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Gray, C., Jones, F., Agostinis, A. and Morris, J.

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EXPERIENCE OF COMPASSION-BASED PRACTICE IN MINDFULNESS FOR HEALTH FOR INDIVIDUALS WITH PERSISTENT PAIN

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Dr Callum Gray, Clinical Psychologist

c.gray@health.gov.je

Pain Management Service, Jersey

Overdale Hospital, Westmount Road, St Helier, Jersey JE2 3UH

Dr Fergal Jones, Research Director and Reader in Clinical Psychology

fergal.jones@canterbury.ac.uk

Canterbury Christ Church University

Lucy Fildes Building, 1 Meadow Rd, Tunbridge Wells TN1 2YG

Dr Alessio Agostinis, Consultant Clinical Psychologist

alessioagostinis@hotmail.com

Dr Julia Morris, Consultant Allied Health Professional

julia.morris@health.gov.je

Pain Service, Jersey

The Enid Quenault Health & Wellbeing Centre, Les Quennevais Park, La Route des Quennevais, JE3 8JW

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Abstract

Purpose of the study: Research indicates that acquiring compassion is an integral part to positive outcomes to Mindfulness-based interventions (MBI), yet there is both theoretic and empirical literature suggesting that people with persistent pain are more likely to experience challenges and distress when engaging compassion-based practices. Mindfulness for Health is a standardised MBI for people with persistent pain and health conditions. This study sought to explore the positive, neutral and difficult experiences of compassion-based practice and meditation for participants in Mindfulness for Health to further understand implications and risks for participants of MBI's.

Method and Design: A qualitative design using Interpretative Phenomenological Analysis was applied to explore how participants understood of the experience of compassion-based practice and the meaning they gave to it. Eight participants who had completed the Mindfulness for Health from four separate groups were interviewed about their experience.

Results: Five master themes were identified 'turning away from self-with-pain', 'self-with-pain experienced as shameful', 'facilitating change', 'turning towards self-with-pain', and 'accepting self'. Participants identified both perceived positive changes and difficult emotional experiences during the meditation practice, which they related to the context of compassion in their past and present life.

Conclusions: developing compassion is an important part of Mindfulness for Health, which is salient for participants as both a challenging and potentially valuable experience. Acquisition of mindfulness skills, supporting group dynamics and modelling compassion are understood as helpful in overcoming personal barriers and challenging experiences. Further research is needed to understand processes involved and explore the experience of non-completers.

Introduction

Persistent Pain

Persistent pain is the most prevalent form of distress that leads people to seek healthcare (Todd et al., 2018), affecting between 8% to 11% of the general population worldwide (Andrews et al., 2018). Persistent pain and chronic pain are used interchangeably in literature, where 'persistent' is a more recent label used to describe pain that lasts for longer than twelve weeks despite treatment (Treede et al., 2015) and is severe and enduring enough to affect how people manage in their daily life (Nicholas et al., 2019). Sensory, cognitive and affective factors are involved in a person's experience of persistent pain (Moseley & Butler, 2015) and those who seek healthcare support are usually not only seeking pain relief, but also support with the interference and emotional distress it causes (Ehde et al., 2003), such as depression and anxiety (Gureje et al., 1998).

Treatment for persistent pain is focused not only on pharmaceutical pain relief (Tauben, 2015), but also multidisciplinary interventions aimed at considering biopsychosocial factors surrounding the person and their experience of pain (Bevers et al., 2016). Within the approaches adopted by medicine and allied health professionals, mindfulness-based interventions (MBIs) have recently been developed to help alleviate pain and pain-related distress, with the view of educating and equipping people to better manage their persistent pain conditions (Chiesa & Serretti, 2011).

Mindfulness-based interventions for pain: Mindfulness for Health

The empirical support for MBIs use in the treatment of persistent pain is growing, especially regarding Mindfulness-Based Stress Reduction (Kabat-Zinn, 2003) and Mindfulness-based Cognitive Therapy (Segal et al., 2002) for physical and psychological

distress (Gu et al. 2015). Within these MBIs, Mindfulness is understood as a metacognitive skill of self-regulating attention and nurturing a relationship to one's own experiences with curiosity and acceptance (Brown & Ryan, 2003). This has been popularly summarised as '*the practice of purposely bringing one's attention in the present moment without evaluation*' (Kabat-Zinn, 2003), which is a process that is taught through meditative practice, mindfulness theory, and the encouragement to apply mindfulness practices in daily life. Mindfulness for health (MfH; Burch & Penman, 2013) is a more recent MBI deriving closely from Mindfulness-Based Stress Reduction as an eight-week programme that focuses on alleviating psychological suffering related to health conditions and persistent pain, where psychological suffering is understood as a "secondary" to the "primary" experience of physical pain and ill-health. MfH is a standardised approach, where facilitators are required to undergo accredited teaching and on-going supervision to promote treatment fidelity and that material remains grounded in Mindfulness.

There is a growing evidence base suggesting that MBIs reduce pain intensity (Reiner et al., 2013; Pardos-Gascón et al., 2021) and pain sensitivity (Grant et al., 2011) in persistent pain populations. Theoretically, the mindfulness meditations focus on changing sensory, cognitive, and affective factors relating to subjective experience of pain (Brown & Jones, 2010; Grant & Rainville, 2009), where increased attentional capacity in meditators are thought to help modify the elaboration of nociceptive information into pain (Zeidan et al., 2011). In addition, acceptance and non-judgemental evaluation are theorised to reduce negative evaluation of pain, which otherwise lead to 'secondary suffering'. This includes habitual patterns that worsen pain intensity, such as avoidance strategies, pain catastrophizing, psychological distress and physiological responses to threat (Crombez et al., 2012; Zeidan et al., 2011). This theory has been supported by neuroimaging studies that have

reported changes consistent with the targets of mindfulness (Grant et al., 2011; Zeidan et al., 2019).

Later sessions within MfH and Mindfulness-Based Stress Reduction include elements associated with compassion-based understanding of suffering and meditations that foster compassion. This process is reflected in the structure of Mindfulness-Based Stress Reduction and, accordingly, research on Mindfulness-Based Stress Reduction has reported increases in self-report self-compassion (Birnie et al., 2010; Kuyken et al., 2010; Rimes & Wingrove, 2011; Shapiro et al., 2007). Further research also indicates that changes in self-compassion play a significant role in positive outcomes and engagement with Mindfulness-Based Stress Reduction (Gu et al., 2015; Keng et al., 2012).

Compassion in Mindfulness for Health

Deriving from the Latin word ‘compati’, meaning “*to suffer together with*”, compassion is widely associated with feeling for a person who is suffering and the motivation to alleviate that suffering (Goetz & Simon-Thomas, 2017; Strauss et al., 2016), which has been described as *“an openness to the suffering of others with a commitment to relieve it*” in Buddhist philosophy (Lama & Thupte, 1995). Mindfulness and compassion have a degree of cross-over in their clinical application, namely in their focus on turning towards pain with acceptance in the hope of reducing pain-related distress. Where compassion extends from mindfulness is in the feelings of care for the person suffering and an understanding that suffering is a shared human experience (Neff & Dahm, 2015). Within MBIs, mindfulness is understood as necessary to facilitate the development of compassion, where Tirch (2010) hypothesised that mindful awareness of one’s own inner experience is necessary to foster compassion for the self-with-pain. Accordingly, in MfH, mindful meditations precede the compassion-based ‘loving kindness’ and ‘open heart’ meditations, which are presented with

an educational component on the three emotion regulation systems model originating from compassion-focused therapy (Gilbert 2000).

The experience of compassion in MfH for people with persistent pain

While compassion is recognised as a central component in MfH, there is emerging research on distress experienced in compassion-based practice (Fredrickson et al., 2008), in-session barriers to meditation (Barnhofer et al., 2010), difficulties with maintaining engagement (Crane et al, 2010), and treatment adherence in persistent pain populations on MBIs (Malins et al., 2020) suggesting that some participants might experience barriers, challenges or adverse experiences with compassion-based practices in MBIs. This connects with the theoretical reasons and empirical research that offer some understanding as to why participants with persistent pain drop-out of MBIs. Firstly, studies suggest that participants often experience increased distress before more meaningful positive change in MBIs, which can be influenced by on-going mental health distress (Farias et al., 2020). Persistent pain populations are vulnerable to heightened mental health distress, avoidance of distress, and self-criticism (Tunks et al., 2008), which has been linked with poor treatment adherence and outcomes in MBIs and compassion-based interventions (Wakelin et al., 2021). Additionally, Gilbert (2009) discussed how compassion-based interventions can elicit difficult memories of attachment experiences, such as the absence of being cared for, interpersonal traumas and grief in exercises such as loving-kindness practice (Fredrickson et al., 2008). This might reflect a population who have been reported as having twice the rates of disorganised attachments than in the general population (Davies et al., 2009). In the absence of a secure-attachment with a caregiver, Mikulincer and Shaver (2005) theorized that a person might have difficulties internalising compassion towards themselves and, therefore, be unable to self-soothe from the distress elicited by difficult memories during such meditations.

Rationale

Potentially distressing somatic and psychological experiences have been historically overlooked in MBI research (Lutkajtis, 2018), which might result from participants not sharing these experiences with services and in research that is not asking the necessary questions (Britton et al., 2021). However, qualitative research into the experience of interventions can be helpful in exploring the nuance and diversity of aversive or distressing experiences, as well as positive experiences and beneficial outcomes (Braun & Clarke, 2019; Charmaz & Henwood, 2017; Tuffour, 2017). Research that specifically investigates adverse experiences is important to consider risk of harm and treatment adherence to inform adaptations to support a population which is at higher risk of compassion-based practice eliciting distressing memories.

Previous research on the experience of persistent pain participants participating in compassion-based interventions is limited by study quality, piloted bespoke programmes and research questions and findings that did not explicitly addressing potential adverse experiences (Chapin 2014; Gooding et al., 2020; Parry & Malpus). There is more extensive qualitative research on MBIs for persistent pain (Hawtin & Sullivan, 2011; Kerr et al., 2011; Luiggi-Hernandez et al., 2018; Moore & Martin, 2015; Morone et al., 2008; Van Gordon, 2016), with recent studies designed to explore adverse experiences (Bawa et al., 2021). However, none of these studies cover the experiences of compassion-based practice. Furthermore, the existing research into challenges experienced in compassion-based meditation has been not been with people experiencing persistent pain and so cannot be assumed to transfer to this population.

Therefore, the current study aims to explore the experiences of participants of MfH with persistent pain during the compassion-based session, including the compassion-based

meditation ("open-heart meditation"), their perception of how they manage both pleasant and difficult experiences and how they perceive these experiences to relate contextual factors. MfH is chosen as a standardised approach based on evidence-based MBIs specifically for people with pain and health conditions.

The study aimed to address the following questions:

- What are the positive, neutral and difficult experiences of participants during the compassion-based session of the MfH?
- Where participants have encountered difficult experiences, how do they talk about managing these experiences?
- What is the individual's perception of how their context interacts with their experience of compassion-based session?

Method

Design

The study aimed to understand the experiences of participants, a qualitative approach was adopted (Harper & Thompson, 2011) and more specifically Interpretative Phenomenological Analysis (IPA). IPA is designed to explore the meaning that individuals describe to explain their experiences, whilst minimising the overt influence of scientific theory or psychological models (Smith et al., 2012). IPA has been used extensively with persistent pain populations (Smith, 201) and its use informed the interpretation of participants' experience of compassion and pain within the programme and its wider relevant experience within their lives (Harper & Thompson, 2011).

Participants

A purposive sampling approach was chosen to target persons relevant to the study's aims (Smith et al., 2012). Eight participants were recruited, which is in line with guidance for a doctoral thesis using IPA (Larkin & Thompson, 2012). Participants were recruited from MfH delivered by Breathworks accredited pain management service (Health & Community Services) (Breathworks-mindfulness, retrieved February 2022). The criteria for persistent pain adopted by the service match those listed in ICD-10 (Treede et al., 2015), which was reflected in the sample, and inclusion and exclusion criteria were as detailed in *Table 1.* All participants were adults (aged 42 to 64) White British, with one British-Romanian participant *(see Table 2).* Further details are omitted to protect anonymity of participants.

Table 1

Inclusion and Exclusion Criteria

Inclusion	Exclusion
1) Capacity and willingness to provide informed consent	1) Significant on-going risk to self or others, as assessed by the assessing clinical psychologist at the pain management service
2) Aged eighteen or above	2) Participants who were terminally ill or have a dementia diagnosis
3) A primary concern relating to persistent pain condition (duration exceeding three months)	3) Participants who do not have capacity to consent

4) Ability to communicate and literacy in English	4) Participants who did not complete the session including the open-heart meditation
5) Completed six to eight sessions of the MfH	
6) Had completed the programme within the prior six months	

Table 2

Participant Demographic Details

Pseudonym	Gender	Relevant pain-related information
Beth	Female	Migraine and neuropathic widespread pain
Claudia	Female	Migraine related pain, neck pain
George	Male	Abdominal pain, lower-back pain
Laura	Female	Headache pain, previous cancer, Sjogren’s syndrome
Maria	Female	Previous primary brain tumour, Fibromyalgia
Martha	Female	Lower-back pain
Pauline	Female	Myalgic Encephalomyelitis, Fibromyalgia
Susannah	Female	Musculoskeletal pain, Dysesthesia

Recruitment and procedure

Participants were made aware of the research in the initial MfH session and were approached as a group at their final session, where they were offered participation

information and contact details to find out more. Informed consent was obtained for all participants. The interview was a 45-60-minute semi-structured interview to be flexible in discussion of diverse experiences relevant to the project (Appendix A). Interviews were conducted individually in person. Trust policy and guidance was followed for the safe storage of audio-recording and transcripts on a password-protected, encrypted drive, with personally identifying data removed or replaced with codes for all written transcripts.

Intervention

MfH is an accredited eight-week MBI specifically developed for long-term pain and health difficulties, comprising mindfulness theory, meditative practice and discussion about the meditation experience. Sessions were delivered by Breathworks accredited staff, including a Consultant Clinical Psychologist, Clinical Nurse Specialist and Assistant Psychologist. The group ran eight 2 ½ hour weekly sessions over a nine-week period. The service ran two groups at a time, four times a year. Participants were recruited from four groups over a six month period. Participants accessed the MfH following a multidisciplinary assessment and attendance to a pain education day informed by Explain Pain (Butler & Moseley, 2013). The compassion-based meditation is the ‘open-heart’ meditation, that is presented in week six (Appendix B) with the three regulation systems model (Appendix C)

Semi-Structured Interview

The interview schedule was developed using existing clinical experience and literature in Mindfulness, Compassion and persistent pain. The interview scheduled was piloted with a research consultant with experience in mindfulness before it was finalised. The researcher conducted the interviews and was external to the service and MfH delivery, which helped facilitate a safe environment and minimise social desirability bias in responses concerning treatment, where there could be negative repercussions of disclosure. Initial

questions opened the participant to their wider context ("could you give me a brief history of your experience of pain, from when it started to when you arrived on the Mindfulness for Health programme?"), before focusing more specifically on MfH and session six, with prompts as necessary. Focus progressed to the practice ("As best as you can remember, how did you experience that practice from the beginning?") with further questions relating explicitly to any difficult experiences and how these were reacted to in session.

Ethical Considerations

Ethical approval was sought and obtained through the Health & Community Services Research Ethics Committee. The research was conducted in accordance with the BPS code of ethics and conduct (BPS, 2009) and a risk assessment was completed in service for each participant as required by the service. Personally identifying data was removed or replaced with codes for all written transcripts.

Position of the Researcher

To support the integrity of qualitative research, researchers are advised to engage in reflexive analysis, which involves reflecting on the potential influence of their own experiences on interpretation of the data (Finlay, 2006). The researcher assumed a critical realist stance for this study (Maxwell, 2012), which holds 'pain' and 'compassion' within an ontological realist position, whilst acknowledging a form of epistemological constructivism and relativism. The researcher is a dual British French white male. The researcher has previous experience using mindfulness and compassion-based approaches in clinical settings and has developed an interest into the relationship between compassion and pain from both a professional interest and personal experience with persistent pain. The research considered differences in gender, disability, sociocultural background and age during analytic process (Davis, 2016; Smith et al., 2009).

Data Analysis

Interviews were transcribed by the researcher. The process involved the researcher listening to the audio recording once prior to transcription, during transcription, and once following transcription, to promote accuracy and familiarisation with data. Pseudonyms and the anonymising of personal data ensured confidentiality for participants.

Interview transcripts were analysed using IPA and its principle of 'double hermeneutic', following guidance outlined by Smith et al. (2009). This involved a line-by-line examination of the generated themes, which were developed through careful repeated reading of individual manuscripts and noting descriptive, linguistic and conceptual comments. Generated themes were then identified, which informed a discussion between the author and research supervisor to critically examine the generated themes and inform an interpretative account (Larkin & Thompson, 2012; Smith, 2017).

To promote the validity of the identified themes, an independent researcher not involved with the study and with previous experience in IPA, blind read one transcript and made comments on generated themes. Similar themes were identified in the transcript, with variation in the language used to describe semantically similar themes.

Quality Assurance

Interview schedules were informed by Yardley's (2008) core principles for evaluating the validity of qualitative research: sensitivity to context, commitment and rigour, coherence and transparency and impact and importance. Yardley's (2000) principles of assessing validity of qualitative studies were followed throughout the study, including the importance of reflexivity and ensuring that the analysis was grounded in the data. This included, an external supervisor cross-checking parts of the analysis and the researcher kept a reflective

diary, which was used to consider the researcher's power and involvement, and included reflections on discussions about preconceptions and experience of compassion and mindfulness. One page of anonymised transcript was coded by a researcher external to the research team and compared to the researcher's initial codes, where difference were noted in linguistic rather than conceptual terms.

Results

The analysis generated five master themes ("Turning away from self-with-pain", "Self-with-pain experienced as shameful", "Facilitating change", "Turning towards self-with-pain", and "Accepting self") and eleven sub-themes, illustrated in Table 3, with examples of initial codes from which each theme and sub-theme were developed provided in Appendix D. Quotations are presented as exemplars of interpretative points.

Table 3

Master themes derived from analysis

Master Themes	Sub-themes
Turning away from self-with-pain	• Efforts to control or avoid pain • Previous traumas
Self-with-pain experienced as shameful	• Critical-self and pain • Cultural and personal relationship with compassion • Pleasing others to reduce feelings of shame
Facilitating change	• Personal factors involved in being ready for change • Mindful awareness facilitating compassion practice • Shared experience of challenge as a group
Turning towards self-with-pain	• Experiential learning and process of overcoming personal defences • Confronting difficult experiences in compassion-based meditation
Accepting self	• Evolving sense of empowered self and committing to value-based activities

Master Theme 1: Turning away from self-with-pain

Participants identified a self-with-pain prior to the programme, where they recognised their efforts to control or avoid the experience of pain and distress so that they could manage the obligations of their life. These were understood as long-standing strategies, whose perseverance was not easy to overcome due to their habitual nature and the perceived suffering that would be induced if they were to turn towar.ds the pain. This master theme comprised the following sub-themes.

1.i Effort to control or avoid pain

Participants detailed various strategies to either avoid or control the severity of their pain so that they could engage with activities of daily living. However, these required a detachment from their present self, which could often lead to "boom and bust" cycles, where periods of over-activity are followed by pain flare-ups and self-criticism. For example, with Pauline, there was a lost sense of self and, similarly, George describes the externalised focus on controlling factors in his environment to minimise flare-ups.

"I'm not kind with myself, I just… just get on with it. If that makes sense? Yeah, I'm just (sigh). I'm just here. I just get up, get dressed, go on, go to work, do what I've got to do, get off, take my painkillers. I'm not kind to myself. Don't ask me why, I don't know." Pauline

"Well, I think that's what we all do in life and there's like this… it's a control issue. We feel as if we've always got to control everything that's going, you know, our lives, so there's no pain. To stay away from the pain." George

This reflected in participants' initial experience of compassion meditation that appeared to be influenced by their avoidance of their self-with-pain, manifesting in self-criticism or an aversion toward the invitation for self-compassion. For Claudia, she

recognised that her aversion towards the narrator of the compassion-based meditation arose from feelings of shame and the opposition caused between a self-compassionate self and a self-critical self.

"I found the meditation really hard and I got very agitated and… cross with the lady on the record. She's saying about, you know, love yourself or, you know, be compassionate to yourself. Be kind to yourself or in a kindly manner or something. And I'd sort of in my mind, I'd be answering her back… in a very agitated way, and I'm not going to be compassionate to myself 'cause I don't like myself. So I sort of ended up we're having a… bit of a battle."

This self-criticism was expressed in inner narratives, where some participants described their habit of avoidance clashing with an invitation to turn towards their suffering that initially seemed counter-intuitive.

"Try to be kind with yourself… how can you try to be kind to yourself when you are in pain?" Maria

"We really struggled, like, what am I doing here? Don't quite get it. What… what are we trying to achieve here?" Suzannah

1.ii Previous Traumas

All participants shared difficult memories, adversity or periods of heightened stress that were associated with the beginning or worsening of their pain condition. Participants experienced the distress of the trauma that was felt in the present, suggesting that there were both pain and psychological distress triggered by traumas that continued to impact them. Therefore, pain avoidance existed in addition to avoidance of traumatic events and the consequent negative beliefs about the self. For example, Beth's experiences of ill-health and healthcare were, in themselves, traumatic. However, these were experienced within the

negative self-belief from highly critical interpersonal dynamics with a close family member that has left her 'scarred for life'.

"It takes me right back to my childhood and we went through these things (sigh) I had in my life… five life threatening situations that I've been in. So I've had this excessive trauma and also in my early years… we suffered really toxic, uhm, emotional abuse from, uhm, my father's mother. Actually very, very toxic abuse that has sort…of scarred for life." Beth

Master Theme 2: Self-with-pain experienced as shameful

Participants had both internal and external sources that influenced feelings of shame associated with the self-with-pain. These experiences had a degree of intersectionality, where factors such as their education, family and experiences with healthcare shaped a relationship with pain that sought to hide the self-with-pain rather than nurture it. Experiences of shame were understood to lead to participants trying to promote their self-esteem by controlling social evaluation from others, where to reduce feelings of shame, they often took caring dynamics with others and neglected their own needs.

2.i Critical-self with pain

Participants expressed self-criticism that had manifested in response to pain and pain-related interference, where participants identified with an expected life or previous life that they had lost because of their pain. For example, their pain conditions prevented them from engaging in many activities of daily living, which led to feelings of guilt and social isolation in a social network of people without persistent pain. With Laura, isolation was a factor that influenced self-criticism, as it acted as a reminder of the exclusion that she was experiencing. For example, for Maria, pain-related disability manifested in social interactions, where she

felt shame for the expectation of how she should present and the way in which she thinks that she presents.

"You know, it's a long time to be sat at home, by yourself and not able to drive, do stuff and you do feel really isolated and sort of left to your own devices… hiding away" Laura

"And also feeling blamed for the way things were going…. Because the pain is slowing the brain. I cannot engage in conversations with people. I'm just physically there, but I cannot engage if they bring a subject to the table." Maria

2.ii Cultural and personal relationship with compassion

Participants' understanding of compassion was developed through dynamics with their family, their culture and institutions they interacted with, such as healthcare. Compassion was typically framed as a quality that is given to others, where it is one's duty to serve those who suffer. Whereas, it was understood as shameful to be compassionate towards yourself, such as 'loving yourself'.

"…but we weren't nurtured in a way to be… it was a bad thing if you loved yourself… and compassion towards yourself was associated with arrogance, so it's quite a negative thing. It's almost like, loving yourself was kind of being self-absorbed." Claudia

"You're taught when you grow up that the compassion was for everybody else apart from myself." George.

Compassion towards the self-with-pain was also shaped by a relationship to self and suffering that seeks to eliminate suffering rather than nurture it. In healthcare, this manifested as a focus on a diagnosis that could lead to a treatment within a biomedical understanding of pain rather than care for the self that is suffering.

"It was really, really bad and I didn't know how to describe it and I was searching and searching and trying and trying… for more than three years I was trying to find an answer for it. Trying to speak with people who could help me and find a name for it." Maria

The biomedical framing of a self-with-pain were experienced as shaming, where there was an absence of empathy for symptoms that were not physically visible and the feeling that the lived-experience of pain was disregarded. For Beth, this experience was exemplified in invasive assessment procedures and feedback that felt dismissive and inconclusive. This led to feelings of shame, where being invalidated gave her a sense that there was something wrong with her.

"I had lots of scans, lots of sort of questionnaires, all kinds of things, and each clinic at the end of the investigations they did, they just go "yeah, well, you're absolutely fine" or "you don't quite tick marks" or, you know, "you've not got anything severe" and (sigh) it was very difficult for me."

"And having spent all these years thinking that there was something wrong with me, like why does nobody else see all these symptoms? Why does nobody else take this seriously? Am I just being a fraud? Am I mentally ill?" Beth

2.iii Pleasing others to moderate feelings of shame

To moderate the impact of a self-with-pain that was experienced as shameful, participants described efforts to promote their self-esteem. As self-esteem is dependent on social evaluations, participants described the extent to which they focused on pleasing or appeasing others, often through being carers and attending to their needs at the expense of their own needs.

"I'm not going to give compassion and… well, to myself, anyway. To everybody else, yes. If I've been working like eight hours, if my friend wants to go shopping 'cause she feels bad, I'll just do it even if I was tired, I would… I wouldn't say no, that's me. I'm not the person to say no to other people. I want to help everybody." Martha

With Suzannah, these feelings became very apparent when she was in a hospital bed, which she attributed to illness arising from exhaustion, and she was pushing herself to get better because "*what good am I to them [parents]*" in the hospital. Here, her need to be a carer for her parents was emphasised in her drive to recover so that she can serve her parents, rather than a motivation to alleviate her own suffering in itself.

Master Theme 3: Facilitating change

There were factors at the outset, during the programme and following its completion that participants understood as necessary for managing and engaging with compassion-based practices. From participants arriving at the programme with a commitment to change, to the group and personal processes that support them through difficult experiences, participants' accounts suggested that personal commitment had to co-exist with the foundations of compassion, such as compassion from others, feelings of shared humanity and mindful awareness.

3.i Being ready for change

Participants experienced moments where they noticed the need for a change, which appeared to increase their willingness to engage with the difficult experiences involved in compassion-based practice. These were sometimes accompanied by moments of severe distress, where there were highly salient moments of a change in perspective, such as with

Suzannah, whilst in a hospital bed, noticing that the absence of self-compassion was involved with her ill-health and that she needed to change for herself rather than others.

"I hit a brick wall and I literally went 'I need help' and then suddenly…I said I will take it and grasp it…'cause I...need to look after me." Suzannah

However, others perceived mindfulness as the last available option that could treat their pain condition. Healthcare was described as prioritising biomedical treatments, which were sometimes accompanied by harmful unwanted effects, interpersonal feelings of being dismissed and the failure to find the sought after treatment. Therefore, some participants engaged with MfH as a *"last chance saloon" Beth.*

3.ii Mindful awareness facilitating compassion practice

Participants described the process of developing mindful awareness, whether through meditations or new habits, which were necessary in turning towards pain and, therefore, bringing compassion towards that suffering. These were unique in each participant, for example, Suzannah practiced the breathing anchor and body scan as practices that could be used to promote present awareness of the self and allow her to take a more compassionate position towards herself.

"I had a sore place on my foot and I had been kind to myself because … ordinarily I would have just like, you know, whatever, but I was actually careful with my foot. Consciously careful, which really surprised me, 'cause I've never really done that before, you know? Just hold it." Claudia

The facilitator was understood as important to the process of nurturing the necessary Mindful Awareness. In this way, the facilitator modelled compassion towards participants and assisted the group dynamics.

"She [the facilitator] was good at listening, good at picking up on things that I wouldn't necessarily have picked up on myself, you know, she would hear something and then we would discuss it." Beth

"And so when I was put into this [programme], it was almost like a huge relief (sigh), now someone is going to take me seriously, somebody is actually taking care of me, sees me as who I am, if that makes sense?" Suzannah

Here we understood that the facilitator's person-centred approach was important to the development of a mindful awareness of the self in participants. This was supported by active listening, validation and involving participant's experience in the group discussions.

3.iii Shared experience of challenge as a group

Through the group facilitator assisting an environment where participants felt confident to share their experiences, there was the facilitation of a sense of "shared humanity" in their pain experience. This was particularly salient among people with persistent pain, where participants described an almost unspoken understanding of one another's pain. At other times, there were explicit acts of social support through difficult moments. For most participants, this change from individual to group identification was evident in the change of pronouns from "*I*" to "*we*" or "*the girls*", which emphasised the group's cohesion. It was understood that feelings of shared humanity and being compassionate towards others in the group facilitated being open and compassionate towards their own previously shameful self-with-pain

"There was no like, 'we can't say anything 'cause I think I'm stupid or I don't get this'. Everybody just literally was comfortable with people around them and realised that, you know? And the sharing part for me was the best because it was, you know, it just makes

you feel how different every person thinks. They might feel something different, but they're putting it all in the melting pot and you could take something away." Suzannah

"And so when I returned to compassion to myself, you know, from that I… I think having gone through that little journey of compassion for the entire world, you know…if you go through that little journey actually coming back to compassion for myself was a bit easier."

Master Theme 4: Turning towards the self-with-pain

Some participants described the compassion-based session as overcoming their previous defences (avoidance, control) to turn towards the self-with-pain with acceptance and compassion. The meditations and compassion-based discussions were recognised as challenging and potentially upsetting, but engaging with the practice was seen as rewarding.

4.i Experiential learning and process of overcoming personal defences

During the initial sessions up to the introduction of the three regulation systems, the participants were recognising patterns that were aimed at controlling or avoiding pain and the subsequent importance of removing these barriers to facilitate meaningful change. However, it was through practicing the meditation that all participants noticed changes, where the compassion meditation facilitated a different way to relating to the self and the pain. Taking a non-judgemental position of acceptance allowed participants to engage with the practice without the fear of perceived failure, even where these experiences were not initially pleasant.

"I think what was really good was the way we were told that there's no right or wrong for doing this, 'cause I…think a lot of things you do, in life, you're not confident if you're doing it at home by yourself because you don't know if you're doing it right, and it's

really reassuring if there is no right or wrong answer, don't worry, and listen to what's happening" Pauline.

For some participants, a guided experiential process allowed for a novel way of relating to themselves, which was described in particularly salient and emotive language that suggested a new relation with pain and the self that modelled self-compassion.

"When we were doing it [open heart meditation], he [facilitator] was saying you could hug the pain. Now I've never thought of that 'cause I'd stabbed the pain, kicked the pain all over the place but never thought of hugging it. It's a totally different way of looking at it and honestly never in my life have I sat there and thought 'it's Ok to look at that pain' I'd like to kill the pain. I just smashed it all over the place. This had taught me to love it and that makes me feel different." Pauline.

For *Martha* and *George*, their descriptions of compassion-based practiced remained on an abstracted and conceptual level rather than an account of an experiential process. Neither gave accounts of confronting difficult experiences and one possibility is that this reflects less experiential engagement in practice than others and a tendency to avoid distress.

4.ii Confronting difficult experiences in compassion-based meditation

It was acknowledged by participants that turning towards the self-with-pain with compassion could be difficult, as it involved addressing the distress and loss that they had been avoiding or trying to control up until the meditation. However, for some, engaging with the meditation in the group was seen as helpful as the environment was perceived as containing and supportive.

"Every one of us, you know we ended up in tears at some stage, but it wasn't because we were unhappy, it was because there was some triggering of something in somebody." Suzannah

Although these were often described as revelatory experiences, in their novelty and contrast to previous ways they managed distress, participants took a degree of perspective, understanding that the compassion-meditation was not necessarily a life-changing event but a salient experience that they would want to continue working on.

"Yeah, I think it's to do with being let down. And relationships. And uhm… that's it, it is men and relationships, and I think you just put barriers up because you've got to protect yourself and your daughter and just plough through. So this meditation, it's going to be a… first step…so you're going to chisel away". Claudia

Importantly, these experiences were not confined to the session, with some participants described their commitment to nurturing a self-compassionate position beyond the group. These changes were specific to each individual, who found their own way to turn towards the self-with-pain with the aim of alleviating the suffering. Although not mutually exclusive, this involved either promoting an awareness of the self so that a more self-compassionate position could be taken or recognising one's own suffering and connecting with others to communicate their suffering earnestly and seek the necessary support.

"It made me really think about it because you're so busy doing, you don't often think about yourself. And then what I've taken from the course is actually recognising what I do, which I probably didn't, I would never actually think about." Laura

"[Work said] we understand that you're not well at the moment, and if you need help, you know if you need support then let us know and we can put it in place. You know, I spent a lifetime hiding issues form work." Beth

Here we understood participants addressing a previously critical-self with pain, isolation and a lack of awareness of self, which lead to changes an openness to their social network and acceptance.

Master Theme 5: Accepting self

Most participants described a change following their compassion-based practice, which though powerful in some accounts, was also tentative in the face of uncertainty following the loss of their group and the challenge of living with persistent pain.

5.i Evolving sense of empowered self and committing to value-based activities

The role of compassion manifested in how participants viewed their position in their social network, where a self-with-pain was no longer fused with shame, but had developed into an evolving sense of empowerment that allowed them to feel confident engaging with valued activities. In Beth, this was expressed in spontaneous responses that contrasted with a previous self-critical self, leading to cherished moments that she recounted with pride. With these changes, was a sense that there was a new self-emerging.

"I had a really difficult problem with somebody who'd done something that was really out of line and I decided… I dealt with it in quite an assertive way. I'd felt the anger in me but normally I wouldn't do anything about it when I'm feeling angry, 'cause I don't trust myself. But actually I felt the anger, I recognised where it was. Where I felt it. Why it was anger. And just dealt with it very short and sweet and assertive and is what I'm doing and that, uhm, which was very different to how I would normally have done it. … and that helped

me with the compassion, because I began to think, you know, you are actually worth something, you are actually, you know, quite capable and you can be assertive."

Participants did not describe a sudden transformation despite the salience of some of their experiences, as it was acknowledged that continued self-compassion, awareness and acceptance was necessary to maintain change. For some, they saw the eight sessions as a necessary moment to change their life's trajectory or begin the challenge of addressing their defences and nurturing new ways to respond to suffering.

"Well, maybe there's like a little fissure now in the rock and a tiny trickle of water opening up in this heart on concrete that I have for myself." Claudia

With Maria, there was a sense that the programme had led to positive change, however, she was still seeking guidance to keep her on this new trajectory. Participants often expressed a longing for the group, where they had connected with others and felt a positive change, but were conflicted by the loss of that group, its perceived short-duration and the uncertainty of returning to their lives without the group.

"I've learned things, I've changed things. But I still need guidance and I still need support and… it was a good way of socialising with… Mindfulness, the people there and everyone is moving on with their lives."

The phrasing of socialising with Mindfulness could imply the unique way of relating to others in the group, along with Maria's acceptance of the common humanity in people's separate trajectories and the recognition of challenges that may lie ahead.

Discussion

This study sought to explore how participants understand their experience of compassion-based practice as part of MfH, including how they manage difficult experiences and understand these within their context. The eight participants provided rich and detailed accounts of their experiences and these were analysed with IPA and organised into five master themes. Analysis suggested a process from a self-with-pain experienced as shameful, where individuals described a critical-self within social structures that often felt blaming and dismissive. Turning towards the self-with-pain was understood as integral to the compassion-based practice and towards a compassionate acceptance of self, where personal factors, experiences within the group and mindful awareness helped facilitate this change.

Previous attempts to avoid a critical-self reflected both an understandable attempt to avoid the intensity of unpleasant somatic and psychological distress, and a phenomenon widely acknowledged in persistent pain sufferers that is theorized to maintain their persistent pain condition (Crombez et al., 2012). The reliance on these defences was evident with participants' resistance towards compassion-based practice, which invited them to turn towards their self-with-pain or difficult past experiences. Importantly, strategies to avoid or control pain extended beyond the experience of pain to the emotional distress elicited by difficult memories. This is important when considering the prevalence of mental health concerns and previous trauma in persistent pain populations (Lopez-Martínez et al., 2014).

These efforts to avoid or control pain were understood in the context of the critical-self, where participants noticed pleasing or appeasing others served to negate possible negative social evaluation from social networks and institutions. One example in the findings was healthcare, which is consistent with previous studies that have highlighted interactions that are perceived as eliciting shame in those with persistent pain (Nicola et al., 2021). This

study suggested that such long-term patterns may have related to a family or cultural norm where compassion is given to others rather than the self. Participants also made links to a highly critical environment that led to hyper-vigilance to potential negative social evaluation that manifested as self-criticism, which is a common phenomenon in pain populations (Kempke et al., 2014). Literature suggests that whereas a drive to achieve positive social status and positively judged attributes may reduce interpersonal threat, this can impact acceptance of persistent pain, and necessary adjustment and pacing (Depue & Morrone-Strupinsky, 2005). Therefore, engaging with compassion-based meditation was described as occurring in the context of participants who used avoidance and control to manage a self-with-pain associated with shame.

The experience of the compassion-based session involved a challenge in turning towards the self-with-pain and overcoming the barriers that they adopted to protect them, such as avoidance. The participants' experiences reflected the distress sometimes encountered in meditative practice (Britton et al., 2021), where practice confronts participants with adverse attachment experiences (Gilbert, 2009) and previous traumas (Lutkajtis, 2018). However, the participants described a recognised phenomenon; that it can be necessary to attend to their pain and suffering before they can nurture self-compassion (Farias et al., 2020). This corresponds to a theorised process whereby the participant nurtures an ‘open monitoring’ of experiences so that they can begin to be compassionate towards the self (Zeidan et al., 2011). It appeared that these positive changes were accompanied by acceptance, where feelings of shame were alleviated to facilitate a less judgemental and more compassionate awareness of the self. Where feelings of shame were alleviated, it was understood that this allowed participants to experience less avoidance strategies or self-criticism, as they no longer felt as strong a need to hide their self-with-pain. These changes are consistent with theory and research suggesting a focus on acceptance and non-

judgemental awareness that reduce 'secondary suffering' through addressing habitual patterns that worsen pain intensity, such as avoidance strategies, pain catastrophizing, psychological distress and physiological responses to threat (Chiesa & Serretti, 2011; Crombez et al., 2012; Zeidan et al., 2011). However, although these experiences were often described as highly salient in their novelty, this study indicated that these were understood as the beginning of a change in their trajectory rather than transformative events.

Some participants identified strongly with the group, especially amongst women, who shared a sense of solidarity in their experiences. There is recent literature on disparities in accessing physical and mental healthcare group programmes in men and women (Emslie et al., 2006; Gough & Robertson, 2010), where one explanation is that men are less likely to engage with group-based support due to conflicts between hegemonic masculinity and the perceived 'feminine' activity of engaging with mental-health orientated activities (Noone & Stephens, 2008), including compassion (Yarnel et al., 2019). Additionally, disability and being 'othered' can be a barrier to engaging with a group of non-disabled participants (Johnson et al., 2004). Accordingly, one male participant and a female participant with a disability did not identify strongly with their group and gave accounts of their experience of compassion that were largely abstracted and conceptual rather than emotive and experiential. These participants might have also experienced barriers within the group relating to the experience of difference in disability (Davis, 2016) or difficulties engaging with peer support due to gender norms (Addis et al., 2016). This peer support might have been necessary to create the interpersonal safety that reflects a secure-attachment that Mikulincer and Shaver (2005) theorised as necessary to self-soothe from the distress elicited by difficult experiences during the session. This study suggests that compassion towards others and a sense of 'shared humanity' facilitates an acceptance of the self-with-pain and helps alleviate the shame associated with pain, allowing people to better turn towards their pain. However, where

difference was a barrier to associating with the group, this may have led participants to rely more on avoidance due to the lack of perceived internal safety (shame) and external safety (the group). Therefore, this might have limited the development of 'focused attention' and 'open monitoring' theorised as necessary to bring self-compassion to one's pain and suffering (Lutz et al., 2008; MacLean et al., 2010).

Overall, the way participants described how they managed the initial challenge of compassion practice reflected previous literature, such as using mindful awareness to address avoidance strategies (Tirch, 2010), compassion modelled by an attentive facilitator (Naismith et al., 2019), the feelings of shared humanity in the group to overcome shame (Au et al., 2017; Farr et al., 2021), and acceptance of the-self-with-pain (Smith & Osborn, 2007).

Strengths and limitations

IPA emphasises an in-depth understanding of human experience rather than generalisability of findings (Smith et al., 2009). Importantly, participants were self-selected and only participants who completed the programme participated in research. Completers with adverse experiences of the compassion practice may not have opted in despite the invitation to share both positive and negative experiences. This may have led to a bias towards participants who benefitted from the programme (Collier & Mahoney, 1996). This might be apparent in the diversity of the sample, where mostly White-British women participated and the study did not represent men and those of marginalised ethnicities present in the population (Mills et al., 2019). Research in healthcare group programmes suggest that those of minoritised demographics might experience additional challenges in benefiting from group support (Mentis et al., 2019). This could include barriers to attaining an experience of 'shared humanity' that were understood as facilitating self-compassion in participants.

Unlike many studies in MBIs and compassion-based interventions, data collection and analysis were performed by a researcher external to the facilitation of the programme and not employed by the providing service, reducing potential favourable biases in participant interviews and interpretation of data. However, it can be difficult for participants to provide retrospective accounts of experiences that occurred at a single point some months prior to interviews, making it harder to connect with their initial experience.

Clinical implications

Participants described a primacy of biomedical conceptions of pain in previous healthcare interactions. On uncovering the absence of a clear pathology or structural abnormality, participants described shame and self-criticism, where their suffering was related to having "nothing wrong" with them and, what has been discussed in literature as, the expectation to overcome their disability with their own extraordinary effort (Wendell, 2006). However, the continued search for a biomedical "answer" to pain located not in pathology is, although an understandable response to unbearable suffering and the influence of healthcare, nonetheless a barrier to compassion practice. For compassion practice, it is necessary to be aware of one's suffering, accept suffering within the self and others, and nurture the one who suffers. Similarly, mindfulness has an aim to reduce pain-related suffering rather than target the pain intensity directly. However, a biomedical conception of pain might involve avoiding suffering through a primary aim to control, eliminate or avoid pain (Lima et al., 2014). Therefore, clinicians need to be aware of a participant's paradigm shift between biomedical to psychologically informed understanding of pain, as the intention of compassion-practice is contradictory to biomedical treatment of pain. Therefore, careful preparation and education (e.g. pain education prior to programme) would benefit participants prior to compassion-practice rather than risk contradicting participant's beliefs without them having foundations to ground a new biopsychosocial understanding of their

pain. Such preparation could also address barriers to group entry and drop-out, where participants may disengage because of these conflicts.

Communication that addresses shame is integral to this process, with a population highly alert to shame manifested in vigilance to negative social evaluation and self-criticism. Achieving positive change appears to be more challenging for those with self-criticism (Carvalho et al., 2019) and developing acceptance of pain (Costa & Pinto-Gouveia, 2011), which is reflected in the experiences of participants who dropped out as being socially isolated, having self-critical responses to distressing experiences and not feeling connected to the group. The drive to achieve positive social status by attempts to control how the pain is perceived and strategies control one's own pain is the goal of avoidance strategies and self-critical perfectionist patterns common in people with persistent pain (Kempke et al., 2014), yet these goals impact processes of acceptance and the adjustment and pacing necessary to effectively manage pain (Depue & Morrone-Strupinsky, 2005). In contrast, participants who described positive change often cited a process of pain acceptance and self-compassion that was facilitated by belonging to a group and a sense of shared humanity, which is consistent with literature (Crombez et al., 2012; Wren et al., 2012). This suggests the importance of attending to group dynamics and reaching to socially isolated members of a group to dismantle shame and isolation, rather than a focus predominately on strategies reduce subjective pain or outcomes tied to positive social evaluation. However, clinicians should be attentive to difference within the group that may isolate members from bonding helpfully to the group and feeling able to share difficulties and concerns. This is especially important for characteristics that are associated with societal shame, such as socio-economic background, minority ethnicity and disability (Arboleda-Flórez, 2003). For instance, this research suggests that developing open and trusting relationships with participants can protect participants from adverse outcomes or drop-out by encouraging appropriate disclosure of any negatively

evaluated comments participants receive from the facilitator or group members regarding their identity or difference. This would contrast with participants with difference being socially isolated and potentially harmful exchanges going unaddressed.

However, focusing on the group has several important barriers, including group duration, time to develop trust in the group and the risk of deterioration following its termination due to participants falling back into unhelpful patterns following the programme. Participants also face the challenge of investing and learning in the interventions' contrasting philosophical approaches to the biomedical model of illness and pain, which was linked towards numerous dropouts. Yet, initial worsening of pain experience or discomfort in the group did not necessarily lead to negative outcomes and clinicians may benefit from being aware of the risk of participants being isolated with distress rather than understanding that this could be part of a process to meaningful change. Where appropriate, attending to difficult or upsetting experiences after meditative practice or discussions could help frame distress as part of this process of developing self-awareness and compassionate acceptance, rather than perceived failure. Likewise, these interactions could address dissonance of uncertainty when transitioning from a bio-medical conception of pain to a often complex multifaceted biopsychosocial understanding.

Although MBIs and compassion-based approaches acknowledge that their outcomes have a broader focus on well-being and changes in lifestyle, it is important that clinicians recognise self-reported change in pain intensity, pain-related distress, and pain interference evident in many participants. Despite some changes being attributed to mindful or compassion-related changes in acceptance, awareness and perspective, participants also benefited from a skills-based change and feelings of empowerment that the 'tools' they acquired could be used to manage pain.

Research implications

MBIs and compassion-based interventions do have participants who disengage from the intervention, suggesting that some participants either do not engage or experience adverse experiences without subsequent positive change. Recruiting these participants is challenging, as they are less likely to volunteer (Collier & Mahoney, 1996). Nevertheless, it is important to understand more about the experience of compassion-based practices for those who do not experience positive change, are unable to manage difficult experiences or whose context prevents them from engaging. This could provide useful information regarding how facilitators could best address those who are vulnerable to adverse experiences. Factors such as supportive group dynamics, acceptance of self-with-pain, and successful acquisition of mindfulness skills might be necessary for participants to successfully engage with the compassion session and further research could explore participants who experience barriers with these factors and how to better support them within the programme. This would benefit from more diverse samples, including cultural and ethnic diversity, disability and gender, especially where this research has suggested possible links between a participants' context and their experience of compassion-based practice. There is a growing field of research into the development of acceptance and awareness in pain populations, and linking these meaningfully to the experience of compassion could help further uncover processes and challenges integral to developing compassion in pain.

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