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Evaluating Outcomes of a Compassion Focused Therapy Group for Mothers Under the Care of a Perinatal Community Mental Health Team

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New motherhood is associated with multiple changes and role transitions. The internalization of cultural narratives that idealize motherhood may increase guilt and shame when new mothers perceive that they are failing to meet these standards. Compassion Focused Therapy (CFT) has been adapted as a model for understanding and alleviating distress during the perinatal period. This study evaluates the outcomes of an eight-session, online perinatal CFT group developed and delivered within a Perinatal Community Mental Health Team in East England. Service user feedback is analyzed to explore participants' experiences with the group. Thirty women took part in the CFT group. Three routine outcome measures were used to measure self-criticism, self-reassurance, fears of compassion, and psychological distress, pre- and post-group. Service user feedback was collected verbally and via an online questionnaire. Significant reductions in self-criticism and psychological distress and significant improvements in the

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ability to self-reassure were observed. Qualitative feedback suggested that participants found the group informative and supportive. The service evaluation results suggest that the CFT group appears to be meeting its aims of reducing self-criticism, fears of compassion, and psychological distress.

Keywords: Compassion Focused Therapy, CFT, perinatal mental health

Perinatal mental health difficulties (those occurring during pregnancy or in the first year after birth) are considered a serious public health concern, which, if left untreated, can lead to adverse outcomes for mothers, partners, and infants' well-being and development (British Psychological Society, 2016). The transformation of specialist Perinatal Mental Health Services (PMHS) across England, therefore, was identified as a key priority within the NHS Long Term Plan (NHS England, 2019) and Five Year Forward View (NHS England, 2016). Clinical psychology leadership is argued to play an important role in driving the improvement of PMHS, including increasing access to high-quality, evidence-based psychological interventions to support mothers' mental health needs and associated difficulties in the parent-infant relationship (British Psychological Society, 2019). Given the breadth and complexity of perinatal mental health presentations, national guidance advises that services should offer rapid access to a range of psychological therapies. These may include Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT), and family interventions (NICE, 2014; Royal College of Psychiatrists, 2020).

Compassion Focused Therapy (CFT)

Compassion Focused Therapy (CFT) is an increasingly popular transdiagnostic therapy adapted for treating perinatal mental health difficulties (Cree, 2010; Cree, 2015). Underpinned by attachment theory and evolutionary psychology, CFT aims to reduce shame and self-criticism and cultivate compassion (defined as "a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it"; Gilbert, 2014). Compassion is seen as a relational process that can flow in three directions: toward the self, others, and from others to ourselves. High levels of shame and self-criticism are thought to interfere with the ability to experience affiliative emotions, such

as love, calmness, safety, and affiliative ways of relating, which play important roles in attachment.

Another core component of CFT is the three systems model, whereby emotions are seen as serving three key evolutionary functions: to alert us to threats (threat system), to seek resources and rewards (drive system), and to seek safety (soothing system; Gilbert, 2014). As these systems are said to co-regulate each other, significant over- or under-activity in any one system may lead to difficulties. CFT aims to stimulate the soothing system by encouraging engagement with suffering and taking action to help alleviate this. Fears, blocks, and resistances to experiencing compassion are actively explored as part of CFT.

Since its inception in 2000, CFT has become increasingly popular as an alternative to CBT across various clinical settings. Two recent systematic reviews explored the effectiveness of CFT as a treatment for a range of mental health conditions (Craig et al., 2020; Millard et al., 2023). Results showed that most studies focused on group CFT, but there was considerable variation in the duration and intensity of treatment. While it appeared that CFT led to reduced self-criticism, symptomatology, and increased self-compassion, findings should be taken cautiously, as the quality of studies reviewed was variable. Both reviews highlight the need for longitudinal RCTs, using standardized treatment protocols and comparing CFT to alternative therapies to strengthen the evidence base for the effectiveness of CFT.

The Role of CFT in the Perinatal Period

Although motherhood is often viewed as a time of great joy, evidence suggests that many women find the transition to motherhood difficult and challenging for a variety of reasons (Cree, 2010). Various vulnerabilities may contribute to difficulties around the time of birth, including a lack of social support, hormonal changes, and traumatic birth experiences (Cree, 2015). Furthermore, mothers who feel that they have failed to live up to their view of the "ideal mother" may be more prone to experiencing guilt and shame, which may underlie a range of mental health difficulties (Gilbert, 2009; Gilbert & Irons, 2004, Liss et al., 2013;). CFT, therefore, has been adapted as a model for understanding and helping to alleviate perinatal distress (Cree, 2010).

The evidence base for perinatal CFT is in its infancy. A few studies describe brief, self-guided, compassion-based interventions trialed with

nonclinical samples (Gammer et al., 2020; Kelman et al., 2016; Lennard et al., 2020; Mitchell et al., 2017). For example, an RCT by Gammer et al. (2020) evaluated a low-intensity, compassion-based intervention with a nonclinical, volunteer sample of mothers (n=206). Participants completed an interactive, self-guided online program (Kindness for Mums Online) based on a self-help book. Compared to waitlist controls, those receiving the intervention showed a significantly greater increase in self-compassion and psychological well-being, while changes in psychopathology were not significantly different between groups. However, the study suffered a high attrition rate, with 49% of those in the intervention group not completing post-intervention measures. Furthermore, using a nonclinical sample and low-intensity intervention somewhat limits the generalisability of findings in clinical settings. Further research focusing on perinatal clinical populations is needed.

Local Context: The Perinatal CFT Group

The Perinatal Community Mental Health Team (PCMHT) was set up in 2017 as a local service in the East of England and is commissioned to assess and treat women who are experiencing (or at risk of developing) severe and complex mental health difficulties during pregnancy or up to 24 months after birth. In line with the NHS Long-Term Plan, the psychology provision has expanded to include access to a range of psychological therapies. This project evaluates outcomes from an online perinatal CFT group set up in March 2020 by Clinical Psychologists within the service.

The CFT group is transdiagnostic in nature and is designed for mothers who are experiencing high levels of self-criticism and difficulties with self-compassion, which impacts their ability to manage difficult emotions and challenges during the perinatal period. Case managers make referrals, and individuals are offered a psychological assessment to consider suitability for the group. The group consists of eight weekly, 90-minute sessions facilitated via Zoom by two Clinical Psychologists, with support from Peer Support Workers and Assistant Psychologists. Sessions are based on a workbook and involve a combination of psychoeducation, CFT exercises, and group discussions (Table 1). The group aims to help women better understand their experiences and learn skills to increase self-compassion and reduce emotional distress.

Table 1

Summary of Sessions and Exercises in the CFT Group

Number	Focus of Session	Exercises
1	Understanding our tricky brains	Notice five things Soothing rhythm breathing
2	Influences on our struggles: challenges of the perinatal period and our past experiences	Compassionate color Shark music video Safe place exercise
3	Our affect system (three circles model)	Safe, calm place with baby Drawing our three circles Your kindness to others
4	Safety strategies and unintended consequences	Leaves on a stream The compassionate self
5	Self-to-self relating and self-criticism	The perfect nurturer Three chairs exercise Bringing compassion to the self-critic
6	Applying compassion to thoughts and emotions	Mindfulness of thoughts and emotions Taking a difficult situation to the perfect nurturer
7	Compassionate letter writing	Formulation review
8	Review and reflections	Loving-kindness meditation Compassionate kit bag

Note. Percentages in brackets.

This service evaluation collects routine outcome measures and service user feedback between March 2020 and April 2023 to evaluate whether the CFT group effectively achieves its aims. This will help the PCMHT to evidence therapeutic outcomes, inform future improvements to the group, and contribute to the developing evidence base for perinatal CFT.

This study explored whether the CFT group helped reduce self-criticism, fears of compassion, and global psychological distress. It also explored which aspects of the group participants found helpful or unhelpful and participants' suggestions for improvement.

Method

This service evaluation has a mixed-methods, pre-post design. Participants were asked to complete three standardized outcome measures at the beginning and end of the CFT group. Service user feedback was collected at the end of the group. The total sample consisted of 34 women under the care of the PCMHT who were invited to attend the CFT group between March 2020 and April 2023. The group ran seven times during this period. This project evaluates outcome measures data and service user experience data, which the PCMHT routinely collects. Therefore, separate written consent was not required. Three standardized routine outcome measures were administered at the beginning and end of the CFT group. These measures aim to assess self-criticism, self-reassurance, fears of compassion, and global psychological distress.

This project was registered with the local NHS Trust Research and Development Department. Ethical approval for the service evaluation project was received from the University of East Anglia Faculty of Medicine and Health Sciences Research Ethics Committee.

Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)

The FSCRS is a widely used, 22-item self-report compassion-based measure that assesses how individuals respond to perceived failures (Gilbert et al., 2004; Millard et al., 2023). The FSCRS measures tendencies to be self-critical (considered an important factor in many forms of psychopathology) and, in contrast, the ability to be self-reassuring.

Baião et al. (2015) conducted a confirmatory factor analysis of the FSCRS, collating data from 12 studies. This provided support for a three-factor model of the FSCRS, comprising one factor of *self-reassurance* (a positive, warm view of the self, scored 0-20) and two factors of self-criticism: *inadequate self* (feeling inadequate in response to setbacks, 0-36) and *hated self* (a disgust-based response to setbacks, characterized by self-dislike, 0-32). Gilbert et al. (2004) found that the FSCRS had excellent internal consistency, with Cronbach's alphas for *inadequate self*, *hated self,* and *reassured self* of 0.9, 0.86, and 0.86, respectively. Furthermore, Castilho et al. (2015) found that the FSCRS had acceptable test-retest reliability, with Pearson's correlation coefficients for *inadequate self*, *hated self,* and *reassured self* of $r = 0.72$, $r = 0.78$, and $r = 0.65$, respectively.

Fears of Compassion Scales (FCS)

The FCS is a 28-item self-report measure (introduced during the fourth group cycle), which assesses fears of the three flows of compassion: *for self*, *to others*, and *from others* (Gilbert et al., 2011). Many individuals may find it challenging to receive compassion or practice self-compassion for various reasons, which is important to monitor as part of CFT (Gilbert et al., 2011). Indeed, a meta-analysis by Kirby et al. (2019) found that fears of compassion significantly correlated with mental health outcomes (e.g., shame, self-criticism, depression). The FCS produces three subscale scores: fears of compassion *for self* (0-60), *from others* (0-52), and *for others* (0-40). The scales showed good internal consistency, with Cronbach's alphas of 0.92, 0.85, and 0.84, respectively (Gilbert et al., 2011).

Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-34)

The CORE-34 is a 34-item, self-report transdiagnostic measure of global psychological distress (Evans et al., 2002) routinely collected by the PCMHT to monitor mental health and evaluate therapeutic interventions (Lucas, 2018). The CORE-34 provides a total score (global distress) and four subscale scores (well-being, symptoms, functioning, and risk). The CORE-34 is problem-scored, meaning higher scores indicate greater psychological distress across all subscales. Subscale scores range from 0-4, and total scores range from 0-136.

The CORE-34 has been validated with clinical populations and shown to be sensitive to change and able to differentiate between clinical and nonclinical samples (Connell et al., 2007; Evans et al., 2002). All domains of the CORE-34 show Cronbach's alpha of between 0.75 and 0.95, indicating acceptable internal consistency.

For the first four cycles of the group, participants were invited to complete an anonymous SurveyMonkey questionnaire about their experience with the CFT group. This explored the helpfulness of the sessions and areas for improvement. In subsequent groups, time was allocated during the final session for participants to give verbal feedback about their experience. This was facilitated in a reflective group discussion guided by an informal interview schedule. The group facilitators documented feedback.

G*Power was used to perform an a priori power calculation for paired samples with two-tailed t-tests. Using Cohen's d effect size, a medium effect size of 0.5 was input into the calculation, and it was determined that a sample size of 34 would be required to achieve sufficient power (0.8). Qualitative service user feedback was analyzed using qualitative content analysis (Mayring, 2021).

Results

Thirty women attended the CFT group. The mean age of women attending the group was 31 years (range = 22-41 years, SD= 4.67), and for infants, 6.5 months (range = 0-14 months, SD = 3.68). Eighty-eight percent of participants identified as White British, 9% as White Other, and 3% as Black South African. The most common psychiatric diagnosis was perinatal depression (59%), followed by Post-Traumatic Stress Disorder (PTSD), complex PTSD or birth trauma (32%), perinatal Obsessive Compulsive Disorder (OCD) (21%), Borderline Personality Disorder (BPD) or Emotionally Unstable Personality Disorder (EUPD) (21%), and eating disorders (21%). Sixty-two percent of participants had received more than one psychiatric diagnosis. Attendance data are presented in Table 2.

Table 2

Attendance at the CFT group

Group	Invited	Completed (6-8 Sessions)	Partially Completed (3-5 Sessions)	Not Completed (≥2 Sessions)
1. March – June 2020	6	6	0	0
2. November 2020 – January 2021	5	4	1	0
3. May – July 2021	5	2	3	0
4. November 2021 – January 2022	4	2	0	2
5. June – July 2022	4	3	0	1
6. November – December 2022	6	5	0	1
7. March – April 2023	4	3	1	0
All	34	25 (73)	5 (15)	4 (12)

Note. Percentages in brackets.

Routine Outcome Measures

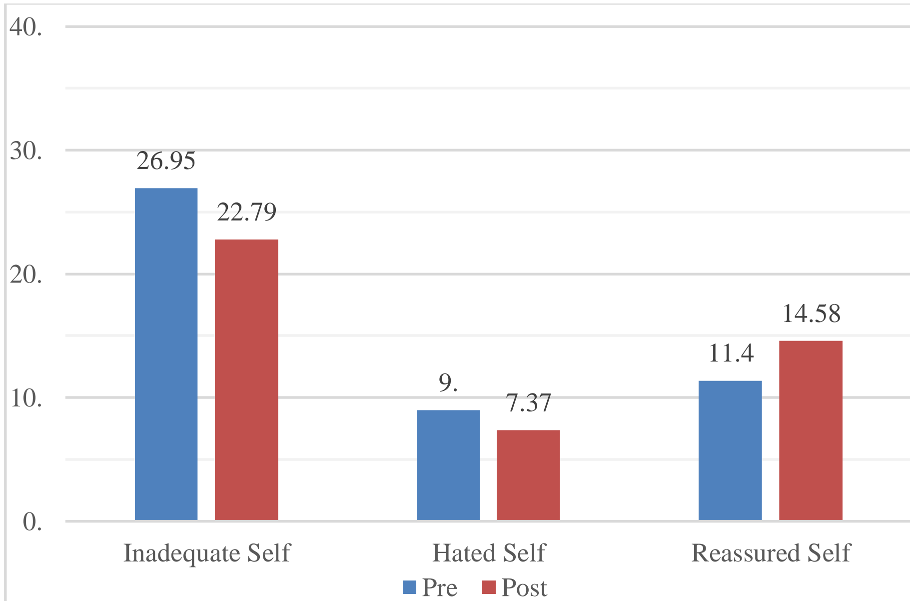
Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)

Twenty-four out of thirty women attending the CFT group completed a pre- and post-FSCRS (80% return rate). However, due to a change in the scoring procedure, three-factor subscale scores were only available for 19 people.

Mean pre- and post-group FSCRS scores are shown in Figure 1. Two-tailed, paired samples t-tests were used to compare scores (Table 3). G*Power was used to perform a post-hoc power calculation, which revealed that the power to detect a medium effect was 0.54. This falls below the recommended threshold (0.8).

Figure 1

Mean FSCRS Scores, Pre- and Post-Group



Note. Possible scores for the *inadequate self* subscale range from 0-36, *hated self*, 0-32, and *reassured self*, 0-20

Table 3

Paired Samples T-Tests Comparing Pre- and Post-FSCRS Scores

	Pre-Group Mean	Post-Group Mean	Difference	T	df	*p*	Effect Size (Cohen's d)
Inadequate Self	26.95 (6.24)	22.79 (7.76)	-4.16	3.55	18	.002	0.59
Hated Self	9 (4.90)	7.37 (5.33)	-1.63	2.03	18	.057	-
Reassured Self	11.38 (4.57)	14.58 (5.78)	+3.2	1.26	18	.004	0.61

Note. Standard deviations in parentheses.
Significant at the $p < .05$ level, with Holm correction for multiple comparisons (Wright, 1992).

The results of the t-tests showed a statistically significant reduction in *inadequate self* scores and a significant increase in *reassured self* scores from the beginning to the end of the CFT group. Effect sizes were medium (Cohen, 1988).

Fears of Compassion Scales (FCS)

The FCS was introduced as an additional outcome measure from the fourth group. Only six of a possible fourteen participants completed a pre- and post-group FCS (43% return rate). Therefore, there was insufficient power to perform inferential statistics. Descriptive statistics are presented in Table 4.

Table 4

Mean FCS scores

	Pre-Group Mean	**Post-Group Mean**	**Difference**
Fears of Compassion *For Self*	25.67 (12.91)	16.12 (15.04)	-9.5
Fears of Compassion *From Others*	21.12 (6.31)	16 (12.33)	-5.17
Fears of Compassion *For Others*	14.67 (8.69)	12.5 (8.96)	-2.17

Note. Standard deviations in parentheses. Higher scores indicate a greater fear of compassion. Possible scores for fears of compassion *for self* range from 0-60, *from others*, 0-52, and *for others,* 0-40.

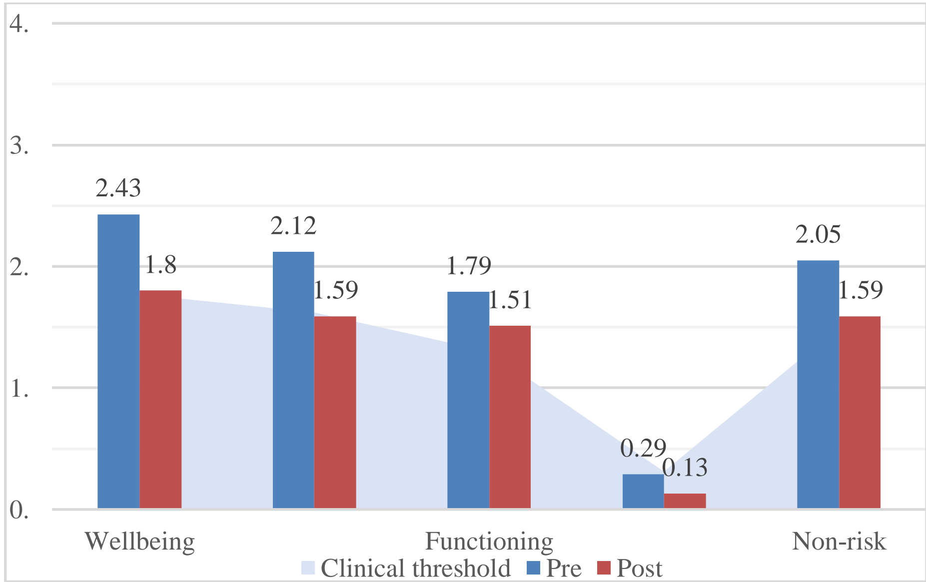
On average, participants' fear of compassion for self, from others, and for others reduced from the beginning to the end of the CFT group. The greatest reduction was in fears of compassion for self.

Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE-34)

Twenty-six out of thirty women completed a pre- and post-group CORE-34 (87% return rate). G*Power was used to perform a post-hoc power calculation for paired samples two-tailed t-tests. Results revealed that the power to detect a medium effect was 0.69, which falls below the recommended threshold.

Mean scores are presented in Figure 2. As can be seen, mean scores on the problems/symptoms and risk subscales moved from the clinical to nonclinical range post-intervention (Evans et al., 1998).

Figure 2



Note. The shaded area represents cut-off scores for differentiating clinical and nonclinical populations, as follows: well-being (1.77), problems (1.62), functioning (1.3), risk (0.31), and non-risk (1.5; Evans et al., 1998).

Two-tailed, paired samples t-tests were used to compare pre-and post-group subscale scores, which met parametric assumptions. Non-parametric data (risk subscale) were analyzed using a Wilcoxon Signed-Rank test.

Table 5

Paired Samples T-Tests Comparing CORE-34 Subscale Scores, Pre- And Post-Group

	Pre-Group Mean	Post-Group Mean	Difference	T	df	*p*	Effect size (Cohen's d)
Well-being	2.43 (0.89)	1.8 (0.88)	-0.63	3.3	25	.003*	0.72
Problems/ symptoms	2.12 (0.84)	1.59 (0.79)	-0.53	3.01	25	.005*	0.78
Functioning	1.79 (0.59)	1.51 (0.76)	-0.28	2.38	25	.025*	0.41
Non-Risk	2.05 (0.67)	1.59 (0.73)	-0.46	3.12	25	.005*	0.66
Total	59 (20.14)	45 (20.79)	-14	3.22	25	.004*	0.68

Note. *Significant at the $p < .05$ level, with Holm correction for multiple comparisons (Wright, 1992). Standard deviations in parentheses. Subscale scores range from 0-4, and total scores from 0-136. Higher scores indicate greater psychological distress.

Results from the t-tests revealed that total scores and scores on well-being, problems or symptoms, functioning, and non-risk subscales significantly reduced, post-intervention. Effect sizes ranged from small to medium (Cohen, 1988).

Table 6

Results of a Wilcoxon Signed-Rank Test Comparing Pre- and Post-Group CORE-34 Risk Scores

	Pre-Group Mean	Post-Group Mean	Change	Z	*p*
Risk	0.29 (0.44)	0.13 (0.2)	-1.6	1.64	.101

Note. Standard deviation in parentheses.
*Significant at the $p < .05$ level.
The difference in mean pre/post-group risk scores was non-significant.

Qualitative Service User Feedback

Service user feedback was analyzed to explore what participants found helpful and unhelpful about the CFT group and their suggestions for improvement. Between March 2020 and April 2023, 18 women provided feedback about their experience (eight people via SurveyMonkey and ten people verbally). In total, 77 comments were collected.

Qualitative content analysis (Mayring, 2023) was used to analyze (categorize) the text. Each comment was treated as a unit of analysis (Graneheim & Lundman, 2003). Following familiarisation with the data, a manifest analysis was felt most appropriate, given the brief, literal nature of the feedback and the service focus on identifying strengths and areas for improvement. Comments were organized according to the project question, and inductive category formation was used to develop categories directly from the material. A summary is presented below.

What Has Been Helpful About the CFT Group?

Forty comments related to helpful aspects of the group. *Understanding* ($n = 18$) was the most common category. Eight comments highlighted the value of CFT exercises (e.g., compassionate letter-writing, three chairs exercise) in facilitating greater self-awareness and important realizations. “Not being so reactive to the lack of compassion I have towards myself. The realization of how un-compassionate I can be towards myself and figuring out why I am like that.”

Six comments related to formulation and sense-making. Participants described having gained a better understanding of their feelings and experiences, which helped to reduce self-blame:

> A lot of things made so much sense because of the past trauma and bad history with my parents. Even though it happened, it wasn’t my fault. It is going to be a big journey, but it’s doable. It normalized things – feeling that you are not the only one going through it. It’s ok. You just have to be compassionate, like you would be to a friend.

Supportive ($n = 13$) was the second most common category. Participants seemed to value opportunities to connect and hear about others’ experiences. Six comments referred to shared experiences; participants described feeling

reassured and less alone. Three comments described the group as a “safe space” where people felt comfortable sharing if they wished. “I liked that a lot of us had the same fears and worries. I felt less weird that I worried my baby would die. I liked that we had [facilitator] from peer support, who had done it before.” Five comments referred to the group's accessibility. Participants commented on some advantages of remote (as opposed to face-to-face) therapy, which included being able to attend to children when needed, feeling less exposed, and not being required to travel.

What Has Been Unhelpful About the CFT Group?

Only five comments related to unhelpful aspects of the group. It was not possible to develop meaningful categories due to the brevity of the comments. However, themes included distractions during the group (e.g., the presence of babies), challenges with maintaining concentration for the session, and other factors associated with the online format, such as the requirement to have one’s camera on.

How Can the Group be Improved?

Twenty comments related to ways in which the group could be improved. *Group format* (n = 10) was the most common category. Six comments related to possible benefits of doing the group face-to-face. These included being able to meet other mothers in person, having fewer distractions, and finding it easier to contribute. Two people described a preference for smaller groups, and two said they would prefer shorter sessions due to difficulties with maintaining concentration. “I found it easier to talk in a smaller group [referencing a session when there were only two participants there].”

Information/materials (n = 8) was the second most common category. Three people suggested improving the CFT workbook (e.g., providing further support with completing individual CFT formulations). Three people said that summaries of sessions and reminder emails would be helpful. “I wasn’t sure how to fill in the formulation [agreed that an example formulation would have helped].”

The final category was *service user involvement* (n = 2). Suggestions included considering ways to inform partners about the group, having guest speakers, and providing a means for participants to remain in contact after the group had completed.

Discussion

Thirty women attended the CFT group between March 2020 and April 2023. Three routine outcome measures were collected, pre- and post-group, to assess change in self-criticism, self-reassurance, symptomatology, and fears of compassion. Qualitative service user feedback, exploring participants' experience of the group, was collected verbally and via a SurveyMonkey questionnaire.

Consistent with group aims, comparisons between pre- and post-group FSCRS scores showed that self-criticism scores (*inadequate self)* had significantly reduced and self-reassurance scores significantly increased. Reductions in symptomatology were observed across all subscales of the CORE-34, but only one of these comparisons was statistically significant, with effect sizes ranging from small to medium. Comparisons between a small number of pre-and post-group FCS scores showed that participants' mean fears of compassion scores (*for self, from others,* and *to others*) had reduced post-intervention; however, there were insufficient responses to perform any statistical analysis of FCS scores. Overall, these results provide tentative support that the CFT group effectively meets its aims of increasing self-compassion and reducing psychological distress.

Qualitative content analysis was used to analyze service user feedback. Eighteen (of thirty) women provided feedback; this was generally very positive. Participants commonly reported having gained a better understanding of their feelings and experiences during motherhood, which helped to reduce self-blame (a core aim of CFT; Gilbert, 2009). Many participants found it reassuring to hear about other mothers' experiences and realize they were not alone. This appears consistent with the aims of perinatal CFT in reducing participants' sense of shame and difference (Cree, 2010). Previous qualitative research with women with perinatal depression suggests that opportunities to connect with others authentically may help to reduce feelings of isolation and offer support and validation (Negron et al., 2013; Taylor et al., 2021).

Twenty comments were collected regarding how the CFT group could be improved. Common suggestions included increasing opportunities for social connection during the group, providing more support with aspects of the workbook (such as completing individual CFT formulations), and finding ways to involve service users and partners. Some of these suggestions have already been implemented by the group facilitators. For example, one-to-one sessions

are offered alongside the group to support completing formulations, and WhatsApp groups provide opportunities for informal contact between participants. Regarding service user and partner involvement, this is an under-researched area that requires further exploration and consultation with the PCMHT service user panel. A meta-synthesis of qualitative studies exploring partners' views of perinatal services found that although partners play a vital role in perinatal mental health, they often feel marginalized and uninformed by services, which are largely mother-baby-oriented (Taylor et al., 2017).

Currently, there is limited evidence for the effectiveness of perinatal CFT. Previous studies have sampled nonclinical populations and described brief, low-intensity interventions (Gammer et al., 2020), which limits the generalisability of findings to perinatal mental health settings. This service evaluation took place within a real-world clinical setting and uses standardized outcome measures, which are well-established within the CFT literature, increasing the replicability of the project.

Craig et al.'s (2020) systematic review of CFT intervention studies concluded that there is an urgent need for treatment standardization within CFT research (i.e., through the development of universal, standardized manuals) to strengthen the existing evidence base. This CFT group was based on a manual developed by Perinatal Clinical Psychologists within the service, drawing on the work of Michelle Cree (2010; 2015), and it may be helpful to consider how this work could be shared more widely (e.g., within perinatal clinical networks).

Regarding limitations, due to missing follow-up data and a change in the FSCRS scoring procedure, the sample size was reduced to below the required statistical power. Although statistically significant improvements were found in self-criticism, self-reassurance, and psychopathology from pre- to post-group, results should be interpreted cautiously as low power may reduce the likelihood of detecting a true effect (Button et al., 2013). Furthermore, the FCS was introduced partway through the service evaluation, and return rates were considerably lower for the FCS than for the FSCRS and CORE-34 (43%, 80%, and 87%, respectively).

Finally, the first two CFT groups took place during coronavirus lockdowns. The pandemic has been associated with increased stress and mental health difficulties among new mothers (Kasaven et al., 2023). This may have adversely impacted post-group outcomes, which may have reduced the size of observed effects.

Conclusion

Perinatal mental health is a critical public health issue that affects not only mothers but also their partners and infants. Implementing effective intervention strategies, such as Compassion Focused Therapy (CFT), presents an opportunity to address the unique challenges that arise during this vulnerable period. CFT, with its emphasis on fostering compassion and reducing self-criticism, aligns well with the complex emotional landscape of new motherhood.

Despite certain limitations, such as the small sample size, the findings from the service evaluation are promising. Consistent with the group aims, results suggest that women attending the CFT group experienced improvements in self-reassurance and reductions in self-criticism and psychological distress. These results are supported by service user feedback, which was largely very positive. The CFT group will continue to run alongside the collection of routine outcome measures and service user feedback. This will help ensure that outcomes are continually reviewed and the service remains responsive to feedback.

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