Developing successful social support: An interpretative phenomenological analysis of mechanisms and processes in a chronic pain support group

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Abstract

Objective. The experience of long-term membership of a successful Chronic Pain Support Group (CPSG) was explored to identify; i) factors associated with social support, and; ii) ways that health-care professionals (HCPs) could help CPSGs become more effective and supportive.

Design. Interpretative Phenomenological Analysis enabled exploration of participants' experiences of membership and rationales for continued attendance.

Main outcome measures. Twelve participants (four males, eight females), recruited from a regional CPSG, completed semi-structured interviews lasting from 45-120 minutes. Following verbatim transcription, idiographic then cross-case analyses were undertaken.

Results. Three superordinate themes emerged: (1) Investing in the new normal; (2) The nurturing environment; (3) Growth facilitation through social evolution. Increased investment and identification with membership, generated snowballing social engagement, enhancing pain management/well-being through collective humour and peer-to-peer support. Explicit guidance by HCPs in early stages of group formation/development, and subsequent implicit influences on group attitudes and actions, promoted the group's development into its current healthy, supportive state.

Conclusion. Contrary to stereotypes, membership offered positive respite from chronic pain through collective coping. Successful CPSGs forge an independent identity, fostering strong group investment and an ability to live well with chronic pain. HCPs can provide a stabilising foundation for CPSGs to develop positively and supportively.

Long-standing, chronic pain represents a significant challenge to patients and healthcare professionals. As a consequence of the distress and disability experienced, quality of life is often impaired (Williams, Eccleston, & Morley, 2012). Behavioural and cognitive treatments for the management of chronic pain have been widely researched and psychological approaches are central to effective multidisciplinary care (Breivik, Collett, Ventafridda, Cohen, & Gallacher, 2006; British Pain Society, 2013; Kaiser, Mooreville, & Kannan, 2015). However, recent research has criticised traditional psychological therapies for their focus on the individual in pain, neglecting the social world in which pain is experienced

(Riekert, Ockene, & Pbert, 2014). Pain is primed by prior experiences, patterned by learning and interpersonal modelling, and strongly influenced by a constant transaction between the person in pain, their social support structures and the healthcare professionals (HCPs) managing their clinical care (Davison, Pennebaker, & Dickerson, 2000; Goubert, Vlaeyen, Crombez, & Craig, 2011). To improve treatment outcomes, there is a need for pain to be addressed in the context of the social support structures that form each individual's social world (Linton & Shaw, 2011; Williams et al., 2012).

Improving social support structures for those facing chronic health conditions has both psychological and physiological benefits. Psychologically, enhanced social support is associated with increased health-related quality of life (Ibrahim, Teo, Che Din, Abdul Gafor, & Ismail, 2015), reduced feelings of illness uncertainty (Hoth et al., 2015), decreased depression (Khalil & Abed, 2014), greater satisfaction with life participation (Hand, Law, McColl, Hanna, & Elliott, 2014) and diminished perception of disease-related stigma (McInnis, McQuaid, Bombay, Matheson, & Anisman, 2015). Physiologically, social support reduces sleep disturbances (Gosling, Batterham, Glozier, & Christensen, 2014), limits development of cardiovascular disease (Compare et al., 2013), reduces stress reactivity (Lovell, Moss, & Wetherell, 2012) and increases longevity (Uchino, 2009; Uchino, Carlisle, Birmingham, & Vaughn, 2011), amongst other outcomes. Social support therefore functions as a moderator of disease progression, promoting psychosocial well-being and buffering the individual from physical and mental decline (Uchino et al., 2011). Chronic pain is strongly associated with reduced social opportunities, with isolation a significant consequence of disease-related reductions in activity and functional ability (Breivik et al., 2006). Therefore, social support structures are important targets for self-management; maintaining or increasing such structures promotes continued quality of life and health-related coping (Rodham, McCabe, & Blake, 2009).

Social support structures are typically varied, categorised as; (a) informal, primary support structures, including family and core friendship groups; or (b) formal, secondary support structures which are commonly larger and involve extended friendship groups, personal-

interest groups and work colleagues (Thoits, 2011). It is possible that the reported outcomes of healthcare-based support groups are variable because the definition of a support group differs widely within the literature. There is heterogeneity over what constitutes a 'support group': healthcare-based (face-to-face) support groups may be (i) HCP-led, (ii) HCP-facilitated, (iii) peer-led, or, (iv) a combination of these approaches. Peer-led CPSGs are predominantly based in the community and provide social events, visiting speakers and informal peer-to-peer networking and health advice on a monthly or bi-monthly basis (XXX & XXX, 2016). Where support groups are set up in affiliation with healthcare services, it is most common that they are HCP-led, with group activity/interaction guided and planned by the HCP, for example in health education support groups (such as Linton, Hellsing, & Larsson, 1997) or nurse-led patient-carer support groups (Nichols & Wright, 2015). If HCP-facilitated, participants are engaged in the organisation and content of the group, under the guidance of HCPs (for example Subramaniam, Stewart, & Smith, 1999). HCP-led and HCP-facilitated groups have been widely utilised and often formalised in terms of recommendations for content delivery, therefore constituting a cross-over between clinical interventions and social support (see for examples, Pratt, MacGregor, Reid, & Given, 2012; Zordan et al., 2015). In HPC-led or HPC-facilitated groups there is obviously a key role for healthcare professionals in contributing to the success of the group in terms of engagement, participation, and potential benefits to participants (Subramaniam et al., 1999). Healthcare-based, clinically-initiated but peer-led support groups are less common, though they exist widely online (Kraut & Resnick, 2011; Mehta & Atreja, 2015).

Social support may be both instrumental (practical) and emotional (psychological support), with emotional support thought to provide greater health-related benefits (Morelli, Lee, Arnn, & Zaki, 2015). Within healthcare contexts, the promotion of social support typically involves secondary structures through the creation of disease-specific support groups. In the context of chronic pain, these are called chronic pain support groups (CPSGs). CPSGs often originate in association with Pain Management Programmes (PMPs), with CPSGs designed to ease the transition from PMP to community-based care (British Pain Society, 2013).

Research has shown that CPSGs enhance willingness to adopt self-management strategies, increase social contact and life satisfaction (Arthur & Edwards, 2005), and enhance self-esteem and functional activity levels (Subramaniam et al., 1999). However, uptake of CPSGs appears low, therefore there is a need to improve engagement (Subramaniam et al., 1999), potentially enhancing long-term patient outcomes as a consequence (Arthur & Edwards, 2005). Barriers to joining CPSGs include perceived stigma (Slade, Molloy, & Keating, 2009) and negative preconceptions about the potentially mood-lowering discussions that may occur during meetings (XXX & XXX, 2016). Ultimately, engaging with a support group does not necessarily *guarantee* improvements in health or well-being (see for example, Linton, Hellsing, & Larsson, 1997), yet to neglect exploring them as a potential avenue for increasing social support may be short-sighted.

Peer-led support groups are thought to provide significant emotional and practical support for those facing health-related disability, increasing agency and autonomy (Arthur & Edwards, 2005; Cowan, 2013). In line with an increasing need for patient-centred care and self-management (NICE, 2012), such peer-led support groups represent a key target for greater integration into healthcare provision. Though progress has been made through recruitment of 'Peer Support Workers' (PSWs), tasked with organising disease-specific but informal support structures (Repper & Carter, 2011), there is room for growth. Even in peer-led groups there remains an important role for HCPs, which can include, for example, acting themselves as expert speakers, providing informal advice, offering guidance for the Committee either in person or from a distance, supporting in the registration for charitable status, developing appropriate and accountable financial structures, signposting the group towards recent research and nominating potential visiting speakers from the healthcare domain.

Due to the role that health care professionals (HCPs) often have in instigating and setting up chronic pain support groups, and encouraging initial attendance (XXX & XXX, 2016), HCPs could potentially influence the nature and quality of social support provided by CPSGs. HCP influences have the potential to operate both explicitly in terms of practical creation and development of groups, and implicitly through priming behaviour and attitudes within the group. There is little available evidence regarding recommended structure or content for

creating effective peer-led chronic pain support groups: knowledge about the actual social/interpersonal mechanisms and processes involved in providing effective long-term social support could inform how HCPs initiate and interact with peer-led support groups. This could help to foster groups in which participants collectively and effectively build an attractive, healthy, functioning social support structure.

The current study aimed to investigate the mechanisms of social support involved in a successful CPSG and how these are activated. In particular, mechanisms facilitating long-term support, engagement and participation that could be primed by HCPs as they help to set up and/or manage support groups. The research also aimed to identify within-group structures that were felt by participants to constitute a successful support group, in order to develop recommendations for HCPs and prospective support group members to maximise integration and engagement. The context of the study was a successful CPSG that has been meeting for over a decade, and interviews were conducted with long-term, engaged members of the group. Interpretative Phenomenological Analysis (IPA) was used to explore the social support mechanisms and processes active within the CPSG as it provides an in-depth insight into the individual and internal world experienced by participants (Smith, Flowers, & Larkin, 2009), maintaining an idiographic stance whilst reflecting the collective perspectives expressed by group members (Smith, 2011).

Method

Participants

Participants were recruited through a Chronic Pain Support Group (CPSG) in the South-East of England. Twelve participants (8 females, 4 males) were purposively sampled (following Smith, Flowers, & Larkin, 2009). Inclusion criteria were: chronic, non-malignant pain, attendance at the CPSG for two or more years, attendance at a minimum of 50% of meetings over the past 12 months and fluency in English. All participants were not currently working, due to unemployment, retirement or health status. Eleven participants were White British and one

participant was of Pakistani origin. Demographic characteristics are shown in Table 1. All identifying information has been changed. Due to their long-standing CPSG attendance, all participants were familiar with each other.

*** Insert Table 1 about here: Participant characteristics and pain history***

Milton Keynes Chronic Pain Support Group (CPSG)

The CPSG was set up in 2004 in association with the Health Psychology Department within the NHS Foundation Trust. Referrals to the group were initially restricted to members who had completed a full hospital-based Pain Management Programme (6 weeks, 12 half-day sessions, 36 hours), but were subsequently extended to those screened as appropriate for membership after a period of treatment with the Hospital multi-disciplinary Pain Team. The CPSG was HCP-led for the initial formative period (3 years), and then informally HCP-facilitated (5 years) with the majority of input being participant-led, before becoming a self-governing, self-funding and peer-led CPSG in 2012. Meetings lasting approximately 2.5 hours, are held monthly in a local community centre and are structured as follows: 30 mins informal chat, tea and coffee, 10 mins notices and welcome by CPSG Committee, 1 hour visiting speaker or activity, 50 mins contingency time for speaker/activity, refreshments and informal discussion. Attendance at meetings ranges between 20 and 40 regular attendees, with larger numbers for the annual Christmas Dinner. The Committee consists of five elected members (range N = 3-6 over the history of the group), including Chair, Treasurer and Secretary and they meet monthly in addition to the CPSG. The group run a peer-written newsletter which is produced monthly and sent electronically to a readership of 120 members. The Group has developed off-shoot groups centred on card-making, crafting, walking, swimming and social events, which meet weekly or bi-monthly with smaller groups of CPSG members. Members pay a small, monthly membership fee, and this income, supplemented by other fund-raising activities, is used to pay for room hire, visiting speakers, and to subsidise the annual Christmas Dinner.

Procedure

Following formal review and ethical approval through the University of XXX, Department of Psychology Research Ethics Committee, the CPSG Committee was approached to discuss the study and provide appropriate permissions for recruitment of their members. Following

permissions, participants were approached through the CPSG newsletter and via an informal presentation at a support group meeting. Prospective participants were given the study information sheet and asked to approach the researcher if they wished to take part in an interview.

After obtaining written, informed consent, interviews were conducted in participants' homes (N = 11) or at the Department of Psychology, University of XXX (N = 1). Interviews lasted between 45 and 120 minutes in length. Participants additionally completed a demographic and pain history questionnaire. All participants received a £30 gift voucher as recognition for their time and travel costs were paid, if appropriate.

Data Collection and Analysis

An open-ended, semi-structured interview was used to promote an atmosphere of openness within interviews, enabling participants to lead the interview through discussion of issues and questions most pertinent to their experiences (following Smith et al., 2009). In accordance with the need for dynamic exploration of thoughts and ideas, participants were encouraged to take ownership of the interview and make sense of their own experiences by raising topics important to them. The researcher retained freedom to probe further on participant-generated subjects which reflected the aims of the research (Smith, 2011; see Table 2 for interview schedule). Interviews began with an open-ended question about chronic pain in order to initiate naturalistic discussion, before moving to exploration of participants' thoughts regarding their CPSG. Interview questions were kept open, and deliberately did not address HCP support or social structures, to minimise the risk of emergent researcher-led content. All interviews were encrypted and audio-recorded and transcribed verbatim. Identifying information, including names and places, has been changed throughout.

Insert Table 2 about here: Interview Schedule

Each transcript was analysed separately in full, to maintain a 'bottom-up', idiographic stance. This allowed the experiences of each participant to be reflected in their entirety, also providing space for the researcher's reflection and reflexive practice (Smith et al., 2009). Transcripts were analysed through a process of constant comparison between the transcripts and emergent themes to firmly ground the analysis in the data.

Transcripts were analysed at multiple levels; they were first read for familiarity and then analysed at descriptive, linguistic and conceptual levels. The collected content of these levels of analysis, in addition to a reflective log kept by the researcher, facilitated development of emergent themes for each individual case. After concluding individual analyses, a cross-case analysis was completed, again maintaining a recursive stance, working closely with emergent themes and all transcripts to abstract superordinate themes and associated, clustered, subordinate themes. Themes represent one possible interpretation of the data, representing convergences, divergences and relationships evident in the data at the time of analysis (Smith et al., 2009). Quotations included in results represent the best examples of the theme under discussion. This study forms the second part of a qualitative research project investigating CPSGs (see also XXX & XXX, 2016 [names obscured for anonymity]).

Quality and Rigour

Throughout the research, caution was employed to ensure that the lived experiences of participants were sensitively reflected and analyses transparent, coherent and rigorous (Yardley, 2007). An idiographic and iterative stance was maintained, ensuring that fidelity to original transcripts kept paramount. Emergent, clustered, subordinate and super-ordinate themes were triangulated by an independent auditor with significant experience both in chronic pain research and IPA. The auditor maintained analytical proximity with transcripts to ensure the representativeness of thematic content. All interpretations were discussed within the Research Team to ensure they were representative of the original data and that clarity of interpretation was strong. The 'double-hermeneutic' recognises that different contextual backgrounds may generate individuated interpretations of the data, therefore the current interpretation may not be the only interpretation of data (Yardley, 2007). However, a reflective log and discussion within the research team supported researchers in their efforts to 'bracket-off' assumptions and pre-conceptions which could impact on analyses (following Smith et al., 2009). This research is therefore deliberately grounded in the data and has sought to avoid an imposition of 'top-down' theory on transcripts (Vangeli & West, 2012).

Results

Analysis of transcripts resulted in three superordinate themes: (1) Investing in the new normal; (2) The nurturing environment; (3) Growth facilitation through social evolution. Superordinate and subordinate themes are presented in Table 3. They identify structures, processes and mechanisms that are associated with effective social support and that have emergent implications for support group members and HCPs.

*** *Insert Table 3 Here: Outline of Themes* ***

Investing in the new normal

The first superordinate theme was expressed by all participants and represented increasing personal and social investment in the support group; by engaging with the organisational structure and interpersonal relationships within the group, participants were able to foster a positive and collective new identity in which functional disability was no longer abnormal. This also provided insights into some of the processes through which positive, supportive aspects of the group had developed, such as the ways that participation in the group supported members in their individual transitions to new identities as people living well with pain, and how the differences among group members paradoxically gave the group members a sense of strength and stability, promoting a desire to invest and engage with this further.

Developing a collective identity through communal coping

Due to a shared health status and regular attendance at the CPSG, a collective identity is fostered within the group. Despite varying medical diagnoses, nine of twelve participants used the phrase 'all in the same boat': the universal experience of chronic pain acts as a collective point of reference, facilitating understanding of others. A cohesive identity as a people living with pain was reflected: 'Everybody sorta being on the same wavelength with the pain and that. I think it just brings everybody together, basically. Because we're all in t'same boat, we're all in pain' (Alison). This sense of togetherness facilitated communal coping embodied through non-judgemental acceptance and inclusivity, creating a genuine atmosphere of openness which was felt unusual and freeing and which enabled identity exploration. For example, Louise gained self-confidence and a sense of value and identity, which she then felt able to express by increasingly voicing her opinions:

So going there, it enabled me to realise that I was a person in my own right at the support group and that I was valuable, I did have interesting things that I could talk about or say my views were just as important as others peoples' and of course I began to make friends.

Acceptance was practically initiated, with new members carefully welcomed, mentored, introduced to others and placed near others with potentially similar interests: 'I think that's what the support group's all about, going up to them, talking to them, including them. 'Cause nobody comes in and sits on their own ever.' (Jasmine). Inclusion was very deliberate, expressed in all participant accounts as a priority need, nurturing the growth and social health of the group.   Consequently, a universal atmosphere of pain acceptance and genuine social support was apparent, whether or not members were coping well or poorly with their pain, and with members sharing pain management strategies for mutual benefit:

It is a support group for people who are in chronic pain […] I'm in pain 24 hours a day, it never goes away, it just gets worse, but you deal with it. There's not that many people who can understand that or handle it, but my [CPSG] friends, they do. They know. They handle it, they teach me different ways to handle it, I teach them different ways o' handling. (Ron)

Participants contrasted 'pain friends' against 'normal friends', stating that 'pain friends' through their health identity, are knowledgeable and accepting of limits facing others in pain.

The people that I count my friends now are people within the support group. 'Coz they understand, as well, they understand that if I say um 'yeah, I'll come for a coffee, I might phone up ten minutes before and say I am sorry, I just can't do it'… Whereas if you've got a circle of normal friends and you do that, they think 'oh God, again? What's the matter now'? But you never get that with pain support friends. (Jasmine)

Through a recognition of the difference in friendships, the collective identity is consolidated, validated and recognised. Collective identity was developed through a process in which members recognised what they shared with other members and, over time, came to identify and value this, so they could look back from their perspective at the time of the study to see how earlier actions and experiences had led to the benefits they described: 'it's nice to see people grow and uh um you can see you can see how you yourself have grown over time' (Louise). This was a social transition in which the group members' previous social ties to people not living with pain were replaced with social ties to people who had pain in common with one another, and the participants recognise how this had affected their perception of what is 'normal'.

Stability in diversity

The natural diversity of the CPSG was considered by participants to be unusual yet beneficial, giving strength and stability: 'You've got all these people from all over the place, completely different. In normal circumstances these people should not be in the same room together. They just wouldn't' (Jane)*.* Participants articulated the paradox of how the interpersonal mix offered strength, and the range of life experience presented participants with new perspectives and opportunities to draw alongside others struggling with pain. For example, Louise described how she experienced the differences between group members as a 'stabilising force' in her continued membership and participation: 'The support group kept on pulling me back because the fact is we've got people that are in their early twenties that go right up to their late seventies […] so that was always a stabilising force there'. Such quotes represent this paradox of stability in diversity, reflecting group members' recognition that their shared experience of chronic pain was more significant and salient to them than their differences in terms of age or social position: 'it means so much to me to be able to go and be able to speak to all these different people' (Rebecca).

Traditional socio-economic variations came to appear more superficial as their new shared identity and conception of what is normal developed, for example Nicole stated: 'I don't know, I just felt welcome, I felt (.) part of like a family maybe a little bit dysfunctional, all different types of people in there from all different cultures, age groups...' (Nicole)

Outside of the group, chronic pain was conceptualised as the cause of isolation and difference from the norm due to a struggle to locate the self within a society that did not fully understand pain. Yet within the group, pain became peripheral and lost its salience as it was a unifying feature that could be assumed and therefore disregarded: 'it's [the CPSG] nothing to do with pain, but everybody is aware because everybody is in the same, everybody is dealing with a similar [pain state] … all for different reasons, all for completely different reasons' (Jane).The CPSG created a 'new normal', where functional disability was no longer unfamiliar and the feeling of being different diminished:

Some of the ladies, like, and men, if they've had to use their sticks or they're having to use their crutches, that can feel really intimidating that you've gotta go on the street like that. […] But they come in with their walkers and their crutches and they don't feel any different. They know they can do that without feeling that […] 'everyone is gonna look at me because I'm having to use crutches'. Nobody looks at yuh. y'know (Rebecca).

Through within-group stability in difference, and the creation of a new normality, the CPSG functioned as a safe base from which to explore life, despite pain.

The ownership snowball

Participants expressed an active sense of ownership of their CPSG, which grew in strength with increased confidence and length of membership. This was particularly evident in the statements of committee members, as they reflected back on their initial decision to take on the management of the group:

Sarah [Consultant Health Psychologist] actually said to a couple of us that she felt we could do it […] would we like to take over as a Committee. So we said yes […] it just took off from there. I mean I'm Chairman now, would you believe. (Jasmine)

Committee members expressed pride in their status and their organisational involvement is attractive to others. Growth in ownership was evident; as new members gained confidence they felt able to get involved in guiding future directions. Nicole expressed such growth clearly: 'If it gets to the point that they need people to be part of the committee, I'd be more than welcome to step up now that I feel confident enough to do that.' (Nicole). Her willingness to sit as a committee member in the future was based on her personal growth in confidence; a growth she felt the group itself had facilitated. Pride in ownership was also demonstrated through satisfaction in self-funding:

We've got to fund ourselves. We don't get any help from anybody else. I think we did at one time, but obviously with all the cuts and that. There's enough of us with enough get up and go to get it up and running. (Alex)

Alex valued personality differences within the group, recognising that in spite of different energy levels and health statuses, the workload could be shared and goals achieved. For him, this invoked a sense of satisfaction in succeeding collectively, running the CPSG as a cohesive group, without external support. As a consequence of the self-governance and sense of investment in the group, participants felt empowered to make suggestions to alter and enhance meetings, for example in room layouts:

I did tell them about the way that they were organising the tables, the thing is you need to make it more of a circle … you don't want a group over there and a little group over there and a group over there. You want to have everybody so you can have a conversation with that one over there or that one over there. They said 'awww that's a good idea'. (Jane)

Through evident pride, ownership, commitment to fund-raising, attendance and support for the committee, the investment of all participants in the CPSG was clearly apparent.

The Nurturing Environment

The second superordinate theme was strongly and repeatedly expressed by all participants, emphasising the importance of adopting the counter-cultural group ethos, which challenges pre-conceptions of CPSGs. For all members, pain talk was peripheral and deliberately avoided, as they felt it predisposed people towards a negative spiral which would become unhelpful; instead participants actively engaged with the giving of emotional and practical support to other group members. Such support was sustainable and positive through the maintenance of distinct and protective boundaries.

Disrupting the pain-talk spiral

Central to CPSG core principles and counter to standard preconceptions of support groups, all participants highlighted the explicit choice made by members not to talk about pain within meetings. This was because members were aware that discussion about pain can often lead from one

negative topic to another, with increasingly negative and depressing emotional tone, hence the use of the term 'spiral'. The negative spiral process, and the reasons for avoiding it, was carefully described by Neil:

We never discuss our pain. Isn't that amazing? We never discuss our pain. I mean I think discussing pain, if you start pressing button A then B will want to prompt in, then C would want to tell you about their pain and before you realise, you're brought down to ground. And you think 'I didn't come here to listen to people's pain problems. I came here to be cheered up'. But that's why we don't talk about it.

By avoiding talking about pain, participants were able to make pain peripheral, focusing instead on positive and social activity, avoiding a negative pain-related spiral. Being exempted from the need to talk about pain challenged what 'normal others' often expected: outside of the group, members were regularly asked about pain, and such intrusion was often unwelcome:

I went along and it was like-minded people and it's nice to be in a room of people who all have chronic pain who when you sit down if you go 'ahhh' as you sit, they don't say [enacts whiney voice] 'oooh, what's the matter, oh what's wrong with with you, oh you look alright…' You know you don't want to lay out your whole medical history. We rarely talk about pain, which is nice. (Jasmine)

Disrupting the pain-talk spiral, did not, however, limit empathic recognition of pain in others: when others were seen to be struggling, this was dealt with in a one-on-one context rather than communally during meetings:

It's strange because nobody talks about their pain. Nobody talks about their pain. But there is a situation where you can tell if somebody's in agony, so one of us, one of the Committee will catch hold of that person, say 'do you wanna come and sit at the back and have a chat wi' me?' (Neil)

Therefore, group meetings recognised pain, empathetically responded, but maintained an alternate focus, rendering pain impotent in the group context.

The laughter drug

All participants were expansive in their discussion of laughter and humour occurring during group meetings, enjoying this and actively desiring more of it. This was considered central to the group's success: 'I think the reason why our support group actually works is there's a sense of

humour. We laugh, we're in enough pain to be able to sit there and cry all day long, but we don't. We laugh.' (Ron). Meetings were therefore multidimensional; practically supportive and engaging but also mood-enhancing, with every participant highlighting their desire for laughter as a further reason for attending meetings regularly. Importantly this humour was not standard practice or personality driven, but was collectively generated in the group context. For example, Rebecca noted her ability to laugh, which had been previously impossible, had been restored through the group:

I couldn't laugh, I'd lost it all, so to get all that back from the support group, I mean I wouldn't have done it without that. It gets me to tears, sorry [weeping quietly, laughing]. It's just remembering it innit. (Rebecca)

Where chronic pain had robbed Rebecca of humour, the CPSG provided opportunity for regaining perspective, something which provoked emotion both in grateful response to the renewal of her positivity and through revisiting the difficult memories of the struggles which came before this. Laughter emerged very naturally within support group meetings, facilitated by common humour regarding side-effects of pain medication or pain-related brain fog, challenges faced similarly by others:

I start talking to some others and we all feel about the same but then we start cracking jokes and laughing and [recounting story] 'you should have heard what I did yesterday; I couldn't even remember how to spell my name [laughs]'. And we'll laugh at it. (Laura)

Prioritisation of laughter within the group was such that they worked to create humour for those members who could not attend meetings, including 'funnies' within the newsletter: 'I try and put in all sorts of things like the disabled swimming available, Reiki at the Well, and the end of it is just jokes because laughter's the best medicine' (Jasmine). Importantly, such laughter countered stereotypical negative perceptions of disabled people as humourless: 'There's a sense of humour. You can laugh, you might be disabled, but you can laugh. You don't have to not laugh, y'know... Just because you're disabled doesn't mean you can't laugh' (Ron). Ron felt that there was an external expectation of humourlessness, which he felt unjust and inaccurate, particularly in the context of a group of 'disabled' people gathered together. Counter-

stereotypical laughter therefore was resonant through all testimonies and all meetings, working as 'the best medicine' for all participants. Humour was actively sought out and collectively initiated for mutual inclusivity.

Boundaried altruism

Many participants expressed sadness at their side-lining by society due to chronic pain; they felt that pain restrictions rendered them potentially incapable of being worthwhile or capable. Yet the support group provided a forum in which they could extend and explore altruistic purpose through practical, emotional and social support:

It is a support group. And we do support each other… It's 'ard work sometimes because somebody's in a real black 'ole. And you need to pull 'em out. You need to drop 'em a lifeline. If they wanna grab the rope, they can. (Ron)

Ron felt that within the group there was gentle recognition of other people's well-being, and a desire to support those who were struggling. Yet this remained optional; though participants were keen to support others, autonomy was considered paramount, with each at liberty to accept or reject help. The group made careful, active choices about support-giving and it was therefore boundaried, matched to the capacity/health status of members. Altruism was represented in practical ways, such as car-pooling for lifts to meetings and advice: the group made collective committee-led decisions about the support (not) offered:

We do support each other because when we go to support group, if we see that people are having problems, we try and cheer them up. […] We don't fill out disability forms and we don't fill out ESA forms, but we do give advice. (Jasmine)

Jasmine felt that the group were therefore actively choosing the remit of their social support, enabling boundaried altruism, which was collectively achievable and mutually beneficial for givers and receivers. A broader, home-bound audience was reached through an active, committee-compiled 'Chronic-all' newsletter, which many members contributed to, engendering a sense of giving back to the CPSG as a consequence. It was widely appreciated by members:

Neil told me that he keeps his [newsletter] and he waits until the middle of the night when he's in such pain that he doesn't know what to do with himself, and then he looks at his Chronic-all. […] So that sort of response means so much to me. (Jasmine)

Neil was therefore using the newsletter as a method of coping with his pain at a difficult period of time, and Jasmine found that this renewed her commitment to writing the newsletter and to providing instrumental social support. Group members consistently verbalised their appreciation of such practical/emotional/social support and expressed, with satisfaction, the powerful impact that receiving such appreciation from CPSG colleagues caused. Consequently, support was extended for current and missed members: embodied in the group ethos is a system of gentle follow-ups, an important system of which Louise felt proud: 'If we haven't heard about somebody for a while then we'll do a little a bit of digging and just see how they are' (Louise). Those members in receipt felt follow-ups validated their status as an important member of the group at a time when they were experiencing personal difficulties: 'I didn't realise I was so thought of' (Neil). Being sought after confirmed the importance of Neil's group membership and consolidated his sense of collective identity. Boundaried altruism was therefore embedded, activated and appreciated within the CPSG at multiple levels, practically, emotionally and socially.

Growth facilitation through social evolution

The final superordinate theme demonstrated a future-oriented approach: participants reflected upon the ability of the CPSG to give perspective, reactivating personal passions and enabling leisure-based activity. This superordinate theme reflected an ability to live well with pain, supporting self-care strategies through developing a repertoire of pain management skills, fostered through peer-to-peer learning.

Passion, purpose and perspective

Living well with chronic pain requires that pain is not focal, but is instead peripheral. This allows personal interests to continue and ensures that social integration is prioritised: through the CPSG and the previous PMP, participants were enabled to recognise that their condition did not isolate them from society as a whole.

Being on the pain support program it enabled me to realise there was lots of people like me, I wasn't a failure (.) I wasn't somebody that was on the outskirts of society 'cause often I felt very much like that, um and I was a very valuable member of society as well. (Louise).

Through a CPSG-initiated perspective shift, Louise regained a sense of herself as valued and valuable, in spite of her chronic pain. For Neil, the support group empowered him to recognise that though pain had a significant impact, he had an active part to play in asserting authority over pain, supported by CPSG colleagues:

I always wondered what chronic pain meant. […] It's not gonna vanish from your life completely, but it's how you deal with it. It can get into your mind and you can get very, very down, but it's how you bring yourself out of it. So that's what happens at the support group. (Neil).

Beyond perspective, support group members also felt that their attendance had expanded social opportunities: CPSG attendance (re)ignited new or dormant interests, which led to joining hobby-based or social interest groups. Directly emerging from the CPSG were smaller social off-shoots, ranging from swimming, to card making, and a general crafting group known as 'Crafty Cripps'. Participants generated a sense of agency in developing their passions, starting off-shoots where they felt they were needed:

Eventually I started a craft group because more and more people wanted to craft with us. Crafty Cripps has gone on from being just ten of us in a shelter scheme to I've opened a second group because that was full and we also meet in Age UK buildings once a month, 1pm-5pm, so that's two full afternoons a month of crafting. So that, plus the pain support group, plus committee meetings, and I do Arts on Prescription, those are the important things in my life. (Jasmine).

For Jasmine, off-shoots provided a fusion of passion and purpose and a scaffold for daily living. Such groups held wider appeal, attracting ever-increasing memberships and significantly extending the social schedules of support group members. Such passions returned to the CPSG as they were integrated into group meetings: members with particular hobbies taught their colleagues and shared their enthusiasm:

It's all these different people have took the step to come to the support group and we encourage them to talk about what it is they like doing. 'Coz it's took a few years to persuade Jane to do a talk on her gardening y'know like. So she's relaxing with that (Rebecca).

Respect for others' individualised skills and deliberate integration of these passions into the fabric of the group collectively nurturing perspective in terms of living with chronic pain. Rebecca highlighted that it could take a while to encourage individuals to share their expertise, but she was active in facilitating that process and felt satisfaction when members reached a point where they could relax fully, sharing their vocations freely. Clearly evidenced was that activities and passions that could thrive in spite of a daily struggle with pain.

Fighting passivity with activity.

Membership of the group was considered by all participants to be a way of avoiding the, often insidious, decline in activity as a result of chronic pain. Eight participants discussed deliberately using the group as a trigger to leave the house:

It's my way of making myself get up, get going and go out and go to this group. […] It's 'I am going to the pain group, I don't care what's going on, I don't care what's going on in my life, I don't care how much pain I'm in today, I'm getting washed, I'm getting dressed, ok I'm exhausted now, I can recover 'coz it doesn't start 'til then, I am going, I made it. Phew, ok'. (Laura).

Laura worked strategically through a process in order to get herself ready for the group, challenging her own passivity step-by-step, setting the group meeting as the end-goal. Despite often fighting physically or psychologically to ensure their attendance, the group offered a way of keeping busy, through engaging activities and meetings:

I'm still going because I love it, because it's different activities every month, like I said, from bingo to potting your plants for the garden. They 'ave somebody different coming in every month, somebody doing something. And if they don't 'ave somebody doing things, then obviously they play bingo and do quizzes and things like that which is really, really good. And it makes me feel 'appy. When I go there I feel really relaxed whereas I'm always like tense everywhere else. (Alison)

By engaging with activity through the CPSG and associated off-shoots, participants better managed moods and emotions and the group acted restoratively, reigniting an ability to continue to cope with pain, challenges and stress.

Peer-to-peer learning and the peer-pain network. The CPSG evidenced a strength in shared knowledge between group members, knowledge which supported the self-care of other members. Sharing pain management techniques was typically informal, but cumulatively highly beneficial for participants:

So y'know it's little things like that that do y'know the little things add up and mean quite a lot, y'know little bits and pieces that you pick up. Someone may come out with a comment and you think 'I'll try that' y'know, just very good really. (Charlotte)

Collectively, knowledge grew, and group members paid close attention to the suggestions of others with a longer or different pain history. The group represented an open forum in which the exchange of ideas was free-flowing and members routinely encouraged others to seek additional support from Healthcare Professionals where they could see a need, primarily in relation to pharmacological medicine.

Really just sort of knowing what others are taking and also knowing that within this pain group there is a drop-in that we can go to for the pain that is at the treatment centre and they've encouraged me to go there to get my medication sorted out y'know, they've all said 'oh you should go'. So I went down and had a very, very good result. (Charlotte).

Charlotte here demonstrated the network of knowledge that was present between group members, and expressed satisfaction that utilising this collective network facilitated better care and outcomes than she had expected, validating her perception of the peer-to-peer learning operating within the group as important and highly beneficial. Peer-to-peer learning often centralised core issues embodying the daily struggle with chronic pain, for example members discussed side-effects of pain medication. By expressing empathy and sharing experience, they were able to identify when side-effects were normal or when difficulties needed to be challenged.

One of the greatest conversations in support group is meds. And um 'do you find that this, are you on Amitryptiline, do you find it turns you into a zombie for eight hours'? 'Yeah'. 'Oh good, it's not just me then'. And it's that; oh thank God it's not just me then. That helps, it helps tremendously. (Ron)

The collective knowledge base offered relief from worry for Ron and other members, offering a point of reference for each individual to assess the 'normality' of their concerns, thereby creating a peer-pain network, in which peer mentoring and support enabled fears to be allayed and core information to be exchanged for mutual benefit and enhanced pain management.

Discussion

This study investigated mechanisms and processes involved in the successful organisation and structure of a long-standing, peer-led CPSG. The results demonstrated the emergence of three superordinate themes: Investing in the new normal; The nurturing environment; and Growth facilitation through social evolution. Together, these themes illustrated the internal processes and structures that allowed the support group to function and develop effectively, in relation to the management and promotion of positive, effective intra-group social support, healthy interpersonal dynamics and practical self-care.

By choosing to *invest in the new normal* through a CPSG, participants were reclaiming a sense of agency and reactivating their internal locus of control; effectively reasserting authority over chronic pain. The collective identity within their support group allowed the members to perceive universality in their (pain) experiences, despite significant (e.g. personality/demographic/health status) diversity. Participants' willingness to strongly identify with a potentially stigmatised group can be defined as 'outness' and is predictive of enhanced physical and mental health (Weisz, Quinn, & Williams, 2015). Exhibiting such strong group identification has been found to foster positive mental health to a greater extent than group contact (defined as frequency of interactions and participation in social activities; Sani, Herrera, Wakefield, Boroch & Gulyas, 2012).

That CPSG members, when reflecting on their continued group participation, prioritised the importance of similarity and belonging, was a key finding. This enabled members to feel accepted, adopt the group identity and invest in the group. Group members projected positive relational ties onto CPSG colleagues, despite knowing some group members only superficially or collectively (Swann, Jetten, Gómez,

Whitehouse, & Bastian, 2012). In this way, diversity became peripheral and within-group cohesion was felt to be more salient. Such identity fusion encouraged individuals to engage more deeply with the group, motivating pro-group behaviour, directing personal effort and agency, and developing strong relational ties between group members (Swann et al., 2014). Investment was found to be progressive; snowballing and enhancing members' ability to live well with pain. The positive, yet evolving nature of CPSG acceptance models the progressive qualitative changes participants expressed in response to pain management programmes (Nizza, Smith, & Kirkham, 2017). It seems, therefore, that the CPSG was able to foster the continual process of moving members towards a sustained and enhanced quality of life despite chronic ill health. The new group identity then insulated participants from the corrosive impact of pain on participants' personal sense of identity (Smith & Osborn, 2007).

In the current study, group members referred to feelings of acceptance in a number of different ways: (1) Acceptance of chronic pain (as a persistent, life-altering but manageable condition), alongside (2) acceptance of the self and (3) acceptance and adoption of group membership. This triumvirate of acceptance steps beyond the self-oriented acceptance that is often considered paramount for positive adjustment to chronic health conditions (McCracken, 2010). Instead it views acceptance as a fusion between the development of a positive personal identity (self-acceptance despite pain) and active acceptance within social support structures such as the CPSG. Conceptualising acceptance as a fused transaction between the individual and their social environment reflects a way in which acceptance can be translated into an effective 'engaged' social support mechanism through a peer-led support group. (Trompetter et al., 2013). Acceptance has been found to be paramount for minimising pain self-enmeshment (Mathias, Parry-Jones, & Huws, 2014; Morley, Davies, & Barton, 2005; Snelgrove, Edwards, & Liossi, 2013), and this was validated in the current research with the CPSG providing members with a positive space for developing or refreshing self, health and social acceptance.

From acceptance, CPSG membership promoted cumulative growth in individual confidence, evidenced through members' increased self-efficacy and involvement in organisational structures/management. That the CPSG encourages progressive development in personal agency is fundamental for successful self-management, as health locus of control is predictive of physical and mental health *following* multidisciplinary PMPs (Keedy, Keffala, Altmaier, & Chen, 2014). Self-investment and ownership were found in this research to be key processes, encompassing engagement, participation and social support and resulting in enhanced psychological flexibility (Yu & McCracken, 2016). The *nurturing environment* allowed for self-exploration, minimising pain-talk, instead enabling learning, networking and activity. Participants found that the CPSG represented a foundational base of advice, modelling and learning, from which social support could be sought and paced activity levels restored in a healthy way, avoiding the risks of overactivity or underactivity (Andrews, Strong, Meredith, Gordon, & Bagraith, 2015).

The CPSG, in essence, formed a library of peer-based expertise and a model through which participants could observe others living well with chronic pain. The current study, in conjunction with the findings surrounding the initial and early decisions to attend the CPSG (xxx & xxx, 2016, [names obscured for peer review]) suggested that standards set within a Pain Management Programme (PMP) may implicitly prime a CPSG. During pre-screening and early weeks of a PMP, talking negatively or complaining about pain is actively discouraged. This ethos was adopted by the CPSG, potentially reducing pain solicitude, a key concern for the management of within-group discussions, as greater interpersonal solicitousness is a strong predictor of continued disability (McWilliams, Higgins, Dick, & Verrier, 2014). By minimising the pain-talk spiral and reducing discussion about pain, standards set by the PMP were translated into avoidance of negativity and complaining within the CPSG, instead facilitating openness and acceptance, factors considered fundamental within social support contexts (Thoits, 2011). Consequently, by exempting members from pain-talk, the CPSG environment challenged anecdotal pre-conceptions about CPSGs as forums for negativity.

Negativity was in fact rare: the emergence of humour and laughter as a core aspect of the group meetings strongly countered a negative CPSG stereotype. The shared pain experience provided room for *collective* humour about the side-effects of daily living with pain; humour shared as a

group with the whole group (Lebowitz, Suh, Diaz, & Emery, 2011). Humour promoted social bonding, allowing for prosocial exploration of common concerns and alleviation of tension (Yoels & Clair, 1995). In this way inclusivity was prioritised and laughter became infectious, restoring perspective, renewing permission to laugh at oneself and increasing positive affect. Laughter has long been associated with psychosomatic well-being and research has validated the benefits of collective humour in geriatric contexts (Ganz & Jacobs, 2014), chronic health conditions (Bennett et al., 2014; Lebowitz et al., 2011) and pain management (Weisenberg, Tepper, & Schwarzwald, 1995; Zweyer, Velker, & Ruch, 2004). Humour is associated with pain modulation, anxiety and depression reduction, improved general well-being, increased pain persistence, mood elevation and use of distraction as a coping strategy (Ganz & Jacobs, 2014; Weisenberg et al., 1995; Zweyer et al., 2004). As behavioural activation of positive affect, humour is associated with an 'upward spiral', enhancing pain resilience and self-management and buffering any maladaptive cognitive/affective coping strategies (Finan & Garland, 2015).

The atmosphere of humour, informality and openness within the CPSG created a peer-pain social support network, reflected in the final superordinate theme, '*Growth facilitation through social evolution*'. Participants discussed empathetic and accountable friendships and the increased social capital the CPSG made available in the context of potentially contracting social worlds. These friendships facilitated emotional support and access to resources and information (instrumental support; Glover & Parry, 2008). The results demonstrated that social support acted as a buffer, mediating the impact of health-related or situational stressors on group members and enhancing resources needed for effective coping (Hodnett, Gates, Hofmeyr, & Sakala, 2013; Thoits, 2011). The social support offered by the group was therefore paramount for enabling adjustment to ill-health and generating a sense of inclusion, where exclusion by others without pain a common and unpleasant experience, as exhibited in other chronic pain populations (Hearn, Cotter, Fine, & Finlay, 2015).

Communal coping was exhibited in the current research through members activating boundaried altruism. Giving, but with respect for one's personal limits and autonomy, has been found to promote longevity, quality of life and well-being: literally, helping helps the helper (Post,

2005; Weinstein & Ryan, 2010). Maintaining boundaries in terms of personal limitations within the CPSG facilitates boundary-setting in wider familial contexts, potentially reducing the boom-bust cycle of pain-related fatigue and flare-ups, instead promoting steady progression towards goal attainment (Van Damme & Kindermans, 2015). Therefore boundaried altruism offers an opportunity to foster self-regulatory practices which are strongly associated with improved health-related and quality of life outcomes (Kabat-Zinn, Lipworth, & Burney, 1985). Altruism enabled participants to maintain a sense of control over their pain and activity levels, control which is so often lost due to the invasive nature of chronic pain (Hearn et al., 2015). Ultimately, the CPSG functioned restoratively for participants: the findings of the current research displayed the beneficial health, personal and practical outcomes generated by committed membership of a CPSG.

Implications for Healthcare Professionals

The findings from this research provide strong insights into the experience of long-term CPSG members' rationales for continued attendance, but they also offer significant insights that could inform the work of HCPs to enable, facilitate and promote CPSGs. In the interviews, participants explored their rationale for continued attendance at the CPSG and their perceptions of the core factors which collectively comprise the successful functioning of the group. Such features of the group could provide targets for HCPs working both explicitly and implicitly with CPSGs, as they strive to progress group development and encourage members towards a life lived well with pain (Richardson, Moore, Bernard, Jordan, & Sim, 2015). These explicit and implicit HCP targets and the group-specific CPSG processes emergent in the results are represented in Figure 1. *** Insert Figure 1 about here***

As a primary goal, HCPs should aim to foster participants' sense of group ownership in accordance with self-determination theory (Ryan & Deci, 2000): i) Promoting awareness and access to the self; ii) Fostering ownership/autonomy alongside responsibility and group identification and; iii) Promoting non-defensive psychological processing of events, cognitions and actions (following Weinstein, Przybylski, &

Ryan, 2013). Practically, HCPs can initiate the three integrative processes through setting up strong governance and committee structures, priming a positive PMP to CPSG transition (Weinstein & Ryan, 2010), and offering discreet and practical advice and guidance *where invited*, consistently respecting and verbally/behaviourally reinforcing the autonomy of the group (Sandman, Granger, Ekman, & Munthe, 2012).

The structural nature of the group, with its inclusion and appreciation of diversity, demonstrate the need for HCPs and peer-led CPSGs to emphasise belonging and interpersonal engagement to initiate stability within the group, minimising difference and maximising communal coping. This is modelled explicitly through acceptance and non-judgement in PMPs (Kaiser et al., 2015) and therefore the way in which HCPs conduct PMPs implicitly primes the atmosphere of social support. HCPs could contribute to the consolidation of a strong CPSG implicitly or explicitly by introducing ideas and concepts related to self-, other- and pain-acceptance into the support group ethos and activities, bringing these values across from those taught in PMPs.

HCPs also have a key role to play in the promotion of the group and framing it to potential members who are completing PMPs. When advertising CPSGs, HCPs could aim to frame the group in terms of opportunities to expand friendship networks and increase social prospects, rather than as a negative forum in which members expound on their pain or their struggles to cope. HCPs must challenge (strong) pre-existing negative stereotypes of health support groups to elevate their perceived attractiveness to future group members. As part of this, CPSGs need to be characterised not as a single entity and an end-point for social involvement, but as an important foundation upon which increased social opportunities can be built.

HCPs could support CPSG committees as they work to change negative stigmas about support groups, by prioritising positive group meetings. These could be enabled by training committee members in how to deal with pain-talk and, if invited, participating as an observer/group member periodically, offering feedback for future group development. HCPs need to maintain an awareness of the need for

levity in group meetings, and to support the development of a flexible timetable/structure that facilitates this. Practically, this may include ensuring that there is adequate space for socialisation within group meetings, recognising and encouraging potential committee members and balancing personalities within leadership roles. It is important that HCPs play a key role in communicating, modelling, setting and adhering to personal and professional boundaries, then ensuring these translate into support group settings. HCPs could model transparent and respectful maintenance of personal and professional boundaries even where the group (or individuals) may push against these (Powell & Davies, 2012).

HCPs could also consider rotating personnel, sending different HCP team members to meetings, or matching the developmental stage of the group (e.g. new or established) to staff members with appropriate levels of expertise, therefore maintaining diverse, positive and flexible involvement. HCPs could maintain a stance as an open forum for discussion (if sought) to balance peer-to-peer informal advice with expert advice. HCPs could enable growth through the provision of dynamic speakers, dissemination of up-to-date medication or education-related healthcare information, promotion of hobbies/talents/giftings within the group membership, and, importantly, championing of the group even in difficult times.

Limitations

In working with an existing CPSG, this research offers an insight into the organisation and structure of a successful, well-established peer-led support group. Yet it is recognised that this sample therefore represents a subset of committed attendees; ultimately, those who are attend the CPSG are those who have chosen to do so (Embuldeniya et al., 2013). Future research could consider the perspectives of those who may have been eligible to join a CPSG but have chosen not to attend. Due to the use of interpretative phenomenological analysis within this study, an interpretative lens was required to fully reflect the interviews. The analyses may not, therefore, be the only interpretations of the data (Smith et al., 2009), but are intended as grounded, dynamic representations of the experiences and thoughts of participants during the course of the study

(Osborn & Smith, 1998). The HCP recommendations are derived from the qualitative data, offering an insightful opportunity to consider the practical roles that may be played by HCPs developing CPSGs.

Another limitation was that although the primary focus of the paper was to understand the processes involved in the development of a successfully functioning and supportive CPSG, the data were collected at a point in time at the end of this process, and participants were looking back retrospectively from that position, therefore they made their own interpretations and attributions about the historical causes or processes from their current standpoint. Analysis of the data was intended to provide psychological insights into the processes of development through which the positive characteristics of the group at the time of the study (as described by the themes) came into being. However, the goal of obtaining insights about process must be balanced with caution about causal over-interpretation. Future qualitative research is needed to directly address the issues pertaining to the priming of CPSG atmosphere, structures and procedures by previous exposure to pain management programmes and advice from healthcare professionals.

Conclusions

The current research has demonstrated the intricate mechanisms of social support involved in a successful CPSG and the potential role of the HCP in priming long-term engagement and, consequently, an enhanced ability to live well with chronic pain. CPSG structures which promoted a heightened sense of agency, internal locus of control and self-efficacy were demonstrated practically through increased member investment and ownership. As a result, the CPSG represented a social foundation by which pain acceptance could be explored multi-dimensionally, fusing personal and social acceptance of pain and identity. Vicarious learning in a peer-pain network facilitated socialisation through open and engaged living, communal coping, levity and altruism. Healthcare professionals creating or working with CPSGs have a unique opportunity to invest both

explicitly and implicitly in a dynamic forum by which day-to-day living with chronic pain in the community can by changed and living well with chronic pain can become a socially-constructed reality.

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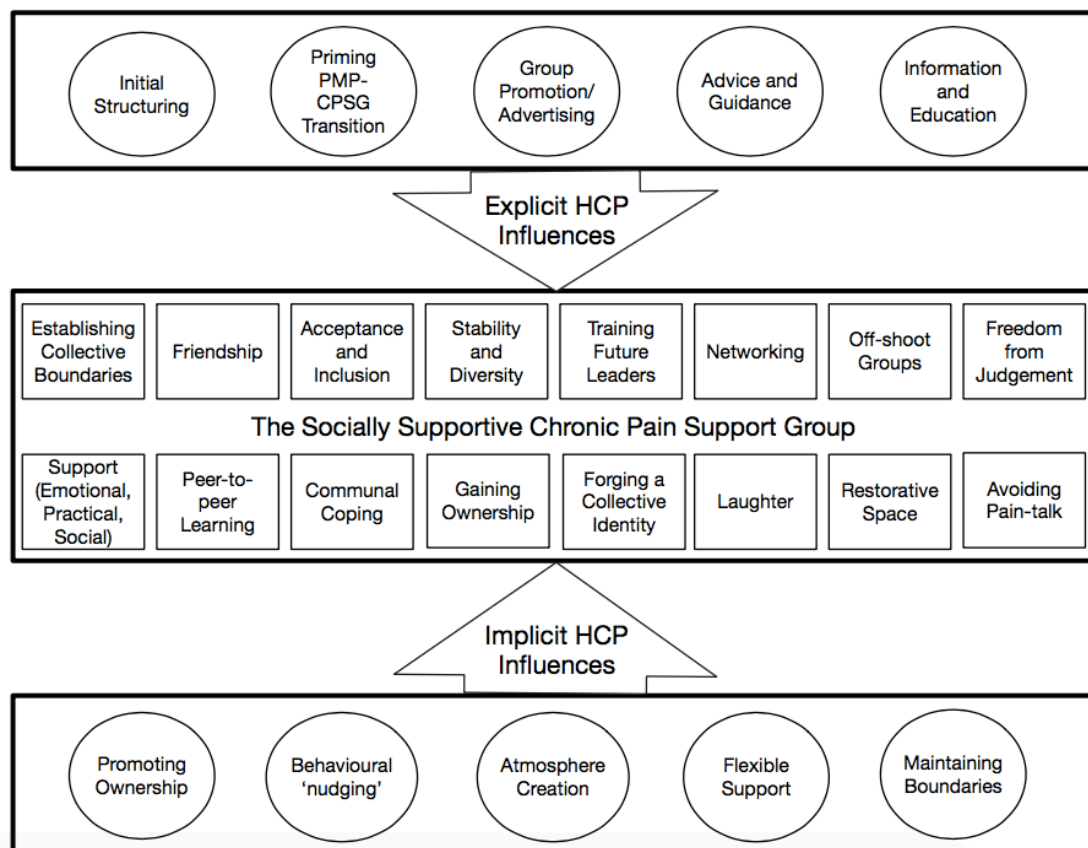
Figure 1. Core outcomes demonstrating HCP and CPSG member roles in promoting a socially supportive CPSG. Square elements of the figure are derived from thematic content and demonstrate the core peer-initiated factors experienced by participants as fundamental to the successful running of a socially supportive CPSG. External circular elements depict explicit, practical guidance sought from HCPs and implicit, ongoing influences that HCPs can maintain once the group becomes established.

Table 1.

Participant characteristics and pain history

	Alison	Alex	Charlotte	Jane	Jasmine	Laura	Louise	Nicole	Neil	Stuart	Ron	Rebecca
Gender	Female	Male	Female	Female	Female	Female	Female	Female	Male	Male	Male	Female
Age (years)	48	66	Declined	55	61	56	56	45	73	57	58	50
Yrs with CP	25	16	20	6	36	8	23	18	4	9	8	13
Yrs since PMP	2	3	2	3	11	4	8	3	3	5	6	12
Length of time at Group	2	3	2	3	11	4	8	3	3	5	6	12
SG Attendance	7	12	10	6	12	6	11	12	10	9	6	12

Notes: Pain-related variables are scored using the Brief Pain Inventory (Cleeland, 1992) from 0-10.

CP = chronic pain; FM = Fibromyalgia; OA = Osteoarthritis; PMP = Pain Management Programme; SG = Support Group

SG attendance = total number of meetings attended in past 12 months; MPS = Mean Pain Severity (max. 10); MPI = Mean Pain Interference

(max. 10). Abbreviated from XXX & XXX (2016, BJHP).

Table 2.

Interview Schedule

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1. Can you tell me about how you came to experience chronic pain?

2. Remembering back to your early visits to the CPSG, can you tell me about that time?

2. Thinking about your years/months attending the CPSG, can you tell me about why you're

continuing to attend?

4. Can you tell me about what it's like to be a member of a CPSG?

5. What does the CPSG mean to you?

Table 3.

Overview of thematic results

Superordinate Themes	Subordinate Themes
Investing in the new normal	Developing a collective identity through communal coping
	Stability in diversity
	The ownership snowball
The nurturing environment	Disrupting the pain-talk spiral
	The laughter drug
	Boundaried altruism
Growth facilitation through social evolution	Passion, purpose and perspective
	Fighting passivity with activity
	Peer-to-peer learning and the pain network

19-Dec-2017

Dear Dr Finlay:

Ref: Developing successful social support: An interpretative phenomenological analysis of mechanisms and processes in a chronic pain support group

Our referees have now considered your paper and have recommended publication in Psychology and Health. We are pleased to accept your paper in its current form which will now be forwarded to the publisher for copy editing and typesetting.

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Sincerely,
Dr Antonia Lyons
Associate Editor, Psychology and Health
a.lyons@massey.ac.nz

Reviewer(s)' Comments to Author:

Reviewer: 1

Comments to the Author
Revisions directly address my concerns more than adequately.

Reviewer: 2

Comments to the Author
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