# *A mixed methods evaluation of a compassion-focused therapy group intervention for people with an intellectual disability*

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ORIGINAL ARTICLE

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# A mixed methods evaluation of a compassion-focused therapy group intervention for people with an intellectual disability

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## Abstract

**Background:** This study investigated the use of a Compassion-Focused Therapy (CFT) group as a psychological intervention for a group of adults with an intellectual disability with a range of psychological issues.

**Method:** Four clients attended the group, which was facilitated by three trainee Clinical Psychologists. The group consisted of 8 weekly sessions.

**Findings:** Standardised outcome measures showed an increase in psychological well-being and self-compassion for all participants postintervention. Two participants showed an increase in psychological distress, while two participants reported decreases in this area. Scores on measures of self-criticism fell for two participants, increased for one participant and showed no change for one participant. Qualitative interviews were conducted with postgroup with all group members (clients and facilitators). Thematic analysis identified two superordinate themes relating to the accessibility of the group content, and interpersonal aspects of the group.

**Conclusion:** The results suggest that clients enjoyed and benefitted from the group. Challenges, such as lack of carer involvement, were identified, and recommendations for future CFT groups are made.

KEYWORDS

clinical psychology, intellectual disability, mental health, psychological therapy

## Accessible Summary

- Some people who find it hard to be kind to themselves can be helped by a therapy called Compassion-Focused Therapy (CFT). Some studies show that CFT might help people with an intellectual disability.
- We ran a group to see if CFT helped people with intellectual disabilities to feel better and think kinder thoughts about themselves.
- We asked people what they thought about the group. We asked them to fill in some questionnaires to see if they felt better.

- The group seemed to help people. People with intellectual disabilities and people running the group enjoyed going to it.
- CFT might be a useful treatment for people with intellectual disabilities.

## 1 | INTRODUCTION

People with intellectual disability are at increased risk of psychological difficulties and mental health conditions (Cooper et al, 2007; Cooper & Frearson, 2017) due to various interpersonal, social and environmental factors. Higher levels of insecure attachments with primary caregivers can result in difficulties in developing self-compassion (Cooper & Frearson, 2017). Experiencing stigma, exclusion and discrimination can negatively impact self-esteem, and contribute to reduced levels of social support, increasing susceptibility to anxiety and depression (Scior & Werner, 2016). Shame can contribute to social exclusion and the development of poor psychological health in people with intellectual disabilities (Marriott et al., 2020). This can affect both self-evaluation and their perception of how they are seen by others (Clapton, Williams, & Jones, 2018). These multiple factors can interact to put people with learning disabilities at greater risk of low self-esteem and subsequently poor mental health.

Compassion-Focused Therapy (CFT) was developed for individuals with mental health conditions characterised by high levels of anxiety, shame and guilt (Clapton, Williams, Griffith, et al., 2018). CFT draws on evolutionary, social and developmental psychology alongside neuroscience and Buddhist teachings. CFT can be seen as especially useful for people with intellectual disabilities, given how it can address various individual and social patterns of behaviour including seeking and receiving care, and belonging to a group (Goad, 2023). It uses various techniques to help clients manage psychological and emotional difficulties through developing self-compassion, regulating threat responses, and developing well-being and pro-social behaviour (Gilbert, 2014). Self-compassion recognises that everyday difficulties and emotions are not the fault of the individual, but a common experience and part of 'being human', and has been found to mediate the relationship between shame and self-esteem in people with intellectual disabilities (Davies et al., 2021). A group setting is more likely to reinforce this through the 'flow of compassion' (Clapton, Williams, Griffith et al., 2018), which refers to compassion towards others, compassion received from others and compassion to ourselves (Gilbert, 2014). Groups can also contribute to psychological well-being through normalising difficult thoughts and emotions and increasing social connections, although group interventions may be less effective than individual therapy (Vereenooghe & Langdon, 2013). Currently, group CFT has a more robust evidence base than individual CFT (Craig et al., 2020). Compassion is negatively associated with anxiety and neuroticism and positively linked to well-being (Hardiman et al., 2018).

CFT is less dependent on an individual's cognitive skills than traditional CBT (Ashworth et al., 2011). CFT teaches strategies to reduce anxiety and increase self-compassion and apply this in everyday life (Clapton, Williams, Griffith et al., 2018). Its adaptability across different levels of cognitive abilities and focus on self-relation and attachment (Cowles et al., 2020) may mean it is of particular benefit to people with intellectual disabilities. Clapton, Williams and Jones (2018) explore the theoretical mechanisms through which shame can lead to the development and maintenance of psychological distress in people with intellectual disabilities and discusses how shame is targeted in CFT.

There is a growing literature around using CFT with people with intellectual disabilities Cowles et al. (2020). A subsequent review of CFT with people with intellectual disabilities found that while adapted CFT can effectively reduce self-criticism and downwards social comparison, robust research protocols are lacking in the literature (Willems et al., 2022). Additional strategies for improving the accessibility of CFT for this client group have been developed (e.g., Goad, 2023; Lucre & Clapton, 2021), which assist clinicians when designing interventions.

A six-session CFT group intervention delivered to six participants found no significant change to levels of psychological distress postintervention, although self-criticism and negative social comparisons were reduced (Clapton, Williams, Griffith et al., 2018). Findings were supported by qualitative data, which showed clients receiving compassion in a group setting found it helpful in 'de-shaming' and developing self-compassion (Clapton, Williams, Griffith et al., 2018). This group has been replicated and extended with six participants attending a group run over 10 sessions (Goad & Parker, 2020) with the authors reporting improvements in mood and self-compassion following a 10-week CFT group intervention.

### 1.1 | Aims

This study aimed to evaluate a CFT group for adults with an intellectual disability who experience a lack of self-compassion. It aimed to replicate the CFT groups described by Clapton, Williams, Griffith, et al. (2018) and Goad and Parker (2020). While these two studies provide some preliminary evidence of the use of CFT within clinical learning disability services, additional studies such as the one being reported are needed to establish and expand this nascent evidence base. Therefore, the current study provides a mixed methods evaluation of a group run within national health service (NHS) clinical learning disability services.

The study aimed to answer the following questions:

Does attending the CFT group improve clients' psychological well-being?

Does attending the CFT group improve clients' self-compassion?

What are the experiences of clients and facilitators of engaging in a CFT group?

## 2 | METHOD

The study design fitted broadly into an explanatory sequential design in which quantitative data collection and analysis was first conducted and followed by qualitative data collection and analysis, which then led to the interpretation of results (Creswell & Clark, 2017). A mixed with a preexperimental design was used for the first part with pre–post data collected for a single group and then interviews conducted with two groups (group clients and facilitators). The mixed method design addressed investigated changes in psychological well-being and self-compassion through standardised outcome measures administered to a single group of clients with a learning disability attending the CFT group at two time points (pre- and postintervention). Individual, semistructured interviews were then conducted with two groups of people (clients with learning disabilities and group facilitators) to explore their experiences of the group.

The epistemological stance taken when using this mixed methods approach was that of pragmatism (Johnson & Onwuegbuzie, 2004) with this methodology expected to provide the best way of answering the research questions and aims of the study, especially given the clinical context.

This was predominantly a service evaluation and, therefore, integrated research application system was not required, but the study was registered with the local NHS Trust Research and Development Service (2019SE03) who provided ethical clearance for the research.

### 2.1 | Group participants

The CFT group consisted of four clients (three women and one man) with an intellectual disability aged 32–43 years (see Table 1 for demographic information). Three clients attended sessions with a support worker. One attended alone.

All clients had been referred to the Psychological Service for People with Learning Disabilities of an NHS Trust in the South of England. Each client was identified from the service's waiting list and their suitability for the CFT group assessed by review of their original referral as well as a telephone interview. Inclusion criteria were being over 18 years old; having an intellectual disability; willingness to participate in the group; significant psychological distress with presenting difficulties including self-criticism, shame, or low self-esteem, and having adequate communication skills to participate in group discussions. Given the nature of CFT, a specific mental health diagnosis was not required to take part in the group. Exclusion criteria were having a severe intellectual disability and presenting with additional issues that made a group intervention unsuitable (e.g., being actively psychotic, posing a risk to self or others).

### 2.2 | Process

All clients gave written informed consent to participate in the CFT group and gave written informed consent for the evaluation of the group, including completing outcome measures and participating in semistructured interviews. Participants were informed that all data would be anonymised to protect confidentiality and they were able to withdraw from the study up to 2 weeks following the interview. Capacity to consent to the intervention was obtained at each point of contact and recorded on patient clinical notes. Written informed consent was obtained from participants and easy-read information provided to support understanding, asking people throughout the process and reminding them about their right to withdraw or if they wanted a break, repeating and rephrasing information as required. Participants were reminded about the use of data at the end of the interviews.

### 2.3 | Group content

The group consisted of 8 weekly sessions of CFT. The session activities and exercises were based on Clapton, Williams, Griffith et al.'s (2018) protocol for CFT groups for people with a learning disability, but adapted to incorporate the specific interests of

**TABLE 1** Demographic data for clients.

| Pseudonym | Age | Ethnicity | Gender | Living situation | Intellectual disability diagnosis | Presenting issues |
|---|---|---|---|---|---|---|
| Julianne | 36 | White British | Female | Independent living with support staff | Mild Intellectual disability | Feeling worried and anxious. Not feeling confident in new situations |
| Luke | 43 | White British | Male | Independent living with support staff | Mild intellectual disability | Diagnosis of depression autistic spectrum disorder |
| Serenity | 36 | White British | Female | Independent living with support staff | Mild intellectual disability | Finding it difficult to get on with other people |
| Shannon | 34 | White British | Female | Family home | Mild Intellectual Disability | Difficulty with self-esteem and not feeling confident in her decisions |

participants and thus improve engagement. The last session recapped the materials presented.

Each group session followed a similar structure. Sessions started with a reminder of the purpose of the group and the group rules, followed by a discussion on how the homework went from the previous session. A breathing exercise was delivered before the main topic was presented. This was presented through audio and visual means, using slides and having the material explained by the facilitators. Similarly, group exercises and discussions were presented verbally and summarised on flipchart paper. Group topics focused on concepts and theories underlying CFT, with all emphasising the importance of compassion (see Table 2 for further details). The session ended with another breathing exercise and instructions for next week's homework.

The group was facilitated by three trainee clinical psychologists. At least two facilitators were present at each session. Weekly supervision as provided to the facilitators by a clinical psychologist in a group format. This was usually face-to-face, but occasionally occurred by telephone. One of the supervising Clinical Psychologists had completed a 2-day training workshop in CFT through the Compassionate Mind Foundation.

All four clients attended at least half of the sessions (see Table 3).

**TABLE 2** Topics covered in weekly group sessions.

| Session number and title | Key topic areas | Experiential exercises |
|---|---|---|
| 1. Welcome to the group | Introductions for group members<br>What is compassion?<br>Establish group rules | Calm breathing (soothing breathing rhythm) |
| 2. What is compassion? | Review compassion<br>Acknowledge life is hard—it is not your fault!<br>Strength and courage as key parts of compassion | Kind voice exercise<br>Calm breathing (soothing breathing rhythm) |
| 3. Our tricky brains | Compassionate thoughts versus bullying or mean thoughts<br>Understanding how our brains work<br>Old brain and new brain | Focusing compassion on others<br>Kind diary |
| 4. Self-compassion | What is self-compassion?<br>Blocks to compassion<br>Practicing our kind inner voice | Calm breathing (soothing breathing rhythm)<br>Kind inner voice<br>Kind diary |
| 5. Getting to know our brains better | Three circles theory<br>Compassionate imagery | Compassionate image exercise<br>Compassionate object exercise |
| 6. Managing threat | Recap of three circles theory<br>Perfect nurturer<br>What triggers threat system? | Visualisation of a safe place<br>Perfect nurturer |
| 7. Being brave | How compassion helps us be brave<br>Facilitators role play<br>Problem solving | Visualisation of a safe place<br>Compassionate role play |
| 8. Being kind after the group | Review of group contents<br>Designing a compassion toolkit for use after the group | Kindness commitments<br>Calm breathing (soothing breathing rhythm) |

**TABLE 3** Pattern of group attendance for participants and facilitators.

| Name | Role | Number of sessions attended | Week 1 | Week 2 | Week 3 | Week 4 | Week 5 | Week 6 | Week 7 | Week 8 |
|---|---|---|---|---|---|---|---|---|---|---|
| Julianne | Client | 8 | X | X | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Luke | Client | 6 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Serenity | Client | 5 | X | X | X | ✓ | ✓ | ✓ | ✓ | ✓ |
| Shannon | Client | 4 | ✓ | ✓ | ✓ | X | X | X | ✓ | X |
| Molly | Facilitator | 8 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Peter | Facilitator | 5 | X | X | ✓ | ✓ | ✓ | X | ✓ | ✓ |
| Wendy | Facilitator | 6 | ✓ | X | ✓ | ✓ | ✓ | ✓ | ✓ | X |

**TABLE 4** Quantitative results form clients pre and postgroup intervention.

| | Julianne | Luke | Shannon | Serenity |
|---|---|---|---|---|
| PTOS psychological well-being total pregroup | 25 | 2 | 19 | 18 |
| PTOS psychological well-being total postgroup | 31 | 9 | 24 | 23 |
| PTOS psychological distress total pregroup | 27 | 33 | 24 | 32 |
| PTOS psychological distress total postgroup | 19 | 24 | 27 | 35 |
| SCS positive subscale 'self-compassion' (self-kindness, common humanity and mindfulness) pre | 0 | 1 | 6 | 0 |
| SCS positive subscale 'self-compassion' (self-kindness, common humanity and mindfulness) post | 6 | 6 | 6 | 0 |
| SCS negative subscale 'self-criticism' (self-judgement, isolation and overidentification) pre | 24 | 0 | 16 | 24 |
| SCS negative subscale 'self-criticism' (self-judgement, isolation and overidentification) post | 17 | 5 | 9 | 24 |

Abbreviations: PTOS, Psychological Therapy Outcome Scale; SCS, Self-Compassion Scale.

## 2.4 | Measures

Two standardised outcome measures were used: the Psychological Therapy Outcome Scale-Intellectual Disabilities (PTOS-ID) and the Self-Compassion Scale Short Form (SCS-SF). The PTOS-ID and SCS were administered both preintervention and postintervention either by a trainee clinical psychologist or a qualified clinical psychologist at the participant's home. These outcome measures were also completed within 1 month of the group finishing at the follow-up appointment (Table 4).

The PTOS-ID (Vlissides et al., 2017) is designed for people with intellectual disabilities. It measures overall positive well-being and psychological distress. Higher scores on the positive well-being index indicate higher levels of well-being and vice versa on the psychological distress index.

The SCS-SF (Raes et al., 2011) measures three factors; self-kindness versus self-judgement, common humanity versus isolation and mindfulness versus overidentification. The SCS-SF has good validity in measuring Neff's (2016) definition of self-compassion and adequate internal consistency (Raes et al., 2011). Costa et al. (2015) recommend a two-factor analysis of scores, whereby the original six subscales are condensed into two subscales, that of 'self-compassion' (incorporating self-kindness, common humanity and mindfulness) and 'self-criticism' (which includes self-judgement, isolation and overidentification). Increase in scores on the positive subscale shows improvement in self-compassion. An increase in scores on the negative subscale shows a reduction in self-compassion.

## 2.5 | Interviews

Two semistructured interview schedules (for clients and facilitators) were compiled following consultation with the existing literature, clinicians working with people with intellectual disabilities and clinicians using CFT in populations with additional cognitive difficulties such as acquired brain injury. Interview questions included:

- Can you tell me a bit about your experience attending the Kind Minds Group?
- How did you find the group content?
- How did you find the group dynamics?
- How did you find the group location?
- What were the most helpful things?
- How did you find the tools that we used?

Individual interviews were conducted face-to-face with clients 4 weeks postgroup at a location of the clients choosing. Interviews with facilitators were conducted 4 months postgroup via video conference. The three group facilitators participating in the interviews were two women and one man, all of White British ethnicity and between 25 and 35 years.

Interviews were conducted by researchers who were neither involved in facilitating the group nor providing supervision for facilitators. All participants gave verbal and written consent to participate in the interviews. Interviews were recorded, transcribed verbatim and anonymised (with names being replaced with pseudonyms) before being analysed.

## 2.6 | Qualitative analysis

The data from both groups of participants (clients and facilitators) were analysed using thematic analysis (Clarke & Braun, 2014), to provide descriptive themes that were closely embedded in participants' accounts. Analysis was completed by O.H., M.B. and S.T., allowing those less familiar with qualitative data analysis to receive detailed supervision. Six stages of data analysis were

followed included familiarisation with the data, thorough and systematic coding of the data, generating initial themes, reviewing initial themes with the coded data, defining and naming themes and interpreting and reporting the themes (Clarke & Braun, 2014).

To ensure qualitative research has been carried out to a high standard, key principles have been established, which include sensitivity to context; commitment and rigour; transparency and coherence and impact and importance (Yardley, 2008). These were considered throughout the research process, and various processes were implemented to uphold these principles. They included developing a separate semistructured interview schedule (with additional prompts) for clients, conducting a bracketing interview before data collection to identify assumptions and biases and using a reflexive log throughout the research. Techniques to increase trustworthiness included more than one person conducting data coding and this being discussed within supervision groups.

## 3 | RESULTS

### 3.1 | Quantitative data

All four participants showed improvements in measures of psychological well-being on the PTOS following the group. Two participants (Julianne and Luke) also showed a small reduction in psychological distress as measured by the PTOS, while two participants showed some increase in this score.

Scores for self-compassion were measured using the SCS. Participants scores either increased (Julianne and Luke) or remained constant (Shannon and Serenity). Self-criticism scores fell for two participants (Julianne and Shannon), remained constant for Serenity and showed some increase for Luke.

Given the small numbers, it is not possible to draw any formal conclusions from this data, although participants seemed to be experiencing somewhat better psychological health and no deterioration in their mental health following the group.

### 3.2 | Qualitative data

Following primary stages of data analysis of the two groups (clients and facilitators), it became evident that combining participants' results across the groups would provide a richer understanding of the themes (through identifying points of commonality and divergence) and avoid repetition (see Table 5). This multiperspectival methodology is especially useful in enhancing the voices of people with intellectual disabilities (Larkin et al., 2019), and has been used to study phenomena such as health interventions from the perspectives of people with intellectual disabilities, professionals and family members (Voss et al., 2020).

## 4 | THEME 1: ACCESSIBILITY OF GROUP CONTENT

This superordinate theme encompasses the extent to which clients understood the theoretical underpinnings of CFT and adaptations made by facilitators to address this.

### 4.1 | Understanding the theory of CFT

Participants showed good understanding and recall regarding the theoretical aspects of CFT. Luke explained three circle theory as 'basically you tense up when you get in the red zone and it gets bigger and bigger the more worried you get the bigger it gets and you have to try and go into your soothe mode, green mode'. Serenity described drive mode as being 'like, oh I'm gonna get up and do this, and I'm gonna have a good day, I'm gonna go out and do, what I need to do'. Julianne felt the facilitators 'explained it very well'. Serenity explained her understanding of 'compassion, like helping other people and they helping you, and trying to help yourself as well'. Peter felt that the concept of compassion was well understood 'because compassion was in it every single week … I think that probably helps it to be well received and helped them to understand it'.

Facilitators felt clients benefitted directly from the theoretical knowledge, which 'helped people understand their feelings more and experiences more … I think all of them in their own way, were able to apply the theory to themselves' (Peter).

Facilitators felt that some topics were harder for clients to comprehend such as 'talking about the brain and how the old brain works, I'm not sure that landed'. Molly felt abstract topics such as a perfect nurturer were harder to grasp compared to more tangible exercises such as safe place imagery. Facilitators were sensitive to how well clients understood concepts and the importance of checking comprehension within sessions. Molly noticed this 'really varied between individuals' with some clients being 'a bit more acquiescent'.

### 4.2 | Adaptions to improve accessibility

Facilitators mentioned various strategies to help clients to engage with materials. Peter noted the three circles theory was repeated 'quite a few times' which was 'partly what helped it to go in'. Tailoring material to the individual was beneficial: 'it's useful to work individually then to check understanding and reinforce what they learnt and get kind of individually tailored to them' (Molly). Peter suggested giving concrete examples to 'illustrate some of the points that might have been missed' and that some content would have benefitted from being 'given more time' to be 'more effective'.

Clients were encouraged to practice their new skills between sessions. Serenity said she 'treated myself to some flowers' as an act of self-compassion. Luke talked about 'having a kind voice rather than

**TABLE 5** A list of superordinate and subordinate themes and who endorsed them.

| Superordinate theme | Subordinate theme | Julianne (client) | Luke (client) | Serenity (client) | Shannon (client) | Peter (facilitator) | Wendy (facilitator) | Molly (facilitator) |
|---|---|---|---|---|---|---|---|---|
| **1.** Accessibility of group content | Understanding the theory of CFT | * | * | * | * | * | * | * |
| | Adaptions to improve accessibility | | * | * | | * | * | * |
| | The importance of experiential exercises | * | * | * | * | * | * | * |
| | The usefulness of written materials and resources | * | * | * | * | * | * | * |
| **2.** Practicalities of running the group | Setting up and recruiting to the group | | | | | * | * | * |
| | Frequency and timing of group sessions | * | | | * | * | * | * |
| | Group size | * | * | * | | * | * | * |
| | Venue and location | * | * | * | | * | * | * |
| **3.** Interpersonal aspects | Negotiating group dynamics | * | * | * | * | * | * | * |
| | Relationships with clients | * | * | * | * | * | * | * |
| | Relationships with facilitators | * | * | * | | * | * | |
| | The role of supporters (staff/families) | * | | * | * | * | * | * |

Abbreviation: CFT, Compassion-Focused Therapy.

a harsh voice'. Practicing skills in different environments helped clients generalise their skills and experience the benefit of using self-compassion on their mood.

### 4.3 | The importance of experiential exercises

Experiential exercises were identified as a key part of the group by clients and facilitators, both to illustrate theoretical constructs of CFT and practice activating the soothe drive.

Most clients could recall exercises from the group and reported enjoying them. Julianne found exercises 'very helpful, especially the breathing exercises'. Serenity liked 'when we did that breathing exercise, the calm, the calm thing, the calm exercise'. Serenity described the perfect nurturer imagery task and how she had imagined the manager of her day service speaking kind words to her which 'helped to make you feel better'. Julianne said that she would 'rather have more exercises and more sheets to do them' as it gave her the opportunity to 'work things out', implying she enjoyed consolidating her knowledge through experiential tasks. Conversely, Luke found the exercises difficult to engage with and said he 'didn't really do much', preferring to talk with facilitators.

Facilitators thought using exercises was a helpful way of communicating the benefit of CFT and that spending time practicing exercises 'such as the inner kind voice exercise was especially beneficial' (Wendy). Molly described 'concrete tasks' such as asking clients to bring a soothing object from home as well-received and could be included more frequently as all participants actively engaged with this task. Peter said, 'flow exercises and giving examples and asking them for examples … worked a bit better' and 'people really engaged with the imagery'.

### 4.4 | The usefulness of written materials and resources

Clients' engagement with homework was variable. Julianne enjoyed practical homework tasks, stating 'it was really good I thought when they asked us to bring a favourite object or something; I brought pictures of my family'. Serenity felt that homework was a 'good thing' as it 'helps you erm learn things'. Shannon and Luke did not engage with homework tasks. Luke disliked homework as it 'reminded him of school'. Julianne found homework 'a bit difficult' to complete without adequate support and explained 'it was more of the reading than the, doing the work, I could do the work, I think it was the understanding what I had to do'.

Facilitators reflected on the clients' lack of engagement with homework, 'I don't know if the lack of homework being done is indicative of motivation um or not understanding it um or forgetting it simply' (Wendy). Peter wondered if positioning homework as central to the group might have improved engagement, although 'the more concrete tasks, for example, make a self-soothe box … everybody did that pretty much'.

Easy-read information and pictures/visuals were used to support group members with learning disabilities. Clients had mixed views about the handouts given in sessions, although all retained these safely for future use. Two clients found the handouts were 'too much'. Julianne used 'just the circles [handout] because I found the circles more better for me'. Luke said, 'I haven't been using the handouts or homework'. Serenity found the quantity of handouts 'just enough' and was keen to show them to the interviewer. She especially liked the written exercise 'ways to be kind' which asked clients to identify 'what the hardest thing to do and what compassionate thing to say about it'. Julianne did not feel she currently needed to consult the handouts as she is usually in the 'green circle' but felt confident she would 'use them when she needs to'. Serenity also said she would use 'just um this, this toolbox [the compassionate toolkit]' in the future. Luke said he would try 'not to go into threat mode as often' and would 'talk to people … or whoever else is around' to prevent this, but doubted he would re-refer to the written materials.

## 5 | THEME 2: INTERPERSONAL ASPECTS

### 5.1 | Negotiating group dynamics

All clients described initial challenges adjusting to a group setting. Julianne described her initial apprehension 'a bit scary at first, but then I got a bit more … easier'. While Luke said he's 'not good with groups of people that I don't know,' he became accustomed to the group setting as he 'got to know them a bit more'. Shannon reported an initial anxiety 'just for a couple of sessions and then it got alright after that … cos the people were friendly, I just felt more relaxed'.

Serenity was unable to 'talk about certain stuff' (due to an ongoing investigation) and felt this limited her ability to fully express her emotions in the group. Shannon found group communication could be difficult at times when 'people were talking over one another'. Luke felt less engaged with the group at times, stating 'no one basically paid attention to me', leaving him 'feeling a bit lonely in the group'. However, Julianne found the group helped normalise her experiences 'I think it was more easier because some people felt the same way as me', and for Serenity 'what I liked best, just like, just like meeting new people'.

Clients discussed establishing the group rules with facilitators at the beginning of the group, which Luke found 'quite fun'. Shannon recalled the group rules, 'we have an agreement, that one person talking over another person then talking'.

Facilitators reflected on this topic. Peter described how 'there was always lots of energy' in the group and clients enjoyed a 'casual chat' before the group and how they 'got into the flow of how the group would work quite well'. Wendy also observed clients 'had a laugh together' and it was 'quite bantery'.

Molly described the relationship between clients as 'encouraging to one another…understanding'. All facilitators commented on the open and accepting atmosphere of the group, and how willing clients

were to share their experiences and feelings with other members. Wendy described how the group 'allowed this um ability to self-disclose' and how this self-disclosure 'dynamically' helped the group. Peter commented how clients were 'really open and well-engaged' and how the 'anxiety about sharing' reduced as the group sessions progressed.

Molly emphasised the importance of support from the group 'I liked it the most when the group members kind of got involved, erm commented on each other's experiences and supported each other…I think particularly with compassion that experience of being in a group is a really important and really powerful way to do the therapy because you don't only experience the compassion from the therapist… you also get that from fellow group members'.

All three facilitators mentioned how one client could negatively affect group dynamics. Molly described how their 'dominant outspoken character,' 'varied quite a lot in their mood' which 'impacted' the group negatively. Peter described this client as having a 'particularly challenging … dynamic' which could be 'outright disruptive, it was fair to say, not from a malicious place or anything, but I do think that was hard for us to um manage, but I do think supervision was really helpful for that'. Wendy explained 'I think fortunately we were 3 facilitators um and as we got to know this person we were able to reflect on that person and the dynamic when we were in our supervision together so we could kind of bring a consistent response for them'.

## 5.2 | Relationships with clients

This subordinate theme included clients' views on their peer relationships, and facilitators' reflections on their relationships with clients.

All group members enjoyed the group and valued their role within it. When discussing her relationship with other clients, Serenity 'liked meeting new people' as it 'makes it more sociable'. When asked about getting on with other clients Julianne said 'I found it really easy if you know what I mean because I like talking'. Luke's relationship with other clients developed positively over time, with it initially being 'not quite good, but I got to know them a bit more'.

Molly felt clients had a more 'diverse array of um difficulties and kind of presenting problems' than in other groups she had run, as well as varying cognitive abilities. Wendy said clients varied in the amount of time and input they required from facilitators.

## 5.3 | Relationships with facilitators

This subordinate theme encompasses the clients' views on their relationship with facilitators, and facilitators' reflections on their peer relationship with the other facilitators.

Clients described the positive impact of the facilitators both within and outside the group. Julianne appreciated facilitators checking their emotional well-being at the start of the group, as well as practical assistance to 'meet me off the bus', 'getting us into the group and some tea, coffee and biscuits' and 'came over and she was helping me' with homework when her support was unavailable. Luke appreciated positive feedback from facilitators about 'being so positive and opening up to the group' and filling in his 'happy book' to acknowledge his attendance. Julianne and Luke thought the facilitators explained topics well. Luke liked 'feeding back' to facilitators and enjoyed these interactions.

Wendy felt that facilitating the group with people she knew meant 'there was an element of trust in the facilitation in kind of knowing the facilitators…doing it with people you trust, I found quite reassuring'. Peter agreed, saying 'the peer supervision certainly was really nice, being able to do it [facilitate the group] with the other trainees, that was, that was great'.

## 5.4 | The role of supporters (staff/families)

Clients received differing levels of support within the group from support workers or family members. Julianne initially came with her support worker as they 'weren't sure what it'd be like', but subsequently enjoyed attending the group independently, as she 'got to know people in there now'. Serenity attended with her support worker, which she described as 'quite nice'. Shannon was the only client to attend sessions with a family member and 'liked having her mum down there'. However, the level of support she received within sessions and outside of the group was unclear. In terms of completing tasks independently, Julianne described, 'doing it on my own because obviously, my support doesn't live with me'. Serenity said, 'I tried to do it [the homework] on my own' but would have preferred input from her support worker. Luke neither had support with him from the first session nor received any support with his homework.

Facilitators commented on staff support. Regarding staff support for one client, Peter said, 'I guess we had some mixed experiences of how available that support was…how much the family thought to be actively supporting them outside of the sessions'. There was difficulty in planning ahead due to unpredictable staff rotas and 'uncertainty about who was going to be their support worker' (Molly). Peter said, 'We had two, one or two, two members of support staff, they weren't always there in the group', and in terms of their engagement with the group he said 'if they're gonna come, I think they should be engaged, I think they shouldn't sit at the back or I think they shouldn't kind of be on their phones or they shouldn't be kind of disengaged or disinterested, I think they should be part of the group and involved'.

Staff and family support was especially important to help clients with generalising new knowledge outside of sessions 'we knew there might be instances where somebody wouldn't understand um but then hopefully the person that was attending with them can pick up on the material and maybe help them with it at home…that was a really critical kind of adaptation running this group with learning disabilities' (Molly). Peter reiterated this, saying '[staff support] never affected their engagement in the actual room cos they engaged really

well in the actual sessions. It's more their ability to understand it and how they implement things outside of the group'.

Peter suggested career engagement could be improved perhaps through offering 'an extra session for carers and family members and you give them a bit of CFT training'. Molly suggested being explicit about the role of support workers and family members as active group members 'maybe making that clearer that those were the kind of expectations from the start' would be beneficial.

## 6 | DISCUSSION

This study aimed to investigate whether a CFT group for adults with an intellectual disability could improve their psychological well-being and self-compassion. It also aimed to understand the experiences of running and attending the group from the perspectives of both the clients and facilitators.

Due to the small number of participants, it is not possible to draw conclusions from the results of standardised measures of psychological well-being and psychological distress (PTOS) or self-compassion and self-criticism (SCS). However, the results, in line with previous studies (Clapton, Williams, Griffith et al., 2018; Goad & Parker, 2020), indicate that psychological well-being improved for all clients and self-compassion either improved or remained constant, implying the group may have provided some benefit in these areas.

The qualitative interviews allowed exploration of participants' experiences of the group, in the role of both facilitator and client. Useful information was gathered about presenting theoretical material in an accessible way, and clients' ability to recall and use this material. Areas where clients' and facilitators' perspectives converged and diverged were identified. While seven is a small number of participants, given the in-depth analysis of the interviews, useful preliminary information about experiences of the intervention has been reported, and hearing directly from people with intellectual disabilities about their experience of health interventions is ethically important (Frankena et al., 2019).

Despite the concept of compassion being key to the group and identified as a central theme in previous CFT research (Lucre & Corten, 2013), it was mentioned relatively infrequently by clients. However, when prompted, clients gave concrete examples of using compassion in their everyday life, and of practicing exercises to increase compassion to self and others. This suggests that while a conceptual understanding of compassion may be lacking, clients could practice and benefit from compassion-based strategies. This discrepancy may be due to the additional barriers to psychological support for people with intellectual disabilities, in accessing support and understanding complex theoretical material. Neither clients nor facilitators explicitly mentioned shame and the 'deshaming' process highlighted in other group interventions (Clapton, Williams & Jones, 2018; Hardiman et al., 2018), or self-esteem. However, within the subtheme 'negotiating group dynamics', participants noted the accepting atmosphere within the group and how this facilitated disclosure and deshaming. Additionally, what was described as the 'energy' and 'flow' of the group fits with the concept of the flow of compassion within CFT, which can be facilitated through a group intervention with this population (Clapton, Williams, Griffith et al., 2018; Clapton, Williams & Jones, 2018).

In line with previous studies (Clapton, Williams, Griffith et al., 2018; Goad & Parker, 2020), clients could engage with and benefit from experiential exercises. These helped clients experience changes in affect and reduced demand on cognitive skills such as verbal reasoning (Clapton, Williams, Griffith et al., 2018). The importance of using tangible and multisensory strategies to stimulate compassion for people with intellectual disabilities has been highlighted within the literature (Lucre & Clapton, 2021; Rawlings et al., 2021).

Building positive relationships with facilitators and other people with intellectual disabilities was seen as important by participants, and links to an increased sense of social safeness, an important tenet of CFT (Goad, 2023). However, the lack of support for clients outside group sessions was raised by facilitators and clients. Clients described a good relationship with facilitators as key to positively experiencing the group. Engagement from support staff could be increased through clarifying the role of the supporter from the start and providing information and training around CFT pregroup. This might improve staff and family understanding of CFT and the importance of generalising skills outside of the group setting, meaning clients make additional gains from the intervention. Difficulties engaging support workers within group psychological interventions for people with intellectual disabilities, and the detrimental impact on client outcomes has been noted (e.g., Idusohan-Moizer et al., 2015).

While this paper largely replicates that of Clapton, Williams, Griffith et al. (2018) and Goad and Parker (2020), it includes qualitative interviews with group facilitators. This allowed a perspective on both the content and dynamics of the group sessions, as well as gathering information about the process of running the group such as screening for appropriate participants, and the importance of peer and clinical supervision. Including the perspectives of group facilitators in a multi-perspectival study design appears to be a novel addition within the intellectual disability literature, to the best of the authors' knowledge, and may provide a more comprehensive understanding of such interventions.

### 6.1 | Strengths and limitations

The group content was taken from Clapton, Williams, Griffith et al. (2018) protocol. Some changes were made to activities and exercises to ensure they were accessible to group members and to tailor examples to the specific interests of group members to improve engagement. No formal fidelity checks were undertaken, which would ensure the intervention has been delivered consistently and reliably. While Clapton, Williams, Griffith et al. (2018) and Clapton, Williams and Jones (2018) original protocol comprised six sessions, Goad and Parker (2020) extended the intervention to 10 sessions. Due to logistical issues (group facilitators coming to the end of their

placement), this intervention offered eight sessions. In addition, none of the supervising clinical psychologists were fully trained and accredited in CFT, although all were confident in using this approach clinically.

Using semistructured interviews allowed in-depth exploration of the experiences of those attending this group, with space for new and unexpected areas to be identified. Adapted qualitative methods can be accessible for people with intellectual disabilities (Sigstad & Garrels, 2018), and allow people with intellectual disabilities to actively participate in developing and shaping their treatment. Using multiple perspectives in qualitative research is especially well suited to increase the voice of people with intellectual disabilities, which can be missing from the literature (Larkin et al., 2019). Particular attention was paid throughout the research process to ensure the quality of the qualitative methodology. Neither member checking of the data analysis nor piloting of the interview schedules were conducted could have been helpful.

Due to the small number of clients no statistical analysis was performed on the quantitative data. A wider range of standardised measures could have provided more detailed information about the psychological processes impacted by the intervention. Groups could become overwhelmingly large when all clients are accompanied by a support worker, so running the same group materials across several groups and analysing the data (with appropriate caution) may allow adequate statistical power to be reached (Goad & Parker, 2020).

Various alternative mixed methods approaches (including methodologies such as single-case experimental design or multiple case studies) could have been employed and potentially provided more robust evidence base for the efficacy of the intervention.

Interviews with clients were conducted up to 4 weeks after the final group session. This delay may have impacted people's ability to provide detailed feedback about their experiences. However, conducting interviews immediately after the group may not have allowed clients time to incorporate CFT materials into their everyday life, and, therefore, may not have captured the benefit of the group. Previous research into novel group interventions with people with intellectual disabilities have used a longer follow-up with effects being shown up to 2 years postintervention (e.g., Hewitt et al., 2019).

## 6.2 | Implications and further research

Future research could include family members and support staff in the evaluation process (Creswell & Clark, 2017). Gaining additional perspectives on the group experience may be beneficial in several ways. It could explore the dynamics between facilitators and carers and identify barriers preventing carers fully engaging with clients and the group process. Since carer involvement is important in ensuring client engagement (Idusohan-Moizer et al., 2015) and improves intervention outcomes (Cooper & Frearson, 2017), adapting the pregroup screening process to ensure that clients receive consistent support over the group sessions may be helpful. This could include discussions with support staff and family members about their ability to regularly accompany a client to the group, and the ability to set aside time outside of the group to review materials and complete homework tasks. Additional avenues for future research could include understanding how best to support people with intellectual disability to generalise skills to everyday life. Including the perspectives of other people in the client's system may be helpful in this.

In conclusion, this paper explores the feasibility of a CFT group intervention for people with an intellectual disability. The intervention was acceptable to both clients and facilitators, although conclusions about its efficacy cannot be drawn (Clapton, Williams, Griffith, et al., 2018). Using multi-perspectival qualitative analysis provided useful feedback and could be expanded as a methodology with this population.

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## CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

## DATA AVAILABILITY STATEMENT

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

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