Introduction

To begin, I want to be very clear that compassion-focused group psychotherapy (CFGP) is a model which is underpinned by interconnected aspects of psychotherapeutic theory and practice. This model is rooted in the evolutionary theory and practice of compassion-focused therapy, with necessary adaptations to make it accessible for people who might attract a diagnosis of personality disorder. The search for the adaptations has taken me to psychodrama, group analysis, and into therapeutic communities. I have had the good fortune to learn from, work with and train in all these models over the course of my career, and hope is that CFGP is a respectful blend.

Beginning to weave these strands together, I need to acknowledge the key influences in the development of this programme. There is a sequence to the evolution of this which I hope will offer the reader an insight into how it came to be as it is. But before that, my starting point is the patient group. Working with those at the outer reaches has been my interest and passion from the outset. This model only makes sense if we first consider those it was developed for.

The very edge of therapeutic opportunity

There are those who have suffered ruptures, absence and intrusion in their primary attachment relationships, in that those who were supposed to love and care for them couldn't or wouldn't. From Bowlby's eloquent description of the human need for attachments, these experiences can rob the child of their confidence to seek proximity, while the experience of both a safe haven and a secure base are fundamentally undermined. In other words, the child learns that calling for help is ineffective, that seeking comfort is pointless or dangerous, and that the experience of safeness cannot be found in a relational context. Therein lies the paradox for this group – often the care and support they need most, they find hardest to tolerate.

Surviving these experiences often results in complex and self-defeating patterns of relating to others which guide their style of interaction throughout life. This in turn makes accessing appropriate psychological therapy difficult. Often, the therapeutic opportunity to make new connections is not available to this group of patients. Sloman and Taylor poignantly suggest the 'early relationship therefore influences the ability to self sooth and regulate emotions later in life'.[1]

Tragically, these survival strategies and behavioural manifestations will often attract a diagnosis of personality disorder, and with it, stigma, judgement and condemnation.

> *'Personality Disorder appears to be an enduring pejorative judgement rather than a clinical diagnosis. It is proposed that the concept be abandoned.'*[2]

Lewis and Appleby made this claim over 35 years ago and this has been followed by repeated and numerous calls for change. However, despite the significant concerns about the use of the term, it remains in common use in health and social care settings as a means of describing a set of behavioural manifestations which are often not connected with their traumatic origins. The diagnosis is often used instead of thinking with, exploring and making sense of the person's difficulties.

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[1]Sloman, L., & Taylor, P. (2016). Impact of child maltreatment on attachment and social rank systems: Introducing an integrated theory. *Trauma, Violence, & Abuse*, *17*(2), 172–185. https://doi.org/10.1177/1524838015584354

[2] Lewis, G., & Appleby, L. (1988). Personality disorder: The patients psychiatrists dislike. *British Journal of Psychiatry*, *153*(1), 44–49. https://doi.org/10.1192/bjp.153.1.44

Reworking the diagnosis through an evolutionary lens

The science and practice of compassion has been deeply helpful in the reconceptualising of this group of troubled and troubling patients. A more reflective perspective on the role of inherited characteristics is essential in enriching our understanding of these patients. There is value in considering the role of epigenetic influences on gene expression[3] and the role of evolution in shaping which characteristics remain within the genome.

> *'Why do we stigmatise people if evolution is perfecting the work, scanning our needs and adjusting the responses?'*[4]

From this perspective, a range of problematic behavioural manifestations can be understood as 'complex adaptations to early adversity' which have, or at least had, an important function to regulate stress.[5] I am a huge fan of the work of Martin Brune who suggests that, given the often dangerous and unpredictable nature of the early environment, these 'adaptations' were functional. However, in the absence of new learning, these strategies remain fixed and can become incongruent and out of context in a seemingly less-hostile environment.

From this behavioural ecological perspective, which borrows from evolutionary ideas of adaptation and survival, we can begin to consider the experience of the child and the response of the child to these adverse (disordered) early environments. It is of course of note that this maltreatment can also take a psychological and less-visible form, and can manifest in an absence of care and affection rather than just the application of harm and abuse. The work of Sheridan and McLaughlin describes these two traumatising pathways, recognising both the distinctive and shared aspects of each pathway.[6] In essence, they highlight the way early life experiences shape our emotional, behavioural and relational ways of being, all of which are sustained by our maturing neurological architecture.

So let us be clear that those who we might find at the outer reaches of therapeutic opportunity are better described as having suffered attachment and relational trauma (A&RT). This is a more accurate and honest way to cluster this group of patients who truly are in need of care.

Mobilising compassion and weaving threads

It was the early learning about compassion-focused therapy (CFT) which got me thinking about how much this could help my shame-drenched patients to begin to normalise their experiences and develop an evolutionary understanding of survival strategies. CFT is an integrated and multi-modal approach that draws on evolutionary, social and developmental psychology and neuroscience, with a particular emphasis on the importance of affiliative processing to mental health and well-being. A central focus in CFT is to help people access and stimulate care-orientated motives, affiliative emotions and various competencies underpinning compassion that play important roles in threat regulation, well-being and prosocial behaviour. To put this another way, CFT focuses on the importance of cultivating reciprocal role relationships in the caring social mentality both intra- and inter-personally. This focus on motivational-level rather than symptom-level change is often part of what is missing for this group of patients.

I had become frustrated with the focus on symptoms change as a measure of success during my brief foray into CBT. I was also very aware that those with A&RT generally did not 'achieve'

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[3] Gilbert, P., & Bailey, K. G. (2014). *Genes on the Couch: Explorations in Evolutionary Psychotherapy*. Routledge.

[4] Ali, A. Y. (2015). Personality & Personality Disorders: Evolutionary Entrances and Exits. *Psychological Bulletin, 140*(5), 1303–1331.

[5] Brüne, M. (2016). Borderline Personality Disorder: Why 'fast and furious'? *Evolution, Medicine, and Public Health*, *2016*(1), 52–66. (p.61)

[6] Sheridan, M. A., & McLaughlin, K. A. (2020). Neurodevelopmental mechanisms linking ACEs with psychopathology. In *Adverse Childhood Experiences* (pp. 265–285). Elsevier. https://www.sciencedirect.com/science/article/pii/B9780128160657000136

symptomatic change without focusing on the underlying causes. Working within one of the few remaining UK residential therapeutic communities showed me that 'It goes beyond the eradication of symptoms into the area of interpersonal reconstruction'.[7] The unit seemed to be offering and supporting the residents to learn how to play and be engaged with others, to build new relationships. I also experienced how living and learning together enabled residents to slowly increase their capacity to be held in mind by each other, another missing element from their early lives.

So I began to weave this strand into the emerging model of compassion-focused group psychotherapy by offering an opportunity for reconstruction through the explicit and implicit cultivation of compassion across three interconnected flows. At the same time, I was moving the groups into a more process-driven way of working, where there is an emphasis on understanding the complex interactions between therapists and group members and the links with experiences in the past. There seemed to be something incredibly important about the authority and autonomy which the group members were being invited to develop. This seemed fundamental to the process of recovery, as they developed new ways of relating to each other.

My time working within the community also introduced me to group analysis, another place where the group is at the centre of the therapeutic process. Sigmund Foulkes (about whom we will learn more in a moment) was very clear about his wish to move away from what he perceived to be several dyadic exchanges in a group to a collective treatment process involving everyone including the therapist. He asserted that all communication should be understood in the context that the group is set, lessening the centrality of the individual group members.

Subsequent group analytic training and group psychotherapy taught me some hard lessons about the value of surrendering to the collective treatment process, where we become vulnerable and dependent on the others in the group. I recall many hours spent defending against this as a group member and then feeling the therapeutic opportunity which stemmed from relinquishing the need to go it alone. I find myself with a wry inner smile when I see this played in my groups. Someone said to me recently, '*Don't think I will ever need any of you'*... suffice to say that this sentiment lost conviction over time.

As I have delved into the group analytic model, I was intrigued to learn that both NHS therapeutic communities and group analysis emerged from the Northfield experiments in Birmingham, a city very close to my heart.[8] These were therapeutic 'experiments' with soldiers returning from the front line during the early 1940s, who we now understand were suffering with post-traumatic stress. The experiment involved psychiatrists and psychotherapists being invited to engage with and offer treatment. The story of this involved both Sigmund Foulkes and Wilfred Bion and others who were motivated to make a therapeutic offer to these soldiers, but I think that perhaps the military wanted a quick fix and so the initial projects floundered.

I have often wondered why Foukes and Bion never spoke of each other or collaborated despite what seems to have been significant overlap in their practice and ideas from their time as part of the Northfield experiments. Psychotherapeutic models are shaped by the circumstances and the life experiences of those who have developed them. This is of course not chosen. There was most certainly significant attachment and relational trauma in the narratives of those who developed these models. Foulkes escaping the devastation of his homeland and the persecution of his people. Bion's active service in the First World War earned him high commendation but no doubt brought traumatic experiences, which sat alongside the loss of his wife in childbirth. There is some talk that Bion was deeply wounded by his experience at

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[7] Behr, H., & Hearst, L. (2008). *Group-analytic Psychotherapy: A meeting of minds*. John Wiley & Sons.

[8] Harrison, T., (2000) *Bion, Rickman, Foulkes, and the Northfield Experiments*. Jessica Kingsley Publishers.

Northfield and that is why, beyond his seminal work, *Experiences in Groups*, he never returned to groupwork of any kind.

The story of these therapeutic modalities emerging from the post-war devastation in the UK and intergenerational trauma, I feel has shaped both models in particular ways. Sigmund Foulkes was influenced by Gestalt Therapy in Europe and developed the idea of the group as a matrix, a network of communications at multiple levels analogous to the neural networks of the brain. This seemed to be a great fit for me with the neuroscientific underpinning of CFT. I often sit in the group programme imagining the new neural pathways being made as the members learn to give and receive compassion. This is entirely consistent with Foulkes' ideas of a web of communication in group spaces with stretches beyond the talking, into the realms of the collective unconscious and into the spiritual joining which can happen in groups. Phase Four will illustrate the ways that we have adapted and extended the ideas from Gestalt Therapy about using chairs as a medium for psychotherapeutic change and growth.

Another central theme that joins therapeutic communities and group analytic theory is the facilitator as conductor, supporting the orchestra to play. This is particularly pertinent for this group of people whose experience of authority has invariably been toxic. I will explore this further in Phase Two, but suffice to say that this idea supports letting go of the need to be 'leading from the front'. In fact, Tom Harrison has in the title of his book about the Northfield experiments, put forward the idea of 'advancing on a different front', referencing the military roots of the work of Sigmund Foulkes, Wilfred Bion and Maxwell Jones.

Working with those who at times could barely tolerate being a room with others, let alone share something of themselves with a group, required more than a talking space. Developing therapeutic day programmes for people with a diagnosis of personality disorder who had been unable to make use of any other therapeutic interventions offered an opportunity to train in and begin to integrate action methods and sociometry. Psychodrama and play seemed to provide something much needed in the group psychotherapy space. But as we will explore later, play is often much feared and scorned by those who have not learned how, or been allowed, to play.

Jacob Moreno, like Foulkes, changed his name, left his home and moved to start his 'theatre of spontaneity' practice in the USA. Foulkes and Moreno were both of the view that the group could be the therapeutic agent for change and flourishing, a distinct move away from the more dyadic ideas that prevailed about the possibilities of group work. Within both models there was an explicit invitation for group members to project aspects of their inner world onto and into the group to enable the development of new meaning. Of course, the method was generally verbal for one and in action for the other, as Zerko Moreno reminds us, 'Don't tell me, show me'.

Moreno's interest has always been in the roles that people inhabit and the consequent impact on their basic functioning. This was underpinned by a move away from more traditional psychoanalytic thinking about pathology and symptomatology and towards a model of understanding the significance of role development as a precursor to personality development:[9]

> *'Moreno's idea is that the concept of role is, above all practical, aimed at helping people to reflect on and change the beliefs they have about themselves.'*[10]

The concept of role-taking was designed within psychodrama as a means of exploring, expanding and strengthening the more functioning aspects of self, via an explicit intentional

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[9] Moreno, J. L. (1987). *The Essential Moreno: Writings on psychodrama, group method, and spontaneity*. Springer Publishing Company. https://books.google.co.uk/books?hl=en&lr=&id=dIAJWORz1JIC&oi=fnd&pg=PR5&dq=moreno+1987&ots=NzPt3GySqx&sig=mvMvaDOLo44HN_BOgFr-W0hVtzo

[10] Blatner, A. (1991). Role dynamics: A comprehensive theory of psychology. *Journal of Group Psychotherapy, Psychodrama & Sociometry*, *44*(1), 33–40. P.34

process. Over time, I have added the explicit practice of compassion, as you will see in later chapters, to form a Compassionate Self. It is therefore congruent as a method for psychological exploration and change, particularly for those whose experience of themselves has been distorted by misattuned, absent or intrusive caregivers.

Moreno's ideas about roles fit well with Paul Gilbert's social mentality theory, which highlights the fact that all living things have certain roles and tasks to perform in life that centre around survival and reproduction.[11] Part of these tasks is to develop social roles with members of the same species. For example, many mammals compete with each other for resources, engage in sexual reproductive behaviour, build alliances, create status hierarchies and engage in caring for offspring. These motivational systems come with their own neurophysiological architectures and physiological mediators. Understanding, enacting and changing roles, multiple selves or parts has come to form the basis of the CFGP programme, based on the weaving of this way of thinking about the self.

Linked to this were Moreno's keen observations of play and spontaneity in children, which are so often lost through the process of ageing and 'maturation'. His intention was to harness this childlike spontaneity and creativity within the psychotherapeutic process. Kipper is keen to differentiate between 'spontaneity' as it is used in common parlance, which implies a level of impulsivity, and the psycho-dramatic concept of 'spontaneity', which describes the energy of action in the present moment.[12] He introduces the concept of 'spontaneity training' as a metaphor for the psychotherapeutic practice which links to Moreno's belief in the positive correlation between capacity for spontaneous and creative action and emotional well-being. This has become a bedrock of my therapeutic work as I have come to the realisation that most of my group members are deeply fearful and mistrusting of play, as we will explore later in the phases. Through action, group members are invited to begin to train their minds in compassion with the use of spontaneous creativity, supported by their fellow group members in an affiliative process of understanding and repair.

Last, but most definitely not least, we turn to Irvine Yalom; you will hear his words of wisdom resonate throughout this book.[13] Bion, Foulkes and Moreno were the architects of defined theoretical models of group psychotherapy, with all the inherent blind spots. But Irvine Yalom has been the gatherer of stories from all these and more to offer sound, helpful and practical advice in setting up and running groups. Yalom's ideas about authenticity, honesty, self-disclosure and, ultimately, compassionate courage sit as a circle of strength around the whole of compassion-focused group psychotherapy. My motivation to share honestly the stories of failure and frustration have been inspired by his work. I recall reading *Love's Executioner* and being moved to tears of connection and a deep gratitude for someone who could share their struggles with such grace.

As we move through the book, I will introduce many of the key ideas from all these theoretical models which I have borrowed and imbibed with compassionate purpose.

Storytelling and our ancestral history

To round off, I turn to stories and storytelling which is the last thread of influence I would like you to consider as we move towards the nuts and bolts of this book. If we are to consider groups and why they might be helpful, we must turn back to our ancestral roots and consider the experiences of hunter gatherer societies, who were successful through connection and cooperation. I think our ancestors got a bad reputation for brutality and a lack of sophistication,

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[11] Gilbert, P. (2005). *Compassion: Conceptualisations, research and use in psychotherapy*. Routledge.
[12] Kipper, D. A. (1986). *Psychotherapy Through Clinical Role Playing*. Brunner/Mazel.
[13] Yalom, I. D. (1995). *The Theory and Practice of Group Psychotherapy*. Basic Books (AZ).

however in the absence of moralising gods they demonstrated a highly cooperative way of being towards the whole community.[14] They co-parented children who were passed around societal groups with great freedom and mutual responsibility.[15] Paul Gilbert reminds us that this way of raising children offers the child multiple secure adults to seek proximity with, rather than relying on a flawed nuclear family ideal. Yuval Harari, in his brief history of mankind, suggests that agriculture brought a lot more hardship and a move towards competing and withholding, and he playfully suggests that the crops domesticated us and not the other way round.[16]

Our human history, regardless of race or culture, is full of the rich oral storytelling traditions, from Odysseus in Greek mythology to 'The Wife of Bath' in *The Canterbury Tales* and all the way back to our ancestors who told stories to keep the cold out and prepare their young ones for the world outside the cave. We have sat around fires jostling for space, laughing, sighing and ultimately shaping cultures and transmitting knowledge for perhaps almost as long as there have been humans. We have often created the ancestral fire in our group room, with scarfs and our imagination, to tell the untold stories of sadness and joy.

Some of us have forgotten about this fundamental aspect of our common humanity, but the inspirational work of Darcia Narvez and her concept of the Evolved Nest has connected me with how fundamental this is in our psychotherapy programmes.[17] Nature-based cultures have most definitely not forgotten that humans have evolved in cooperative bands and groups who survived based on their capacity to cooperate and work together. Darcia makes a distinction between the competitive detachment which is afflicting our society with the consequent impact on physical emotional and spiritual well-being. She suggests ways that we can develop cooperative companionship and a compassionate culture in which we are more careful about where we direct our attention. This, I believe, fits well with all the models I am weaving together: collective responsibility, compassionate courage, living and learning together, and ultimately turning back to and not away from difficulty, pain and suffering.

I have adopted some of these ideas explicitly and implicitly into the developing compassion-focused group psychotherapy programme and we will hear later about the ways that we cultivate this compassionate capacity and how this then manifests in the group experiencing themselves as a tribe with a shared language and common compassionate purpose.

In conclusion

What emerged from all the blending, weaving and mobilising was compassion-focused group psychotherapy which integrates a process-driven group psychotherapy format with more structured components to foster a sense of social safety and safeness, a secure base and safe haven between group members.[18] Dyadic and small group tasks, with careful attention to the

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[14] Smith, A., Pedersen, E. J., Forster, D. E., McCullough, M. E., & Lieberman, D. (2017). Cooperation: The roles of interpersonal value and gratitude. *Evolution and Human Behavior*, *38*(6), 695–703.

[15] Topa, W., & Narvaez, D. (2022). *Restoring the Kinship Worldview: Indigenous voices introduce 28 precepts for rebalancing life on planet earth*. North Atlantic Books. https://books.google.co.uk/books?hl=en&lr=&id=ffE3EAAAQBAJ&oi=fnd&pg=PR17&dq=darcia+narvaez+kinship+worldview&ots=vtMbiJjqJd&sig=DRLeNslQEHKeZeHJWAOaDouBxKY

[16] Harari, Y. N. (2014). Sapiens: A brief history of humankind. *Harvill Secker*. https://books.google.co.uk/books?hl=en&lr=&id=B4ARBAAAQBAJ&oi=fnd&pg=PP9&dq=sapiens+a+brief+history+of+humankind&ots=tQgtmgHsBK&sig=LUvVbPluJxS_tVYPKJQGNUsTzM

[17]Topa, W., & Narvaez, D. (2022). *Restoring the Kinship Worldview: Indigenous voices introduce 28 precepts for rebalancing life on planet earth*. North Atlantic Books. https://books.google.co.uk/books?hl=en&lr=&id=ffE3EAAAQBAJ&oi=fnd&pg=PR17&dq=darcia+narvaez+kinship+worldview&ots=vtMbiJjqJd&sig=DRLeNslQEHKeZeHJWAOaDouBxKY

[18] Kalleklev, J., & Karterud, S. (2018). A comparative study of a mentalization-based versus a psychodynamic group therapy session. *Group Analysis*, *51*(1), 44–60.

development of the capacity of group members to tolerate the shared group space, aim to foster affiliative connections and shared experiences between group members.[19]

CFGP has elements of group analytic theory and practice delivered through a medium of action methods and psychodrama. 'Action methods' describes the use of visual, tactile and role based psychological interventions which were derived from psychodrama to support perspective taking, conflict resolution and the development of new meaning to past events.

Within the psychotherapeutic process of CFGP, the issues of ruptured attachments are addressed initially through explicit teaching – training in the cultivation of compassion for the self and for others, and learning to tolerate receiving it from others. The Compassionate Mind Training (CMT) focus of this aspect of the work is to develop a safe haven within the therapy space to enable habituation to the experience of social safeness and, in time, to enable the movement to a secure base.

On a very basic level, people with A&RT often experience somatic memories of early trauma which are triggered by being in group settings. The combination of CMT practices, with movement and play-based activities, is designed to offer participants practical ways to feel safe and contained in the group space. In doing so, the programme was developed as a model to rebuild some of the functions of attachment such as 'safe-relating' as a secure base, proximity seeking and safe haven, these being primary functions of the early attachment system to enable a process of growth and development.

The cultivated capacity for compassion is then used to turn back to early traumatised attachment relationships and rebuild, change endings, and let go of painful restimulating memories and people.

[19] Bateman, A., & Fonagy, P. (2006). *Mentalization-based Treatment for Borderline Personality Disorder: A Practical Guide*. OUP Oxford.

The Guidebook for CFGP [Chapter head]

So hopefully it is now clear who this programme is for and how and why it was developed. This book is designed to be something of a guidebook for the mountain climb that has now been running for over ten years, without a break. We will start with the first contact with group members, the beginning of the programme, through all the twists and turns, to the ending and beyond.

This group programme is run within an NHS tertiary psychotherapy service in the UK, offering long term psychodynamically informed psychotherapies to people with complex emotional needs and those who may attract a diagnosis of personality disorder. Other versions of this are offered in community outpatient services, prisons and private practice.

Flowchart of the programme

Phase and chapter overview [A-head]

Compassion-focused group psychotherapy has five consecutive phases, shown above in the flowchart and explained in more detail in the table below. We split the 12-week psychoeducation phase from the 12-month exploratory phase to ensure that the group members did not end up doing 12 months of psychoeducation! In practice, the programme is 15 months long with two component parts, a 12-week Preparation and Engagement Group followed by a 12-month compassion-focused trauma group. Group members complete the PEG, Phase Three, on week 12, and start the CFTG on week 13, so there is no break between the two elements of the programme.

My intention is to create a flow in the book which replicates the flow of the five phases of the programme. The unintended consequence of this will be a variation in the lengths of the phases, with some being much longer than others. Each phase will be subdivided into chapters as needed. For example, phase 1.1, 1.2, 1.3 etc. Each section of this book will cover a single phase with the following structure:

- A brief overview of theoretical material.
- A description and explanation of the unique components of the CFGP model.
- Relevant quotations from the qualitative study.
- Case studies and material to illustrate.

- Practical examples of the way the model works in action.

The five phases of compassion-focused group psychotherapy

Programme element		**Format**	**Function**
1. Assessment and formulation process		Three individual sessions with one of the psychotherapists from group programme Opportunity for final group-based assessment session	Initial engagement with patient Establishing trust Safe haven function in the room Commencement of narrative-based formulating and sense making process Containment for the therapeutic work Commencement of psychoeducation phase of treatment
2. Waiting List Support Group Psychoeducation		Monthly one-hour drop-in sessions Facilitated by Lived Experience Practitioner (a service user who has completed the CFGP) and a psychotherapist Informal setting, amplified by the offer of tea and biscuits	For patient to feel 'held in mind' by group facilitators Offering information about programme Opportunity for connection with other patients, pre therapy Continuing development of safe haven function Exposure to an experience of being in a group setting Managing risk during pre-therapy phase of treatment Provision of a consistent containing informal space
3. Preparation and Engagement Phase Group (PEG)		12 weekly sessions Two hours in duration (no break)	Continuation of psychoeducation phase Introduction of compassionate mind training practices and rationale

Psychoeducation and Compassionate Mind Training		Slow paced, experiential, play-based group intervention Facilitated by two highly trained compassion-focused psychotherapists	Early exposure to CFGP model and the experience of compassion across the three flows Continuing development of safe haven and proximity seeking function
4. Compassion-Focused Group Psychotherapy phase (CFGP) Compassion-focused therapy		52 weekly sessions Two hours (no break) 'putting compassion to work' Facilitated by the same two highly trained compassion-focused psychotherapists	Using the capacity for compassion developed in the PEG to turn back towards early ruptured attachment relationships Using the group as a secure base to begin to explore past and present relationships Bringing compassion to shame-based trauma memories Using the group process to develop new attachment relationships Working with conflict (internal and in the group) Using the group process to explicitly and implicitly stimulate the care giving and care receiving social mentalities
5. Moving On Group Individuation		12 monthly one-hour drop-in sessions Patients not discharged if they do not attend Facilitated by Lived Experience Practitioner (a service user who has completed the CFGP) and a psychotherapist Slow-paced group that is member led	Supporting the gradual process of individuation Enabling the grieving process to be resolved Providing a platform for patients to engage in peer led support

The voices from the Group [A-head]

We will stop off on our mountain climb and take in the view, hearing from the group members who have shaped the programme with their generous and sometimes painful feedback. These words of wisdom from the group are taken from a qualitative research study that invited 11 graduates from the programme to share their experiences, and these transcripts were analysed using thematic analysis methodology. The full study is reported in Lucre *et al* (2024) and Lucre *et al* (in press).[20] The group members who contributed to this research and who gave their permission for their words to be used, will not be named and no identifying details about them will be given in this text. The words, however, are a verbatim account of their experience.

Introducing Louie, Adam, Sherelle, Dalvinder and Jane [A-head]

As we move through the five phases of the programme, the key components and practical application of the model will be illustrated with examples and case studies of group members. We will particularly focus on the journeys of five group members, their struggles and triumphs through the CFGP programme. All circumstantial material, background history and presenting issues will be based on actual events and people, but each case study is an amalgamation of multiple people, a composite character. It is important to note, however, that all the scenarios presented are factually accurate and did indeed occur in the way described.

Significant changes in the personal and historical details have been made and key information mixed up to protect the confidentiality of each of the group members whose journey in compassion will provide the foundation for this book. It is my wish that the illustrative material you read is authentic and represents the complexity, struggles and perseverance of the group members in this programme. So it may be that group members who read this book may recognise a scenario described but all the identifiable information will have been changed.

The phases will also be illustrated by case vignettes of other group members whose stories will be reported accurately with significant details changed. But first, let us turn to the characters whose psychotherapeutic journey we will be following.

Louie [B-head]

Louie is a 54-year-old man of mixed heritage, referred to psychotherapy services after many years of short-term cognitive behavioural interventions, mainly focused on managing anger. Most had been reportedly unsuccessful as it has been difficult for Louie to tolerate being challenged.

Louie grew up in a large family as one of the youngest of seven siblings, all of whom suffered with significant emotional and mental health difficulties. Both parents had significant alcohol dependency, and by the time I met Louie, his parents had both died from alcohol related illness. There was brutal, cruel and instrumental violence within the family where parents and siblings used violence indiscriminately. Louie had not managed to complete his education, having been excluded from school in the context of repeated absence and violent incidents.

He was involved with criminal gangs from a young age, but avoided prison, stating that he ‘got away with it’. Louie had been diagnosed with narcissistic and paranoid personality disorder, with

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[20] Lucre, K. (2022). Compassion Focused Group Psychotherapy for people who could attract a diagnosis of personality disorder. In *Compassion Focused Therapy: Clinical practice and applications*. Routledge/Taylor & Francis Group.

reports indicating that he presented with little or no remorse or his actions. There was a general sense of therapeutic pessimism about Louie's capacity to engage with any therapeutic work.

There was some suggestion that his previous partner had fled taking their son with her, out of concern for her safety. Although it was not clear at the time of assessment, there was some suggestion in his notes that he may have posed a risk to his intimate partners. He came to CFGP stating that this was the 'end of the road' and he had been told by his care team that it was his last chance. No pressure there then!

Adam [B-head]

Adam, a white English man, came to psychotherapy services at the age of 35 as a new referral to mental health services. At this point after an initial meeting with a psychiatrist, he was diagnosed with borderline and paranoid personality disorder.

He had been in the prison system but had never been assessed or offered any form of psychotherapy or mental health care. Despite a significant history of physical abuse, neglect and sexual trauma (at the hands of an individual known to his family), he never came to the attention of services. He was groomed over many years and sexually abused. This continued despite disclosing the abuse to his mother. This was in the context of prolonged neglect and physical abuse from his mother which teachers at school 'turned a blind eye' to. Adam had no siblings and never knew his father, and despite requests, was never given any information about him by his mother.

He had struggled significantly with addiction to substances and had been convicted of multiple offences related to possession and distribution, which had involved a number of prison sentences. The ways in which he hurt and punished himself included starving himself, pulling the hair from his beard and hitting himself, often with objects. This did not come to light until much later in his journey. Adam had been in a committed relationship in his early adulthood and had a daughter. This relationship had ended abruptly in the context of a serious incident of domestic violence. We were not aware of any of this until much later in the therapeutic work. He came to psychotherapy services perhaps quite unclear about what, if anything, could be offered or would be helpful, or even if he had the right to ask for anything.

Sherelle [B-head]

Sherelle, of mixed heritage, was referred to psychotherapy services at the age of 38 having been involved in social care and health services her entire life. Sherelle's notes indicate that she was diagnosed with dependent and borderline personality disorder in her late teenage years, but this was not communicated to her. She tells a story about her mother screaming in a courtroom holding Sherelle as a newborn baby when the family court decision was made to remove her from the care of her parents. Her early life was scattered across multiple failed foster and care home placements, separation from her siblings and sporadic contact with her parents, which generally ended in re-entry into the care system until their early alcohol-related deaths. She had two younger siblings who were placed in different homes and eventually adopted by the same family. She lost touch with them after this.

Sherelle's young life was characterised by repeated experiences of intrusion and abuse. Her parents were both neglectful, intrusive and abusive, at times coming to the care homes to try to forcibly remove her, often resulting in violent exchanges with the home staff, Sherelle and her

parents. Sherelle started her therapy journey with a fixed belief that she and her parents had been wronged by the system and that they had always had her best interests at heart.

Sherelle's adult life followed a similar pattern, with many violent and controlling partners, and five children who were all taken into the care system, which she has fought tirelessly. She has had many admissions to inpatient services following impulsive overdoses and taking herself to a local car park where she considered jumping. All these events have been connected with significant decisions made in relation to her children. Two of her children are in the care of her ex-partner's family, despite her disclosure of domestic violence and abuse in the relationship.

Dalvinder [B-head]

Dalvinder, of Pakistani heritage, came to the psychotherapy service at age 28, in the midst of a conflict and rupture with their mental health care team, whom they perceived had been withholding care. This had led to a complaint which had taken many months to resolve, which had further delayed their access to an assessment and subsequent treatment. This experience seems to be a mirror of Dalvinder's early life, which had involved being a carer for their mother without any recourse to support (formal or informal). In their early life, their own needs had been subjugated and feelings of anger or injustice were not permitted. They spoke of constantly being reminded of how much their mother was suffering and that they ought not to complain. This suppression also included Dalvinder's gender identity, as non-binary, which was also denied and evoked disgust and anger from within their community. Dalvinder's father had been authoritarian and harsh, abdicating all responsibility for the care of his wife to Dalvinder before leaving the family in dire financial straits.

The sexual abuse they suffered from a school support teacher created further fragmentation with the approach-avoidance conflict, with this teacher being one of the first people to take an interest in and provide support for Dalvinder.

Dalvinder had struggled with intimate relationships and seemed to be unsure of their sexual orientation. Within their social network, it seemed that they were either pulled into a caring role or in a battle to be cared for by friends. Their broader social network evolved around campaigning for change in the community, but this seemed generally unsatisfying to Dalvinder. Often Dalvinder was caught in a battle with services and external agencies to ensure that services met their needs, perhaps replacing friendships and partners with care coordinators and support workers.

Dalvinder had been given a diagnosis of borderline personality disorder but they did not agree and had raised a formal complaint and demanded a second opinion.

Jane [B-head]

Sixty-year-old Jane, a retired white English woman who lived alone for all of her adult life, was referred to psychotherapy services following the completion of 12 sessions of CBT to treat depression. Jane was diagnosed with a depressive disorder, but this did not take into account the significant early trauma that marred her childhood. Her early life had been characterised by heavily critical and physically harmful parents who had insisted on her admission to inpatient services at the age of 14 years, where she remained on and off until the age of 17. It was difficult to establish the reasons for the long admission beyond an impulsive overdose at the age of 14 years.

Jane had one young sister who she had felt was the favourite. She had been heavily involved in caring for her sister, with a wish to protect her from the overly punitive and harsh treatment she had received. Jane's sister Joanne went on to have healthy, stable relationships, and she married and had children. Conversely, Jane has avoided intimate relationships and close friendships of any kind throughout her life. The understandable threads of resentment that she carried did not emerge until later in the therapeutic work.

Despite graduating from her medical training with honours, she was never able to sustain work as a doctor and sought part-time work in a local library. Jane struggled with binge-eating difficulties and found it almost impossible to throw anything away, to the point where only one room in her home was accessible (we didn't know this about Jane until much later in the group process).

I will remind the reader of the details of each character prior to their first appearance in the text.

The use and importance of language [A-head]

Although I will be introducing you to the idea of therapists as 'conductors' of the group, I will use the term 'facilitator' to describe the therapists who run the group. During the assessment phase, they are referred to as 'therapists'.

I will refer to our group members as either 'patients' or 'group members' depending on which phase they are in within the psychotherapy programme. The use of word 'patient' is important as this links to the original meaning of the term from the Latin, meaning 'one who suffers'. Recent studies involving patients have also indicated a preference for this term which is understood and familiar, over 'client or service user'.[21] This resonates with the model of compassion-focused group psychotherapy, supporting a process whereby those who suffer can be supported to turn back to and not away from suffering, and find healing and growth.

Once in group, patients become 'group members', with the inferred collective responsibility that accompanies this term. They move from being singular often isolated and alone, to becoming part of (the) group, 'family' or 'tribe'. As one group member described, 'I went from being all on my own, very much just me, to being like we were all a bunch of warriors'.

'It only worked when we all put in something it's like full group full room, it's like the group was the catalyst kind of thing but what made the substance of the work and what helped was us all being the participants in it, definitely, if we hadn't done what we done together, joined in it wouldn't have worked.'

This quote describes the importance of the group and everyone being in the room together, with a shared intention towards themselves and each other, which we will return to throughout the book.

The development of a shared language for the group programme is essential to ensure that everyone is clear about what compassion is and, more importantly, what it is not. It takes huge courage to turn back to and not away from the suffering caused by others. It is therefore equally important that we start with a shared understanding of compassion and how this underpins the

[21] Adil, J. (2010). Ancient origins of the term patient. *The Psychiatrist*, *34*(3), 117–118. https://doi.org/10.1192/pb.34.3.117b

compassion-focused group psychotherapy programme and my reason for writing this book and doing this work.

Final thought [A-head]

'Everyone wants to live on top of the mountain, but all the happiness and growth occur while you are climbing it.'

Climbing, I believe, is a lot like psychotherapy. It is during the journey towards discovery, change and growth that we learn the most about ourselves, not when we reach the summit. Often there is no summit, as the journey is lifelong. Change and compassion are not something we 'nail', tick off or complete. They are goals we commit to journeying towards for the rest of our lives. I will take you on a journey, which is inextricably linked with the science and practice of compassion. This path first invites us to turn back to, and not away from, suffering and difficulty, and to do so courageously and with strength, before moving into wise action to alleviate and prevent.

So too it is for compassion-focused group psychotherapy. Members are invited to join and support each other through the psychotherapeutic process and beyond. But as Yalom reminds us, 'If you want to choose the pleasure of growth, prepare yourself for some pain'. Group psychotherapy is not for the faint hearted, as one of our programme graduates reminds us:

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

I am constantly reminded of the immense courage and commitment required to keep turning up week after week, to tolerate the ruptures, manage the repairs, and slowly use the group to develop new attachment relationships, with compassion at their core:

> *'Compassion is not a relationship between the healer and the wounded. It's a relationship between equals. Only when we know our own darkness well can we be present with the darkness of others. Compassion becomes real when we recognize our shared humanity.'*[22]

This is certainly true for all elements of the programme. Group members are invited to join up with the facilitators and each other to co-create safeness for a space for therapeutic change and growth to be possible. The facilitators are guides on the journey, not the leaders, and will learn much about themselves in the process.

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[22] Chodron, P. (2018). *Becoming Bodhisattvas: A Guidebook for Compassionate Action*. Shambhala Publications. https://books.google.co.uk/books?hl=en&lr=&id=dQBlDwAAQBAJ&oi=fnd&pg=PT7&dq=pema+choden+buddhism&ots=zDmlD_0gVh&sig=sG5_g1LxHGX2V6jAsq5Ujz9s6Ks