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# A multi-method evaluation of a compassion-focused cognitive behavioural psychotherapy group for people who self-harm

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## Abstract

**Objective:** This paper describes the content and multi-method evaluation of a compassion-focused cognitive behavioural psychotherapy (CBT) group for people who self-harm/injure.

**Method:** Quantitative questionnaires and a qualitative focus group were used for the three participants. Reflective diary contents were analysed.

**Results:** Descriptive statistics were used to analyse the questionnaires. These demonstrated positive reductions in the GAD-7 and PHQ-9 scores but no significant change in self-compassion scores. The Cognitions of Self-Injurious Behaviour Scale demonstrated some positive belief changes. Participants reported improved self-awareness, alternative coping and improved emotional regulation. All participants reported anger, anxiety and sadness in their diaries; one reported self-hatred, and another reported feeling dead and numb. Distraction was considered a useful strategy to avoid or delay self-harm. Interpretative Phenomenological Analysis (IPA) was used and identified six superordinate themes: 'The secret's out! Openness & Honesty', 'Care without fear: calm acceptance', 'Skills not Spills', 'We're all in it together', 'Compassion, not competition nor comparison' and 'Fear of flying solo'.

**Conclusion:** Despite the small number of participants, the combination of compassion-focused therapy and CBT appears to hold future promise for further research on effectiveness.

KEYWORDS
cognitive behavioural therapy (CBT), compassion focused therapy (CFT), interpretive phenomenological analysis (IPA), multi-method evaluation, non suicidal self-injury (NSSI), psychotherapy group, self-harm

## 1 | INTRODUCTION AND CLINICAL SIGNIFICANCE

Self-harm is a way of coping with life for many people, but for some people, this can also be linked to increased suicide risk and mental health issues (Hawton et al., 2000). Indeed, this is considered a major public health concern in the UK and globally (Perry et al., 2012). Whilst some people may not wish to change their self-harm, other people are keen to access psychological services. Regular access to psychotherapy groups for people who self-harm can improve

well-being and reduce contact with other health services such as wound care in GP surgeries, mental health services or assessment for hospital admission.

In England, Improving Access to Psychological Therapies (IAPT) services cater well for people with mild-to-moderate anxiety and depression and services such as the Early Detection and Intervention Team (EDIT) cater for people who have psychotic experiences (Clark, 2018). People who have a formal severe and enduring mental health issue can be referred to secondary mental health services. However, people who self-harm are often excluded from IAPT services due to self-harm, but often do not have severe and enduring mental health issues and thus find themselves between services. It is for this reason that lecturers and cognitive behavioural psychotherapy students at a UK university offered help to this group of people. This project was created and led by the first author and a team of academic staff working with students on an MSc in Cognitive Behavioural Psychotherapy. The students and staff were co-facilitators of the psychotherapy group, co-researchers and authors of this paper and conference presentations. The research project was funded by a local Clinical Commissioning Group Innovation Award, through a competitive bidding process.

The NICE guidelines (2011) for the long-term management of self-harm have recommended that people have access to psychotherapy groups for between 3 and 12 sessions. There is plenty of international psychotherapeutic interest in self-harm but, to date, single modalities of therapy are demonstrating limited effectiveness. Cognitive behavioural therapy-based (CBT) group work for young people has demonstrated some hope in the UK (Wood et al., 2001) but with little successful replication yet either within the UK or in other countries. In their systematic review of non-suicidal self-injury, Turner et al. (2014) concluded that structure and collaboration were the most effective components of treatment, but did not identify a clear front runner in psychological interventions. Many of the participants in Turner's review had a diagnosis of borderline personality disorder (emotionally unstable personality disorder), whereas one participant in the present study had a diagnosis of borderline personality disorder and the other two had been diagnosed with anxiety.

Within this paper, we have chosen to use the term 'self-harm' to describe the physical cutting of the body, as experienced by all the participants. The participants chose this term even though they initially referred to this as 'it'. Eventually, they used the term self-harm; they preferred this to self-injury. In the wider literature, however, cutting can be defined as self-injury or non-suicidal self-injury (NSSI) (Rayner & Warne, 2016).

Other psychotherapy groups have also not included interpersonal processes associated with self-harm. Rayner and Warne's (2016) cycle of shame was discussed in the group, and consideration was given to how other people's reactions may exacerbate self-harm and become a maintenance cycle, keeping the person stuck. Compassion-focused therapy integrated with cognitive behavioural psychotherapy has also not been evaluated before with this client group.

**Implications for practice**

- Increasing self-compassion could help people who self-harm.
- Honesty and acceptance are essential, demonstrated firstly by others and then enhancing personal ability to do this towards themselves.
- Skills-based work is useful for focusing on increasing compassion and recognising blocks to compassion.

**Implications for policy**

- Results may take time, so formal measures may not demonstrate change until the interventions have been widely practised.
- Staff need training and supervision focusing on compassion, acceptance, validation and the therapeutic core conditions when working with people who self-harm.
- Group work can be helpful to reduce shame and increase self-acceptance.

### 1.1 | Psychotherapy group intervention

The intervention evaluated was the provision of a 12-session psychotherapy group for people who self-harm (aged 16 and older). The psychotherapy group was an integration of compassion-focused therapy (CFT) (Gilbert, 2010) and cognitive behavioural therapy (CBT) (Sutton, 2004). As part of a CBT approach, participants' maintenance cycles, cognitions, emotions and behaviours were explored and conceptualised through the use of formulation and functional analysis. CFT (incorporating mindfulness) was used to increase self-compassion and assist with other ways of being in the world and coping with self-harm. The psychotherapy group was originally designed and psychotherapeutically supervised by the project lead and the first author of this paper. Please see Table 1 for details of session contents.

## 2 | OBJECTIVE

The aim of this study was to explore the impact of a psychotherapy group for people who self-harm.

The objectives were:

1. To measure any changes in emotional well-being and self-compassion.

2. To explore further detail on urges or episodes of self-harm.

3. To provide a detailed exploration of the experiences of the participants of the psychotherapy group.

See Table 2 for inclusion and exclusion criteria.

**TABLE 1** Group content

| *Session* | *Group content* |
|---|---|
| 1 | Welcome, group rules, aims and content |
| 2 | Compassion and definitions of self-harm |
| 3 | Soothing rhythm breathing and mindfulness. Compassionate soothe boxes and coping strategies |
| 4 | CFT physiology of our tricky brains |
| 5 | Why do people SH? What helps or makes this worse? |
| 6 | Thoughts and SH, compassionate thinking |
| 7 | How do other people react to SH? How does this help or make us worse? |
| 8 | Fears and blocks to compassion |
| 9 | Compassionate choice visit content (Animal therapy) |
| 10 | Problem-solving, compassionate letter writing and sharing compassionate soothe boxes |
| 11 | Assertiveness and plan endings—How to keep compassionately safe? |
| 12 | Focus group—Evaluations<br>Revisit aims of the group—Were these achieved? Goodbyes and endings. |
| 13 | Staggered ending follow-up session 1: mindfulness practice and review of what is working. Sharing of helpful coping. What's worked |
| 14 | Staggered ending follow-up session 2: mindfulness practice and review of what is working. Sharing of helpful coping. What's worked |
| 15 | (3 month follow-up) Review of how everyone is, focus group and questionnaires |

**TABLE 2** Inclusion and exclusion criteria

| **Inclusion criteria** |
|---|
| People aged 16+ who repetitively self-harmed (more than 3 times in the last year) |
| People who had capacity to consent |
| People who were in community settings and discharged from hospital |
| **Exclusion criteria** |
| People who did not self-harm or have self-harmed less than three times in the last year |
| People who could not give informed consent |
| People who were on a section of the mental health act |
| People who were admitted on acute mental health or medical wards |

## 3 | METHOD

Recruitment for the psychotherapy group was initially carried out by the local liaison psychiatry team in the accident unit following the presentation for cutting. After this, the following organisations were targeted: universities and further education colleges; mental health charities; and then other charities in the local area.

Although a long recruitment process took place (six months), only five people attended the assessment interviews and only three were suitable for the group; all were women aged between 21 and 28 years. One man required one-to-one therapy and was referred to another provider, and another woman could not attend the group on that specific day of the week. Participants had a full private risk assessment completed by the psychotherapists prior to and during the group as required if any suicidal thoughts were evident.

The facilitators of the group discussed the nature of the therapy with the participants and provided information about the research study at assessment, and then again during the first session. It was made clear that the research participation was not compulsory, and they could attend the group even if they did not wish to be included in the research. All participants agreed to take part in the group and the research process. University and NHS ethics approval was attained prior to commencing the study.

A pilot multi-method evaluation study was created (Morse, 2003). This included the use of the following methods:

1. Questionnaires using repeated measures in the first and final sessions (Week 12), then at 3-month follow-up.
2. A reflective diary during the group.
3. Qualitative focus groups at Week 12 and at 3-month follow-up.

### 3.1 | Quantitative questionnaires

Four questionnaires were used: the Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001), the General Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006), the Self-Compassion Scale (SCS; Neff, 2003) and the Cognitions of Self-Injurious Behaviour Scale (Siddaway et al., 2019). This helped us to measure any changes in cognitions and whether these were associated with self-injury or suicide.

### 3.2 | Reflective diary

A reflective diary was created based on CBT principles. Participants were invited to report pre- and post-incidents of self-harm, rating severity, function, method, effect and contact with services.

### 3.3 | Qualitative focus group

Two one-hour focus groups (Krueger & Casey, 2009) were facilitated at Week 12, and three months later. In this paper, we have included the analysis of the first focus group only, due to restricted word count. The data were thematically analysed (Clarke & Braun, 2014). The questions were co-designed with participants of the group and focused broadly on:

1. What were the effects of the group?
2. Did anything change as a result of this?

## 4 | RESULTS

### 4.1 | Questionnaires

Descriptive statistics were used for the results of the questionnaires as participant numbers were too low for statistical analysis. Please see Figure 1 for a summary.

At Week 12, participant 1 showed a reduction in the GAD-7 and the SCS, but not the PHQ-9. Participant 2 had a reduction in the SCS only, and Participant 3 showed a lower post-intervention score on the GAD-7 and PHQ-9, but not the SCS.

At 3-month follow-up, scores on the SCS improved slightly, but this was not statistically significant. When these questionnaires were completed, the participants were still struggling with blocks to compassion as they did not think they deserved this.

The mean group scores were then considered pre-intervention, post-intervention and at 3-month follow-up (FU). The GAD-7 pre-intervention mean score was 9.6, post-intervention was 11.6, and FU was 7 (a reduction in the pre-to-FU score of −2.6.) The PHQ-9 pre-intervention mean score was 14, post-intervention was 14.6, and 3-month FU score was 8 (a reduction in the pre-to-FU score of −6). There was some evidence of increasing anxiety and depression at 12 weeks (approaching the end of the intervention). The group needed to be evaluated before the final session as the session dates had to be changed. At this point, the participants were just starting to consider the ending of the group and this may explain the increased scores. For the Self-Compassion Scale, there was a very slight increase in the pre-to-FU score of 0.3, but this was not statistically significant and would be recognised as remaining the same. The SCS pre-intervention score was 40, the post-intervention score was 37.6, and the FU score was 40.3. The dip at post-intervention was interesting as the participants reported in the focus group a heightened awareness of how their self-harm caused more negative consequences than they had realised. It may have been that this slightly increased their self-criticism and thus reduced self-compassion at this time. At FU, this had risen to a mean of 0.3 above the pre-intervention score.

There were some strong changes in participants' thoughts in relation to self-harm by the end of the group, as documented by the Cognitions of Self-injurious Behaviour Scale (Siddaway et al., 2019). Participants reported a strong reduction in agreement with self-harm helping them escape negative emotions, problems, deserving to suffer, not being able to cope without self-harm, and people not understanding it. These were positive changes. Please see Table 3 for more detail on the items that all participants agreed did not change and also those which changed for all participants, or two of three. Other statements changed for one person only (with a small reduction in agreement), so these have not been reported upon in the table due to low numbers and level of change.

### 4.2 | Diary contents

The diaries were collected at three months and were analysed using descriptive methods and thematic analysis. Participants completed the diary for one incident each, so all contents submitted were used for the analysis. Unfortunately, this was something the participants did not continue to complete. Please see Table 4 for the summary of main themes.

All participants reported anger, anxiety and sadness; one reported self-hatred and feeling dead and numb. All participants reported wanting to run away/escape, two reported feeling alone and one reported feeling useless, small and unable to breathe. Two people reported not cutting, and the third person reported cutting. For the participants, urges lasted from 3-4 hrs to 3 days.

In terms of what was reported to help participants, distraction was reported to have helped. Specific activities included the following: cleaning, TV, crafts and paper cutting. Talking to others helped two people; one person would think comforting things that her friends may say (self-talk).

In terms of what made the self-harm worse, alcohol made it worse for two people (one who recognised alcohol and the other to whom alcohol was given as an antecedent). Also focusing on self-harm or planning made it worse for two people, as did being alone.

### 4.3 | Qualitative focus group

Although in the questionnaires there was little change in self-compassion at 12 weeks, the participants reported in the focus group that they had experienced increased self-compassion. All three participants consented to take part in the focus group, and rather than using pseudonyms, they chose to be named as colours (purple, pink and blue), which is how they referred to themselves throughout the focus group. This had a dual benefit of anonymising the data at a very early stage, including within the voice recording. Three is a small sample but is deemed to be

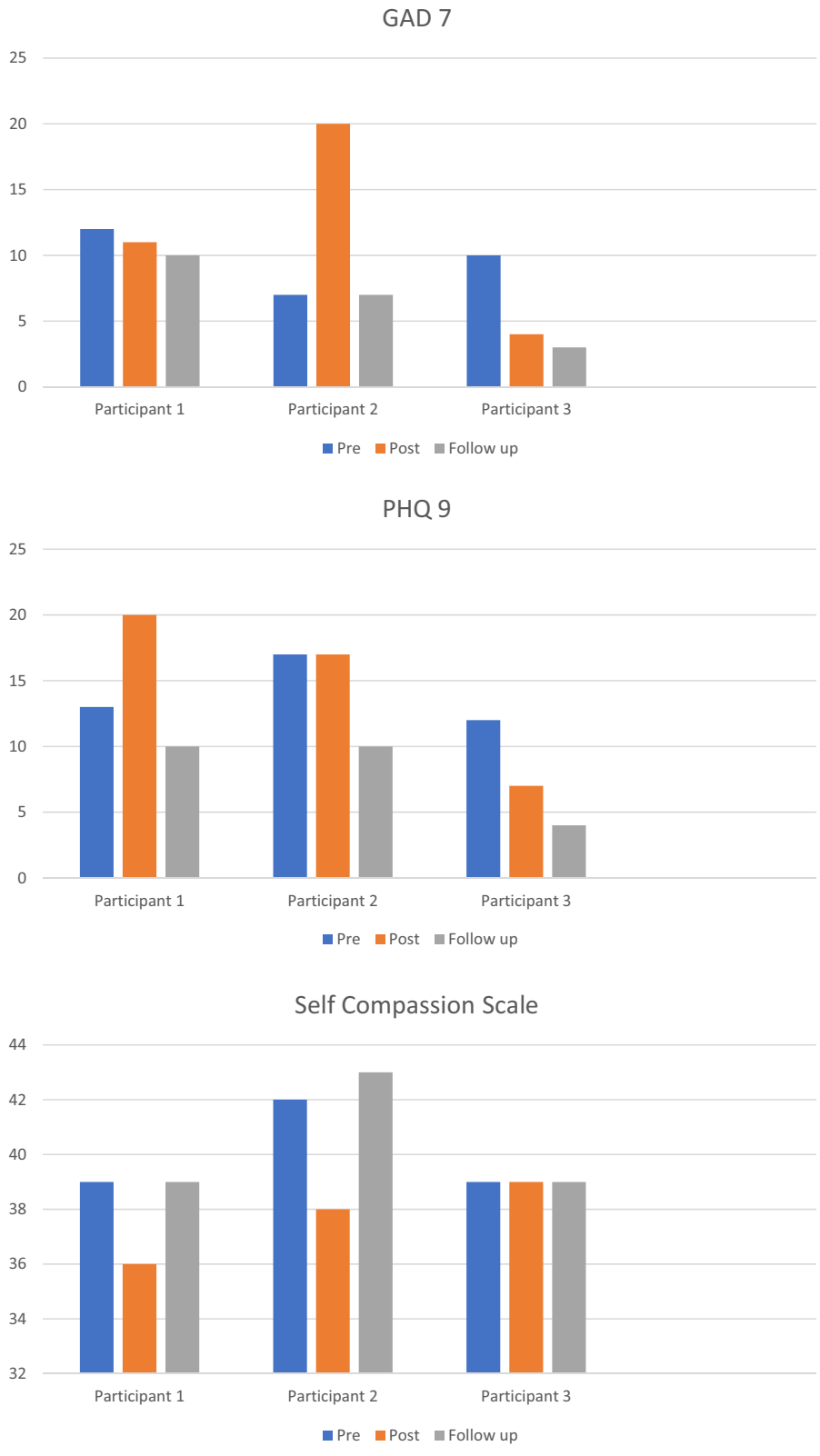


**FIGURE 1** Questionnaire scores pre- and post-intervention and at follow-up (3 months)

acceptable for an interpretative phenomenological analysis (IPA) study, which aims to achieve an 'in-depth' understanding of participants' experiences (Smith et al., 2009). Open-ended questions were asked, starting with '*tell me about your experience of the group*', which aimed to create a natural flow of conversation and to facilitate discussion about their lived experience of the group therapy. The research was conducted in the same room, with the same configuration of seating as the therapy group, thus allowing the three women to feel at ease and connect readily to their experience of the group.

**TABLE 3** Non-Suicidal Self-Injury scale questionnaire results

| |
|---|
| This was analysed using the specific questions. |
| Questions remaining the same for **all participants** were as follows: |
| Q28 **Non-suicidal self-injury (NSSI) is a way to intentionally upset people**. All participants strongly disagreed. This demonstrated their NSSI was not intended to upset others. |
| Q29 **NSSI makes people sorry for the way they treated me**. All strongly agreed, so there was a perceived consequence to others of possible guilt. |
| Q32 **My NSSI persuades other people to change their mind**. All strongly agreed, so there was a perceived possible way of getting other people to change their minds. This would make sense as all participants in the group spoke about often self-injuring in private and did not seek affects or reactions in other people. However, they seemed to perceive a change in mind and emotional reaction in others. |
| Items which saw a reduction in agreement (all or 2 of 3 participants) were as follows: |
| Q1 **NSSI helps me escape negative emotions**. There was a reduction in agreement for two people. There was a strong reduction here; this could possibly connect to more learning and recognition of their cycles of self-injury and shame. |
| Q4 **NSSI helps me escape from my problems**. There was a reduction in agreement here and an increase in disagreement for all. Therefore, there was an increased awareness that self-injury did not help them escape from their problems. |
| Q5 **I use NSSI because I deserve to suffer**. There was a reduction in agreement for two of three participants. This may be due to the challenging of thoughts around 'I'm to blame, I need to suffer' that was promoted in the group. |
| Q12 **I cannot cope without NSSI**. There was a reduction in agreement and a good improvement here as all participants disagreed with the statement or neither agreed nor disagreed at 3-month FU. So, there was more confidence that they could cope without NSSI. |
| Q36 **People do not understand my self-injury**. Two people changed from severe to mild agreement. This possibly connected to the group discussions and feedback in the focus group that this was the first time other people seemed to have understood self-injury. Comments were made during the group that the group provided a safe space to discuss with people who did demonstrate an understanding and non-judgemental outlook. It may have helped to change their opinion of people 'as a whole' to 'some people' don't understand. Mild agreement might support the idea that they feel still some people lack understanding, but the group changed their opinion that nobody understands. |
| Items which saw an increase in agreement for all participants were as follows: |
| Q19 **NSSI creates a lot of problems for me**. An increase in agreement with this statement was found for all participants, indicating an increased understanding of how they were more aware of problems caused by NSSI. |
| The other statements changed for one person only (a small reduction in agreement), so these have not been reported upon here. |

## 5 | RESULTS/FINDINGS

The focus group discussion was approximately one hour in length and was transcribed verbatim. This was read and re-read before being interpreted by two researchers (and co-authors of this paper) following the guidelines in Smith et al. (2009). IPA allows the perspective, attitudes and beliefs to remain at the centre of the analysis (Shaw, 2001).

Six superordinate themes were identified: 'The secret's out! Openness & Honesty'; 'Care without fear: calm acceptance'; 'Skills not Spills'; 'We're all in it together [acceptance]'; 'Compassion, not competition nor comparison'; and 'Fear of flying solo'. These are considered individually using direct quotes from the participants.

### 5.1 | The secret's out! Openness & Honesty

The women were unanimous in their belief that their experience had led to a mutual understanding of each other and a shared understanding of the therapy. Blue believed that this contributed to the subsequent openness within their conversations, which were non-judgemental and felt safe and secure:

> *Everybody is open and just say anything, you know they are not going to judge you because they are in the same boat and everybody is just understanding, basically, you can just sort of say anything and you feel a little bit safer.*
>
> [Blue]

Initially, there had been a reluctance to use the words 'self-harm', but the development of the safety and alliance between the group members elicited a freedom to talk and to share; as their active 'self-harm' was accepted, there was no secrecy. Purple said that talking about self-harm *'takes the power away'* from the words and thus made it smaller and more manageable. However, the value seemed to be that they appreciated other group members' explanations, which resonated with their own, as can be seen in the words of Pink, below:

> *I think there has been a couple of times when someone else has said something and it's just really made everything really, really clear…you know that they understand your experience and there has been a lot of times, I have been unable to vocalise or even explain at all what sort of feeling or something, and then someone else will say something and then it will just completely explain exactly what I am thinking… so I don't have to fully explain things, because you really understand it.*
>
> [Pink]

Hence, they could concentrate on the therapy within a culture of openness and honesty where they could admit that they were struggling and gain support from each other.

### 5.2 | Care without fear: calm acceptance

The women reported that it was a refreshing experience to be able to use the phrase 'self-harm' without creating fear in the worker or therapist, which had been their previous experiences:

**TABLE 4** Summary of diary contents submitted (one incident each)

| Questions in Diary | Participant 1 | Participant 2 | Participant 3 |
|---|---|---|---|
| What happened before? | Interpersonal incident | Interpersonal incident | Interpersonal incident |
| What emotions did I feel? | Anger, sadness and anxiety | Anger, anxiety and sadness | Anxiety, sadness and panic |
| What did I think? | I need to stop my head from spinning, I'm alone, I want to escape | I've messed everything up I'm a failure, I feel dead and numb,<br>I hate myself, I want to run away, I'm useless/feel small and can't breathe | I need to calm down, I'm alone,<br>I want to run away, my head's spinning |
| What did I do? | Cut | Used distraction techniques - didn't cut | Used crafting to distract and kept busy. Didn't cut |
| How long did the urge last? | 3–4 hrs | 3 days | Few days |
| What helped? | Nothing | Distraction<br>Crying<br>Talking | Speaking to tutors<br>Cleaning<br>TV<br>Think comforting self-talk |
| What made it worse? | Alcohol, being alone | Rumination | Focusing on it, being alone |

> *…that was a weird experience, to have a professional that wasn't, I don't think afraid is the right word, but wasn't taken aback by the whole subject, they were just very calm and that really helped, and it was like, oh there are professionals that will actually talk about self-harm and are not scared by it, and not over react, we are just going to sit calmly and have a conversation and they do understand, and they do have the expertise to sort of help us.*
>
> [Purple]

The phrase they all used was that the therapist *'got it'*, they understood and could carry on in a calm and relaxed way as so many before them had been uneasy and risk-averse as though they did not know how to deal with it or them. The ultimate result of such encounters was that they were all afraid of telling people about their self-harm because they were not sure of what reaction would ensue; indeed, Pink described her previous workers as being 'aggressively worried', to the extent that she felt 'told off':

> *I think I have had a lot of professionals not just sort of therapists and that but teachers at schools who respond quite, aggressively worried … I almost felt like I was being told off.*
>
> [Pink]

Purple reinforced this view, but added that the therapists here were helpful because of their proactivity and frankness when they discussed self-harm:

> *I agree, it's that because when you do say self-harm I think when you have got the experience of people reacting badly to that it has sort of become this big thing and you know it's difficult to say 'oh I self-harm' …it's this massive thing that you have got to deal with on your own but then when they came in and would just say 'right, we are going to talk about, you know, reasons people self-harm' it sort of takes a lot of that power away from the word and its accepting that, it's not this massive horrible thing, it's something that a lot of people deal with and it makes it so much smaller, more manageable rather than treading on eggshells, 'oh so that behaviour thing that you do'. Actually, saying ok, self-harm what are we going to talk about today, and it was really, really helpful.*
>
> *[Purple]*

## 5.3 | Skills not spills

One of the aims of the group therapy was to assist the participants to gain skills to deal with their distress and subsequent urge to self-harm. This was a little surprising to the women, who had expected to have to talk about 'personal things' and to disclose, but found that this was not the case:

> *I thought it would be more, not intrusive, but like personal, that you would have to talk about the specifics of your experiences, whereas it hasn't been like that and previously I would have thought that would have been more helpful to sort of go through your own, but actually it's been so much better this way because there has been no pressure to, you know to spill your life to anybody or, there has been no pressure at all to do anything and that's made it easy to actually join in with the group, and like they have used the pseudo name Angela as somebody to*

*discuss rather than discussing your own experiences, and I think that has been really helpful because you don't feel as vulnerable because you are sort of objective to it and I like that fact, because I did think there would be pressure to be like 'ok, so why are you here, what have you done' whereas there has not been any of that.*

[Purple]

They mentioned several skills learned, for example, distraction, urge surfing and mindfulness, and they described the experience of learning these skills as being potentiated because of the positive group dynamics. However, Pink described two internal conversations going on at the same time. These were the needs in her to 'do the work' associated with the therapy whilst also 'tuning into herself', which was connected to the teaching of mindfulness within the therapy.

Purple described the paradox of this, since 'mindfulness' was a term that she hugely disliked and believed was misused by her previous workers. Within the focus group, there was quite a rage against 'mindfulness' being used as a '*fobbing off*' when they have been in crisis without any training on how to be mindful, as if it was an easy solution to switch off the distress and switch on the mindfulness. All three were in agreement about this, and after investing in the skills of mindfulness, related to a 'habit tracker', they understood the value of practising being mindful regularly, every day, to keep well, not as a cure-all for a crisis:

*…I get quite distracted, but the mindfulness ones I find really helpful which I did not think that I would because I had a sort of grudge against mindfulness because every time I sort of talk to a professional about my self harm they would always say 'mindfulness, you need to do some mindfulness', and there has been times where I have been sort of in crisis and in A&E and they have said 'do some mindfulness' and it was more that I felt that I was getting fobbed off, but really like, because so many different people said it to me I should have sort of thought 'well maybe this is what I need to do', but I didn't. So then when I came here and they said 'ok, were are going to do some mindfulness', I thought 'oh god no not again', but it has actually changed my view on it which I didn't think was possible at all.*

[Purple]

The therapy encouraged them to consider their feelings, to 'sit with it', not to let those feelings take them over, and this was not only a skill but an acceptance that the urge to self-harm can be acknowledged without being acted upon.

## 5.4 | We're all in it together [acceptance]

The positive impact of the group alliance was expressed by all three women as being pivotal to their recovery, but this extended to include the therapists, who were perceived as being part of their journey. Pink expressed this well:

*I have not thought about it before but it's like they share an appropriate amount that doesn't feel unprofessional, but it also feels like they're not just a therapist, they are a person. Whereas a lot of therapists, and I understand training-wise they are probably told not to share too much because that's unprofessional, but a lot of other therapists actually just keep everything completely closed and I find that really hard because I am going in saying sort of my deepest darkest secrets and it's just like well you are just sitting there nodding and I find that really hard. Whereas here it's just like we are all, we are all in it together.*

*[Pink]*

## 5.5 | Compassion, not competition nor comparison

Initially, the compassion exercises were found to be more *'difficult'*, which was *attributed* to the use of imagination:

*…we did a lot of compassion exercises as well which I find quite difficult. I am not sure why I find them difficult. I think it's just because a lot of it is to do with imagination and I get quite distracted.*

[Purple]

Nevertheless, they persevered with the exercises as the focus on the learning of skills and not on the discussion of self-harm, so they could see the value of working at it. Previous experiences of sitting with others who self-harmed and the subsequent construction of a type of competition regarding each participant's self-harm and its severity were spoken about by all three young women, who proposed that, for the group to be therapeutic, they must not focus on the self-harm, so that no comparisons are made and no competition exists. Purple suggested that it was almost as though they had to be *'bad enough'* to warrant a service, and Pink emphasised that their reasons for self-harming were not all the same, and neither were they the same, nor had the same needs. The self-harm is what connected them, not what defined them:

*I don't understand why these are linked by this one thing and now it kind of was a real, yes like eye opening of it can be different for different times and that's, but a lot of therapists don't seem to understand that …we are all going to have different experiences, but like we are all connected by this thing, we understand it but at the same time we would have all had different people's reactions. Different experiences with it having talked about it, not talked about it, things like that, and I think what the group does really well in terms of not having to talk about*

*your own personal experiences because then there is no competition thing.*

[Pink]

Equally, the smallness of this group enabled expression, as Blue had often found it difficult to express herself:

*I don't like group stuff usually, talking in front of groups… [I] just sit more quietly in the corner and not participate… a smaller group means being closer without it being too in your face…you know, you can just say anything but at the same time you don't have to.*

[Blue]

The consensus amongst the three participants, Pink, Blue and Purple, was that it was the smallness of the group that made it safe and enabled them to be open with each other, suggesting that any more than five participants would have been too much, as they needed the chance to learn about each other and to develop a relationship with each other, not just the therapist.

### 5.6 | Fear of 'flying solo'

The positive relationship that had developed between the participants also created a sense of anxiety about when the group would come to an end and they would be separated:

*I know it sounds really weird…I have not actually thought about finishing the group, because it's been like a proper little support network where its going to be really weird not coming, even though I have to be dragged up the stairs every single week; it's going to be the first Thursday and be like… even though we have got our little packs and stuff to focus on, there is no people even though we have got tutors, there is no people.*

[Blue]]

The relationship was deemed as important, and all members were experienced as therapeutic and helpful, not just the therapist:

*…like, it doesn't feel like it's a therapist or two therapists sort of looking down and teaching. It is like a group and everyone discusses what they want to discuss including the therapist and it feels like everybody is on the same level which I think is important. Like nobody, nobody comes across as like, 'I am running it so today we are going to talk about what I want to talk about', there is none of that, and it feels like the therapists as well have been quite open and it's made me more like, more comfortable opening up to them, so I think it is the relationship between everybody.*

[Pink]

This level of inclusivity, where everyone is on the same level, erodes any sense of therapist power or control and creates and environment of comfort that they did not want to lose. One participant requested a…

little check in service, little check in because it's going to stop and then it's going to like, you just find a nest and off you go, flying solo.

[Blue].

During the therapy, the participants had agreed not to speak to each other between sessions, so the end of the group therapy also meant the end of their relationship, which they were both anxious and sad about.

It was an unusual focus group because it was so overwhelmingly positive, and no amount of probing and questioning elicited any negativity from any members of the group.

## 6 | DISCUSSION

This study aimed to explore the impact of a compassion-focused and cognitive behavioural psychotherapy group for people who self-harm. As far as the authors are aware, it is the first study that has explored this combination of interventions within a non-clinical group population.

Participation in the group was an overwhelmingly positive experience for the group participants, who reported numerous benefits from their engagement with the programme. Whilst scores at Week 12 showed only modest reductions in the GAD-7 and PHQ-9 and decreases in self-compassion scores, at 3-month follow-up, there were good reductions in GAD-7 and PHQ-9, although improvements in self-compassion remained negligible. However, focus group findings showed reported increased self-compassion and a better understanding of the thoughts, emotions and behaviours associated with self-harm.

This study supports previous research findings, which found that time lapse is an intervening variable on the impact of compassion-focused treatment (Zade & Mojtabaie, 2016). This suggests, as proposed by Welford (2016), that there is an 'accumulation effect', which occurs in the practice of compassion. According to Welford, compassion-focused exercises connect with each other and time is needed before compassionate imagery can be stored in the long-term memory and be made available for subsequent use in thoughts and action. This theory seems to support participants' initial difficulties with the compassionate imagery and mindfulness exercises, which they found more valuable with further practice and perseverance.

Participants within this study openly expressed fears, blocks and resistance to compassion, which further explains results at the 12 week stage. Theorists (Gilbert, 2009, 2010; Neff, 2003a, 2003b) describe the notion of compassionate flow as having three directions: compassion from oneself to others, compassion from others to self and compassion from self to self. Whilst participants were able to express and experience compassion for others, receiving

compassion from others and, most particularly, compassion for oneself was a much more difficult concept to accept and practise. Irons and Beaumont (2017) suggest that high engagement with the threat system and self-criticism interfere with the ability to experience compassion. Given that research indicates individuals who engage in self-harm report higher levels of self-criticism than those who do not (Glassman et al., 2007; Klonsky et al., 2007), it was expected that participants may initially struggle with the exercises.

Irons and Beaumont (2017) suggest individuals can view compassion as 'weak', 'alien' or 'letting themselves off the hook'. These were certainly themes which emerged very strongly during the group sessions. Gilbert & Proctor (2006) discussed the importance of addressing the fear of compassion, suggesting that unless this is achieved, individuals can be very reluctant to give up self-criticism. Discussion that explored the difference between Gilbert's (2009) ideas of shame-based criticism versus compassionate self-correction generated open and honest discussion within the group, helping participants to explore a new understanding of self-compassion. This perhaps gave participants permission to contemplate experimenting with being kinder to themselves (Neff, 2003a), opening a door that had been previously firmly closed to compassion. At follow-up, participants were beginning to share examples of self-compassion and clearly felt more deserving of this than at the start of the group.

All of the participants were apprehensive at the start of the group, with fears that it would potentially a) increase self-harm, b) trigger competition in relation to acts of self-harm, and c) necessitate engagement in painful self-disclosure. The psychoeducational nature of the sessions, as well as the use of the proxy 'Angela', was therefore helpful as it eliminated the need for self-disclosure, thus removing potential for comparisons and competition. Gilbert (1992, 2009) highlights the role of social comparison in processing relations to, and the link between, the domains of inferior–superior and shame and self-criticism. The format of the group discouraged comparison whilst instead encouraging connection, which led to improved group relationships.

Indeed, participants reported that the relationships within the group, between participants and with the therapists, played a key role in the positive outcomes. Singh (2014) suggests a number of core competencies for effective group therapy facilitation including the fostering of universality, cohesion, mutual aid and social contact. Our participants reported that these factors played a significant role in their experience of the group and its benefits. Universality (a sense of sharing the same experiences) and cohesion (the connectedness of the group members to one another), as well as the small group size, facilitated openness and honesty by providing an environment that felt safe and secure. This allowed participants to learn from each other's experiences without feeling judged. As mutual aid (interaction in which participants help one another) developed, the group began sharing 'alternatives to self-harm' strategies, such as craft cutting demonstrations and soothe box sharing. Social contact within the group facilitated interaction with peers and therapists on an equal footing rather than a power imbalance, which was particularly valued by the group. This promoted a sense of common humanity, rather than isolation, a key component in the cultivation of compassion (Neff, 2009).

Interpersonal effectiveness of the therapists further emerged as an important factor in the focus group discussions. Participants valued the therapists' calm acceptance, understanding, non-judgement and educationally-focused facilitation of discussion, with no demand for self-disclosure. This was considered pivotal as participants had previously experienced a range of negative reactions to their disclosures of self-harm from friends and family members and during their interactions with child, adolescent and, subsequently, adult mental health services. Others (including psychotherapists) would not know how to respond and would avoid the issue or, worse, panic and overreact with 'aggressive worry'. This escalation would reinforce their beliefs that self-harm is best kept a solitary and shameful secret. Discussions within the group indicated this was the *first time* they had ever explored self-harm in a calm and relaxed setting. They particularly valued a calm physical and therapeutic space in which they were given an opportunity to understand self-harm and how it related to their own cycles of thinking, feeling and acting. This took the 'power' away from self-harm, making the topic feel smaller and more manageable.

Research exploring mental health professionals' responses to disclosures of self-harm shows they experience a range of emotions including shock, frustration, helplessness, horror, guilt, fury, betrayal, disgust and sadness (Favazza, 1989; Fleet & Mintz, 2013). Sanderson (2006) emphasises that counsellors can experience a sense of powerlessness and inadequacy, with Sexton (1999) suggesting this can lead to therapist cynicism, despair and loss of hope. Rayner and Warner (2003) suggest that professionals may in fact hold more negative attitudes towards self-harm than laypeople and propose that, within a complex exchange, professionals and those who self-harm experience parallel interpersonal processes and adopt some similar defence mechanisms (Rayner & Warne, 2016). Understanding this interplay can be beneficial in recognising important aspects of staff training and treatment planning, which are often neglected.

Results of this study further emphasise the significant role of therapist attitudes towards individuals who self-harm. Negative and judgemental attitudes are seen as unhelpful, reinforcing stigma and preventing understanding of the functions of self-harm (Nehls, 1999) and reinforcing feelings of rejection and low self-worth (Pembroke, 1994). Listening, caring and empathic understanding are considered sensitive to past experiences, supportive and hopeful (Lingren et al., 2004; Weber, 2002).

The group identified a range of functions of self-harm; they did not always self-harm in the same way or for the same reasons. Analysis of the diaries indicated self-harm was used to cope with feelings of anger, anxiety, sadness, self-hatred, feeling dead and numbness. Previous research has also identified that self-injury serves varied purposes, although an empirical review suggests the most common function is the regulation of negative affect (Klonsky, 2007). As in other research (Briere & Gil, 1998; Laye-Gindhu & Schonert-Reichl,

2005; Ross & Heath, 2002), cutting was the most common form of self-injury reported by the participants.

The findings indicate participant urges to self-harm lasted from 3-4 hrs to 3 days, indicating persistent and intense experiences, which are less commonly experienced than the more frequent fleeting thoughts of self-harm suggested in previous literature (Turner et al., 2019). Many people who self-harm spend less than a few minutes contemplating cutting before engaging in the act, meaning there is often little time between urges to contemplate alternatives (Nock & Prinstein, 2005). The present findings suggest that whilst participants had time in which to contemplate alternatives, factors such as alcohol use, planning self-harm and being alone made urges more difficult to resist.

Previous longitudinal studies found that urges to self-harm were associated with a combination of rumination and low emotion differentiation (Zaki et al., 2013). It is therefore interesting to find that exploring the forms and functions of self-harm appeared to help participants recognise the cycle of shame when using self-injury (Rayner & Warner, 2003).

Group interventions including mindfulness practice and self-soothing strategies helped participants to acknowledge and sit with acceptance of their feelings, learning that urges did not need to be acted upon. Recognising how they and others used different functions of self-injury at different times could therefore help increase emotional differentiation, which is known to be associated with emotional well-being (Kashdan et al., 2015).

As in previous studies (Klonsky & Glenn, 2008; Turner et al., 2019), participants used a range of strategies to resist urges to self-injure. Distraction, cleaning, crafting, talking to others and imagining comforting statements from others were the strategies reported to have been utilised and found to be helpful. Skills such as urge surfing and mindfulness were potentiated through the positive group dynamics. Whilst more data are needed to elucidate this, it seems participants may have listed some compassionate exercises as distraction within the diary entries, not necessarily distinguishing between 'directing attention to pleasant or neutral activities' (Hilt et al., 2012) and compassionate feelings of caring and kindness towards oneself (Neff, 2003a). Whilst both distraction (Nolen-Hoeksema, 1991) and self-compassion (Neff, 2003b) are better responses than rumination to regulate negative mood, self-compassion is likely more effective for emotional regulation as it provides a process for working through negative thoughts and emotions. In a study testing 152 undergraduates on a negative mood induction task, Odou and Brinker (2015) found that whilst both rumination and distraction equally reduced negative mood, self-compassion was better than distraction at improving positive affect. Therefore, it would be helpful in future studies to structure diary self-reporting to facilitate better distinction.

Interestingly, none of the participants reported recreational sport or exercise as a means of resisting urges to self-harm, despite evidence suggesting this is a particularly helpful method (Klonsky & Glenn, 2008). In future groups, it may be beneficial to focus more on this activity to further explore its benefits.

### 6.1 | Limitations of the study

This is the first study that has examined a combination of compassion-focused and cognitive behavioural interventions within a non-clinical group setting. There are, however, limitations requiring consideration. Recruitment was very challenging, resulting in low numbers. Whilst the group generated significant interest, some potential participants feared the group format would necessitate personal disclosure and did not join as a result. Although participants reported the small group size as a positive factor, statistical analysis of the data was limited and only descriptive analysis was possible. Future studies will require a larger number of participants to enable statistical analysis of the data. Having three participants really did limit the evaluation of the project. However, the group participants reported liking the small size of the group (with two facilitators) and they stated it helped them feel safer than they would have done in a larger group.

Looking forward, we recommend running more groups with larger numbers of participants (up to 10) to enable the use of statistical analysis for the questionnaires. Future research bids should be co-produced with people who self-injure, especially for consultation on the recruitment process and posters.

### 6.2 | Learning points

How much participants could learn and understand about other people's self-harm in a safer way before thinking about and discussing their own self-harm was only known towards the end of the group. It was also important to spend some time at the start of the group agreeing on group rules to help all members feel secure.

The participants expressed a fear of compassion and many blocks to compassion. This manifested in limited improvement in self-compassion scores at the end of the group. This indicated a need for an increaded number of sessions, possibly around 20, with more time dedicated to working on the termination of the therapy.

From the transcribed focus group, the participants had some top tips for therapists.

- The therapist and participants can usually tell when they need a break; they can also have hand gestures that they can use to indicate that they need some space.
- Don't tell people to change—tell them to be how they want to be.
- Don't finish abruptly—phase out sessions slowly.

## 7 | CONCLUSION

This research highlights the importance of interpersonal effectiveness (Blackburn et al., 2001), therapeutic core conditions (Rogers, 1986a,1986b) and adequate training and supervision (Rayner & Warner, 2003) in creating a facilitative space where discussions relating to self-harm and ideas previously considered 'hidden' and 'shameful' can be safely explored. Psychoeducation utilising case

studies reduces the need for self-disclosure, removing the potential for comparisons and competition. Calm exploration of self-harm, and psychoeducation relating to the understanding and practice of compassion and the cycle of shame has the potential to facilitate strong positive changes in the cognitions related to self-harm.

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## CONFLICT OF INTEREST

The authors have no conflict of interest.

## ETHICAL APPROVAL

University and NHS Ethics approval was granted.

## CONSENT STATEMENT

Participants formally consented to take part in the group and the research and also agreed that anonymised information could be shared and published.

## DATA AVAILABILITY STATEMENT

Data have now been deleted as stated in the ethical review.

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**Gosia Bowling** is a BABCP-accredited Cognitive Behavioural Psychotherapist and EMDR UK & Europe-accredited EMDR (Eye Movement Desensitisation and Reprocessing) Psychotherapist with over 25 years of experience of working in mental health. She is also Fellow of the Higher Education Academy, having worked as a Senior Lecturer in UK universities, leading education programmes, designing curriculums and delivering and evaluating training in counselling and psychotherapy at both undergraduate and postgraduate levels. Gosia currently works for the UK's leading trading charity, Nuffield Health, leading their Mental Health Prevention and Enhancement Service. Gosia is interested in new therapeutic developments, which integrate our understanding of mind and body, and her research interests explore the use and integration of CBT, compassion-focused therapy, self-harm, exercise and virtual reality. She was co-facilitator of the psychotherapy group and co-authored the workbook/learning resource.

**Lisa Bluff** is a Mental Health Nurse and CBT Therapist. She is passionate about Perinatal Mental Health, and after teaching at the University of Salford for 15 years, she now works as Perinatal Training and Workforce Lead for Greater Manchester Mental Health NHS Foundation Trust. She believes that we all should be a bit kinder to ourselves and other people as we are all trying our best. She was co-facilitator of the psychotherapy group and co-authored the workbook/learning resource.

**Karen Wright's** career has spanned nearly 40 years and has included a diverse range of clinical experience from cardiothoracic surgery, post-qualifying, to her last clinical post as Nurse Consultant for Personality Disorder at Ashworth High Security Hospital in Mersey Care NHS Trust. In that time, she had led and developed services, which have transformed both practice and care. Some examples of such evidence-based innovation in clinical settings include an in-service training for urgent care and mental health services across Chorley and South Ribble. This focused on responding to 'self-harm' at a time when research and resources were scarce in this area (1996), and hence, the care and treatment were poorly informed; establishing a specialised Palliative Care Unit for people in late-stage dementia in 1998, and one of the first 'Crisis Intervention Teams' in the UK in 2000. In addition to her educational leadership and clinical consultancy, Karen is a qualified Cognitive Behavioural Psychotherapist and nurse consultant for an inpatient Eating Disorder Service, ensuring that evidence-based practice is delivered and that her work is grounded in the real experience of service users, their families and their care team.

**Anneliese Ashworth-Lord** is a qualified Cognitive Behavioural Psychotherapist and currently works for the Child and Adolescent Mental Health Service (CAMHS). Anneliese's specialism within mental health is assessing and treating neurodevelopmental conditions within childhood, such as autism and ADHD. Self-injurious behaviours are often prevalent and common within her particular client group and so Anneliese has always had an interest in understanding self-harming behaviours. Anneliese works with both children and adolescents, as well as their parents and families, and so her research interests explore how a systemic approach can be integrated into direct clinical treatment. Anneliese's other areas of interest and her research publications involve understanding our minds and memory and how we learn and produce memories, and therefore, Anneliese is keen to explore new therapeutic interventions that incorporate such research and knowledge. She was co-facilitator of the psychotherapy group and co-authored the workbook/learning resource.

**Catriona Laird** is a BABCP-accredited Cognitive Behavioural Psychotherapist working with Salford Psychological Services. She has over 15 years of dedicated service with both the Glasgow and Manchester Mental Health Crisis Teams. Whilst in service with these organisations, Catriona has worked with ethnically diverse groups, enabling the development of complex systems of care. Working as a CBT Psychotherapist, Catriona has gained an intrinsic knowledge of the practice, and wider determinants of health and well-being care. This has been cultivated into a special interest in patients with complex post-traumatic stress disorder and those diagnosed with personality disorder. As for therapeutic interests, there lies a need in the integration of CBT and compassion-focused therapy as a wholistic approach to give a greater depth and wider comprehension to individuals to progress through the therapeutic process. Her work has encompassed, but is not limited to, one-to-one therapy, group work and individualised research with a special interest in understanding and helping people who self-harm. She was co-facilitator of the psychotherapy group and co-authored the workbook/learning resource.

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