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'All these things don't take the pain away but they do help you to accept it': making the case for compassion-focused therapy in the management of persistent pain

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Abstract

Background: People with persistent pain are frequently offered a pain management programme (PMP) as part of their care plan. Cognitive behavioural therapy (CBT) principles often underpin PMPs and has a good evidence base; nevertheless, more recent systematic reviews have suggested that its effectiveness is limited. Compassion-focused therapy (CFT) is a form of 'third-wave CBT' that offers an alternative and complementary view of pain, encouraging the person to be alongside their experience of pain and respond to it using skills of compassion they have learnt.

Method: The current research explored the effectiveness of a 12-week CFT group for people who experience persistent pain. Research interviews explored CFT members' experiences of the CFT group. Feedback was collected on the facilitators' experience of running the group and questionnaire data collected on participants' mood, pain disability, acceptance of chronic pain and levels of self-criticism and self-reassurance.

Results: Interviews were analysed using interpretative phenomenological analysis that revealed five master superordinate themes representative across all interviews. These were then triangulated with data from the questionnaires and facilitator feedback.

Conclusion: In people whose persistent pain was compounded by a significant psychological component, a CFT group approach helped reduce feelings of isolation, improve ability to self-reassure, learn new ways of coping and develop a growing acceptance of the limitations associated with their pain. The possible implications for future clinical practice are considered.

Keywords

Compassion-focused therapy, compassion, connection, acceptance, persistent pain, chronic pain, feasibility, interpretative phenomenological analysis

Introduction

Those who suffer from chronic pain are often offered a pain management programme (PMP), either instead of or in addition to a pharmacological intervention.[1] Cognitive behavioural therapy (CBT) principles frequently underpin PMPs, and there is an evidence base demonstrating some efficacy.[1] CBT approaches to chronic pain theorise that a person may have an 'excessive internal focus' that can develop into a heightened

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state of anxiety sensitivity and greater pain perception. This may increase their level of functional impairment and pain disability.[2] CBT interventions presuppose that the difficulties experienced from pain are cognitively mediated; thus, if we work to change a person's problematic thinking and inaccurate beliefs, we can improve their functioning.[3]

A recent systematic review of randomised control trial (RCT) research looked at the psychological therapies used in the management of chronic pain. The authors found that the majority of PMPs were based on CBT, but their effectiveness was inconsistent.[4] The review was to update an earlier 2009 review and found that the design of RCTs had improved but the quality of treatment provided had not; with fewer hours of contact time and content delivered by less experienced staff. Overall, CBT outcome effect sizes on pain, disability and mood had been sustained from 2009. The additional measure of catastrophizing found only small effect sizes when compared with active controls at post-treatment, and this was not maintained at follow-up. The strongest effects were found on mood outcomes with moderate improvements at post-treatment when compared with treatment as usual (TAU), but this decreased to small at follow-up. The authors highlighted limitations in the studies, as the largest effect sizes were found when comparisons were made against TAU and average scores often masked bimodal scores. Little research considered process outcomes to investigate what specific features of CBT influenced change.[4] Therefore, while CBT remains the main psychological therapy approach used in pain management, it appears to have only limited effectiveness. Furthermore, the current evidence base seems to warrant consideration of the potential mechanisms underlying effective change in PMPs.

Evidence is now emerging about the application of 'third-wave CBT' therapies in pain management settings.[2] 'Third-wave CBT' approaches have grown in popularity over the past 25 years and integrate elements of acceptance, mindfulness and non-judgmental awareness into traditional CBT approaches.[2] Approaches such as Acceptance and Commitment Therapy (ACT) and mindfulness-based interventions have been adapted for use in pain settings with promising findings.[5,6] In the ACT literature, although effect sizes are not superior to CBT, for those who may struggle to engage with traditional CBT due to high levels of avoidance of difficult emotions and difficulty attributing meaning to their lives, ACT may offer a preferred therapeutic approach.[5]

Why use compassion-focused therapy in the management of persistent pain?

Compassion-focused therapy (CFT) is a form of 'third-wave CBT' growing in popularity as a psychotherapeutic approach.[7,8] To consider why CFT may be suitable in the management of persistent pain, we first need to understand more about the relationship between pain and emotion. In recent years, the idea of mind–body dualism has been increasingly challenged and more sophisticated models of pain recognise that both biological and psychological processes are inextricably integrated.[9] Thus, it is important to consider the impact of psychological stress and trauma on persistent pain and its maintenance.

Evidence shows that psychological stress and/or trauma is associated with persistent pain and that people with persistent pain are more likely to be exposed to stressful life events such as loss of marriage and employment.[9] Those who suffered childhood abuse/neglect are at an increased risk of developing chronic pain in adulthood.[10] Consequently, it is proposed that unresolved stressors throughout life may be relevant to our understanding of persistent pain.[9]

Negative emotions can stem both from stressful life events and the experience of being in pain. It is important for people to be able to recognise and process different emotions related to pain as our ability to do this strongly influences our emotional states.[9] Research indicates that difficulties in emotional awareness are related to somatosensory amplification, experiencing normal somatic sensations as intense, which may increase physical sensations related to pain.[11] People who find it harder to express their emotions and prone to defensive and avoidant suppression are more likely to experience greater pain and struggle to adjust to pain.[9] Within social contexts, difficulties encountered by the restrictions of pain such as impact on social role performance can be a contributory factor in people experiencing feelings of embarrassment and humiliation.[12] In a survey of adults with chronic pain, 38% identified with the concept of internalised stigma; negative appraisals of the self caused by perception or anticipation of negative social reactions from others, because of their pain. Internalised stigma was found to have a negative relationship with their perceived self-esteem and pain self-efficacy.[13] This is supported by Smith and Osborn[14] who interviewed people with persistent pain and found people reported experiencing feelings of shame when in social and relational contexts through the process of negative self re-appraisal.[14]

Thus, interventions that encourage emotional experiencing through enhancing acceptance and awareness of one's internal states hold promise. Purdie and Morley[15] propose interventions that focus on developing compassion may be beneficial for people who suffer from persistent pain. CFT offers an alternative view of pain, encouraging the person to be alongside their experience of pain, and respond to it using the skills of compassion they have been taught.[16,17] The model recognises the

Table 1. Overview of the content of the current compassion-focused therapy pain group run by the pain team.

Content overview
Psychoeducation about the nature of the mind–body link
The concept of compassion
Applying compassion to the experience of pain
Working with the self-critic
Exercises aimed at connecting with the experience of compassion and self-soothing the threat response – introducing compassionate letter writing (a compassionate mind training exercise)
Working with fears and blocks to self-compassion

levels of shame and self-criticism a person may have and considers how this may impact upon affect regulation.[18] The compassionate mind model proposes a more comprehensible way of conceptualising human affect regulation by considering the evolutionary function and drivers behind different emotional states. The affect regulation system is made up of three subsystems: threat and self-protection; incentive and resource-seeking and the soothing and contentment system.[18] CFT theorises that people with high levels of shame and self-criticism have great difficulty in being self-compassionate; this disrupts the balance within their affect regulation system with the threat and self-protection system becoming more dominant.[17] Our ability to regulate the three systems is influenced by our 'tricky brains'; the interaction between our old, mammalian brain and new brain which leads to us being caught in competing mentalities and motives.[17] Recent systematic reviews show CFT to be a promising intervention especially when working with individuals who are highly self-critical, but further research is still needed.[7,8] CFT has been applied to physical health settings such as acquired brain injury[19] and used in group therapy contexts.[20–22] However, to date, there is little published literature applying CFT to a pain management setting.

Context and rationale

Dysregulation of the threat system and difficulties with self-soothing may be apparent in people who experience persistent pain. Their high levels of self-criticism and shame may undermine their ability to self-manage and regulate emotions. It has been shown that a person's level of self-compassion can be a predictor in their ability to adjust to pain.[23] The proposed mechanism of this relationship is that those who report higher levels of self-compassion take a more mindful and accepting attitude towards the limitations of their pain. Self-compassion may also buffer against people engaging in negative coping strategies.[24] Therefore, a CFT intervention may be of benefit when working with people with persistent pain.

Aims and objectives

The aim of this study was to explore the effectiveness of a 12-week CFT group intervention for people with persistent pain in a clinical setting. Both psychotherapeutic group and individual change processes were considered. The objectives to meet this aim were as follows:

To explore people's experiences of being in the CFT group, how it has impacted on them following the group and what they found helpful or unhelpful about the group.

To use standardised questionnaires to collect further demographic data on mood, pain disability, acceptance of pain, self-criticism and self-reassurance for group members.

To review the previous objectives in combination with reflections from the facilitators of the CFT group.

Clinical context

The CFT group is a 12-week therapeutic group run in a National Health Service (NHS) pain management service in the South West, designed and facilitated by Clinical Psychologists. Each session runs for 2 hours a week over a 12-week period. A summary of session topics covered in the group can be found in Table 1. This format had been used for two previous CFT groups. The lead author worked closely with the local collaborator in the design of the research based on informal and formal feedback from participants of previous groups. All four questionnaires used in the research were introduced in previous groups. Informal feedback was sought regarding the appropriateness of the questionnaires in relation to people's pain conditions and length of questionnaire.

Method

Semi-structured interviews were used to explore participants' lived experience of the CFT group. To supplement this, questionnaire data were collected and

feedback sought on facilitators' experiences. These findings were considered in relation to the interview data to work towards triangulation of the research findings.[25]

Research design

Qualitative. Qualitative data were gathered to gain a detailed understanding of people's experiences of the CFT group. A semi-structured interview schedule was used as a guide. However, participants were encouraged to discuss anything they felt was important to their experience. The semi-structured interview was designed to explore how people's quality of life (QoL) may have changed, their experiences of pain disability on a daily basis and their ability to apply the 'tools' and 'strategies' learnt in the group. The interview schedule was designed and developed by the lead author and checked by the second author. Using a qualitative interview was in line with recommendations by Kirby[7] on strengthening further CFT research designs as well as focusing the research on component analyses of the intervention used. To address this question, the Helpful Aspects of Therapy (HAT) questionnaire was integrated into the semi-structured interview to prompt feedback on what was most and least helpful about participating in the CFT group.[26] Participants were also invited to consider whether there were specific events that stood out during the group where change took place.

The interviews were analysed using an interpretative phenomenological analysis (IPA). IPA is concerned with understanding 'experiences and meanings … from the point of view of those who experience them' (p. 94).[27] IPA has been used in previous research that has explored people's experiences of pain[18,28] and research focusing on people's experiences of CFT.[29] It is an idiographic qualitative methodology that analyses and interprets each individual case separately before the researcher moves on to develop master themes across interviews.[28,30] The researchers' goal in the analysis is to interpret the participants' account, of themselves, making sense of what has happened to them; the double hermeneutic.[30]

Questionnaires. Questionnaires were used to collate information on participants' mood, level of pain disability, acceptance of pain, self-criticism and ability to self-reassure. The purpose of this data collection was to collate further demographic information about the population. The sample size was too small to conduct any formal analyses.

Facilitator feedback. The lead author sought feedback from the group facilitators on their experiences of running the group. This was carried out at two stages. The facilitators recorded their own reflections at the end of the CFT group course. This was not given to the lead author until after the analysis process to avoid contamination of the data. Once the data had been analysed, a feedback meeting was arranged whereby the lead author shared emergent themes and sought facilitator feedback on whether this resonated with their experiences of the group.

Participants. All participants were provided with written information about the study and given the opportunity to ask questions. Written consent was taken by either the lead author or local collaborator and participants informed of their right to withdraw at any time. All participants were adults (18+ years) who had experienced persistent pain for a minimum of 2 years and had an open referral with the pain management team. All participants completed the CFT group, but all missed at least one session during the 12 weeks due to unforeseen circumstances.

Five people completed the CFT group. Out of those, four agreed to participate in the qualitative interviews. Three were male and one was female, aged between 47 and 76 years. Further demographic information be found in Table 2.

Five other people did not complete the CFT group for a number of reasons: mental health crisis, physical health crisis, conflicted with a planned hospital procedure, anxiety about opening up in a group and other treatment contraindicating use of group. This was a higher than usual dropout rate than in previous groups run by the team.

Procedure

Qualitative interviews. Interviews took place 1 month after participants completed the CFT group. Interviews were held in either a therapy room in the local Psychology Department or at the participant's home. Interviews lasted between 25 and 50 minutes and were recorded on a Dictaphone. The interview recordings were then uploaded onto an encrypted Safe Stick and deleted from the recording device. The interviewer kept reflections on their experience of each interview for purposes of analysis. Participants were invited to choose their own pseudonym for anonymity in the research. Interviews were transcribed and any identifiable information removed. Transcripts were imported into Nvivo© 11.4, a software used to organise, store and retrieve data from transcripts which helped aid the coding process. Nvivo allowed the lead author to pull together codes from each individual interview and take into account the frequency of each theme across the transcript in line with the analytic process of numeration.

Table 2. The further demographic information of participants in the CFT group and the number of sessions attended.

Participant (pseudonym was used; $n=4$)	Type of pain	Questionnaires completed	Number of sessions attended
Alun	Neuropathic pain	Yes	9
Pete	Persistent lower back pain	Yes	10
Steve	Persistent lower back pain	Yes	11
Mary	Persistent widespread pain and fibromyalgia	No	10

CFT: compassion-focused therapy.

Questionnaires. Participants completed four questionnaires at three different time points: 'pre' (in the first session), 'post' (in the last session 12 weeks later) and at a 1 month follow-up. The questionnaires used were as follows:

Depression and Anxiety Stress Scale (DASS-21)[31]

This is a shortened version of the DASS-42. It is a 21-item self-report measure of depression, anxiety, tension and stress.

The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)[32]

FSCRS is a 22-item scale to measure a person's self-criticism and ability to self-reassure.

The Chronic Pain Acceptance Questionnaire (CPAQ)[33]

CPAQ is a 20-item self-report measure of acceptance of chronic pain.

The Pain Disability Index (PDI)[34]

PDI assesses the impact of pain on a person's ability to engage with essential life activities.

Analysis

Qualitative interviews. The interview data were analysed using IPA. The stages of analysis were drawn upon those used by Smith and Osborn.[14] Stages 1–4 were conducted on each individual transcript before moving onto the next transcript. Stages 5 and 6 involved looking at all four transcripts. Details of the stages were as follows:

1. Interview transcripts were read and re-read several times. Notes of potential themes and points of interest were annotated. Comments on the interviewer's experience of the interview itself were included.
2. The text was then re-read and any emergent themes were identified and organised tentatively.
3. Attention was then drawn to looking at the emergent themes and defining them while considering their possible interrelationships. The focus was on the psychological phenomena under study and the data were condensed.
4. The shared themes were then organised to make consistent and meaningful statements which contribute to an account of the meaning and essence of the participants' experience in their own words. Superordinate themes were then developed by grouping emergent themes together through the use of abstraction, contextualisation and numeration. At this stage, the first transcripts were re-read to check for emerging themes.
5. All interviews were then compared and master themes developed that were consistent across all interviews.
6. The master themes across all four interviews were then compiled in a master table. Connections between the themes were considered and a narrative account of the participants' experiences presented.

The lead author received regular supervision during each stage of analysis to ensure cross-validation of the data as well as sharing data with an IPA peer support group run by a lecturer at the university.

Questionnaires. Questionnaire data were collected across three time points. These data were used to contribute further to the demographic information of the sample and in the triangulation process. Questionnaires relating to acceptance of pain and to forms of self-criticising and self-reassurance appeared to be sensitive to change over time, but the sample was too small to draw any firm conclusions from this. Participants scored in the clinically severe ranges for both depression and anxiety on the DASS-21 and in the moderate range for stress. Not all participants returned their questionnaires at each time point to observe meaningful change overtime.

Reflexive positioning. The lead author was a researcher and Trainee Clinical Psychologist who had

previously worked in pain management services and worked with clients who have persistent pain. The lead author sought support using bracketing interviews with a colleague throughout the research process due to the sensitive nature of the research and to help understand how the lead authors' assumptions and experiences may impact upon the research design and process.[35] Questions in these interviews were based around Ahern's[36] tips for reflexive bracketing.

Results

Results from IPA

Five master superordinate themes were found that resonated with experiences described by all participants. Each theme, sub-theme with supporting quotes and summary description are depicted in Table 3. Two of the superordinate themes in particular seemed relevant to how CFT specifically may have been helpful for the group and a more detailed account of these themes is provided.

Meaning of connection and belonging in the group. Connection was a significant component that participants felt was a core part of the group. For many in the group, the impact of pain on daily life had left them often feeling isolated and alone. By being in a group, it brought people together and participants spoke of valuing that opportunity to connect with others:

> The group itself and the volunteers [facilitators] within in the group were like the apex of importance to me. (Alun)

> We'd sort of come to bond more towards the end of the group and felt more comfortable talking within the group. (Steve)

Both Alun and Steve describe this feeling of togetherness with members of the group and the group facilitators. It could be suggested that what is described here is a sense of common humanity; an important element of self-compassion. The participants in the group did not just connect because they all shared a common experience of persistent pain but a common experience of being human. Feeling connected with others seemed to reduce the feelings of isolation people experienced. There was a sense that it enabled people to engage with some of the suffering they experienced in relation to their pain together as described by Mary:

> When you're with a group of people that are all the same … all trying to be the same, when of course when you are all on your own, you think you are the only one. (Mary)

Steve similarly spoke of the struggle of coping with pain on his own. When talking in his interview about how this had changed since the group he would often refer to the common 'we' when describing his experiences:

> As I say there is no cure for what *we* have. You have to learn to live with it and it's a difficult thing. (Steve)

Participants' experience of warm and affiliative interactions in the group created a sense of social connectedness which may in turn have activated their soothing/contentment system. This is important as activating this system can lead to creating a calmness in one's self and can alter pain thresholds.

The importance of the connection in the group was particularly evident when the group ended. Many participants spoke of finding the end of the group difficult as it felt similar to other losses they had experienced. Many were left wondering how they could continue to maintain that connection and sense of togetherness after the group:

> It took me a long time to be able to get things out there from what I wanted to say, and felt comfortable saying, and then it was all over and I just, you know, it was too soon for me. (Pete)

> Sorry, I get very emotional when talking about pain.
>
> …
>
> I suppose in a sense it's an indication of what the group interaction has meant to me and what it continues to mean to me. (Alun)

Engaging with the emotions connected to the pain experience. Participants gave examples of times where they had felt emotions such as shame, hopelessness and embarrassment due to pain. Pete spoke in detail about trying to have an injection to reduce his pain. Eventually, he was unable to go through with the procedure and said,

> I mean I was in so much pain, I was crying. So, he just said 'I'll have to stop because I haven't even gone through the muscle yet', which is another … you know, so he just gave me some Lignocaine injections but it doesn't do anything. (Pete)

For Pete, it felt important to be able to express to someone such an intimate interaction between professional and patient so that he communicated the intensity of his pain. Yet, this interaction was one that he felt shame about and confessing that he cried appeared to be more difficult for him as a man as he alluded that this was not something he should have done. When talking about the impact of pain on activities of daily living (ADLs), Mary appeared to use the word 'silly' to

Table 3. Summary of the superordinate themes across all qualitative interviews.

Superordinate theme	Summary description of theme	Subthemes and supporting quotes
The immense impact of pain on daily life	Participants spoke candidly about the enormous impact pain had on their quality of life. For all, they rarely experienced any relief from their pain. They shared how the physical aspects of pain restricted even basic activities of daily living. This experience of loss, left them with little sense of enjoyment or fulfilment in life and the accounts given felt quite hopeless and helpless. It left people questioning their identity, meaning and purpose in life.	Physical aspects of pain *Even if they could give me something that would give me one day a week where I could go for a walk. (Pete)* Influence of pain on construction of identity *It's about enabling us individuals with persistent pain to present as normal people, with problems that aren't their fault and this is how they are trying to get through their day. (Alun)* Experience of loss *It prevents me from doing many of the things that I used to do. (Steve)*
Meaning of connection and belonging in the group	Connection was a significant component of the group. Being in the group brought people together and participants spoke of valuing the opportunity to connect with others. It appeared to help reduce feelings of isolation and there was a sense that people could engage in the suffering they experienced together. The ending of the group was difficult for many and some were left wondering how they could maintain this sense of connection after the group had finished.	Valuing connection *I think when you come together as a group, you know you're all there for similar reasons. (Mary)* Connection reducing feelings of isolation *It's being with other people that are the same and don't judge you. (Pete)* The impact of the loss of connection with the group *It took me a long time to be able to get things out there from what I wanted to say, and felt comfortable saying, and then it was all over and I just, you know, it was too soon for me. (Pete)*
Engaging with the emotions connected to the pain experience	Participants shared examples of times where they had felt emotions such as shame, hopelessness and embarrassment in connection to their pain. The safe environment created in the group by facilitators and the other group members allowed participants to show vulnerability and engage with difficult emotions connected to their experience of pain.	Sharing negative feelings connected to pain *It became quite deep discussions at times; we all had different problems and it seemed to bring the problems to the surface at a time, for some people, so we had good discussions. (Steve)* Engaging with emotions connected to pain *It took me a long time to be able to get things out there from what I wanted to say and felt comfortable saying. (Pete)* Showing vulnerability *Over time I did start to open up more myself and I think that's good. (Mary)*
Recognising the process of the change in the group	Change was talked about as a process by participants. Change happened at a different pace for different people and a key part of that process seemed to be developing acceptance of pain and of their current situation. There was an overall sense that the group had been a helpful and powerful experience for people. There was also recognition that this was only the start of the journey of change. Participants acknowledged that there may be hurdles to overcome to fully integrate some of the ideas from the group into daily life.	Change occurring over time *Yes, as I say, I have learnt to accept my condition whereas before I was frustrated by it and often angry by it. I don't get that now; I've learnt to control that. (Steve)* The powerful experience of being in the group *I actually came away from it thinking this has been an invaluable experience and to be quite frank, it's something I will cherish. (Alun)* Change being hard to achieve *... its comfort back here, I know what I'm doing, I know where I am and if I go forward I'm not really sure what I'm going to. (Mary)*
Applying learning from the group	Participants shared how they had applied their learning from the group. In doing so, they spoke of developing new ways of coping through being more self-compassionate and kinder towards themselves and considered how this had impacted upon the interactions they had with others. Specific parts of the CFT approach were referred to, such as understanding the tricky brain and the process of developing the compassionate self which allowed participants to start to feel less self-critical. Mindfulness was viewed as beneficial and many had integrated this into daily life.	Developing new ways of coping *I soon realised that I still need to invest a certain element of time into myself before I can start trying to support other people's problems. (Alun)* Specific techniques of the CFT approach *The next best thing was the way they explained the mind and how it was working ... you understood a bit more of why you might be feeling the way you were feeling. (Mary)* So, understanding the dynamic between the compassionate self and the critical self, for me, they were very closely linked. (Alun) Changes to daily life *... through the group it's helped me not to dip or peak, just come to a nice level which is making day to day life more manageable. (Alun)*

minimise the potentially difficult feelings she felt about needing additional aids to help her complete basic ADLs:

> Oh yeah, even silly things like just going to the toilet. You know, to get off the toilet … to get onto the toilet, I've got to have a bar there! So, it is every single thing. (Mary)

The connection and shared understanding in the group allowed participants to engage with and tolerate some of these emotions linked to their pain. By the facilitators creating a safe, trusting and compassionate environment in the group, participants were able to express some of their vulnerability without fear of judgement. Being vulnerable and opening up took time for some participants:

> … to me, saying things it brings out emotions in me and I usually well up and have tears. You don't always want to show that to people that you don't know. (Pete)

When people in the group were able to open up, the conversations that emerged from were valued by the wider group:

> It became quite deep discussions at times; we all had different problems and it seemed to bring the problems to the surface at a time, for some people, so we had good discussions. (Steve)

> … it helps because again, they're saying what's going with them and how they're feeling and then you go, 'I know what you mean'. (Pete)

Participants seemed able to start to engage with negative emotions connected to their experience of pain. The therapeutic relationship is key in CFT, and skills of the facilitators in tracking and amplifying emotion in the room during the group appeared important in participants being able to start to accept, tolerate and work with those emotions and understand their role better:

> … because coming here [to the group] I can get out, kind of, what I've been feeling and wanting to say and how sort of life has affected me. (Pete)

Feedback from group facilitators

The group facilitators reported a higher level of attrition in this group than in previous groups. Attendance was more inconsistent, reflected in Table 2. The facilitators were curious about the impact this had on attendees' experience of the group. The group was predominantly male which was unusual and the facilitators wondered about how this impacted upon social role performance in the expression of emotion in the group. They noted that initially conversation could be quite humorous, light hearted and that it took longer than in previous groups for participants to communicate the emotions they felt about their pain. Overall, facilitators perceived that participants were experiencing high levels of depression and hopelessness, and the questionnaire data lend some support to this. They felt that this may have impacted upon the process of change, as it appeared to take longer than in previous groups. Both facilitators agreed though that by the end of the group, they had noticed a change in participants as they were more able to show vulnerability and support one another. A key part of the CFT group is compassionate letter writing. All participants chose not to engage in this activity during the group, but some participated in the exercise in individual follow-up sessions with facilitators.

Reflecting conversations

Results were triangulated across methods (questionnaires and qualitative interviews) and across different informants (participants and facilitators).

Participants in the CFT group appeared to be at a particularly vulnerable starting point. This was reflected in the scores on the DASS-21, facilitator feedback and from participants, captured in the theme 'engaging with emotions connected to the experience of pain'.

Both facilitators and participants recognised the process of change in the group over time, observing that through the sense of connection and belonging in the group, participants appeared to be able to show more vulnerability and tolerate the more difficult emotions connected to their experiences of pain.

Finally, mean scores on the Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS) at the 1-month follow-up time point indicated that there had been improvements for participants on their ability to self-reassure and reductions in their sense of their inadequate self and hated self. This resonates with participant interviews as they spoke of increasing acceptance of their conditions through connection in the group and using tools they had learnt that were specific to the CFT approach.

Discussion

This study aimed to explore the effectiveness of a 12-week CFT group for people with persistent pain in an NHS pain management service in the South West of England. Qualitative interviews gathered feedback from participants of their experience of the group. This was triangulated with feedback from facilitators on their reflections of running the group and questionnaire data.

Four out of five participants participated in a qualitative interview about their experiences of the group. This revealed five themes relating to people's experiences of the group represented across all interviews. Themes suggested that participants benefitted from being in the group as it allowed them to experience a sense of belonging and affiliation with others that had a positive impact on their wellbeing and contentment. Through the therapeutic relationship created, participants were able to emotionally process difficult emotions related to their experience of pain and learn to self-soothe. Through the shared understanding of the 'tricky brain', participants had started to take responsibility for change drawing upon techniques learnt from compassionate mind practice.

Clinical implications

The participants were a particularly vulnerable client group experiencing high levels of depression and hopelessness reported by facilitators and reflected in the mean score of depression on the DASS-21. As the evidence base of using CFT in groups emerges, researchers have trialled a number of different durations of groups and follow-up periods.[16] For some participants, change occurred late in the 12-week programme and participants found the loss of connection from the group difficult. The compassionate mind model highlights the value of social connectedness in regulating difficult emotions. Members of the group found this experience of connecting with others they would not normally connect with a valuable experience making the loss of this hard. Therefore, future CFT groups in pain management services would benefit from considering different lengths of groups and/or whether to include individual preparation sessions to allow patients to consider what to expect from the group and/or longer follow-up sessions. In conditions that have developed over a long time with a high likelihood of co-morbidity with other conditions, a longer group may be warranted. This research was implemented in a pain management service, but people experiencing persistent pain also access other services such as primary care services and adult mental health settings. The research has highlighted the complex nature of the relationship between pain and emotion, and it would be important for clinicians facilitating CFT group in non-specialist services to consider this in the design and facilitation of their groups.

Our findings suggest that for a subgroup of pain management patients who may experience high levels of shame and self-criticism, a CFT group may offer a meaningful psychotherapeutic intervention. In principle, this could be included alongside other pain management services. This raises the question of how to adequately screen patients so that they are suitable for a CFT or CFT-informed PMP. Participants spoke of turning towards suffering and engaging with negative emotions related to their experience of pain as well as the process of change being a journey and something they needed to be motivated to achieve. New questionnaires such as the Compassionate Engagement and Action Scales[37] may be a useful screening and therapeutic tool to assess a person's motivation to engage with difficult emotions and level of ability to take action to understand those emotions further. This should be alongside psychological assessment interview. We recognise, however, that services can be stretched, so it is more feasible that pain management teams could consider offering one or two CFT-informed PMPs alongside more conventional programmes of treatment. We have not demonstrated, however, that CFT can form an effective and integral psychological component in a multidisciplinary PMP. We understand that research trials are in progress to explore that possibility (https://ukctg.nihr.ac.uk/trials/trial-details/trial-details?trialNumber=NCT03471637).

Limitations

This exploratory study looking at the effectiveness of a CFT group for persistent pain has revealed a number of areas for consideration in future research. Due to the level of attrition from the CFT group, this minimised the researchers' opportunity to interview as many participants as anticipated. The number of participants interviewed allowed the research objectives to be met and similarities and differences to be derived across accounts. However, a larger number of interviewees may have allowed for more diversity across accounts, in particular to hear more female voices on their experience of the group. Facilitators highlighted the variance between groups and this group having a higher level of attrition. Therefore, this limits how generalisable the data are as it is unclear whether this was due to group process or the demographic make-up of the group. Due to the variance, it would be beneficial to repeat this element of the study to see whether similar themes emerged in another group.

Conclusion

This is a small-scale study exploring the effectiveness of a CFT group for persistent pain which suggests that it has value for a particular subgroup of patients whose experience of pain has a significant psychological component. Participants' accounts confirm that people's experiences of persistent pain are multifaceted and unique to the individual. This poses a challenge for service delivery as what is offered may not adequately

meet all people's needs. A CFT approach may address this. It would offer a psychotherapeutic approach for people where the psychological component of their pain interacts significantly with the physical experience of pain, through increased social connectedness. This may allow for improved emotional regulation and the ability to self-soothe. Although this may not reduce the intensity of a person's pain, this could lead to an enhanced quality of life.

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Conflict of interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Contributorship

HG, JS and DC equally contributed to this study.

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