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An Evaluation of the Effectiveness and Experiences of Compassion-Focused Therapy in an Inpatient Mother and Baby Unit

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Growing evidence supports the value of compassion-focused therapy (CFT) groups in specialist perinatal mental health community services. However, little is known about their effectiveness in acute inpatient Mother and Baby Units (MBUs), specialist wards for women with severe mental health difficulties and their babies, where stays are short and presentations complex. To our knowledge, this service evaluation is the first to examine a brief, transdiagnostic CFT group for mothers admitted to an MBU. A mixed-methods design assessed a five-session CFT group (two hours per session, workbook-supported) delivered in an 8-bed MBU. Quantitative data included the Forms of Self-Criticizing/Attacking & Self-Reassuring Scale (FSCRS) and Fears of Compassion Scale (FCS), collected pre- and post-group, alongside sessional ratings of calm and distress and group connection. Qualitative data comprised open-text feedback (n = 56) and semi-structured interviews (n = 6), analyzed using content and reflexive thematic analysis. Large, statistically significant pre-post improvements were observed across FCRS subscales (range: -0.66 to -0.81) and all FCS domains (range: -0.55 to -0.68). Sessional data showed significant changes in calmness and connectedness. On average, mothers attended three of the five sessions. The following qualitative themes were identified: feelings and understandings upon arrival at the MBU, experiencing containment, gaining insight and practical tools, obstacles to engaging with the group, and CFT beyond the MBU. Findings suggest that a brief CFT group is feasible and clinically promising for mothers in an acute MBU, targeting shame reduction, increased safeness, and fears of compassion. Implementation should prioritize facilitator skill, sensory and soothing environments, and inclusive group processes.

Keywords: compassion-focused therapy (CFT), mother-baby unit, perinatal mental health

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Mother and Baby Units

Currently, there are 22 inpatient mental health Mother and Baby Units (MBUs) in the United Kingdom (Maternal Mental Health Alliance, 2023), which provide specialist care for women who require hospital admission for significant mental health difficulties following the birth of their baby. Women can be admitted from the third trimester to receive treatment while staying with their babies, and provision is available for women with babies up to one year old. MBUs are composed of multidisciplinary teams (MDTs) that include clinical psychologists, nurses, nursery nurses, peer support workers, and psychiatrists. Notably, a systematic review of outcomes for mothers staying at MBUs internationally found that they experience reduced clinical symptoms and significant improvements in interactions with their babies (Gillham & Wittkowski, 2015).

NICE Guidelines

The National Institute for Health and Care Excellence guidelines (NICE, 2014) recommend that MBUs deliver personalized psychological interventions. These range from bonding with the baby to addressing traumatic birthing experiences and providing family support. An audit across 16 MBUs in the UK recorded that the most common psychological interventions offered to mothers during their stay included individual psychology and psychotherapy sessions, group interventions, video-feedback, and cognitive behavioral therapy (CBT) (Wittkowski & Santos, 2017).

Whilst the audit highlighted the benefits of psychological interventions on mothers' well-being and mother-baby relationships, limited indication was provided on the effectiveness of specific interventions using standardized outcome measures. There was considerable variability in the availability of these interventions depending on the expertise within the team, limiting the generalizability and standardization of interventions delivered across MBUs. Given that the average stay at an MBU in the UK is around 6–7 weeks (Jovanović et al., 2025; Wittkowski & Santos, 2017), it is essential to understand which interventions are most impactful and cost-effective in this short period, particularly as CBT remains the most commonly offered approach (Stephenson et al., 2018).

Compassion Focused Therapy

Compassion-focused therapy (CFT) was first developed by Paul Gilbert (2010) to support individuals with high levels of shame and self-criticism, which are understood as transdiagnostic processes underlying a range of psychological difficulties, including depression, anxiety, posttraumatic stress disorder (PTSD), and psychosis (Craig et al., 2020). Gilbert (2014) defined compassion as "a sensitivity to the suffering in self and others, with a commitment to alleviate and prevent it" (p. 19). Within CFT, compassion is conceptualized as operating through three flows: compassion towards oneself, towards others, and receiving compassion from others.

The soothing system is associated with feelings of safety, contentment, and social connectedness, facilitating rest, recovery, and affiliative relationships. In contrast, the threat

system detects and responds to danger and is linked to emotions such as anxiety, anger, and disgust. The drive system is oriented towards goal pursuit and resource acquisition and is associated with feelings of excitement and satisfaction. In individuals experiencing psychological difficulties, the threat and drive systems are often conceptualized as overactivated relative to the soothing system.

The relevance of CFT in the perinatal period is crucial. Cree (2010) claims that mothers may experience emotional dysregulation as their threat system becomes overactive, limiting the accessibility of the soothing system. This is consistent with findings that mothers feel shame when they believe they have not met their own, their partner's, and society's expectations of a "good mother" (Liss et al., 2013). Subsequently, they may engage in self-criticism and form unhelpful views of themselves, which can fuel threat-system activation (Lawrence et al., 2024). Shame and self-criticism have been found to affect mothers' relationships with themselves, their babies, and partners (Jackson et al., 2024). Cree (2015) adapted CFT for mothers and developed a 12-session perinatal CFT group to support mothers in bonding with their baby and reactivating their soothing system.

Effectiveness of CFT

The existing literature on the effectiveness of CFT in clinical populations is limited. A systematic review of five CFT groups by Millard and Wittkowski (2023) showed small improvements in self-compassion, depression, and anxiety for mothers. Notably, the impact on anxiety and depression symptoms was greater for participants assigned to CFT than for those assigned to CBT. Inconsistency was observed in the positive findings related to changes in self-criticism. As studies were largely conducted among non-clinical populations and online, it is difficult to generalize these findings.

Recently, Lawrence et al. (2024) evaluated the effectiveness of CFT in community perinatal services. 114 women from Northwest England attended 10 online CFT sessions. Consistent with Millard and Wittkowski (2023), participants showed significant reductions in psychological distress and self-criticism and improvements in self-compassion. A small-to-medium effect size was also demonstrated in the mother-infant bonding relationship at follow-up. Mothers felt less anxious and more attuned to their babies 'needs, suggesting that self-compassion may significantly impact how mothers relate to their babies.

Thirkettle et al. (2024) conducted a service evaluation of online CFT groups in perinatal community mental health teams. 30 women participated in eight weekly sessions with pre- and post-scores available for 26 women on the CORE-34 (Clinical Outcomes in Routine Evaluation), 24 on the FSCRS (Forms of Self-Criticizing/Attacking & Self-Reassuring Scale), and 6 on the FCS (Fears of Compassion Scale). Consistent with previous research (Lawrence et al., 2024), participants showed significant reductions in pre- and post-scores for psychological symptoms and self-criticism. Improvements were also observed in overall well-being and functioning.

Of the women who completed the questionnaires, 18 also completed surveys, which were then analyzed using content analysis (Thirkettle et al., 2024). Participants described the group as

supportive and informative, which facilitated their understanding and development of self-compassion. Some reported challenges with attending lengthy sessions and needing to attend to their baby. No indication was given on the impact of the group on the mother-baby and parenting couple relationships.

Thirkettle et al. (2024) and Lawrence et al. (2024) made significant contributions to the literature on CFT among the clinical perinatal population and in understanding participants' experiences. Similar qualitative themes have been reported for CFT in non-perinatal acute inpatient settings (Heriot-Maitland et al., 2014; Stroud & Griffiths, 2021). However, little is known about how CFT may translate to acute inpatient perinatal settings such as MBUs, where admissions are short and clinical presentations complex.

Service Context and Project Aims

The Yorkshire and Humber MBU consists of 8 beds and an MDT that offers a range of interventions. CFT groups were first introduced in January 2024. The groups consist of five rolling sessions that last up to two hours with a break in the middle. Each session is designed to be delivered on a stand-alone basis to meet the nature of MBU settings, given new admissions and short stays (Heriot-Maitland et al., 2014). An overview of the sessions is provided in Table 1. They incorporate elements from research on the delivery of brief CFT in inpatient services (Heriot-Maitland et al., 2014; Kirby et al., 2023; Stroud & Griffiths, 2021), group settings (Griner et al., 2022), and P-CFT concepts (Cree, 2015).

Table 1

Summary of CFT Group Session Content and Exercises

Session Number	Session Content	Exercises
1: Three emotional regulation systems	• Psychoeducation on three emotional regulation systems (threat, drive and soothing), and how the perinatal period can influence these systems • Understanding baby's emotional regulation systems	• Soothing Rhythm Breathing, three circle videos and discussions
2: Mind-full or mindful?	• Psychoeducation on the tricky brain, and loops in the perinatal period • Mindfulness and bringing a compassionate lens to mindful activities • Understanding how mindfulness can increase mother-baby bond and help mothers to soothe their babies	• Mindful Awareness • Spotlight of attention • Five stepping stones to soothing system (posture/facial expressions)
3: Getting to know our inner critic and compassionate coach	• Exploration of the inner self-critic. • Understanding the function of the self-critic and the unintended consequences on self and relationship with baby • How to respond to our experiences with a compassionate coach	• Understanding our self-critic • Developing a compassionate coach

Session Number	Session Content	Exercises
4: Compassion	• Defining compassion. • Understanding compassion and its three flows • Exploring fears, blocks, and resistances to compassion in the context of early experiences • Developing skills and attributes to bring a compassionate motivation online, and compassionate engagement and responses in relation to self, others, and baby	• Exercise to explore blocks, fears, and resistances and the three flows of compassion • Compassionate color exercise • Compassionate engagement exercise
5: Imagery	• Exploring the power of imagery to connect to internal experiences that cultivate a compassionate mind and connection to baby • Building skills in self-compassion	• Welcoming place • Developing a compassionate self

Routine outcome measures were available from mothers who had attended the CFT groups between March 2024 and March 2025. The service evaluation project (SEP) was commissioned to evaluate the effectiveness of the group and participants' experience, to provide evidence of therapeutic outcomes, to consider future group developments, and to add to the CFT evidence base in perinatal inpatient settings.

The SEP aimed to clarify whether CFT groups were effective in reducing self-criticism/shame and improving the flows of compassion, to examine mothers' experiences of attending CFT groups in an MBU setting and the changes they experienced after attending, and to offer key recommendations for future CFT groups.

Methods

A mixed-methods design was employed to address the aims of the current SEP. Quantitative data consisted of anonymized routine outcome measures collected by the service from participants before and after attending the CFT group. Simultaneously, qualitative data were collected via semi-structured interviews. Ethical approval was granted by the University of Leeds Research Ethics Committee for the School of Medicine.

Participants for the interviews were sought through purposive sampling. They were required to have attended all five CFT sessions, experiencing moderate mental health difficulties to reduce risks to self and others, and discharged or due to be discharged from the MBU.

A total of six participants were interviewed in line with recommendations for small qualitative studies. Participants were required to have attended all five sessions in total. All six participants identified as White. Mothers' ages ranged from 28 to 37, and babies' ages ranged from 0 to 11 months. Three mothers were diagnosed with depression, one with schizoaffective disorder, one with psychosis, and one with obsessive-compulsive disorder.

Data Collection

Quantitative Data

The forms of Self-Criticizing/Attacking and Self-Reassurance Scale (FSCRS; Gilbert et al., 2004) and Fears of Compassion Scale (FSC; Gilbert et al., 2011) were collected before and after the group intervention. Pre- and post-session measures were obtained at the start and end of each session. Questionnaires were readily scored and anonymized on an Excel database before the evaluator accessed it. These measures are summarized in Table 2.

Table 2

Quantitative Outcome Measures

Measure	Description
FSCRS	The forms of self-criticizing/attacking and self-reassurance scale (FSCRS; Gilbert et al., 2004) is a 22-item self-report measure. It aims to identify forms of self-criticism and self-reassuring thoughts people engage in when they are met with setbacks. Each item is rated on a 5-point Likert scale ranging from 0 (not at all like me) to 4 (extremely like me). The overall score is then recorded for each of the three subscales: inadequate self (0–36), hated self (0–20) and reassured self (0–32). The FSCRS has been found to be a good reliable measure for different psychological difficulties and has an excellent internal reliability (Baião et al., 2015; Gilbert et al., 2004).
FCS	Fears of Compassion Scale (FCS; Gilbert et al., 2011) is a 38-item self-report measure consisting of three scales aimed to identify fears of compassion for others, from others and for self. Each item is rated on a 5-point Likert scale ranging from 0 (don't agree at all) to 4 (completely agree). The overall scores fall within the range of 0–152. Higher scores suggest higher fears of compassion. The FCS has been found to be a good reliable measure for a range of clinical presentations and shows good internal reliability (Gilbert et al., 2011; Kirby et al., 2019).
Pre- and Post-Session Questionnaire	Pre- and post-sessional measures were adapted from Heriot-Maitland et al.'s (2014) study on CFT in acute inpatient settings. *Distress and Calmness levels:* Participants were requested to rate their level of calm or distress (threat system) pre and post session on a Likert scale ranging from 1 (extremely distressed) to 6 (extremely calm).
	Connectedness levels: Participants were required to rate their levels of connection (soothing system) to the group on a 6-point Likert scale ranging from 1 (very disconnected) to 6 (very connected). These were completed pre and post session.
	Understanding and Helpfulness: Participants were asked about how well they understood the group content and how helpful they found the session on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).
	Open Text Box Responses: Participants were then asked what they found helpful about the session, recommendations to improving the group and whether they had used any CFT ideas or exercises following previously attended sessions.

Note. FSCR = Forms of Self-Criticizing/Attacking and Self-Reassuring Scale; FCS = Fears of Compassion Scale

Qualitative Procedure

An interview topic guide was developed to gather qualitative feedback on the understanding and impact of the CFT group. Potential participants indicated their interest in the SEP by consenting to being contacted by the researcher upon discharge. Participants were then contacted by the group facilitator to regain consent before being contacted by the SEP evaluator. Interviews were conducted by the evaluator online via Microsoft Teams or face-to-face at the MBU. All interviews were recorded using Microsoft Teams to offer an initial transcript. Interviews lasted between 25 and 40 minutes.

Data Analysis

Quantitative Analysis

Descriptive statistics were produced using IBM SPSS Statistics (SPSS) to provide an overview of the participants' demographics attending the group. As the sample size was small and the data were ordinal, a nonparametric Wilcoxon signed-rank test was conducted to calculate statistically significant differences pre- and post-group for FSCRS and FCS (Field, 2024). Effect sizes were calculated using the r formula: $r = Z / \sqrt{N}$.

Similarly, a nonparametric Wilcoxon signed rank test was conducted to calculate statistically significant differences between pre- and post-distress and connection levels. Means were then generated in SPSS to examine the understanding and helpfulness of the session.

Qualitative Analysis

Open-text-box responses to post-session questions were analyzed using content analysis (CA) informed by Vears and Gillam (2022). Responses were read and reread for familiarization. Big picture meaning units were identified regarding the research question, and subsequently, subcategories and fine-grained codes were developed and refined. Finally, the synthesis and interpretation of the data were written up.

Interviews were transcribed and analyzed following Braun and Clarke's (2022) steps for TA: familiarization with the dataset, coding of data, generation of initial themes, development and review of initial themes, refining, defining, and naming themes, and writing the final report. Accordingly, during the revision of naming themes, credibility checks were conducted on two coded transcripts, the final themes, and the subthemes with a doctor from the inpatient MBU.

Results

Quantitative Results

A total of 49 mothers attended the CFT group between March 2024 and March 2025 (Table 3). Eleven groups were run during this period. Seven mothers completed the group more than once. On average, mothers attended 3 of the 5 sessions. Table 4 shows questionnaire responses.

Table 3

Demographic Characteristics of Group Participants

Demographics	Number
Ethnicity	
White British	35
Asian British	6
Black British	4
Mixed	3
Unidentified	1
Diagnosis	
Depression	21
Psychosis	19
Anxiety	5
Posttraumatic stress disorder	2
Bipolar Disorder	1
Schizoaffective disorder	1
Dual diagnosis	13
Age	
Mean age of mothers (range)	32 (23-44)
Mean age of babies (range)	3 months (0-11).

Table 4

Questionnaire Responses

Questionnaire	Number of Prior Responses	Number of Post Responses	Number of Pre-and Post- Responses
Group Measures			
FCS	33	19	18
FSCR	35	20	18
Sessional Measures			
Distress	126	119	102
Connection	124	117	99
Understanding	-	114	-
Helpfulness	-	114	-

Note. FSCR = Forms of Self-Criticizing/Attacking and Self-Reassuring Scale; FCS = Fears of Compassion Scale

Group-level Results

For FSCR's inadequate self and hated self, a Wilcoxon Signed-Rank Test indicated that the median post-test ranks were statistically significantly lower than the median pre-test ranks (Table 5). For FSCR reassured self, median post-test ranks were statistically significantly higher than the median pre-test ranks. Large effect sizes were observed across all three subscales. Scores are presented in Table 4. A large effect size was observed across all three subscales.

For FCS total, for others, from others, and self, median post-test ranks were statistically significantly lower than the median pre-test ranks. Large effect sizes were observed across FCS total and all subscales.

Table 5

Wilcoxon Signed Rank Test Results

Measure	Pre-group MDN	Post-group MDN	*n*	T	*Z* Score	*p*	Effect size *r*	% Improved
FSCR								
FSCR-Inadequate Self	25	14.5	18	4	-3.44	<.001*	-0.81	83.3
FSCR-Reassured Self	11.5	20	18	4	-3.31	<.001*	-0.78	83.3
FSCR-Hated Self	10.5	5	18	11	-2.79	0.005*	-0.66	72.2
FCS								
FCS-Total	60.5	35	18	17.5	-2.79	0.005*	-0.66	72.2
FCS-For Others	14	11.5	18	19	-2.34	0.019*	-0.55	61.1
FCS-From Others	21	11	18	16	-2.87	0.004*	-0.68	83.3
FCS-Self	21	11.5	18	21	-2.43	0.015*	-0.57	72.2

Note. FSCR = Forms of Self-Criticizing/Attacking and Self-Reassuring Scale; FCS = Fears of Compassion Scale; MDN = median, *n* = number of participants, T = Wilcoxon test statistic; *$p < 0.05$

Session-level Results

Distress Levels. Overall, a significant improvement was found in post-distress scores compared to pre-session scores. A Wilcoxon Signed-Rank Test indicated that this change was statistically significant, with a moderate effect size. This suggests that participation in sessions was associated with reductions in distress at the session level.

Connection Levels. Significant improvements were also observed in post-connection levels relative to pre-session ratings, with moderate-to-large effect sizes across sessions. Increases in

connectedness were evident across sessions, with particularly marked changes in sessions one and two (three regulation systems and mindfulness).

Understanding and Helpfulness. Participants rated their understanding of the session as high across all sessions, with an average of 4.37 out of 5. Likewise, participants rated the helpfulness of the session as high, irrespective of the session, with an average of 4.46 out of 5.

Qualitative Survey Results

Fifty-six mothers completed three open-text questions following CFT group sessions. Responses were analyzed using content analysis and are presented here as an integrated summary of key themes, which informed and contextualized the subsequent qualitative findings.

Perceived Benefits of the Group: Understanding, Practice, and Validation

Mothers consistently reported that learning about CFT concepts and psychological processes was "helpful and useful." They described developing an improved "understanding" of the "three systems" and the "inner critic," which they were able to apply to themselves by "noticing" which system they were in and "how to see the self-critic."

Participants also valued practicing experiential exercises within sessions, describing these as "practical" tools to stimulate their "soothing system." Commonly named practices included "mindful awareness," "compassionate other imagery," and "self-compassionate exercises."

In addition, mothers highlighted the importance of the group context itself. They appreciated "talking to other mothers" and feeling "validated" by recognizing that "others think and feel the same." The accessibility of content through "videos" and "visual aids" was also valued, as it supported different learning styles.

Barriers and Suggestions for Improvement

Mothers identified several areas where the group experience could be improved, including clearer guidance for exercises, particularly for those who joined sessions later. For example, participants noted the importance of "not to pick a person we know prior to the compassionate other exercise," or described feeling they had joined later and "missed a key part and struggled to understand." Tailoring exercises to individual needs was also seen as helpful, with one participant recommending that mothers be encouraged to "pre-notice ideas of compassionate other so [they] can use the exercise more easily."

Applying CFT Beyond the Sessions

Mothers also reflected on how they used CFT ideas between sessions and beyond the group. Participants reported recalling core CFT concepts such as the "three systems" and the distinction between "old brain" and "new brain." Others described actively using CFT practices, including

"self-compassionate exercises" and "mindful awareness," to help shift themselves into a more soothed state.

In addition, participants expressed a desire for greater access to CFT beyond the inpatient setting. Suggestions included increased availability of CFT groups in the community, opportunities to continue or repeat sessions after discharge, and the development of additional resources such as a "partners group," further written materials, or brief individual follow-up sessions.

Qualitative Interviews Results

Five overarching themes were identified, with 15 subthemes.

Arriving at the group. Several participants described prior feelings of "shame" and "self-blame." For instance, participant 3 expressed, "I was really in a not great place. I was… resentful… This is not an environment I want to be in." Similarly, participants felt "skeptical" about whether the group "would actually help" and feel "safe." Despite this, participants were keen to attend the groups to feel "better."

Participants also reported that their former sense of self-compassion was one of "weakness," and an attribute they "shouldn't need." Most mothers described themselves as being "self-critical," and hoped to "develop" self-compassion.

Experiencing Containment. Participants experienced the group as a safe space. The regularity of the groups offered participants "structure" at an unpredictable time, as inpatients and new mothers. The facilitator's expertise and "buy into CFT" increased participants' motivation to engage with the groups, suggesting a sense of trust between the two. Participants were surprised by the respect they were shown. This is powerfully captured in participant 3's reflection: "I thought people would talk down to me, but I was always made to feel welcomed."

Mothers discussed receiving compassion from facilitators and from one another. This was experienced through the "soothing objects" (e.g., hand creams and scented soaps) available to them throughout the group and compassionate acts such as the offering of "tea and biscuits." Consequently, mothers felt cared for, which is indicated by participant 4's use of the phrase "nurturing."

Participants also viewed the group as being inclusive**.** The setup "invited" mothers to "bring [their] babies" and "come and go" at any time. Being offered this flexibility was "reassuring" for participant 2 as she felt it was "[their] space," which may have been a different experience from being outside the group on the ward. Participants appreciated that the facilitator "altered [the sessions] and made it more bespoke to [them]." For instance, when a participant's first language was not English, "the facilitator tried… to explain things… on multiple levels."

Finally, participants highlighted feeling together in solidarity through "getting to know other mums" with similar experiences. They were able to "trust them" and be "vulnerable," thereby recognizing that struggling with motherhood is universal.

Implementation and Practice. Participants acknowledged that they gained new insight through learning about CFT concepts, such as "the three systems." Simultaneously, participants developed a better understanding of themselves. For example, participant 1 reported, "I found it really helpful to be able to understand why I felt the way I do." Participants also established a positive view of compassion. This was demonstrated in participant 1's following account, "a firefighter being compassionate… nothing to do with... weakness."

Subsequently, mothers frequently quoted developing self-compassion. This was conveyed through participants connecting with their "soothing system" and compassionate "imagery," using CFT ideas such as "it's not your fault," and being kinder to themselves.

Participants also indicated that integrating CFT into their lives required an ongoing commitment and practice. Some engaged further with CFT "resources," including "books" and "apps," whilst others continued to review the "handouts" from the groups.

Obstacles to Engagement. Few participants reported individual preferences regarding group structure and their expectations. Some participants found it "tricky" to navigate the shift in group dynamics when new members, including professionals, joined. They felt uncertain about whether it was safe to share their experiences. Participant 4 implies this in the following: "So you think this is the group for today… you might… made yourself vulnerable… and then somebody else comes in later and then it's like the dynamic might change."

For new attendees, the content felt like a "jump" if they were unfamiliar with CFT. However, when content was "repeated," returning mothers found this counterproductive, as it impacted the quantity of content covered. For example, participant 4 explained that "we would have to miss or skip past bits." This was also attributed to an imbalance between sharing experiences and getting through the content. Nevertheless, participants acknowledged that having new people allowed for "new perspectives," and professionals could "understand" their experiences.

Logistics. Participants reported benefitting from a large-sized room, as participant 6 shared she felt the space "was just about OK" for four mothers. Although mothers acknowledged the importance of being with their baby in the group, some found it "challenging" to be with their baby and attend to the group simultaneously.

CFT beyond the MBU. Mothers reportedly experienced blocks to practicing compassion upon discharge. They struggled to remember self-compassion and experienced recurring "guilt." For instance, participant 4 said she "forgets" and got "out of the habit" of practicing compassion. Some attributed this to the completion of the intervention.

Participants also felt that CFT was relevant to everyone. This was conveyed through participant 1 "mentioning [CFT] to [her] friends" and participant 4 bringing "this thinking [CFT] to [her] workplace." Notably, participants believed that educating partners about CFT was crucial to help them develop self-compassion and improve their parenting relationships. For example, participant 1 voiced that, "it will be… good and…helpful for this kind of thing to be available to dads."

Mothers felt disempowered by the limited accessibility of CFT groups in the community. Participant 1 captures this in the following, “it's just annoying that you have to be admitted to Mother baby unit to A have heard of it and B have a go at experiencing it in a group.” To resolve this, mothers requested more “funding” for CFT groups.

Furthermore, participants reported a ripple effect of attending the group on other areas of their lives. Mothers felt able to manage conflict better with their partners and family members, whilst also showing them “compassion.” Accordingly, participant 2 noted improvement in her “relationship with [her] partner.” They also felt more confident in their parenting abilities and attuned to their baby. For instance, participant 5 shared, “I’m meeting all her needs and that she's absolutely fine.”

Discussion

The current Service evaluation aimed to assess the effectiveness of CFT groups in an inpatient mental health MBU setting, mothers’ experiences of these, and to offer suggestions for future group development. This evaluation is the first of its kind to explore rolling CFT group interventions delivered within an inpatient perinatal setting where participants attended on average three out of five sessions. The findings offer insights into the potential impact of CFT as a brief intervention delivered across a range of diagnoses within the constraints of inpatient care. Importantly, findings suggest that meaningful psychological change may occur even with partial attendance, which is particularly relevant in MBUs where admissions are short and attendance is necessarily variable.

Effectiveness of CFT

The results indicated that the CFT group showed clinical promise in reducing self-criticism and improving participants’ ability to self-reassure. This finding is consistent with those of Lawrence et al. (2024) and Thirkettle et al. (2024), who evaluated online CFT groups among clinical perinatal populations in community settings.

Notably, reductions in inadequate self-criticism were the largest, which suggests even limited exposure to a CFT intervention may support reductions in shame-based evaluative processes. This may reflect both the focus of CFT on de-shaming processes and the potential normalizing effects of a group-based intervention.

From a social mentality perspective, this may also reflect group-based normalization processes that support mothers to connect to a sense of common humanity and an evolved understanding that their experiences are not their fault. If self-worth can be affected by perceived rank in comparison to others (Halamová et al., 2018), then a group experience might have supported participants to recognize that all mothers experience hardships, reducing feelings of self-inadequacy and social rank threat.

Mothers also showed reductions in fears of compassion. However, in contrast to findings by Thirkettle et al. (2024), who found that fears of compassion towards self were most improved, the current study showed the largest improvement in fears of compassion from others. This difference

may reflect the particular relational context of inpatient care where threat is heightened and autonomy reduced. Inpatient populations are known to experience increased threat related to hospitalization and loss of control (Waite et al., 2025), which may increase fears of dependency, vulnerability, or perceived weakness. For many mothers, a cultural narrative that they should be able to cope alone might further increase their sense of failure should they need support. A further possibility that warrants future investigation is that this population tends to have attachment styles biased towards a more avoidant style and, as such, struggles to ask for or accept help from others. One possible explanation is that the group provided a corrective relational experience, supporting mothers to understand their blocks to compassion and feel safer in receiving care and compassion from others. A further possibility that warrants careful future investigation is whether difficulties in seeking or accepting support may be more common among mothers admitted to MBUs, potentially reflecting avoidant or self-reliant relational strategies developed in earlier contexts. Importantly, this should not be understood as a causal explanation or individual deficit, but rather as a relational pattern that may increase vulnerability at times of heightened stress. From this perspective, the CFT group may have provided a corrective relational experience, enabling mothers to recognize and work with blocks to receiving compassion and to feel safer in accepting care and support from others

Session Level Change

Significant improvements in session-level distress and increases in connectedness levels were also observed, consistent with findings from other CFT groups delivered in inpatient settings (Heriot-Maitland et al., 2014). Taken together, session-level findings suggest the group was experienced as regulating and connective rather than overwhelming, even within a context of acute mental health difficulties and the demands of inpatient motherhood. This is particularly important in MBUs where interventions must balance emotional exploration with the need to maintain psychological stability and support caregiving capacity.

Experience of the Groups

Qualitative findings indicated that participants experienced the groups as containing due to several interacting factors, including a sense of safety, connecting with other mothers, knowledgeable facilitators, and being recipients of compassion. These results are in line with broader qualitative literature indicating the importance of relational safeness and facilitator credibility and compassionate modeling within CFT (Garrett et al., 2025; Griner et al., 2022)

Participants valued the educational and experiential components of the group. Learning about CFT concepts and skills alongside practicing compassion-based exercises appeared to support insight into their own emotional processes and those of their babies. Consistent with other research, Heriot-Maitland et al. (2014) and Thirkettle et al. (2024) suggest this combination of psychoeducation and experiential practice may support both cognitive understanding and embodied emotional changes. The flexibility of the group structure, including the ability to attend

with babies and accommodating varied attendance, was also identified as important for engagement and opportunities to practice childcare in group settings.

Impact Beyond the Groups

Participants commonly cited using CFT ideas and practices outside the group and post-discharge. This included both recalling conceptual frameworks, such as the three emotional regulation systems, and actively using compassion-based practices to support emotional regulation. Mothers felt more confident in their parenting and better able to manage conflict with their partners and other family members, suggesting that just brief exposure to CFT may provide transferable skills that mothers could use not only with their baby but also in their interpersonal functioning.

Participants also described a growing sense of common humanity, recognizing that struggling in motherhood was a shared human experience. A similar theme of participants developing a sense of common humanity was reported by Heriot-Maitland et al. (2014) and Thirkettle et al. (2024). Sharing experiences with others may have reduced feelings of isolation and shame (Garrett et al., 2025). The experience of receiving compassion within the group may also have positively reinforced participants' compassion towards themselves and others, potentially contributing to broader relational benefits.

Clinical and Service Implications

Although the findings suggest that brief CFT groups are feasible within MBU's, owing to the lack of a controlled group, these results should be considered preliminary and warrant further investigation. Clinically meaningful change was observed despite the women being acutely unwell, heterogeneous presentations, and limited lengths of stay. The observation that meaningful psychological change occurred within an average of three sessions supports a growing evidence base that this may be a potentially efficient approach for delivering psychological support in perinatal services. This support may be delivered even earlier, with some key concepts provided in a handout to pregnant women and new mothers as part of routine support.

Participants' accounts suggest that therapeutic impact was not simply due to intervention content but also the experience of being cared for and contained in the group setting. CFT emphasizes affiliative processes, social safety, and compassion as key mechanisms of change, which may be particularly important for mothers experiencing high shame and self-criticism. Services delivering CFT in MBUs may therefore need to consider not just intervention fidelity but relational and environmental conditions that support safeness.

Participants also highlighted the potential value of extending CFT principles beyond the group context. This included training ward staff in core CFT to support consistency of care and increase access. CFT resources following discharge. Requests for partner involvement and continued access to CFT reflect a desire for shared understanding and ongoing support beyond the inpatient setting, consistent with findings from other perinatal CFT evaluations (Thirkettle et al., 2024).

Limitations

There are several limitations that warrant consideration. The sample size was relatively small and underpowered, requiring caution when interpreting quantitative findings. Participants were heterogeneous in terms of diagnosis and attendance, and all interview participants identified as White, limiting the generalizability of qualitative findings. In a service evaluation without a control group, the findings should be interpreted as preliminary rather than confirmatory.

Conclusion

This service evaluation provides preliminary evidence that a brief CFT group is both feasible and clinically beneficial in an inpatient MBU setting. Significant reductions in self-criticism and fears of compassion (across all domains), alongside increased self-reassurance, and session-level improvements in distress and connectedness, suggest that even limited exposure to CFT may support meaningful psychological change for mothers experiencing severe perinatal mental health difficulties.

Importantly, these changes occurred despite variable attendance, with mothers attending an average of three sessions, indicating that stand-alone sessions may suit the reality of inpatient perinatal care. Qualitative findings highlight the importance of relational safeness, skilled facilitation, and compassionate group environments in supporting engagement.

Although findings should be interpreted cautiously due to the small sample size and service-evaluation design, this study contributes to early evidence that brief CFT groups may offer a valuable, compassion-based intervention within MBUs and warrants further research in larger, controlled studies.

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