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RESEARCH ARTICLE

Compassion Focused Group Psychotherapy for attachment and relational trauma: Engaging people with a diagnosis of personality disorder

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Abstract

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

Design: This study utilised a quasi-experimental non-randomised within subject controlled design for the evaluation of the efficacy of the programme.

Methods: Participants were recruited from tertiary care services. The programme consisted of a 12-week Preparation and Engagement intervention (PEG) which was Compassionate Mind Training and Psychoeducation, followed by a 40-week Compassion Focused Trauma Group intervention. The cohort was then followed up after 12 months during which period they received treatment as usual. A comprehensive selection of self-report measures was administered at various points during the therapeutic process and following completion of the group interventions.

Results: The results of the research showed that the provision of a long-term, slow-paced, Compassion Focused Group Psychotherapy intervention, resulted in significant changes across all measures which were maintained at 12-month follow-up. These significant results were maintained following intention to treat and reliable change analyses. These data were supported by a significant reduction in service usage and a significant increase in engagement in employment and education.

Conclusions: This study has identified that within Compassion Focused Group Psychotherapy, there is a therapeutic process of establishing group-based safeness as a necessary precursor to cultivating compassion and reworking early shame-based trauma memories.

KEYWORDS
attachment and relational trauma, Compassion Focused Group Psychotherapy, personality disorder

INTRODUCTION

There are a group of patients, who have complex enduring needs and present significant challenges to service providers, commissioners and therapists (Crawford et al., 2008; Lucre, 2022). They are likely to have multiple attendances to mental health services and present with high-risk aggressive and/or antagonistic patterns of relating to service providers. Such behaviour can result in them being offered either little in the way of active interventions or a wide range of interventions without a clear rationale or a clear treatment pathway (Lucre, 2022; Lucre & Corten, 2013; McMurran & Ward, 2010). This seems to have resulted in a paucity of 'rigorously evaluated psychotherapies', being offered, due to complexity of need coupled with the restrictions on research methods (Corrigan & Hull, 2015a, p. 86, 2015b). Many will be given a diagnosis of personality disorder which is sometimes taken as a derogatory term associated with shame and 'untreatability' (Lucre, 2022; Stalker et al., 2005) and lower empathy (McGrath & Dowling, 2012).

The early lives of these individuals are often characterised by intrusive, abusive or absent attachment relationships. These kinds of attachment relationships can present motivational conflicts when the infant in distress instinctively turns to the primary caregiver for comfort but is confused by the parent being also the source of threat and 'no consistent behavioural strategy will resolve the threat' (Holmes & Slade, 2017, p. 182). This is not a pathological disturbance or disorder (Gilbert, 2011; Holmes, 2001; Liotti, 2017). This attachment style is also described as 'unresolved' by Main (1995), thereby the manifestations in adult behaviour often replicate the early attachment relationship patterns which have been disturbing. There is now considerable evidence that these rearing environments also have negative effects on a range of psychophysiological processes including epigenetics (Cowan et al., 2016), the central nervous system (Gold et al., 2016; Lippard & Nemeroff, 2020) and the autonomic nervous system (Stone et al., 2018). These result in problems in maturing what is necessary for emotional and self-regulation (Liotti, 2011; Liotti & Gilbert, 2011), the development of social trust and competencies such as empathising and mentalizing (Luyten et al., 2020). This in turn compromises the ability to feel connected and socially safe (Kelly & Dupasquier, 2016), seek appropriate care and support and self-soothe (Gallop, 2002; Sloman & Taylor, 2016).

These are many of the capacities required to engage in psychotherapeutic interventions, thus creating a significant barrier to engaging with and making use of the very interventions which could provide healing and growth (Bateman & Fonagy, 2010; Lucre, 2022). As a consequence, of tragic early attachment experiences, these patients are prone to suffer with excessive shame and self-criticism (Andrews, 1998; Feiring & Taska, 2005; Gilbert, 2011, 2017; Karan et al., 2014; Lucre, 2022; Naismith et al., 2019).

Rather than disorder, a more accurate description of the behavioural consequences of such early experiences are 'survival strategies' and as such can be viewed as adaptive and understandable responses to the extraordinary circumstances of ruptured and absent early attachment relationships (Brüne, 2016; Gilbert & Simos, 2022; Lucre, 2022; Molina et al., 2009). Therefore, it is proposed that attachment and relational trauma (A&RT) is a more appropriate and less stigmatising way to categorise this group of patients.

COMPASSION FOCUSED THERAPY FOR ATTACHMENT AND RELATIONAL TRAUMA

> The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery therefore is based upon empowerment of the survivor and the creation of new connections.
>
> (Herman, 2002, p. 98)

Compassion focused therapy (CFT) is an evolution-informed biopsychosocial approach that explores the way evolved motivational systems are linked to emotions and various forms of cognitive competencies such as empathy (Gilbert, 2014, 2020; Gilbert & Simos, 2022). Different motives (e.g. to defend, to eat, compete care or for sex) organise the brain in different ways. CFT seeks to recruit the psychophysiological mechanisms, such as oxytocin system and ventral branch of the Vagus nerve (Carter, 2014; Carter & Porges, 2013; Porges & Dana, 2018) that evolved with caring. These systems reorganise brain processes that facilitate emotion regulation and the development of prosocial relationships to themselves and others.

Humans have evolved to be emotionally regulated within relationships and have neurophysiological systems, especially those linked to oxytocin, which enable affiliation to regulate threat (Depue & Morrone-Strupinsky, 2005). Considerable research on attachment development and behaviour has demonstrated that children raised in the context of caring and stable relationships will have been soothed by caregivers when distressed (Bowlby, 1969, 1973, 1980; Gilbert, 2020, 2022; Liotti, 2004; Lyddon & Sherry, 2001; Mikulincer & Shaver, 2007a, 2007b; Sheridan & McLaughlin, 2020). Repeated care and affiliative interactions between an infant and caregiver enable the development of positive internal models or representation of self as capable, others as caring and distress as tolerable (Mikulincer & Shaver, 2007a, 2007b). Thus, the child develops the capacity to use the carer as a 'safe haven', to seek proximity to, and be soothed by in times of stress and threat system activation. Further, the child learns to use the carer as a 'secure base', from which to explore the world (Bowlby, 1980; Holmes, 2001). The activation of the soothing and safeness system via interpersonal interactions is therefore key to the regulation of the threat and drive system (Cozolino, 2008, 2017). For a more detailed explanation and exploration of the three emotional regulation systems model, see Gilbert (2020) and Gilbert and Simos (2022).

However, those whose early life attachment relationships, lacked the experience of safeness and connection, can be shifted towards greater threat-focused motivation and away from pro-social and social connectedness. There are many complex and interconnected ways of understanding how this poor regulation can arise, be accentuated and maintained. For many, the neurophysiological consequences of ruptured or absent early attachment relationships can result in unprocessed traumatic memories, which are maintained and experienced as threatening through rumination or by living in hostile critical environments (Matos & Pinto-Gouveia, 2010; Pinto-Gouveia & Matos, 2011). These factors combine to create a 'toxic cocktail' of biological, neurological and cognitive bias towards threat-based processing of all experiences (Bertsch et al., 2017; Bilek et al., 2019; Herpertz & Bertsch, 2015).

There has been considerable work in recent years to develop psychotherapeutic interventions which can directly address some of the issues which interfere with the capacity to engage in psychotherapeutic work (Bateman & Fonagy, 2010; Crawford et al., 2008; Gilbert, 2009; Linehan, 2014; Lucre, 2022; Lucre & Corten, 2013; McMurran, 2012). There is growing evidence supporting the development of longer-term programmes which combine structured components with more traditional psychodynamic theories and practice (Bateman & Fonagy, 2006; Fonagy et al., 2017). Compassion-focused therapy is a motivation-focused therapy and has integrated attachment processes in order to address both psychosocial and physiological change (Gilbert, 2014, 2019, 2020). Flores and Porges (2017) also propose a model combining attachment theory and polyvagal principles in group psychotherapy, while many programmes are now proposing DBT combined with

TABLE 1 The phases of Compassion Focused Group Psychotherapy.

Programme element	Format	Function
1. Assessment and formulation process	Three, individual sessions with one of the psychotherapists from group programme Opportunity for final group-based assessment session	Initial engagement with patient Establishing trust Safe haven function in the room Commencement of narrative-based formulating and sense-making process Containment for the therapeutic work Commencement of psychoeducation phase of treatment
2. Waiting List Support Group Psychoeducation	Monthly 1h drop-in sessions Facilitated by lived experience practitioner (service user who has completed the CFGP) and psychotherapist Informal setting, amplified by the offer of tea and biscuits	For patient to feel 'held in mind' by group facilitators Offering information about programme Opportunity for connection with other patients, pre-therapy Continuing development of safe haven function Exposure to an experience of being in a group setting Managing risk during pre-therapy phase of treatment Provision of a consistent containing informal space
3. Preparation and Engagement Phase Group (PEG) Psychoeducation and compassionate mind training	12 weekly sessions Two hours in duration (no break) Slow-paced, experiential, play-based group intervention Facilitated by two highly trained compassion focused psychotherapists	Continuation of psychoeducation phase Introduction of compassionate mind training practices and rationale Early exposure to CFGP model and the experience of compassion across the three flows Continuing development of safe haven and proximity-seeking function
4. Compassion Focused Group Psychotherapy Phase (CFGP) Compassion focused therapy	52 weekly sessions 2h (no break) 'putting compassion to work' Facilitated by the same two highly trained compassion focused psychotherapists	Using the capacity for compassion developed in the PEG to turn back towards early ruptured attachment relationships Using the group as a secure base to begin to explore past and present relationships Bringing compassion to shame-based trauma memories Using the group process to develop new attachment relationships Working with conflict (internal and in the group) Using the group process to explicitly and implicitly stimulate the care giving and care receiving social mentalities
5. Moving On Group Individuation	12 monthly 1h drop-in sessions Patients not discharged if they do not attend Facilitated by lived experience practitioner (service user who has completed the CFGP) and psychotherapist Slow-paced group member-led	Supporting the gradual process of individuation Enabling the grieving process to be resolved Providing a platform for patients to engage in peer-led support

psychodynamic principles (Arlo, 2019; Leiderman, 2020). Therapeutic communities (TCs) are multimodal programmes often offering more process-driven groups. Within these programmes, there is an emphasis on understanding the complex interactions between patient and therapist and the links with experiences in the past, rather than interventions that focus on the content, what is said and delivered in the room. These programmes have a structured format with a focus on democratic decision-making and empowerment for group members (Capone et al., 2016; Haigh & Pearce, 2017; Veale et al., 2015).

THE FIVE-PHASE MODEL OF COMPASSION FOCUSED GROUP PSYCHOTHERAPY TREATMENT OF ATTACHMENT AND RELATIONAL TRAUMA

> Recovery can only take place only within the context of relationships; it cannot occur in isolation
>
> (Herman, 1992:133)

Compassion Focused Group Psychotherapy (CFGP) is one such intervention, that is process driven (Lucre, 2022) and has been devised according to the evolutionary psychology model and neuroscience-based psychotherapeutic intervention of CFT (Gilbert, 2009, 2010, 2014). The model includes principles and practice from Therapeutic Communities (Capone et al., 2016: Haigh & Pearce, 2017) delivered through a medium of action methods and psychodrama (Tomasulo, 1998). Action methods describe the use of visual, tactile and role-based psychological interventions which were derived from psychodrama to support perspective taking, conflict resolution and the development of new meaning to past events and can also support the repair and restoration of ruptured attachment systems (Baim, 2017; Holmes et al., 2014; Lawrence, 2015). On a very basic level people with A&RT often experience somatic memories of early trauma which are triggered by being in group settings, and as such the combination of compassionate mind training practices, with movement- and play-based activities is designed to offer participants practical ways to feel safe and contained in the group space (Lucre, 2022). In doing so, the programme was developed as a model to rebuild some of the functions of attachment such as secure base, safe haven and seeking proximity to the group, to enable a process of growth and development (Music, 2018). At the heart of CFT and indeed CFGP, is the implicit and explicit focus on the exploration and resolution of shame and shame-based trauma memories which characterise the experience of people with A&RT and is often missing from other therapeutic modalities designed for this group (Gilbert, 2011; Irons & Lad, 2017; Karan et al., 2014; Matos & Pinto-Gouveia, 2010).

The main emphasis for a programme for people with A&RT is to provide 'a corrective emotional experience for individuals to facilitate the development of adaptive ways of relating with others' (Capone et al., 2016, p. 4). The clinical evidence as outlined above indicates the need for a staged, progressive structured treatment plan in which the client progresses from an assessment and formulation stage, then to a preparation and engagement stage and then to a compassion focused trauma group and finally a moving on group. The five-phase model is summarised in Table 1, further details of this model are provided in Lucre (2022).

One of the key identified components of CFT within a group setting requires the cultivation of the conditions for the experience of safeness within and between group members (Lucre, 2022; Lucre & Clapton, 2021). In essence, this concept describes creating the conditions for the development of compassion implicitly and explicitly across the three flows. By giving compassion to group members in the context of listening and engaging with the suffering, receiving compassion from others and by attending to the group process, a compassionate motivation to self is implicitly and explicitly developed.

Group therapy has been identified as an opportunity for the resolution of shame, through the experience of others as affiliative and caring (Lucre, 2022; Rathbone, 2012; Yalom, 1995).

Yalom (1995) also named 11 therapeutic factors which can enable growth and change within the medium of group therapy. The processing of early trauma occurs through the corrective reliving of early family dynamics, within a containing framework where information is imparted and hope instilled, coupled with a deep affiliative connection with others who are suffering. Interestingly, Yalom (1995) also found the equal significance of the therapist and group members' impact on the therapeutic process, showing the importance of creating a framework for group members to relate to one another.

Working with those with A&RT will require the therapeutic process to have a strong relational component, in that the trauma is rooted in the emotional memories of abusive and ruptured early attachment relationships (Campling, 1995; Haigh, 2002; Herman, 2002; Hobson, 2013; Gilbert, 2011). The therapeutic programme will therefore need to be of sufficient duration to facilitate this (Herman, 2002; Lucre, 2022).

The approach taken here builds on the initial findings of Gilbert and Procter (2006) and subsequently Lucre and Corten (2013). Lucre and Corten (2013) developed a 16-week programme. This resulted in significant improvement across all process and symptom measures which were maintained, with continued non-significant improvement at 12-month follow-up.

DESIGN

This is a quantitative study to evaluate the efficacy and impact of a Compassion Focused Group Psychotherapy programme. A non-randomised within subject controlled design was used. This paper describes the quantitative results of the evaluation. A qualitative study that explored the participants' experience of this treatment is reported in a separate published paper.

Procedure and ethical review

Following the initial screening process, those participants who met the criteria were invited to take part in the study. This involved being presented with an information sheet, an opportunity to discuss the study and the right to withdraw at any time during the study.

Participants were then invited to join the CFGP programme [12-week PEG +40-week Compassion Focused Trauma Group (CFTG)]. See Table 1 for details of the five phases of treatment (Lucre, 2022). This was followed by 12 months of treatment as usual (TAU), after which time all participants were contacted to complete the final set of measures. Figure 1 offers a timeline and description of the evaluation points mapped onto the phases of the study. The full study obtained ethical approval from NHS Health Research Authority (IRAS No. 15/WM/0387) and from the West Midlands University Ethics Committee.

Research aims

The aims of this study were

1. To conduct an evaluation of long-term within group outcomes, measuring change and maintenance over the 2-year study period.
2. To explore change at an individual level by evaluating the overall level of reliable and meaningful change.

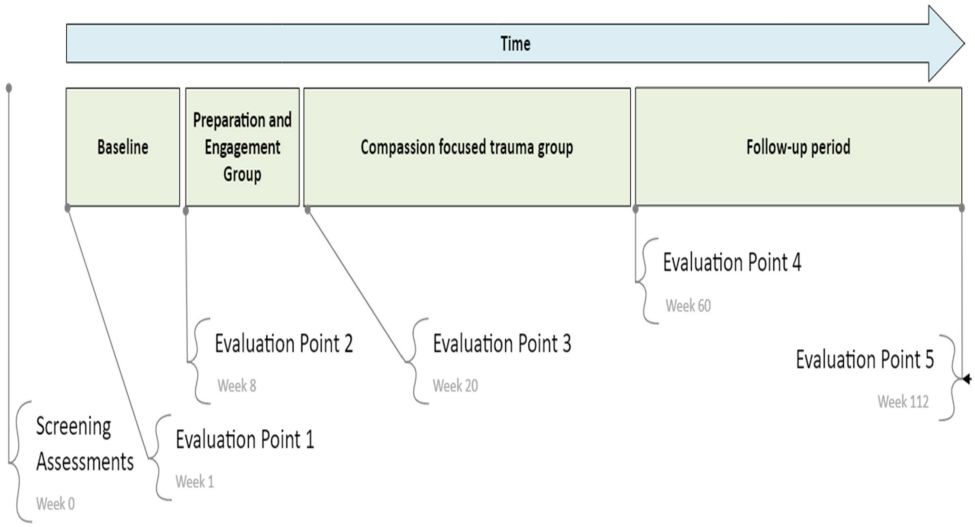

FIGURE 1 Progression of the participants through the preparatory and engagement phase, through 40 weeks of compassion focused trauma group and finally the assessment of long-term outcomes after a 12 month period of TAU.

3. To establish if significant change was maintained after the inclusion of an intention to treat (ITT) analysis to account for participant drop out.

Participants

A total of 41 participants, whose age ranged from 23 years to 66 years; mean age 45 years, took part in the study. Table 2 details the demographic data of the sample. In total, 95% of the cohort had a diagnosis of personality disorder. Eighty-seven per cent of the cohort had been given a Health of the Nation Scales (HoNOS) cluster of 7 or 8, indicating high levels of complex needs and severe distress, these clusters are linked with F60 diagnostic categories relating to the disorders of personality (Ride & Jacobs, 2018). In total, 50% of the sample was single at the outset of the study and 85% of the participants were unable to work due to sickness. Despite the ethnic diversity of the sampling area, 76% of the sample was White English.

INCLUSION CRITERIA

The cohort was recruited from referrals to an NHS tertiary Specialist Psychotherapy Service and included those who had been assessed as suitable for a 12-month CFGP programme. The inclusion criteria for participants were based on a screening tool (FSCSRS Scale, see measures section below). The inclusion criteria were a score of 4 on at least three items of the Inadequate Self and Hated Self subscales and 0 on at least three items of the Reassured Self subscale. This was not based on researched clinical cuts for this measure but believed by the authors to give an indication of severity of self-criticism and self-hatred.

Measures

The following self-report scales were administered to measure symptoms of mental distress, process and adjustment.

TABLE 2 Demographic variables of the participants.

	Cohort 1 $n = 41$
Age (years)	
>25	1 (2%)
25–35	8 (19%)
36–45	12 (29%)
46–55	13 (32%)
56+	7 (18%)
Gender *n* (%)	
Male	13 (32%)
Female	28 (68%)
Marital status *n* (%)	
Single	20 (50%)
Cohabiting/civil partnership	11 (27%)
Divorced/separated	3 (8%)
Married	6 (15%)
Ethnicity *n* (%)	
White English	31 (76%)
Mixed or multiple ethnic group	6 (15%)
Asian or Asian British	4 (9%)
Primary diagnosis *n* (%)	
EUPD	24 (58%)
PD not specified	2 (5%)
PD avoidant	7 (17%)
PD paranoid	2 (5%)
PD dependent	2 (5%)
PD narcissistic	2 (5%)
Depressive illness	2 (5%)
Documented early attachment trauma (%)	41 (100%)
Employment status *n* (%)	
Employed	6 (8%)
PT employed	2 (5%)
Voluntary	0
Education	1 (2%)
Unable to work (sick)	32 (85%)
HoNOS cluster	
Cluster 4	6 (13%)
Cluster 7	11 (28%)
Cluster 8	24 (59%)

Symptom measures

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

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

Adjustment measures

The adjustment measures provide assessment of functional adjustment.

1. The Work and Social Adjustment Scale (Mundt et al., 2002).
2. Impact of Event Scale (IES) developed by Horowitz et al. (1979).

Process measures

1. Forms of Self-Criticising/Attacking & Self-Reassuring Scale (FSCSRS) (Gilbert et al., 2004).
2. Social Comparison Scale (SCS) (Allan & Gilbert, 1995).
3. The 'Other as Shamer' Scale (Goss et al., 1994).
4. Submissive Behaviour Scale (SBS) (Allan & Gilbert, 1997).
5. Fear of Compassion Scale (Arieti & Bemporad, 1980).
6. Internal Shame Scale Rybak et al. (1996)

A service utilisation questionnaire was also used which was adapted from a standard measure utilised within the psychotherapy service to gather information regarding general and psychiatric service usage, employment status and benefit status. It is of note that this was as self-report measure and therefore must be treated with caution as the service utilisation data was not corroborated.

Previous therapy

At the time of assessment, 88% (*N*: 36) of the cohort had previous engagement with psychological therapy. Table 3 highlights the proportion of the cohort who had multiple episodes. These multiple episodes were generally of shorter duration (60% were 12 weeks or less) and the majority (78%) were offered either cognitive behavioural therapy (CBT) or CBT mixed with another modality (78%).

RESULTS

Attendance rates

The 12-week preparation and engagement group (PEG) programme began in September 2014 and data was gathered from this group until May 2018 when the final research participants completed the 12-week group. The 40-week CFTG intervention started in December 2014 and data were gathered from the participants in this group until March 2019 when the last participants completed the programme.

Overall attendance was 83% for the 12-week PEG, with 10% did not attend (no contact with the service) and 7% sending apologies. These data were calculated on a session-by-session basis and cross-referenced with electronic databases for recording session attendance. The group was run on a slow open-rolling format with fixed entry and exit points. Participants entered the programme at the beginning of each module, represented by the triangles in Figure 2. Attendance increased slightly to 85% for the 40-week CFTG intervention, with 9% did not attend (no contact with the service) and 6% sending apologies.

TABLE 3 Participants previous therapy.

Episode No:	None	1 episode	2 episodes	3 episodes	4 episodes	5+ episodes
Number (%) of participants	5(12%)	6(15%)	8(20%)	10(24%)	9(22%)	3(7%)

Dropout

Within the first 12 weeks of the intervention, one participant dropped out. During the 40-week CFTG intervention, eight participants dropped out. All the eight who dropped out of the 40-week CFTG did so in the first 8 weeks of CFTG, many who dropped out at that stage cited the transition from the 12-week PEG into the 40-week CFTG as part of the reason for drop out. These conclusions have not been tested and should be treated with caution. Overall, the drop out from the study was 21%.

One participant refused the follow-up meeting/home visit and decided not to complete the measures and one participant took their own life 9 months after the end of the therapy intervention. Therefore, follow-up data was gathered for 29 participants.

Research Aim 1—Evaluation of the long-term within group outcomes, measuring change and maintenance over the two-year study period

Data were analysed using the SPSS (v. 27: IBM Corporation). A within subjects' pair-wise difference analysis of the stages of treatment were calculated using a Bonferroni correction for multiple comparison (see Table 4). The within subject analyses will be presented with a summary overview of the pictorial representations of the data.

The range of missing data for most of the measures was up to 5%. However, this figure rose to 15% for IES and 24% for CORE. Indicating that overall, the number of participants who completed these measures is lower than for the other measures.

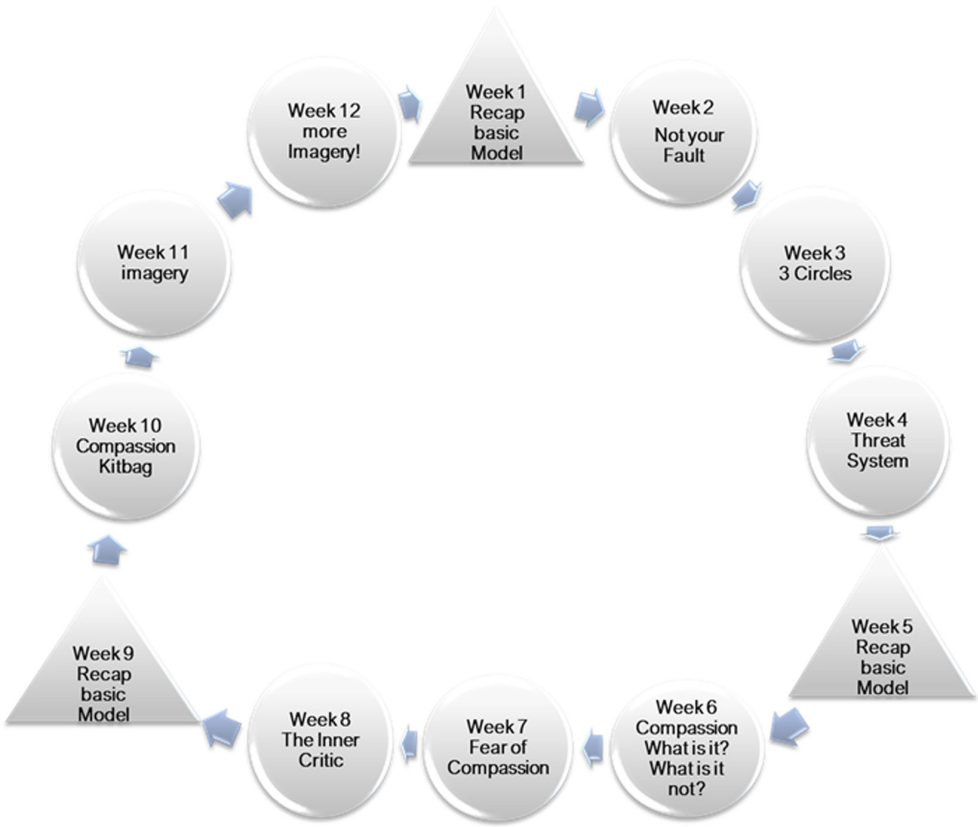

FIGURE 2 Summary of PEG modules with entry points.

The purpose of multiple comparisons across the CFGP programme was intended to examine the differential responses to phases three (Preparation and Engagement Group) and four (Compassion Focused Trauma Group), with the added analysis of the phase five (TAU). See Table 4.

There was no significant change (improvement or deterioration) during the baseline period, which ranged from 8 to 16 weeks (phase two). This was the time period following completion of assessment, acceptance into and starting the programme, which could also be described as the 'waiting list'.

During the first 12 weeks of PEG (phase three), nine subscales showed significant improvement. Four were highly significant ($p = <.001$), Problems (CORE), Intrusions (IES), Expressing Compassion for Self (FCS) and Expressing Compassion to Others (FCS). A further five were significant at .05 level, Depression (DASS), Wellbeing (CORE), Reassured Self (FSRSA), Shame (ISS), Submissive Behaviour wellbeing (CORE) and Depression (DASS).

All measures and subscales achieved significance at <.001 during the CFTG (phase four) of the programme. Significant improvement in Self Esteem (ISS), Shame (ISS) and Expressing Compassion to Others (FCS), at .05 and Inadequate Self (FSRSAS) and Submissive Behaviour at <.001 were maintained at 1 year follow-up.

Significant improvement in Fear of Expressing Compassion to Others (FCS), Shame (ISS) and Submissive Behaviour (SBS) achieved significance across the whole treatment and follow-up period.

Figure 3 offers a sample pictorial representation of the flow of change across the timescale of the intervention and follow-up.

Research Aim 2—Analysing change at an individual level to evaluate the overall level of reliable and meaningful change

To identify the individual participants who had shown clinically or statistically meaningful change, the 65% CI and the 95% CI were calculated for each of the symptom and process measures using the procedures described by Jacobson and Truax (1992). Start and end of programme (S—EP) scores were then plotted and the bands for clinically meaningful change (66% CI) and statistically reliable change (95% CI) were calculated. Table 5 illustrates the percentage of individual scores reaching the threshold for clinically meaningful and statistically reliable improvement and deterioration when tested on an individual level. This analysis was conducted on the intervention, rather than the two component parts, as the exploration of reliable change is concerned with CFGP as a whole programme.

Overall, the reliable change charts show that examination on an individual level is consistent with the previous analysis of overall meaningful improvement with low levels of deterioration.

The range of statistically reliable improvement ranged from 13% to 74%, IES was the only scale to measure below 20% SR improvement. Between 26% and 90% demonstrated clinically meaningful improvement and only the three scales of Impact of Event Scale measured below 50%.

Those self-report subscales which measured social ranking (SE, SB, SCS and OAS) and self to self-relating (ECS) and Expressing Compassion to Others (FCS) were the only scales to report Statistically Reliable deterioration at 3%–6% level (equates to 1–2 participants). Between 3% and 9% reported clinically meaningful deterioration (1–4 participants).

Research Aim 3—Establishing if a significant change is maintained after the inclusion of an ITT analysis to account for participant drop out

In the case of significant results from the pairwise difference analysis tests, an ITT analysis was undertaken to enable an estimation of the treatment effect size controlling for participants who were lost to attrition, either due to drop out from the study or failure to complete the end of 12-week therapy measures. A 'null result' was calculated for those participants who were lost to attrition by calculating the average of the lowest tenth percentile of scores on that outcome measure. A repeat measure ANOVA

TABLE 4 Summary of within subjects' pair-wise difference analysis.

	Assessment to start of PEG *n*: 40		Start of peg to start of CFTG *N*: 38		Start of CFTG to end of Prog *N*: 31		12 month TAU Fup *N*: 29	
Measure	**Mean diff (SE)**	**Sig.[a]**	**Mean diff (SE)**	**Sig.[a]**	**Mean diff (SE)**	**Sig.[a]**	**Mean diff (SE)**	**Sig.[a]**
DASS—Depression	.536 (.576)	.361	2.179* (.754)	.008**	4.357* (1.024)	.000**	1.536 (.883)	.093
DASS—Anxiety	1.036 (.966)	.293	1.429 (.8440)	.102	3.357* (.882)	.001**	1.214 (.645)	.071
DASS—Stress	.821 (.671)	.231	.571 (695)	.418	4.786* (.986)	.000**	1.000 (.907)	.280
CORE—Risk	1.136 (.768)	.154	.682 (.632)	.293	4.000* (1.140)	.002**	1.227 (.792)	.136
CORE—Wellbeing	0.45 (.397)	.910	1.409* (4.73)	.007**	3.364* (.852)	.001**	.455 (.657)	.497
CORE—Function	1.136 (1.201)	.355	2.091 (1.638)	.216	10.409* (2.706)	.001**	3.182 (1.919)	.112
CORE—Problems	0.45 (1.194)	.970	2.500* (1.130)	.038*	11.136* (2.354)	.000**	2.000 (2.118)	.356
Work & Social Adjustment	−.276 (.858)	1.00	3.138 (1.47)	.107	8.345* (1.322)	.001**	1.000 (1.520)	1.000
IES—Hyperarousal	−.214 (915)	.818	2.286 (1.247)	.090	5.143* (1.522)	.005**	.214 (1.254)	.867
IES—Intrusion	−1.357 (.782)	.106	3.000* (1.186)	.025*	6.500* (1.728)	.002**	1.429 (1.152)	.237
IES—Avoidance	−.286 (.963)	.771	2.071 (1.999)	.319	6.786* (2.089)	.006**	−1.143 (2.286)	.626
FCS—ECS	−2.241 (2.867)	.441	5.655* (2.470)	.030*	12.207* (2.214)	.000**	−.552 (2.133)	.798
FCS—ECO	1.000 (2.857)	.729	3.897* (1.724)	.032*	4.345* (2.027)	.000**	3.241* (1.897)	.012*
FCS—RCO	.103 (3.078)	.978	2.345 (1.881)	.223	11.793* (2.182)	.000**	3.069 (2.077)	.151
FSRSA—IS	.241 (.420)	.570	1.069 (.775)	.179	6.379* (1.074)	.000**	3.172* (1.081)	.007**
FSRSA—RS	.000 (.577)	1.000	−2.103* (.626)	.002**	−4.414* (1.033)	.000**	−1.690 (1.039)	.115
FSRSA—HS	.483 (.316)	.138	1.000 (.651)	.136	5.000 (.874)	.000**	.241 (.894)	.789
ISS—Shame	1.357 (1.505)	.375	5.593* (1.875)	.006**	16.857 (4.343)	.001**	7.857* (3.123)	.018*
ISS—Self Esteem	−.714 (.493)	.159	−1.222 (.709)	.097	−3.929* (.718)	.000**	−1.500* (.704)	.042*
Submissive Behaviour	.536 (.734)	.472	2.964* (1.009)	.007**	4.286* (1.626)	.001**	5.286* (1.594)	.003**
Social Comparison	−.690 (.947)	.473	−.241 (1.992)	.904	−13.103* (2.513)	.000**	−3.138 (2.031)	.134
Other as Shamer	1.103 (1.413)	.441	3.862 (1.994)	.063	9.483* (2.033)	.000**	3.724 (2.037)	.078

Note: Based on estimated marginal means.

*The mean difference is significant at the .05 level. **The mean difference is significant at <.001.

[a]Adjustment for multiple comparisons: least significant difference (equivalent to no adjustments).

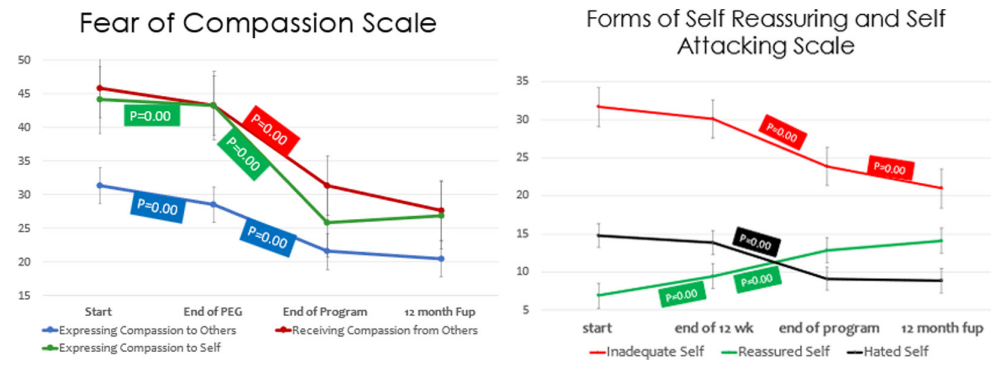

FIGURE 3 Outcomes across the entire period of evaluation for the FSRSA and FCS 95% confidence interval of the mean is provided for each time point.

TABLE 5 Percentage of the individual participants reaching the criteria for clinical and statistical improvement or deterioration.

Measure	Statistically reliable improvement (%)	Clinically meaningful improvement (%)	Clinically meaningful deterioration (%)	Statistically reliable deterioration (%)
DASS—Depression	42	61	6	0
DASS—Anxiety	42	51	3	0
DASS—Stress	25	51	3	0
CORE—Risk	35	58	3	0
CORE—Wellbeing	70	77	6	0
CORE—Function	52	68	0	0
CORE—Problems	55	61	3	0
Work & Social Adjustment	41	68	0	0
IES—Hyperarousal	13	29	3	0
IES—Intrusion	16	35	0	0
IES—Avoidance	13	26	6	0
FCS—ECS	71	81	3	3
FCS—ECO	54	74	9	6
FCS—RCO	81	81	9	0
FSRSA—IS	39	61	0	0
FSRSA—RS	42	71	6	0
FSRSA—HS	32	61	6	0
ISS—Shame	74	90	0	0
ISS—Self Esteem	42	65	9	3
Submissive Behaviour	42	55	6	3
Social Comparison	55	58	9	3
Other as Shamer	68	87	3	3

compared the means of the measures at the start of PEG and end of programme and the Greenhouse Geisser adjusted F and significance values are reported in Table 6.

The highly statistically significant interaction between cohort and time of outcome measurement remained following an ITT correction for missing data for all measures at <.001, with one exception.

TABLE 6 Summary of ITT analysis by measure.

Depression anxiety and stress			Clinical outcome in routine evaluation			
Anxiety	**Depression**	**Stress**	**Risk**	**Wellbeing**	**Function**	**Problems**
$F = 13.27$**	$F = 18.03$**	$F = 14.54$**	$F = 13.33$**	$F = 41.78$**	$F = 33.34$**	$F = 39.90$**
Fears of Compassion Scale						
ECO	**RCO**	**ECS**	**SBS**	**SCS**	**OAS**	**WASA**
$F = 14.33$**	$F = 15.44$**	$F = 29.66$**	$F = 5.07$**	$F = 19.78$**	$F = 17.84$**	$F = 43.64$**

Impact of Events Scale			Internal Shame Scale		Forms self-reassuring and self-attacking		
Hyper	**Intrusion**	**Avoidance**	**Shame**	**Self Esteem**	**Inadequate**	**Reassured**	**Hated**
$F = 4.25$**	$F = 17.89$**	$F = 86.858$**	$F = 49.96$**	$F = 10.74$**	$F = 24.95$**	$F = 11.45$*	$F = 18.58$**

*The mean difference is significant at the .05 level. **Significant at <.001.

The Reassured Self subscale (FSRSA) reported $p = .002$ which remains highly significant. This additional rigorous analysis demonstrates that the inclusion of the 'worst possible' outcomes for those who did not submit end of programme data or dropped out, does not alter the significance of the overall improvement across all measures.

DISCUSSION

This study mapped the therapeutic outcomes of a group of patients referred to a psychotherapy service and recruited to join a 12-month Compassion Focused Group Psychotherapy programme. To the author's knowledge, this study reports data for the first exploratory Compassion Focused Group Psychotherapy programme to be developed and evaluated with a 12-month follow-up evaluation. This study also provides some preliminary support for the motivationally rather than symptom-orientated therapies which can cater for a wider group than just those with a diagnosis of BPD (Inchausti et al., 2020; Popolo et al., 2018).

Engagement with the programme was encouraging, in that only 21% of participants dropped out, coupled with an 85% session attendance rate that was consistent across the duration of therapy. It is possible that the attendance level positively correlates with the sustained outcome data and specific attention to the cultivation of safeness in the therapeutic process in CFGP which has been cited as a missing component in other therapies (Barnicot et al., 2022). This attrition rate was lower than that of published literature reviews of treatments for people with a diagnosis of personality disorder which indicated 37% non-completion rate (Arntz et al., 2023; Hummelen et al., 2007; McMurran & Ward, 2010). This study and others have also recommended the use of preparation and engagement programmes to reduce attrition (Barnicot et al., 2022; Haigh &Pearce, 2017; McMurran, 2012; Webb & McMurran, 2009). The inclusion of the PEG component therefore supports the current body of evidence for the efficacy of these types of preparatory groups.

Aim 1

In examining the data from phase two (PEG), it may be that the significant reduction in the self-report of depressive symptoms (DASS) could be correlated with the improvement in wellbeing (CORE) reassured self (FSRSA) and linked to the reduction in experience of problems (CORE) and of self-hatred (FSRSA). The significant reduction in the fear of expressing compassion to self (FCS) and others could be linked to the focus in the early stages of the group with pacing and encouraging cohesion within and

between the group members (Lucre, 2022). The similarly significant reduction in the experience of submissive behaviour (SBS) could also be correlated with the format of the group which invites everyone to speak and share during the 'check in' (Lucre, 2022).

There is also a clear connection between the experience of social safeness and capacity to give and receive compassion, which is dependent on the quality of early attachment relationships (Kelly & Dupasquier, 2016; Silva et al., 2019). The significant reductions in the Fear of Compassion Scale across all three subscales is an indication of the increased capacity of participants to give and receive compassion in the context of increased social safeness and feelings of connection with the group. It is possible that the combination of the group process and explicit cultivation of compassion has decreased the experience of shame and improved the capacity for assertiveness which sits firmly within the CFT model and aims (Gilbert & Simos, 2022; Gilbert, 2019; Lucre & Corten, 2013). Coupled with this, the significant improvements in the reported symptoms of social ranking, Social Comparison Scale, Submissive Behaviour Scale and Other as Shamer may also have facilitated the social safeness dynamic and increased connection with other group members and facilitators. The Internal Shame Scale also had significant reductions which are encouraging given the explicit and implicit group-based processing and reworking of early shame-based trauma. This is supported by the literature which connects the experience of shame to early A&RT memories (Ashfield et al., 2021; Lawrence & Lee, 2014; Lee & James, 2012).

Aim 2

Analysis of the data on an individual level lends support to the whole group data analysis finding. Exploring the data in more detail it is of note that the number of participants across all measures who showed any form of deterioration was not larger than 3–4. The only measures to show deterioration at an individual level were social rank (OAS, SCS and SBS). Although this has not been tested, those who showed deterioration in the social rank measures had scored very high at the commencement of the study perhaps reflecting a 'defensive or grandiose' presentation which was addressed directly through the therapeutic process, resulting in a rebalancing of the levels of submissive behaviour and social comparison to reflect a more compassionate view of the self and others. It is of note that these participants were also those who had been diagnosed with narcissistic or paranoid personality disorder. This is a novel finding and would merit further exploration but is supported by the literature in working with grandiose type defences (Bateman, 1998; Young et al., 2006).

It is of note that The Impact of Event Scale showed the lowest levels of statistically reliable improvement (13%–16%) compared to 35%–81% for the rest of the measures. This could be explained by the low response rate and in particular the low return rate of this measure which anecdotally some explained as the questions no longer being of relevance.

Aim 3

The analysis across the 12-month intervention identified significant changes across all measures of therapeutic and symptomatic experience, which were maintained following a robust ITT analysis. During the 12-month follow-up period, the level of improvement was sustained and in the case of several measures, further significant improvement was observed.

The provision of programmes of adequate duration (12 months or more) are likely to produce not only sustained change in symptom, process and adjustment measures but also to result in a reduction in usage of psychiatric and general medical services, coupled with an increase in employment and education (Bateman & Fonagy, 2010; Crawford et al., 2008; Davies & Campling, 2003). At the conclusion of the study, nearly half of the cohort had been discharged from mental health services, representing a significant reduction in service usage. This correlates with the significant changes in

the WASA scale. It is also significant that 77% of this discharged group were in some form of education, employment or voluntary work at the 12-month follow-up time point. This points perhaps to a process of 'internalising' the therapy experience to enable engagement with meaningful activity beyond the therapeutic process.

Mechanisms of change

The explicit attention to the cultivation of the conditions for safeness throughout the five phases of the programme has been identified as the superordinate theme from a qualitative study of participant feedback about the mechanisms of change). This is supported by the body of literature about the importance of establishing safeness for psychological work with this patient group (Gilbert, 2017, 2020; Hermanto & Zuroff, 2016; Lucre & Clapton, 2021; Matos et al., 2021; Music, 2018; Yalom & Leszcz, 2005). This overarching theme was a strand which emerged in each of the other subordinate themes and seems to have been the foundational internal construct which facilitated the necessary therapeutic engagement and mechanism of change. This is consistent with the findings of the other three qualitative studies of CFT. Lucre and Corten (2013, p. 9) reported 'the comfort of shared group experiences', Ashfield et al. (2021, p. 8) described 'the group as a key mechanism of change' and Lawrence and Lee (2014, p. 501) reported the 'emotional experience of therapy'.

Limitations

There were several limitations to be considered when interpreting the findings. The naturalistic setting of this study, although to some extent a strength, meant that it was not possible for participants to be randomised to the different arms of the study and further there was no control group. There was also a significant therapist impact on study, as the therapist was also chief investigator and responsible for all data collection.

Areas for future research

Given the positive promising outcomes from the current study, the next stage for research would be to undertake a more rigorous evaluation of this intervention, preferably in the form of a randomised controlled trial. However, given the ethical considerations, the length of the intervention and TAU period, this will need careful management.

There was a high level of significance attributed to the experience of safeness as a mechanism for change and undertaking psychological work. It would, therefore, be helpful to measure this explicitly in future research. Therefore, using the Early Memories of Warmth and Social Safeness Scale is recommended to explore the experience of participants of their social world as safe or otherwise (Capinha et al., 2020). This would enable a more thorough exploration of participants' experience of safeness in the context of therapeutic experience coupled with a further test of the qualitative findings.

The study focused on the provision of a psychotherapeutic intervention for patients who had suffered A&RT and had consequent difficulties in managing relationships, it is suggested that future research also utilise the Adverse Childhood Experiences Scale (Ford et al., 2014), The Central Relationships Questionnaire (Barber et al., 1998) and The Experiences of Close Relationships scale (Fraley et al., 2011). This would enable a more accurate picture of the early life experiences and attachment patterns of the group, rather than relying on the redundant personality disorder diagnostic categories.

Understanding the qualitative experiences of participants would be beneficial and a qualitative study exploring this is published in a separate paper (see Anon, in press).

CONCLUDING REMARKS

This study has offered an alternative way of describing patients diagnosed with a personality disorder, as those with A&RT. This redefining aims to offer a more robust understanding of causes of the difficulties, that is, early attachment ruptures, rather than a categorisation of the behaviour which often accompanies these early experiences (Anon, in press). The reworking of this diagnosis to a more formulation-based description through an evolutionary lens aims to offer a de-shaming perspective on this cluster of interpersonal, emotional, cognitive and indeed neurobiological difficulties, which often attract stigma, denigration and exclusion from therapeutic provision (Brüne, 2016; Lucre, 2022; Stalker et al., 2005).

The Compassion Focused Group Psychotherapy Programme was developed to provide therapeutic opportunity to this group and the result of the study lends some support to the original hypothesis that effective treatments for people with A&RT need to be of longer duration, slower paced with greater flexibility within a structured model to manage and repair the inevitable ruptures associated with this work (King-Casas et al., 2008). This study identified a therapeutic process of establishing group-based safeness as a necessary precursor to cultivating compassion and reworking early shame-based trauma memories. This will explored further in the qualitative arm of this study (Anon, in press).

These conclusions are supported by a three-level analysis that demonstrated that significant change across symptom, process and adjustment was achieved on a group and individual level and that change was maintained following an ITT analysis and in some cases extended at 1-year follow-up.

AUTHOR CONTRIBUTIONS

Kate Lucre: Methodology; investigation; writing – original draft; writing – review and editing; conceptualization; formal analysis; project administration; data curation. **Fiona Ashworth:** Supervision. **Alex Copello:** Methodology; validation; supervision. **Chris Jones:** Formal analysis; supervision; data curation; methodology. **Paul Gilbert:** Conceptualization; supervision.

CONFLICT OF INTEREST STATEMENT

There are no conflicts of interest associated with this articled or the co-authors involved.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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