



THE BRITISH PAIN SOCIETY

Original Article

New approaches towards chronic pain: patient experiences of a solution-focused pain management programme

British Journal of Pain
2014, Vol 8(1) 34–42
© The British Pain Society 2013
Reprints and permissions:
sagepub.co.uk/
journalsPermissions.nav
DOI: 10.1177/2049463713516755
bjp.sagepub.com



Peter J Dargan¹, Rebecca Simm² and Craig Murray¹

Abstract

Research has suggested that Solution-Focused Brief Therapy (SFBT) may be effective in facilitating meaningful change for those living with chronic pain. This study aimed to further this understanding through exploring the experiences of people living with chronic pain, who had attended an 8-week solution-focused pain management programme. The design of this study was conducted in consultation with a service-user advisory group, and employed a qualitative and interpretative design rooted in critical community psychology, participatory research frameworks and emancipatory disability research. Five participants opted-in to the study following an opportunity sampling method of persons who had attended a programme in the last 18 months. Interviews were transcribed verbatim and analysed using inductive thematic analysis. Five main themes were identified: 'Accessing the pain management programme', 'A solution-focused group', 'The solution-focused clinician', 'Solutions and changes' and 'Challenges and improvements'. Clinical and research implications of the findings are discussed.

Summary points

1. There has been an international proliferation of pain management programmes (PMPs) aimed at helping those with chronic pain to live well, despite an unremitting condition.
2. Arguably, the most popular psychological approaches used within PMPs are informed by cognitive behavioural therapy (CBT).
3. Despite a supportive evidence base for psychological approaches in pain management, there is a recognised need for further research into alternative approaches and their effectiveness.
4. Emerging research and policy recommendations are beginning to value the expertise of those living with chronic conditions, particularly how these perspectives can be used to develop effective treatments and services.
5. SFBT is an approach aimed at achieving a patient's goals or 'preferred future' through identifying and utilising their expertise. SFBT may have significant efficacy in helping those with chronic conditions to live improved, meaningful lives.

Keywords

Solution-focused, chronic pain, pain management, qualitative research

¹Department of Clinical Psychology, Lancaster University, Lancaster, UK

²Clinical Health Psychology Service and Community Pain Service, Southport & Ormskirk Hospital NHS Trust, Southport, UK

Corresponding author:

Peter J Dargan, Department of Clinical Psychology, Lancaster University, Lancaster, LA1 4AY, UK.
Email: peter.dargan@lancaster.ac.uk

Introduction

Chronic pain has the potential to negatively impact patients across multiple domains. Research utilising a variety of methodologies has consistently demonstrated that this impact breaches multiple aspects of the self, including – but not limited to – physical, neurological, psychological, social and spiritual concerns.¹

The breadth of this impact may be reflected in the changing emphasis towards biopsychosocial and holistic approaches to health care that are increasingly being encouraged in medical practice and policy. Moreover, as chronic pain is among the most prevalent of chronic conditions,² there has been an increase in the availability of ‘Pain Management Programmes’ (PMPs) which attempt to offer accessible understanding, education and support to the significant number of people living with chronic pain (see The British Pain Society’s *Guidelines for pain management programmes for adults*).³

Patients with chronic pain are encouraged to take an active role in self-managing their symptoms. Consequently, PMPs often focus on domains judged to be more amenable to change – particularly behavioural and psychological modifications in one’s response to pain. Arguably, the most popular psychological approach is ‘Cognitive Behavioural Therapy’ (CBT), which is among the most evidence-based psychological treatments in Western medicine for physical health concerns.⁴ A recent systematic review suggests that CBT is effective in the management of chronic pain, with successful outcomes sustained upon mood and catastrophising at 6 months after treatment, although improvements upon pain are weaker and only significant immediately post treatment.⁵ Newer treatment approaches drawing on CBT theory are also gaining evidence, such as ‘mindfulness’ and ‘Acceptance and Commitment Therapy’⁶ and may be helpful in ascertaining which types of psychological approach work best for which type of patient and why.⁵

Another emerging psychological approach within health care is Solution-Focused Brief Therapy (SFBT). SFBT can be briefly defined as an approach which builds upon a client’s inherent competence, with the aim of facilitating goal-directed action.⁷ SFBT provides a framework designed to elicit a person’s best hopes (or ‘preferred future’), and to reveal existing personal resources – often with the aim of amplifying the frequency or likelihood of a desired outcome.⁸ Techniques include developing concrete and behavioural descriptions of a preferred or hoped-for future (e.g. *How would you like things to be different?*), noticing exceptions to target problems (e.g. *When has your mood been best this week?*) and utilising 0–10 scaling to help

clients move from all-or-nothing goals to more manageable steps. (For a fuller description of the solution-focused (SF) approach to pain management, see Simm et al.⁹)

Outcome research for SF interventions has been mixed. For instance, a recent systematic review of SFBT found that 74% of studies reported significant positive behavioural and psychological outcomes and 23% reported positive trends.¹⁰ Studies which examined length of treatment all found that SFBT used fewer treatment sessions than comparative interventions, and the strongest evidence of effectiveness was found in the treatment of depression. In contrast meta-analysis of 21 studies of SFBT outcome research comprising a total of 1421 patients demonstrated only small to moderate positive effects on treatment outcomes ($d = .37$) and was not more effective than treatment as usual.¹¹ The largest effects of SFBT were demonstrated upon behavioural problems ($d = .61$). While direct research regarding SFBT and physical health is more limited, studies have found the SF approach to be effective in facilitating outcomes that are meaningful to those with chronic pain. For example, SF group therapy has been found to improve the rehabilitation of orthopaedic patients on sick leave in two studies (60% SFBT group vs 13% Control)¹² and (68% SFBT vs 4% Control).¹³

While direct outcome research is lacking for SF approaches to chronic pain, existing pain literature may indicate that exploring this link further is worthwhile. Eccleston and Crombez,¹⁴ for instance, describe that living with chronic pain is an active process of searching for solutions, and to react passively to pain is ‘counter biological’. The emphasis on searching for solutions to chronic pain can be demonstrated through conceptual models of ‘misdirected problem solving’¹⁵ (whereby patients develop problem-solving behaviours and beliefs that are ultimately unhelpful or dysfunctional to their goals), or through a number of studies indicating that the mechanism by which psychological therapies can reduce the negative effects of chronic pain is through increasing positive and meaningful behavioural change.^{16,17} The concept of a ‘preferred future’ when living with pain has also more recently been given focus by pain researchers,^{18–20} as have techniques such as focusing on successes during pain consultations.²¹ Such frameworks share key similarities with many of the core features of SFBT and recommendations for working with patients living with chronic conditions.^{22,23}

Given the paucity of research examining SF approaches in physical health settings, this study aimed to broadly explore the experiences of patients who had attended an 8-week SF PMP in a community setting. It was hoped that qualitative practice-based evidence

could aid the interpretation of outcome data⁹ and reveal elements of the programme participants experienced as significant.

Method

Design

A qualitative design was employed utilising a semi-structured interview schedule. Perspectives of critical community psychology and participatory research informed the study design. These frameworks attempt to involve the communities whom the research is about in the study design and implementation, through a partnership approach. Consequently, the views and expertise of those using service were incorporated into the research to reflect the expert knowledge and experience people living with pain have of the issues being investigated, and the increased validity and utility that their involvement might bring – in line with emancipatory disability research.²⁴ A blend of collaboration and consultation²⁵ with a service-user support group achieved these ends.

Service-user involvement. Prior to the sampling of participants, a patient-led support group was consulted regarding the study design, recruitment, interview schedule and procedure. The views of 12 expert patients were sourced during a 2-hour drop-in group. A scaffold of proposed interview questions and processes were shared among the group members who were invited to share their perspectives upon the research, how accurately they felt interview questions would elicit information and what questions they felt should be asked about the programme. In particular, group members felt it was important that the interview process was more accessible and that potential participants were given the option of a neutral venue for the research interviews in addition to their own homes. Group members provided their views as to which interview questions would best explore the impact of the PMP upon both their relationship with pain and their holistic well-being. The minutes of this consultation were used to alter the structure of the research project accordingly.

Participants

Participants consisted of two men and three women (N = 5; age range = 25–75 years; time with chronic pain range = 3–12 years). As the findings of the research were disseminated locally and involved the service-user consultation group, specific information regarding type of pain and health conditions have not been reported to protect anonymity.

All persons who had participated in 87.5% of any of the three most recent PMPs (7 of 8 weekly sessions – 2 × exercise sessions per week plus 1 × biopsychosocial discussion per week) were invited to participate (N = 30). Six participants expressed an interest in the study, five of whom were available to take part. As the study was opt-in only, no information is available on those who chose not to participate (either outcome data or opt-out reason). An additional recruitment sample of potential participants was not deemed necessary due to the saturation of data themes. Participants were invited to select their own pseudonym for representation in the research.

The only exclusion criteria were concerns regarding cognitive ability, capacity to provide informed consent, concerns regarding significant harm to self or others or partial completion of the PMP (less than 87.5% – this was judged to be a level of involvement that would reflect participation in core features of the programme).

Procedure

Following approval by the local National Health Service (NHS) ethics committee, participants were able to opt in to the research via email, telephone or letter. A semi-structured interview schedule principally guided discussions, but participants were encouraged to take a lead and prioritise what felt important to them. Interviews lasted between 50 and 70 minutes and were recorded using digital audio equipment. Interviews were carried out by the main author.

Interview schedule. A semi-structured interview schedule was developed in accordance with the stated aims and related research questions and was refined through the service-user consultation. While participants were encouraged to talk about what was important to them in their experiences of the programme, interview prompts and questions fell broadly across the following three areas: (1) experiences of the programme, (2) exploring whether the programme made a difference to living with chronic pain and (3) exploring how the PMP was experienced within the context of participant's wider experiences of services.

Analysis

All data were collected prior to analysis. Interviews were transcribed verbatim and analysed thematically according to a six-stage process outlined by Braun and Clarke.²⁶ As this research aimed to be exploratory in nature, thematic analysis was considered to be an appropriate analysis due to its flexibility and theoretical freedom to give an exploratory account of the data.

A rigorous inductive approach to qualitative research was ensured through regularly corroborating emerging themes with initial data, such as providing a digital audio link to each paragraph of the transcript, so that sections could be listened to again within their initial context to preserve intentionality and meaning.

A focus of the analytical methodology was on synthesising participants' accounts into an interpretative whole without losing each individual's experience within the data. Therefore, following the analysis of the first interview, codes from subsequent interviews were reflexively accommodated into a developing synthesis through searching for similarly cohesive information that developed the narrative of experience, while being open to and accommodating of new material to develop the interpretative synthesis. This technique aims to encourage methodological rigour and facilitate reflexivity within the researcher that will ensure the interpretative nature of the research is reflective of participant's experiences. Comparisons with the extant literature were made after data had been collected and analysed in order to ensure that the analysis was inductive and to minimise influence on the development of themes. The quality and coherence of the final themes were appraised by two independent research supervisors in an endeavour to strengthen the validity of the analytical process.

Epistemology and factors affecting interpretation of the research

At the time of undertaking the study, the lead researcher was a male doctoral clinical psychology trainee of White British working class origin, without experience of chronic pain. The lead researcher had no affiliations to the Community Pain Service at which the study was conducted and no personal or working relationships with any of the staff members or service users involved in the research. The lead researcher works clinically within cognitive analytic, cognitive behavioural and psychodynamic modalities but also has an interest in the application of SF and third wave CBT principles.

The lead researcher approached the research from an epistemological position of critical realism in developing the study rationale, which considers how dominant discourses and power structures may limit the scope for considering alternative perspectives in health research, and an interpretivist position for the purposes of the analytical method (thematic analysis).

Results

Five main themes were identified from the analysis. Supportive quotes are provided for each theme, along with participant pseudonyms and transcript line.

'I was curious to see what they could do' – Accessing the programme

This theme captures participants' experiences in initially accessing the programme, and their preliminary hopes and expectations of what they could achieve from attending.

All participants expressed possessing a limited amount of knowledge or expectations when they were initially referred to the PMP. Importantly, participants' previous experiences of services seemed most predictive of their hopes and expectations, rather than the information which had been provided about the PMP. These hopes and expectations appeared to be less focused upon reducing pain severity and more on gaining control and independence. For many participants, this could be represented by changes in medication:

I hoped I could come off some medication, erm because as I said there before trying to deal with the pain [had been difficult] so if I could manage it er by different means [...] I might be able to come off the medication. (Brenda, 338–344)

Many participants also described experiencing referral to the PMP as a 'last resort' only after all other treatments were found to be unsuccessful. For some participants, this experience appeared to carry a sense of invalidation in their reality of pain, with one person questioning whether she had been 'chronic enough' to be referred earlier before further unsuccessful treatment experiences:

People would have friends or relatives in chronic pain really struggling and they've never been offered a place on the pain management programme [laughs], and erm yeah the first time I went [...] I wasn't offered a place on it, and maybe it was just thought that I hadn't been chronic enough. (Audrey, 1019–1025)

As many participants had accepted that their pain was permanent prior to the programme, an additional feature within participants' accounts regarded how they were simply curious to attend a group aimed at helping people to improve living with a chronic condition when there is 'no cure':

I knew that there was nothing that they could do about the pain, so I went knowing that so I was curious to see what they could [do]. (Eleanor, 248–249)

While negative experiences of services could lead participants to feel hesitant about attending the PMP. It appeared that people who adopted a curious stance were more able to engage with the programme. These participants seemed to suggest that they had attended

the group with an open mind and would 'try anything' to improve their experience of living with pain.

'United by the experience of pain – A solution-focused group'

This theme captures participants' experiences of the SF approach upon the group dynamics of the PMP. In addition to common group factors that may promote engagement in PMPs (e.g. a sense of understanding from others living with pain), several aspects of the SF approach were noted to have positive impacts upon the group experience.

In particular, participants described how they were regularly encouraged to share their individual knowledge and expertise derived from living with chronic pain. Several participants described how this led to perceived increases in feelings of support within the group:

We all had different medical conditions, different lifestyles, but the pain ... the experience of the pain...and how much what impact that has on your life and your relationships and things like that...to hear it from other people ... it made it kind of positive and encouraging [...] so there's that erm there definitely was a big ethos of support. (Audrey, 152–160)

Examples of invited expertise included 'practical strategies for managing pain', 'knowledge of activities and services within the community' and 'new ways of understanding living with a chronic condition'. In addition to feeling a sense of support from the sharing of expertise, participants also described that they were able to practically benefit from the competence of others:

Everyone had different ways of dealing with their own pain, one person would stand and rock as she was standing, and she found that helped to relieve the back pain. (Brenda, 79–85)

[A group member] said it's about doing half as much and achieving twice as much and I wrote that down because I thought it was really good. (Audrey, 519–523)

Participants described that being invited to share such expertise provided a sense of meaning, purpose and connectedness with others, that had previously felt missing from their lives. Being able to participate in the PMP sessions as a group member with existing competence (rather than a participant to be taught) meant that group members felt listened to and important:

It was just the fact that they listened, you feel as if you're important. (Eleanor, 223–224)

They were so caring – The solution-focused clinician

In addition to observations and reflections regarding the impact of the SF approach upon group members, participants also shared their thoughts and feelings about how SF clinicians approached them as individuals.

A sense of having their individual identities and needs recognised within the group was described by all participants. In particular, the use of one-to-one communication within group exercises appeared to ensure that participants felt their personal goals and competence levels were recognised and valued. Several participants stated although the PMP used a group setting, the use of one-to-one communication enhanced a sense of the programme feeling 'tailored' due to its sensitivity to their individual needs:

I went over and said look I said I don't know whether I can do all this [exercise component] ... So when they start the stretching thing she got me a chair and said here you are you sit on a chair [motions helping action], [...] and you could see her walk around everyone and she was doing one-to-ones [rather than working with the group as a whole]. (Darren, 794–820)

The tailoring of elements of the programme to participants' individual contexts meant they felt taken seriously when they were living with an 'invisible condition' which was often invalidated:

They took it all seriously, you know you felt as if you were being treated as someone who was in pain [...] although you can't see you know. (Eleanor, 383–386)

The valuing of each individual within the group process was also described to model positive conversations to other group members, which then began to occur naturally:

The way they set it up, and the way they spoke to people and listened to people I think helped other people to do the same and what with the group. (Audrey, 342–346)

'It provided a vital understanding of what was so important to me' – Solutions and changes

This theme reflects aspects of the SF approach participants felt were effective in facilitating meaningful change in life with a chronic health condition. In particular, group members felt participation in the programme had provided them with the confidence or 'permission' to push themselves within their daily lives, and to achieve the most they could within the limitations of their pain:

It's pushing myself out [to do things] pushing my boundaries but that's only because of the bit of confidence I've had from the pain management group. (Brenda, 507–517)

A significant mediating factor in enhancing self-belief was related to an increase in self-management and/or self-determination. Participants described how they had been encouraged to develop independence in a way which contrasted with other programmes. It appeared that in addition to feeling interventions were personalised, participants also felt encouraged to use resources outside of the programme due to an emphasis upon action and behaviour in the future. Here, Audrey contrasts the SF approach to relaxation with another PMP which had incorporated similar resources:

I like relaxation and I've tried it before in different situations and felt that I benefited from it, but hadn't got anything structured for me – a proper resource to use on my own at home for instance and now I have, so that was a very individual thing. (Audrey, 852–862)

Of essential importance to participants was the valuing of life outside of the PMP – rather than viewing the group itself as a 'treatment' – and the focus upon functioning after the PMP had finished. Participants described that the future-orientated focus and commitment to follow-up helped them to feel reassured and that 'you don't feel dumped' (Audrey 475–476).

Importantly, for many participants, being able to exercise this independence and self-determination in practice appeared to facilitate an enhanced sense of self-understanding, particularly with regard to which aspects of their chronic condition were within their control and a sense of acceptance about what elements of change were possible:

I've started to accept that I've got it [chronic pain] not because I've done anything wrong or bad in my life ... its taught me to cope a lot better with it it's taught me that it can't be cured but it's not the worst thing in the world [...] now I couldn't have said that three or four months back. (Darren, 526–535)

'It's a hell of a step' – Challenges and improve-ments

Participants also described the elements of the PMP that were challenging or more difficult than others, or ways that could further improve the effectiveness of the programme.

These accounts revolved predominantly around intra-group difficulties arguably inherent to the group process, such as negativity, dominance from other

group members, or gender differences creating difficulties when discussing sensitive topics – such as sexual issues.

However, the greatest challenge of the programme described by participants was in making the transition from making self-determined changes with the support of the group, to continuing to uphold these positive changes after the group, where it was difficult to access the support of others. Participants indicated this is an area where further support may be beneficial:

I was hesitant [about being managing outside of the group], once you're in a group environment because you've been stuck by yourself for so long, to work on that once everyone had broken down the barriers and everything else to actually go out and involve yourself in a community it's a hell of a step. (Brenda, 487–492)

Discussion

The purpose of this study was to investigate the experiences of a SF PMP from the perspective of recent service users. Thematic analysis revealed five operationalising themes relevant to the research question.

While much of the phenomenology participants described regarding the attainment of positive and meaningful change in being able to 'live well' appeared to mirror much of the extant literature regarding life with a chronic condition, this research has been novel in exploring how the SF approach may facilitate these changes and be experienced by participants.

Possible mediators of positive change may be found in participants' accounts of feeling that their individual hopes, needs and competencies were always in focus. As generation and attainment of the client's goals are consistently a central focus of the SF approach, it may be possible that participants experienced meaningful change due to increases in self-efficacy,²⁷ which have previously been implicated in facilitating improvements in living with chronic pain.²⁸

For instance, the valuing of an individual focus which allowed participants to find 'what works for me' may have contributed to patients gaining a greater sense of control or mastery over their pain. As high self-efficacy is suggested to be a more robust determinant of disability than pain intensity or duration,²⁹ this may indicate why a strengths-based ethos in the SF PMP could facilitate meaningful change.

Self-efficacy may also be intimately related to, or be contained within, the concept of self-determination,³⁰ which is concerned with one's autonomy, sense of competence and relatedness to others. As SFBT is an autonomy-centred intervention where the patient must identify, initiate and sustain change during therapy,

and the positive group environment was experienced as high in relatedness by participants, this may account for the responsibility and control participants took towards making changes in their lives through being empowered to do so.

Practice implications

This study has also revealed several further issues that may be of interest to health-care services. In particular, many participants discussed being referred to a PMP only after an abundance of unsuccessful treatments which had promoted a sense of permanence and helplessness, and several patients wondered why they had not been referred to a programme sooner. It may be important for health professionals to be transparent with patients about referral pathways and/or to evaluate whether the point of referral to a PMP reflects optimum clinical efficacy. Indeed, studies have shown that combining the pain management approach with disease management can be effective for patients living with arthritis,^{31,32} whereby pain management is not seen as a last resort, and could be important to consider further with other types of pain.³

Additionally, participants valued having opportunities to share their expertise with staff and peers within the programme, and discussed the benefits both in learning from others and feeling valued and capable through sharing their perspectives. These experiences mirror the recommendations in policy guidance^{22,33,34} and demonstrate how they can be effective in practice. It may be important for services to evaluate how they tangibly value patient expertise in practice. This also seemed linked to participants' sense of 'using my own resources' and 'being helped to help myself'. It may be important that services empower patients to be involved in treatment decisions/care packages so they are seen as key decision makers who can own successes; rather than passive or inactive recipients of care.

Participants also valued the notion of 'aftercare' following the programme, whereby they could access future sessions to support them in times of challenge or difficulty, and felt that this encouraged them to maintain positive change. Several participants described how, following other treatments, they have felt 'dumped' or 'like a number', which may indicate the importance of follow-up contacts as a routine component of PMPs. It is interesting that despite follow-up sessions being offered in this study, it was still identified as the most significant challenge of the programme.

Strengths and limitations

The involvement of those living with chronic pain (CP) to shape the research design and interview

focus is considered as a strength of the study, as the information gained from the research is more likely to be of relevance to those using services.²⁴ However, as participants were recruited via opportunity sampling, this is a recognised feature that may affect the representation and generalisation of findings. It is also unknown whether the positive effects participants described can be attributed to SFBT or PMPs more widely. However, quantitative analysis of the PMP involved in the present research suggests positive change can be maintained for up to 12 months upon both measures of statistical and clinical significance.⁹

Conclusion

This study explored the experiences of five service users of a community-based PMP which took a SF approach, and has discussed relevant clinical and research implications. Participants felt that overall, their experiences of the PMP had been important in encouraging positive psychological and behavioural changes which allowed them to live better in the presence of chronic pain. Both future research and clinical practice may benefit from exploring SF techniques in the facilitation of meaningful change in chronic pain, in addition to the importance of self-determination theory in mediating outcomes. The findings from this research suggest that a community-based SF approach to PMP may be of value to those living with chronic pain.

Conflict of interest

The authors declare that there is no conflict of interest.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

References

1. Smith BH, Hopton JL and Chambers WA. Chronic pain in primary care. *Fam Pract* 1999; 16: 475–482.
2. Cornally N and McCarthy G. Chronic pain: the help-seeking behavior, attitudes, and beliefs of older adults living in the community. *Pain Manag Nurs* 2011; 12: 206–217.
3. The British Pain Society. *Guidelines for pain management programmes for adults*. London: The British Pain Society, 2012.
4. Roy R. *Psychosocial interventions for chronic pain: in search of evidence*. New York: Springer-Verlag, 2008, p. 200.
5. Williams AC, Eccleston C and Morley S. Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database Syst Rev* 2012; 11: CD007407.

6. Hofmann SG, Sawyer AT and Fang A. The empirical status of the 'new wave' of cognitive behavioral therapy. *Psychiatr Clin North Am* 2010; 33: 701–710.
7. Ratner H, George E and Iveson C. *Solution-focused brief therapy: 100 key points and techniques*. London: Routledge, 2012.
8. Iveson C. Solution-focused brief therapy. *Adv Psychiatr Treat* 2002; 8: 149–156.
9. Simm R, Iddon J and Barker C. A community pain service solution-focused pain management programme: delivery and preliminary outcome data. *Br J Pain* 2014; 8: 49–56.
10. Gingerich WJ and Peterson LT. Effectiveness of solution-focused brief therapy: a systematic qualitative review of controlled outcome studies. *Res Social Work Prac* 2013; 27: 266–283.
11. Stams GJ, Dekovic M, Buist K, et al. Efficacy of solution-focused brief therapy: a meta-analysis. *Dutch J Behav Ther* 2006; 39: 81–95.
12. Thorslund KW. Solution-focused group therapy for patients on long-term sick leave: a comparative outcome study. *J Fam Psychother* 2007; 18: 11–24.
13. Cockburn JT, Thomas FN and Cockburn OJ. Solution-focused brief therapy and psychosocial adjustment to orthopedic rehabilitation in a work hardening program. *J Occup Rehabil* 1997; 7: 97–106.
14. Eccleston C and Crombez G. Worry and chronic pain: a misdirected problem solving model. *Pain* 2007; 132: 233–236.
15. Aldrich S, Eccleston C and Crombez G. Worrying about chronic pain: vigilance to threat and misdirected problem solving. *Behav Res Ther* 2000; 38: 457–470.
16. Berman BM and Swyers JP. Establishing a research agenda for investigating alternative medical interventions for chronic pain. *Prim Care* 1997; 24: 743–758.
17. Rainville J, Sobel J, Hartigan C, et al. Decreasing disability in chronic back pain through aggressive spine rehabilitation. *J Rehabil Res Dev* 1997; 34: 383–393.
18. Brandstadter J and Rothermund K. The life-course dynamics of goal pursuit and goal adjustment: a two process framework. *Dev Rev* 2002; 22: 117–150.
19. Brandstadter J and Rothermund K. Self-percepts of control in middle and later adulthood: buffering losses by rescaling goals. *Psychol Aging* 1994; 9: 265–273.
20. Crombez G, Eccleston C, De Vlieger P, et al. Is it better to have controlled and lost than never to have controlled at all? An experimental investigation of control over pain. *Pain* 2008; 137: 631–639.
21. Williamson A. Chronic psychosomatic pain alleviated by brief therapy. *Contemp Hypn* 2002; 19: 118–124.
22. Department of Health (DOH). *Our health, our care, our say: a new direction for community services*. White paper. Cm 6737, January 2006. London: Department of Health.
23. Department of Health. *The expert patients programme*. London: Department of Health, 2007.
24. Barnes C. What a difference a decade makes: reflections on doing 'emancipatory' disability research. *Disabil Soc* 2003; 18: 3–17.
25. McLaughlin H. Keeping service user involvement in research honest. *Br J Soc Work* 2010; 40: 1591–1608.
26. Braun V and Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3: 77–101.
27. Bandura A. *Self-efficacy in changing societies*. New York: Cambridge University Press, 1995.
28. Nicholas MK. The pain self-efficacy questionnaire: taking pain into account. *Eur J Pain* 2007; 11: 153–163.
29. Denison E, Asenlof P and Lindberg P. Self-efficacy, fear avoidance, and pain intensity as predictors of disability in subacute and chronic musculoskeletal pain patients in primary health care. *Pain* 2004; 111: 245–252.
30. Ryan R and Deci E. Self-determination theory and the facilitation of intrinsic motivation, social development and well-being. *Am Psychol* 2000; 55: 68–78.
31. Dixon KE, Keefe FJ, Scipio CD, et al. Psychological interventions for arthritis pain management in adults: a meta-analysis. *Health Psychol* 2007; 26: 241–250.
32. Knittle K, Maes S and de Gucht V. Psychological interventions for rheumatoid arthritis: examining the role of self-regulation with a systematic review and meta-analysis of randomized controlled trials. *Arthritis Care Res* 2010; 62: 1460–1472.
33. Department of Health. *The expert patient: a new approach to chronic disease management for the 21st century*. London: Department of Health, 2001.
34. Department of Health. *Equity and excellence: liberating the NHS*. London: Department of Health, 2010.

Multiple-choice questions

1. Which one of the following statements best reflects the aims and scope of Solution-Focused Brief Therapy when applied to the treatment of chronic pain?
 - a) A way of understanding how one's thoughts and beliefs about pain can influence their behavioural responses, feelings and affect their experience of pain.
 - b) A way of helping patients achieve their goals when living with pain, through focusing on their expertise, and evoking desired behaviours and outcomes.
 - c) A way of modifying maladaptive behaviour patterns by helping patients engage in new responses to their pain that will improve their lives
 - d) A way for patients to find positives in living with a chronic condition.
2. What are the benefits of practice-based evidence?
 - a) High in external validity and clinical significance.
 - b) Provides a way of exploring a hypothesis or theory from an alternative epistemological position to evidence-based practice.

- c) Recommendations from research are likely to be of direct relevance to similar health-care services.
 - d) All of the above.
3. What important policy document and recommendations in particular do the findings of this study reflect?
- a) The National Institute for Health and Care Excellence (NICE) guidance on chronic conditions

- b) The National Health Service (NHS) Psychological Management of Pain Strategy
- c) The Department of Health Expert Patient Agenda
- d) The British Psychological Society standards of therapeutic group work

Answers:

- 1. b
- 2. d
- 3. c