

Experiences and Outcomes of Attending a Facial Pain Management Program: A Qualitative Study

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Aims: To understand the experiences of patients diagnosed with chronic facial pain (CFP) who attended a specialist facial pain management program (PMP); specifically, to explore how they experienced attending the facial PMP itself and how they felt it impacted their management of CFP. **Methods:** Qualitative methodology and focus groups were used to gather patients' views and experiences of attending a facial PMP. Two focus groups were conducted for patients who had all completed the facial PMP. Discussions were recorded and transcribed. Data were then analyzed using thematic analysis to establish key themes relating to participants' experiences of the facial PMP. **Results:** Thematic analysis identified three main themes, with numerous subthemes within them. The theme "psychologic change" had subthemes of self-compassion, acceptance, and reflection. The theme "behavioral change" contained subthemes of re-engagement with valued activity, medication, and communication. The theme "structure and process" contained subthemes of concentration, need for one-on-one time with the clinician, meeting others, and not enough time (clinical and nonclinical). **Conclusion:** Facial PMPs may provide a valuable treatment to support long-term coping and adaptation for patients with CFP. Positive changes to coping include both psychologic and behavioral elements. Further research is necessary to clarify how group-based facial PMPs should be structured and delivered. *J Oral Facial Pain Headache 2021;35:208–217. doi: 10.11607/ofph.2858*

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Chronic facial pain (CFP) is defined as persistent pain in the mouth or face (usually stemming from trigeminal nerve territory) of a duration of 3 months or longer, despite medications or treatment. A recent publication based on data from 500,000 people indicates an overall prevalence of facial pain of 1.9%, 48% of which is CFP.¹ Consistent with research into other chronic pain (CP) conditions, the literature on CFP emphasizes the biopsychosocial consequences of CFP and the need for a multidisciplinary approach to treatment.²

As with other CP conditions, there is a long-standing relationship between CFP and psychologic distress, particularly depression.^{3,4} Despite recognition of the significance of psychologic factors associated with CFP, interventions and assessments have often remained more biomedical in their focus.⁵ The dual-axis structure of the Research Diagnostic Criteria for Temporomandibular Disorders (RDC/TMD) reflects the value in taking a more biopsychosocial approach to assessment and intervention of patients with CFP.⁶ However, there remain challenges and barriers to fully implementing this approach.⁷ Available evidence suggests that more biopsychosocial treatments for CFP, which include cognitive behavioral therapy (CBT), can be effective^{8,9}; however, the evidence is limited, particularly in the context of group-based CBT treatments for CFP.

Pain management programs (PMPs) are recommended for patients with a variety of CP conditions to promote improved quality of life and coping despite pain.¹⁰ Treatment involves a shift from a curative to a rehabilitative and self-management approach, focused on improving functioning rather than reducing pain. PMPs are a psychologically in-

Table 1 Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> ▪ Primary diagnosis of chronic facial pain ▪ Patients motivated to engage in a self-management approach ▪ Practically/logistically able to attend PMP (eg, with work, childcare) ▪ No general physical health problems making them unable to engage in the PMP (eg, uncontrolled epilepsy, unstable medications) ▪ No comorbidities requiring active treatment or further pain-related investigations ▪ Aged 18 years and over 	<ul style="list-style-type: none"> ▪ Limited life expectancy or rapidly deteriorating disease/condition ▪ Psychiatric or psychologic difficulties independent of pain (eg, unstable bipolar disorder, PTSD, current psychotic episode) possibly requiring treatment prior to PMP; 6-month period of stability required ▪ Current illicit drug and/or alcohol abuse; 6-month period of stability required ▪ Would cause a safety/risk concern for both staff and other patients on the PMP (eg, verbally/physically aggressive or abusive) ▪ Recent physical health problem requiring investigation and/or treatment (delay in PMP referral) ▪ Pregnancy in the first or third trimester ▪ Inability to process/retain information or cope well in a group-based PMP setting (eg, language difficulties, cognitive impairment, significantly distressed)

formed treatment and tend to be underpinned by principles of CBT. While there is a long-established evidence base for the effectiveness of PMPs in the management of CP, there is much less research on the potential benefits of PMPs specifically for patients with CFP.¹¹

A tertiary level NHS pain management service in the UK established a specialist facial PMP in 2015. The facial PMP is an 8-week, half-day program with a maximum of 10 patients. Patients attend 4 x 45-minute group sessions, all on one morning per week. Sessions were facilitated by a specialist occupational therapist, specialist clinical psychologist (C.A.), and specialist physiotherapist, and an education session was provided by a consultant in pain medicine (R.C.). Sessions included education, guided practical work (such as exercise or meditation), and guided group discussion. The service is free at the point of access.

Patients with facial pain referred to the pain service are initially seen in a complex facial pain clinic, which includes a consultant in pain medicine, consultant oral surgeon, and consultant functional neurosurgeon. The clinic ensures securing the best possible diagnosis to explain the pain presentation and optimization of medical management using medications or surgical or neuromodulation treatments, as indicated. Patients from this clinic with the potential to benefit from a facial PMP are then referred to an assessment clinic for the facial PMP and seen by a specialist clinical psychologist, specialist occupational therapist, and specialist physiotherapist to assess suitability for attending. The inclusion criterion for the facial PMP is outlined in Table 1. At this assessment clinic, demographic information is collected, and a range of psychometric measures are consistently administered. These include pain intensity rating, pain distress rating, the Beck Depression Inventory (BDI-II), the Pain Catastrophizing Scale (PCS), the Pain Self-

Efficacy Questionnaire (SEQ), and the Canadian Occupational Performance Measure (COPM).^{12–15} Additionally, some patients also completed the Chronic Pain Acceptance Questionnaire (CPAQ).¹⁶

This article aims to explore the experience of a group of patients with CFP who completed the above-mentioned facial PMP, with the specific aim of exploring their experiences of attending the facial PMP as well as its perceived impact on how they managed CFP. This includes not only any relevant changes to the management of their CFP itself, but any wider changes of relevance to the participants.

Materials and Methods

Participants were recruited through an existing NHS database of patients. Participants in this database met the study requirements of having a diagnosis of CFP, having completed a facial PMP within the NHS pain management service, were able to provide consent for themselves, and were able to engage in a verbal discussion in English. A total of 29 patients met the study criteria and were sent an invitation letter and information sheet providing details of the study and were given a minimum of 2 weeks to consider their potential involvement. Following this 2-week period, telephone contact was made from a member of the research team to establish further involvement in the study. Eleven of the 29 potential participants responded and verbally consented to participate. These 11 participants were recruited and allocated to one of two focus groups. Participants provided written informed consent to both participate and be audio recorded at the start of each focus group. Participants were aware that they could withdraw from the study at any time.

Table 2 Focus Group Interview Schedule

- Which aspects of the facial pain management program were most helpful?
- What were the least helpful aspects of the facial pain management program?
- How did you find the structure of the FPMP?
- What was your experience of the physiotherapy sessions?
- What was your experience of the occupational therapy sessions?
- What was your experience of the psychology sessions?
- What was your experience of the medical talk sessions?
- What would you change about the facial pain management program to improve it further?

For those participating in the focus group, the mean age at the PMP assessment clinic was 50 years (range 45 to 57). There were 5 men and 6 women, and their mean pain duration was 94 months (range 21 to 204). The facial pain diagnoses of the participants commonly included trigeminal neuropathic pain occurring after a dental procedure, temporomandibular joint (TMJ) procedure, or intracranial intervention, though some cases occurred without a preceding incident. Most of the patients had secondary myofascial pain in or around the TMJ and neck muscles. No pattern of comorbidities was identified; however, migraine headaches were commonly observed. From the completed psychometric data, 4 participants were in the severe range for symptoms of depression, 3 in the moderate range, 2 in the mild range, and 1 in the minimal range. Depression data for the final participant were not available.

Design

Focus groups were chosen as the method of data collection for this exploratory study. A focus group is a form of group discussion in which the facilitators take on the role of mediator, presenting questions or topics for discussion and allowing the group to discuss and produce their own narrative.¹⁷ The focus group format gives voice to both personal and collective experiences, providing rich and meaningful data about the participants' shared and common experiences.¹⁸

Two separate focus groups were facilitated within the pain management service to explore both the experiences and outcomes of individuals who attended a facial PMP. These were carried out over a 2-month period and were conducted face to face in a room within the pain management service. Some participants had met each other previously in the same facial PMP, but not all, as they had not all attended the same PMP. Participants had completed a facial PMP within 3 years of attendance of the focus groups. The

Table 3 Phases of Thematic Analysis²⁰

Phase	Description of the process
1 Familiarizing yourself with your data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas
2 Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code
3 Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme
4 Reviewing themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic "map" of the analysis
5 Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme
6 Producing the report	The final opportunity for analysis: selection of vivid, compelling extract examples, final analysis of selected extracts, and relating back to the research question and literature, producing a scholarly report of the analysis

researchers were guided by the literature in the planning and organization of the group^{17,18} to allow optimal numbers to facilitate the discussion, while also creating an environment in which participants felt comfortable and confident participating. The duration of the focus groups ranged between 65 and 77 minutes. The focus groups were facilitated by a clinical psychologist (C.A.) with either an occupational therapist (A.B.) or physiotherapist. The clinical psychologist had worked clinically with all participants facilitating the sessions on the facial PMP itself. The occupational therapist and physiotherapist were both experienced clinicians working in the field of CP, but had not had clinical contact with the participants. The researchers adopted a semi-structured interview guide to provide focus and to facilitate discussion. Table 2 refers to the semi-structured interview schedule compiled to guide the discussion. The aim of this was not to direct, but rather to facilitate the participants in sharing their experiences of participating in the PMP and the impact it had on their management of CFP. The focus groups were audio-recorded, and the audio records were transcribed verbatim by a typist outside of the research team to facilitate data analysis. The transcriptions were then verified by the research team by listening to the audio recordings to confirm the accuracy of the transcriptions.

A thematic analysis was adopted, as described by Braun and Clarke,¹⁹ to analyze the data (Table 3).

Table 4 Example of Data Analysis Leading to the Development of Themes

Data extract	Initial codes generated	Theme
"I tended [to] think we could have maybe done a bit more, but then it's time and there are nine of you on the course."—P7	<ul style="list-style-type: none"> ▪ Felt more could have been done in the PMP 	Not enough time (Clinical)
"It did feel a bit rushed. It did not seem long enough. You were giving us all this information, trying to sink it in."—P5	<ul style="list-style-type: none"> ▪ Feeling rushed ▪ Trying to process information 	
"Once we had all done our bit and asked us all questions an hour wasn't actually long enough for it really."—P7	<ul style="list-style-type: none"> ▪ Sessions not long enough 	
"I think we needed longer, more weeks to take in."—P9	<ul style="list-style-type: none"> ▪ PMP needed to be longer 	
"More spaced out and more weeks to cover because there would not be enough time to go in depth of the full course."—P11	<ul style="list-style-type: none"> ▪ Longer, more spaced out PMP needed 	
"The gym was always rushed, we did not have a lot of time in there at all. It was always rushed, we never ended up finishing whatever we were meant to be doing."—P1	<ul style="list-style-type: none"> ▪ Gym sessions felt rushed ▪ Not completing tasks in the gym 	
"It was all a bit of a rush and then come back. Yes, it was good, but I did just think it was like even the occupational health, if you had an hour—once we had all done our bit and asked us all questions an hour wasn't actually long enough for it really. Yes."—P4	<ul style="list-style-type: none"> ▪ Felt rushed ▪ Sessions not long enough 	
"To me some of the sessions just were not long enough, and so although we would explore things, sometimes it would be good to explore them in more detail and understand more about how other people feel about things."—P2	<ul style="list-style-type: none"> ▪ Felt rushed ▪ Sessions not long enough 	
"I just felt there wasn't enough time to talk about input or to go into more depth about, you know, various aspects of what we were talking about. You know, I would have liked perhaps an hour plus for the psychology sessions, because in a way it sort of—it is the area I suppose that has had a big impact on my life."—P3	<ul style="list-style-type: none"> ▪ Sessions not long enough/need for more time to explore content in more depth 	
"I think more time would have been—yes again—more time with them [medics]"—P6	<ul style="list-style-type: none"> ▪ Not enough time to discuss content ▪ Psychology sessions needed to be longer ▪ Importance of psychology sessions ▪ More time needed with medics 	

The anonymized data were analyzed by the clinical psychologist and occupational therapist who had facilitated the focus group and an additional researcher not involved in the focus groups. The latter had not been involved in the gathering of the data for the study and did not work in the field of CFP, which helped enhance the rigor of the study. In terms of epistemologic orientation, the authors adopted a constructionist position, acknowledging that "meaning" is created in coordination with, rather than separately from, others, and that interpretations of reality are subjective and diverse. The researchers completed phases 1 to 3 independently, with all coding being completed manually before collectively completing phases 4 and 5. An example of how data were developed into a final theme is given in Table 4. This process allowed the researchers to explore and challenge each other's understanding and interpretation of the data to sup-

port the development of themes. Focus groups can be regarded as producing complex and challenging data that can be difficult to analyze.²⁰ In order to fully immerse themselves in the data, the analysis took several months to complete. Similarly, the process of analysis did not proceed in a linear fashion, but rather involved an organic process of constantly reviewing and refining codes until a satisfactory data map emerged. As the analysis proceeded, the data from the different focus groups were gradually perceived as one data set, though with origins clearly traceable back to the separate groups. This process allowed the researchers to produce a thematic map to reflect the outcomes of the focus group.

Ethics

Ethical approval was granted by North West Haydock Research Ethics Committee 17/NW/0557.

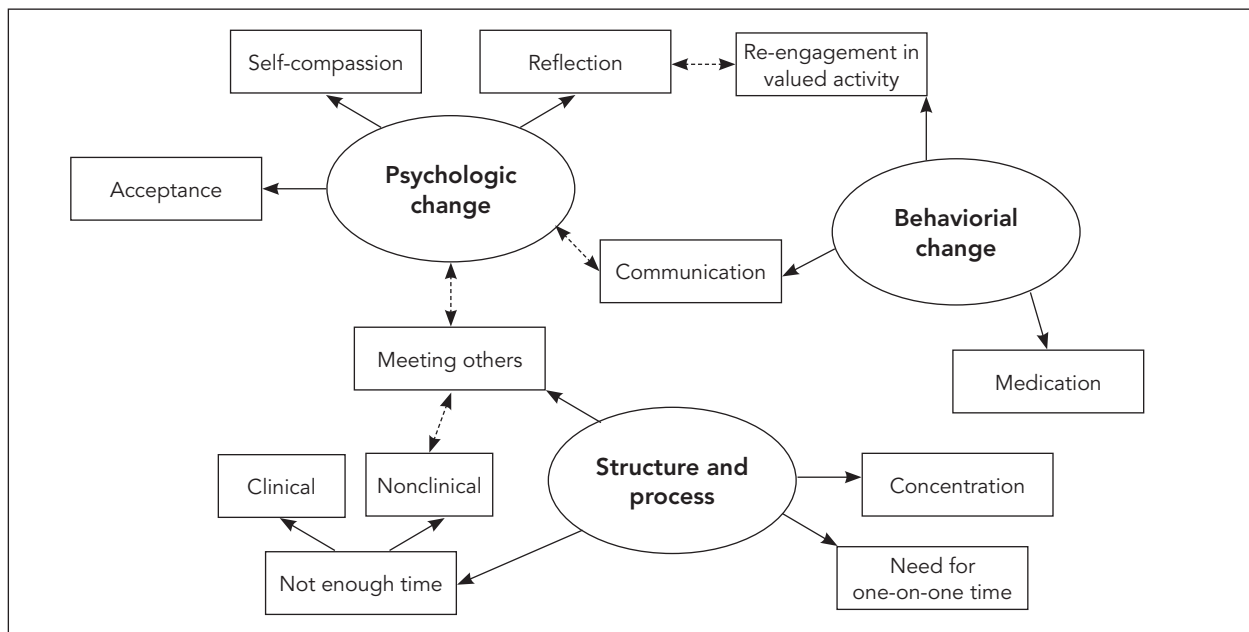


Fig 1 Thematic map showing the themes (circles) and subthemes (boxes) of the qualitative data obtained from the focus groups.

Results

From the thematic analysis of the focus groups, three overarching themes emerged: (1) psychologic change; (2) behavioral change; and (3) structure and process. Numerous subthemes were identified within these overarching themes. A thematic data map can be seen in Fig 1.

Theme 1: Psychologic Change

Many participants spoke of the positive psychologic impact of attending the facial PMP. This related to both cognitive and emotional changes. There were a number of subthemes linked to this theme, such as the development of self-compassion. Participants provided anecdotal accounts of changes related to becoming more compassionate toward themselves; for example, in beginning to prioritize and focus on their own needs more, giving themselves permission to do so, reduced feelings of guilt, and being kinder to themselves in general:

"You have so many other things and family and children and you run around all the time, and I think finishing the course, I actually had permission to actually go – actually I now know it is a bit of me time every day and I now can sit down and I can think . . . It just gave you time to think of yourself rather than everybody else."—P1

"I give myself permission to take time for myself, which I did not do before; and I don't feel guilty about it, I don't think I should be doing something else . . . Because I would have thought I should be doing, you know, I should be doing the dishes, you know, making tea or checking somebody's homework or, you know, any number of things, ringing my parents to make sure . . . You know those sorts of things. No . . . this is my time."—P2

"There are times also when you think, well I just cannot do that at the moment, but that is OK because I will come back to doing it . . . I do join in with things, but when things are bad, I feel comfortable saying I cannot come this time. It's OK, it's fine."—P3

Another subtheme was that of "acceptance," whereby participants indicated that they had made progress in terms of adjusting to the chronicity of their condition. Some participants reflected that developing acceptance allowed them to refocus on other areas of their life and supported them when identifying what is important to them as individuals. Participants referred to accepting how CFP continues to impact their life, linking in with the previous subtheme of self-compassion:

"It motivated me really. OK, I've got to accept it now and I never did beforehand. I have accepted it now and I am just getting on with life as best I can."—P4

"I was so upset about, you know, life and wanting to turn back. I have accepted that now. My heart is still there, but I have accepted."—P5

"I think when you have accepted some of that . . . you feel a bit more equipped; then I think you have got the skills then, or the know-how, to move on to looking at things with your family and friends."—P6

The final subtheme was that of "reflection." Participants' comments suggested that the opportunity to reflect on their current situation and previous ways of coping was challenging, but ultimately a key element in the process of making positive changes. Many spoke of how attending the facial PMP enabled

them to re-evaluate what was important to them. In turn, this helped them to re-engage in valued activities. Similarly, they spoke of how beneficial it was to have some space to make sense of their situation in order to help them manage more effectively.

"I think it is about evaluating what is important to you and that is really what should be driving you forward. Helping you deal with linking, coping mechanism, your values and what you feel is important to yourself."—P10

"Yes, the course does make you self-evaluate—you can't not, it is there, right in your face, and you have to do it and that is the only way that you can kind of move on and try and get to the next, the next step by yourself or by your relationships."—P1

"I think in more depth about isolation and it had quite a big impact on me. It was sort of like dealing with one thing at a time. I could not deal with it all, I had to sort of break it down in my mind."—P2

Theme 2: Behavioral Change

An overarching theme identified during the analysis was the significant behavioral changes participants made through attending the facial PMP. This theme reflects concrete and practical changes that participants had made away from the facial PMP, all of which were perceived in a positive light. These positive reflections were made up of a number of subthemes, such as "communication." This focused on the changes made in communication within close relationships, including family and friends. In turn, these changes in communication were linked to a sense that others understood them better, which had a positive psychologic impact:

"My closer friendship group, you know, they knew I had a chronic pain problem. Not to the extent I think, and you know, once I explained a bit more, or my husband explained a bit more, you know, where it is and how it impacts on me . . . I think that has worked out better for the friendship group."—P3

"You know, I felt as though we talked about my pain a lot in the house and my children perhaps got a better understanding of it."—P6

"I was able to be more open about the facial pain with my manager and work colleagues."—P2

Another significant behavioral change reported by participants was a reduction in their use of medication. The subtheme of "medication" reflects how many participants reduced their use of CFP medications as a result of attending. This reduction was often linked to an improved understanding of how their situation could be managed more effectively by focusing on other, nonmedical strategies.

"One of my aims was to try and reduce my meds so that I felt better . . . The meds were dominating my life, so that was one of my aims, and I managed to get that done now and I feel a lot better."—P8

"What it did was it opened my mind to the fact that it was not just medication or it was not just physiotherapy—there were other ways you could attack this. In actual fact, maybe there are even more ways that you can look at it. So my attitude towards it now is that I am far more open."—P9

"I was on 13 types of medication. I stopped 4 of them straight-away because the medication or how they make the medication was acting."—P4

The final subtheme was "re-engagement in valued activity." Participants reflected on how their initial response to developing CFP often led to them disengaging from activities that reflected their core values. In contrast, attending the facial PMP led to them re-engaging in various important activities, which appeared to have a positive impact on their wellbeing:

"I did nothing before the course . . . And I did no reflectiveness on why I was like this. It was just the fact that the pain was so intense that I could not be bothered, and I liked music, and I stopped going to the concerts, I stopped listening to music . . . I am getting back there now. It is taking a while, but it is coming . . . and this is good."—P7

"I realized . . . that I had isolated myself a lot more—subconsciously to begin with, but then . . . I was deliberately doing it because it felt comfortable and safe. But I suppose one thing I have worked on . . . is socializing more . . . we are going out a lot more now . . . I have been willing to go out a lot more—either just me and my husband or with friends. That has been quite good for me really."—P6

"I appreciate being with my children, my family or like recently I have had a go at gardening again, which is something I had stopped for a few years. So I do think the course has made me think about what I was not doing and what I could try to do and push myself a bit, and that was really beneficial."—P11

Theme 3: Structure and Process

Participants spoke at length regarding how the facial PMP was structured and run. Comments highlighted both the strengths and limitations of the PMP in this regard.

The subtheme of "not enough time" highlighted that many participants felt that the facial PMP was not sufficiently long enough. Within this subtheme, two further divisions were made in terms of participants' desires for more clinical and nonclinical time on the PMP. With respect to the former, many spoke of feeling that some themes raised in the group were not discussed in sufficient depth, which they would have liked:

"I just felt there wasn't enough time to talk about input or to go into more depth . . . I would have liked perhaps an hour plus for the psychology sessions, because in a way it sort of—it is the area I suppose that has had a big impact on my life . . . It is perhaps good to unpick things and try and make sense of what is going on for you, your family, and I suppose your wider circle, or what you are not confronting yourself."—P3

"To me some of the sessions just were not long enough, and so although we would explore things, sometimes it would be good to explore them in more detail . . . and understand more about how other people feel about things."—P2

"It did feel a bit rushed. It did not seem long enough. You were giving us all this information, trying to sink it in."—P5

Participants also spoke of wanting to spend more time with their group members away from formal clinical sessions. This related both to a desire to spend more time informally socializing, but also having a more informal space to discuss themes that emerged in the group. Comments also highlighted how some felt this additional time together would have helped bond group members together more, develop trust, and even reduce feelings of embarrassment.

". . . it would have been nice because we were a good group that we had more time together without anybody, so we could talk about the conditions . . ."—P5

"I think you know, we are put together as a group and we share things as a group in the sessions, but you don't have time outside the sessions to talk about various things."—P2

"Talking as a group without anybody around, say in the break times, you can do, you know, you have a cup of tea, have a little chat and stuff like that and it becomes slightly more relaxed . . . having the time to start to bond and build relationships within the group . . . start to open up—to start to trust people and not feel ashamed and embarrassed and stuff like that—I think it is really important."—P10

Many participants felt that they would have liked some one-on-one time with an individual clinician while in the PMP. Some participants did not specify how they might have used this time, though some did note specifically how one-on-one psychologic support may have helped. Others noted that they could perhaps open up more about certain issues or explore them in more depth on a one-on-one basis:

"Yes, I think it would have been better having more time with you. Possibly a one-to-one [psychology]."—P5

"I think more people might open up if it was one-to-one. I opened up but not 100%."—P4

"The second half of the program, we could do one-to-one and have a little bit more, one-to-one time."—P10

Another subtheme was that of "concentration." While concentration is itself a more cognitive factor, participants often explicitly made links to how the structure of the PMP itself could impact concentration. This led to issues such as not being able to take information in, struggling to follow discussions, and feeling physically tired:

"I think because of the pain is in our head that we cannot concentrate and think for long. So yes, I was like you, I was going home thinking—god I really wanted to know that and I really could not . . . I think it was when we did all morning without a break, and then I suddenly thought I need—I can't concentrate all that time. Even if it is like 10 minutes, go to the toilet and come back or just grab a coffee and come back . . . It makes a huge difference and then you can come back and refocus and go—right OK I can concentrate."—P1

"Well maybe a bit longer, it would be like 10 weeks or something, maybe 12, but yes, I think the thing with a lot of us was that [we] . . . struggled with the breaks and . . . could not concentrate, I've got to go, I cannot concentrate anymore. It's a lot to take in."—P8

"I felt myself when I was struggling—asking someone to repeat what the question was or what was being said or I think my medication affects—well I always think it is my memory, but my GP says it is concentration, and you know, sometimes you find yourself having to ask, 'what was that again?'"—P2

The final subtheme was that of "meeting others." The group-based nature of the PMP and the opportunity this afforded in terms of meeting others diagnosed with CFP was seen by many as a hugely beneficial element of the treatment. In this respect, the theme both related to the structure of the PMP but also had strong links to psychologic changes, which is highlighted in Fig 1. Some spoke of how comforting it was to meet others with CFP, and others spoke of how helpful it was feeling part of a supportive group:

"It [what helped] was to talk as well and being with other people who are similar."—P4

"Meeting other people who have facial pain or significant facial pain. You know, I had not really talked to anybody else with facial pain, and it was comforting . . . to realize that there are people, there are other people and you could share understanding or experiences or perhaps techniques, and that for me to begin with, was significant."—P6

"The biggest thing I actually really got out of it was that I met [the group]—that was my biggest . . . talking to these and going through the pain and stuff like that, and like, we are in a group now, and that is helpful isn't it . . . I know we all help each other and we are all there for each other aren't we?"—P5

Discussion

The identified themes indicate that participants in this study noted significant positive improvements to their management of CFP through attending a PMP. These improvements were related to both psychologic and behavioral changes. Psychologic benefits included improved CFP acceptance, self-compassion, the opportunity to reflect on life with CFP, and finding it helpful to meet others with CFP. Positive behavioral changes included improved engagement

in valued activities, reduced medication use, and improved communication (which itself had psychologic benefits). While elements of the structure of the PMP they attended were beneficial, such as the opportunity to meet others with CFP, there was evidence that a lengthier treatment would have been helpful in terms of discussing content fully and providing more time spent with others diagnosed with CFP. Similarly, many participants felt that it was difficult to maintain a suitable level of concentration during some sessions. Individual sessions with clinicians were also identified as something patients felt they may have benefitted from, particularly to discuss psychologic difficulties they did not wish to discuss within the group.

The facial PMP outlined in the present study, and the wider service it is embedded within, exemplifies a more biopsychosocial approach to the treatment of CFP. In this respect, it can be said to reflect an approach that incorporates both Axes I and II of the RDC/TMD.⁷ Participants clearly benefitted from a treatment that recognized that successful management of their condition involved recognition not only of the physical impact of pain, but also its wider impact. This is reflected in the broad range of psychologic and behavioral changes that participants associated with improved management of their condition. Similarly, it also raises important questions about when it is most helpful to offer one-on-one treatments, compared to when there may be benefits from a more group-based approach. Certainly, in the present study, the opportunity to meet others also diagnosed with CFP was a positive experience that would not have been possible without a group-based treatment. Previous studies have supported the use of CBT-informed treatments for patients with CFP.^{11,21} The results of this study suggest that facial PMPs guided by CBT can have positive benefits and provide more specific details on patient perspectives on key areas of change.

PMPs in general aim to improve quality of life despite pain and to facilitate engagement in valued activities despite pain.¹⁰ They involve a move away from symptom management to a focus on living well with pain. This study suggests that facial PMPs can have similar benefits and promote living well with CFP. For example, adjusting to, and coming to terms with, the presence of CP is a difficult process. Evidence from more general chronic pain studies indicates that developing acceptance of CP is associated with reduced pain, disability, depression, and pain-related anxiety.²¹ In a similar vein, the development of self-compassion has been associated with improved CP acceptance, as well as reduced anxiety, depression, and stress.²² While the methodology of this study does not warrant broad inferences regarding CFP patients, it is promising that participants report improvements with both acceptance of CFP and de-

velopments of self-compassion in view of its positive benefits in the CP literature in general.

The issue of the ideal length of treatment for a PMP has been subject to much discussion, with a suggestion that, while more standard PMPs (around 36 hours of treatment) can provide benefits, more intensive programs often provide greater improvements.¹⁰ The present study involved a facial PMP that, in total, involved 27 hours of treatment (including a follow-up appointment after 6 months). Evidence from other studies in conjunction with the reflections of the patients within this study regarding a need for more treatment time clearly indicate that the question of the ideal length of a facial PMP warrants further study. Similarly, it would be helpful to consider whether different-length facial PMPs may be suitable depending on the degree of distress associated with living with CFP.

In addition to clarity on ideal length of treatment, the difficulties some patients noted in terms of concentration raise important questions about the best way to structure sessions themselves. CFP and associated distress are likely to affect concentration directly at times, and, even when it does not, there will naturally be limits in terms of attention span. Similarly, participants clearly felt they would have benefitted from more time together as a group when not engaged in clinical sessions, which may also facilitate improved attention within sessions themselves. It is also likely that a desire for more time together with group members away from clinical sessions was, in part, related to the benefits noted in the “meeting others” subtheme. Both for future research purposes and for services offering or developing facial PMPs, questions about how the treatment is structured are clearly important.

While the present study was guided by principles of CBT, it did contain content influenced by acceptance and commitment therapy (ACT), a key facet of which is the importance of identifying core values and taking steps to live more in line with these values to improve wellbeing.²³ Participant reports of re-engagement in valued activity are likely to reflect improved wellbeing despite pain and further re-enforce the benefits of a CFT treatment that is more biopsychosocial in approach rather than exclusively medical. It is speculated that, in the present study, re-engagement in valued activity was in part facilitated by the opportunity patients had in the facial PMP to reflect on their situation and treatment content. Similarly, patient reports of reduced medication and improvements in communication and understanding with significant others further highlight the improvements in CFP management that stem from a biopsychosocial focus.

Finally, while group-based treatments are well known to be beneficial across a range of CP conditions, participant comments regarding the potential benefits of more one-on-one time clearly indicate the importance of considering the addition of individual sessions to facilitate discussion of subjects that participants did not feel would be appropriate to discuss in groups. The present authors would like to note that, since this study was completed, the facial PMP in the present study now allows all patients to have one-on-one time with a clinician to discuss progress and identify any areas of difficulty. The present authors also suggest that, at a minimum, some one-on-one time away from the group is important to fully gauge progress and to clarify any needs not being met by the group elements of the facial PMP.

Limitations

The limited number of participants in the present study naturally means that results cannot be generalized to the wider CFP population. Similarly, it has been suggested that three or four focus groups should aid theoretical saturation.²⁴ In this respect, it is possible that data quality would be improved with more participants and focus groups. Unfortunately, it was not possible to recruit any more participants in this instance; however, the authors believe that the results are useful in highlighting how patients may experience facial PMPs and providing helpful pointers for further study. Results may also be helpful in terms of informing treatment content and structure of existing facial PMPs or those in development.

The focus groups and analyses themselves were conducted by clinicians working within the pain management service. To minimize the potential of bias in the interpretations and in the interview process itself, a clinician who did not work on the facial PMP was involved in both the focus groups and the analysis. However, it remains possible that some participants may not have discussed key aspects of their experiences; if, for example, it was felt that this might be viewed negatively by the clinicians conducting the interview, particularly the clinical psychologist who worked with participants on the facial PMPs themselves. Despite this, it should be noted that some of the themes, notably those focused on structure and process, involved participants openly discussing less helpful aspects of the facial PMP, suggesting that they were willing to identify both positive and negative aspects of their experiences. Finally, it may have been helpful to have a researcher involved in the analysis and focus groups themselves who did not work within the field of chronic pain, given the potential influence of the researchers' wider understanding of CP and PMPs in general.

Conclusions

This qualitative evaluation explores patient experiences of attending a facial PMP, as well as its impact on their management of CFP. Participants report positive benefits, both psychologically and practically, of attending. These benefits are broadly in line with those noted in other more general PMPs and suggest that facial PMPs are a beneficial treatment for patients with CFP. In particular, themes indicate the benefits of providing a more psychologically informed treatment that is not exclusively medical in its focus. This study also highlights the importance of considering how facial PMPs are structured to maximize patient engagement and benefits from the treatment.

Highlights

- Group-based, CBT-informed treatments such as facial PMP can support the long-term self-management of CFP.
- A key benefit of a facial PMP is the biopsychosocial approach, allowing patients with CFP to manage not only CFP itself, but also its wider impact on life.
- Further research is required to establish the ideal length and structure of facial PMPs.

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