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# Learning to Combat Chronic Pain: Exploring the Effectiveness of a Six-week Patient Psychoeducation Course Teaching Self-management of Chronic Pain

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This research is a product of the Doctor of Psychology (PsyD) program at George Fox University. [Find out more](#) about the program.

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Learning to Combat Chronic Pain: Exploring the Effectiveness of a Six-week Patient  
Psychoeducation Course Teaching Self-management of Chronic Pain

by

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Presented to the Faculty of the  
Graduate Department of Clinical Psychology

George Fox University

in partial fulfillment

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in Clinical Psychology

Newberg, Oregon

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**Abstract**

Chronic pain is a highly prevalent health problem in the U.S. and poses a large economic and temporal cost to the medical system (Institute of Medicine, 2011; Marcus, 2003). Patients with chronic pain typically report a decrease in emotional, social, and economic functioning (Bair et. al, 2009; Breen, 2002; Kang, Backstrand, & Parker, 2013). This study investigated the efficacy of a 6-week evidence-based group psychoeducation course for the self-management of chronic pain. Pre- and post-test measures were utilized to assess results of the course. Data were analyzed using a paired sample *t*-test in order to explore the relationship and degree of effect pre- and post-intervention, as well as comparing the treatment and control group results. Due to the small sample size, many of the results were not statistically significant. However, there was significant improvement in reported wellbeing within the treatment group. Moreover, there were observable changes in the control group- specifically an increased sense of pain disability and decreased sense of wellbeing- but these results were not statistically significant. Through the

implementation of this study, several limitations and barriers to intervention were discovered.

These discoveries provide valuable information for future applications of chronic pain management groups. If developers of these groups consider the insights gained in this study, the programs would prove to be a highly valuable resource to the medical and psychological community, in turn reducing the burden on primary care providers and improving patient wellbeing.

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## **Chapter 1**

### **Introduction**

Chronic pain is the most common health complaint in the United States (Disorbio, Bruns, & Barolat, 2006; Marcus, 2003). The medical community is struggling to meet the demand and adequately treat chronic pain patients (Huffman, Stubbs, Kroenke, & Damush, 2010; Institute of Medicine, 2011). This issue is creating high economic costs and overwhelming the primary care system (Vijayaraghavan, Penko, Guzman, Miaskowski, & Kushel, 2012). As a result, the field is in need of alternative forms of patient care. Moreover, chronic pain can be devastating to patients and their families, affecting the physical, psychological, social, and occupational realms. Given the biopsychosocial effects of chronic pain, a multidisciplinary treatment approach would be the most applicable. The following study attempted to implement a multidisciplinary psychoeducation group to assist chronic pain patients in learning to live well despite chronic pain.

### **Prevalence**

Chronic pain has been found to be the most common complaint in primary care visits, averaging 20% of appointments (Disorbio et al., 2006; Marcus, 2003). Studies have shown that over 1.5 billion people worldwide and 100 million American adults suffer from chronic pain (American Academy of Pain Medicine [AAPM], 2011). In the United States alone, one third of adults are reported chronic pain sufferers (Meyers, 2013). According to the AAPM (2011), more Americans are afflicted with chronic pain than diabetes, heart disease, and cancer combined.

The National Center for Health Statistics (2006) reported that an estimated 76.5 million people in the U.S. over the age of 20, or 26% of the population, suffer from persistent pain, and the AAPM (2011) reports that older adults are particularly prone to chronic pain. Moreover, adults aged 45-64 years are most likely to report pain lasting more than 24 hours (AAPM, 2011). Women are more likely than men to report pain, especially in the form of migraines, neck pain, lower back pain, or face or jaw pain (Schiller, Lucas, Ward, & Peregoy, 2012).

### **Definition of Chronic Pain**

Chronic pain is defined by the International Association for the Study of Pain (IASP) as pain that has persisted beyond normal tissue healing time (Flor & Turk, 2011). Any pain lasting for three months or more is typically considered chronic pain (Health Talk Online & University of Oxford, 2012a; Khouzam, 2000). Chronic pain may or may not be the result of an injury or illness, and often results in negative physical, psychological, economic, and social consequences (Breen, 2002). According to the AAPM (AAPM, 2011), acute pain is a sensation activated in the nervous system that alerts an individual to the possibility of injury and the need to take care of oneself. However, in chronic pain, those pain signals continue to fire in the nervous system for months, years, or even longer. Common chronic pain complaints include headache, back pain, cancer pain, arthritis, and neurogenic pain, which is pain resulting from damaged nerves (AAPM, 2011).

### **Biopsychosocial Model of Pain**

The biopsychosocial model is an approach to conceptualizing and treating healthcare issues. It analytically weighs biological, psychological, and social factors, as well as their complex interactions, as a means of understanding health (Engel, 1977). It has been shown to be

an effective means of conceptualization, helpful for multidimensional treatment, and more in line with patient needs than the traditional biomedical model (Kirby et al., 2009). The biopsychosocial model was included in the current study because of the complex effects of chronic pain on patients' lives. Chronic pain affects the physical, emotional, social, and occupational realms of a person's life. Therefore, it is more effective to treat the multifaceted issue from an encompassing approach, rather than a strictly biological medical model.

**Gate control theory.** The Gate Control Theory originated in 1965 by Melzack and Wall (as cited in McCaffrey, Frock, & Garguilo, 2003). Essentially, the theory is that a gating system in the dorsal horn cells, within the central nervous system, opens or closes the afferent and efferent pain pathways to and from the brain (British Medical Journal, 1978; McCaffrey et al., 2003). The "gate" can be opened or closed based on "physiological, psychological, cognitive and emotional components that regulate the perception of pain" (McCaffrey et al., 2003, p 283). In other words, Melzack believed that an individual should be able to moderate his or her pain through means such as distracting him or herself with pleasant stimuli, being in a better emotional state, or rubbing the painful area. These types of factors will then transmit positive signals that cause the gate of the pain pathway to close, thereby reducing the sensation of pain that the mind perceives. The gate control theory has been utilized extensively in pain research and has shown to be a helpful psychoeducation tool for pain patients because it validates that their pain exist, but also gives them a sense of control over the pain (Kopala, & Keitel, 2003).

**Sleep and Pain.** Sleep problems are highly common in pain patients; "an estimated 20% of American adults (42 million people) report that pain or physical discomfort disrupts their sleep a few nights a week or more" (AAPM, 2011, sect. 4, para. 3). Sleep disruption is one of

the most frequent complaints of chronic pain patients (Smith & Haythornthwaite, 2004).

Research suggests that “the relationship between sleep disturbance and pain might be reciprocal, such that pain disturbs sleep continuity/quality and poor sleep further exacerbates pain” (Smith & Haythornthwaite, 2004, p 119). It must be noted that pain does not need to be severe to cause sleep disturbances, and the sleeper does not have to be fully awoken during the night to feel unrested in the morning. Even less intense pain can result in “micro arousals,” which are instances where pain sensations interrupt the brain’s sleep cycle, shifting the individual back into a lighter sleep stage; the person may not become fully conscious, or remember waking, but such disjointed sleep often causes the person to feel unrested the next morning (Lavigne, 2003).

**Psychological and Emotional Factors.** The psychological and emotional consequences of chronic pain are numerous as well. Chronic pain sufferers are more likely to experience depression, anxiety, activity limitations, and unfavorable health perceptions” (Breen, 2002, p 48). Common complaints of chronic pain patients include sadness or lower self-esteem due to decreases in physical abilities, employment, financial resources, and quality of relationships (Kang et al., 2013). In the study by Kang and colleagues (2013), patients also endorsed feeling lonely as well as self-conscious regarding their physical disabilities and limitations. When an individual struggles with chronic pain, he or she can easily develop negative thought patterns that lead to depressed mood, disrupted sleep, increased irritability, and poorer memory and concentration. These experiences can affect the individual’s ability to cope with the pain and can even lead to increased perception of pain (Health Talk Online & University of Oxford, 2012b).

Finucane, Dima, Ferreira, & Halvorsen (2012) found that in comparison to healthy participants, those with chronic pain experienced more fear, anger, and sadness. The University

of Oxford collaborated with Health Talk Online (2012b) to interview several individuals who experience chronic pain. In their research, they found that anxiety in chronic pain patients is often centered on the fear of the future, especially early on when patients are apprehensive about the cause of the pain and frightened of the potential for worsening pain. Moreover, the most distressing period for many chronic pain patients was enduring the exasperating, discouraging, and often ineffective process of seeking a diagnosis and treatment plan for their conditions. Other common anxiety provoking aspects of chronic pain include stress related to interpersonal conflict, financial strain, and interacting with the medical system, especially being falsely suspected of drug seeking (Kang et al., 2013).

Moreover, the fear of pain increasing with activity is highly limiting to the chronic pain patient in that it leads to avoidance of multiple hobbies and activities of daily living (Kang et al., 2013). Alappattu and Bishop (2011) discuss pain-related fear within the framework of the fear-avoidance model (FAM) of pain. The FAM hypothesizes that certain individuals are more prone to developing and maintaining pain after injuries due to their behavioral or emotional responses to the pain. Furthermore, the FAM explains two classes of pain sufferers: those with lower fear, who combat pain, and recover from their injuries, and those who catastrophize. Catastrophizing pain is a response that brings about avoidance or escape behaviors, disuse of injured area, and potentially disability as well (Alappattu & Bishop, 2011).

**Social implications.** Social ramifications are a significant aspect of chronic pain. These individuals often experience communication problems, feeling misunderstood or unsupported, feeling like a burden and/or asking too much of loved ones (Bair et al., 2009; Kang et al., 2013). Common complaints from individuals experiencing chronic pain also include not knowing how

to help loved ones understand and feeling frustrated with their medical providers (see Health Talk Online & University of Oxford, 2012b; Matthias et al., 2010; Partners Against Pain, 2013; Rope, 2008). Due to these social factors, many chronic pain sufferers experience a reduction in quality of relationships. Pain patients also commonly experience loss of their previous social roles, with relationships tending to be limited to family members, and patients feeling isolated from other social groups (Silva, Sampaio, Mancini, Luz, & Alcântara, 2010).

**Substance abuse.** Several studies have found a correlation between chronic pain and substance abuse, most especially regarding narcotic or opioid pain medications (Olsen & Daumit, 2002). Approximately 5% to 20% of patients utilizing psychoactive medication – such as opioid pain medication- for pain management find themselves involved in substance abuse or addiction problems (Grinstead, 2002; Stimmel, 1997). However, other research has shown that substance use is no more common in chronic pain patients than the general population (Fishbain, Cutler, Rosomoff, & Rosomoff, 1997). Even though the field has yet to agree, substance use was deemed important enough to be included in the current study's coursework.

**Economic ramifications of pain.** The monetary cost resulting from chronic pain is substantial at both the individual and societal levels. According to the Institute of Medicine (2011), pain is a substantial problem in public health, costing society a minimum of \$560-\$635 billion each year. That figure includes the total cost of pain-related health care, which averages between \$261 and \$300 billion, as well as lost productivity averaging \$297 to \$336 billion. This financial statistic translates to approximately \$2,000.00 for every U.S. resident.

**Current Modes of Treatment & the Stress on Primary Care**

Although multiple treatment modalities for chronic pain are available, current methods have been found to be inadequate in addressing the prevention, assessment, and treatment of patients with chronic pain (Huffman et al., 2010; Institute of Medicine, 2011). However, multidisciplinary pain clinics have yielded positive results regarding chronic pain management. For instance, Hoffman, Papas, Chatkoff, and Kerns (2007) performed a meta-analysis of several studies and found that compared to control conditions, multidisciplinary methods that incorporated psychological interventions had positive effects on pain disability and patients' ability to return to work.

Williams (n.d.) purported that the goal of multidisciplinary treatment is to supply a more exhaustive treatment of pain by incorporating various disciplines. The basis of these programs is often cognitive behavioral, with the goal being to decrease the frequency of dysfunctional behaviors and increase healthy behaviors. He goes on to state that the treatment goal shifts from pain relief to improving physical activity and muscle strength, "decreasing pain behaviors, eliminating reliance on certain medications such as narcotic analgesics or muscle relaxants, and reducing depression, and social isolation" (Williams, n.d., slide 12). An example is a study by Dysvik, Kvaløy, Stokkeland, and Natvig (2009) that combined therapeutic conversations and training, physical activity, and elements that specifically emphasized the psychosocial features of chronic pain.

Unfortunately, such multidisciplinary resources are not widely available (Holten & Veasey, 2008). Therefore, patients with chronic pain often rely solely on their primary care providers for the management and treatment of chronic pain. However, primary care physicians

(PCPs) often feel overburdened and unequipped to provide comprehensive care to patients with chronic pain, due to the complexity of the pain and the high frequency of comorbid conditions (Vijayaraghavan et al., 2012).

**Self-management of chronic pain.** Contemporary research suggests that improved self-management of chronic pain through psycho-education and patient skill development leads to overall improvement in pain severity, as well as the functional abilities of pain patients (Holten & Veasey, 2008). *Self-management* is defined as the “the ability to manage the symptoms, treatment, physical and psychosocial consequences and life-style changes inherent in living with a chronic condition” (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002; as cited in Bair, et al., 2009, p. 1281).

**Effectiveness of group treatment.** Group educational programs have been found to reduce distress and preserve a higher level of functioning in chronic pain patients (see Haugli, Steen, Laerum, Nygard & Finset, 2003; LeFort, 2000; McBee, Westreich, & Likourezos 2004; Nelson & Tucker, 2006). For example, McGillion et al. (2008) found their six-week psychoeducation program to be effective for improving participants’ general health, pain symptoms, physical functioning, and self-efficacy to manage their pain. Unfortunately, attendance of chronic pain patients to these types of groups can be relatively poor. For instance, De Góes Salvetti, et al. (2012) found that 36% of participants in their pain psychoeducation group exhibited low treatment adherence; multiple individuals that completed the program provided incomplete information and had to be excluded from analysis; and only 36% of the valid responders completed a follow-up assessment. This indicates the importance of patient motivation and/or incentives to increase engagement.

**Cognitive behavioral approach to pain.** The cognitive behavioral perspective (CBT) emphasizes the “reciprocal and synergistic relationships among physical, cognitive, affective, and behavioral factors (Flor & Turk, 2011) that guide experiences and responses over time” (Skinner, Wilson, & Turk, 2012, p. 95). When working within a CBT framework, the therapist teaches patients skills to increase their feelings of control regarding the effect pain has on their lives, and to help the patients to alter the emotional, cognitive, behavioral, and sensory components of the situation (Skinner et al., 2012).

CBT conceptualization and techniques make up an integral part of the six-week workshop protocol of the current study because CBT has become the most widely accepted psychological treatment for chronic pain sufferers (Gatchel & Okifuji, 2006; Morley, Eccleston, & Williams, 1999; Skinner et al., 2012). Research evidences that CBT is beneficial to such patients (Flor & Turk, 2011; Skinner et al., 2012), and that CBT results in improvements of pain, as well as physical, and emotional functioning (Dixon, Keefe, Scipio, Perri, & Abernethy, 2007; Hoffman et al., 2007; Morley et al., 1999; Skinner, et al., 2012). Coping skills and relaxation techniques in particular were integrated into each week’s class schedule because they have been found to be helpful in coping with distress and reducing pain (e.g., Boroń, 2009; McBee et al. 2004). Devine (2003) performed a meta-analysis on 25 psychoeducation intervention studies that had been published from 1978-2001, and found a beneficial and statistically significant effect on pain. Devine purported that there is modestly strong evidence that supports “relaxation-based cognitive-behavioral interventions, education about analgesic usage, and supportive counseling” (p. 75).

**Medication use.** Medication use was a highly relevant topic to include in the current study's psychoeducation workshop because prescription drugs are such a common pain management tool. The American College of Preventive Medicine (ACPM; 2011) reported:

The past two decades have witnessed an expansion of analgesic use, especially opioid use for patients who have chronic noncancer pain. The National Center on Addiction and Substance Abuse (CASA) found that from 1992 to 2002 the number of prescriptions for controlled drugs increased 154.3% compared to 56.6% for non-controlled drugs during a time when the US population only rose 13%. (Section 4, para. 1)

Moreover, 7 million people abuse or misuse prescription medication each month (ACPM, 2011), so discussing proper medication management, side effects, and communication with physicians became important aspects of the current psychoeducation workshop.

### **Current Intervention Development**

The current researcher and colleagues developed a six-week psychoeducation course to augment patients' capacity for effective self-management of chronic pain. The coursework touched on topics such as understanding pain, Gate Control Theory, biopsychosocial model, relaxation techniques, cognitive distortions, negative thought patterns, cognitive behavioral therapy (CBT) for pain, medication use, substance abuse, the relationship between sleep and pain, communication, and coping skills.

The group protocol was developed by the current researcher, along with two other masters-level pre-doctoral psychology students, and was tested in a pilot study in April 2013. It consists of six sessions regarding the psychoeducation topics for the workshop. Session 1

includes general psychoeducation regarding definitions of pain, the Gate Control Theory, the biopsychosocial model, and common misconceptions about pain. Session 2 describes aspects of cognitive behavioral therapy (CBT) that can be useful in managing chronic pain, such as the concept of automatic thoughts, understanding the relationship between automatic thoughts and pain, cognitive distortions, and the ABC Model. Session 3 continues discussing CBT concepts, including a review of the previous week, in addition to cognitive restructuring, and coping skills. Session 4 revolves around the relationship between chronic pain and sleep as well as substance abuse. Session 5 focuses on communication skills, both with physicians and loved ones, specifically regarding self-advocacy, coping with lack of support, and improving relationships. Session 6 includes reviewing the previous weeks, discussion time, and additions of whatever resources the patients had requested over the course of the six weeks.

### **Hypotheses of the Current Study**

Given the complex nature of chronic pain, and the vast deficit in adequate treatment, this six-week patient psychoeducation course fills a need. The study hypotheses included:

1. Participants who complete the course will have shown improvement in their perception of pain, as indicated by the Pain Belief and Perception Inventory (PBPI) and Health-Related Quality Of Life- Healthy Days Measure (HRQOL-4). Chronic pain significantly affects patients in many ways, and their beliefs about their pain can lead to depression and anxiety (Breen, 2002). The cognitive behavioral therapy and psychoeducation modules of the current study's intervention were designed to address patients' beliefs and perceptions about pain. Therefore, measuring participants' beliefs and perceptions of

pain with the PBPI and HRQOL-4 will assist in determining the effectiveness of the intervention.

2. Participants who complete the course will note having better coping skills to deal with pain because of the intervention's focus on increasing patient education, changing unhealthy patterns of thought and behavior, and improving communication skills to seek social support. Coping will be measured via participant report on the feedback form as well as the Pain Disability Index (PDI). The PDI is an appropriate measure of this variable because subjective level of disability is inversely correlated with increased coping ability. For instance, a literature review by Jensen, Turner, Romano, and Karoly (1991) found that individuals with chronic pain exhibit improved functioning when they feel more in control of their pain, resist catastrophizing, and do not deem themselves exceedingly disabled.
3. Participants who complete the course will feel better prepared to communicate about their pain, as indicated by the feedback form comments. The communication skills module of the intervention will directly address this variable. This hypothesis is included because chronic pain sufferers commonly report feeling unsupported, misunderstood, and frustrated with regards to their medical providers and loved ones (see Health Talk Online & University of Oxford, 2012c; Matthias, et al., 2010; Partners Against Pain, 2013; Rope, 2008). The feedback form will provide adequate space for qualitative reports within this area.
4. Participants who complete the course will display a better sense of self-advocacy regarding pain control and living life with pain. They will have a more proactive attitude

rather than a resigned victim stance. This type of attitude may arbitrate a portion of the connection between severity of pain and patient adjustment (Jensen et al., 1991).

Samwel, Evers, Crul, and Kraaimaat (2006) found that helplessness was a significant predictor in level of pain. Self-advocacy and attitude will be measured by the PBPI.

5. Participants who complete the course will indicate a higher sense of wellbeing, as indicated by results on the Outcome Rating Scale (ORS). This is important because the biopsychosocial effects of chronic pain can seriously impair a patient's sense of wellbeing and life satisfaction. The intervention will address this by increasing participants' understanding of pain, coping skills, communication abilities, and tools for managing their pain in more effective ways. This will likely increase the participants' sense of control over their pain, increase their functioning, and improve their satisfaction with their lives.
6. Control group participants will demonstrate little to no change in pre- and post-test results, as evidenced by each of the measures, because they are not receiving the support and education that is hypothesized to be so helpful to those in the treatment group.
7. Control group scores will report lower life satisfaction (ORS), more disability (PDI and HRQOL-4), and less proactive attitude regarding pain (PBPI) as well.

## **Chapter 2**

### **Method**

#### **Participants**

A sample size of 11 participants was selected to participate in this study. They were recruited through flyers advertising the workshop, as well as referrals from their healthcare providers. Participants were identified patients with chronic pain, stemming from a variety of health concerns. Two patients opted to act as a control sample, completing pre- and post-test measures but not attending the workshop. Four participants completed the workshop and all pre- and post-test data measures. Five out of the original sample did not complete the program.

Participants' ages ranged from 24 to 71 with a mean age of 48. There were four men and seven women, which is in accordance with typical chronic pain statistics. All participants identified themselves as European American. Three of the participants were married, three were single, two were engaged, and two were divorced. Seven identified as Christian or Protestant, one Baptist, and two Latter Day Saints. Four were employed full time, one part time, one unemployed, one retired, and three on disability. Two made less than \$15,000 annual income, seven made between \$15,000 and \$30,000, and one made over \$40,000. Nine out of ten held insurance. Two participants identified the causes of their pain to be work-related injuries; one participant experienced a sports injury; one an unspecified type of accident; one birth defect; one degenerative disease; and one unknown cause. All participants' pain was reportedly located in multiple areas of each of their bodies, including the head (4 participants), neck (8 participants), shoulder (5 participants), chest (1 participant), back (5 participants), low back (6 participants),

arm (3 participants), hand or wrist (3 participants), hip (4 participants), thigh (1 participant), knee (3 participants), calf or shin (2 participants), foot (2 participants), and stomach (1 participant).

Each participant described his or her pain with multiple adjectives: eight described aching pain; six described “shooting” pain; two burning; three “pins and needles”; and five participants experienced numbness. See Table 1 for participant data.

Table 1

*Participant Demographic Descriptors, Full Sample*

Variable	<i>N</i>	<i>M</i>	<i>SD</i>
Gender			
Male	4		
Female	7		
Age	11	48.54	14.75
Highest education achieved			
No diploma or GED	0		
High school diploma/GED	4		
Some college	3		
Professional/vocational school	1		
College degree	1		
Some graduate school	2		
Graduate degree	0		
Marital status			
Married	3		
Single	3		
Engaged	2		
Divorced	2		
Religious affiliation			
Protestant	7		
Baptist	1		
Latter Day Saints	2		
Importance of religion**	9	4.11	0.92
Level of faith activity			
Attend once per week	3		

(Table continues)

Table 1 (Continued)  
*Participant Demographic Descriptors, Full Sample*

Variable	<i>N</i>	<i>M</i>	<i>SD</i>
Attend 1 to 2 per month	1		
Attend 1 to 2 per year	3		
Sporadic/irregular attendance	3		
No faith community involvement	1		
Employment status			
Full-time	4		
Part-time	1		
Unemployed	1		
Retired	1		
Disability	3		
Annual income			
Less than \$15,000	2		
\$15,000 to \$30,000	7		
Over \$40,000	1		
Insurance	9		
Insured			
Not insured	1		
Causes of pain			
Work-related	2		
Sports injury	1		
Other accident	1		
Birth defect	1		
Degenerative disease	1		
Unknown cause	1		
Location of pain			
Head	4		
Neck	8		
Shoulder	5		
Chest	1		
Back	5		
Low back	6		
Arm	3		
Hand/wrist	3		
Hip	4		
Thigh	1		
Knee	3		

(Table continues)

Table 1 (Continued)

*Participant Demographic Descriptors, Full Sample*

Variable	<i>N</i>	<i>M</i>	<i>SD</i>
Lower leg	2		
Foot	2		
Stomach	1		
Perception description			
Ache	9		
Shooting	6		
Burning	2		
Pins & needles	3		
Numb	5		

*Note.* \*\*Importance of Religion (1 = *Not at all*, 3= *Somewhat*, 5= *Extremely Important*) .

## Materials

The participants completed a demographic questionnaire in the first session and a qualitative comments and feedback sheet at the end of the course. Assessment measures included The Pain Disability Index (PDI; Pollard, 1984), The Pain Belief and Perception Inventory (PBPI; William & Throne, 1989), Health-Related Quality Of Life- Healthy Days Measure (HRQOL-4; Moriarty, Zack, & Kobau, 2003), and The Outcome Rating Scale (ORS) (see Appendix A). Each participant who successfully completed the treatment course received a certificate of completion as well as a gift card as compensation.

**Demographic questionnaire.** The demographic questionnaire created for this study consists of 12 categorical, likert-scale and short answer items. The items include the participants' age, gender, ethnicity, marital status, education level, religious affiliation, importance placed on faith, level of activity in faith community, employment and insurance status, socioeconomic status, and the nature of the injury or condition that caused the chronic

pain. The measure also contains a diagram intended to allow participants to indicate the locations of and sensations caused by the pain (e.g., aching, stabbing, burning).

**Feedback form.** The feedback form created for this study consists of 14 items on a 5-point likert scale, ranging from “poor” to “excellent”, and two questions regarding patient perceived positives and negatives, as well as space for additional comments and suggestions. The questionnaire evaluates aspects such as the effectiveness of the course, satisfaction with the presenter’s approach and knowledge, and patients’ perception of any change in their ability to self-manage chronic pain.

**The Pain Disability Index (PDI; Pollard, 1984).** The Pain Disability Index (PDI; Pollard, 1984) was completed by participants in each workshop session. The PDI is a rating scale designed to measure the degree to which aspects of the patient’s life are disrupted by chronic pain. It is a self-report measure in which participants rate the extent that pain interferes in seven areas of daily living: family/home, recreation, social, occupation, sexual, self-care, life-support, and overall average disability. It is a 7-item scale, in likert format. Each item ranges from 1 (no disability) to 10 (worst disability). Administration takes approximately five minutes. The PDI shows modest test-retest reliability and differentiates between low and high levels of disability (Loretz, 2005).

**The Pain Belief and Perception Inventory (PBPI; Williams & Throne, 1989).** The Pain Belief and Perception Inventory (PBPI; Williams & Throne, 1989) was administered in the first and last sessions. It consists of 16 items, which are on a 4-point likert scale ranging from *Strongly Disagree* (-2) to *Strongly Agree* (2). The PBPI measures four subconcepts within beliefs and perception related to pain: Mystery, Pain Permanence, Pain Constancy, and Self-

Blame (Williams, Robinson, & Geisser, 1994). Higher scores on the PBPI indicate higher agreement with those beliefs. These subscales have been found to have moderate internal consistency (Morley & Wilkinson, 1995). Mikail, D'Eon, and Gagné (1996) found that the internal consistency of the PBPI ranged from 0.63 for Mystery to 0.75 for Permanence. Morley and Wilkinson (1995) found internal consistency ranging from .80 to .89. Mikail et al. (1996) determined that test-retest reliability ranged from .43 to .68. They also determined construct validity by comparing the PBPI to the Beck Depression Inventory, the McGill Pain Questionnaire, the Multidimensional Pain Inventory, and a self-blame questionnaire. They found moderate correlations for Self-Blame and Constancy, and weak correlations for Permanence and Mystery.

**Health-Related Quality of Life – Healthy Days Measure (HRQOL-4; Moriarty et al., 2003).** Participants' health-related quality of life (HRQOL) was measured in the first and last sessions using the Healthy Days Measure (HRQOL-4; Moriarty et al., 2003). "The concept of HRQOL refers to a person's or group's perceived physical and mental health over time" (Moriarty, Zack, & Kobau, 2003, as cited in Robinson & Reiter, 2007, p. 133). This facilitates the measurement of how chronic pain impacts the patients' quality of life, and particularly if it changes in response to this intervention. The HRQOL-4 is a self-report questionnaire assessing the patient's overall health as well as the number of recent days when a person was physically unhealthy, mentally unhealthy, or limited in day-to-day activities. The HRQOL-4 was found to have acceptable test-retest reliability and strong internal validity (Andresen, Catlin, Wyrwich, & Jackson-Thompson, 2003; Moriarty et al., 2003).

**Outcome Rating Scale (ORS).** Participants completed the Outcome Rating Scale (ORS) in each session. It is a brief four-item visual analog scale that measures the participant's functioning in various areas of life that are known to change as a result of therapeutic intervention. It measures participants' individual, interpersonal, social, and overall wellbeing. The ORS has been found in multiple studies to have strong internal consistency, high test-retest reliability, and moderate concurrent validity (Bringham, Watson, Miller, & Duncan, 2006; Miller, Duncan, Brown, Sparks, & Claud, 2003).

### **Procedure**

Participants were recruited through flyers advertising the workshop, as well as referrals from their healthcare providers. The flyers were posted and/or distributed via the offices of physical therapists, massage therapists, mental health professionals, chiropractors, emergency departments, and physicians. To be eligible, participants were identified patients with chronic pain, stemming from a variety of health concerns. The six-week workshop was offered on three occasions. One of the courses was five sessions rather than six, because the researcher and participants opted to combine the material for the final two sessions. The number of participants in the five-week variation was two, while there were two participants who fully completed the six-week variation as well as the pre- and post-test measures.

The weekly classes followed a protocol outline consisting of psychoeducation topics related to chronic pain management (see Appendix B). Each of the sessions was 90 minutes in length. In the first week, participants completed the demographic questionnaire, informed consent, and pre-test measures. Each session began with a relaxation exercise, participants completing the ORS measure, and discussing the previous week's homework. At the end of each

session, participants were assigned homework to complete before the next week. Refreshments were provided each session. Participants then completed the assessments a second time, in addition to the feedback form, in the final session. The final session also included awarding of certificates of completion and gift card incentives. Control group participants attended the first session to complete the pre-test measures, did not participate in following sessions, and returned the post-test measures via mail. Control group participants received a gift card as compensation after successful return of the measures. All of the collected data from both samples was de-identified and analyzed after the workshop concluded.

## **Chapter 3**

### **Results**

The original sample size consisted of 10 participants in the treatment group and nine in the control group. Six out of 10 participants completed pre- and post-test measures, which is a 40% attrition rate within the treatment sample. Two of nine control group participants completed pre- and post-test measures, which is a 78% attrition rate within the control sample. From the six treatment condition data sets, an additional two were removed due to an excess of missing data. Two of the treatment participants added a zero to the PBPI scale, so those measures were scored accordingly. Two participants remarked on the PDI pre- and post-test that item five (i.e., level of sexual disability) was not applicable, so those items were labeled as zeroes in the data set.

The aim of this study was to evaluate the effectiveness of a six-week patient psychoeducation workshop regarding the self-management of chronic pain. This was achieved by comparing assessment data from pre-test and post-test conditions, as well as treatment group against control group data. A series of paired-sample T-tests was used to determine whether there were any significant differences in these results.

#### **Hypothesis 1**

The first hypothesis of this study was that participants who complete the course would show improvement in their perception of pain, as indicated by changes on the PBPI and

HRQOL-4 results. Statistical analysis indicated no significant difference in this area on the PBPI when comparing pre-test to post-test scores (See Table 2 for details).

Table 2

*Treatment Group Descriptive Statistics and Analysis of Pre- and Post-Test Pain Belief and Perception Inventory (PBPI)*

Subconcept	N	Pre		Post		Paired Sample T-test				
		M	SD	M	SD	M	SD	df	T	p
Mystery	4	-1.87	0.68	-0.56	0.31	0.37	0.92	3	0.81	0.47
Pain Permanence	4	0.75	0.84	0.43	0.51	0.31	0.42	3	1.46	0.23
Pain constancy	4	0.5	0.7	-0.12	0.66	0.62	0.72	3	1.73	0.18
Self-blame	4	-0.5	1.22	-0.81	0.96	0.31	0.42	3	1.46	0.23

However, there were observable changes in the pre-test and post-test HRQOL-4 results. In the first week, one participant rated their health as “very good” (score of 2), one as “good” (3), and two as “fair” (4). Two participants reported experiencing 30 days of poor physical health out of the past 30 days. One reported 25 out of 30 days, and one reported 20 out of 30 days. One patient reported 30 days of poor mental health out of the past 30 days, another reported 20 days out of 30, another reported 2 days out of 30, and another did not respond to that question. Out of the past 30 days, the participants were kept from completing usual activities due to poor physical or mental health 30, 20, 1 and 0 days respectfully.

Post-intervention, three participants described their health as “good” (3) and one as “fair” (4). One participant reported experiencing 30 days of poor physical health out of the past 30, one reported 25 days, one reported 12 days, and the other reported 5 days out of 30. One patient reported experiencing 25 days of poor mental health out of 30, one reported 20 days out of 30, and the others reported six and zero days of poor mental health. They reported feeling unable to

complete their usual activities due to poor physical or mental health 15, 10, 2, and 1 days out of 30.

## Hypothesis 2

This hypothesis postulated that participants who completed the course would report having better coping skills to deal with pain, as indicated by the feedback form comments and the Pain Disability Index (PDI). Analysis indicated no statistically significant difference in this area when comparing pre-test PDI scores ( $M = 26, SD = 13.29$ ) to post-test scores ( $M = 26, SD = 11.43$ ),  $t(3) = .000, p < .1.0$  (See Table 3). However, the qualitative data of participant comments on the feedback form indicated that they learned new and helpful ways of living better with chronic pain. For example, participants noted that the workshop provided “good ideas on how to think more positively” and “suggestions for changing bad habits.” One participant stated, “I learned some stuff I hadn't heard before. Learning relaxation techniques will help me the best.”

Table 3

*Treatment Group Descriptive Statistics and Analysis of Pre- and Post-Test for Pain Disability Index (PDI) and Outcome Rating Scales (ORS)*

	N	Week One		Week Six		Paired Sample T-test				
		M	SD	M	SD	M	SD	df	T	p*
PDI total	4	26	13.3	26	11.43	0	10.29	3	1	0.47
ORS total	2	17.80	3.25	31.10	3.39	-13.30	0.14	1	-133.00	<b>.005</b>

Note. \*  $p < .05$ .

**Hypothesis 3**

The third hypothesis was that participants who completed the course would feel better prepared to communicate about their pain. The qualitative data of participant comments on the feedback form indicated that patients felt better able to communicate effectively with loved ones and medical providers after having attended the workshop. Specific comments regarding helpful aspects of the workshop included “being able to relate to others with pain,” “hearing about others' experience,” “changing the way to communicate,” and receiving “instruction on dealing with [the] medical field about chronic pain.”

**Hypothesis 4**

This hypothesis proposed that participants who completed the course would display a better sense of self-advocacy regarding pain control and living with pain, as well as a more proactive attitude. These were measured by the PBPI. A paired sample T-test revealed no statistical significant difference in these areas on the PBPI pre- and post-test. (See table 2).

**Hypothesis 5**

The fifth hypothesis was that participants who completed the course would indicate a higher sense of wellbeing, as indicated by results on the ORS. Because one course of the workshop ended a week early, there are only two complete participant data sets for comparing ORS scores from weeks one and six. A paired sample T-test revealed a statistically significant improvement in this area when comparing pre-treatment ( $M = 17.8, SD = 3.25$ ) and post-treatment ORS scores ( $M = 31.1, SD = 3.39$ );  $t(1) = -133.0, p < .005$ ; 95% CI [-14.57, -12.02]. (See Table 3). Cohen's effect size value ( $d = -4.00$ ) suggested high practical significance.

### Hypothesis 6

This hypothesis was that control group members would demonstrate little to no change in pre- and post-test results, as evidenced by each of the measures. Paired sample T-tests indicated no statistically significant changes in control group results on all measures given at the beginning and end of the treatment period. (See Table 2 for PBPI; table 5 for ORS and PDI).

### Hypothesis 7

The seventh hypothesis of this study predicted that control group members would report lower life satisfaction according to the ORS, more disability according to the PDI and HRQOL-4, and less proactive attitude regarding pain according to the PBPI. Statistical analysis reported no significant change in these results. (See Table 4 for PBPI; Table 5 for ORS and PDI).

Although there were not statistically significant differences, control group members did demonstrate worse outcomes on the PDI and ORS when comparing pre-tests and post-test scores.

Table 4

*Control Group Descriptive Statistics and Analysis of Pre- and Post-Test Pain Belief and Perception Inventory (PBPI)*

Subconcept	N	Pre		Post		Paired Sample T-test				
		M	SD	M	SD	M	SD	df	T	p
Mystery	2	1.37	0.17	0.75	1.76	0.62	1.94	1	0.45	0.72
Pain Permanence	2	1.12	0.17	0.62	0.88	0.50	1.06	1	0.66	0.62
Pain constancy	2	-0.27	1.44	-0.75	1.06	0.47	0.38	1	1.75	0.33
Self-blame	2	-0.25	1.76	-1.00	1.06	0.75	0.70	1	1.5	0.37

Table 5

*Control Group Descriptive Statistics and Analysis of Pre- and Post-Test for Pain Disability Index (PDI) and Outcome Rating Scales (ORS)*

	N	Week One		Week Six		Paired Sample T-test				
		M	SD	M	SD	M	SD	df	T	p*
PDI total	2	25.50	10.60	39.00	7.07	-13.50	3.53	1	-5.40	0.11
ORS total	2	21.45	17.60	21.40	21.07	0.05	3.46	1	0.02	<b>0.98</b>

Note. \* p<.05

For the control group's HRQOL-4 pre-test, one described his/her overall health as "good" (3) and one as "fair" (4). Their answers did not change from pre- to post-test. In pre-test, one control participant reported feeling poor physical health 4.5 days out of the past 30, poor mental health 2.5 days, and unable to complete his/her usual activities 3.5 out of 30. In post-test, he/she reported seven days out of 30 of poor physical health, one of poor mental health, and four days of being unable to complete duties. In the pre-test, the other control participant reported 30 days out of 30 of each poor physical health, poor mental health, and inability to complete usual activities. In post-test, this participant's responses were 15 days of poor physical health, 28 of poor mental health, and 30 days of being unable to complete tasks.

## **Chapter 4**

### **Discussion**

In this study, there was a statically significant improvement in reported wellbeing within the treatment group, as evidenced by the scores on the ORS. There was also a clinically relevant change in participants' reported ability to communicate effectively regarding their pain, which is important because of common complaints of individuals with chronic pain that they feel unsupported and misunderstood (see Bair et al., 2009; Health Talk Online & University of Oxford, 2012c; Kang, et al., 2013; Matthias, et al., 2010; Partners Against Pain, 2013; Rope, 2008). Moreover, there were observable changes in the control group- specifically an increased sense of pain disability and decreased sense of wellbeing. Although these results were not statistically significant, they are meaningful because they indicate that individuals with chronic pain may not improve or may deteriorate if not given adequate skills and support. No statistical significance was found for the hypotheses that participants who completed the course would show improvement in their perception of pain, report having better coping skills to deal with pain, feel better prepared to communicate about their pain, display a better sense of self-advocacy regarding pain control and living with pain, and exhibit a more proactive attitude. A likely explanation for the lack of statistical significance is the small sample size. Several participants reported improvements, but the data did not change enough for statistical significance. The positive effects of the intervention may have been more apparent with a larger sampling of data. The limited size of the sample is not unprecedented, as research has shown

that the attendance of chronic pain patients to these types of groups can be poor (e.g., De Góes Salvetti, et al., 2012).

Another possible explanation for the current study's limited significance is that the measures used were too low in specificity and/or sensitivity. Perhaps more robust measures would have led to better results. An additional reason could be that the workshop was not an effective intervention for improving the variables hypothesized. However, similar self-help models have shown to be effective for chronic pain patients (Haugli et al., 2003; LeFort, 2000; McBee et al., 2004; Nelson & Tucker, 2006). Lastly, the fact that the facilitator of the workshop was a doctoral student may have influenced patient participation and attrition. Most often, psychoeducation such as this study's group is often conducted by nurses (LeFort, Gray-Donald, Rowat, & Jeans, 1998), social workers (McBee et al., 2004), physical therapists, or psychologists (Gatchel & Mayer, 2008).

### **Barriers to Implementation**

Barriers to implementing the intervention were also present. Specifically, the researcher did not have access to as many referral sources as would have been preferred, nor to a large meeting space within a healthcare facility. The fact that patients had to commute to the class and the location was not a healthcare facility likely acted as deterrents to participation. The high attrition rate significantly altered the results as several of the participant response sets were excluded due to an excess of missing data. Many patients with chronic pain exhibit a resistance to alternative or non-pharmacological pain management interventions (Frey, 2008; Kerns & Rosenberg, 2000) likely due to the societal overreliance on opioid pain medications. A study by Vijayaraghavan et al. (2012) found that the majority of primary care providers (PCPs) prescribed

opioid analgesics for the treatment of chronic pain, but that they also described “low confidence and satisfaction levels in treating chronic pain” (p. 1141).

### **Limitations**

Limitations of this study include the small sample size, as noted above, which was largely due to attrition. In addition, all of the participants identified as white, or European-American, so generalizability to other ethnic groups is uncertain. For instance, in a study by Green et al. (2003), African-American chronic pain patients endorsed more frequent use of passive pain coping strategies and higher levels of hypervigilance. Examples of *passive pain coping* include abandoning social activities and being dependent upon medications to relieve pain (Tidy, 2014). Passive coping has been found to be disadvantageous and is linked to increases in pain, disability, and depression (Tidy, 2014).

The majority of the current study’s participants were in the middle-aged group, which may have affected results as well. Molton et al. (2008) found that older adults, ages 60 and up, were better at implementing pain management strategies, seeking social support, and using “coping self-statements” than younger or middle-aged individuals. Therefore, the age makeup of the current study may be seen as a limitation as well.

### **Future Applications**

The limitations and barriers affecting this study indicate important information for future pain management applications. Specifically, future group intervention attempts would do well to ensure large amounts of referral sources, including providers in various sectors of the medical and alternative pain management fields. Working with physicians to make a psychoeducation course such as this one a requirement of treatment would increase attendance as well. Requiring

the patients to pay a fee for the group intervention may increase buy-in and decrease attrition. Several participants suggested including more of a support group discussion time into each session as a means of improvement as well. Furthermore, a change in the overall length of the course may prove helpful. Reducing the workshop to a fewer amount of sessions would make it easier for patients to commit, but increasing the amount of sessions would allow for more time for participants to learn and practice the new habits. Making such changes would depend upon resources, interest, and setting. The current study can be viewed as a pilot study to assist in creating a larger, more robust, and more easily administered study. Future researchers will want to use measures that have been found to be more sensitive and specific to the variables and hypotheses.

### **Implications**

If the limitations of this study were negated, particularly attrition, this patient psychoeducation program would prove to be a highly valuable resource to the medical and psychological communities. One hypothesized method for increasing patient engagement and decreasing attrition would be to work with prescribers to make opioid prescription refills contingent upon group attendance. If self-help interventions such as this one were regularly implemented, they would reduce the burden on primary care providers and decrease financial costs on the system. It would be beneficial to the patient population in that they would learn improved coping, feel better educated about chronic pain, and improve their skills for managing pain via their thought and behavior patterns. They would also feel better prepared to communicate with loved ones and medical professionals about their experiences, and feel decreased need for expensive and time-consuming medical visits.

**Conclusion**

Chronic pain is a highly prevalent and expensive health issue that is overwhelming the primary care system. Therefore, there is a need for alternative means of patient care. Moreover, chronic pain causes not only physical ramifications in patients' lives, but psychological, social, and occupational consequences as well. Given the biopsychosocial effects of chronic pain, a multidisciplinary treatment approach would be the most applicable.

This study implemented a biopsychosocial group psychoeducation workshop to facilitate improved patient self-management of chronic pain. Assessment pre- and post-intervention revealed a statistically significant improvement in participants' reported wellbeing, as well as clinically noteworthy improvements in their abilities to communicate effectively about their pain. Furthermore, the control group revealed observable changes in an increased sense of pain disability and decreased sense of wellbeing over the same time period. Like similar programs, (e.g., LeFort et al., 1998), this psychoeducation course would prove to be a valuable addition to the medical community if the limitations of this study were eliminated, namely the small sample size and attrition rate. It would also help patients take a more active role in improving their health and functioning.

Due to the small sample size, however, the principle value of this study lies not in the statistical results of the measures but in the implications for program development. The experiences of the current researcher have shown what is and is not effective for recruiting, engaging, and helping patients with chronic pain. This data can prove extremely valuable to future developers so as to create a pain management program that will be a valuable contribution to the multidisciplinary treatment of this major health problem.

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**Appendix A**

**Measures**

**Demographic Questionnaire**

*Please check the answer that best applies or fill in the corresponding empty space with the most appropriate answer.*

1. What is your gender:

- Male
- Female

2. What is your date of birth: \_\_\_\_\_

3. What is your race/Ethnicity (please check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Black/African American  | <input type="checkbox"/> Native American/Alaska Native |
| <input type="checkbox"/> Hispanic/Latino(a)      | <input type="checkbox"/> European American/Caucasian   |
| <input type="checkbox"/> Asian American          | <input type="checkbox"/> Hawaiian/Pacific Islander     |
| <input type="checkbox"/> Other (please specify): |  |

4. What is your current marital status?

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Single, Never Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Married               | <input type="checkbox"/> Divorced  |
| <input type="checkbox"/> Living with a partner | <input type="checkbox"/> Widowed   |

5. What is your highest education level received?

- |   |   |
|---|---|
| <input type="checkbox"/> No high school diploma/GED     | <input type="checkbox"/> College degree       |
| <input type="checkbox"/> High school diploma/GED        | <input type="checkbox"/> Some graduate school |
| <input type="checkbox"/> Some college                   | <input type="checkbox"/> Graduate degree      |
| <input type="checkbox"/> Professional/vocational school |   |

6. What is your religious affiliation: \_\_\_\_\_

7. How important is your religion to you? (circle one)

- |                                   |   |          |   |   |
|-----------------------------------|---|----------|---|---|
| 1                                 | 2 | 3        | 4 | 5   |
| Not at all,<br>I have no religion |   | Somewhat |   | Extremely important,<br>it is center of my life |

8. How active are you in your faith community?

- Attend services/events 2+ days a week
- Attend services/events once a week
- Attend 1-2 services/events a month
- Attend 1-2 services/events a year
- Irregular or sporadic attendance
- No faith community involvement

9. What is your employment status?

- Full time
- Unemployed
- Retired
- Part time
- On disability

10. What is your estimated household income?

- Less than \$15,000/year
- Between \$15,000-\$30,000
- Between \$30,000-\$45,000
- Over \$45,000

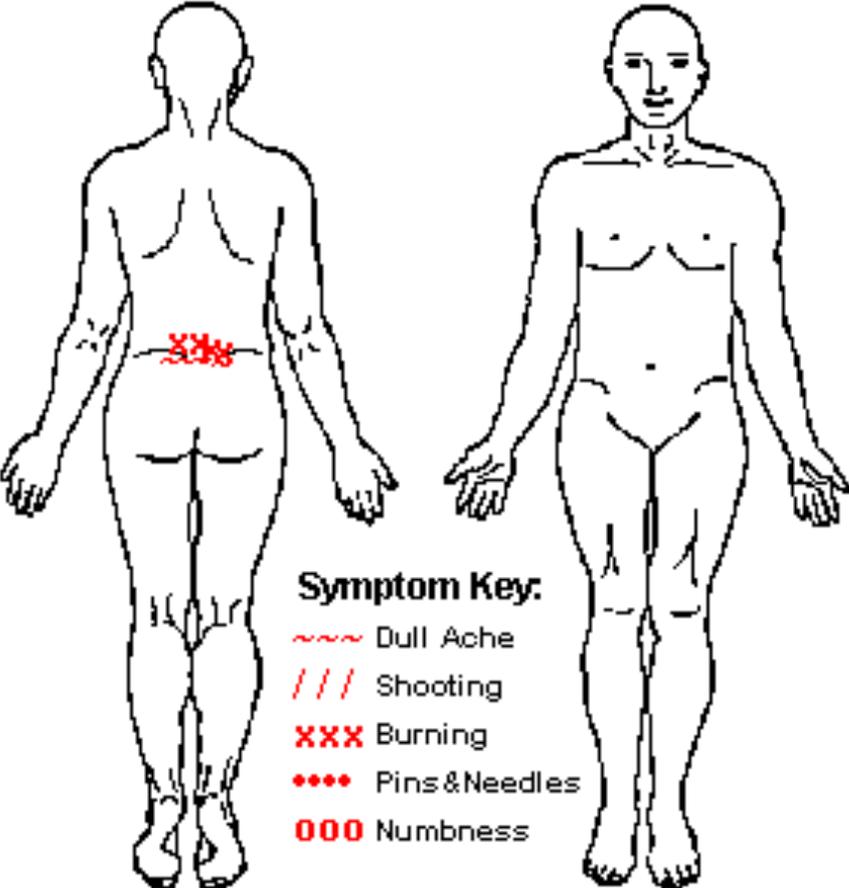
11. Do you currently have insurance?

- Yes
- No

12. Please indicate the identified cause of your chronic pain as well as the location and describe the sensation. You may use the drawing below if preferred.

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**The Healthy Days Questions (HRQOL-4)**

1. Would you say that in general your health is; Excellent, Very good, Good, Fair or Poor?

2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

**Outcome Rating Scale (ORS)**

Name _____
Date: _____

---

Looking back over the last week, including today, help me understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

---

**Individually**  
(Personal well-being)

I-----I

**Interpersonally**  
(Family, close relationships)

I-----I

**Socially**  
(Work, school, friendships)

I-----I

**Overall**  
(General sense of well-being)

I-----I

Institute for the Study of Therapeutic Change

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www.talkingcure.com

**Pain Beliefs And Perceptions Inventory**

Williams &amp; Thorn (1989)

*Please indicate the degree to which you agree or disagree with each of the following statements. Simply circle/highlight the number that corresponds with your level of agreement.*

<b>Statement</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
No one's been able to tell me exactly why I'm in pain.	-2	-1	1	2
I used to think my pain was curable but now I'm not so sure.	-2	-1	1	2
There are times when I am pain-free	-2	-1	1	2
My pain is confusing to me.	-2	-1	1	2
My pain is here to stay.	-2	-1	1	2
I am continuously in pain.	-2	-1	1	2
If I am in pain, it is my own fault	-2	-1	1	2
I don't know enough about my pain.	-2	-1	1	2
My pain is a temporary problem in my life.	-2	-1	1	2
It seems like I wake up with pain and I go to sleep with pain.	-2	-1	1	2
I am the cause of my pain.	-2	-1	1	2
There is a cure for my pain.	-2	-1	1	2
I blame myself if I am in pain.	-2	-1	1	2
I can't figure out why I'm in pain.	-2	-1	1	2
Someday I'll be 100% pain-free again.	-2	-1	1	2
My pain varies in intensity but is always with me.	-2	-1	1	2

**Pain Disability Index**

The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst. For each of the 7 categories of life activity listed, please *circle/highlight the number on the scale that describes the level of disability you typically experience*. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

**Family/Home Responsibilities:** This category refers to activities of the home or family. It includes chores or duties performed around the house (eg, yard work) and errands or favors for other family members (eg, driving the children to school).

(No disability) 0 1 2 3 4 5 6 7 8 9 10 (Worst disability)

**Recreation:** This category includes hobbies, sports, and other similar leisure time activities.

(No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability)

**Social Activity:** This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

(No disability) 0 1 2 3 4 5 6 7 8 9 10 (Worst disability)

**Occupation:** This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

(No disability) 0 1 2 3 4 5 6 7 8 9 10 (Worst disability)

**Sexual Behavior:** This category refers to the frequency and quality of one's sex life.

(No disability) 0 1 2 3 4 5 6 7 8 9 10 (Worst disability)

**Self-Care:** this category includes activities that involve personal maintenance and independent daily living (eg, taking a shower, driving, getting dressed, etc.)

(No disability) 0 1 2 3 4 5 6 7 8 9 10 (Worst disability)

**Life-Support Activity:** This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

(No disability) 0 1 2 3 4 5 6 7 8 9 10 (Worst disability)

**Appendix B**

**Protocol Document**

**A 6-week Protocol for Self-Management of Chronic  
Pain Group**

Tina Kang, MS, Serita Backstrand, MA, & Trinity Parker, MA  
March 2013

## Chronic Pain Group Protocol

### Week 1: PSYCHOEDUCATION

Welcome

Informed consent and pre-test measures

Overview of workshop: provide outline of 6 week program

Explain Role/Purpose of Relaxation

Begin with relaxation technique- Deep breathing exercise

What is Pain?

- Definitions and prevalence
- Origin of pain
- Overview different types of pain (acute, recurrent, chronic)
- Pain perception and pain pathways

Gate Control Theory

- Explain Gate Control Theory
- Provide demonstration of theory visually

Biopsychosocial Model

- Pain stress diathesis model
- Demonstrate Biopsychosocial model visually
- Influence of psychological and social aspects on pain management
- Revisit role of relaxation in pain management

Common Misconceptions about pain

- Present common misconceptions about pain
- Myths and facts about pain
- Group discussion about personal beliefs about pain

What do you want to learn about pain?

- Group discussion about personal interests or goals for class

Goals:

- Introduce significance of relaxation strategies
- Provide general information about pain: origins, influences, misconceptions, pain management options
- Open discussion of group members personal experiences and interests regarding pain management

Handouts:

- Relaxation
- Calming Technique
- Biopsychosocial model

Homework:

Practice deep breathing minimum 3x over the week

Complete personal Biopsychosocial handout

Week 2: COGNITIVE BEHAVIORAL THERAPY

Welcome – Have participants fill out ORS

Review Practice of deep breathing exercise

Begin with relaxation technique-Progressive Muscle Relaxation

Understanding how thoughts influence emotions/behavior

- Explain automatic thoughts and relationship to pain

Provide Cognitive Distortions handout

- Discuss what cognitive distortions are; providing example for each

Explain ABC Model

- Go through an example.
- Provide ABC Model handout

Provide homework and ask for any questions/comments

Goals:

- To understand how thoughts have a significant influence (positive or negative) on the experience of pain.
- To help identify *automatic thoughts* related to pain and how they may be related to misconceptions about pain.
- To recognize how thoughts may lead to emotions.
- To identify triggers.
- To recognize the use of cognitive errors and how its relationship to pain

Handouts:

ABC Model

Cognitive Distortions

Cognitive Distortions – list of 3 commonly used

Behavioral Goals sheet

Progressive Muscle Relaxation

Homework:

Use the ABC Model worksheet to identify reoccurring beliefs and consequences.

Minimum 3 examples.

Review the list of cognitive distortions and identify common errors. Minimum 3 examples.

Create 3 behavioral goals for the week.

### Week 3: COGNITIVE BEHAVIORAL THERAPY

Welcome- Have participants fill out ORS

Review use of Progressive Muscle Relaxation  
Begin with relaxation technique-Guided Imagery

Re-cap – cognitive distortions and ABC model

- Emotions and behaviors = result of thoughts
- Thoughts shape how we interpret and respond. Unfortunately, sometimes our thoughts are not helpful, as they contain distortions, errors, or biases.
- Discuss difficulties, challenges, etc. with hw from last week

Provide example of cognitive restricting

- “a therapeutic approach that teaches clients to question the automatic beliefs, assumptions, and predictions that often lead to negative emotions and to replace negative thinking with more realistic and positive beliefs”  
(<http://www.cram.com/flashcards/treatment-of-psychological-disorder-2967922>)

Transformation of thoughts: negative to positive

Introduce concept behind cognitive restructuring

- Cognitive restructuring is a technique for increasing awareness of our thoughts and modifying those that are distorted or not useful.
- This is not distorting reality or attempting to believe the unbelievable. “Rather, it uses reason and evidence to replace distorted thought patterns with more accurate, believable, and functional ones” (Binggeli, 2010) <http://www.nelsonbinggeli.net/NB/CBT-CR.html>
- Cognitive Restructuring: “a process of evaluating cognitions systematically, determining their accuracy, and changing those that are unrealistic or inaccurate.”  
(<http://quizlet.com/19945715/cognitive-behavioral-approach-family-therapy-flash-cards/>)
- Example
- Handout

Coping Thoughts specific to pain

- Coping Statements Handout
- Coping cards (<http://www.health.com/health/condition-article/0,,20189554,00.html>)
  - Write negative thought on one side of a card and rational comeback to that thought on other side.
  - When a destructive thought comes, look at card and repeat the coping statement to self
  - “Just having the card in their wallet makes them more aware of their tendency to think that way, and it helps them to know they have an option, a different way to think about the situation.”

Goals:

- To reinforce cognitive restructuring and practice
- To understand and learn positive coping statements

Handouts:

Cognitive Restructuring  
Coping Statements  
Behavioral Goals sheet

Homework:

Use the cognitive restructuring worksheet to work through changing cognitions.  
Minimum 3 examples.  
Create 3 behavioral goals for the week.

Week 4: SLEEP & SUBSTANCE ABUSE

Welcome –participants fill out ORS

Review use of Guided Imagery

Determine participants' favorite relaxation method

Begin with relaxation technique-Participants choose

Cycle of insomnia & pain

Explanation of how pain can cause difficulty falling and staying asleep

Sleep hygiene

Psychological approaches for insomnia

Break

General Medication Information

- Role of medication in management of pain
- Benefits and concerns about medication
- What medication cannot do

Substance abuse

- Provide different terms used by professionals to discuss substance abuse
- General review of interaction between substance use and pain
- Why is past or current substance abuse a concern?
- Discussion of alcohol use and pain management

Goals:

- To understand interaction between sleep problems and pain
- To help identify tips for improving sleep quality and quantity
- To recognize how medication may play a role in sleep
- Increase understanding of substances and pain management
- Discuss available resources

Handouts:

Relaxation/deep breathing tips  
Sleep hygiene

Homework:

Practice relaxation and sleep hygiene for the week and monitor any changes in sleep quantity/quality

Week 5: COMMUNICATION

“Communicating about chronic pain often adds distress on top of living with pain”

Welcome – participants fill out ORS

Begin with relaxation technique-participants choose

Coping with a lack of support & communicating with loved ones

- Share your knowledge
  - Bring person along to your doctor
  - Plan & write a list of questions together for the doctor
- Expand your support system, don't always take your problems to the same friends
  - Include support groups and online forums
  - However, don't be afraid to leave if a group is not a good fit.
    - Let people say "no"
  - Be willing to ask for help when you need it, but you also need to be alright with loved ones saying "no" sometimes
  - If someone feels unable to say no, an unhealthy, codependent relationship may form. This could result in burnout in even your strongest supporter persons
    - Consider therapy
  - For yourself
  - Family therapy or couples counseling
    - Educate the people around you
  - Help people understand what is happening in your body and why it's making you miserable
    - Sharpen your own coping skills
  - In addition to support, work to develop tools for managing and coping with pain
  - Ask others what works for them
  - Distract yourself with a hobby
- Get yourself a collaborative team
  - Include your doctor and/or nurse practitioner, a social worker, a psychologist, a dietitian
  - If you need more assistance with a chronic illness, a patient-centered medical home may be a good option
    - Join in when you can
  - When you feel up to it, make time for fun loved ones- even if it is only for a short time or a simple activity
  - Do what you can, rest when you need to

- Let others know your limitations, but also that they do not have to postpone their activity for you. Tell them you will join them for what you feel you can handle.
  - Think of "no" as an opportunity
- No one person will be able to be there for you all of the time.
- Think of it as an opportunity to learn other ways to get help, or to help yourself. Re-explore what you can do, you might be pleasantly surprised
  - Find a new doc, if necessary
- It is unacceptable if your doctor is not helpful or supportive as much as possible
- If you're not happy, ask around for recommendations of a new doctor

## Break

### Communicating with your doctor

- Doctor's perspective
  - Concerned about helping you return to a high level of functioning
  - May need to pass over emotions in order to treat pain
  - Required to follow certain protocols in treating chronic pain
- Follow your doctor's treatment plan. If you disagree with a treatment plan - communicate this to your doctor right away. They don't know if you don't tell them.
- Be consistent, open, honest, specific & prepared
- Keep the emotional complaining to a minimum; instead, focus on solutions.
- Keep your doctor updated
- Strengthen your relationship with your doctor
  - Think about your own pain management goals.
  - Clear and realistic (work towards smaller goals to get to the big ones to avoid setbacks)
- Confronting your Doctor:
  - Try not to be hostile
  - If you have a treatment idea in mind, present it. Bring research and experiences to support your reasoning.
    - If your doctor implies that there is nothing more to do- don't give up!
  - Ask why
  - Remind him/her of your specific symptoms and issues (bring a list to each appointment)
  - Ask for a referral to a pain clinic/communicate that you believe it is time to go a different way with your treatment.
  - Always leave the door open to come back
    - It never hurts to say thank you or ask how your doctor's is doing either

Goals:

- Easier and more productive communication with medical providers
- Understanding dynamics of relationships when dealing with chronic pain
- Tips for advocating for yourself while still improving relationships with loved ones
- Increased sense of support

Handouts:

- The 5 Secrets of Effective Communication
- Communication Skills
- Criticism, Contempt, etc.
- Communication Roadblocks
- Identifying Communication Roadblocks
- Feedback Model

Homework:

Review and complete worksheets

Week 6: REVIEW AND CONCLUSION

Welcome – Have participants fill out post-test measures and feedback form

Begin with relaxation technique of participants choice

Discuss homework and last week's goals

Open discussion about the workshop

Address any questions or topics raised by participants

Celebration and presentation of certificates & resources

Conclusion

**Appendix C**

Curriculum Vitae

**SERITA C. BACKSTRAND**  
**sbackstrand10@georgefox.edu**

**EDUCATION**

**GEORGE FOX UNIVERSITY**

SEPTEMBER 2010-PRESENT

APA Accredited Doctor of Clinical Psychology Program;  
Newberg, OR

MA in Clinical Psychology obtained June 2012

Doctorate expected September 2015

DISSERTATION: Learning to Combat Chronic Pain: Exploring  
the Effectiveness of a Six-week Patient Psychoeducation  
Course Teaching Self-management of Chronic Pain

**OREGON STATE UNIVERSITY**

SEPTEMBER 2006 – JUNE 2010

Honors Baccalaureate of Arts, Psychology; Corvallis, OR  
Minor in Spanish Language & Culture  
Cum Laude

**CLINICAL EXPERIENCE**

**WESTERN PSYCHOLOGICAL & COUNSELING SERVICES, PC**

**Clinical Psychology Intern**

SEPTEMBER 2014- PRESENT

Setting: Community Mental Health; Portland, OR

Supervisor: Joni Moon, PsyD

- Conducting individual therapy with Medicaid population (child through adult)
- Leading skills-based group therapy
- Wrote comprehensive diagnostic assessments and treatment plans
- Administrative and case management duties
- Weekly individual supervision and group professional development

**NW FAMILY PSYCHOLOGY**

**Independent Consultant & Evaluator**

MAY 2014- SEPTEMBER 2014

Setting: Forensic Private Practice; Vancouver, WA

Supervisor: Nicole Zenger, PhD.

- Conducted neuropsychological assessments related to parental fitness and social security disability
- Wrote comprehensive integrated reports

**NW FAMILY PSYCHOLOGY**

OCTOBER 2013- MAY 2014

**Practicum Clinician & Evaluator**

Setting: Forensic Private Practice; Vancouver, WA

Supervisor: Landon Poppleton, PhD.

- Conducted psychological assessments related to the forensic setting, including parental fitness, dependency, custody battles, and diminished capacity of alleged offenders.
- Wrote comprehensive integrated reports
- Weekly group and individual supervision

**NEW HORIZONS WELLNESS SERVICES, LLC**

SEPTEMBER 2013-PRESENT

**Practicum Clinician & Evaluator**

Setting: Private Practice; Beaverton, OR

Supervisor: Patrick Ethel-King, PhD

- Performed comprehensive psychological assessments and psychodiagnostic evaluations
- Conducted intake interviews
- Wrote comprehensive reports
- Referral questions include learning disability, ADHD, adoption and forensic assessment
- Weekly individual supervision

**GEORGE FOX BEHAVIORAL HEALTH CLINIC**

SEPTEMBER 2012- AUGUST  
2013

**Practicum Therapist**

Setting: Community Mental Health; Newberg, OR

Supervisor: Joel Gregor, PsyD

- Provided individual and family therapy to uninsured and underinsured clients, ranging from children to elderly
- Short term, solution-focused therapy
- Long term therapy with Axis II client
- Conducted psychological assessments, wrote comprehensive reports, and provided feedback to clients
- Co-led a parenting skills class
- Administrative and case management duties, such as scheduling and client referrals
- Weekly group and individual supervision
- Biweekly didactic training in assessments or therapy approaches

**NORTH CLACKAMAS SCHOOL DISTRICT**

SEPTEMBER 2011-JUNE 2012

**Practicum Therapist**

Setting: Alder Creek Middle School; Milwaukie, OR

Supervisors: Patrick Joyce, Ed.S. & Fiorella Kassab, PhD

- Provided individual therapy to middle school students who qualified for special education services due to ADHD, emotional disturbances, and/or autism spectrum disorders
- Lead social skills and process groups for special education students
- Utilized research and workbooks to develop social skills curriculum to cater to each student's needs (i.e., "How to deal with bullies")
- Coordinated case load of over 20 students, working within system of teachers and parents
- Documented progress in detailed notes each trimester to be included in the students' Individualized Education Plans (IEPs)
- Conducted cognitive, achievement, and developmental assessments as needed
- Weekly group and individual supervision

**GEORGE FOX UNIVERSITY**

FEBRUARY 2010 – MAY 2010

**Pre-Practicum Therapist**

Setting: University Student Health & Counseling Center;  
Newberg, OR

Supervisors: Mary Peterson, PhD and Ryan Stayley, MA

- Provided psychotherapy for two undergraduate students on a weekly basis
- Conducted clinical interviews, treatment planning, therapeutic interventions, and termination
- Wrote formal psychological reports and weekly progress notes
- Received group and individual supervision/consultation with videotape review and peer case presentations each week

**JACKSON STREET YOUTH SHELTER, INC.**

JANUARY 2010-MARCH 2010

**Intern Caseworker**

Setting: Jackson Street Youth Shelter; Corvallis, OR

Supervisor: Kendra Sue Phillips-Neal

- Arranged emergency shelter for homeless youth age 10-17
- Gained exposure to individuals with varying psychopathologies, including bi-polar, borderline, and conduct disorders
- Provided support and supervision to shelter residents
- Facilitated activities for youth, including art therapy, music lessons, and recreational exercise
- Recorded daily progress notes about each resident

- Assisted in student development activities such as independent living skills workshops, and tutoring

**TEACHING EXPERIENCE**

**GEORGE FOX UNIVERSITY**

MAY 2013

**Teaching Assistant- Multicultural Therapy Class (PsyD 541)**

- Created quizzes
- Graded exams and assignments
- Attended each class to facilitate discussions
- Assisted in planning class activities and excursions
- Provided extra help to students as needed

**RESEARCH EXPERIENCE**

**GEORGE FOX UNIVERSITY**

**Dissertation Research**

JUNE 2013-APRIL 2015

Advisor: Winston Seegobin, PsyD

- Conducted literature review for dissertation on self-management of chronic pain;
- Conducted patient psychoeducation groups on living with chronic pain
- Collected data on the patients' perception of pain, quality of life, and level of disability before and after the course
- Compared pre- and post-workshop patient data to determine the helpfulness of the psychoeducation course
- Pilot study listed below

**Research Assistant**

OCTOBER 2013

Supervisors: Heather Deming, M.A.

- Administration and scoring of the WRAML-2, a standardized cognitive measure, to adult volunteers as part of data collection for a dissertation assessing the memory implications associated with mild to moderate hearing loss.

**Program Development/Consultation**

MAY 2013-APRIL 2013

Supervisor: Marie-Christine Goodworth, PhD

- Co-created and led a 6-week workshop teaching patients skills for the self-management of chronic pain, as a consultant with Providence Health & Services and the George Fox Behavioral Health Clinic

**Supplemental Research with Research Vertical Team (RVT)**

Advisor: Winston Seegobin, PsyD

- Analyzing survey data regarding students perceptions of multicultural awareness and support within George Fox University JANUARY 2013- AUGUST 2013
- Analyzing data regarding PsyD student community service as integration JANUARY 2013- JULY 2013
- Evaluating the supervision courses of graduate psychology programs across the country SEPT 2011-AUGUST 2012

### OREGON STATE UNIVERSITY

#### Honors Thesis Project

JUNE 2009- MAY 2010

Advisor: Katherine MacTavish, PhD

- Explored qualitative archival data, collected from in-depth interviews, to investigate causes of frequent housing relocation in low-income children
- Organized findings in order to suggest ways to reduce residential mobility for the benefit of the children
- Completed a thesis document, poster and defense presentation

### PUBLICATIONS/PRESENTATIONS

- Backstrand, S.,** Holt, J., Theye, A., Nelson, A. Seegobin, W., & Perez, J. (July 2013). *Ethnic/Racial Diversity in Graduate Programs at a Christian University*. Poster presented at the annual conference of the American Psychological Association, Honolulu, HI. JULY 2013
- Kang, T., **Backstrand, S.,** & Parker, T. (May 2013). A 6-week pilot study evaluating the effectiveness of providing self-management skills for patients with chronic pain. Poster presented at the annual conference of the Oregon Psychological Association, Eugene, OR. MAY 2013
- Seegobin, W., Holt, J., Theye, A., Gleave, D., & **Backstrand, S.** (April 2013). *Teaching integration as service: A model for psychologists*. Symposium presented at the annual conference of the Christian Association for Psychological Studies, Portland, OR. APRIL 2013
- Backstrand, S.** (February 2013). *The New York Secure Ammunition and Firearms Enforcement (NY SAFE) Act & implications for mental health duty to warn*. Community outreach presentation for local chapter of National Alliance on Mental Illness (NAMI), Newberg, OR. FEBRUARY 2013

Bufford, R. K., Seegobin, W., Taloyo, C., **Backstrand, S.**, Gleave, D., & Lee, J. (August 2012). *Training in supervision*. Poster presented at the annual conference of the American Psychological Association, Orlando, FL. AUGUST 2012

**Holte, S.** (2010). *Residential mobility push/pull factors & the implications of high levels of mobility on child development*. University Honors College thesis document, poster, and defense. Oregon State University, Corvallis, OR JUNE 2010

**VOLUNTEER EXPERIENCE**

**GEORGE FOX UNIVERSITY**

SEPTEMBER 2012 & 2013

**NEWBERG/MCMINNVILLE, OR**

**University Serve Day**

- Worked on a team serving Juliette's House, an organization dedicated to the prevention, assessment, and support of children and families who may have been impacted by child abuse.
- Tasks included interior cleaning as well as yard maintenance

**MENORES EN SITUACIÓN EXTRAORDINARIA (MESE)**

MARCH 2010

**MORELIA, MICHOACÁN, MÉXICO**

**Service-Learning Experience through Oregon State University Honors College**

- Served with MESE organization to provide underprivileged children with an education, food, blankets, and household needs, in order to protect them from the need to work in the streets
- Personally distributed boxes of food and blankets
- Assisted teachers in the children's English language and art classes

**BIRTHRIGHT  
MEDFORD, OR**

- Organizing and distributing baby supplies to mothers in need

JUNE 2006

**EAGLE POINT COMMUNITY BIBLE CHURCH YOUTH GROUP  
EAGLE POINT, OR**

SEPTEMBER 2002-JUNE 2006

- Assembled and delivered Christmas, Thanksgiving, and Get Well food/gift baskets to families in need and patients of a children's hospital
- Fundraised for World Vision to end child hunger

**AFFILIATIONS/MEMBERSHIPS**

**GEORGE FOX UNIVERSITY**

**Oversight Supervisor of second year student**

SEPTEMBER 2013- JUNE 2014

**Multicultural Committee Member**

FEBRUARY 2012-JUNE 2014

- Position on Training & Awareness subcommittee

**Peer Mentor**

AUGUST 2011-JUNE 2014

**AMERICAN PSYCHOLOGICAL ASSOCIATION**

**Graduate Student Member**

2010-PRESENT

**THE NATIONAL HONOR SOCIETY IN PSYCHOLOGY (Psi  
CHI)**

2009-PRESENT

**HONORS & AWARDS**

**OREGON STATE UNIVERSITY**

Cum Laude

JUNE 2010

Foreign Languages & Literature Academic Excellence Award

JUNE 2010

University Honors College

NOVEMBER 2007-JUNE 2010

Diversity Achievement Scholarship

SEPTEMBER 2006-JUNE 2010

**PROFESSIONAL DEVELOPMENT****COLLOQUIA/GRAND ROUNDS/CONTINUING EDUCATION SEMINARS:****Measuring Success: Treatment Planning**

Julie Keanaaina, LCSW

APRIL 2015

**Forensic Neuropsychology: Essential Information to Know Before  
Embarking on a Path Less (but Increasingly) Traveled**

Chriscelyn Tussey, PsyD, ABPP

MARCH 2015

**Suicide Assessment & Intervention**

Julie Keanaaina, LCSW

FEBRUARY 2015

**Demystifying the DSM-5 for Your EPPP Preparation**

Presenter: Taylor Study Method, LLC

JUNE 2014

**Evidenced Based Treatments for PTSD in Veteran Populations:  
Clinical & Integrative Perspectives**

Presenter: David Beil-Adaskin, PsyD

MARCH 2014

**DSM 5, Essential Changes in Form and Function**

Presenters: Mary Peterson, PhD, ABPP &amp; Jeri Turgesen, PsyD

JANUARY 2014

**Primary Care Behavioral Health**

Presenters: Brian Sandoval, PsyD, &amp; Juliette Cutts, PsyD.

SEPTEMBER 2013

**Using Tests of Effort in a Psychological Assessment**

Presenter: Paul Green, PhD

MAY 2013

**Assessing Mild Cognitive Impairment & Dementia**

Presenter: Mark Bondi, PhD, ABPP

MAY 2013

**Video Games & Internet Use: Where is the Balance?**

Presenter: Jessica Cornwell, PsyD

Presented at the Oregon Psychological Association annual conference

MAY 2013

**Detecting Deception in Psychological Evaluations**

Presenter: Shawn Johnston, PhD

Presented at the Oregon Psychological Association annual conference

MAY 2013

**Redesigning Primary Care: The Mental Health Clinic of the Future**

Presenters: Benjamin Miller, PsyD &amp; Robin Henderson, PsyD

Presented at the Oregon Psychological Association annual conference

MAY 2013

**Toward a New View of Intergenerational Trauma**

MARCH 2013

Presenter: Eduardo Duran, Ph.D.

**African American History, Culture, Addictions & Mental Health**

JANUARY 2013

Presenters: Marcus Sharpe, PsyD & Dannette Haynes, LCSW

**Sexual Identity**

NOVEMBER 2012

Presenter: Erica Tan, PsyD

**Treating Gender Variant Clients: Christian Integration**

OCTOBER 2012

Presenter: Erica Tan, PsyD

**The Mini-Mental Status Exam- 2<sup>nd</sup> Edition**

JUNE 2012

Presenter: Joel Gregor, PsyD

**Assessment & Treatment of Bullying & Other Anger Disorders in Children & Adults**

JUNE 2012

Presenter: Raymond DiGiuseppe, PhD, D.Sc., ABPP

**Thoughtful Psychopharmacology**

FEBRUARY 2012

Presenter: Michael Tso, M.D.

**Cross-Cultural Psychological Assessment**

NOVEMBER 2011

Presenter: Tedd Judd, Ph.D., ABPP-CN

**Motivational Interviewing**

OCTOBER 2011

Presenter: Michael Fulop, PsyD.

**Assessment of ADHD in Children & Adults**

JUNE 2011

Presenter: Steve Hughes, PhD, ABPdN

**Challenges & Opportunities in Child Custody: Assessment & Guidelines for Interviewing Children**

MARCH 2011

Presenters: Wendy Bourg-Ransford, PhD & Todd Ransford, PhD

**Best Practices for Treatment When Working with Lesbian, Gay, Bisexual, & Transgendered Populations**

FEBRUARY 2011

Presenter: Jennifer Bearse, M.A.

**CLINICAL INTERVENTION, ASSESSMENT & SUPERVISION HOURS**

**PROJECTED TOTALS AT  
END OF YEAR**

**CURRENT TOTALS**

Clinical Intervention Hours: 965

Assessment Hours: 50

Supervision Hours: 440

1500

55

500

**REFERENCES**

**DR. WINSTON SEEOBIN, PSYD**

Director of Diversity- GFU Graduate Dept. of Clinical Psychology  
Licensed Psychologist  
Newberg, OR (503) 554-2381

**DR. JOEL GREGOR, PSYD**

Director of GFU Behavioral Health Clinic  
Licensed Psychologist  
Newberg, OR (503)-554-2368

**MR. PATRICK JOYCE, ED.S.**

School Psychologist  
Portland, OR (503) 896-0968

**DR. MARY PETERSON, PHD, ABPP**

Director of Graduate Dept. of Clinical Psychology & Licensed Psychologist  
Newberg, OR (503) 554-2763