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Facilitators and Barriers to Participation in a Peer Support Intervention for Veterans with Chronic Pain

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Abstract

Objective—To understand facilitators and barriers to participation in a peer support intervention for self-management of chronic pain.

Methods—After completing a pilot intervention study, peer coaches and their Veteran patients took part in a qualitative, semi-structured interview to explore their experiences with the intervention. Data were analyzed using an immersion/crystallization approach.

Results—Three facilitators and two barriers to patient participation in a peer support intervention for veterans with chronic pain emerged. Facilitators were 1) having a shared identity as veterans, 2) being partnered with a person who also has chronic pain, and 3) support from the study staff. Barriers were 1) logistical challenges, and 2) challenges to motivation and engagement in the intervention.

Discussion—Awareness of facilitators and barriers to participation in a peer supported self-management program for chronic pain, as well as strategies to capitalize on facilitators and mitigate barriers, are essential for further study and ultimate clinical implementation of such a program.

Keywords

chronic pain; self-management; peer support

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Introduction

Chronic pain is an important public health problem, affecting over 100 million Americans.[1] Chronic pain reduces quality of life and is associated with deleterious psychological outcomes, including depression, anxiety, and anger.[1] Pain self-management is widely recognized as an effective and important component of chronic pain management. Evidence indicates that self-management programs are effective for both low back pain and osteoarthritis, with possible secondary benefits in reducing psychological distress.[1-6] For patients with chronic pain, self-management involves a combination of treatment adherence, behavioral change, adapting life roles, managing negative emotions, and coping skills.

Implementation of a pain self-management program is challenging in busy clinical settings for several reasons. First, clinic staff often face time constraints and may not have adequate time to deliver this type of program, which is most effective if tailored to individuals' needs.[7] Second, primary care visits, where the majority of chronic pain is managed, are brief and not adequately structured to deliver pain self-management instruction, particularly when other pressing health issues present and need attention. These competing demands and time constraints decrease the time available to discuss pain concerns.[8,9] Third, self-management interventions in a healthcare setting frequently involve nurse care managers, pain psychologists, social workers, and other healthcare professionals who deliver self-management instruction and provide follow-up to patients, which allows for tailored delivery of relevant information.[7,10,11] However, such professionals are not always readily available in clinics, and individualized attention is resource intensive. Fourth, prior work has demonstrated that patients need more than information about self-management exercises and strategies. Patients need additional support in their efforts to self-manage, particularly because self-management occurs between clinic visits, in and around people's daily lives and activities. Patients have described the importance of motivation and accountability, particularly when they become discouraged or have difficulty with treatment adherence.[12,13] Indeed, the lack of support from others and poor motivation to maintain self-management activities have been identified as key barriers to self-management adherence. Conversely identifying support, particularly from family, friends, and healthcare professionals, have been described as important facilitators to chronic pain self-management.[7,12,13]

Peer or lay-led pain self-management programs, which have yielded positive results for patients with chronic pain,[14] may provide a care delivery model to overcome some of these barriers. In addition, peer support models are becoming increasingly recognized as an effective means to help patients manage chronic conditions, including diabetes and mental health conditions.[15-18] Peer support involves “lay individuals with experiential knowledge who extend natural (embedded) social networks and complement professional health services.”[19] Peer support extends beyond lay-led self-management programs because peer programs provide emotional and appraisal support in addition to relevant information.[19] Emotional support involves caring, encouragement, attentive listening, reassurance, and avoiding criticism, while appraisal support engenders motivation to persist and endure (e.g., encouragement to “keep going,” reassurances that efforts will lead to positive outcomes, assistance in overcoming frustration).[13,19] Though understudied in chronic pain, preliminary evidence indicates that peer support may reduce pain, as well as increase self-efficacy,

perceived social support, coping, and patient activation.[20] Given the positive effects of peer support in chronic conditions in general, the positive effects of pain self-management programs on patients with chronic pain, and the implementation challenges related to such programs, a peer support model for chronic pain has potential to help improve pain-related outcomes, while also reaching a larger number of patients, since such a program can be self-sustaining as mentored patients eventually become peer coaches themselves. Thus, as investigation into the effectiveness of peer support for chronic pain advances, it is also essential to understand potential facilitators and barriers to patient participation in such a program.

Materials and Methods

This article reports qualitative results from a pilot study of a peer support intervention for veterans with chronic pain (Improving Pain using Peer-Reinforced Self-Management Strategies, IMPPRESS, NCT01748227). Details and study results are reported elsewhere.[20] In brief, 10 peer coaches and 20 veteran patients, all of whom were male veterans with chronic musculoskeletal pain, participated. Peer coaches had all participated in the intervention arm of a prior study involving pain self-management and had consented to be contacted for future pain studies. Potential patients and coaches were excluded if they had a serious medical condition (e.g., New York Heart Association Class III or IV heart failure) that precluded participation, had been hospitalized for psychiatric or substance abuse reasons in the last 6 months, had active suicidal ideation, or severe hearing or speech impairment. Patients were also excluded if they had prior or pending back surgery. After an initial three-hour training session focused on pain self-management, peer coaches were each assigned two veterans to work with one-on-one during the study. Peer coaches were asked to contact each of their assigned veteran patients every two weeks, for a total of 8 contacts during the four-month study period. Pairs (peer coach/veteran patient) conducted meetings in person, by telephone, or a combination, depending on their needs and preferences. All participants were given a study manual, designed specifically for the study and adapted from our prior work in pain self-management, which contained information about pain self-management. The manual comprised eight sections: 1) Introduction to Pain Self-Management; 2) Pain Education; 3) Activity Pacing; 4) Relaxation Skills; 5) Self-Care Skills; 6) Interpersonal Skills; 7) Relapse Prevention; and 8) Informational Resources. In addition, peer coaches' study manuals included a section entitled “How to be a Peer,” which outlined expectations and guidance for peer coaches.

At the final, four-month outcome assessment, all participants who remained in the study (n=9 peer coaches, n=17 veterans) participated in a face-to-face, one-on-one, semi-structured qualitative interview, conducted by a research assistant experienced in qualitative interviewing. The interview covered participants' experiences with the intervention, including what was perceived as most and least helpful, intervention weaknesses and/or suggestions for improvement, and what took place during their meetings (e.g., setting self-management goals, discussing self-management strategies, engaging in social conversation). Questions were informed by the pain self-management literature, including our prior qualitative work in pain self-management, and by questions that emerged during conduct of the study. In addition to these questions, suggested probes were included in the interview

guide, but specific probes varied based on participants' responses. All interviews were audio recorded, professionally transcribed, checked for accuracy, and de-identified.

Data Analysis

The first author led qualitative data analysis, using an immersion/crystallization approach.[21] Analysis consisted of two broad phases: open coding and focused coding.[21,22] In the first phase, the first author read through all transcripts to gain a general understanding of the data and variation across participants. Through subsequent readings, themes were identified and refined by combining, adding, and eliminating, based on the data. Next, these preliminary themes were applied to a subset of transcripts line-by-line, with codes being added, deleted, combined, or otherwise clarified to reflect meanings in the data. Once coding became stable and consistent (i.e., no new themes emerged, no changes were made to the code list), phase 2 of analysis, focused coding, began. In phase 2, codes derived in the first phase were applied to all transcripts, including the transcripts used for code development in phase 1. During data analysis, one quarter of transcripts were analyzed by two additional authors to facilitate comparison, ensure consistency in coding, and ensure that no themes were missed. All authors provided oversight, critiques, and input into the interpretation of the results in phase 2.

Results

Three facilitators and two barriers to patient participation in a peer support intervention for veterans with chronic pain emerged. Facilitators were 1) having a shared identity as veterans, 2) being partnered with a person who also has chronic pain, and 3) support from the study staff. Barriers were 1) logistical challenges, and 2) challenges to motivation and engagement in the intervention.

Facilitators to Participation

Three factors emerged from interviews that served as facilitators to participation in a peer support intervention for veterans with chronic pain. The most prominent facilitator, emerging in all but two interviews, was the notion that peer coaches and veteran patients had common ground from which to begin their relationship. In particular, two commonalities were important for intervention participants: their shared veteran identity, and being partnered with an individual who also has chronic pain.

Shared Veteran Identity—Participants highly valued being partnered with another veteran. For them, this shared experience provided immediate common ground, which helped to facilitate a new relationship. The following peer coach explained why he believed that a common military background was important:

> I think that a vet talking to another vet any time benefits from it. You know, when you can sit down and talk because somebody has done the same stuff, been in the same places, been hot, been miserable, had crappy food. He understands you… There was a bond there from guys in the service that I don't think they would have gotten from somebody who hadn't been in the service. (Peer 101)

Importantly, to participants, this shared identity transcended other potential barriers, such as military rank and sociodemographics:

> [We] served our country in uniform and dealt with some of the issues that are unique to people who serve in uniform. So already you're on somewhat of a level playing field, even if you come from completely different socioeconomic backgrounds, even if you're at different levels within the military, just the fact that you were in the military together, you share something. (Peer 106)

Veteran patients strongly agreed with the sentiments expressed by the peer coaches regarding working with a peer coach who is also a veteran. This veteran, when asked what the most important part of the intervention was for him, responded as follows:

> Having a peer that was in my age group and I could talk to. We both went to Vietnam. We're [within a] couple of years of each other's age, and that made it easier to talk to someone who has had similar experiences. (Veteran 202)

Another veteran, when asked why he said his peer was a good match, responded similarly:

> ‘Cause we both been in the service together, and that was something we could talk about. We had a lot of things in common, things we did, things that he went through, I went through. (Veteran 214)

Having a Partner with Chronic Pain—Beyond sharing a veteran identity, participants identified being paired with someone else with chronic pain as important. One peer coach reflected that,

> there's people out there that need someone to talk to, to be on the same level….Their family members don't know or sometimes even care. But…I've been through the same thing, and I'm going to try to help [others] as much as I got help. (Peer 109)

Veteran patients expressed similar views, recognizing that regardless of how much a family member cares, they cannot always provide the same insights and support that someone who suffers from chronic pain can provide. One veteran, after being asked what the most important part of the peer study was, replied,

> I guess just discussing [my pain] with somebody that had almost the same problems as I had….I mean, I can talk with my family, and they're there for me 100%, but at the same time, they don't know what I'm going through. But [my peer coach] does. So I think that helped more than anything, talking to somebody that knows--it seemed like he had a lot of the same problems I did, so he was easy to talk to. (Veteran 205)

Sometimes pain experiences motivated peer coaches to participate in the study, hoping that they could use their experiences to help someone else. For example:

> I've had back pain, I've had different physical pains and I've seen people…[with] no one to talk to them or to even care about them, or think about them, and that bothers me. So, I leaped at the chance to be a peer…because I feel with my past experiences, I could help someone. (Peer 111)

Another peer coach expressed similar sentiments:

> I have that same pain. I know how it feels…It really is important to let people who are in pain know that there are people walking around every 10 feet from them in this hospital who are in pain. And that they're not the only ones that have to deal with it, but there are ways to deal with it, [there] are things that you can do. (Peer 107)

Veteran participants also highly valued having peer coaches who had many of the same pain experiences.

> It's so much better if you talk to someone, and if that person understands what you're going through that's so much better…If you have someone to talk to that understands what you're going through it makes a ton of difference, it really does. (Veteran 213)

In some cases, peer coaches and their assigned patients shared other struggles related to their pain. The following patient described how shared struggles with weight, and the accompanying challenges being overweight places on pain self-management, helped to facilitate a better working relationship between himself and his peer coach:

> My issues were similar to [my peer's]… He's dealt with being overweight before, so he understands. He was not as heavy as I am, but he knows what it's like to be overweight and uncomfortable and knows how frustrating it can be when you start exercising…And he's been down that road…I really appreciate him. He's a good listener, and he gives me really good advice. (Veteran 215)

This veteran went on to say that his peer coach's experience with weight struggles helped to foster understanding and empathy when they discussed his pain, which provided a marked contrast to his experience with others in his life:

> He's dealt with being overweight before, so he understands…I've had discouraging moments from other people before when I discuss my pain and they say, “Well, you're up to 280 pounds. What do you think you're supposed to feel like?” You know, he's never done that. He's never done that to me. And I appreciate him for it, that he listens instead of trying to point out a negative. He tries to encourage me to do something that's going to help in the way of dealing with the pain.

Support from Study Staff—In addition to valuing commonalities inherent in peer support programs, participants also spoke extensively about the support and consultation provided by the study staff as important for their participation in the study. Specifically, regular supervision of the peer coaches and the information from the study manual (which was provided to all participants) were cited as important facilitators. Peer coach supervision, which occurred after an initial 3-hour training session, consisted of two components: 1) regular group conference calls with the other peer coaches, directed by the study psychologist, and 2) individual phone calls from the psychologist, who provided supervision, advice, and support.

Regarding supervision in general, many peer coaches appreciated knowing that they had backup and support if they found themselves in a difficult situation. For example, one peer coach, in response to a question asking what the most important part of the study for him, replied, “I would probably say just the knowledge that that there was going to be staff there to support [me] if I needed it.” (Peer 102)

Another veteran shared similar views: “I felt that [study staff] had my back just in case, you know. Just in case.” He went on to say of the study psychologist who supervised the peer coaches, “I felt that if I needed her, she was there. And she could probably answer any question or any problem. I felt she was in my back pocket if I needed her. All I had to do was reach in my pocket and pull her out.” (Peer 111) Another peer coach said, simply, “I never felt like I was on my own.” (Peer 106)

In addition to having this “safety net,” peer coaches described benefitting from sharing information and experiences during the supervision calls. While the peer coaches appreciated the contributions of the study team, they especially appreciated learning from each other and sharing ideas during the supervision calls.

> Hearing the other peers talk…you can pick up things that maybe you just hadn't thought of. They had different ideas and different ways of dealing with people, and I liked that…because there's been some ideas thrown out there that I thought hey, I ought to try that (Peer 105)

> I heard the other peers say something and [I thought], yeah, that's a good idea. And sometimes I would say something or come up with something that would help the other peers. [The calls] were quite helpful…It was great. (Peer 111)

The second aspect of study team support was related to guidance provided by the study manual, although some participants found this more valuable than others. As outlined previously, the manual covered different aspects of self-management. For peer coaches, the manual included a section entitled “How to be a Peer Coach” as a resource. Some peer coaches commented on this section specifically. For example, when asked what the most helpful part of the study was, the following peer coach replied:

> Well, the fact that you gave us the support with the manual. All of it was there. It was clear-cut the way that you presented it as far as what your expectations were. I pretty well understood what you wanted [from me as a peer coach]. (Peer 104)

The following peer coach valued the manual, especially the Peer section, which served as an important tool to facilitate peer coach-veteran meetings:

> I think [the manual] worked great because first of all it tells you how to be a peer. Of course you're going to use your own thing anyway, but this gives you a head start on how to be a peer. And then different little things. My veterans and I, we'd go to different pages or different sections and say “Hey, have you tried this exercise yet? I haven't tried this one yet, or, how you feeling today” and you know, “you might want to try this one next, you know you don't want to try anything too strenuous” and so forth, so the book was great. I thought it was great because I've been through it probably five or six times. (Peer 111)

One peer coach described the manual serving as a sort of “crutch” since he did not know his veteran partners well:

> Every meeting I'll go through the book and I would go through the prior discussions that we'd had…It helps them and it helps me because I didn't know them as well as my other friends [I've known] for 15 or 20 years. (Peer 107)

The study manual was not identified as a facilitator by all participants. Although most peer coaches found the manual helpful, one coach described why he tried to minimize his use of the manual during phone meetings:

> I really didn't use it much…The last thing I wanted to do was…sit there and let him picture me reading out of a book, so I was trying to make it more conversational. I used their ideas and tried to get the information that they wanted, you know, goals and, and you know, different things like that, but I mean as far as actually having it right there with me, I didn't do that. (Peer 105)

At the extreme, one peer coach was especially skeptical of the manual's value because it was written by professionals and not by people with pain:

> Was the manual written by somebody in a wheelchair? No. Was the manual written by someone who had their legs blown out from underneath of them? (Interviewer: No) Then, what the hell? (Peer 112)

Veteran patients also identified the manual as an important facilitator, although there were exceptions among this group as well. Many described using the manual as a resource with their peer coach, as a reference to consult when questions arose, and as a way to reinforce what some already knew about managing their pain. Others admitted that once they received the manual, they placed it on the shelf, never to open it. The following veteran described how his peer coach used the manual in their meetings:

> I had such a good [peer coach]. [My peer] used the manual as a guide and he added things to it that he had found and had used before in his own pain management, so, it was an informational outline which he adhered to for the most part and then when he had some additional things, he gave me those and they were helpful also. (202)

Barriers to Participation

Two main barriers to implementation of a peer-support program emerged. The first related to logistical challenges, including barriers to connecting and meeting with one another. The second was lack of motivation or engagement among veterans and some peer coaches.

Logistical Challenges—Participants sometimes cited difficulties meeting with their partners. Some discussed problems meeting in person, exacerbated by financial challenges. The following participant illustrates these challenges:

> I told [my peer coach], I got to ride the bus to get [to the medical center to meet]. I said that's four bucks. I said I have to look at that money because I'm on a fixed income. I said I know it's a lot of gas for you, and gas at that time was almost $4 a gallon. That's why we decided to do the phone calls. (Veteran 210)

Some peer-coach/veteran patient pairs chose to meet over the phone, either because of financial barriers as with the above participant, or sometimes because of geographical distance or simply for convenience. While this worked well for most, telephone contacts posed their own set of challenges, especially for one veteran with limited phone minutes, who had to be mindful of the time he spent on the phone with his peer coach.

For other participants, their busy lives created a barrier to participation in the study. One veteran experienced a house fire during the study period, and much of his time was taken up with finding temporary housing, working with his insurance company, and other tasks related to the fire, which made it difficult for him to participate fully with his peer coach. Another participant explained that taking care of his girlfriend, who had been sick for many months, often interfered with meetings:

> There was times where we had scheduled [a meeting] and I wasn't able to make it… some days I just didn't feel like it, especially taking care of my girlfriend. She has been sick for months and months. So that took up a lot of time. (Veteran 214)

Another participant voiced his appreciation of his peer coach and the time he spent with him, but admitted his new job interfered with their meetings:

> I didn't get out of [the study] what I wanted, but it's not the study's fault. It's my job. My new job didn't permit me the time off to come to every session. But other than that, after every time the [peer coach] group met [for their supervision calls], [my peer coach] would give me a call and let me know what was discussed. He would share some things, new tips that people may have talked about to help them manage their pain, and that did help. I appreciated his [my peer's] time. (Veteran 215)

One participant concisely summarized these issues: “Just living your life interferes a lot of times with what we're supposed to doing, you know, unexpectancies that come about.” (217)

Challenges to Motivation and Engagement—Challenges to engagement presented for both peer coaches and veteran patients at times. One peer coach in particular had difficulty with his veteran patients' engagement. Of the first two veterans he was assigned, one withdrew from the study. He was reassigned a new veteran; however, neither of his partners engaged fully with him or the study. He described how this experience interfered with his ability to deliver the intervention:

> About the only problem I had was getting [my assigned veterans] to talk to me… trying to get information about their personal lives, what their struggles were, what their frame of mind was, their mental condition, whether they had some type of mental block about their pain, whether they felt overwhelmed by it. So, I spent quite a bit of time just talking to them, trying to assess their situations, and of course there were so many breaks because they just wouldn't show up. I kind of felt like I had to start over again, so yeah, there's probably a lot that I didn't get to cover. (Peer 105)

Although he did say that he would consider being a peer coach again, he described his frustration with his experience:

> Under some circumstances I might [be a peer coach again]. I felt like this was a good experience. [But] I've got so much to do and it did take a lot of [time]. I put all these meetings on my calendar and half the guys didn't show up. I just don't have time to give if I can't get these guys to come in. (Peer 105)

Although the above peer coach was an extreme example of participants' lack of engagement, other participants, particularly peer coaches, admitted that they sometimes had difficulties motivating themselves to contact their partners. The following peer coach told us candidly:

> There were times that I lacked motivation [to contact my veterans]. You know, I'd think to myself, “Well, how can I motivate them to do anything when I'm not necessarily as motivated as I could or should be?” But once I actually started talking it got better, and then once I actually got off the phone I said “Okay, that's good.” (Peer 102)

Another peer coach described his lack of motivation, although, according to his two veteran partners, who described benefitting from their peer coach's involvement, he may have been overly critical of himself:

> I have a real difficult time now about following up and completing things…I would call them, but I didn't like every two weeks. I sort of thought I let them down in a way. You know, because I'd made the commitment to do it and then I didn't do it. So that's a problem. But I did talk to them and I think I accomplished some things, but not as much. Maybe I'd give myself a C instead of a B or an A on that, okay? Very average job. (Peer 104)

For one peer coach, his own pain sometimes interfered with his ability to offer support and guidance to his assigned partners:

> Sometimes I was also weak. I didn't call or nothing because I was spaced out. My disabilities were taking over, and I just would come into the house and just sit in the corner in my chair… and watch TV. (Peer 109)

Discussion

Pain self-management is an evidence-based treatment for chronic pain, advocated widely by organizations such as the Institute of Medicine and the Department of Veterans Affairs. However, implementation of pain self-management programs is challenging and resource-intensive, placing additional demands on already busy health care professionals, such as nurses, psychologists, and others who must deliver the content of these programs.

Further exacerbating these challenges is evidence suggesting that patients prefer pain self-management that is tailored to their own particular needs and life circumstances,[7] and that pain self-management is seen by patients as more than dissemination of information. In two studies of patients who had participated in interventions involving pain self-management instruction, patients spoke more about receiving encouragement, motivation, and support, and having someone to listen to them, than they did about the self-management activities and behaviors themselves.[12,13] Findings from these studies, coupled with the frequent comorbidity of chronic pain and psychiatric conditions such as depression and anxiety, as

well as general suffering, suggest that teaching pain self-management strategies alone may be insufficient, and patients value having another person to support them through these activities.

Given these apparent needs, peer support is a natural delivery mode for pain self-management instruction and support. Assigning peer coaches to support patients one-on-one allows for tailoring of self-management strategies, while also partnering patients with someone who is well-positioned to provide empathy, motivation, and encouragement. The purpose of the current study was to better understand facilitators and barriers to participation in a peer support intervention for chronic pain, in an effort to guide future research and ultimately implementation of peer support programs for patients with pain.

Three facilitators emerged from this work: 1) having a shared identity as veterans, 2) being partnered with a person who also has chronic pain, and 3) support from the study staff. The barriers identified by participants were 1) logistical challenges, and 2) challenges to motivation and engagement in the intervention.

In terms of facilitators, sharing similar characteristics and experiences was important to both peer coaches and patients. A peer coach who shares similarities with patients may be better suited to deliver self-management information and support than a health care professional. Empirical support for this idea is lacking for pain and represents an important evidence gap. However, in diabetes, Heisler and colleagues found that patients randomized to a peer support group experienced significantly greater reductions in Hemoglobin A1c levels than those assigned to nurse care management (who actually experienced increases in HbA1c levels).[17]

With respect to barriers, logistical challenges are not new for patients learning pain self-management. Obstacles such as time constraints and having other life priorities have emerged previously,[7] and peer support interventions need to have sufficient flexibility to accommodate and overcome these constraints. Some participants in this study noted that making contact with their partners via telephone was preferable because of convenience as well as cost savings (e.g., gas, parking). This suggests that designing a peer support intervention that is telephone-based might better meet patients' needs, thereby facilitating participation as well as retention. A recent meta-analysis showed that peer support delivered through telephone calls were just as effective as in-person contacts for patients with diabetes.[23] This is particularly important because these authors also found that greater frequency of contact with peers was a critical factor for successful outcomes. Telephone-delivered support is a relatively low-cost, readily available means to facilitate contact frequency between patients and peer coaches.

Motivational challenges are expected and are not unique to peer support interventions. Other studies of pain self-management have revealed that patients sometimes lack motivation and have difficulty adhering to recommended strategies.[7,12,13] In a peer support intervention, mitigating barriers to motivation may be especially challenging since both peer coaches and patients may require help with motivation. Ongoing study team support and supervision, cited as an important facilitator in the present study, may be especially important to help

peer coaches to overcome these obstacles. For example, future interventions can capitalize on the positive effects peer coaches described from the supervision sessions. Talking and sharing ideas with other coaches on the supervision calls created a sense of common purpose and community among peer coaches, which could ultimately foster greater motivation about their roles as coaches. Offering the option to meet in person for supervision sessions, in addition to calling in, or having periodic in-person meetings, perhaps with a social component (e.g., a “pizza party”) could be effective strategies to enhance connections, sense of community, and ultimately motivation, for peer coaches.

For patients, evidence-based motivational strategies, designed to foster and strengthen intrinsic motivation to change, may be an effective approach[24] and have been used with success in a peer support intervention for African Americans with diabetes.[25] Although many of these strategies were incorporated into the peer coach training and supervision for IMPPRESS, it is unclear the degree to which the peer coaches were able to employ these strategies in their meetings with their veteran patients. Future research should explore peer coaches' use of and adherence to motivational strategies with their patients to maximize patient motivation, engagement, and retention.

This study is limited in that it was a pilot study at a single medical center with a relatively small sample size. This, coupled with the descriptive, qualitative nature of this study, and a sample of male veterans, means that results may not generalize to other institutions or peer support programs. In addition, we did not interview health care providers or administrators, whose views would play an important role in eventual implementation of a peer support program for patients with chronic pain. Moreover, participants who were lost to follow-up (n=1 peer coach, 3 veteran patients) were not available to be interviewed, resulting in potential loss of information that might be helpful in planning future interventions. For example, the literature suggests that other barriers, not found in this study, may emerge in peer support interventions. A particularly noteworthy barrier was uncovered by Leahy and Wing in their pilot study of weight loss support. They found that, compared to being partnered with either a health care professional or a peer who was still struggling with weight loss, patients who were paired with a “mentor” (i.e., a peer who had successfully lost weight) experienced poorer weight loss outcomes.[26] It is possible that being “too successful” at weight loss could foster judgment from peer coaches or feelings of inferiority on the part of the person being mentored (whether intentional or unintentional). Likewise, it is possible that peer coaches who are “too good” at pain self-management might not be as effective as peer coaches who still struggle to some degree. At the same time, it is probably not optimal to have a peer coach who has not achieved some level of successful pain self-management. Very little is known about what characteristics are associated with the most successful peer coaches, in pain or any condition, and this is an important area for future research.

Peer support for veterans with chronic pain represents an innovative and promising approach to help manage the complexities of chronic pain. Preliminary evidence suggesting that this approach is effective for pain and coping, coupled with a greater understanding of facilitators and barriers to such a program, will help to guide future research and practice, with the ultimate goal of providing additional and much-needed clinical resources to help patients better manage chronic pain.

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