Compassion focused therapy: Exploring the effectiveness with a transdiagnostic group and potential processes of change

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\textbf{Objectives.} This study aimed to examine the effectiveness of a compassion focused therapy (CFT) group with a transdiagnostic population, as compared to treatment as usual (TAU). A secondary aim was to explore the potential processes of change within the treatment.

\textbf{Design.} A non-randomized control trial was used.

\textbf{Method.} Fifty-eight participants who engaged in group CFT were compared to 29 participants receiving TAU. Group CFT consisted of 14 sessions twice weekly for 5 weeks and once weekly for 4 weeks. Participants completed measures of psychopathology, shame, self-criticism, fears of self-compassion, and social safeness, at pre-treatment, post-treatment, and 2-month follow-up. Potential processes of change were examined using correlations and regression analysis.

\textbf{Results.} Significantly greater improvements were found for levels of psychopathology, fears of self-compassion and social safeness for CFT, compared to TAU. Additionally, analyses showed improvements in shame and self-criticism within the CFT group but not the TAU group. All improvements were maintained at 2-month follow-up. Improvements in psychopathology were predicted by changes in self-criticism and fears of self-compassion.

\textbf{Conclusion.} Compassion focused therapy appears to be an effective group intervention for a range of mental health difficulties. The positive impact of the CFT model with a transdiagnostic group emphasizes the value of addressing underlying psychological process, rather than symptoms alone.

\textbf{Practitioner points}

- Compassion focused therapy is a multimodal therapy designed to target high levels of shame and self-criticism.
- Compassion focused therapy has been shown previously to have positive results within a range of diagnostic-specific populations. While there is an emerging research base, limited studies assessing effectiveness with transdiagnostic populations have been published.

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Compassion focused therapy (CFT) was developed to address difficulties with shame and self-criticism, which are seen as transdiagnostic factors that can contribute to and maintain a range of mental health problems (Gilbert & Procter, 2006). Whelton and Greenberg (2005) stated that the pathogenic qualities of self-criticism are linked to feelings of anger, disgust, and contempt towards the self. Tangney and Dearing (2003) conceptualized shame as including an affective desire to be unseen by others and a self-perception of being deeply flawed, incapable, and unacceptable. Over the past number of decades, a large number of studies have found shame and self-criticism to be a central feature of psychological distress, for example in relation to depression and anxiety (Judge, Cleghorn, McEwan, & Gilbert, 2012; Rector, Bagby, Segal, Joffe, & Levitt, 2000), trauma (Lawrence & Lee, 2014), personality disorders (Lucre & Corten, 2013), psychosis (Braehler et al., 2013; Laithwaite et al., 2009), and eating disorders (Gale, Gilbert, Read, & Goss, 2014; Goss & Allan, 2014).

Compassion focused therapy is an integrative, scientifically based model which is informed by evolutionary psychology, the neuroscience of affiliation, attachment theory, behaviourism, and cognitive behavioural therapy (Kolts, 2016). It also draws on Buddhist teachings about mindfulness and compassion (Gilbert, 2010). Gilbert proposes a model of affect regulation involving three evolved systems: the threat and self-protection system, the drive and resource-seeking system, and the soothing and connection system. Each system has an evolved function related to our motivations to survive, achieve, and connect with others (Gilbert, 2009). Mental health difficulties are understood as resulting, in part, from an imbalance among the three systems, typically an overactivation of the threat system and an underactivation of the affiliative system (Gilbert, 2010). The intervention aims to de-shame and normalize emotional difficulties as resulting in part from the way our brains have evolved, the propensity to respond from our threat system, and the social and emotional learning experiences that have shaped us over the course of our lives. Socratic teaching is used to develop an awareness of this way of understanding how people develop mental health difficulties.

A main of objective of CFT is to increase an individual’s felt sense of compassion. This is done through utilizing a number of skills (e.g., compassionate thought balancing, mindfulness and compassionate acts towards self and others) and experiential exercises (e.g., soothing rhythm breathing, perfect nurturer and compassionate flow). Interested readers can refer to Gilbert and Irons (2004) for further information.

Compassion focused therapy is an approach that seeks to de-pathologize adaptations to difficult environments (Gilbert, 2010, 2014). The aim is to develop the affiliative system as a means of regulating the threat system. It is suggested that people who are self-critical may not have access to memories of being cared for and soothed and can have problems accessing feelings of warmth, compassion, and reassurance (Gilbert & Irons, 2004). People who have had early experiences of neglect or trauma, or whose early attachment relationships were highly threat-focused, are thought to have greater difficulty generating positive affiliative emotions and are therefore more vulnerable to psychopathology (Lawrence & Lee, 2014).
Qualitative research with clients who have experienced complex trauma has suggested that a key part of the therapeutic process in CFT involves overcoming obstacles to developing self-compassion (Lawrence & Lee, 2014). As noted above, difficulties accessing the affiliative system are expected when attachment experiences have been highly threat-focused and these result in obstacles that become a focus of treatment. For further discussion of this, interested readers are directed to Gilbert and Irons (2004). To bring about a felt sense of safeness in exploring these obstacles, the role of the therapist as a secure base is seen as particularly important (Kolts, 2016).

Compassion has been defined as acknowledgement and engagement with one’s own suffering and the suffering of others, together with a deep commitment to work towards alleviating and preventing that suffering (Dalai Lama, 1995). This definition highlights two psychological components of compassion which provide a direction for the therapy. Firstly, compassion involves a motivation and intention to approach, tolerate, and engage with suffering. Secondly, there is a corresponding commitment to try to alleviate suffering and seek to prevent future suffering (Gilbert, 2010). CFT encourages clients to develop key attributes of compassion, identified by Gilbert (2009) as care for well-being, sensitivity, distress tolerance, sympathy, empathy, and non-judgement. These attributes are enhanced and enacted through learning and practicing skills in the areas of attention, imagery, behaviour, reasoning, sensation, and emotion (Gilbert, 2009; Leaviss & Uttley, 2015).

Research has shown CFT to be effective in the treatment of specific mental health difficulties such as psychosis (Braehler et al., 2013), anxiety (Gilbert & Procter, 2006), eating disorders (Gale et al., 2014; Goss & Allan, 2014), as well as mood and personality disorders (Gilbert & Procter, 2006). Other research has shown CFT to be effective in reducing general levels of psychopathology (Judge et al., 2012) and distress (Heriot-Maitland, Vidal, Ball, & Irons, 2014). Furthermore, a recent systematic review by Leaviss and Uttley (2015) indicated that CFT may be more effective than treatment as usual for people who are markedly self-critical. The review noted that research designs ranged from observational studies to randomized controlled trials and called for more research with robust methodologies (Leaviss & Uttley, 2015).

Research examining the long-term effectiveness of CFT has recently begun to emerge. Lucre and Corten’s (2013) evaluation of a CFT group for outpatients with personality disorders found significant reductions in shame, social comparison, feelings of self-hatred, and symptoms of depression and stress. Furthermore, the results indicated group members experienced an increase in their ability to reassure themselves. Follow-up at 1 year showed that improvements were maintained, although it should be noted that the sample size was small (n = 10).

Research has also begun to explore the effectiveness of CFT with transdiagnostic populations (Heriot-Maitland et al., 2014; Judge et al., 2012). Judge et al. (2012) evaluated the effectiveness and accessibility of a CFT group with a transdiagnostic population in a community mental health setting. The transdiagnostic sample comprised of anxiety disorders, depressive disorders, and personality disorders. Client feedback indicated that CFT was easily understood and helpful. Further, there were significant improvements in depression, anxiety, stress, self-criticism, shame, submissive behaviour, and social comparison post-intervention. While this was one of the first studies to explore CFT in a transdiagnostic population, it is of note that the design did not include a control group. Heriot-Maitland et al. (2014) evaluated a modified group CFT intervention with an inpatient, transdiagnostic population. They chose to run a series of open, stand-alone groups suited to an acute setting. They measured levels of distress and calmness, as
associated with the threat and soothing systems. Perceived levels of understanding of the content of the group and its helpfulness for everyday life were also measured. Their results indicated significant increases in calmness and decreases in distress for the participants who completed measures pre-and post-session. Participant ratings indicated high levels of understanding and helpfulness. While these findings provide further support for the use of CFT with a transdiagnostic group, the authors did not use standardized measures. These studies highlight the need for future research examining CFT for transdiagnostic populations to include a control group and standardized measures.

Implementing an intervention within a clinical setting gains from an understanding of how the intervention works, what the process of change is, and how conditions can be optimized (Kazdin, 2007). Research that examines potential processes of change is important as it also allows the theoretical model underlying a therapy to be tested. To date, only one study has examined the process of change in CFT. In their randomized controlled trial, Braehler et al. (2013) reported that clinical improvement following CFT was associated with significant increases in compassion. They found a moderate correlation between an increase in compassion and reduction in levels of depression and perceived social marginalization. The authors proposed that the development of compassion may lead to a reduced sense of exclusion and shame and to a reduction in depressed affect.

**Current study**

The primary aim of the current study was to explore the effectiveness of a CFT group intervention in a transdiagnostic population. It was hypothesized that there would be significantly greater reductions in overall levels of psychopathology following a group CFT intervention when compared with treatment as usual (TAU). A secondary aim was to explore the process of change in group CFT. The current study examined relationships among fears of self-compassion, social safeness, shame, and self-criticism and psychopathology.

**Method**

**Participants**

Participants were clients of an independent, not-for-profit mental health service accessed by people across the island of Ireland. The group was open to both inpatients and outpatients with problematic levels of shame and self-criticism linked to their mental health difficulties. This was assessed in two separate clinical interviews and a battery of psychometric measures was utilized (Gilbert, Clarke, Hempel, Miles, & Irons, 2004; Goss, Gilbert, & Allan, 1994). As there are no cut-off scores, the clinical interviews and questionnaires were used to determine the impact of constructs on day-to-day functioning.

Exclusion criteria included substance misuse at a level requiring specialist treatment, acute psychotic symptoms, and risk assessment requiring treatment within the secure unit of the hospital. Participants (CFT \( n = 58; \) TAU \( n = 29 \)) ranged in age from 18 to 69 years old and had a range of mental health diagnoses as communicated by the multidisciplinary team on referral (see Table 1). Approximately 44% of the participants were inpatient at some stage during the CFT intervention; however, no one was an inpatient for the duration of the intervention. The average attendance for participants was 14 group CFT sessions. Three participants completed nine sessions or less. Two participants did not complete the CFT group (Figure 1).
Study design and procedure
The study was granted ethical approval by the hospital ethics committee, and informed written consent was obtained from all participants. This was a non-randomized controlled trial conducted across two sites within the same mental health service. Participants were referred to the CFT programme by the psychologist on their multidisciplinary teams and offered an individual assessment interview, which included a battery of psychometric measures. If a place was available in the CFT programme at the time of their referral, eligible participants were offered places and commenced the intervention (\(n=58\)). Participants who were referred when there were no places available were placed on a waitlist and offered places in the next available group (\(n=29\)). These participants continued to receive their TAU and acted as the control condition. For the CFT group, data were collected at pre-intervention, post-intervention (i.e., 9 weeks later), and 2-month follow-up. For the TAU group, data were collected at time of assessment and approximately 9 weeks later.

Compassion focused therapy
The CFT group intervention was delivered over 14 sessions, each lasting 3 hr. Sessions took place twice a week for 5 weeks, then once a week for a further 4 weeks. After this intensive part of the group, sessions were offered once a month for 4 months to support continued skills practice and generalization. The current research study captured only the first of these follow-up sessions. There was an average of eight members per group. The group was facilitated by a Senior Counselling Psychologist and Senior Clinical Psychologist, both of whom were trained in delivering CFT by Prof. Paul Gilbert, the treatment developer, and regularly consulted with him about the delivery of the group. Previous CFT group interventions have facilitated up to 32 therapeutic hours (Gale et al., 2014; Judge et al., 2012; Lucre & Corten, 2013). Following the work of other CFT group facilitators, such as Lucre and Corten (2013) who recommended increasing contact with clients, the current group was offered 14 sessions and four booster sessions, resulting in 52 contact hours.

The first phase of the CFT group was psycho-educational and included guided discussions about the evolved human brain, the social construction of the self, and a proposed model of emotion regulation and motivation (Gilbert, 2009). Discussions also

<table>
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<tr>
<th>Diagnosis</th>
<th>CFT</th>
<th>TAU</th>
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<tr>
<td></td>
<td>(n = 58)</td>
<td>(n = 29)</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>46.6%</td>
<td>34.5%</td>
</tr>
<tr>
<td>Personality disorders</td>
<td>15.5%</td>
<td>13.8%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>13.8%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Trauma related disorders</td>
<td>6.9%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Psychotic disorders</td>
<td>5.2%</td>
<td>0%</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>3.5%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Missing</td>
<td>8.6%</td>
<td>31.0%</td>
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</table>

Table 1. Percentage of diagnosis
explored both evolved and learned ways of coping. Group members were encouraged to reflect on the intended and unintended consequences of their personal ways of coping in an effort to facilitate awareness, acceptance, and motivation to change. Self-criticism was addressed through functional analysis to allow group members to develop an understanding of the purpose of self-criticism in their lives. (Gilbert, 2010).
The next phase of CFT involved learning about attributes of the compassionate self and specific skills in the areas of imagery, behaviour, sensation, emotion, reasoning, and attention were taught. Explanation and delivery of these attributes and skills can be found in ‘Compassion Focused Therapy: The CBT Distinctive Features Series’ (Gilbert, 2010). Participants were encouraged to complete practices between sessions to support skills development. Towards the end of the weekly sessions, participants were encouraged to begin to put together a compassionate ‘first aid box’ that they could use after group ended. The group was also supported by handouts that provided succinct guides to what was covered in each group. Following each session, one of the facilitators prepared a written summary of the discussion and process in the group. These summaries allowed group members to retain a record of the learning and experiences in their group.

Throughout the group, the process involved not only learning material and skills but also engaging with emotion, practicing the flow of compassion with each other, and taking opportunities for personal reflection and validation. These experiences were included to promote feelings of social safeness and affiliation, which are particularly important for people who suffer from high levels of shame (Heriot-Maitland et al., 2014).

Notably, the CFT group was offered in addition to TAU. All group members continued to receive treatment from their multidisciplinary team (MDT) while participating in the groups.

**Treatment as usual**

The TAU condition continued to receive their usual treatment from their MDT and commenced CFT when a new group started. TAU was delivered across both inpatient and community clinic settings. TAU typically included various combinations of in- and outpatient care, regular psychiatric review and pharmacology, and psycho-education groups related to psychiatric diagnoses. In some cases, participants may also have received individual supports such as occupational therapy, psychological therapy, or social work.

**Measures**

**Outcome variable**

The Brief Symptom Inventory (BSI; Derogatis & Fitzpatrick, 2004) is a shortened version of the Symptom Checklist-90-Revised (SCL-90-R, Derogatis, 1975), which is a frequently used measure of psychopathology. The Global Severity Index (GSI) indicated the level of perceived distress experienced across nine dimensions (somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism). The BSI has been shown to have both good internal consistency and good test retest reliability (Ryan, 2007). Ryan (2007) found the measure also had good predictive validity and was sensitive to change within a clinical population. In the present study, Cronbach’s α was .96, indicating a good internal consistency.

**Potential processes of change**

The Functions of Self-Criticism Scale (Gilbert et al., 2004) was used to assess self-reported reasons for self-criticism and self-attacking. The 21-item measure is comprised of two subscales: self-persecution and self-correction. Responses are rated on a 5-point Likert scale (ranging from 0 = ‘not at all like me’, to 4 = ‘extremely like me’). Previous research
reported good Cronbach’s alphas of .92 for self-correction and self-persecution (Gilbert et al., 2004). In the present study, there was good internal consistency, with Cronbach’s alpha of .89 for self-correction, and .87 for self-correction found.

The Fears of Self-Compassion subscale of the Fears of Compassion Scales (Gilbert, McEwan, Matos, & Rivis, 2011) measures fears of compassion directed towards the self. The 15 items rated on a 5-point Likert scale (ranging from $0 = \text{Don’t agree at all}$ to $4 = \text{ Completely agree}$). The measure has a good Cronbach’s alpha of .83 (Gilbert, 2009; Gilbert et al., 2011). In the present study, there was a good internal consistency of Cronbach’s alpha .86 found.

The Other as Shamer Scale (Goss et al., 1994) measures external shame, defined as the shame we experience when we think about how we live in the minds of others (Goss et al., 1994). The 18 items are rated on a 5-point Likert scale, based on the frequency of evaluations about how others judge the self (ranging from $0 = \text{Never}$ to $4 = \text{Almost always}$). The scale has displayed good internal consistency with a Cronbach’s alpha of .92. In the present study, there was also a good internal consistency, with Cronbach’s alpha of .93 found.

The Social Safeness and Pleasure Scale (Gilbert et al., 2009) was designed to measure the extent to which people perceive their social world as safe. It also measures participants’ perceptions of feelings of warmth, acceptance, and belonging from others. The 11 items are rated on a 5-point Likert scale (1 = Almost never, 5 = Almost all the time). Cronbach’s alpha was .86 indicating good internal consistency.

**Data analyses**

Preliminary analysis was conducted to determine the suitability of using parametric tests. The assumption of normal distribution was explored using descriptive statistics (mean, 5% trimmed mean, median), the Kolmogorov–Smirnov test of normality, histograms, box plots, and by calculating skewness and kurtosis values. The majority of the results did not violate the assumptions; however, social safeness and self-persecution violated normality only for Kolmogorov–Smirnov scores. It was therefore decided that both parametric and nonparametric tests would be run for these variables. As no difference in the results of both analyses was found, parametric results will be presented. The assumption of homogeneity of variances between the CFT and TAU groups was examined using Levene’s test.

Independent sample t-tests or chi-square analyses were conducted to examine baseline differences between the CFT and TAU groups. Changes over time within each group were examined using a series of paired t-tests. Differences between the groups were explored using a series of ANCOVAs, controlling for the baseline scores on each measure. Separate ANCOVAs were completed for psychopathology, self-criticism, shame, social safeness, and fears of self-compassion. Then, a series of repeated-measures ANOVAs were conducted on the CFT data to explore potential changes between pre-CFT, post-CFT, and follow-up data on levels of psychopathology, self-criticism, shame, fear of self-compassion, and social safeness. The last observation carried forward method (LOCF) was used to maximize power and reduce potential missing data bias in these analyses. To ensure that this did not affect overall results, analysis compared data with and without last observation carried forward: No significant difference was found. Missing data at follow-up were as managed similar to post-data. Analysis with and without last observation carried forward was conducted, with no significant difference found.

Pearson correlation coefficients and multiple regression analyses were used to examine the potential relationships between residualized change scores on the measure of psychopathology and on the measures of the proposed processes of change.
Effect sizes were computed with the partial $\eta^2$ and interpreted using the following guidelines: small = .01–.06, medium = .07–.14, large = .14+ (Cohen, 1998). All analyses were completed with both the LOCF data set and the completer’s data set. No significant differences were found, so the results from LOCF data are reported throughout this article.

Results

Demographic characteristics and baseline measures

Table 1 displays participant clinical diagnoses. Table 2 displays baseline scores for CFT and TAU groups. No significant differences were found on any of the demographic or clinical measures between groups at baseline. The CFT group consisted of females (69%) with a mean age of 41.98 years ($SD = 12.56$), and males (31%) with a mean age of 44.08 ($SD = 11.59$). The TAU group consisted of females (66.7%) with a mean age 42.17 ($SD = 13.02$), and males (33.3%) with a mean age of 47.22 ($SD = 7.42$). There was no significant difference found between age and gender for CFT and TAU.

Intervention outcomes

The pre-group and post-group descriptive statistics for the CFT and TAU groups, and paired t-tests examining change over time are presented in Table 2. Significant improvements on all measures were identified in the CFT group, apart from the self-persecution subscale of the Functions of Self-Criticism Scale (Gilbert, 2014). No significant change was found on any of the measures for the TAU group.

Differences between the groups were examined using a series of ANCOVAs, controlling for scores at baseline. There were significant differences between the groups on levels of psychopathology, $F(2, 84) = 6.84, p < .05$, $\eta^2 = .08$, fears of self-compassion, $F(2, 84) = 18.12, p < .001$, $\eta^2 = .18$, and social safeness, $F(2, 84) = 10.94, p < .005$, $\eta^2 = .12$. Examination of mean scores indicated greater improvement for the CFT group.

There were no significant differences between the groups for other as shamer, $F(2, 84) = 2.41, p = .13$, $\eta^2 = .03$, or either measure of self-criticism: self-persecution, self-correction.

### Table 2. Pre- and post-measures for the CFT and TAU groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>CFT (M (SD), n = 58)</th>
<th>TAU (M (SD), n = 29)</th>
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<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>GSI of the BSI (0–.94)</td>
<td>0.49 (0.13)</td>
<td>0.43 (0.11)***</td>
</tr>
<tr>
<td>Fear of Self-Compassion (0–60)</td>
<td>32.60 (13.90)</td>
<td>23.59 (13.70)***</td>
</tr>
<tr>
<td>Social Safeness (11–55)</td>
<td>25.40 (8.82)</td>
<td>30.29 (10.13)***</td>
</tr>
<tr>
<td>Other as Shamer (0–72)</td>
<td>39.69 (13.47)</td>
<td>35.00 (14.00)***</td>
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<tr>
<td>Self-Persecution (0–52)</td>
<td>13.74 (8.88)</td>
<td>12.34 (7.88)</td>
</tr>
<tr>
<td>Self-Correction (0–32)</td>
<td>29.24 (10.60)</td>
<td>27.02 (10.20)*</td>
</tr>
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</table>

Notes. Results are generated using data with LOCF.

* $p < .05$; ** $p < .01$; *** $p < .001$. 
Two-month follow-up
The repeated-measures ANOVA showed a significant effect was found for time (pre, post and follow-up) on each of the measures. Post hoc tests showed all variables, except self-persecution, were significantly improved from pre- to post-CFT. There was a significant difference between pre-CFT and 2-month follow-up ($p < .05$) for self-persecution. Post hoc tests also showed no significant differences between post-CFT and 2-month follow-up for any of the variables; however, mean scores indicate that improvements were generally maintained (see Table 3).

While only 57% of those who completed the post-group measures also completed the follow-up, there were no significant differences between post-group scores on any of the measures when comparing those who completed follow-up and those lost to follow-up.

Potential processes of change
The second aim of this study was to explore potential processes of change. This was done through exploring relationships among changes in levels of psychopathology and changes in measures of self-criticism, shame, social safeness, and fears of self-compassion (see Table 4). Residualized change scores were calculated for all measures. Pearson’s correlation coefficients indicated significant positive correlations between the residualized change scores on the Global Severity Index on the BSI and most of the potential processes of change: fears of self-compassion ($r = .57$), self-persecution ($r = .51$), shame ($r = .47$), and self-correction ($r = .30$). A significant negative correlation was found between change scores on the BSI and the social safeness measure ($r = -.34$).

The results of the multiple regression indicated that the potential processes of change explained 39% of the variance ($R^2 = .39$), $F (5, 81) = 13.30, p < .001$, in

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<th>Table 3. Means, SD and the significance of change across the time periods</th>
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<tr>
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<tr>
<td></td>
</tr>
<tr>
<td>Brief symptom inventory</td>
</tr>
<tr>
<td>Fear of compassion</td>
</tr>
<tr>
<td>Social safeness</td>
</tr>
<tr>
<td>Functions of self-criticism: self-persecution</td>
</tr>
<tr>
<td>Functions of self-criticism: self-correction</td>
</tr>
</tbody>
</table>

Notes. Results are generated using data with LOCF.

*p < .05; **p < .01; ***p < .001.
psychopathology. Fears of self-compassion ($\beta = .42, p < .001$) and self-persecution ($\beta = .38, p < .001$) made significant unique contributions to the change in BSI over the course of treatment.

**Discussion**

The primary aim of this study was to explore the effectiveness of a CFT group intervention with a transdiagnostic sample. Significantly greater reductions in levels of psychopathology were found for the CFT group as compared to those receiving TAU. It is noteworthy that a large effect size was found for changes in psychopathology for the CFT group. It is important to consider the impact of the intensity of the CFT group on the large effect size. Furthermore, these reductions in psychopathology were shown to be maintained at 2-month follow-up. These findings support and extend previous research exploring the effectiveness of CFT and, in particular, CFT group interventions with transdiagnostic samples. Several authors have noted improvements in mental health associated with CFT groups (e.g., Braehler et al., 2013; Gale et al., 2014; Lucre & Corten, 2013). More recently research had shown CFT groups were useful interventions for transdiagnostic samples (Heriot-Maitland et al., 2014; Judge et al., 2012). This study has extended the previous research by including a comparison group who were receiving TAU. To the best of our knowledge this is the first study to show that a CFT group intervention with a transdiagnostic sample is associated with significantly greater improvements in psychopathology than TAU.

Our findings also indicated significantly greater improvements in fears of self-compassion, and social safeness, for the CFT group as compared to those receiving TAU. Similar findings have been reported for previous CFT group interventions (e.g., Gilbert & Procter, 2006; McEwan, P. & Gilbert, K. unpublished data, as cited in Leaiviss & Uttley, 2015). The current study adds to the CFT literature by replicating these findings.

The findings show there were no significant differences in shame, self-persecution, and self-correction between the groups at time two. However, there was significant improvement on the measures of shame and self-correction for the CFT group from pre- to post-intervention. These changes were not seen in those receiving TAU. Furthermore, there was a trend towards improvement in self-persecution post-group and a significant improvement by 2-month follow-up for the CFT group.

This study also explored potential relationships between the improvements in psychopathology and the proposed processes of change. Results showed that reductions in self-criticism, shame, and fears of self-compassion were significantly correlated with

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<th></th>
<th>$M$ (SD)</th>
<th>$r$</th>
<th>$B$</th>
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<tbody>
<tr>
<td>Fear of self-compassion</td>
<td>9.02 (12.44)</td>
<td>.57***</td>
<td>.42***</td>
</tr>
<tr>
<td>Social safeness</td>
<td>-4.90 (7.63)</td>
<td>-.34**</td>
<td>-.02</td>
</tr>
<tr>
<td>Other as shamer</td>
<td>4.69 (10.54)</td>
<td>-.47***</td>
<td>.08</td>
</tr>
<tr>
<td>Functions of self-criticism: Self-persecution</td>
<td>1.40 (6.04)</td>
<td>.51***</td>
<td>.38***</td>
</tr>
<tr>
<td>Functions of self-criticism: Self-correction</td>
<td>2.22 (7.68)</td>
<td>.30***</td>
<td>-.11</td>
</tr>
</tbody>
</table>

*Notes. Results are generated using data with LOCF.*

*p < .05; **p < .01; ***p < .001.*
improvements in psychopathology. Increased levels of social safeness were significantly correlated with improvements in psychopathology. Furthermore, a regression analysis showed that the reductions in self-criticism, in relation to self-persecution and in fears of self-compassion, significantly predicted the improvements in psychopathology. This important finding provides additional support for the process of change proposed by Gilbert’s model (Gilbert, 2010).

**Implications**

This study has added to the emerging literature that has examined the effectiveness of CFT for a transdiagnostic population. CFT was developed to target self-criticism and shame, both of which can contribute to a broad range of mental health difficulties (Gilbert, 2010). This provided the rationale for delivering the treatment to transdiagnostic groups. The majority of previous studies on CFT had examined its effectiveness with diagnosis-specific populations (Ashworth, Gracey, & Gilbert, 2011; Gale et al., 2014; Lucre & Corten, 2013; Mayhew & Gilbert, 2008). Establishing the effectiveness of CFT for transdiagnostic groups allows clients with more complex or multiple difficulties to be included because the treatment is not guided by symptoms alone. Instead, underlying core psychological constructs (i.e., shame and self-criticism) are the focus of the treatment.

This study has contributed to the literature by exploring potential processes for change in CFT and has identified some factors worthy of further research, namely self-persecution and fears of self-compassion. Research on processes of change is important as it tests the proposed therapeutic models and can facilitate treatment development. CFT interventions focus on reducing shame and self-criticism by developing key attributes of compassion through learning and practising specific skills, as outlined above (Gilbert, 2009). The evidence presented here indicates not only that CFT targets difficulties for which it was designed, but also that changes in these areas are associated with improvements in mental health difficulties.

The observed increase in social safeness and its negative correlation with psychopathology has implications for clinical practice. The results tentatively indicate that group CFT generates an experience of safeness with other people, and that this safeness is related to a reduction in psychopathology. This finding may suggest that in line with theory, individuals in the CFT group were able to activate their evolved soothing/connection systems and that doing so facilitated the reduction of perceived threat (Gilbert, 2009). Additional research is required to test this possibility.

While self-persecution had not significantly improved at the post-CFT assessment, it had significantly improved by the 2-month follow-up. Previous research has highlighted that self-persecution may be difficult to change, perhaps due to its perceived link with an individual’s identity (Gilbert, 2010). Our findings indicate that improvements in self-persecution may occur more slowly than improvements in self-correction, social safeness, fears of self-compassion, and shame. Interested clinicians should consider the need for allowing sufficient time for change in self-persecution to occur when planning CFT interventions, as improvements in self-persecution significantly predicted the improvements in mental health difficulties.

**Limitations**

Some limitations of the study should be noted when interpreting these findings. Firstly, for ethical and clinical reasons, a randomized design was not possible in the treatment setting.
The study design included a treatment as usual group to allow for comparison, which has been identified as the preferred design when randomization is not possible (Schulz, Altman, & Moher, 2010). The study also used one-way ANCOVAs to control for pre-condition scores, as randomization was not suitable. The design, also, did not allow for all booster sessions to be included. Follow-up studies should aim to capture the impact of the entire intervention.

The use of a control group has been shown to be a suitable design in assessing the effectiveness of interventions (Craig et al., 2009). The non-significant effect of TAU supports the hypothesis that the relatively positive findings may be due to engagement in CFT, rather than regression to the mean, maturation, or natural history effects. These findings are noteworthy given the majority of previous research in the area of CFT has not used a comparison or control group.

Secondly, the response rate at 2-month follow-up was low (i.e., 57% of those who completed post-intervention). This limits the conclusions that can be drawn about the maintenance of the treatment gains. However, there were no differences between those who completed the follow-up and those who did not on any of the post-intervention measures, which reduces the likelihood that only those who benefitted most from CFT continued to complete the follow-up. Additionally, the choice of time frame for the follow-up measurement was influenced by other demands on the research team and a longer period of time to follow-up would have been preferable. Notably, the high attrition rate at follow-up was primarily due to external factors, such as distance from the hospital. As referenced the hospital is a national service, and many clients encounter practical difficulties with attending follow-up groups after they have been discharged.

A third limitation is that the sample size ($n = 58$) available for the regression analysis provided sufficient power to detect large effect sizes only. The findings from the regression, that changes in self-criticism and fears of compassion predicted improvements in psychopathology, should be interpreted cautiously and require replication in a larger sample.

An additional limitation relates to the analyses of the processes of change. Although the regression analysis indicates that the residualized changes in the processes predicted changes in symptoms, the analysis cannot establish if changes in processes preceded the symptom changes. Future research is required to determine the temporal precedence of the relationship between changes in the processes and symptoms.

Finally, using the GSI score as the only measure of psychopathology within this transdiagnostic population may not have been optimal. The GSI is a composite score that is calculated from a respondent’s score on nine separate subscales of the BSI. On reflection, the choice of a composite score may not have been sufficient to represent the difficulties experienced by the study participants.

**Future research**

The current study indicates some potential areas for future research on CFT group interventions. The findings have suggested some potential processes for change within CFT group interventions, namely self-persecution and fears of self-compassion. Future research using designs that allow processes of change to be robustly examined is recommended (Kazdin, 2007). This would contribute to both the development of the intervention and allow the theoretical model underlying CFT to be tested. The current study also highlights that CFT group interventions can be beneficial for transdiagnostic...
populations. These findings require replication in a larger sample and with longer periods to follow-up.

**Conclusion**

Our findings showed group CFT was more effective in reducing psychopathology than TAU. Importantly, the improvements in psychopathology were predicted by improvements in self-criticism and fears of self-compassion, as proposed in the treatment model (see Gilbert, 2010). Additionally, this study highlights that a focus on underlying core psychological constructs, as opposed to symptoms, can be a valuable framework for effective intervention in mental health services.

**References**


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