Each item on the checklist has three levels of quality which were applied to each study in turn. Where a study met the criterion, a rationale for this decision was added to the table and, for the purpose of gaining an overview, was assigned the colour 'green'. Where the criterion was partially met, it was assigned the colour 'amber' and where the study did not meet the criterion at all it was assigned 'red'. Each study was then rated according to the NICE guidance for overall assessment; ++ where almost all of the criteria have been fulfilled, + where some of the criteria have been fulfilled or not adequately described or – where few or no criteria have been fulfilled and it is likely that this will impact on conclusions drawn (NICE, 2012). The same 'green', 'amber' and 'red' colours were assigned to denote these three levels of assessment (please see appendix for full quality appraisal table including rationale).

The results of the quality appraisal served to identify any common areas of the methodological weakness across the studies. The results also indicated study quality which was considered when looking at the contribution of studies at data analysis stage to ensure that key decisions about themes were not based predominantly on lower quality studies.

Data extraction (phase 3)

The study characteristics for each paper was extracted. This comprised a summary of the paper author, year of publication, research question(s)/aim(s), the geographical location where the study was carried out, a summary of the participant demographics, the format and delivery of the intervention and the data collection and analysis methodology.

The raw data from each study was extracted into an Excel document. The entire results section was extracted at sub-theme level, including first order constructs such as participant quotes. Second order constructs such as author commentary and interpretation were also included in data extraction (Noblit & Hare, 1988).

Analysis & synthesis (phases 4-7)

The raw extracted data was held on a central spreadsheet document. To assist with the translation stage, hard copies of raw data were printed to allow for close reading of the data alongside consideration of the study context that is captured in the study characteristics data. Key quotes and themes were highlighted, and the use of different colours enabled the identification of themes across the papers.

Translation, the comparing of concepts between papers (Noblit & Hare, 1988) was initially carried out using the printed hard copies of data. Starting with an identified index paper of high quality (Noblit & Hare, 1988), a summary of the themes from that paper was identified before repeating the process across the other papers. Points of divergence were noted as well as points of similarity. Sometimes during this process the original papers were referred back to. Key quotes for each concept were also collated. At several stages during analysis and synthesis the researcher received close supervision and translations were discussed with the supervisor. The translations and themes were captured in narrative form. The number of papers that contributed to each theme and sub-theme was also noted.

Results

Study characteristics

A total of thirteen studies were included in the ethnography (see table 1.4 below for study characteristics). All studies reported on client experiences of group CFT with three

studies reporting on a combination of group and individually delivered CFT. All studies apart from three were conducted in the UK, predominantly in National Health Service (NHS) services. Of the studies from outside of the UK, one was conducted in Sweden and the other two were conducted in Australia. As per the inclusion criteria, all participants were adults aged over eighteen and a total 99 participants were included in this ethnography. The ethnography is transdiagnostic therefore includes studies from a range of clinical and non-clinical populations; adults with diagnoses of personality disorder, PTSD, eating disorder, acquired brain injury and a diagnosis of a learning disability. Two of the studies were transdiagnostic and included participants across a range of psychological difficulties. Non-clinical populations included healthcare students, university students and the parents of adolescents receiving support for their mental health difficulties.

Of the studies included, eight were mixed method studies that utilised a qualitative methodology and analysis as part of a larger mixed method approach. A majority of studies utilised Thematic Analysis methodology, three studies utilised Interpretive Phenomenological Analysis (IPA), one utilised Grounded Theory, one utilised Content analysis and the final methodology was Reflective Lifeworld Research. A majority of data was collected via semi-structured interviews either individually or via focus groups and two studies used written accounts or reflections in their analysis.

Table 1.4: Summary of study characteristics.

Research paper & author	Study aims / purpose	Geographical location	Participants & study demographics	Intervention & format of delivery	Data collection & analysis
Lucre & Corten (2013)	To explore the emerging themes relating to what participants found useful about the therapy. The qualitative data was also	UK (NHS)	N=9 (7 females, 2 males) White British Personality disorder diagnosis according to ICD-10 Recruited as voluntary sample	Group CFT 16 weekly sessions	Mixed method study Written reflections post group intervention & at one year follow up. Content analysis by senior clinician to identify themes.

	undertaken to identify clients' own personal experiences.		following referral to group programme		
Lawrence & Lee (2014)	To produce an in-depth understanding of the experience of completing a course of compassion-focused therapy and of the process of developing self-compassion.	UK (NHS)	N= 7 (5 females, 2 males) Aged 30-54years Met DSM-IV criteria for PTSD Recruited as voluntary sample following completion of either individual or group CFT intervention	Group CFT (4 participants) Individual CFT (3 participants) Session number not specified	Semi-structured interviews Interpretive Phenomenological Analysis
Ashworth et al (2014)	To explore emerging themes relating to patients' experience of psychological difficulties, psychological change, and the experience of CFT.	UK (NHS)	N=7 All participants had diagnosed acquired brain injury Recruited as voluntary sample following attendance at outpatient neurological rehabilitation centre	Group CFT + Individual CFT 18 sessions of each	Mixed method study Semi-structured interviews Interpretive Phenomenological Analysis
Heriot-Maitland et al (2014)	To explore the experiences of group participants of an adapted four session, modular CFT group in inpatient mental health settings	UK (NHS)	N=4 Transdiagnostic group (including diagnoses of schizophrenia, schizoaffective disorder, bipolar affective disorder, personality disorder, depression, and anxiety.) Participants were volunteers recruited from a CFT group running on an acute inpatient ward	Group CFT 4 sessions	Mixed method study Semi-structured interviews Deductive thematic analysis
Clapton et al (2018)	To investigate whether a CFT intervention	UK (NHS)	N=6 (4 females, 2 males) M= 38.5 years	Group CFT-LD 6 sessions	Mixed method study

	was feasible for adults with a learning disability and concurrent mental health difficulties. The study also aimed to gather qualitative data regarding participants experience of and within the group.		All adults with a diagnosed learning disability Participants were volunteers recruited via referral from a community learning disability team		Focus groups using a semi-structured interview schedule Thematic analysis
Bratt et al (2019)	To describe the lived experience of group based CFT for the parents of adolescents who had been treated in a child and adolescent psychiatric outpatient speciality clinic.	Sweden	N=11 parents (6 females, 5 males) Parents of adolescents receiving mental health intervention in group format Participants were volunteers sampled from a larger research study	Group CFT 8 sessions	Semi-structured interviews Reflective Lifeworld Research
Bennet Levy et al (2020)	To determine whether Art-based Compassion Skills training (ABCST) might be an acceptable, feasible, and culturally safe way to deliver a compassion-based program derived from CFT in an Indigenous Australian context.	Australia	N=6 (5 females, 1 male) M=46.7years 2 clients, 4 health-care professionals, all Indigenous Australians Participants were volunteers from purposive sample accessing ABCST group	Group CFT 6 sessions Arts-based, adapted CFT	Semi-structured interviews Thematic analysis
Carter et al (2020)	To investigate participants' experience and satisfaction of 12 session CFT for body weight shame.	Australia	N=5 (4 females, 1 male) M= 30.6 years All participants had expressed body weight shame (minimum score	Group CFT 12 sessions	Mixed method study Focus groups Thematic analysis

			on the 14-item Body Image Shame Scale) and had a self-report BMI greater than 30. Recruited by convenience sampling and snowballing using flyers and adverts on University campus and social media		
Mullen et al (2020)	To explore the experiences of individuals attending a CFT-E2 group intervention, considering patterns of relating prior to CFT-E and after.	Ireland	N= 13 pre interviews (aged 19-58 years), 9 post interviews (aged 21-58 years) All participants had attended 1 of 2 cycles of CFT-E2, a focused CFT programme for individuals with Eating Disorders. Recruited as volunteers following psychoeducation session.	Group CFT-E + Individual reviews Approx 16 sessions	Semi-structured interviews Thematic Analysis Relational Analysis
Ashfield, Chan & Lee (2021)	To understand the process of change for individuals with complex PTSD who had attended a group treatment based on CFT.	UK (NHS)	N= 11 (all females) Age not specified All participants had completed Compassionate-Resilience Group programme. Recruited as voluntary sample from specialist PTSD service.	Group CFT (Number of sessions not specified)	Semi-structured interviews Constructionist grounded theory Epistemology; Constructionist position recognising subjectivity and researcher influence
Beaumont et al (2021)	To explore the impact CMT had on students' self-compassion and self-criticism, and	UK	N= 8 completed interviews, up to 15 participants completed diaries. Aged 24-49 years	Group CFT 12 sessions	Mixed method study Diaries & focus group interviews Thematic Analysis

	on their client work.		Students undertaking CFT module whilst working in healthcare profession. Recruited as voluntary sample following enrolment on course.		
Rayner et al (2021)	Report on findings from a course evaluation for health educators introduced to compassion-focused therapy (CFT) in a university setting.	UK	N= 6 (from participant pool of 28 whose age ranged from 25-60 years) Educators from a range of healthcare professional backgrounds attended CFT course ran at University of Salford. Participants self-selected to partake in course and study.	Group CFT 3-day programme	Mixed method study Focus groups & semi-structured interviews Interpretive Thematic Analysis
Altavilla & Strudwick (2022)	To evaluate effectiveness using interviews to investigate group content and process. The exploration also aimed to determine the most helpful and unhelpful aspects of the group which can then be used to modify future groups to increase their effectiveness.	UK (NHS)	N=6 (5 women, 1 man) Aged between 34-69 (3 working age, 3 older age). Completers of Compassionate Mind Group, with a range of psychological difficulties. All participants White British Recruited as voluntary sample of existing service users in secondary mental health service.	Group CFT 20 sessions	Mixed method study Semi structured interviews Thematic Analysis Epistemology; Critical realist perspective

Quality appraisal

Overall, the studies included in this synthesis were of mixed quality, although the majority were suitably robust in their design and confidence in the findings. Ten of the thirteen papers were rated as being overall good quality with a rating of '++'. Three papers were rated as '+'. No papers were rated as overall poor quality. The highest quality papers were those that focused on the report of only qualitative data. Where studies tended to demonstrate lower quality or concerns about their quality, these tended to relate to level of detail in which the data analysis was described and appeared robust. In some of the mixed-methods studies where qualitative results were presented alongside quantitative data, there appeared to be a reduction in the level of depth and richness of the data. However, richness of data was observed in three mixed method studies. Papers tended to not report a lot of detail about the data analysis e.g. stages of analysis, how they were carried out and the context around the researcher and their role in the project. However, across all papers included, the suitability of a qualitative design and clarity of the study aims was consistently high quality.

Table 1.5: Quality appraisal framework

Study	Theoretical approach		Study design	Data collection	Trustworthiness			Analysis						Ethics	Intervention	Overall
	Is the qualitative approach appropriate?	Is the study clear in what it seeks to do?	How defensible/rigorous is the research design/methodology?	How well was the data collection carried out?	Is the role of the researcher clearly described?	Is the context clearly described?	Were the methods reliable?	Is the data analysis sufficiently rigorous?	Is the data 'rich'?	Is the analysis reliable?	Are the findings convincing?	Are the findings relevant to the aims of the study?	Conclusions (and limitations)	How clear and coherent is the reporting of ethics?	How well is the intervention described?	Overall assessment
Lucre & Corten (2013)																+
Lawrence & Lee (2014)																++
Heriot-Maitland et al (2014)																+
Ashworth et al (2015)																++
Clapton et al (2018)																++
Bratt et al (2019)																++
Bennett-Levy et al (2020)																++
Carter et al (2020)																++
Mullen et al (2020)																++
Ashfield et al (2021)																++
Beaumont et al (2021)																+
Rayner et al (2021)																++
Altavilla & Strudwick (2022)																++

Meta-ethnography themes

Presented below are the three themes identified in this meta-ethnography (see table 1.6 for summary of thematic structure). The first and second themes, 'Psychological safeness' and 'Active ingredients of CFT' has two subthemes. The final subtheme, 'Processes of change' comprises three subthemes.

Table 1.6: Summary of themes and related sub-themes.

Theme	**Number of papers that contribute to theme**	**Sub-themes**
1. Psychological safeness	11	1.1 Therapist approach 1.2 The shared experience
2. Active ingredients of CFT	11	2.1 Connection/resonance of the model 2.2 Therapy tools & practicing
3. Processes of change	11	3.1 Barriers to self-compassion 3.2 Noticing & having choice 3.3 How I see myself & my future

Theme 1: Psychological Safeness

This theme explores the differing ways in which participants engaging in CFT interventions experience psychological safeness as well as highlighting the challenges when psychological safeness is not present. Psychological safeness, is understood in CFT as the experience, in this case in the therapeutic environment, where those present feel calm, cared for, reassured by and connected to others (Gilbert et al., 2008, Kelly & Dupasquier, 2016). Lucre and Clapton (2021) recognise the importance of safeness in not only leading to containment for individuals but encouraging a sense of openness and opportunity to explore in therapy. CFT interventions aim to develop this "safe haven within the therapy space"

(Lucre & Clapton, 2021, p. 500) and this is particularly salient where interventions are offered in group settings.

Across studies, the experience of psychological safeness seemed to be fundamental to participants' experience of, and ability to engage meaningfully in the therapy, as captured in this participant quote: "…it was a nice little safety net, I could go there for a couple of hours and I'd be alright" (Altavilla & Strudwick 2012., p. 221). In contrast, the absence of psychological safeness appeared to be a barrier to meaningful engagement, as described by the authors in Beaumont et al., (2021) who noted a need from participants to "hold back from the experiential aspects of the course as a form of 'self- protection'" (p. 9). Two key factors seemed to influence participants' experience of psychological safeness captured in the subthemes: 'the therapists' approach' and 'the shared experience'.

1.1 The Therapists' Approach

The approach of the therapist(s) was identified as one of the key aspects that seemed to influence a sense of safeness in the group. There was suggestion that the therapists' approach embodied the CFT model and the idea of compassion as captured by this participant:

> The encouragement that we got and the whole approach of [the facilitators] was so compassionate… and it was so, it was done in such a caring way and a sensitive way that it just kind of left it wide open for you to engage with it. There was no barriers unless you put them up yourself… it was just so compassionately done, so I think probably what helped me the most (Mullen et al., 2020, p. 258).

In Bennett-Levy et al. (2020), the authors related the warmth and safeness experienced by participants in the group setting to particular therapist characteristics and attributes that

embodied a CFT approach: “In reference to the facilitators (clinical psychologists and artists), they used terms such as ‘humble,’ ‘gentle,’ ‘non-threatening,’ ‘non-judgmental,’ ‘mindful,’ and ‘accommodating,’ as well as more upbeat terms like ‘animated’.” (Bennett-Levy et al., 2020, p. 5). Key qualities such as ‘kindness’, “One of the strongest things was the actual therapists themselves. Erm they were so kind.” (Lawrence & Lee, 2014, p. 499) were identified by some participants as valued characteristics of the therapist.

These compassionate qualities embodied by the therapist may have contributed to a sense of safeness for participants, as shown in this participant quote: “I just felt like I was in an environment where I was understood and I could relax” (Ashworth et al, 2015., p. 155). Ashfield et al (2021) suggest that safeness in turn encouraged engagement with the material and a sense that participants could be contained by the therapists: “…group facilitators provided a contained and compassionate space in which individuals felt able to share as much or as little as they wanted to.” (Ashfield et al., 2021, p. 293).

Whilst embodying the compassionate qualities as a therapist appeared important, so did a sense that the therapists were perceived as humans and not separate from other members during group interventions. One participant noted in Lawrence and Lee (2014) that these were human qualities that transcended their professional roles:

> One of the strongest things was the actual therapists themselves… Erm not only as doctors but as human beings. Their generosity was, I'd never come across that level of kindness before and, and their empathy erm at the same time they were very challenging and they made us work hard (p. 499-500).

One of the participants included by Bennett-Levy et al., (2020) similarly recognised that the psychologists delivering the interventions felt embedded in the group: “there was no distinction made between facilitators and participants” (p.5) and that ultimately the

experience felt “non-hierarchical” (p.5) and participants appreciated that the psychologists would “get down and dirty” (p.5). This suggests that therapists were perceived as being involved in the group and sharing the experience alongside participants rather than being positioned as facilitators.

Alongside the value placed on therapist(s)’ human and compassionate qualities, participants highlighted the need for therapists to show professionalism and expertise in the approach. Some participants described the therapists as being in a “steering” and “guiding” role (Lawrence & Lee, 2014., p. 500). There is some suggestion by Heriot-Maitland and colleagues (2014) that the therapists needed to be skilled in being able to deliver the material in a way that felt accessible for participants: “between didactic and experiential aspects of the group, along with space for reflection and digestion of learning points” (p. 90). This was also highlighted by Altavilla & Strudwick (2022) who identified facilitators finding the “mix of learning and discussion” (p. 222).

Taken together, it is perhaps the combination of knowledge and the therapists’ style that encompasses the ‘therapists’ approach’. Being attuned to the needs of the client/s and pitching the delivery of material whilst embodying the human qualities of compassion contributes to clients feeling understood. With this perceived safeness elicited by the therapists’ approach, participants have identified an openess to fostering connection with the material:

> You sit there and you think, you can’t know how I’m feeling...but because of how they do it and how they word it and you’ve got the slides on the board and absolutely everything you find yourself, even if you’re cynical...you’re looking round the room and everybody’s nodding and you’re thinking there is something in this (Ashfield et al, 2021, p.294).

1.2 The Shared Experience

Most papers that reported on group interventions contributed to the theme 'Psychological Safeness' from a sense of a shared group experience. Heriot-Maitland et al. (2014) acknowledged that "one of core principles of CFT is to create space for affiliative sharing, relating, and learning about self and others" (p. 87) and this was captured across most the papers included in this review. The shared experience where group interventions were offered can be considered as composing of three factors: generating a sense of not being alone in the struggle, experiencing shared humanity and the openness to sharing experiences as a result of these.

A common finding shared by participants was that hearing about other group members' experiences and struggles, which resonated with their own, helped to reduce their sense of isolation: "We had a lot of these groups between us... that was a real help because it can be very isolating, well, always had been for me, very isolating" (Ashworth et al., 2015 p.155). Seeing their own struggles and ways of responding reflected in shared experiences of other group members seemed to support a realisation by one participant that they were not alone: "You think you are the only one and then you realize that you are not alone. There are other people who feel the same and you are not alone. It's just unfortunate that you have been through these experiences." (Lawrence & Lee., 2014, p. 500).

Common humanity refers to the notion of a human, shared experience that moves away from "them and us" (p.223) that recognises the "ubiquitous nature of psychological distress" (p. 223) (Altavilla & Strudwick, 2022). Several papers specifically highlighted the sense of common humanity, and the idea that others have or are experiencing something similar, with one participate sharing the idea of: "…being in like the same boat and all that" (Clapton et al., 2017, p). This emphasised to participants the idea of a shared struggle, as

captured by this participant quote: “It showed to me that I am not the only person that needed self-compassion. There are a lot of people out there that need self-compassion just as much as me” (Bennett-Levy et al., 2020, p. 7).

Related to this idea of a common humanity, another participant recognised an increased connection with others and the development of a sense of belonging:

> It was nice having other people around who I didn’t feel, well you’re okay and I’m not so I really shouldn’t talk to you, cos you’ll pick up on my not okayness. It was kinda like, well we're all kind of in this group together not being very ok with it all and trying very hard. So, I think the group was helpful in that” (Altavilla & Strudwick, 2022., p. 220).

Heriot- Maitland and colleagues (2014) recognised that these experiences were linked to an understanding of the “normality of suffering” (p.88). With that normality of suffering came a sense of relief for some participants as described here by one participant in Bennett-Levy et al (2020):

> When you hear other people’s stories, and you kind of like ‘oh, I can relate to that’. And it’s good to know. . . that we are not the only one that is feeling like that. To hear it from somebody else, it makes you feel. a bit of relief (p.7).

For some participants this increased connection with others was identified by the authors as having a a powerful de-shaming effect (Clapton et al, 2017). A participant from Lawrence and Lee (2014) capture this in the following quote:

> It can make you feel less desperate. That there are other people that feel like you and you are not the only person who went through that experience. If you are really struggling it could be quite hard to see. Or it could be good to know of other people that have been through it and are doing better in life than you are. So it's quite, I think

> when you get to know people better, you get to know that actually you all have the same issues, the same anxieties" (p. 500).

Feeling less shame about their experience enabled one participant in Bratt et al (2019) to feel less self-blame:

> It's also super useful to get to listen too. Some people's experiences were identical to my own. So it's really, really nice to hear other parents who have problems, that you're not alone, not different in any way. It's made me open up to others too. And it's so helpful. Instead of being ashamed that we're the way we are, talk about it and then you see that loads of people have these problems, but maybe they just haven't sought help for themselves (p.6).

As captured above, the experience of a common humanity and reduced shame led participants to feel more able to share their own experiences. It was noted by some participants that an absence of psychological safeness, prompted fear that they may be negatively judged, and this was described by one participant as leaving them reluctant to share: "Don't want to throw your hat in the ring, you know" (Altavilla & Strudwick., p. 220).

From the shared group experience, participants were able to draw strength and courage from the group and as shown in this participant quote, this encouraged engagement with the therapy:

> The validation and the warmth from everybody is so soothing...but also gave me such courage that...even though I was struggling, I was able to keep coming, I guess, because I knew when I got there that I would be understood, that I wouldn't be judged (Ashfield et al., 2021, p.293).

Seeing their experience reflected in others and identifying a common humanity encouraged participants to continue learning in a reciprocal way: "I want to learn more, and also share my

little bit of life outside" (Heriot-Maitland et al., 2014 p.87). Being invited into other's experiences and feeling the safeness to share their own appeared to highlight to this participant how little compassion they were able to show themselves at the start of therapy:

> I think it was just listening to everybody else and seeing how upset and their little prisons that they were in and it was like a reflection of me, is this what I'm like? Because I wouldn't want that for that person, and yet I'm doing it for me (Ashfield et al., 2021 p.294).

The shared experience also provided participants with an opportunity to experience some of the practices of CFT, particularly experience of the flows of compassion. Initially some of these concepts felt unfamiliar and somewhat uncomfortable, as captured in this quote by Carter et al (2021): "although participants shared their struggles, when the other group members directed compassion towards them, they felt uncomfortable. Over time, this reaction to others compassion began to change". Ashfield et al. (2021) went on to recognise that accepting compassion from others as an "important step for becoming receptive to developing self-compassion" (p.295). In some ways it may be that the group therapeutic experience enabled participants to practice the giving and receiving of compassion in an environment of safeness as described by one participant:

> Just the suggestion sort of intellectually of being nice to yourself is all very well but when they did the meditation, that actual example, of somebody being so nice to you when you haven't experienced that for as long as you can remember it does sort of provoke a very strong emotional reaction (Ashfield et al., 2021, p.295).

Taken together the first theme encompasses the factors that contributed to participants experiencing psychological safeness during CFT and this appeared to relate to both therapist qualities and the shared group experience.

Theme 2: CFT Active Ingredients

This theme relates to the model specific therapeutic tools that are intrinsic to CFT and how these are understood, experienced, and applied by participants during and after therapy. Where participants encountered barriers to connecting with the model or applying some of the tools, these are also captured within this theme.

2.1 Connection & Resonance of the Model

The sub-theme 'Connection & Resonance of the Model' refers to participants feeling attuned to the CFT model. Most papers made some reference to some aspect of the model resonating with participants' experience. This was highlighted as an important aspect of the therapy that allowed participants to make sense of their emotional experience and ultimately made the model meaningful to participants.

Rayner and colleagues (2021) noted that evolutionary CFT concepts such as the old brain/new brain appeared to resonate with some participants and the 'three systems model' was recognised in some papers as a salient concept that resonated with participants. One participant in Bennett-Levy et al (2020) described feeling able to connect to the model and apply it to their own experiences:

> I am sort of in drive and threat a lot of the time, so I have to connect more to the soothing, to centre myself a bit more, calm, decision making changes too. A lot of different things stem of that" (p.7)

The resonance of the model was also observed in participant accounts such as this one, where they have been able to explain concepts in their own words and identify its meaning to them and their own experience: "The red one is where you're worried a lot…the green one is where you're so peaceful and relaxed" (Clapton et al., 2017, p.144)

Where the CFT interventions had been offered to professional groups, rather than in clinical populations, one participant was able to recognise personal resonance: “Looking into our own drive systems and taking this for-ward...it does feel like a springboard...like being on a fantastic journey.” (Beaumont et al., 2021., p.9). In addition, another participant recognised where the model had value in them understanding their professional role or place of work:

> I think we should assume that every single patient we meet has a massive threat system. Because if you’re in hospital, then it’s inevitable, isn’t it? There was an understanding within the group that when patients are ill or in crisis, their threat system would be triggered (Rayner et al, 2021., p. 717).

Similarly, where participants were parents, they were able to identify where the CFT model resonated with their experience in a parental role as demonstrated in this participant account: “it helped parents reflect upon whether their reactions were appropriate or not” (Bratt et al., 2019., p.5).

Ashfield and colleagues (2021) recognise that the impact of connecting and resonating with the model appeared to lead to an increased understanding for some participants of their own emotional experience and allowed them to “make sense of difficulties and understand why they were feeling and acting as they were.” (p.294). In addition, for some participants, this sense making of their experience using the CFT model went beyond them just identifying and naming their emotional experience. As captured in the following quote, where participants were able to connect with the model, this had a de-shaming effect. This particular participant was able to connect with the model’s offer of an explanation of suffering that is fundamentally human and locate the distress in an evolutionary understanding rather than a “personal problem” (p.294):

> I really liked the sort of clinical psychology aspect of it...explaining to us how our brain works because then you don't feel like it's such a personal problem, it's like, well all humans have the same brains and this is why my brain's done that and you don't feel alone you think oh I'm part of the human race then and this is how we all work (Ashfield et al., 2021., p. 294).

2.2 Therapeutic Tools and Practice

Across most papers, participants described CFT enabling them to develop specific tools and skills which Ashworth and colleagues described as a "toolkit or repertoire" (p.155). Some studies identified specific strategies that participants found helpful, for example soothing-rhythm breathing. Soothing-rhythm breathing was reported across several papers and often by a large number of participants as a beneficial practice. One participants described the practice as: "really quite useful…it's not a wonder cure, but it definitely helped" (Altavilla & Strudwick, 2022, p.222). The authors, Clapton and colleagues (2017), identified a connection between the exercise and an increased sense of "affiliative and contented emotion, such as feeling calmer, safer and more relaxed, a core therapeutic target in CFT" (p.146).

Across different therapeutic strategies, Carter and colleagues (2021) highlighted the important of practice in participants' accounts that enabled skills to become "stuck and integrated in their daily living" (p.101). Some participants, such as this participant from Mullen et al (2019) attributed the integration of tools from practicing them in therapy and them being experiential exercises that then became routine fixtures in their daily life:

> I suppose a positive aspect… was the exercises that we used to do … the repetitive nature of some of the things, the hands on… it's like logic has sort of stepped in… I would describe the course as going through loads of fog to get to the end and now it's kind of like the fog has kind of cleared and so now… I feel like I have the skills to be

> able to move on clearly you know… it's like stuff clicked into place (Mullen et al., 2019 p.257).

Integration of tools also appeared to be facilitated by reminders of the group experience that they could take forward into life outside. In Bennett-Levy (2020), a participant appeared to value tangible reminders in the form of artwork from the group that reconnected them with their experiences there:

> I put mine on my breakfast table and look at them every morning, a different card each day. . . And just reflecting back to that memory and that time sitting around the table. Like sitting around a campfire. That yarn coming up again. Yeah and that yarn is going to carry on and linger, you know, and it is going to linger and linger and linger. It is never going to go away (p.8)

For another participant, transitional objects reorientated them to beneficial practices, suggesting that aspects of the group had become integrated and able to be called upon during times of difficulty: "I still have my stone and use it often to ground my thoughts" (Lucre & Corten., 2013, p.395).

As captured in this quote from Ashworth et al. (2015) below, for one participant, once practiced and integrated into daily life, tools could be called upon during times of distress:

> Without being compassionate to myself, I would still not have had the tools to be able to stop myself going into the deep depression stages. I would have perhaps had tools to not get into the situations so much but, like I said earlier, there are times where you are still going to muck it up and it's how you respond to that, that is where the compassionate mind really comes in to its own (p.156).

Similarly, where professionals had received an intervention, some of the tools became integrated into their professional identities and daily practice. This helped one participant build

confidence, as they felt able to tailor therapy to meet their client's needs: ‘Tailoring the exercises to the client. I’ve used it with the strength that the client has brought, so creatively…I use the compassionate first aid kit…it’s been a more collaborative thing I guess’. (Beaumont et al, p.9)

In summary, this second theme captures the key ingredients of a CFT intervention including the model and approach resonating with clients experience and them then being able to take this forward and practice what has been learnt.

Theme 3: Processes of Change

Across papers, common processes of changes were identified. These were ‘noticing and having choice’ and ‘changes to how I see myself and my future’. At the same time, a common theme across papers was barriers to developing self-compassion.

3.1 Barriers to self-compassion

Participants and authors often recognised the challenges experienced during and following CFT. Perhaps the most salient of these barriers, described by the authors Lucre and Corten (2013) relates to participants “fear of self-compassion” (p. 395). One participant described the idea that self-compassion was something unknown and to be feared: “I was frightened of it…it’s like being an atheist and someone trying to convert you” (Lawrence & Lee, 2014. p. 499). Beyond fear, participants often arrived at therapy with some scepticism about compassion, such as the following participant quotes who both identified compassion as representing undesirable qualities such as “I always thought compassion stuff would make me weak…pathetic” (Lucre & Corten, 2013., p. 395) and “If I am being self-compassionate to myself I will become self-indulgent and cocky and lazy” (Mullen et al., 2020, p.259). In other instances, the authors Lawrence and Lee (2014) noted that fear related to a loss of a familiar self-identity for participant that was characterised by self-criticism and “losing this part of

themselves was an uncomfortable prospect" (p. 501). For one participant in Lawrence and Lee (2014), wanting to reject the concept of compassion came from beliefs about the intervention being ineffective: "There is no way at the end of 6 months that I am gonna think like this at all. I thought I might as well go home now" (p. 499).

Some papers evidenced how fears and blocks to compassion changed over time. In some instances, the experience of completing the intervention bought with it new beliefs about compassion such as one participant in Mullen et al (2020) who described: "…but now I remember that it's something that I actually need and it's not necessarily something that is earned when you have like a great achievement" (p. 259). In Lucre and Corten (2013) another participant also identified development of new beliefs: "I never realized that being kind to myself could help me DO things…but now I feel that it has made me stronger" (p. 395).

3.2 Noticing & Having Choice

A frequently reported change was an increase in paying attention to the personal experience which was noted across several papers. This was described by Beaumont and colleagues (2021) as an increased "attentional awareness of their thinking style" (p.10). Often, in becoming more aware of their thinking style, this also bought with it an increased awareness of self-criticism. Noticing the 'inner critic' described by Lucre and Corten (2013) was also echoed by Carter and colleagues (2021). Both papers go on to extend the concept of increased noticing enabling 'assertive action', the notion that instead of blaming and focusing on its presence, participants had gone on to develop strategies to manage self-criticism (Lucre & Corten, 2013). This development is captured in the following participant quotes: "When I am doing it (criticising) I am able to kind of check back in with myself more quickly… it doesn't escalate into this never ending loop." (Carter et al., 2021.,p.101) and "I catch myself out daily

using the ‘I should have / could have/ ought to have..’ type phrases and swiftly remind myself to ‘be compassionate!” (Lucre & Corten, 2013., p.396).

Alongside increased awareness of thinking style, some participants described an increased awareness of felt emotions. Lawrence and Lee (2014) captured the experience of one participant in being more attuned to felt emotions:

> In the beginning I didn't believe it. I would say I'm trying to be compassionate to myself but I didn't actually see that...I'd think to myself oh, you know, well, that's fine and I'm happy and on the surface everything's okay. But I never felt it. But as it went on, now, I can feel it. You know, I can feel it in my body than, rather than just in my mind (p. 500).

For some participants, the CFT intervention prompted them to directly challenge previously avoided emotional experiences, and as captured in this participant quote, this was only possible due to the safeness of the group:

> I’ve always prided myself on not showing emotion and keeping it buttoned down and now I realise that’s something really quite negative to do to yourself, and I remember...I just burst out crying and couldn’t stop and she [other group member] gave me a really big hug and it made me cry more but that was what was important and going back in to tackle the rest of that week...meant that I was emotionally raw and receptive and I think that’s why I got such a strong epiphany as, ‘cause I was already kind of open and I wouldn’t have necessarily had that if I’d dissociated and shut everything down (Ashfield et al., 2021, p.295).

A common experience in relation to increased awareness of feelings was noticing that emotions are transient experiences. This fostered a sense for this participant of being able to manage them: “I suppose the biggest thing is that nothing really lasts forever. You know you might feel absolutely down in the dumps one day, or angry or felt rejected, or any negative emotion but it won’t last forever” (Altavilla et al., p.222).

With increased awareness of thinking style and emotional experience is the concept of ‘assertive action’, which was observable in other papers where authors had recognised the increased choice and flexibility in participants in their responses, particularly towards themselves. In Beaumont et al (2021), the authors note that participants recognised that rather than entirely “lose the self-critic” (p.10), interventions had given them the opportunity to see the options available to them. For another participant, this involved identifying the self-critic: “I have been able to separate the constructive from the destructive” (Carter et al., 2020, p.101) and for another participant, ultimately make a decision about choices, e.g. “‘I am choosing to make a healthy choice rather than saying something horrible to myself” (Carter et al., 2020, p.107). Having more authority and a sense of self control appeared to be a freeing experience and opened up choice for another participant about how they could respond differently and continue to make changes:

> I really feel like I have gained some control back for myself, not through medication or negative actions but real self control over my feelings. I have learned things that I am sure I will keep with me for the rest of my life. Of course I’m not saying that I am now healed ..but I can feel positive about things and believe that I can improve (Lucre & Corten et al., 2013 p.396)

It appeared that a decrease in self-criticism or a change to how the self-critic was addressed was reported by many participants. One participant identified “I’m not that negative

like I used to be" (Clapton et al., 2017, p.146) and less "beating yourself up" (p.147). One participant in Ashfield et al. (2021) described being able to apply a different view of self when self-critical thoughts:

> I'm just able to talk myself down from it...where I'm going, oh you know you're really crap and you, I don't like you and it just becomes do you know what, you're not crap and you do like yourself, you're just having a really tough moment but that's fine, we can get through it and it's just handling myself better (p. 297).

For some participants they reported a more fundamental change and difference. Beaumont and colleagues (2021) captured this in the idea that "compassion is an investment and a different way of being" (p.10) and for one particular participant, it had broadened their perspective: "It's kind of helped me to take a step back and really appreciate what's going on around me instead of having tunnel vision" (p.10).

3.3 How I See Myself & My Future

A majority of authors highlighted how participants described increased self-compassion and the impact this had on their view of self. In some papers, such as Clapton et al (2017), this more positive self-to-self relating was unanimous across participants. Beaumont and colleagues (2021) identified that increased choice gave way for a "more balanced view" (p.10) where participants could "give themselves permission to attend to their needs" (p.10) as further described in this participant quote: "I think that what this has enabled me to do is to not feel as critical of myself and to recognise when I need some-thing it is okay...not judging myself" (p.10)

To view themselves with more compassion and/or less self-criticism, participants were aided by an increased sense of being deserving of that compassion. Ashfield and colleagues (2021) captured this in the idea that their participants were able to "develop a belief that they

were worthy of compassion" (p. 296) and "feeling deserving of self-care and the sense of empowerment to accept the fulfil their own needs" (p. 297). Beaumont and collegues (2021) described this as participants "giving self permission to attend to their own needs" (p. 10) and Heriot-Maitland et al. (2014) understood the participants in their paper as being "more sensitive to their own…needs" (p. 88). A participant in Ashworth et al. (2015) captured this sense of being worthy in feeling 'more of a priority':

> I have started caring more about myself and what I want out of life and not thinking so much about others–not saying that I don't care about others, because I do, but I have started to put myself first now, not others (p. 156).

Some participants described this improved self-to self-relating as a powerful and almost transformative experience such as this participant account taken from Clapton et al (2017): "Finding the person you really are…on the inside" (p.147). In Lawrence and Lee (2014), one participant described increased self-compassion "like getting a drink of water in the desert" (p. 500) and another described an embodied response to self-compassion: "I had a reaction that I could feel. No question about it there was a definite wow, that sort of feeling that you get shivers all the way down your back. It's like wow! Erm really quite something." (p. 500).

With changes to self-to-self relating, there appeared to be an increased hope described by this participant for their futures: "My whole outlook is different. I feel like I've got a future now…I need to look towards my future and I deserve to have my future" (Lawrence & Lee., 2014, p. 501). For some participants, this was an increased belief in their on-going recovery as captured in the following participant quote: "I have seen like when the programme works…the effects of it so I can trust it now" (Mullen et al., 2020, p.257). For another participant, it was a recognition that even when challenges inevitably lay ahead, they felt more equipped to manage them: "It does that, you know somewhere inside yourself that things are going to be okay, but

that this is a part of life. Things can't always be easy either. I guess you have to go with the flow". (Bratt et al., 2019., p. 6).

This final subtheme explores the possible change experiences during CFT for participants. This included the initial barriers to change and once overcome, participants experienced an increased awareness of their emotions and this experience. With increased awareness, participants recognised a changed view of self and their future.

Discussion

This meta-ethnography has developed an understanding of participants experience of compassion-focused therapy (CFT) interventions, offered both individually, but predominantly in groups. The ethnography was concerned with the experience of CFT based interventions trans-diagnostically, offering a synthesis of the current data in what is a rapidly expanding field.

The three themes identified capture a range of participant experiences of CFT interventions. The first theme, psychological safeness, encompassed the approach of the therapist and when interventions were offered in groups, the sense of a shared experience with others. The second theme considers the specific CFT ingredients that resonated with participants and their ability to practice and integrate these. The final theme revealed a sense of the changes participants had made, first exploring the barriers to compassion but once overcome, they experienced increased awareness and changed view of self and the future.

This meta-ethnography highlighted that in group therapy settings, the shared experience appeared valuable for participants to identify a sense of not being alone and connect with a sense of a common humanity. For some this reduced shame, fostered openness and encouraged practice some of the compassionate principles within the group. It is well

documented in syntheses of therapy experience that participants report benefits from the group experience (Wyatt et al., 2014). There are some consistencies with the findings of this synthesis with the paper produced by Allen et al., (2009) who explored client experience of mindfulness-based intervention. Allen et al (2009) found that where participants recognised the powerful impact of de-stigmatisation in a group setting and that this had a positive impact on their feelings of isolation and sense of not feeling alone.

Whilst there are these commonalities with other therapeutic approaches, 'psychological safeness' has an attachment to the existing CFT base and the understanding that suffering is part of the human experience and groups allow a connection with that common humanity (Gilbert, 2014). Gilbert (2009) describes the aim of CFT as to rebalance the three emotional regulation systems which often involves developing the soothing, affiliative system which in doing so often reduces perception of threat. In their empirical paper, Cuppage et al (2018) observed an increase in safeness reduced participants experience of psychopathology and was indicative of group CFT interventions generating an experience of safeness with others. Therefore, it could be understood that experiences where participants are able to connect with others and therefore stimulate their affiliative system (Gilbert, 2014), has implications for change.

The findings around 'Psychological safeness' have value in refining and developing future interventions given the richness of data in participants experience of this, particularly in group settings. This contributes to an already promising evidence base in favour of group CFT interventions (Craig et al, 2020). This synthesis takes steps towards understanding what it is about the group experience that is of value and may explain the more robust evidence for group interventions compared to individual CFT therapy (Millard et al, 2023). 'Psychological safeness' captured a range of participant experiences, but with shared recognition of the group being a de-shaming experience.

Aside from shared group experiences, ‘Psychological safeness’ included aspects of the ‘therapists approach’ and what a CFT informed therapist bought to the experience of therapy. This theme included interpersonal safeness and soothing, along with embodiment of compassion and source of expertise. These findings are consistent with existing literature around safeness in the therapeutic relationship. Gilbert and Leahy (2007) found that the use of compassion can facilitate a therapist being able to create safeness and this experience of safeness if key to progress in therapy. Participants remarked on the compassionate qualities of importance, but also recognised that therapists appearing human and non-hierarchical was important. A level of expertise and knowledge was also valued and this contributes to future development of interventions when considering the skill mix and resources available.

The findings from this study also contribute to other existing literature around therapeutic experience. In the Allen et al (2009) review of mindfulness-based approaches, a theme was identified around ‘valuing the self’ which highlighted the importance of recognising and meeting own needs. This process is identified in the current findings which highlighted a journey in CFT from experiencing barriers such as feeling undeserving of compassion to increased awareness of emotional experiences, followed by processes of change such as improving self-self relating. Given the theoretical underpinnings of CFT and the focus on the flows of compassion and the balancing of the three emotional regulation systems, participants describing a ‘struggle’ but moving towards change is in-keeping with what is known so far about mechanisms of change (Gilbert, 2014).

Gilbert (2014) stipulates that there are four mechanisms of change within CFT and some of these concepts may feature in some of the themes of this ethnography. The first mechanism of change, ‘cultivating self-reassurance’ is considered in some literature as the “central presumed mechanism of CFT” (Sommers-Spijkerman et al. (2018b). Cultivating self-reassurance is the ability to relate to the self with warmth, reassurance and soothing

during times of challenge or when things go wrong (Gilbert, 2004, Sommers-Spijkerman et al., 2018b). There was one instance of this concept in this ethnography where a participant recognised a sense that when challenges lay ahead they had recognised something inside the self that suggested they could manage (Bratt et al., 2019). There is more evidence in this ethnography to support the second mechanism of change, 'disengaging from self-critical thoughts' (Gilbert, 2014) as several participants across papers identified an ability to see themselves differently such as being "worthy of compassion" (Ashfield et al., 2021 p.296) and "deserving of care" (p.297). In the theme 'Processes of change' participants were able to articulate a sense of being able to make a choice about how they responded to their self-critic, rather than a total move away from that narrative. This was facilitated often by the concept of common humanity and the opportunity to connect with both therapists and/or other participants and the experiential aspects of giving and receiving compassion in therapy. The sub-theme 'noticing and having choice' has some consideration for the final two mechanisms of change identified by Gilbert (2014); 'stimulating attention for and processing of positive affect' and 'improving distress tolerance and decreasing negative affect'. Participants in this synthesis remarked on their development of awareness, particularly of their thinking styles and emotional experiences. With awareness bought an opportunity for choice in how they were able to respond and this increased choice was facilitated by the learning that they had done in therapy.

The result of this meta-ethnography highlighted that participants were able to identify which aspects of the model resonated and connected with their personal experience and encouraged them to invest in some of the 'toolkit' that CFT had to offer. This theme evidences from a participant perspective some of the CFT concepts that appear in the literature. Participants remarked on the need to practice what had been learnt in therapy for this to be integrated and embedded into their daily lives. The experiential experience of CMT

exercises in therapy was noted of importance, but memories of the experiences and transitional objects were suggested as some of the mediators of this integrated learning. This finding adds to the concept of a 'Compassionate Kitbag', where a shared meaning in developed in therapy to stimulate and cultivate compassion through the use of creative signals in the kitbag (Lucre & Clapton, 2021).

Strengths and limitations

The above synthesis should be considered in the context of its strengths and limitations. The meta-ethnographic approach offers a re-interpretation of conceptual data, offering a unique synthesis based upon a combination of data across papers (France et al., 2016). Approaching the synthesis with the systematic method proposed by Noblit and Hare (1988), offers an overview of the current understanding of CFT experience at this time point. Following a reputable methodology enables a level of confidence that the synthesis was completed with an adequate level of rigour.

As meta-ethnography is an interpretative approach, this is influenced by the researcher (Sattar et al, 2021). To ensure rigour, my position of a researcher was considered throughout the research process and reflected upon during supervision. As a trainee clinical psychologist with a personal interest in CFT and engaging in clinical work utilising CFT alongside this research, it was important to reflect upon this in supervision, e.g. reflecting upon my personal experiences as a therapist. When developing interpretations these were also discussed in supervision.

A large proportion of the papers included in this synthesis employed mixed methodological approaches. The inclusion of mixed-method papers was considered in the planning of the meta-ethnography and informed by the scoping searches. Including mixed method papers in the review enabled coverage of a broader body of literature. This fulfilled

one of the key aims of the synthesis to explore experience of CFT across a range of clinical and non-clinical populations, supporting the understanding that CFT is a transdiagnostic approach (Gilbert, 2009). Some of the mixed method studies did include briefer results sections, however, many of them were still judged to be of good quality according to the appraisal framework. Each theme was also based on findings across several studies, including those to be judged of good quality increasing confidence in the results.

Implications

This synthesis has implications for on-going qualitative research. Although this review offers a synthesis of the current qualitative literature on CFT experience, many of the studies included are feasibility studies or early pilot interventions where CFT has been trialled in particular populations. Whilst this is reflective of the relative infancy of CFT as a therapeutic approach, it leaves opportunity for further, high quality qualitative studies to examine the therapeutic experience further. The evidence base and understanding of mechanisms of change is sparse and although this synthesis does contribute some thematic evidence of change processes, further empirical research is needed.

With regards to clinical implications, this synthesis further evidences the transdiagnostic utility of CFT in adult populations. The studies included in the review are varied in terms of their clinical and non-clinical populations, but common themes across the papers supports the notion that CFT has a place in supporting those who experience high levels of shame or self-criticism, whether that be contributing to a particular mental health difficulty or professional experience. Future research should look to explore the long-term effects of the mechanisms of change and begin determining whether CFT specific ingredients and have a lasting impact for participants.

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Experiences of Compassion in People with Attachment and Relational Trauma 5-7 years After Completing a Long-term Compassion-Focused Therapy Group: An IPA study

Introduction: This IPA aimed at addressing a gap in the literature surrounding long-term follow up and client experience of compassion following CFT.

Method: Participants were recruited from a pool of participants from a previous study. All participants had completed a 12-month CFT intervention and were identified as having experienced attachment and relational trauma. Seven IPA stages were followed alongside reflexivity and credibility checks including consultation with the wider research team during the development of themes and research supervision.

Results: 3 overarching themes and 7 subthemes were identified. These included participants experience of initial therapeutic 'epiphanies', steps taken to integrate ideas and their experiences of compassion post therapy. The transformative impact of compassion on their decision making post therapy and their key relationships are also highlighted. A sense that compassion is a work in progress is also identified.

Discussion: The concept of epiphanies are discussed in the context of the broader behaviour change literature as well as the idea of compassion being likened to a journey. The contribution of these findings to the CFT literature base is highlighted as prior follow-up study was scarce and short in duration. Potential limitations are discussed as well as the clinical implications for services supporting adults with attachment and relational trauma.

Introduction

Follow-up studies in psychotherapy research

Research that explores therapy process and outcomes has implications for the development of theory and can inform practice for clinicians and services (McLeod et al, 2021). Much of the research concerning psychotherapy relies upon comparing self-report measures of symptoms before therapy and post-therapy, and where possible, follow-up measures may be employed (McLeod et al, 2021). When studies are concerned with exploring outcomes following a therapeutic intervention, follow-up may provide insight into aspects of the therapy process that have continued post therapy, or as described by Ekroll and Rønnestad (2016), what skills or insights participants are continuing to carry with them.

In the psychotherapy literature, where follow-up data has been obtained, these tend to be over short periods and remain scarce (Von Bracel et al., 2019). Long-term follow-up studies tend to be quantitative efficacy studies of CBT interventions which although fair well compared to controls, there is some suggestion of deterioration of outcomes over time (Durham et al., 2005). In the psychodynamic therapy literature, there are similar mix of findings and limited consensus about the long-term outcomes for participants (Knekt et al., 2016, De Smet and Meganck, 2018).

The role of qualitative studies

Quantitative studies dominate the psychotherapy literature base (McLeod et al., 2021). Whilst these have value for indicating efficacy, there is a limit to what can be understood about participant's change processes (Ekroll and Rønnestad, 2016). A need to understand what therapy is like for those who receive it is recognised (McPherson et al., 2020) and some steps have been taken to explore participant experience of therapy. In a 3-4

year follow up study by Ekroll and Rønnestad (2016), participants identified a sense of the therapy process continuing even after the ending of therapy. This is in keeping with an early finding that suggests changes that occur during therapy may transcend participants lives when the therapy ends, an example of which might be the ability of participants to internalise a sense of their therapist (Knox, 2003).

Compassion Focused Therapy

Understanding long-term outcomes for participants who have experienced Compassion Focused Therapy (CFT) is of interest due to the fundamental aims of CFT interventions. The transdiagnostic application of CFT indicates the purpose is to address psychological processes such as reduced self-criticism, shame and fears of compassion rather than specific symptomology (Cuppage et al., 2018). CFT aims to develop individuals' capacity to access their affiliative motives and emotions and is therefore concerned with motivational level- change rather than symptom level change (Gilbert, 2014). This is based upon the understanding that humans have innate motivational systems related to our functioning as social beings and form alliances with others (Gilbert, 2014). According to Gilbert, the conflict between our basic innate social motivation systems and our developed cognitive skills can result in mental health difficulties, therefore the aim of CFT is to cultivate compassion for the self and others and connect with our affiliative motivation systems in an emotionally healthy way (Gilbert, 2014). Where individuals are very reliant on a threat-based social rank mentality, CFT strives to re-balance the emotional regulation system and re-connect with care-giving and care-receiving social mentalities (Lucre & Clapton, 2021). CFT utilises compassionate mind training (CMT) as the tool for this motivation level change (Lucre & Clapton, 2021) and there is an emerging evidence base for the mechanisms of

change that underpin CFT, with self-reassurance, self-criticism and positive/negative affect understood to mediate the efficacy of CFT (Sommers-Spijkerman et al., 2018).

Follow-up studies in CFT

There are a small number of quantitative CFT follow-up studies. A recent meta-analysis reported limited mixed findings in relation to the maintenance of effects at follow-up in clinical populations (Millard et al., 2023). Despite some promising findings suggesting improvements to self-criticism and self-compassion, the authors highlighted that elsewhere compassion-based outcomes were less favourable (Duarte et al., 2017, Millard et al., 2023). A mixed methods pre-post study followed up participants who had received group CFT for personality disorders at 1 year post intervention (Lucre & Corten, 2013). This study found continued but not significant improvement at 1 year follow-up on self-report measures of shame, social comparison, self-reassurance and depression/stress measures (Lucre & Corten, 2013). The qualitative findings indicated fears of compassion, but participants spoke positively of the group experience, improved awareness of self-criticism and the ability to address this with assertive action (Lucre & Corten, 2013). This qualitative data combined post-intervention and follow-up data so it is not possible to identify specific experiences or processes identified by participants as important at follow-up. This mixed picture of findings suggests that the maintenance of compassion is a complex area and there is little known about how much about long-term maintenance or experiences of compassion beyond therapy.

Qualitative studies are uniquely placed to start to make sense of this mixed picture. As CFT is concerned with addressing psychological processes via mechanisms of change (Cuppage et al., 2018), studies that explore the subjective experience of the intervention (Ekroll and Rønnestad, 2016) may contribute to understanding from a participant perspective,

what therapeutic change have they experienced. Where CFT change processes have been developed following exploration of participant experience, the need to consider the on-going nature of change processes has been highlighted (Ashfield et al., 2020).

Experiences of therapy of those with attachment trauma

Understanding mechanisms of change and how they evolve for service users over time is particularly important in marginalised or hard to reach groups where there is a higher drop-out rate and repeated presentations to services, known in the literature as the 'revolving door phenomenon' (Fonesca Barbosa & Marques, 2023). Individuals with attachment trauma who may attract a diagnosis of a personality disorder are one such group (Fonesca Barbosa & Marques, 2023). Research has found that individuals diagnosed with a personality disorder are more likely to frequent mental health services compared to other clinical populations (Ansell et al., 2007) and this high rate of access to mental health services is considered the outcome of complex co-morbidities including mood or anxiety difficulties, substance misuse (Tomoko et al., 2012) as well as difficulties with functioning within social relationships (Ansell et al., 2007).

Individuals who may meet criteria for a diagnosis of personality disorder are recognised as often experiencing high levels of self-criticism and shame (Bateman & Fogarty, 2004). CFT, designed specifically for individuals experiencing high levels of shame and self-criticism (Gilbert, 2009) arguably has a place in supporting this clinical group due to the de-shaming explanations of difficulties proposed by CFT and its evolutionary roots (Lucre & Corten., 2013). If self-criticism is high, it is postulated that those individuals have limited access to experiences of care from early life experiences, there more likely to have difficulties accessing affiliative states of compassion and feelings of warmth (Gilbert & Irons., 2004). CFT understands that experiencing high levels of threat and difficulties in accessing the

soothing affiliative system are understandable consequences of attachment experiences highly dominated by threat (Cuppage et al., 2018). The impact of trauma on the affiliative system is then understood to increase vulnerability to psychopathology (Lawrence & Lee, 2014) and therefore the need of individuals to seek support from services.

Lucre & Clapton (2021) highlight the likely complex history of relational difficulties that adults with attachment or relational trauma may repeat in therapeutic relationships which may serve as a challenge in developing therapeutic rapport and may contribute to a lack of representation of this group in research and service development initiatives. Research that strives to understand the experience of CFT for adults with attachment trauma has emerged (Lucre & Corten., 2013) alongside exploration of CFT for adults with post-traumatic stress disorder (PTSD) and trauma (Lawrence & Lee., 2014).

Studies that focus on participant experience may contribute to understanding what participants take forward after therapy (Ekroll and Rønnestad., 2016). Focusing on client experience has implications for the design of interventions and therapeutic provision offered by services (McPherson et al., 2020). There is arguably an increased need for consideration of participant experience in groups of participants where there are high levels of access to statutory services and seeking of therapeutic intervention (Fonesca Barbosa & Marques., 2023). It is especially relevant to examine the experiences of compassion in the long-term for these individuals to help develop the capacity of services to meet the needs of a group where there have been questions about their amenability to therapy (Lucre & Clapton., 2021).

The current study

This current study aims to address the limited exploration to date of how participants experience and make sense of compassion following a CFT group intervention. Moving

towards an understanding of how participants have made sense of their therapeutic experience and which aspects have they carried forward to a point of follow-up has utility in understanding which aspects of therapy have participants held onto. This may have clinical implications for the delivery and design of CFT interventions, particularly when considering the applicability of this intervention to clinical groups where engagement with services has been challenging due to traumatic early life experiences but an increased access to mental health services is observed (Ansell et al, 2007, Lucre & Clapton, 2021).

This study aims to answer the following research question; 'What are people's experiences of compassion up to 7 years after completing a 12-month CFT group-based programme for people with attachment and relational trauma?'

Methodology

Theoretical underpinning of study

Interpretative Phenomenological Analysis (IPA) is a qualitative methodology concerned with examining how people make sense of their own life experiences, particularly when something important has happened (Smith et al., 2021). The phenomenological roots of IPA is indicative of the approach's concern with lived experience and IPA research strives to be close to a participants experience (Smith et al., 2021). Informed by hermeneutics, it is interpretative in its approach and considers human beings as "sense making creatures" (p.3) therefore what participants share about their experience reflects their sense making of that experience (Smith et al., 2021). The role of the researcher in IPA is second-order, utilising a systematic approach to sense making of a participants' sense making (Smith et al., 2021). The concern of IPA is to understand the experience of a particular person, therefore it is idiographic, with the small sample sizes allowing for exploration of commonalities and

divergences across a purposive sample of participants who have experience of the topic of interest (Smith et al., 2021).

In the case of the present study, IPA was deemed an appropriate method for the purposes of detailed exploration of participant experience, but also allowed for exploration across the sample which in this case was bound by experience of the same therapeutic intervention. IPA understands the accounts of participants to "reflect their attempts to make sense of their experiences" (Smith et al, 2021 p.3) and the method enables detailed examination of these reflections. The current study is concerned with participants' experiences of compassion, the significance of and the potential sense making they have engaged with in the years following a CFT intervention. Therefore, exploration of individual participants' sense-making of compassion and exploration of the potential convergences and divergences in the participant group could be approached using IPA methodology.

Recruitment and participants

Ethical approval was granted by the NHS Health Research Authority (HRA) and the Research and Development (R&D) department of the recruiting Trust. All participants in the current study were recruited from an earlier mixed method study examining the efficacy of a long-term CFT group (Lucre, 2021). The participants included in this prior study were 41 participants aged between 23 and 66 years who were referred to an NHS specialist tertiary psychotherapy service. All participants had experiences of attachment and relational trauma and engaged with a 12-month CFT group intervention. The original study stipulated that to be eligible for the intervention, participants needed to meet routine service protocol for eligibility for CFT. This included being identified as experiencing mental health difficulties with a level of complexity as indicated by the care cluster utilised across the service's NHS

Trust (Lucre, 2021). Additional inclusion criteria included scores above cut off on routine measures of self-attacking, self-reassuring and self-hating (Gilbert et al, 2004).

Details about the CFT intervention are taken from Lucre (2021) and described below in table 2.1. The intervention comprises three phases of intervention from initial assessment to determine suitability for group, engagement in skills based psycho-education group and finally a trauma focused compassion focused therapy group over 40 sessions (Lucre, 2021).

Table 2.1: Overview of intervention from (Lucre, 2021)

Intervention sequence	Intervention stage	Content/focus of stage
Phase 1	Assessment & formulation	3 individual sessions with therapist
Phase 2	Preparation group sessions	12 weekly sessions 2 hours in duration Focusing on psycho-education and compassionate mind skills
Phase 3	Compassion-Focused Therapy group	40 weekly sessions Exploration of relationships in group Development of new attachment relationships Working with shame using compassion

A list of all participants who attended the 12-month CFT group programme is held at the host NHS site as part of routine clinical documentation. This information was only available to the participants current treating clinician or the previous therapist and was not accessible to the research team. All potential participants were contacted via letter or telephone to inform them of the current study. Potential participants wishing to receive further information about the current study were required to complete a consent to be contacted form or to contact the researcher directly to express interest. Once the potential participant had made initial contact, they were then contacted by the researcher with the participant information sheet and the opportunity to ask further questions. If participants met the inclusion criteria for the study (see table 2.2 below) and wished to take part in an interview about their experiences, they were given the opportunity to provide informed consent.

Table 2.2: Inclusion and exclusion criteria for the current study

Inclusion criteria	**Exclusion criteria**
Adult (aged over 18)	Under 18
Able to communicate in English sufficient to give informed consent and take part in the interviews.	Not able to communicate in English to a level that allows the participant to engage fully with the informed consent process
Able to give informed consent to take part	Unable to give informed consent to take part
Attended the 12-month CFT group	Attendance at the skills based 12-week group only, not the 12-month CFT group
Identify themselves as someone able to speak about their experiences	Identify themselves as someone who would be unduly impacted by talking about their experiences

Participant sample

In total, six participants were recruited via purposive sampling. This number was selected as recommended for a doctorate scale project and for the purpose of wanting to understand the lived experience of a particular group (Smith et al, 2021). A sample size of six also takes into account the primary aim of IPA to explore detailed accounts of lived experience and given the potential complexity of those experiences, smaller sample sizes are recommended to allow a focussed study of a particular human phenomena (Smith et al, 2021).

A summary of participant characteristics is provided rather than a detailed table of demographics to minimise the potential that participants could be identified. Participants were three men and three women, aged between 25 and 55, who had completed the CFT intervention. All participants had completed the group programme between the year 2014 and 2019 and were sampled from across six different cohorts. Each cohort refers to the 12-month period at which the group was completed. All participants were understood to have some difficulties relating to attachment or relational trauma at point of entry to the group programme, that would be understood in some literature as individuals meeting a diagnosis of personality disorder (Lucre & Clapton, 2021). Ethical approval did not permit access to the participants medical history and data was not collected on specific diagnoses or trauma history.

The six participants included in the current study can be considered a sub-sample of the original participant sample from (Lucre, 2021). In describing the current participants, some consideration can be given to the characteristics of the larger subsample to contextualise the sub-sample. The larger participant pool of 41 participants comprised 68%

females. The sub-sample of 6 participants included 50% females therefore there is a larger representation of male participants in the current study. The age range of the 41 participants fell largely in the same range to the current study where participants were between 25 and 55 years. In the original sample of 41 participants, there was additional representation of 1 participant being aged under 25 and 7 participants being over 56 years of age.

Data collection

Data was collected using individual semi-structured interviews, conducted at an NHS Trust location. Interviews were audio recorded.

The interview schedule (see appendix H) comprised of open questions about participants' experiences of compassion, alongside some orienting questions to remind participants about the group which they may have completed several years ago. The schedule was designed to explore participants' experiences of giving and receiving compassion currently, exploring their experiences of compassion post-therapy and consideration of how these experiences have changed over time. Interviews were between 45-minutes and 90-minutes in length and were transcribed verbatim by the author. Participants were reminded at the end of the interview of the two-week period to withdraw their data at which point their data would be securely destroyed and not transcribed or analysed. No participants opted to withdraw, but if they had their securely stored data would have been destroyed and not used in the analysis. All participant transcripts were anonymised using pseudonyms for participant and other names. Other potentially identifiable information was changed, either entirely omitted or generalised to protect participant anonymity.

Analysis

The analysis stages proposed by Smith et al. (2021) were followed (see table 2.3 below). At the first step, the interview transcript for the first participant was read several times and any observations or reflections on the interview recorded. At step two, "exploratory

noting" (Smith et al, 2021, p.79) was added to the right-hand column of the transcript with notes highlighting what matters to the participant and this included descriptive, linguistic and conceptual codes (see table 2.3, Smith et al, 2021). At step three, experiential statements were constructed for each interview in the left-hand column of the transcript, comprising a "concise and pithy summary" (p.87) of that stretch of transcript (Smith et al., 2021). At steps four and five, connections across experiential statements were identified and they were grouped together to form personal experiential themes (PETS) which were named and consolidated in table format (Smith et al, 2021). This process was repeated across the six participants at step six before examination across participants to produce group experiential themes' (GETS) at step seven (Smith et al, 2021).

Table 2.3: Overview of IPA stages

Analysis stage (Smith et al, 2021)	Description	Application in current study
1. Reading and re-reading	"Immersing oneself in the original data" (p.78). Researcher becomes familiar and focused on the experience of the participant. "Allows for note making of striking aspects of the transcript and initial ideas" (Smith et al, 2021, p. 78).	Transcripts were prepared to be double spaced and printed to enable initial reading to be carried out with hard copies. This allowed for reading of the transcripts to be carried out away from computer screen and in an environment where it was possible to feel immersed in the data.

2. Exploratory noting	Examining of the semantic and language within the transcript (Smith et al, 2021, p.79). Initial notes are about key points of interest and enable the researcher to become more familiar with the content and make comments that are closely linked to participants meaning: these notes can be "descriptive" (content focused), "linguistic" (explicit spoken word language and other aspects such as pauses and laughter) or "conceptual" (Smith et al, 2021, p.79).	Hard copies of transcripts were highlighted during the initial rounds of noting, highlighting key words and phrases of interest. Further exploratory notes were added by hand to the right hand side margin and linguistic codes highlighted further in the transcript.
3. Constructing experiential statements	This stage is marked by an "analytic shift" (p.86) as it focuses on working directly with the exploratory notes as opposed to the transcript. The statements as suggested by the name should closely	Experiential statements were added to the left hand column of the printed transcript to provide a summary statement that captures the experience of the participant in that

	relate to the participants experiences but also include statements made by the researcher as part of their analysis (Smith et al, 2021, p.86).	passage of transcript. Experiential statements were devised for each participant in turn.
4. Searching for connections across experiential statements	This stage is concerned with pulling together the participants experiential statements (p.91) that enables the researcher to identify common connections that in turn indicates the most salient aspects of the participants' account (Smith et al, 2021, p.90).	Photocopies of the transcripts (including notes and experiential statements) were made. Experiential statements were cut from the transcripts and laid out on the floor due to large amounts of data. Experiential statements were physically grouped together by moving the cuttings.
5. Naming the personal experiential themes (PETS) & organising them	Once the experiential themes have been grouped together, they are assigned a name that describes them, devising a personal experiential theme for that participant (Smith et al, 2021, p.94).	Names for PETS based on the content of that grouping were written and the contributory experiential statements clipped together. PETs were identified largely in a linear order and where large numbers of statements

		were initially clustered together, they were re-examined to refine the PET. PETS were compiled together into a table for each participant.
6. Continuing individual analysis of other cases	Repetition of above stages for each participant in turn with a recognition that analysis will be influenced by preceding analyses (Smith et al, 2021, p.99).	Each participant analysis was conducted in order that the interview was carried out and transcript completed.
7. Working with personal experiential themes to develop group experiential themes across cases (GETS)	Aim of "GETS" (p.101) is to highlight where the experiences of participants coverage and diverge (Smith et al, 2021, p.100).	PET statements were re-examined for each participant and the list of PETs for each participant looked at together in hard copy form. Where similar language or content was noted across participants, these formed a GET. Where participant PETs suggested something different this was noted as a point of divergence. PET statements

		were physically clustered together with experiential statements which allowed for re-examination of the data at participant level.

Reflexivity and credibility checks

I kept a reflective journal during the entire research process. This was utilised particularly during data collection and data analysis stages to capture initial impressions and thoughts. Alongside supervision and consultation with the wider research team, a qualitative research support group was attended approximately once per month by the author alongside other trainee clinical psychologists who were using IPA in their research. The support group was facilitated by two experienced qualitative researchers and provided opportunity for regular discussion of each stage of the research process. During data analysis, proposed PETS and GETS were reviewed by members of the research team.

I am a third year trainee clinical psychologist with an interest in third-wave CBT approaches such as CFT. I was interested in this research project because I was interested in qualitative approaches and research that is concerned with clinical populations and their experiences. I have some pre-training experience of delivering a transdiagnostic CFT group for adults in a secondary mental health service as well as some experience of integrating CFT ideas in individual therapy as a trainee. My interest in and experience of delivering CFT interventions has positioned me as someone with a keen interest in understanding the experience of CFT and its impact for clients or participants.

Prior to data collection I had completed my meta-ethnography exploring client experience of CFT interventions therefore I was aware that my findings from this may have influenced my role as a researcher. I discussed these observations and reflections with my supervisor in regular research supervision where I acknowledged my position and how this may has influenced my role. An example of this is my interest is hearing from clients about their experiences of the therapy itself in addition to experiences of compassion at follow-up. My position as a trainee interested in delivering interventions may have influenced both the development of the interview schedule and the avenues I explored during the interview process. To mitigate against this, the interview schedule was developed with the support of the research supervisor and another experienced qualitative researcher. In addition, after the first interview, the transcript was reviewed in supervision and discussed with the supervisor to consider any changes required to the schedule or my approach to interviewing.

Results

Three superordinate themes (table 2.4) are presented from the data analysis relating to participants initial experiences of developing compassion from the starting point of 'initial epiphanies'; recognising the ways that compassion has impacted on their life post therapy and appreciating where they are on their individual journeys and what work is left to be done.

Table 2.4: Overview of themes

Superordinate theme & number of participants contributing (n)	Sub-themes & number of participants contributing (n)
1. Developing compassion (n=6)	1.1 Initial epiphanies (n=4) 1.2 Practice and integration (n=5)

2. Compassion beyond therapy (n=6)	2.1 Compassion becomes embedded (n=5) 2.2 Relationships have been shaped by compassion (n=6) 2.3 Compassion impacts life choices (n=5)
3. Compassion can be transformative (n=6)	3.1 Transformation of life and how I see myself (n=5) 3.2 Compassion is a work in progress (n=4)

Superordinate theme 1: Developing compassion

This theme focuses on participants' experience of developing compassion in its initial early stages. The theme considers the importance of participants having an 'epiphany' where the concepts of compassion have resonated with their personal experience. It is from this point that participants can begin practising and integrating concepts into their daily lives.

Subtheme 1.1: Initial epiphanies

Across participants accounts, there was a strong sense of initial moments of realisation in therapy which seemed to relate to compassion concepts and shared group experiences resonating with their own experience and providing a new perspective and understanding of those experiences. Part of these initial epiphanies were participants' experiences of noticing and becoming aware of their own emotions, patterns of thinking and ways of relating as the first step in enabling them to be more compassionate.

Participants described the CFT model providing them with a language and framework to understand their emotional responses. For Ian, this is captured in the following quotation where he articulates the experience of beginning to develop a language for and emotional understanding of his felt physical experience:

> Erm I was a guy that just…you don't…well I didn't handle emotion at all. I actually described myself as emotion-less erm and I…I…I honestly did not...until the groups…I honestly did not have the emotional vocabulary most people have. I could talk a good game but I didn't know what was going on with myself I could mimic but I couldn't actually say that I could feel at the time. I couldn't say, I couldn't pin-point any sort of what I felt, I knew what I felt in my gut…I knew what things went on in my head but I couldn't put emotion to that erm and that's what the therapy was helping with erm…was actually to learn a vocabulary, to learn how things felt mentally as well as physically…erm…and actually start to deal with some of them. There was a lot of epiphanies going through. (Ian, p.1, line.34).

Ian's use of the word 'epiphanies' here, which was repeated throughout his account, suggests a sense of realisation and the remarkable quality of this.

The concept of 'epiphanies' is echoed in other participants' language and accounts of their therapeutic experience. For some participants, there appeared to be key moments in the therapy where the content of the sessions resonated with their experience. In his account, Matthew, referred multiple times to a 'penny dropping' and the powerful impact this had on his understanding and perspective: "when the penny drops then that's, that's the transformation there…'it's not like that, it's like this' and that's when everything changes" (Matthew, p.27, line 674). Both Ian and Matthew's accounts suggest a transformational quality to their new perspectives.

For other participants moments of realisation, seem to be related to the shared group experience. For example, Anya describes:

> Erm, well I think it was good because if nothing else, it made you realise you weren't on your own. There would be so many weeks that you'd sit there and listen to the

> other people in the group talk and be like 'wow' you know, I feel like that, I feel like that and I feel like that. That in itself can kinda make you feel better because you don't think it's because I'm raving mad that I'm like this erm. (Anya, p.14, line 324).

The use of 'wow' suggests an immediate quality to Anya's realisation that other group members' experiences resonate with her own. She also describes an initial shift in her perspective "you don't think I'm raving mad". Paul also described powerful moments of recognition that he wasn't alone:

> I always say 'cause erm you get a few people say sometimes in a therapy setting the saying 'we're all in the same boat'…and I hate that. This is how I always say it…'we're not in the same boat, but we're on the same river', so it's good to be….to see other boats, to hear others, 'cause you know it's not just you that things happen to but you kind of feel like it's only you. So it's good to hear other people. Seeing some people, seeing how much they're struggling and seeing how brave they are just to speak up, things like that really stood out to me. (Paul 6, p.3, line 102).

Key to initial moments of realisation, were participants' awareness of their own emotions and patterns of relating. Matthew describes a particular 'epiphany' whilst trying to grapple with the concept of compassion, where a moment with one of his therapists enabled him to recognise his own patterns of relating:

> Erm, so yeh compassion is a difficult and knotty subject. One of the things that Mike* said in one of the sessions that kind of hit me was erm we were talking about feeling unlovable you know as a consequence of whatever, usually stuff that happened a long time ago, and of course the flipside of being unlovable is feeling that the love you have to give is not good enough. Erm and that just floored me as I'd never thought

about the flipside of it and I thought that's me, that's me all over. (Matthew, p. 15, line 356).

While all participants spoke to the power of moments of realisation, some accounts also voiced the challenging nature of increased awareness and noticing.

Paul described the shared experience of the group as "eye-opening" (p. 3, line. 97) but also articulated the challenge that comes with awareness:

> It just suddenly, like I said, I'd in the one group therapy, I said I'd managed to box everything away and then I'd punted it off to the moon. And therapy had put it back onto my lap…but then it ended, and I was just sitting there with a box which I'd spent my life *burying.* (Paul, p.14, line. 558)

Here Paul identifies the contrast between emotional avoidance prior to therapy and then having to face the emotions and experiences he has been "burying" (p. 14, line 462). In identifying the therapy ending, Paul acknowledges that the challenge of these 'epiphanies' and his sense of being left with this increased awareness but feeling uncertain of where to go next.

This subtheme highlights the experience of participants when CFT concepts or group experiences serve as 'epiphanies' and moments of increased awareness. Language used such as 'eye-opening' and 'wow' suggests these were unexpected but important realisations for participants. However, for some participants, being more aware of emotions and patterns of thinking left them with a sense of challenge about where to go next.

Subtheme 1.2 Practice and Integration

While the initial moments of realisation described in the previous subtheme appeared to be an important aspect of the initial development of compassion, at the same time participants' accounts highlighted the need to practice and integrate compassion into their daily lives. This seemed particularly important for participants and the way that they relate to themselves. Self-to-self relating appeared to arise as a journey that started in the therapy room and continued into participants lives post therapy. For example Ian described:

> But to err as the group went on an understanding became the root. The understanding of emotion came along, the understanding of mindfulness came along and as I say being mindful of myself helped me be mindful of others and once you're mindful of self you can become compassionate with self (Ian, p. 9, line 347).

The use of the word 'root' implies Ian's sense that the group served as the starting point for change, but for this to continue he needed to put into practice what was learnt and extend his learning beyond the group. For Laura, increased emotional awareness seemed to be the basis for compassionate actions and decisions, as if this was a necessary first step in responding to self differently:

> Well it's, I always go back to for me what I've done post therapy is try to build my life, structured around the two psychologies. So one of the things I always avoided pre-therapy was sitting with my pain. I would do anything to avoid it. So the first thing I try to do is sit with whatever is troubling me, and the second thing I do is decide that I have a compassionate intention to act, to do something to alleviate my own suffering. (Laura, p. 3, line 88).

Participants noted where learning from the group had become integrated and featured in their post therapy life. For many participants a key change they identified was an increased recognition of unhelpful patterns of reacting during therapy and that increased awareness

allowed them to consider compassionate alternatives. This appeared to be a process of increased awareness and committed action to respond differently with new knowledge available. In this quotation from Anya, she draws upon her pre-therapy experience, what she has learnt, and how those principles have started to change how she responds to herself during times of challenge:

> Erm probably more, so pre breakdown, pre compassion-focused, I'd have just soldiered on. It just would have been you know you've got no choice, you've got to go to work, you've got to do this, you've got to do that, whatever the day needed to happen erm I'd just do, get your head down, get it done, push it, push it all away. Whereas now, ermm I don't do that. There are certain things that I have to do, but erm I've learnt that my limit is…okay well you've done a lot today so I'm not doing anymore or I'm gonna go and have a lie down or erm I'm gonna take five minutes and have a cup of tea, you know, just try and slow things down a little bit if life is getting that bit too quick again…that kind of scenario. (Anya, p. 7, line. 151).

Laura similarly describes a process of recognising previously unhelpful patterns of reacting which in turn frees her up to choose to respond differently:

> "I became really aware of what I always thought of as proud perfectionism or the desire to do a good job whatever I was kind of focused on, I've become aware of that fact that that was, that was an un-kindness to myself, that was hypervigilance, it was a vehicle for self-criticism, it was a vehicle for all of those voice from the past to tell me that I'd never done quite a good enough job…why was it 99% when it could have been 100. Erm….so yeh, that, once that became apparent it was much easier for me to notice when I'm in that dysregulated place because I'm, I'm, it's the striving not

> driving thing, trying to push forward regardless of how I'm feeling, regardless of my current experiences. I *don't* do that now." (Laura, p. 4, line. 131).

Increased choice in the face of on-going challenge was described across several participants. A common concept was the idea that the challenges faced by participants post therapy were unchanged, but their response and ways of coping had been enhanced through compassion:

> Being able to sit with and being okay with whatever lands because my life hasn't really changed post therapy, its my interaction with the world that's changed. Life still presents the same bullshit challenges, I still can't pay my gas bill, I've still got irritating clients, all of these things that are the same, but my reaction to them is, is very different. (Laura, p.2, line. 77).

Here Laura identifies that daily life really puts what was learnt in the therapy room 'to the test'. In a similar way, Ian describes below facing emotional challenges with a sense of being better equipped and empowered to respond to them differently:

> "…but the idea now is right, why am I still thinking that way and how can I help myself? What can I do to smooth that through and understand why I'm feeling that way. And you do give yourself a mindfulness session where you just sit in quiet, start to quell the noise that's in your head and just move forward" (Ian, p.11, line. 446).

For some participants they were able to relate pivotal moments from the group that have now become integrated in their daily language, particularly in the way that they speak to themselves. Concepts from the group appear to have been impactful and fostered a sense for some that they were deserving of self-compassion:

> … the compassion thing I suppose it's partly that realisation that as I'm listening to someone talk about how awful their week has been, like I say, wanting to put your arms around them and I can't make it go away but I can give you a hug sort of thing,

> but why can't I do that for myself. And then a short, brief argument with the inner judge along the lines of 'because you don't bloody deserve it' and then no actually, I do. (Matthew, p.9, line 200).

In the sharing of this quotation, Matthew used a different voice when describing the self-critical thought about being not deserving. This suggests a clear differentiation for Matthew between how he spoke to and about himself before therapy and how he has since learnt to respond to himself with more self-compassion. All participants recognised this newfound ability to show more compassion towards themselves and that this was something they had developed since the group therapy. Despite being consistently reported, self-compassion looked arguably different in participants lives, but was often marked by a contrast to their relationship with self-compassion pre-therapy: "It's just erm I probably am a lot better at being compassionate towards myself now than I was then" (Matthew, p.18, line. 429). In other instances, self-compassion was identifiable in a reduction in critical self-talk: "but erm everything…doing things that I actually want to do. Like it's still a very novel concept, but, just being able to just exist, without 'oh but I should be', all these 'shoulds'" (Jess, p.7, line. 287).

This subtheme builds upon subtheme 1.1 where participants have identified pivotal moments during therapy which formed the root that they then needed to nurture and bring into their daily lives. For many participants this initial integration of compassion into daily life focused around their self-to-self relating, allowing themselves more choice in responding to daily challenges and giving themselves permission to be more compassionate.

Superordinate theme 2: Compassion beyond therapy

This theme focuses on participants experience of compassion beyond the group experience, particularly how compassion has been taken forward and shaped participants wider lives. The theme explores the journey of compassion becoming embedded in participants' lives as well as its impact upon relationships and the paths that participants have chosen post-therapy.

Subtheme 2.1: Compassion becomes embedded

This sub-theme refers to the integration of compassionate concepts into how participants live their lives. Most participants considered the group therapy as the starting point of change, or the 'catalyst' (Laura, p.18, line. 427) but this initial change was accompanied by a sense of taking responsibility to go on and take forward what was learnt into their life post therapy: "It's a goodbye, we're taking the training wheels off you're bike, you've got to go and ride off on your own now but you get to revisit. That's what it felt like, wobbling off on my bike" (Laura, p. 12, line 501). The use of 'wobbling' suggests viewing the self as a novice at the start of a journey that still requires the practice of compassionate skills for them to become embedded.

Practice of skills was often described by participants through examples that they had continued to utilise and consideration given to when they had used them in their lives. For some participants, transitional objects appeared to serve as physical reminders of compassionate mind exercises and skills learnt in the group:

> And I still carry stones. Even from the group!... That's a stone from the group….and that's a stone from the group… Yes. Erm and its something that I progressed for myself, erm….because having something in my pocket that I carry around, if I start to feel a certain way, or if I start to feel anxious in anyway, my hand goes into my pocket and I just hold onto one and I recognise where I want to be, how I want to be. I

> wouldn't say all the time, but most the time it helps me through so there's the compassion focused group erm not only helps you erm identify where you are and what you want from the group but it also gives you ideas and ways of coping with what you are going through. (Ian, p.3, line. 129).

Throughout his account, Ian referred to his stones and had them in his pocket during the interview and spoke about them being a constant in his life since the end of therapy.

Other participants identified particular compassionate mind skills and highlighted when they choose to apply these in life beyond therapy. For Anya, using the soothing breathe from the group had become integrated into her repertoire of strategies in times of need: "If I'm ever having something done that's not nice or unpleasant, then I'll close my eyes and I'll go to [place]. I go to that walk" (Anya, p.4, line. 84). Similarly, in this quotation from Paul, he describes the powerful, regulating effect of soothing rhythm breathing during times of distress:

"It helps me…..mmm…the breathe works, it's strange, it's very powerful. It is, it kinda doesn't make sense to me that something so basic can hold so much on you in that sense, because…it's just breathing. But it actually makes a huge difference" (Paul, p.11, line. 419).

Alongside the need for skills practice, some participants remarked on compassion becoming a part of their lives and therefore positioning themselves further along on the journey to compassion being embedded. For these participants, developing compassion appeared to be part of a more fundamental change in their lives. Described by Jess as having "put a proper foundation down" (p.1, line.40), some of concepts appeared irreversible, had become a permanent fixture in participants lives and their identity:

> It's not just a one off, it's not just oh the groups finished right don't need that part, so either that hat can come off or that part of my brain can come out. Once you've been through erm a focused group for that length of time it's not something that you can discard, it's an understanding that erm…that change becomes part of you. (Ian, p.10, line. 426).

Jess uses the word 'click' to describe compassionate principles falling into place; "Once some of it clicks like there is kind of only one way forward, you can't go back on some of these things" (Jess, p.7, line.260). These quotes taken together suggest that compassion concepts post therapy were now present in their lives and therefore could not be reversed or taken away. Once learnt and practiced compassion appears to 'stick' for participants and enables them to continue to integrate compassion into their wider lies post therapy. Both of these participants have referred to not being able to turn back or take compassion away once learnt, therefore once compassion is present, they feel it can only continue to be a part of their lives.

This subtheme captures the experience of participants in taking the skills learnt in therapy and beginning to practice them and see how they fit into their wider lives. Participants remarked on key skills their utility and a sense that once they are present these concepts will 'stick'.

Subtheme 2.2: Relationships have been shaped by compassion

This subtheme describes that for participants post therapy, their relationships with others are another area of their lives that have been shaped by compassion. This unfolds differently for participants. Where participants identified an improved sense of understanding the self, they identified ways that this had become extrapolated to wider relationships. This takes into consideration the concept of compassionate flows between the self and others. Once participants understood themselves, this shaped relationships: "In a weird way erm it

helped me…one understanding of myself erm actually learning the emotions and what was going on actually helped me with my relationships outside." (Ian, p.9, line. 370). A sense of compassion 'feeding' compassion was highlighted: "Others to self, self to self to be able to give from self to others. And yes, it turns into a full circle eventually" (Ian, p.8, line 338). Similarly, a number of participants identified that following the group they felt more resourced to give compassion to others: " 'love yourself first'… And the more I can, I know I can do that for myself, the more I can give out as well, the more I can actually help people if erm I need to." (Jess, p.8, line, 322).

In addition to giving compassion, which was often reported by participants as the flow that was the most established, for some participants, increased self-compassion enabled them to be more open to receiving compassion from others. For Laura, this acceptance of support appeared to be precipitated by an increased ability to see herself as deserving of more balanced compassion flows:

> But I've, I've definitely become so much more self-compassionate and I can ask for help from people that I trust, which is definitely a step forward because at one point I asked for help from nobody, I wouldn't accept help from anybody. Erm, so yeh I have like a little coterie of people in my life that I trust and if I'm struggling, I will go to them, for a number of reasons those are my people. Yeh so in terms of the flows I experience a lot more balance. (Laura, p.3, line. 120).

For some participants, improved self-compassion has impacted their relationships differently. Matthew, alongside a recognition that he was deserving of compassion for others, identified his sense that he no longer requires it:

> err it kind of feels like I don't need as much compassion from other people because I know now. I don't need you in the sense of the construction of the sentence…I don't

> need you to tell me "no it's okay". You know, and frankly I don't really care whether you think it's okay or not because I'm safe within it now (Matthew, p. 8, line.180).

The use feeling 'safe' suggests Matthew feels more content with his understanding of self. Where previously he might have sought compassion from others, he now feels he depends on this less due to his own improved sense of self.

Several participants remarked that compassion had shaped their relationships by becoming part of their language they used with others and aided communication. Some participants described a motivation to share some of the compassionate message in key relationships. For example, Anya described how compassionate concepts became part of the language she uses, explaining how this enhances communication about emotions within her relationships:

> I also remembered just that they sort of taught us quite a lot about the brain and how your brain works on different levels like the primal part of the brain, I do remember that and that comes in handy you know like when I'm talking to friends or maybe about them or me and I'll be like 'I'm clearly in fight or flight mode (Anya, p. 6, line. 138).

Where participants spoke about their experiences as parents, they highlighted ways that they had used compassionate concepts in their relationships with their children. Sharing concepts that had been useful for them became part of the language within the family:

> Mmhmm, I explain to them about what a panic attack is and how about breathing to re-regulate, yeh, yeh that's how much it stuck out to me. I try and pass it onto my children…Whenever they're in say an anxious moment or anything, I bring up that knowledge I was given really to pass it on. At every opportunity I'll explain to them

> ‘no, that’s old brain reacting, blah, blah, blah’. So yeh I’ve really carried that with me in that sense. (Paul, p.2, line. 50).

This subtheme captures the ways in which participants’ relationships have been shaped by compassion. In some instances, compassion was evident in flows between the self and for others, including a recognition that increased self-compassion had drawn some towards and others away from receiving compassion from others. Where compassionate ideas had become embedded in participants’ language and understanding of themselves this was highlighted as enhancing their relationships with others.

Subtheme 2.3: Compassion impacts life choices

This subtheme is concerned with the ways that compassion has impacted participants’ lives and the choices they have made post therapy. For some participants, this included making difficult choices.

Participants remarked on how impactful the group and their relationship with compassion was on the decisions that came next for them. For some participants, decisions related to going on to have further therapy:

> No way in hell would I be doing the work I am now, I wouldn’t have even considered it. Wouldn’t have even been an option to be honest, yeh so, it was necessary for my journey, for me to continue my journey. (Paul, p.13, line.514).

The use of the word ‘journey’ affirms the idea that for Paul, the group therapy was the starting point that set his life on a particular path of change. For other participants, the journey looked different, but the therapy experience still appeared to have a guiding role in their future directions and ultimately the path they chose:

> Well the group was the catalyst…that was the starting point. But if I, I wonder about this sometimes…if I had finished group therapy and then not pursued this line of work, if I'd gone back into my previous career…I don't know…how I would be now. I, I don't know if the work would have stuck, I don't know how it would have resonated, it's all 'what ifs' isn't it because you only know the path you chose. I just, I just know that something…something to do with my core landed for me during that therapy. Something that felt like… this is an idea, this is a concept that I feel like I could commit my life to. It felt that big. I wasn't sure what that was gonna look like and it's very unlike me to just let life unfold in front of me, I was always a right I'm gonna do this in 2019 and this in 2020, and, but, I've just left it to unfold. So, I don't really know. (Laura, p.11, line. 427).

Here Laura's curiosity about how life would have been different without therapy is indicative of the impact it has had her decisions and path chosen. Describing herself as "committing" to a life with compassion and this allowing her to let life "unfold" is described by Laura as markedly different to how she would have approached life's uncertainty prior.

For several participants, the paths they chose post therapy also included making some difficult decisions. Where participants identified an imbalance or dissatisfaction in relationships, these were often then addressed with compassionate action. Decisions required bravery and this appeared to stem from some of the compassionate concepts that were now present in participants lives: "Erm, it's given me the courage to let go of a lot of things in my life that were not working for me, relationships erm attachments to things." (Laura, p.7, line.254). For Jess, being courageous and making difficult decisions entailed asserting boundaries and establishing more equity in her contribution to relationships:

> Erm, well like I was saying I try and view everything as 50/50 now, like every relationship, every erm, anything…friends, it has to be 50/50, and it's like I will meet you halfway and I will erm you know, I will help if I can but it has to be 50/50 otherwise it's…not only is it detrimental to me, it's detrimental to them too. (Jess, p.5, line. 181).

For other participants, their experience post therapy was an increased awareness of unhelpful relationships in their lives. Matthew described that having self-compassion meant prioritising his wellbeing, and to do this it sometimes required him to make bold decisions about his relationships: "so somebody's got to go this isn't working and go…so that is also an act of compassion" (Matthew, p.15, line. 372). All participants recognised these as difficult decisions to make, but it was often remarked that these were possible because of their changed view of self and relationship with compassion:

> And kind of doing things for yourself that might upset other people. So being a bit selfish with the compassion for yourself as well, like cutting people out my life… it's horrible. But I've got….I had to do it, I've got no choice…whereas before, that would never have been an option, it would have been I've just got to put up with (Anya, p.17, line. 389).

This subtheme brings together the experience of participants in moving through life after therapy. The experiences and changes they identified from therapy have influenced participants' decisions, the paths that they have chosen and when needed, encouraged them make difficult decisions. This was particularly salient where participants had recognised a difficult decision had the potential to improve their wellbeing.

Superordinate theme 3: Compassion can be transformative

This final theme focuses on the transformation that compassion has had on participants lives. The variety of experiences across participants are considered including some of the more fundamental changes that some participants have recognised. These changes are considered alongside participants' on-going journey with compassion and the need for this concept to require further development in their lives.

Subtheme 3.1 Transformation of life and how I see myself

This subtheme encompasses the transformative nature of compassion in participants' lives. Participants described changes to how they navigate life, as well as for some participants, fundamental changes in how they see and understand themselves as a person.

The notion that compassion has been transformative is echoed in participants' language, for some capturing the 'life changing' quality of the work they have done: "For me personally, it's changed my life. Once I had an understanding of you know, what this work was supposed to feel like, yeh…it's life changing" (Laura, p.6, line.246). For Ian, he describes the changes made post-therapy have completely transformed what life looks like:

"Erm… and if I hadn't been through what I'd been through, that family wouldn't be there. It…it just wouldn't, I would have been able to have the capacity to…because I started again…But it's through errr help from the group, from erm the actual mindf…understanding mindfulness and compassion focused group that helped that happen. So I actually have a lot to thank that group for, because I wouldn't have the home, I wouldn't have the family that I have now, so yeh." (Ian, p.10, line.414).

This far-reaching impact is also noted by Jess who identifies the transformation that has rippled, and continues to ripple through her life: "It's affected every part of my life in some way, it really has….and it still is now." (Jess, p.13, line. 557).

As well as impacting on current experience and life post therapy, for some, an increased sense of self and compassion offered new perspectives on their past experiences. This appeared to then transform how they viewed their personal histories and personalities. It appeared to function like a new lens through which participants could view their past experiences, offering a new perspective that previously had been unavailable to them:

> Erm, and it necessitated that I go through my entire life and my experiences and re-evaluate them and realise that all through my childhood, teens, twenties and indeed in my marriage, I had this constant barrage of "oh you're bloody useless, lazy idiot", this kind of stuff. It was entirely misplaced and unjustified and I didn't deserve any of it, it's not true. And now I've got to re-build…well build something (Matthew, p.5, line. 111)

Matthew's use of language such as 'misplaced' suggests that the lens through which he previously viewed his experiences and ultimately himself has been replaced. This indicates an acceptance of the person that he is and viewing aspects of his character with compassion and kindness that was previously absent. This is echoed in Anya's account of accepting different aspects of her character and being able to hold these with less criticism:

> "Erm yeh probably just to be a bit more forgiving of yourself. But then I also learnt that sometimes, because for me I can be quite fiery erm and I always kinda took that as a bad thing and sometimes I still do. But it's also a fierce compassion…if I'm angry or frustrated it's because it's a fierce compassion and something that I really care about and that's not a bad thing. And that's okay actually to get annoyed by it." (Anya, p.5, line 113).

Beyond re-evaluating themselves and their experiences, some participants remarked on coming to a fundamental understanding of who there are as a person. This often included participants re-gaining or establishing agency over their own lives:

> Now, it's more part of me. It's more part of *who* I am. And that makes me like who I am now erm….I'm actually getting a bit emotional over it because who I was, was erm….a dangerous, reactionary, automaton. Simple as. Now…it's me, I'm the person now. (Ian, p. 16, line. 685).

The use of 'automaton' suggests Ian's perception that he was moving through life responding in a controlled way that was perhaps lacking in emotion. 'Automaton' is also indicative of something mechanical and engineered as opposed to being human and flawed. The contrast Ian draws between previously being an 'automaton' and now being 'the person' implies a reconnection with his emotions and a sense of agency about how he responds in life.

This sense of becoming their true self through connecting with compassion is reiterated in other participants accounts: "I duno just…being me. I don't really know how else to say it…learning just to kind of be me, an authentic me" (Jess, p.8, line. 310). For Laura, compassion seemed to be core to humanity itself and she remarked on being "more human" as a result of compassion: "it was an organic experience so for me it all kind of blended together as one thing that I, over time made me feel just more human in my own skin" (Laura, p.13, line. 514).

The fundamental nature of the change described by some participants is captured in Jess's metaphor of a 'new house':

> "I always explain it like, it's like when you're….it's like you're trying to build a house and that's your…this is my house, this is my life, this is what I'm working towards and you have like a little, this is my house. When you've had such a horrible

childhood, it's almost like it's rotted to the core, like if you didn't have parents in the first place and you missed all of that, like, you just spend all this time trying to paint and wallpaper the walls, but nothing, and that group was almost like…for a very long time I viewed it as they helped me put a proper foundation down, like it's not completely built, but, they've put something in that's not going to budge, it's there permanently and it's just buildable upon." (Jess, p.1, line. 32).

The use of the 'new house' metaphor is indicative of both a new beginning and something that is solid and unmoveable and for Jess is here to stay. Similarly, Ian uses metaphor to describe the fundamental transformation compassion has had on his life in a similar way to mark the start of a new journey or beginning:

"Yeh one of the big metaphors that I used in the group was and I know that Claire uses it, is erm, I love tarantulas right…but every now and again a tarantula sheds it's skin and to a certain degree I feel like that tarantula, the old me has gone, the new me has come through and when a tarantula sheds it's skin, it changes its eyes it changes it's fangs, it changes half it's intestines, if you've only got half a leg it will grow a leg over a certain amount of sheds so it will, with each change it improves, it becomes brighter. So to a certain degree, I am that tarantula, I am shedding my skin and I shed during the group, that was me shedding my skin. That was me not just nudging the lid of Pandora's Box, it was flipping it open and seeing exactly what was there. Some of it was not nice, but having the compassion to understand that, having that compassion to listen to other people, have the mindfulness to take the parts that I needed from erm not their criticism, their critique yeh and being able to use that to help myself, to make that change, to shed that skin." (Ian, p.18, line. 752).

Beyond this quote, Ian's use of language progressed throughout the interview as if in parallel with him developing his understanding throughout the interview. He used this tarantula metaphor to articulate a move away from being an entirely different person but to capture his understanding of an evolution that occurred during and post therapy. The use of 'shedding' suggests a fundamental change from the 'old me' to the 'new' but also suggests that at the core he is the same person, but he is now in touch with his true self. The 'shedding of skin' how he presents and moves through life looks starkly different and has been shaped by compassion.

This subtheme encompassed the transformative nature of compassion on participants lives. This appeared to be on a continuum across different participants including newfound perspectives on their sense of self, an increased sense of agency and for some a recognition of a fundamental change that underpins their life moving forward.

Subtheme 3.2 Compassion is a work in progress

Despite the transformative nature of compassion described in the previous subtheme, across participant accounts, participants described compassion not as an end point but as an ongoing process, where they envisage there is work to still be done. The increased presence of compassion in their lives was accompanied by the concept of it being a "work in progress":

> Erm, there are still things that I, I see in my own sort of day-to-day life and my behaviours which are signs to me that my self-compassion still needs some tuning, it still needs toning up, but I still try to hold those with kindness as well…you know, because otherwise I'm back on the perfection wagon. Errrr yeh so that's something I became really aware of, a thing that I kind of held like a badge of honour was part of

> my un-well-ness. That hypervigilance, that need to kind of try and retain some illusion of control by getting everything right all the time. Yeh I now see that as part of my sickness, so letting that go is a huge part in making space for more self-compassion. (Laura, p.4, line. 148).

Laura recognises that there are times that her self-compassion is challenged but what she has learnt has enabled to frame this challenge differently. Other participants also commented on this need to develop self-compassion further but they were able to hold this need for improvement with a level of acceptance rather than criticism: "…not being so hard on yourself, give yourself a break. I think that's still very much a working progress, I think it probably always will be" (Anya, p.5, line 107). Being a working progress was also considered to be indicative of an openness to change: "With the awareness, there's somewhere to go, you know it means I'm keeping an open mind to the possibility of change so I'm okay with that. I'm fine with being a working progress at this point" (Laura, p.7, line 279). On-going development of compassion was recognised by Jess as being a likely feature of their future, however this did not detract from the significant changes they had observed and the optimism for the future now that their relationship with self had improved:

> "Erm, I think it's a work in progress…but I also think it's, I think it's always going to be a work in progress, I think it's something that always needs, but you have to participate in it. Again, a bit like the group, you're gonna have to participate in compassion otherwise, yeh. But again like my house with the foundation, once you've kinda, once the group kinda put the groundwork in it's kinda like I'm never, I feel like I'm never going to be able to get as…I'm never gonna get as lonely or as miserable or as suicidal as I was, like I'm not gonna to go back, like up to that point had been in and out, in and out, in and out, in and out and now there's that brickwork in" (Jess, p. 9, line. 173).

For other participants, they recognised they were not so far into the journey and the work to be done feels greater:

> "I'm definitely still working on…I've got a bit of a better understanding of it, it's just to me, it's a very complicated word because if someone asks me to think of compassion, well I can't reference anything in my life." (Paul, page 15, line. 589).

Here Paul still identifies an openness to change and a desire to keep working on the challenge echoed in other participants accounts. He is able to hold the progress that he has made and identifies increased understanding, however, he also identifies how difficult change is in the context of his own experiences and familiarity with compassion. Elsewhere, Paul also describes some blocks he experiences of compassion "It's just a very large part of my brain can only see compassion as weakness. So it's difficult to put a good light around it, in that sense. I can kind of see it, but it's really distant. (Paul, p.6, line 200). The use of 'distant' suggests there is a void between where he is currently and where he would like to be in his relationship with compassion and that ultimately it remains a work in progress.

The position of participants on their compassionate journey is captured in this subtheme. Alongside recognising significant changes, there was still room to develop their relationship with compassion further.

Discussion

The aim of the current study was to explore participants experiences of compassion up to 7 years after completing a 12-month CFT group-based programme for people with attachment and relational trauma. The study aimed to understand at point of follow-up how compassion appears in their life. IPA of 6 participant accounts identified three overarching themes with seven associated sub-themes including contributions from all participant

accounts. The results suggest that participants experienced initial moments of realisation ('epiphanies') during therapy where an experience within the group resonated with them and their understanding of self. These 'epiphanies' served as a catalyst for change that was then developed by on-going practice and integration of compassionate skills and concepts. The themes also captured participants' experience of compassion beyond therapy and how this had become a feature in their lives. For some participants, compassion had a transformative effect on the way they see and understand themselves. Compassion was also conceptualised as 'a work in progress' rather than an end point. The findings and their contribution to literature is considered below.

Developing compassion

The first sub-theme, 'initial epiphanies' can contribute to the wider therapeutic literature beyond CFT. Ian referred to epiphanies' during the course of therapy and key moments where experiences within the therapy room resonated with his experience and provided a framework at which he could begin making sense of his difficulties. These key moments were echoed in other participant accounts including 'penny drop' moments (Matthew, p.27, line 674), 'wow' moments (Anya, p.14, line 324) and moments that were 'eye-opening' (Paul, p. 3, line. 97). Taken together these were understood to be 'epiphanies' and moments of therapeutic surprise which triggered awareness of their internal emotional experience. In the behaviour change literature, 'epiphany' is described by Chilton (2015) as a 'sudden, immediate, and unplanned clarity regarding circumstance' (p.17). This concept is documented elsewhere in the behaviour change and medical literature including: quantum change (Miller & C' de Baca, 2001), turning points (Berglund, 2014) and pivotal experiences (Bhattacharya et al., 2018). Of interest for CFT is the consistent reporting of these pivotal moments during therapy. In a paper currently in preparation, using data from Lucre (2021), a

key theme from analysis was the idea of 'moments of change', where participants identified therapeutic sudden and unexpected moments that supported sense making.

Taken together the current findings contribute to the notion that becoming compassionate is experienced like a journey for participants, to which the 'epiphany' moments are only the start. In the existing CFT literature, the use of 'journey' in the process of becoming more compassionate is a finding in other qualitative papers. Ashfield et al (2021) proposed a "journey of change model" (p.291) that considers participant experience prior to therapy, overcoming barriers, the activation of change processes during therapy which results in personal changes for participants. Lawrence and Lee (2014) echo a similar initial resistance prior to pivotal change. Whilst these studies contribute to the understanding of that journey through therapy, the current study offers a unique account of participants' journey beyond therapy. Where existing literature has sought to compile participants experience of CFT, this has tended to focus primarily on their development of self-compassion (Lawrence & Lee, 2014, Ashfield et al, 2021) whereas the option to follow-up participants up to seven years post therapy has revealed the impact of compassion on their lives more broadly.

Compassion beyond therapy

The reported impact by participants of compassion on relationships, life choices and how they view themselves and their lives suggests something about the types of changes they have experienced following CFT. CFT proposes that the ability to be compassionate is underpinned by core motivational and emotional systems and the balance within these systems is dependent on the social mentality or social role at work (Gilbert, 2014). CFT therefore strives for motivational rather than symptom level change and a re-balancing of the three emotional regulation systems (Gilbert, 2014) that is inclusive of the affiliative soothe

system and resource seeking drive system (Gilbert, 2010). This study focused primarily on experiences of compassion rather than of symptomatic changes experienced by participants. This focus on affiliative relationships (Gilbert, 2010) is mirrored in the findings of this study where participants have highlighted the impact on compassion on their relationships with others, e.g. sharing compassionate ideas with others or experiencing an increased understanding of others; "In a weird way erm it helped me…one understanding of myself erm actually learning the emotions and what was going on actually helped me with my relationships outside." (Ian, p.9, line. 370). Equally, the focus on the affiliative system also encompasses the flow of compassion from self to self (Gilbert, 2014) which is echoed in participants experience of a changed view of self: "…made me feel just more human in my own skin" (Laura, p.13, line. 514).

The richness of participants' accounts a minimum of five years post the therapeutic experience, and the extent to which they report changes in their lives contributes to the existing literature around mechanisms of change for CFT (Cuppage et al., 2018, Sommers-Spijkerman et al., 2018). There is scope to interpret the experience of participants as internalising aspects of CFT and taking this forward into their lives post therapy. Ekroll and Rønnestad understood the internalisation of therapy involved a continued awareness of particular skills or insights. This is consistent with participants' descriptions of particular CFT skills such as soothing rhythm breathing that they continue to practice or share within relationships. This supports existing literature around unique compassion focused interventions and exercises such as the compassionate kitbag (Lucre & Clapton, 2021). Similarly, participants described carrying with them CFT informed understanding such as Laura who described structuring her life post therapy by CFT principles: "I've done post therapy is try to build my life, structured around the two psychologies" (Laura, p. 3, line 88). Knox (2003) recognised that change transcending therapy may also be facilitated by

participants internalising a sense of their therapist. Participants were able to recall specific metaphors and spoken phrases from the therapists: “One of the things that Mike* said in one of the sessions that kind of hit me” (Matthew, p. 15, line 356). For some participants, there was an internalisation of some of the messages from other group members: “we’re not in the same boat, but we’re on the same river’, so it’s good to be….to see other boats” (Paul 6, p.3, line 102).

Compassion can be transformative

Thie study offers the first qualitative account of compassion at long-term follow-up and therefore in the unique position of being able to offer findings about the potentially transformative nature of compassion. At point of follow-up, participants identified a sense of having built a “new foundation” (Jess, p.1, line. 32) or shed “my old skin” (Ian, p.18, line. 752). This changed version of the self also echoes findings from other qualitative studies of CFT where a changed life outlook was observed (Lawrence & Lee, 2014), however this study included a short period of follow-up only. Lawrence and Lee (2014) also identified that alongside a hopefulness for the future, participants post CFT had recognised the realism of the on-going struggle in life. The current study identified a similar sense of compassion being a ‘work in progress’. Participants were by no means the complete article in their relationship with compassion, but willing to acknowledge where there was still work to be done.

Strengths and limitations

This study is the first of its kind to follow-up participants between 5- and 7-years post CFT intervention. The length of time post therapy at which this data was collected is a significant strength. Prior research has focused on experiences of compassion either immediately following CFT intervention (Lawrence & Lee, 2014) or after a short period of

follow-up of 1 year (Lucre & Corten, 2013). Not only does this study contribute follow-up data to the CFT and psychotherapy literature, these findings are particularly important in this participant group. Prior research has recognised the need for follow-up study of adults with attachment and relational trauma in order to further explore the utility of interventions in this population (Batemen & Fonagy, 2018, Bateman et al, 2015). This study provided a voice to participants, as well as providing follow-up data in a scarce field (Bateman et al. 2015). Follow-up data also has value in its contribution to this group due to the long-term nature of mental health difficulties and the consequent returns to mental health services (Ansell et al., 2007, Fonesca Barbosa & Marques., 2023).

As with many IPA studies the sample size is relatively small, however this did not hinder the richness of the data obtained. The use of a semi-structured interview allowed participants to engage with and share their own narrative about their experiences of compassion with a researcher who was not involved in the delivery of the intervention.

The experience of compassion may well vary across participants who have engaged in a CFT intervention. This IPA analysis included participants from a range of different intervention cohorts and therefore their prior and post group therapy experiences may be very varied. It is known from the participant accounts that some participants had varying degrees of therapy experience prior to the CFT intervention described and for others have gone on to have further therapy since. The nature and impact of these different therapy experiences may have influenced their experiences of compassion. Therefore, further exploration of compassion following other CFT interventions would be of benefit.

Similarly, the experience of participants who volunteered to take part may be different from those who did not. However, a range of experiences of compassion was expressed in the participant accounts and represented across the final themes. IPA enabled the consideration

of where these experiences were shared amongst participants and where there were divergences. Future research could expand upon the participant pool in this study. Including the option to collect follow-up data as part of recruitment in other intervention studies may encourage a broader spectrum of volunteers.

Clinical considerations

For clinicians and services offering CFT interventions or working with adults with relational or attachment trauma, this study may have implications for service delivery. For this group of participants, their relationship with compassion had continued after group therapy. The suggestion that there were therapeutic 'epiphanies' has implications for service delivery and the importance of the model and it's concept resonating with participants. This may inform the design of interventions of this nature such as the mix of psycho-education elements of CFT and the therapists level of expertise in CFT. For some participants, the 'epiphanies' came from other group members highlighting the potential value of offering this therapy in group format. Similarly, participants recognised the value of practice and integration of concepts learnt in the group in their lives outside. This too may have implications for the delivery of such interventions where clinicians may wish to prepare service users of the factors that may aid their experience of compassion, e.g. out of therapy practice and application of skills.

Adults with relational or attachment trauma are known to be more frequent users of mental health services (Ansell et al., 2007). Therefore, therapies that provide these individuals with the opportunity to develop a more compassionate relationship with the self and recovery from psychological distress (Lawrence & Lee, 2014) has implications for commissions and services aiming to offer therapeutic interventions.

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Press release: Chapter 1 Meta Ethnography

Experience of compassion up to 7 years after therapy

In a new follow-up study by the University of Birmingham, individuals have shared their experiences of compassion since completing a 12-month group therapy programme 5-7 years ago. The study utilised interviews with individuals about their experiences to build upon the limited literature around which aspects of compassion, individuals take forward in their lives after therapy. A total of 6 individuals shared their experiences and contributed to the current findings.

Firstly, academic literature and research that follows up individuals after a long period is lacking. This was a significant motivator to pursue this current research. Also, Compassion-Focused Therapy (CFT) as a relatively new model of therapy has a growing evidence base across a number of populations. Prior research had focused on understanding compassion during and immediately after CFT and there was a noticeable absence of long-term follow up data beyond 1 year.

Experiences of compassion can be described as showing an awareness of suffering in the self or others and taking steps to change this. Drawing upon evolutionary ideas, CFT understands emotional difficulties to be fundamental human experiences and related to how humans respond to threats in their environment. Exposure to threatening experiences are likely to be elevated in individuals who have experienced past attachment or relational trauma. This group are understood to be frequent users of mental health services.

The research highlighted the journey individuals experienced in their relationship with compassion. The interviews highlighted key moments during therapy where individuals could relate to compassionate ideas. From this, they described being able to practice compassionate skills and experience what these were like in their lives outside of the therapy room. For the group studied, compassion had a lasting, transformative impact upon their lives, influencing their relationships with others, how they felt about themselves and for some influenced the paths they chose following the group. Results also showed that individuals, despite the key role compassion had in their lives, they still felt aspects of being compassionate were a work in progress.

Results conclude that individuals up to 7 years post therapy are able to recognise more compassion in their lives. For individuals who's lives continue to present challenges are able to approach these with compassion and share some of these new found concepts with loved ones. Described by some as changing how they live their lives, according to individual accounts, compassion has a presence in their lives.

With a view to developing research further, it must be highlighted that the practical implications of such study can be impacted by a lack of client interaction, be this out of choice or where there are difficulties contacting individuals after they have left services. This study benefitted from its position in an active research field with well established networks amongst the research team as well as being a follow-up with a known group of previous participants. The connections between previous studies enabled the current study to be accessed by individuals keen to share their experiences.

Lead researcher Elizabeth Maund offered the following comment: "I am so grateful to the individuals who took the time to meet with me and share their experiences. It was incredible to hear about the journey that they have been on, hearing about those key moments

during therapy to the role that compassion has in their life now. It was powerful to hear about the transformative effect compassion has had on their lives and this has implications for how we understand compassion after CFT and what aspects of compassion really stick for those who have experienced it.

Press release: Chapter 2 Empirical Paper

Press release: Empirical Paper

What is it like to experience Compassion-Focused Therapy?

A meta-ethnography carried out by researchers at the University of Birmingham has provided an overview of the current literature exploring what it is like to receive Compassion Focused Therapy (CFT). Prior to this study there was an absence of synthesised literature on CFT experience due to the relative infancy of this field. The paper has bought together the findings of 13 qualitative papers that contribute to the emerging picture of what CFT is like to experience for individuals.

The value of synthesis is to add to an ever growing body of academic work and enlighten current and future researcher opportunities. In the case of this paper, there is value to public services such as the NHS where CFT is being offered as part of mental health care for adults. The emerging evidence base for CFT prompted exploration of unchartered ground for both academic and clinicians alike.

The findings identified 3 key areas of CFT experience. This included participants feeling a sense of safeness with therapists and group members (when offered as a group therapy) due to compassionate qualities and identification that they were not alone in their struggles. The second theme identified the active ingredients of CFT that distinguish it from other therapies and the need for participants to practice some of these skills. Finally, the

paper contributes findings on potential processes of change, including the barriers that participants experienced towards compassion. Once these fears had been overcome, participants remarked that they gained increased awareness of themselves and this led to a shift in their view of the future. How this relates to the wider therapy literature is also considered.

Lead researcher Elizabeth Maund provided the following comment: “This was such an exciting project to be a part of, particularly for those working in the field of mental health research and therapy. By bringing together the evidence so far we can make some gains in understanding what CFT is like for those who have experienced it and this has implications for delivering good services. It was great to see that there were some early signs that CFT is being experienced positively by service users and it was surprising to see the broad applicability of the intervention to date in both the UK and beyond”.

Appendices

Appendix A: NICE Quality Appraisal Checklist- qualitative studies

Study identification: Include author, title, reference, year of publication		
Guidance topic:	**Key research question/aim:**	
Checklist completed by:		
Theoretical approach		
1. Is a qualitative approach appropriate? For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? • Could a quantitative approach better have addressed the research question?	Appropriate Inappropriate Not sure	Comments:
2. Is the study clear in what it seeks to do? For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature? • Are underpinning values/assumptions/theory discussed?	Clear Unclear Mixed	Comments:
Study design		
3. How defensible/rigorous is the research design/methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach?	Defensible Indefensible Not sure	Comments:

• Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?		
Data collection		
4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/inadequately reported	Comments:
Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	Clearly described Unclear Not described	Comments:
6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example: • Was data collected by more than 1 method?	Reliable Unreliable Not sure	Comments:

• Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?		
Analysis		
8. Is the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e., is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	Rigorous Not rigorous Not sure/not reported	Comments:
9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites?	Rich Poor Not sure/not reported	Comments:
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feedback on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	Reliable Unreliable Not sure/not reported	Comments:
11. Are the findings convincing? For example:	Convincing Not convincing	Comments:

• Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	Not sure	
12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:
13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined? **Is there adequate discussion of any limitations encountered?**	Adequate Inadequate Not sure	Comments:
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g., do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	Appropriate Inappropriate Not sure/not reported	Comments:
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)	++	Comments:

	+ –	

Appendix B: Complete quality appraisal framework with rationale for classification

Paper, author	Is the qualitative approach appropriate?	Is the study clear in what it seeks to do?	How defensible/rigorous is the research design/methodology?	How well was the data collection carried out?	Is the role of the researcher clearly described?	Is the context clearly described?	Were the methods reliable?	Is the data analysis sufficiently rigorous?	Is the data 'rich'?	Is the analysis reliable?	Are the findings convincing?	Are the findings relevant to the aims of the study?	Conclusions & limitations	How clear and coherent is the reporting of the ethics?	Was the intervention sufficiently described?	Overall rating
Lucre & Corten (2013)	Yes, paper aims to explore experience of CFT groupwork for individuals with PD	Rationale for mixed methods is stated and the specific contribution of the qualitative analysis is described	Content analysis selected due to its utility in identifying helpful aspects of therapy No further rationale provided	Data collection was briefly described	Role of researcher/s was described including their level of experience and supervision	Participant characteristics and well considered in terms of suitability for intervention and background Bias not explicitly stated but supplementary information about the researchers is provided	Data was collected via written reflections on the therapy experience post therapy and at follow-up No mention of triangulation or involvement of additional researchers	Procedure is not described in detail	Data covers all identified themes but not in a lot of depth Supporting quotes are used well	No mention of additional researcher involvement	Findings are well presented and offer a coherent narrative Original quotes are used but without referencing participants	The findings appear relevant to the aim of the study which was exploring client experience of group CFT	Conclusions more focused on quantitative data Less reference to the qualitative data but the implications and limitations are well described The closing remarks are helpful to guide future research	No reference to ethical approval	Intervention is very well described with details about decision making and modality of delivery	+
Lawrence & Lee (2014)	Yes, paper aims to experiences of experiences of CFT for trauma using IPA	Yes, study aims are clearly stated and rationale in terms of gap in current literature base described	Detailed rationale for use of IPA provided as well as its possible limitations described Research design suitable for research question exploring experiences	Detailed account of the data collection process given Specific decisions about question choice and rationale for these also well described	Yes, the role of the researcher is described alongside where others were part of the data analysis Researchers' role in terms of ethical access to information was also outlined	Participants characteristics described and the boundaries of their intervention whether group or individual	Suitable method employed using semi-structured interviews with open questions to capture participant experience	Method of data analysis well described in terms of the relevant IPA steps and associated reflexivity and credibility checks	Yes, data described in detail including summary table and further in-depth exploration of the themes and subthemes	Themes were checked by additional researchers and use of reflective journal and supervision described	Findings are clearly presented in table form and text; participant quotes are used effectively	The findings are relevant to the aims of the study and includes implications for clinical practice and future research	Limitations are acknowledged e g small sample size and focus of the diagnostic group	Ethical approval and relevant committee reported in the paper	Mix of what intervention described in terms of split between individual CFT and group CFT, but interventions not described in details	++

Heriot-Maitland et al (2014)	Yes, paper aims to consider client experience of CFT group	Yes, study aims clearly stated and the rationale in terms of exploring feasibility and acceptability Intervention and study grounded in existing literature	Design appeared appropriate for the aim given that the study aimed to explore feasibility and acceptability and therefore use of pre-defined themes	Semi-structured interviews questions provided, and the process of recording described Development of questions described briefly	Researcher who completed the interviews was not involved in the delivery of the intervention No detail provided about how the research was presented to the participants Researchers position in terms of research as part of their qualification stated Critical reflections of the process included	Limited information about participants provided Some detail about inclusion/exclusion criteria added Some description of the setting but limited detail	Data was collected via semi-structured interviews, with consideration for the development of suitable open questions	Data analysis method described in limited detail Little description given of the how analysis provided results	Quotes from a range of participants included with more than one quote per theme Relatively short quotes provided	Little to no report of analysis and who conducted this	Findings are clearly presented, and quotes are used to support	The findings are relevant to the aims of the study and includes implications for clinical practice and future research	Conclusions made are relevant to research question and scope of the data Particular limitations to the qualitative method provided and future research suggestions made	Approval for the service evaluation was granted by local Trust ethics committee	Intervention in terms of structure and content well described in a lot of detail, as well as modifications required for in-patient population considered	+
Ashworth et al (2015)	Yes, paper aims to experiences of experiences of CFT using IPA	Yes, study aims clearly stated and the qualitative aspect of mixed methods study is identified The gap in the literature around mechanisms of change and the need for further info on this clinical population is well described	Rationale for using IPA was provided and why this offers something beyond the quantitative measures Purposive sampling and justification for this in context of IPA was described	Semi-structured interview questions were provided as well as the location and considerations around who qualitative data was collected from	Yes, the role of the researchers and their role in the delivery of the CFT intervention is described Relationship of interviewer described but little information about how the research was presented to participants was described beyond stating consent	Participants characteristics were well described alongside details about the context where the intervention was received	Suitable method employed using semi-structured interviews with open questions to capture participant experience	Method of data analysis described, and consideration given to potential interviewer bias Supervision structure and suitable experience of methodology described	Quotes from a range of participants included, emergent themes presented in overview diagram, relatively short quotes used at times and sometimes only 1 to represent a subtheme	Validation guidelines for qualitative research consulted, only 1 researcher completed coding, but other members of the research team were consulted in the development of themes	Findings are clearly presented in diagrammatic form and narrative Quotes to support themes utilised from a range of participants	The findings are relevant to the aims of the study and includes implications for clinical practice and future research	Conclusions contribute to emerging evidence base for CFT for individuals with ABI Limitations are well explored Credible links to future research and clinical implications are described	Ethical process adequately described and rationale for not requiring further ethical approval beyond approval already obtained for service evaluation purposes	Yes, details about the group and individual CFT sessions were well described	++
Clapton et al (2018)	Yes, paper aims to explore client experience of and in a CFT group	Yes, study states in position in terms of exploring feasibility of group for population with LD diagnosis	Methodology appears appropriate to the question and the aim to explore feasibility and acceptability Rationale for thematic analysis justified	Semi-structured interviews in form of focus groups employed and process of recording for transcribing described	Role of the researcher described in terms of their none-involvement in the delivery of the intervention No comment on reflexivity or how research was presented to participants	Participants characteristics well described alongside details about the delivery of the intervention in the context of the service/facilitators	Data was collected by focus group using semi-structured interviews Consideration given to the timing of the focus groups compared to completion of intervention	Analysis procedure described including reference to particular stages	Quotes from a range of participants including, particularly helpful were longer quotes to support themes This is presented with a clear narrative	Stages of analysis and who was involved clearly stated, including involvement of external expert	Findings are presented with a clear narrative, and a range of longer quotes are used to support	The findings are relevant to the study and include quotes and accounts of client experience	Conclusions are clearly drawn from the data and considered in the context of existing literature Themes are compared/contrasted to other similar studies Some limitations offered	Approval for the study obtained from both University and NHS ethics	Intervention and its adaptations well described and clearly grounded in existing literature/research	++

Bratt et al (2019)	Yes, paper aims to explore lived experience of group CFT	Yes, study states aim and position in context of existing literature and rationale for CFT for parents	Methodology appears appropriate in context of its phenomenological stance and aim to describe lived experience	Detailed inverviews were conducted using open-ended questions rather than formal set of questions, examples of prompts described Use of translation also described	Researches role and none-involvement in the delivery of the intervention described Information provided to the participants is described briefly	Characteristics and context at which participants engaged in the intervention described The setting and context was well described	Data was collected by interviews and the style of questions/level of prompting was well considered in context of the research aims and methodology	Stages of analysis described and how these bridged between the data and the presented results was considered	Data was rich in terms of narrative and quotes used in support The quotes were not attributed to particular participants so not possible to determine where data has come from	Only 1 researcher coded and analysed the data although this was well described	Findings are presented alongside a clear narrative Quotes from the original data is used but not referenced specifically	The findings map onto the aims of the study and suitable levels of summary are provided	Conclusions are rooted in the data and quotes are used to support this Where there were unexpected findings these are considered Gaps in current literature noted and clinical implications stated	Approval from the relevant ethics board stated	Intervention described briefly	++
Bennett-Levy et al (2020)	Yes, paper aims to explore experience of adapted arts based CFT	Yes the study states its aims to explore feasibility and acceptability of adapted CFT intervention Gap in current literature base considered	Methodology appears appropriate to the question Analysis method considered in keeping with processes observed in study Sampling based upon session attendance considered	Interview schedule and data collection steps described in detail with systematic steps described in detail	Role of researcher and their none involvement in the intervention stated Specific role of each researcher was clearly stated in the context of data collection processes	Sampling and participant details were well described Account of the setting was well described Potential conflicts of interest were reported	Triangulation utilising 3 researchers stated Data was collection predominantly in form of interviews, but also supported by examples of art work	Procedure for data analysis very well described Example art work used in conjunction with interview data, clear journey described from data to themes	Data was rich in terms of a strong narrative but also providing an overview of the interactions across themes Distinctions made between client and professional participants and detailed quotes used	Role of researchers in data analysis very clear and multiple researchers both involved and external to the intervention contributed to theme development	Findings are well presented along with supporting quotes and artwork examples Quotes are well referenced and it is possible to see client vs professional participants	Findings map well onto aims of the study, and initial interaction between themes included	Conclusions are plausible in context of cultural adaptations and nature of pilot intervention Conclusions are drawn about the adaptations of art integration and these are supported by quotes and data	Ethical approval provided in statement alongside clarification about written consent process	Intervention and schedule was well described including the structure	++
Carter et al (2020)	Yes, paper aims to explore experience of intervention	Yes the study states specific aims for the qualitative aspect to examine experience and satisfaction	Methodology appears appropriate for the question	Data collected via focus groups with set script/questions	Role of researchers as co-facilitators stated Recruitment described	Sampling and recruitment well described and the participant characteristics were well described	Data collected via 1 method Not stated if multiple researchers were involved in analysis/collection	Procedure described in brief overview of steps Themes described but without detail about how they were derived from the data	Themes are covered in narrative form and quotes are used to support	Only 1 researcher engaged in the analysis	Findings are well presented in themes, and well supported by quotes from a range of participants and referenced	Findings map well onto aims of the study and focus on experience of intervention	Conclusions bring together both quantitative data and qualitative Contributes to research topic as it is a pilot Limitations and future recommendations are described	Trial described as registered but little explicit detail about ethical approval	Intervention described in very brief detail	++

Mullen et al (2020)	Yes, paper aims to explore experience of CFT in eating disorder population	Yes the study is clear in its aims to explore experience of CFT-E	Design appears suitable for the research question, epistemology is considered in rationale	Data collection is described including rationale for missing data and timing of collection	Role of researcher stated and none-involvement in intervention stated	Participant characteristics presented well in table format and context of the intervention is well described Bias is explored well	Data was collected via 1 method but at 2 different time points, pre and post Utilisation of inter-rater reliability and use of second researcher analysing	Procedure overview is described but with limited detail	Data is rich and provides depth of data in both pre and post interviews Comparisons are made between two data sets	Quality standards referenced, consideration of potential bias and second researcher completed 10% of analysis	Findings are well presented and detailed, offering sample quotes to support Quotes are used and participants referenced appropriately	Findings are relevant to study aims and offer pre and psot intervention exploration of client experiences	Conclusions are well supported by data and figures used to demonstrate these Policy and clinical implications stated as well as limitations	Ethical approval reported	Overview of intervention is provided in table form with detail about time and distribution of sessions	++
Ashfield et al (2021)	Yes, paper aims to examine participant experience	Yes the study states its aims to explore experience and mechanisms of change This is considered with the current literature base	Design appeared appropriate for aim to develop an explanatory model of the experience accounts Sampling was suitable for the research aims Experts by experience utilised in interview design	Collection methods well described including considerations for the methodological approach Systematic approach to data collection including time frames and reflections	Information provided about how the research was presented to participants including consent considerations Researcher role was clear in terms fo data collection and where supervision/consultancy was used	Consideration of participant criteria provided and context of different group cohorts described Setting and service described	Data was collected by semi-structured interview shortly after completion of the group and reflections also recorded as well as the interview data	Process of analysis described and detail about the credibility checks were well presented	Rich data provided for a suitable number of participants with quotes to support model and detailed quotes are used	Detailed account of reflexivity and credibility checks described Consultancy and supervision utilised	Findings are clearly presented in diagrammatic form and narrative Quotes to support themes included from a range of participants	Findings are relevant to study aims and offers model of understanding in addition to themes	Conclusions are well supported by quotes and the robust development of the model Themes and findings are suitably related to other literature Clinical and research implications are described	Ethical approval reported in detail including dates and board	Little detail about intervention provided in paper but reference provided	++
Beaumont et al (2021)	Yes, the paper aims to exmaine experience as part of examination of impact of training on healthcare professionals	Rationale for mixed methods is stated and the contribution of the qualitative data is described	Minimal rationale given for the particular qualitative approach but appears appropriate for the research question	Combination of data collection methods described including diary entries and focus group interviews	Role of researchers was stated including boundaries between research and who was involved in delivery of intervention Recruitment strategy including contact of participants provided	Participant characteristics are described Setting not described in a lot of detail, consideration given to focus groups being run by someone outside of intervention	3 researchers were involved in analysis and convergence and divergence discussed by the research team Data was collected using more than 1 method	Data analysis methodology is mentioned but not described in detail Not clear how the data contributed to the themes	Short quotes provided, covering range of sub-themes but relatively shallow in depth	Triangulation described and invovlement of research team Data collected from 2 sources	Findings are clearly presented in table and narrative form Quotes are used to support themes but no indication of origin of data across participants	Findings are relvent to the aims of the study	Conclusions are related to the data that is presented Limitations are offered as well as implications which are well defined	Ethical approval stated	Intervention and specific exercises well described	+
Rayner et al (2021)	Yes, the papers aims to explore impact and experience of CFT intervention	Rationale is described in context of current demands and potential value of intervention and wanting to clarify the efficacy of this	Design appears appropriate for the research question and use of mixed methods and the purpose of the qualitative element is considered Small sample agree to take part	Data collected by focus group with detail of the questions asked mentioned briefly	Not explicit in stating the role of the researcher who conducted the focus groups and role of authors in delivery of intervention	Profession mix of participants described and based demographics described Setting also described	Data collected via 1 method and evidence that 2 of the authors were involved in independent analysis of the data	Procedure is described very briefly, although it appears that the systematic steps of the method were considered	Rich data provided with a range of quotes from different participants	2 of the authors were involved in independent data analysis and development of themes was reviewed across	Findings are clearly presented in narrative form, supporting quotes are used from a range of participants	Findings are relevant to the aims of the study and cover a range of sub-themes	Conclusions make suitable use of existing literature and contributes to gap in literature Limitations are also considered	University ethics obtained	Overview of the exercises provided with detail provided about the function	++

Altavilla & Strudwick (2022)	Yes, the papers aim to explore the effectiveness of a transdiagnostic CFT group	Rationale is well described including the need for exploration of client experiences	Design appears appropriate for question and use of mixed methods and purpose of the qualitative element is considered	Data collection by semi-structured interview described which fits with method of analysis	Role of researcher is clearly defined including exclusion of conflicts of interest Researcher who conducted interviews had not taken part in the intervention Clear consideration given to approaching participants ethically	Characteristics of participants described separately to the quantitative data Setting also described	Data collected only via 1 method Independent researcher was utilised to refine themes	Procedure of TA is described with mention of extra checks and the supervision/expertise available Systematic approach to devising themes noted	Data appears rich and covers a range of participants contributions Specific in quantifying contributions Not broken down into sub themes, only entire themes	Role of independent researcher to support development of themes described Position of the researcher was explained	Findings are clearly presented and well supported by quotes Original data used	Findings are relevent to the aims of the study and cover a large range of themes	Conclusions are grounded in existing literature base and appear plausible and valuable Limitations are also considered	University and NHS ethics obtained and stated	Intervention is well described and referenced with other existing and researched protocols	++

Appendix C: HRA ethical approval

NHS
Health Research Authority

[redacted]-[redacted] Research Ethics Committee
[redacted]

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

01 November 2022

[redacted]

Dear [redacted]

Study title:	**An Evaluation of Compassion Focussed Group Psychotherapy**
REC reference:	**15/WM/0387**
Amendment number:	**AM 01**
Amendment date:	**24 June 2022**
IRAS project ID:	**160319**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Completed Amendment Tool [160319_AM 01]		24 June 2022
Covering letter on headed paper [Covering letter for consent to contact]	1.2	14 October 2022
Interview schedules or topic guides for participants [Topic guide version 1.2]	1.2	28 September 2022
Participant consent form [Consent form (quant)_DV]	1	24 June 2022
Participant consent form [Consent to be contacted form qual]	1.2	28 October 2022
Participant consent form [Consent to be contacted form quant]	1	14 October 2022
Participant consent form [Consent form (qual)]	1.2	16 September 2022

A Research Ethics Committee established by the Health Research Authority

Participant information sheet (PIS) [Final Participant information sheet-qual in person interviews]	1.3	14 October 2022
Participant information sheet (PIS) [Final Participant information sheet-qual online interview]	1.4	14 October 2022
Participant information sheet (PIS) [Final Participant information sheet-quant]	1.4	14 October 2022
Participant information sheet (PIS) [Final Participant information sheet-quant V1 amended]	1.2	16 September 2022
Research protocol or project proposal [Final Protocol with changes amended]	2.3	14 October 2022
Summary CV for student [Student CV]	1	23 May 2022
Validated questionnaire [12 months follow up]	1.2	11 September 2022

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Amendments related to COVID-19

We will update your research summary for the above study on the research summaries section of our website. During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you have not already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project.

Statement of compliance

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.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS Project ID - 160319:	**Please quote this number on all correspondence**

Yours sincerely

Appendix D: Initial contact letter sent to potential participants

Participant address

XXXXXXXXX

XXXXXXXXXX

XXXXXXXXX

XXXXXXXX

Dear (PARTICIPANT NAME),

Re: Research study 'An Evaluation of Compassion Focussed Group Psychotherapy'

We are contacting you regarding the above named project in relation to the compassion-focused therapy group. Please read the enclosed forms and respond if you are interested in finding out more about the research.

If you have been discharged from the service where you completed this group therapy, unless you choose to contact the research team, you will not receive any further letters or communication in relation to the study.

The contact details of those involved in the project are available on the forms should you have any further questions.

Yours sincerely,

Name of care-co-ordinator/ [XXXXXXXXXX]

Appendix E: Consent to be contacted form sent to prospective participants

Invitation to participate in research

Study title: An Evaluation of Compassion Focussed Group Psychotherapy

Chief Investigator: Dr Chris Jones

This study is being conducted by Elizabeth Maund, Trainee Clinical Psychologist at the University of Birmingham and is being completed as part of a doctoral qualification

What is the purpose of the study?

The research aims to explore the experiences of compassion in people who have taken part in a Compassion Focused Psychotherapy group offered by the [XXXXXXXXXXXXX] between 2014 and 2019. We are interested in hearing about the experience of compassion from those who have received this therapy and how this is experienced by them several years later.

What does the study involve?

- You will participate in one interview lasting around 60 minutes.
- Interviews will either be conducted online via Teams or face-to-face on an agreed date.

What should I do if I am interested in finding out more?

If you are interested in finding out more about participating in the study, you can:

- Fill in your details on the consent to contact page and post it to the below address or give to your care coordinator.
- Email me on the address below with your details and how you would like to be contacted

I will then contact you to give you more information and answer any questions you may have about participating.

Elizabeth Maund- Trainee Clinical Psychologist

Email: [redacted]

Post: School of Clinical Psychology, Department of Psychology, University of Birmingham, Edgbaston, Birmingham, B15 2TT.

Consent to Contact

Please provide a phone number and either an email address or a postal address you can be contacted on.

I will contact you via telephone to give you the chance to ask any initial questions.

Then, if you would like to proceed, I will ask you to complete a consent to participate form.

I agree to be contacted about the study.

Please indicate below the method that suits you best.

I prefer to be contacted by:

- Phone call ☐
- Email ☐
- Post ☐

Please provide your contact details below:

Phone number: ……

Email address: ……..

Postal address:

……

……

....

Name (Please print) Signature:

Appendix F: Participant information sheet

Client Participant Information Sheet

Study Title: An Evaluation of Compassion Focussed Group Psychotherapy

Interview- in person

Chief Investigator: Dr Chris Jones

We would like to invite you to take part in some further research following your previous participation in group-based Compassion Focussed Psychotherapy. Before you decide you need to understand why the research is being done and what it would involve for you. 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. Talk to others about the study if you wish. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study is exploring the experiences of compassion in people who completed a Compassion Focused Psychotherapy group offered by the [XXXXXXXXXXX] between 2014 and 2019. To date, much of the existing research into Compassion Focused Psychotherapy has focused on evaluating how effective the therapy has been and even fewer studies have considered group interventions. There is a lack of research following up individuals after completing the intervention therefore we are interested in hearing about the experience of compassion from those who have completed a Compassion Focused Psychotherapy group programme and how this is experienced by them several years following the programme. It may have been several years since you completed the group, but we are still interested in your experiences.

Why have I been invited to take part?

You have been invited to take part because you have previously attended a Compassion Focused Psychotherapy group. We are interested to hear the experiences of those who completed the group programme and feel that they are making use of compassion and the therapeutic aspects of the group. As participation will include talking about your experiences of compassion and the group experience, those taking part should consider themselves unlikely to be unduly distressed by talking about these experiences.

Do I have to take part?

No, your participation in this study is completely voluntary and it is up to you to decide whether to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. Whether or not you provide your consent for participation in this research study will have no effect on your current or future relationship with [XXXXXXXXXXX] or [XXXXXXX].

What will happen to me if I take part?

If you agree to take part, you will be contacted by the researcher to enquire if you are happy to participate and to answer any questions you may have. If you would like to take part, you will be asked to complete and return the consent form you received with this information sheet via email or post and we will arrange an interview. The researcher will need to have received your consent form before the interviews can take place.

We will be recruiting 6-8 participants to take part in the study. This means that not all of those who express an interest to be interviewed will be contacted.

If you are invited to part in a face-to-face interview, this will be with the researcher lasting about 60 minutes. We will discuss your experiences of compassion and your experiences of the Compassion Focused Psychotherapy group.

The interviews will take place in a private room at the [XXXXXXXXX] which is part of the [XXXXXXXXXXXXX] at a time convenient for you during normal working hours. Participants will be reimbursed a one-off payment of £10 to cover travel expenses to attend the interview. The interview will be audio-recorded using an encrypted Dictaphone. After the interview, the recording will be typed up word-for-word by Elizabeth Maund who can then analyse it at a later date. The interview transcript will not be seen by individuals outside of the research team.

What are the possible disadvantages and risks of taking part?

Some participants may find it distressing to discuss their experiences of compassion and the Compassion-Focused Psychotherapy group. If this happens, participants will be able to take a break during the interview and if required, stop the interview entirely.

If you are affected by any of the topics in the research, the following support services are available:

- Your GP
- The Samaritans: Call 116 123 for a confidential, free to call service 24 hours a day, 365 days a year. For other ways to contact, please see their website: https://www.samaritans.org/

If it is felt that further support is needed, then with your consent, another member of the research team, [XXXXX], will be the first point of contact.

[XXXXXXXXX] can be contacted via;

- **email [XXXXXXXXX]**
- **telephone [XXXXXXXXX]**

In addition, support can be sought from the [XXXXXXXXXXX]. The first point of contact is the Team manager, [XXXXXXXXXXX]

- **Email [XXXXXXXXXXXXXX]**
- **Telephone [XXXXXXXXX]**

If you remain open to a Community Mental Health Team, the research team member, [XXXXXXXXXX] will signpost you to further support from your care co-ordinator.

What are the benefits of taking part?

There are no anticipated direct benefits to you, but your contribution may help us to understand how people experience and make use of compassion-focused interventions in the long-term.

Will my taking part in this study be kept confidential?

We will need to use information from you for this research project. This might also include relevant

access to your medical records as per the original study. These would only be accessed when required by the research team. This information will include your initials, name, contact details and information from the interview. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure. Your name and other identifying information will be changed to protect your anonymity. This means that the things you say in the interview are not linked with your name or other information that might identify you. Direct quotations from the interviews will be used in the write up of the project.

Your personal details will be kept separately from the information collected so that it will only be possible to connect your interview data to you via a special code. Only members of the research team will have access to your personal details and full interview recording. All data collection, storage and processing will comply with the principles of the Data Protection Act 2018. Under no circumstances will identifiable responses be provided to any other third party.

If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study.

Confidentiality would be breached if you said anything during the interview that made the researcher concerned that you or someone else's safety was at risk. In this instance, the other members of the research team, Darrelle Villa and [XXXXXXXXXX], would be notified to decide what action needs to be taken.

Who is organising and funding the research?
The research is being conducted as part of a Doctorate programme in Clinical Psychology at the University of Birmingham. The study is sponsored and insured by the University of Birmingham and will contribute to a doctoral qualification for a member of the research team.

What will happen if I don't want to carry on with the study?

You can stop being part of the study at any time, without giving a reason.

Even after you have given consent, you are free to leave the study. You are free to stop and leave the interview at any time without giving a reason. You do not have to answer a question if you do not wish to.

At the end of the interview, you will have an opportunity to identify any sections of the interview that you would prefer not to be used in the research study. These sections will not appear in the typed record and will not be used in the analysis.

Even after participation in the interview, you can withdraw from the study. You will have **two weeks** after your final interview to inform the researcher that you want to withdraw from the study by emailing them on the email address below. The researcher will destroy any data collected including audio-recordings. After this time, it will not be possible to destroy your data as data analysis will have commenced.

If you decide to withdraw from the study, this will **not** affect the payment of £10 for travel expenses.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

How will any research data be stored?

All information provided by you will be stored securely with analysis of the information obtained undertaken by the research team. Participants personal information such as consent forms will be stored separately to interview data. All information will be stored securely on the University of Birmingham server and in secure University offices.

According to University regulations, after the study is finished your data, including the typed record of your interview and your consent form with your personal information will be kept for 10 years after which they will be disposed of. The audio recording of your interview will be kept until the interview has been typed up for analysis. At that time, it will be deleted. Please note that no personally identifiable information will be included in the write up of the research but direct quotes will be included.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What will happen to the results of the research study?

The results from this research 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.

If you would like to find out about the results of the study, you can request that a brief summary of the final themes generated by the study can be emailed to you when these have been finalised. This summary will not contain any personally identifiable information or any direct quotations and it will not be possible to identify which participants contributed to the themes.

Where can I find out more about how my information is used?

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from **www.hra.nhs.uk/patientdataandresearch**
- by asking one of the research team
- by sending an email to dataprotection@contacts.bham.ac.uk

What do I do if I have a complaint?
If you have a complaint you can contact:
The sponsor for this study, The University of Birmingham;researchgovernance@contacts.bham.ac.uk

Patient Advice and Liaison Service (PALS) on
[XXXXXXXXXXX] (8am – 8pm Monday to Friday)
If you would like to contact any member of the research team, please see our contact details below:

Elizabeth Maund- email: [redacted]
Dr. Darrelle Villa: [redacted]
[XXXXXXXXXXXXX]: [XXXXXXXXXXXXX]
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: Participant consent form

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: An Evaluation of Compassion Focussed Group Psychotherapy

Chief Investigator: Dr Chris Jones

Research team member: Elizabeth Maund

Please initial box

1. I confirm that I have read the information sheet dated 16/09/2022 for 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. I understand I have 2 weeks after the interview to request my data is destroyed. ☐
3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from [XXXXXXXXXXX] the University of Birmingham or 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. By ticking this box, 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. This is optional. ☐
5. I agree to be contacted to take part in a semi structured interview as part of my involvement in this study. I will not be contacted beyond this involvement. I understand the interview will be audio recorded. ☐
6. I understand that any direct quotes form the interview data may be used and will be made non-identifiable in the write up of the study ☐
7. I agree to take part in the above study ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix H: Semi-structured interview topic guide

Interview topic guide

This topic guide is a prompt to guide the areas that will be covered in interview. As the interview is semi-structured, it is expected that the interviewer will follow up on avenues related to the research question as they arise in the interview.

Note: Topics presented in **bold** with example questions below.

Orientating questions about the group:

- Do you remember taking part in the compassion-focused therapy group with Kate and Graham?
- When did you attend the group?
- Do you remember what the group was about?
    - Do you remember the approach being used?
    - What did you do in the group?
    - Is there anything that stands out about the group?
- Looking back now what were the most important aspects of the group for you?

Example questions related to experiences of compassion:

- What does compassion mean to you?
    - Prompts orienting participants to compassion e.g. Do you remember the flows of compassion? [to establish the researcher and participant are discussing similar concepts]
- How does compassion fit in your life?
- What does compassion look like in your life?
- Can you think of any examples of compassion in your life?
- Are there ways that you use compassion?
- How do you feel about compassion?
- What's your relationship with compassion?

Example questions related to the experiences of compassion identified:
In this block, the researcher will follow-up on areas of compassion that the participant talks about (self-compassion, compassion to others, compassion from others) and explore each of these in turn.

- You talked about (_____).
    - What does (_____) look like in your life?
    - Can you think of any examples of (_____) in your life?
    - Are there ways that you use (_____)?
    - How do you feel about (_____)?
    - What's your relationship with (_____)?

Example questions related to if/how their experience of compassion has changed over time

- How did you feel when Kate / Graham first introduced the concept of compassion?
- How do you feel about that now?
- How has that changed / stayed the same?

- How did that link with your experience of compassion?
- Has the way you understand compassion changed over time?
    - Can you tell me more about that? Can you think of any examples of that?
- Has the way you feel about compassion changed over time?
    - Can you tell me more about that? Can you think of any examples of that?
- Has your relationship with compassion changed over time?
    - Can you tell me more about that? Can you think of any examples of that?
- How do you make sense of that change/no change (whatever is reported)?
    - How do you think that came about?