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*ARTICLE***Solution-Focused Chronic Pain Self-Management Education:
A Pilot Study**

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Abstract

Roughly one out of every three adults in the U.S. today has chronic pain. For this reason, the U.S. government recently issued a National Pain Strategy that advocates, among other things, the education of patients in proactive self-management techniques. To evaluate the efficacy of Solution-Focused Chronic Pain Management (SFCPM)—a new outpatient psychoeducational program based on Solution-Focused Brief Therapy (SFBT)—a pilot study was conducted in Longmont, Colorado. Five self-report assessments were administered. Due to the small sample size ($n = 12$), only percent changes from baseline to follow-up were calculated. Improvements were noted in quality of life (41.4%), pain self-efficacy (22%), hope (16%), mental well-being (9.3%), and problem disengagement (12.3%). Initial results suggest that more rigorous investigation may be warranted. The solution-focused model offers a personalized, empowering alternative to more problem-focused approaches. Instead of fixating on what's wrong, participants focus on what's right with their bodies, minds, and lives—despite chronic pain.

Keywords: chronic pain, biopsychosocial, solution-focused, psychoeducation, self-management

Introduction

According to the Institute of Medicine, chronic pain afflicts roughly 100 million Americans (Institute of Medicine, 2011), or one out of every three adults in the U.S. today. Pain is typically considered chronic if it lasts longer than three to six months, the expected time for normal healing (Mersky & Bogduk, 1994). The longer pain persists, the more it dominates a person's life and consciousness. Not only does it undermine physical functioning, but also emotional, social, and (often) economic well-being (Foreman, 2014).

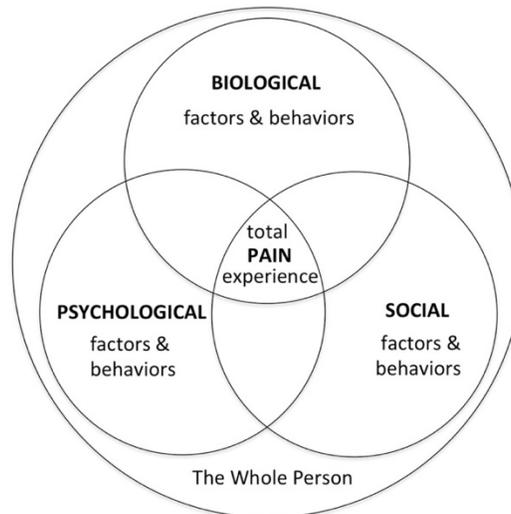
The extent of this suffering is reflected in the medical community's growing awareness that chronic pain treatment requires more holistic, "biopsychosocial" approaches (Gatchel et al., 2014; Moseley & Butler, 2015a; U.S. Department of Health & Human Services [HHS], 2016). Why? Because, according to modern pain science research, unlike acute pain, chronic pain never has just one cause (Moseley & Butler, 2015b). It is, in fact, a highly complex phenomenon with myriad causes and components. Pain is never simply a physiological problem. Biological, psychological, social, interpersonal, financial, even existential factors can and do both exacerbate and alleviate pain. The most effective solutions, therefore, must be multi-modal or *interdisciplinary*. They must transcend mere medication and even medical treatment by taking into account a broader range of biopsychosocial factors and behaviors (see Figure 1). The ultimate goal is to treat the whole person.

Supporting this growing awareness, the U.S. government recently issued its first-ever National Pain Strategy (HHS, 2016). This new patient-centered strategy seeks to tackle the epidemic of chronic pain—considered by some a disease in itself—by proposing, among other things, the adoption of interdisciplinary or biopsychosocial models of health care. Interdisciplinary care typically *integrates* some form of biological treatment (such as exercise or physical therapy and, typically, medication) with psychological treatment (such as meditation or psychotherapy), often in socially supportive group settings involving multiple health care providers and other patients or participants, even family members or friends. Finally, these biopsychosocial programs aim to educate patients in proactive *self-management* techniques.

The primary purpose of pain self-management is not so much to eliminate pain, but rather to cultivate an individual's capacity to live the best life he or she can, even if the pain never goes away (Simm et al., 2014; LeFort et al., 2015).

Self-management approaches focus on what people suffering from chronic pain can do for themselves (De Silva, 2011)—between doctor’s visits. In this regard, any form of self-management is complementary, not alternative, to conventional medical care.

Figure 1



Note. The biopsychosocial model of pain takes into account the influence of psychological (mental, emotional, existential) and social (interpersonal, economic, cultural) factors and behaviors, as well as biological causes and symptoms. Biopsychosocial care seeks to treat the whole person, not just the body.

Pain Self-Management Programs

In North America, several psychoeducational training courses in pain self-management have emerged in recent decades, alongside purely medical interventions. These include the Chronic Pain Self-Management Program (CPSMP) developed by Stanford University (LeFort et al., 1998), the Mindfulness-Based Stress Reduction (MBSR) course developed at the University of Massachusetts Medical School (Kabat-Zinn, 1990), and an enhanced Mindfulness-Based Chronic Pain Management (MBCPM) program developed at a hospital in Ontario, Canada (Gardner-Nix & Costin-Hall, 2009). Almost 15 years ago, the UK National Health Service (NHS) began developing its own pain management programs, based on well-known psychological interventions such as cognitive behavioral therapy (CBT) and acceptance and commitment therapy (ACT) (Simm et al., 2014). The UK Department of Health had published a new “Expert Patient” vision for the 21st century. It advocated the propagation of more patient-centered self-management programs in the NHS that would take into account the “knowledge and experience held by patients, which has been for too long an *untapped resource*” (UK Department of Health, 2001, p. 5). The U.S. National Pain Strategy echoes this approach.

However, few existing psychoeducational self-management programs actually treat patients suffering from chronic pain as “experts” in their own right. Instead, they are often seen as vessels needing to be filled by specialists—medical, mental health, and meditation experts—who believe *they* know what people ought to do, to think, or to learn. As a result, most programs focus on dispensing expert advice and teaching skills, information, and knowledge they feel patients currently *lack*. Such approaches represent largely deficit-based models of change, akin to the standard medical model (Simm et al., 2014).

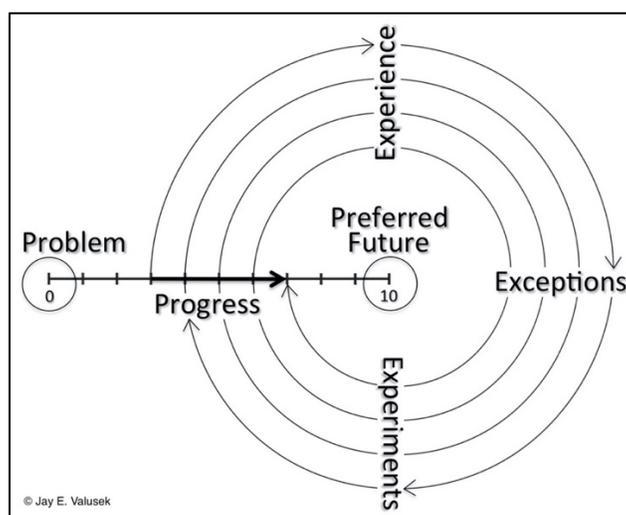
As an alternative, clinicians in the UK National Health Service decided to evaluate a significantly different approach to pain self-management—one that takes seriously the patient’s hard-won wisdom, existing resources, and implicit competence (Simm et al., 2014; Dargan et al., 2014). They developed a pioneering “solution-focused” pain management program, based primarily on the principles and practices of Solution-Focused Brief Therapy (SFBT).

SFBT is an evidence-based model of change developed in the 1980s by Steve de Shazer, Insoo Kim Berg and associates at the Brief Family Therapy Center in Milwaukee, Wisconsin (Franklin et al., 2012). Partly due to its simplicity and

applicability to a wide range of presenting problems (De Jong & Berg, 2008), solution-focused tools and techniques have spread beyond counseling and psychotherapy into other fields, including business coaching (Berg & Szabo, 2005; Szabo & Meier, 2009; Iveson et al., 2012), management and organizational consulting (Jackson & McKergow, 2007), education (Ajmal, 2018) and, more recently, health care (Franklin et al., 2012; Carr et al., 2014; Burns, 2016; Zhang et al., 2018). The term “solution-focused” is meant to distinguish this approach from traditional “problem-focused” and expert-driven models that continue to dominate psychology, medicine, and business.

Instead of teaching patients what the “experts” believe they should know or do, the solution-focused approach to pain self-management enables patients—through a dynamic, iterative process—to discover (with expert assistance) their own, often quite unique solutions to the complex biopsychosocial challenges of living with chronic pain (see Figure 2). It represents, therefore, a strengths-based model of change.

Figure 2



Note. The solution-focused change model shifts attention from the problem (in this case, chronic pain and its complex biopsychosocial impact), and places the patient’s “preferred future” at the center of a dynamic, iterative process. By exploring life experiences (past) and exceptions to the problem (present), session by session, people begin to recall, discover, or simply notice uniquely effective solutions of their own. By brainstorming new ideas, conducting experiments, and taking small steps day by day, they make incremental progress toward a future worth living for, despite chronic pain.

An initial outcome evaluation of this innovative new approach to pain self-management in the UK (Simm et al., 2014)—the first psychoeducational program of its kind in the world—included 85 patients from 28 to 83 years of age who were diagnosed with a variety of chronic pain conditions. From pre-test to post-test, participants in this eight-week program experienced a 22% average increase in mental and emotional well-being, and a 47% increase in pain self-efficacy or belief in one’s ability to live, work, and function effectively despite the presence of chronic pain. The NHS program was a true interdisciplinary service facilitated by physicians, psychologists, physical and occupational therapists, requiring more than 125 clinician hours per course and costing approximately \$500 per patient (Simm & Barker, 2018).

Unfortunately, the UK program’s design and contents are proprietary to the National Health Service (R. Simm, personal communication, January 29, 2016). Therefore, the only way to offer a similar solution-focused program would be, in effect, to reinvent the wheel based on the same underlying SFBT model. After corresponding with the lead psychologist for the UK program, and searching the literature for research and applications of SFBT to chronic pain (Cockburn et al., 1997; Berg & Dolan, 2001; Johnson & Webster, 2002; Nichols et al., 2011; Carr et al., 2014; Franklin et al., 2012; Simm et al., 2014; Dargan et al., 2014; Bray et al., 2015), that is exactly what the present author did to design the five-week pilot study described herein. This is the first specifically solution-focused adult education and training program for chronic pain self-management in North America.

Objectives of the Study

The purpose of the study was to pilot test a new outpatient psychoeducational program called Solution-Focused Chronic Pain Management (SFCPM), aimed at empowering adults to enhance the overall quality of their lives—physiologically, psychologically, and socially—despite chronic pain. As noted above, unlike medical pain management approaches, the goal was not necessarily to reduce the severity, frequency, or duration of actual pain sensations (although the door to that possibility was left open).

Because the program design was new and attempted to integrate the solution-focused model of change with the biopsychosocial model of pain, the overall intent of the study was simply to gather preliminary quantitative data on its efficacy, to demonstrate proof of concept. Five measurable objectives were identified: (1) to improve quality of life, as noted above, (2) to increase mental and emotional well-being, (3) to enhance hope for the future, (4) to improve pain self-efficacy, and (5) to shift participants' focus away from what's *wrong* (“problem-focused thinking”) toward what's *right* with their bodies, minds and lives (“solution-focused thinking”).

The hypothesis going into this pilot study was that participants would begin to experience at least small improvements in each of these areas within five weeks. The hope was that they would gain sufficient momentum during that time to sustain the journey toward greater biopsychosocial well-being over the longer term.

Methods

Design of the Study

A pretest-posttest design was used to quantify outcomes of the five-week program. At the beginning of session one, five baseline self-report measures were administered. Post-intervention measures were collected at the end of session five. Also at the end, participants wrote anonymous answers to two open-ended evaluation questions: (1) What did you find most helpful or beneficial about this program? and (2) What did you find most difficult or challenging about this program? There was no control group.

Other pain self-management courses tend to meet weekly for six or eight or up to 13 weeks, for up to three hours per session. That amount of time and energy seemed like a rather heavy commitment for people wrestling with chronic pain. Therefore, the SFCPM pilot program met for only five weeks, two hours per session, except for the first session, which lasted 2.5 hours.

Session topics and activities included brief presentations of the solution-focused model of change and the biopsychosocial model of pain and well-being, questions for reflection and discussion, written exercises, goal setting, action planning, and homework review. Unlike the model UK program, no *physical* exercises were part of the SFCPM pilot study, except for what participants chose to do outside of class. In addition, no “expert” advice of any kind was given. This differed from the UK program in that a *certain amount* of expert advice was offered there, although mostly “by invitation” (Simm et al., 2014, p. 52).

In keeping with the solution-focused methodology, SFCPM training was more *conversational than informational*. It focused on drawing out participants' inherent expertise through a proven series of “deceptively simple” (Grant et al., 2012, p. 334) questions (Bannik, 2006). The following core components of SFBT (Franklin et al., 2012; Pichot & Dolan, 2003) were part of the program design:

- *Minimal Problem Talk*. Maintaining a dominant focus on “what’s right” (e.g. “What helps, what’s working, what’s better?”) rather than complaining about or diagnosing “what’s wrong.”
- *Exceptions*. Searching for “exceptions” to the problems of living with chronic pain, i.e. times when physical, psychological, or social challenges are absent or even a little bit less severe.
- *Preferred Future*. Using the “miracle” question (i.e. “If a miracle happened, what would you be doing differently?”), and other future-oriented questions aimed at envisioning a “preferred future” worth striving for, a time when chronic pain would no longer undermine one’s quality of life.

- *Difference and Relationship Questions.* Asking “difference” questions (e.g. “What positive difference would it make to do or to change X?”) and “relationship” questions (e.g. “Who else is involved with your pain? How? And what would they see you doing differently?”) to expand initial responses and perspectives.
- *Existing Expertise.* Identifying potential “solutions”—existing but overlooked, underappreciated, or forgotten self-management skills, knowledge, strategies and coping mechanisms (e.g. “What do you already know? What works, even a little bit?”).
- *Goals and Small Steps.* Setting small-scale goals, brainstorming experiments (e.g. “If what you’re doing clearly is not working, what could you do differently?”), self-assigning homework tasks, and taking small steps.
- *Scales.* Using 0-10 scales (where 0 = worst and 10 = best) to evaluate progress toward goals and preferred futures.
- *Compliments.* Noticing, reflecting back, and “complimenting” participants’ on apparent strengths, resources, and existing competence.

Pilot Study Participants

Pilot study participants were recruited through flyers posted in public places, mailings to health care professionals, a press release in the local newspaper, and referrals from staff at Longmont United Hospital. No random sampling was involved. Thirteen individuals signed up for the five-week program, and one dropped out at session three, so data are reported below only for those who finished (n = 12).

There were nine women (75%) and three men (25%), ranging in age from 41 to 73, with a mean of 59 years. Seven participants (58%) were still employed, full-time or part-time, while five (42%) were retired, unemployed, or receiving disability benefits from the government. Occupations included: acupuncturist, electrical engineer, part-time temp worker, physical therapist, retired dog groomer, retired nurse, sales support, teacher, and upholsterer.

Duration of chronic pain ranged from approximately two years to more than 25, with a mean of approximately 11 years. Types of chronic conditions included: arthritis, chronic fatigue, compression fractures, fibromyalgia, general musculoskeletal pain, high blood pressure, Lyme disease, lymphedema, myeloma, migraines, neuropathies (peripheral and unspecified), obesity, post-mastectomy pain syndrome, ruptured disks, scoliosis, and viral infection. Participants experienced chronic pain in the head, sinuses, neck, shoulders, upper and lower back, spine, chest wall, stomach, abdomen, pelvis, hips, hands, knees, legs, and “all over.”

Outcome Measures

Five pre-post self-report instruments were administered to measure outcomes of the five-week program. In keeping with the solution-focused model—which purposely steers attention away from what’s wrong (the problem)—no attempt was made to measure pain itself on a conventional 0-10 scale. Some studies suggest that a repeated focus on pain sensations may cause patients more harm than good (Bray et al., 2015), possibly because whatever one measures inevitably comes to dominate one’s awareness. Each of the outcome measures selected for this study was chosen for its overall “fit” with the solution-focused approach, which is more concerned with the cultivation of well-being than the reduction of negative symptoms (Simm et al., 2014). In addition, each instrument was chosen based on evidence of testing to ensure sufficient reliability and validity. Participants completed the following assessments:

1. *Quality of Life Uniscale* (Sloan, 2005) is a single-item scale from 0-10 (identical, in fact, to a conventional pain scale, but with 10 representing “as good as it can be”), which measures an individual’s overall (or average) quality of life during the past week. Solution-focused practitioners have been using similar 0-10 scales for decades. This particular uniscale emerged from numerous research studies with oncology patients (Frost & Sloan, 2002; Qi et al., 2009), indicating shorter assessments were as effective as longer, multiple-item questionnaires in detecting clinically significant changes in quality of life. Since the primary objective of chronic pain self-management is, in fact, improvement in quality of life, this scale may be considered a solution-focused alternative to the traditional problem-focused pain scale.
2. *Pain Self-Efficacy Questionnaire (PSEQ)* (Nicholas, 2007), is a 10-item assessment consisting of 0-6 Likert scales, which measure a participant’s belief in his or her ability to perform ordinary tasks and engage in positive activities, despite the presence of pain. This instrument was chosen because it was one of the tools used in the

UK solution-focused pain management program (Simm et al., 2014), which inspired this five-week pilot study. Examples of questions include: “I can enjoy things, despite the pain,” “I can do most household tasks (cleaning, dishes, laundry, etc.), despite the pain,” and “I can do some form of work (paid or unpaid), despite the pain.”

3. *Warwick-Edinburgh Mental Well-Being Scale (WEBWBS)* (Tennant et al., 2007) is a 14-item assessment consisting of 1-5 Likert scales, which measure subjective mental and emotional well-being through positively worded statements. This tool was also chosen because it was used in the UK solution-focused pain management program, and because users in the NHS indicated they preferred this positive outcome measure over conventional tools (Simm et al., 2014) that focus on negative moods and emotions, such as depression or anxiety. Examples of questions include: “I’ve been feeling relaxed,” “I’ve been thinking clearly,” and “I’ve been interested in new things.”
4. *State Hope Scale* (Snyder et al., 1996) is a 6-item assessment consisting of 1-8 Likert scales, which measure a participant’s orientation toward the future, or goal-directed thinking, at a particular moment in time. It has two subscales, and a score for total hope. One subscale measures “agency” thinking, which means an individual believes he or she is capable of having at least some influence over future outcomes. The other subscale measures “pathways” thinking, which means an individual can generate alternative routes toward a goal, especially when faced with obstacles or setbacks. The ability to detect an increase in hope is critical for people suffering from chronic pain, or they may lack sufficient motivation for the hard work of behavioral change.
5. *Solution-Focused Inventory* (Grant et al., 2012), is a 12-item assessment consisting of 1-6 Likert scales intended to track changes in solution-focused (as opposed to problem-focused) thinking while participants engage in a goal-oriented coaching or therapeutic training program. It has three subscales: problem disengagement (PD), goal orientation (GO), and resource activation (RA). PD refers to the ability to avoid becoming enmeshed in negative thinking and ruminating on problems. GO refers to the ability to clearly envision goals, create action plans to achieve them, and monitor progress. RA refers to awareness and application of one’s own strengths and resources.

Results

Due primarily to the small sample size ($n = 12$), as well as lack of access to or expertise in SPSS and similar software, no statistical analyses were performed on the outcome data. Only percent changes from baseline to follow-up were calculated. Therefore, the quantitative data presented here are largely suggestive.

Table 1 provides the mean values and percent changes from pre-test to post-test over the SFCPM pilot study period of five weeks. Positive changes were found in quality of life, pain self-efficacy, mental well-being, hope (agency, pathways, and total score), and the problem disengagement (PD) subscale of solution-focused thinking. Negative changes were found in the goal orientation and resource activation subscales, as well as the total score for solution-focused thinking.

Discussion

The pilot study was intended as a preliminary evaluation of the efficacy of a new psychoeducational training program in chronic pain self-management based on Solution-Focused Brief Therapy and the emerging biopsychosocial model of pain and well-being. Although the sample size was not large enough to determine statistical significance, a few observations may be in order. Based on percent changes and written feedback from participants (anonymous comments from the end of session five), all five of the initial pilot study objectives were met, at least in principle.

Quality of Life

On a uniscale from 0 to 10 (where 10 meant “as good as it can be” and 0 “as bad as it can be”), participants’ pre-test responses ranged from a low of 1 to a high of 7, with a mean of 4.42. Post-test responses ranged from a low of 3 to a high of 9, with a mean of 6.25. This represented an average 41.4% improvement in quality of life, despite the presence and persistence of pain. Participant feedback supported this observation:

- “I feel a little bit more like my old self before the rug of life was yanked out from under me.”
- “I found this a positive new methodology for working on my own pain management.”
- “It helped to learn that I am already surprisingly good at managing my life despite chronic pain.”

Table 1

Mean changes in quality of life, pain self-efficacy, mental well-being, hope, and solution-focused thinking from pre-test to post-test five weeks later (n = 12).

Outcome Measure	Pre-SFCPM	Post-SFCPM	% change
Quality of Life	4.42	6.25	+ 41.4
Pain Self-Efficacy	31.3	38.2	+ 22.0
Mental Well-Being	44.3	48.4	+ 9.3
Hope (<i>agency</i>)	13.8	17.2	+ 24.6
Hope (<i>pathways</i>)	16.8	18.4	+ 9.5
Hope (<i>total</i>)	30.7	35.6	+ 16.0
SF* Thinking (<i>PD</i>)*	13.8	15.5	+ 12.3
SF Thinking (<i>GO</i>)*	17.3	15.3	- 11.6
SF Thinking (<i>RA</i>)*	18.3	17.8	- 2.7
SF Thinking (<i>total</i>)	50.0	48.7	- 2.6

Note. SF = solution-focused, PD = problem disengagement, GO = goal orientation, RA = resource activation.

Pain Self-Efficacy

Participants' perceived ability to live, work, and function well despite chronic pain improved an average 22% from pre-test to post-test. Recall that these improvements came not from expert advice or medical treatment, but from participants' application of the solution-focused process to their own experience and experiments. Participant feedback also reinforced this observation:

- “Learning to notice ‘exceptions’—times when there is no pain or less pain—and focusing on what I’m doing at those times was beneficial.”
- “I’m learning there are small steps I can take, things I can do to change my life. So I feel like I have more control.”
- “I have a new set of tools that I can use to manage my pain, and a brand-new outlook on my life.”

Mental and Emotional Well-Being

Despite suffering from chronic pain for many years, with all of its attendant moods and emotions, participants' mental and emotional well-being scores improved a mean of 9.3% from pre-test to post-test. This increase may appear modest, but given the range of psychological issues participants brought to the program—including grief, anger, disappointment, anxiety, fear, depression, guilt, regret, shame, low self-esteem, hopelessness, and meaninglessness—it may represent a promising shift in the right direction. Comments included:

- “One of the biggest things I’m learning is patience. Psychologically, it took years to get to where I’m at, so it’s not going to be solved overnight or even in a few weeks or months.”
- “I came to the realization that change is good, acceptance is good, and enjoying the moment is good.”
- “When I came here five weeks ago, I was so depressed. It felt like I had lost control. Now I feel I can whip any problem the world throws at me. I’m back on my feet. I’ve reclaimed my life.”

Hope: Agency and Pathways

While both subscales of the State Hope Scale (Snyder et al., 1996) showed positive improvements from pre-test to post-test, agency—the belief in one’s capacity to have at least some influence over the future—increased the most: an average of 24.6%. Like pain self-efficacy, this represents an internal shift in belief about oneself despite the ongoing presence of pain, obstacles or set-backs. Hope is essential to the motivation needed to persist on what may prove to be a long, difficult journey to greater health and well-being. Participant comments included:

- “There was a single moment the first week when I actually noticed I was not in pain. That was eye-opening. Maybe it was happening before, but I just didn’t notice. I’m feeling hopeful now—and it’s all from that one moment.”
- “I enjoyed looking for my preferred future.”
- “This process will allow me to find and remember the things that work, and apply them as a lifestyle change—not just next week, or next month, but forever.”

Solution-Focused Thinking

Pre-test to post-test changes on the Solution-Focused Inventory (Grant et al., 2012) showed a mean increase on one subscale and decreases on the other two. Goal Orientation (GO) declined an average 11.6% and Resource Activation (RA) dipped 2.7%. Why? One can only speculate. However, several factors may have been at work. For one thing, some participants may have realized they were doing just fine in the here and now. Others clearly struggled to imagine or define personal goals and “preferred futures.” People who suffer from chronic pain for a long time (in this case, an average of 11 years) often focus less on the future than simply “getting by” day to day. Without a compelling vision of the future in mind, however, it can prove daunting to generate concrete action plans, rally one’s seemingly meager resources, and monitor incremental progress week by week—all aspects of GO and RA. Another factor may have been the brevity of the program, which was, admittedly, shorter than other pain self-management courses. Participant feedback supported these observations:

- “It was challenging for me to set goals and identify small steps toward them.”
- “The course was too short to really see change. Two weeks on each of the three [biopsychosocial] areas might be better.”

Meanwhile, scores on the Problem Disengagement (PD) subscale improved 12.3%. This suggests that, over the course of the five-week program, participants actually began to switch their dominant focus from ruminating on “what’s wrong” (pain and problems) to discovering and noticing “what’s right” (exceptions and solutions)—which was, in fact, one of this study’s objectives. Comments included:

- “The change in perspective was one of the most beneficial aspects of the program.”
- “It helped to shift from thinking about how many bad days I have to focusing more on how many good—or amazing—days I’m having.”
- “Learning to look at problems associated with chronic pain from a positive, rather than negative, viewpoint was helpful.”

Social Connection and Support

Another positive outcome of the SFCPM pilot study was the apparent enhancement of social connection, engagement and support. All too often, social isolation and loneliness accompany chronic pain (LeFort et al., 2015). The

biopsychosocial model stresses that social—as well as physical, psychological and even spiritual—factors contribute to the total subjective experience of pain (Bray et al., 2015). In addition, the solution-focused model, which originated within the field of family therapy, regularly investigates the impact of relationships, social context, and other people's perspectives (Pichot & Dolan, 2003).

While no instrument was administered specifically to measure perceived changes in social well-being, two items on the Pain Self-Efficacy Questionnaire (“I can socialize with friends or family as often as I used to, despite the pain,” and “I can do some form of work (paid or unpaid), despite the pain”) and three on the Mental Well-Being Scale (“I've been feeling interested in other people,” “I've been feeling close to other people,” “I've been feeling loved”) addressed the social impact of chronic pain. Responses to these five social questions revealed a mean increase of just 6.4% from pre-test to post-test. Despite this seemingly small change, participants noted various social benefits they gained from meeting and working together:

- “Finding what works for me and working on goals in a supportive group proved useful.”
- “The group was an emotionally safe place where I could be seen and accepted.”
- “The small class size, the sharing of personal stories, and the group discussion were all helpful to me.”
- “It was therapeutic to be with others in a group, all facing the limitations of chronic pain. Listening to others set goals and watching them accomplish small steps was very helpful as a role model to me.”
- “The social aspects of the course make you feel you are not alone in this.”

Strengths and Limitations

A particular strength of the SFCPM pilot study was that, unlike its UK predecessor, it evaluated a novel solution-focused approach to chronic pain self-management in which no expert advice or education (apart from the methodology itself) was offered. This means that all reported post-intervention gains reflect the expertise and initiative of the participants themselves, not the actions or expertise of the facilitator or anyone else. Therefore, this appears to be the first solution-focused psychoeducational pain management program in the world that made no attempt to fill any gaps in the participants' knowledge, skills, or experience. To do so required a radical trust on the part of the facilitator in both the underlying model and in people's inherent capacity to discover their own solutions.

Another strength of this particular study was that it was facilitated by a single, well-trained professional, rather than a multidisciplinary team, offering a true biopsychosocial approach at a fraction of the clinical investment.

Clearly, however, the pilot study suffered from various methodological limitations including the small sample size, lack of random sampling or a control group, absence of longitudinal follow-up, and lack of statistical expertise and analysis. In addition, all data were collected and reported by the same individual who delivered the training. As such, social desirability bias on the part of participants could not be ruled out.

The primary reason for these limitations was that no funding whatsoever and only limited institutional resources and assistance were available. The author—the primary sponsor and facilitator—was a solution-focused practitioner in private practice, with only a shoe-string budget. Co-sponsorship by Longmont United Hospital consisted of moral support, permission to use the hospital's name, distribution of flyers, referrals, and use of a conference room for some of the program meetings.

Conclusions

Based on observations and lessons learned while facilitating this pilot study, many subtle changes were made to improve both the design and delivery of the Solution-Focused Chronic Pain Management training program. Despite the study's limitations, improvements in all five of its initial measurable objectives, as well as enhanced social support, appear quite promising or at the very least suggestive. Preliminary outcomes—including open-ended feedback from participants regarding benefits they received from the program—suggest that this new approach may warrant further, more rigorous investigation in the future.

Meanwhile, health care professionals and medical facilities serving patients who suffer from chronic pain might consider exploring SFCPM as a complementary component of either an integrative or interdisciplinary team approach to pain management. Combined with the biopsychosocial model of pain and well-being, the solution-focused model offers a tantalizing, highly personalized, proactive, and potentially empowering alternative to familiar problem-focused,

expert-driven approaches to chronic pain self-management. Instead of fixating on or attempting to fix what's wrong, SFCPM enables participants to focus on and amplify what's still right with their bodies, minds, and lives—despite chronic pain.

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