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Experience of Loss and Resilience in Persons with Chronic Pain

Lauren Abshire

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Experience of Loss and Resilience in Persons with Chronic Pain

by

Lauren Abshire

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Lauren Abshire, M.A.

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Approval Page

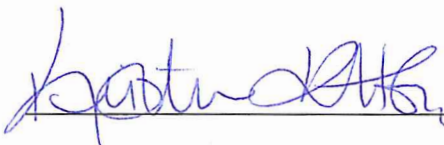
Signatures:



Marie-Christine Goodworth, Ph.D., Chair



Mary Peterson, Ph.D., ABPP, Member



Kristie Knows His Gun, Psy.D., ABPP, Member

Date: 4.28.21

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Lauren Abshire

Graduate School of Clinical Psychology

George Fox University

Newberg, OR

Abstract

Chronic pain is one of the most common concerns people seek medical treatment for, yet it is historically difficult to treat. The current best evidence practice in chronic pain treatment is through a multidisciplinary team with psychologists implementing cognitive behavioral therapy or acceptance commitment therapy. These approaches are efficacious in decreasing pain-related behaviors and improving mood and quality of life. Resilience has also been shown to mitigate the impact of chronic pain. However, the sense of loss or grief related to the experience of chronic pain has been inadequately explored in the research literature and may be related to poor treatment outcomes and lower levels of resilience. This study aims to understand pain-related loss or grief and its relationship to resilience and pain interference in individuals with chronic pain. A two-sample unpaired *t*-test and correlations were utilized to analyze the data. Results indicate that individuals with chronic pain are experiencing grief to similar degrees as individuals following the loss of a loved one ($t = .539; p = .589$). There is a significant negative relationship between pain related grief and pain resilience ($r(93) = -.48, p < .001$). Additionally, the level of pain interference in a person's life is more indicative of grief ($r(93) = .552, p < .001$) than it is to pain resiliency ($r(93) = -.203, p < .05$), suggesting that an individual may have

greater pain interference yet have high levels of resiliency. Implications include that individuals with chronic pain experience grief related to loss that is comparable to bereaved individuals and this suggests that pain related grief should be included in conceptualization and treatment of people with chronic pain. Pain resiliency may be a protective factor for this grief that could be utilized to mitigate negative psychosocial stressors related to grief.

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Chapter 1

Introduction

Living with chronic pain impacts a person's entire being and adapting to life with pain may be accompanied by a grief process. Pain is historically one of the most common reasons people seek medical treatment, and physiological etiologies are often unknown when struggling with chronic pain (Meldrum, 2003). For hundreds of years, humans sought to understand and heal pain, and yet, the medical system still struggles today to adequately treat the affliction of chronic pain (Meldrum, 2003). While the understanding and treatment continues to progress, the area of perceived losses related to chronic pain as well as resiliency factors that improve quality of life for these individuals needs to develop further.

The International Association for the Study of Pain in 2020 redefined pain as “an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage” (Raja et al., 2020, p. 2). This new definition expands the experience of pain to make space for individuals who are experiencing pain with or without real or perceived tissue damage. This important delineation is inclusive to the individuals who experience chronic pain without a known etiology founded in tissue damage. Chronic pain is further clarified as pain persisting longer than the typical healing time, which is often considered as more than three months (Treede et al., 2015). In 2016, approximately 20% of the U.S. adult population had chronic pain, and 8% of U.S. adults had high-impact chronic pain, or pain that significantly interfered with daily life (Dahlhamer et al., 2018). The annual national cost of

chronic pain management is estimated to be as high as \$635 billion, which is higher than the annual cost of cancer, heart disease, or diabetes (Gaskin & Richard, 2012). The rising costs and significant prevalence of chronic pain continue to challenge the medical system. Understanding effective treatment for chronic pain remains relevant.

Chronic Pain Treatment History

For years, medical providers were trained that opiates could help reduce and treat pain and in the 1990s they were commonly prescribed as the primary treatment (Ellis et al., 2018). While the “opiate epidemic” in the U.S. might feel like a recent discovery as media coverage grows, the health concerns and addiction potential of opiates is not a revolutionary concept. Physicians in the 1870s were concerned about the “morphine habit” they observed causing iatrogenic addiction at alarming rates (Meldrum, 2003). Those concerns built the foundation for the Harrison Narcotic Control Act in 1914 to begin regulating the availability of opiates and other narcotic drugs (Meldrum, 2003). As opiates were less available and required a prescription, the pressure was placed on physicians to relieve patient’s pain, while managing their own anxieties about the often-slippery slope of prescribing pain pills.

In 2016, the Centers for Disease Control (CDC) published guidelines recommending that for pain outside of active cancer patients, palliative care, and end-of-life care; providers should be implementing nonpharmacological therapy and nonopioid pharmacological therapy and that opioids should only be continued or initiated if the anticipated benefits for pain and function outweigh the risks (Dowell et al., 2016). With this new guideline, many physicians stopped prescribing opioids to many of their long term opioid chronic pain patients without a readily available treatment to substitute for pain management.

Before the 1960s, chronic pain was predominately considered a biological problem, but by the late 1960s, it was clear that psychosocial factors play a role in chronic pain as well, which is when psychologists began researching and treating these individuals (Jensen & Turk, 2014). Basic CBT as a treatment for pain management initially seemed to be missing some of the important components of pain. While it emphasized cognitive restructuring, relaxation training, mood regulation, problem solving, sleep hygiene, exercise, and goal setting; it seemed to lack specificity to pain. Traditional CBT was then adapted and modified for pain, creating pain-CBT, which is now the gold standard in pain management and is backed by three decades of research (Darnall, 2019; Murphey et al., n.d.). Pain-CBT now implements pain specificity to the previously mentioned interventions and added foundational pain education, validation that the pain is real, activity pacing, pain catastrophizing, and pain beliefs (Darnall, 2019). Studies demonstrate that pain-CBT can increase the volume in the regions of the brain associated with pain processing (Darnall, 2019). Cosio's study on veterans indicated that acceptance commitment therapy (ACT) for pain is as effective in reducing pain intensity and pain distress as CBT (Cosio, 2016). CBT and ACT are both effective in reducing catastrophizing behaviors, distress, and illness-focused coping strategies that often reduce mobility in individuals with chronic pain (Cosio, 2016). Many of these treatments emphasize training the brain to relax the body while restructuring the way individuals think about, and relate to, their experience of chronic pain.

Part of the goal of many of these CBT and ACT based therapies is to reduce the level of pain interference in an individual's life. Pain interference is the degree to which chronic pain impacts or inhibits an individual's ability to complete tasks of daily living (Miettinen et al., 2019). The brief pain inventory, which is the most commonly utilized pain measure, identified

two main components of interference consisting of activity and affective interference (Miettinen, et al., 2019). One clinical study found a significant correlation between anxiety and depression in individuals who reported a greater degree of pain interference than individuals who reported lower degrees of pain interference (Arola et al., 2010). This finding suggests there is a relationship between pain interference and affect.

While these methods of managing pain from a cognitive-behavioral or acceptance-commitment approach are helpful in reducing unhelpful pain-related thought patterns and behaviors, these interventions tend to miss out on addressing the impact of grief from the losses associated with having one's life altered by chronic pain. Without providing space for grief work, pain-CBT or ACT for pain may unintentionally invalidate the often-emotional grief process of living with chronic pain.

Pain-Related Grief or Loss

Loss and grief have been used interchangeably in the literature; the following studies have focused on loss. Walker et al. (2005), sought to understand the experience of those with chronic back pain through a qualitative study of individuals with back pain at a pain clinic and found that loss was one of the five major themes to occur. They defined the concept of loss as life events or changes that resulted in feeling deprived of something of value (Walker et al., 2005). Losses described by their participants included those related to loss of abilities and roles, employment, finances, relationships, identity, and hope. They suggested that pain-related loss was an area that warranted further study and may need to be included in therapeutic interventions for better outcomes (Walker et al., 2005).

Grief has been described as “anguish experienced after significant loss” which often results in symptoms such as anxiety, confusion, physiological distress, yearning, obsessive

dwelling on the past, and apprehension about the future (VandenBos & American Psychological Association, 2007). Elizabeth Kübler-Ross developed the five stages of grief to help clarify the typical symptoms she found in individuals experiencing grief including, denial, anger, bargaining, depression, and acceptance (Kübler-Ross, 1970). While others have since added onto or adjusted these five stages, they are still considered the core symptoms expressed in grief or loss. Living with chronic pain is also an experience of loss for individuals as they adapt to life with pain. While limited research has been completed in the realm of chronic pain and loss, several clinical groups have started to incorporate grief work in their chronic pain groups such as the VA in Southern Arizona (Southern Arizona VA, 2020).

Individuals with chronic pain all have different types of losses such as those mentioned above. Some of the common statements made by individuals with chronic pain include: “pain is like a bereavement... it’s taken over my life,” “we planned so much the things we wanted to do... but we can’t now,” and “I can’t do anything” (Walker et al., 2005, p. 204). These phrases are often said in context of sharing how they can no longer work or no longer be the person they wanted to be for their family (Walker et al., 2005). The emotional content behind these comments is one of sorrow and shame as they experience what some researchers refer to as secondary loss (Gatchel et al., 2002). While chronic pain may be considered the primary trauma or negative stressor, the impact of pain creates ripple effects of secondary loss for the individual to cope with and adapt to (Gatchel et al., 2002). It is no longer just the chronic pain a person is trying to adapt to; they now have to adapt to all of the things the pain changed or took away from them, including hopes and visions for the future (Gatchel et al., 2002).

A component of what makes grief or loss associated with chronic pain so painful, might be the disenfranchisement of grief that they experience. Disenfranchised grief occurs when an

individual's right to grieve is not provided or is interfered with in some capacity (Attig, 2004). This often occurs in contexts in which others don't believe a griever should be grieving or that others think it might be inappropriate for them to be grieving (Attig, 2004). A failure to be empathic toward a person grieving might be stepping blocks to begin feeling sentiments of disenfranchised grief (Attig, 2004). It can occur in the context of chronic pain when individuals are not feeling well supported or are feeling isolated by their pain (Curtis & Pirie, 2018). It is both important, and exhausting, to educate loved ones on the impact chronic pain has in a person's life and the losses it has caused, so that they may understand and allow space for the grief (Curtis & Pirie, 2018). This might be indicative of how positive social support and feeling understood in the context of one's experience of chronic pain may be a protective factor in feelings of grief or disenfranchised grief.

Although grief related to chronic pain lacks much research, grief in other chronic ailments has been studied, including a population with chronic obstructive pulmonary disease (COPD). One study found that individuals with COPD endorsed components of grief including denial, resistance, acceptance, and sorrow (Boer, et al., 2013). They further discussed the potential that other chronic ailments, including chronic pain, may also experience similar grief factors that may help guide treatment planning and outcomes (Boer, et al. 2013).

Haraldseid et al.'s (2014) qualitative study identified the loss of ability to engage in meaningful activities, loss of relationships, and loss of self as the most poignant losses those with chronic pain experience. They further explored whether addressing these losses in CBT-based pain groups would improve outcomes. While they were unable to isolate the effect of the inclusion of loss processing in their groups, they argue that failing to address these losses might minimize the benefits of pain groups (Haraldseid et al., 2014). With the potential to enhance the

positive effects of pain groups, it is imperative to address the impact of pain-related loss and to understand what losses an individual with chronic pain may be experiencing. Equally as important is identifying and utilizing an individual's resilience in the face of chronic pain.

Resilience

Resilience is viewed as “the process of adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress” (American Psychological Association, 2014, para. 4). Individual resilience has been shown to help mitigate the effects of a number of these challenges and decrease the need for professional intervention for individuals with greater resiliency factors (Bonanno, 2008). Resilience differs greatly from recovery, while recovery indicates an individual's normal functioning was initially significantly diminished and able to mitigate the impact of the stressor over time; in resilience, individuals never experience the same level of initial distress and their normal functioning is not significantly altered by it (Bonanno, 2008). Grief and PTSD theorists often assumed that if an individual experienced a loss or trauma without grieving or having a trauma response that meant they were suppressing and in denial; however, research suggests that resiliency factors and the human ability to cope and adapt to life's stressors is why these individuals continue to function well (Bonanno, 2008). One study demonstrated that widows who reported less grief symptoms following the loss of their partner, had lower levels of depression prior to the loss than those that reported more grief symptoms. They also found that the individuals who reported fewer grief symptoms had higher levels of resilience (Bonanno et al., 2002). The implications of this study suggest there is a relationship between grief and resilience that should be studied further.

In the context of chronic pain, pain resilience is identified as the ability to restore and sustain a fulfilling life in the presence of pain (Goubert & Trompetter, 2017). Being able to

identify and understand what resiliency factors an individual possesses can allow for a more strengths-based treatment approach. Some qualities of resiliency that have demonstrated to improve treatment outcomes include psychological flexibility, positive emotions, and satisfaction of basic psychological needs (Goubert & Trompetter, 2017). Qualities of resilience in individuals with pain include developing a personal sense of control, actively engaging in health treatments, building social connections, exhibiting pain acceptance and positive affect (Rolbiechi et al., 2017). Talking about resiliency factors and utilizing them promotes and supports better adaptation to pain and improves treatment outcomes (Goubert & Trompetter, 2017). However, addressing resilience to pain in treatment without addressing grief might interfere with adapting to chronic pain.

Current qualitative research understands the experience of loss in chronic pain. However, the current treatments struggle to acknowledge and treat the emotional impact of these losses on an individual. Resiliency factors may indicate positive treatment outcomes and may inform providers on resiliency-based CBT interventions. There may be a connection between loss associated with chronic pain and an individual's resilience level; however, there has not yet been much research in this area.

Purpose of the Study

With the large number of individuals with chronic pain in the U.S., the financial strain on the nation, and the side effects of medical treatment, it is imperative we continue to research chronic pain and explore different treatment options. The current biopsychosocial approach to managing chronic pain has emphasized multidisciplinary teams. The psychological approach of CBT and ACT models of pain management emphasizing building relaxation skills and cognitive

restructuring are efficacious but may miss the mark in acknowledging the impact of loss on an individual with chronic pain.

This study explored the experience of grief in persons with chronic pain, examined the relationship between grief and resilience, as well as the relationship between pain severity, pain interference, pain-related loss, and pain-resilience by utilizing quantitative methodology.

Hypotheses

Hypothesis 1: It was predicted that individuals with chronic pain will have levels of grief comparable with other groups of bereaved people.

Hypothesis 2: It was predicted that individuals with higher resilience will be negatively correlated with grief and pain interference.

Hypothesis 3: It was predicted that behavioral perseverance will be inversely correlated to non-acceptance and cognitive and affective positivity will be inversely correlated to thoughts and emotional responsiveness.

Chapter 2

Methods

Participants

The study consisted of 95 adult participants who experience one or more chronic pain conditions. Demographic information included age: 22-84 ($M = 50.24$, $SD = 16.71$, $N = 86$), gender (Male = 11.6%, Female = 85.3%, Gender queer = 2.1%, Prefer not to say = 1.1%, $N = 95$), ethnicity (White = 85.3%, African American = 2.1%, Latino or Hispanic = 2.1%, Native American or Alaska Native = 1.1%, Native Hawaiian or Pacific Islander = 1.1%, Middle Eastern or Arabic = 1.1%, Unknown = 1.1%, Prefer not to say = 2.1%, Other = 3.3%), years since pain onset ($M = 14.32$, $SD = 13.66$, $N = 94$), whether onset was sudden or gradual (Sudden = 35.8%, Gradual = 64.2%), whether participants feel those closest to them are supportive of them (Yes = 66.3%, No = 2.1%, Somewhat = 31.6%) and level of employment (Unemployed = 3.2%, Unemployed due to disability = 9.5%, Part-time = 14.7%, Full-time = 40%, Student = 6.3%, Retired = 24.2%, Prefer not to say = 2.1%). Participants were recruited through distributing the survey on social media platforms (predominantly Facebook) and word of mouth.

Instruments

Instruments included the *Brief Pain Inventory (BPI)*, the *Acceptance of Disease and Impairments Questionnaire (ADIQ)*, a modified version of the *Texas Revised Inventory of Grief*, and the *Pain Resilience Scale*. A measure was created to assess the degree that individuals grieved the loss of various life domains due to chronic pain. The life domains selected for this measure utilized a qualitative study that implemented grounded theory to identify domains of life

most impacted by chronic pain (Haraldseid et al., 2014). Additionally, demographics were collected as noted above.

Brief Pain Inventory (BPI) (Cleeland, 1991). This scale is a 9-item scale with three subscales identified as “pain severity,” “pain interference,” and “other.” For the purposes of this study, we will omit the “other” subscale as the items on that scale have not been psychometrically evaluated. The pain severity subscale consists of 4-items that ask participants to rate their pain on a scale ranging from 0 (*no pain*) to 10 (*pain as bad as you can imagine*). The pain interference subscale consists of 7 items in which participants rate how much their pain interfered in the prior 24 hours with their general activity, mood, walking ability, normal work, relations with others, sleep, and enjoyment of life. Each item is rated from 0 (*no interference*) to 10 (*completely interferes*). The mean of each subscale’s items provides the subscale score. The scale was initially developed and validated on individuals in treatment for cancer. Factor analysis found strong internal consistency for both subscales (pain severity $\alpha = .8-.87$; pain interference $\alpha = .89-.92$). Subsequent data supported this strong internal consistency across many countries and languages confirming the robustness of these subscales. Initial short-term reliability (1 day to 1 week) of pain severity showed high test-retest reliability ($\alpha = .93$) and usual or average pain of patients was also highly reliable ($\alpha = .78$); however “now” pain severity had lower test-retest reliability ($\alpha = .59$) because pain severity tends to fluctuate over time. Various studies consistently found the test-retest reliability of pain interference is strong ($\alpha = .81-.98$) (Cleeland, 1991).

Acceptance of Disease and Impairments Questionnaire (ADIQ) (Boer et al. 2013). This scale is a 14-item scale intended to measure four stages of grief: denial, resistance, sorrow, and acceptance. Participants are asked to rate the level to which they agree with each item on a scale

from 1 (*disagree*) to 4 (*entirely agree*). The four subscales of grief are calculated by taking the total score of Items 1-4 for the denial subscale, Items 5-7 for the resistance subscale, Items 8-10 for the sorrow subscale, and Items 11-14 for the acceptance subscale. The scale was initially developed and validated on a population of three different sample groups of individuals with chronic obstructive pulmonary disease (COPD) and the developers of the measurement suggested this measure could be used on populations of individuals with chronic medical conditions such as chronic pain. It was found to have a good internal consistency (denial $\alpha = .65-.87$; resistance $\alpha = .9-.98$; sorrow $\alpha = .83-1.01$; acceptance $\alpha = .75-.89$) and reliability ($\alpha = .79$) (Boer, et al. 2013).

Texas Revised Inventory of Grief (TRIG) (Futterman et al. 2015). This scale is a 13-item scale which asks participants to rate their grief-related responses on a 5-point scale including *Completely False, Mostly False, True and False, Mostly True, and Completely True*. The scale consists of three factors including “emotional response” (Items 1, 2, 5, 7, 13), “thoughts” (Items 4, 6, 8, 9, 11), and “non-acceptance” (Items 3, 10, 12) regarding a loss. The TRIG total score is calculated by measuring the mean of all items. It was found to have good internal consistency for all factors ($\alpha = .75-.87$) and reliability (non-acceptance $\alpha = .7$; thoughts $\alpha = .8$; emotional response $\alpha = .84$). For this study, this measure will be adapted to measure pain-related grief rather than grief from the loss of a loved one. Each item will substitute phrases such as “the person who died” with “who I was before chronic pain” (see Appendix C for adapted TRIG). While this adapted version of this measure has not been validated, maintaining the integrity of each item in relation to the grief process may provide insight to the grief process those with chronic pain experience (Futterman et al. 2015).

Pain Resilience Scale (PRS) (Ankawi et al., 2017). This scale is a 14-item scale which asks participants to rate the degree that intense or prolonged pain impacts their behaviors and mood using a 5-point scale ranging from 0 (*not at all*) to 4 (*all the time*). The scale consists of two subscales including behavioral perseverance and cognitive/affective positivity. Item responses are totaled to give a total pain resilience score. The subscales are calculated by totaling the sum of Items 1-5 for the behavioral perseverance subscale and Items 6-14 for the cognitive/affective positivity subscale. The scale was initially developed and validated on an undergraduate population without chronic pain. It was later validated on a population with chronic pain and found to have a strong internal consistency ($\alpha = .93$; cognitive/affective positivity $\alpha = .91$; behavioral perseverance $\alpha = .87$) with acceptable test-retest reliability over a 1-month interval ($\alpha = .80$) (Ankawi et al., 2017).

Procedures

The instruments were uploaded on Survey Monkey and distributed on social media platforms, such as Facebook. Specifically, the survey was sent to various community groups that emphasize building community for individuals who experience chronic pain. Individuals completed the survey and the data was downloaded into SPSS. There were 126 people who opened the survey link. Of those 126, 31 either elected not to participate or were disqualified based on being under 18 or not having chronic pain. Ninety-five people completed the survey.

Chapter 3

Results

For missing data, the item score was replaced with the mean score of all participants on the related item. Five participants did not respond to the item “to what degree do you grieve the loss of your job due to chronic pain” which was replaced with the mean of all participants’ responses for the item ($M = 2.83$). Each of the following items had a single missing data point, each replaced respectively with the mean of all participants: Item 3 of the BPI pain interference subscale ($M = 5.54$), Item 2 of the ADIQ ($M = 2.44$), Item 7 of the ADIQ ($M = 2.38$), Item 1 of the TRIG ($M = 2.59$), Item 8 of the TRIG ($M = 3.57$), Item 9 of the TRIG ($M = 2.48$), Item 13 of the TRIG ($M = 2.31$), and Item 8 of the PRS ($M = 2.92$).

Grief

To compare whether the participant’s responses on the adapted TRIG were similar to that of another bereaved group, this researcher utilized a research study completed by Holm et al. (2018) for comparison. Their study evaluated the psychometric properties of the TRIG and provided the mean, standard deviation, and population size of their participant’s responses which were used to complete an unpaired two-tailed t test.

A t -test was used to compare the relationship between the adapted TRIG for chronic pain and a group of bereaved people. Participant’s responses to the adapted TRIG revealed no statistically significant difference when compared to the responses of a sample of bereaved persons who completed the TRIG ($t(113.28) = .54; p = .589$). The mean of participants’

responses ($M = 35.56$, $SD = 13.59$) did not differ from that of a population of bereaved persons ($M = 36.5$, $SD = 11.9$). See Table 1.

Table 1

Independent Grief Study Comparison

Measure	Study Sample			Comparison Sample (Holm, et al., 2018)						
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	df	95% CL
Grief	95	35.56	13.59	129	36.5	11.9	0.54	0.58	113.28	-4.39, 2.51

Participant's responses to the adapted TRIG total revealed a statistically significant positive correlation to the sorrow subscale of the ADIQ ($r(93) = .8$, $p < .001$). Participant's responses to the adapted TRIG total revealed a statistically significant positive correlation to the resistance subscale of the ADIQ ($r(93) = .61$, $p < .001$). Participant's responses to the adapted TRIG total revealed a statistically significant negative correlation to the acceptance subscale of the ADIQ ($r(93) = -.61$, $p < .001$). There is no evidence of a statistically significant relationship between participant's responses to the adapted TRIG and the denial subscale of the ADIQ ($r(93) = .07$, $p = .49$). See Table 2.

A frequency distribution was used to evaluate participant's responses to the measure constructed to assess the degree of grief related to losses of various life domains. Approximately 48% of participants reported they often or always grieve the loss of their self-identity due to chronic pain. Approximately 56% of participants reported they often or always grieve the loss of their roles in life due to chronic pain. Approximately 67% of participants reported they often or always grieve the loss of their physical abilities due to chronic pain. Approximately 43% of

Table 2*Grief Measures Correlation*

		Denial	Resistance	Sorrow	Acceptance
Grief	Pearson <i>r</i>	.07	.61**	.8**	-.61**
	<i>P</i>	.49	.00	.00	.00
	N	95	95	95	95

Note. **Correlation is significant at the 0.01 level (2-tailed).

participants reported they often or always grieve the loss of their social life due to chronic pain. Approximately 43% of participants reported they often or always grieve the loss of their job due to chronic pain. Approximately 52% of participants reported they often or always grieve the loss of their goals and dreams due to chronic pain. See Table 3.

Table 3*Frequency of Grief from Loss due to Chronic Pain in Percentages*

	Always	Often	Sometimes	Rarely	Never
Self-identity	9.5	38.9	25.3	20.0	5.0
Roles in life	13.7	42.1	25.3	13.7	5.3
Physical abilities	29.5	37.9	27.4	4.2	1.1
Social life	10.5	32.6	27.4	22.1	7.4
Job*	20.0	23.2	22.1	11.6	17.9
Goals and dreams	10.5	41.1	23.2	16.8	8.4

Note. **n* = 90, 5 participants did not respond.

Pain Resilience, Grief, and Pain Interference

A correlation was used to compare the relationship between pain resilience (as measured by the pain resilience scale total, subscales of cognitive and affective positivity and behavioral

perseverance will be included), grief (as measured by the TRIG total), and pain interference (as measured by the pain interference subscale on the BPI). Participant's responses revealed a statistically significant negative correlation between pain resilience and grief ($r(93) = -.48, p < .001$). Participant's responses revealed a statistically significant positive correlation between pain interference and grief ($r(93) = .55, p < .001$). Participant's responses revealed a small effect of a statistically significant negative correlation between pain resilience and pain interference ($r(93) = -.20, p < .05$). See Table 4.

Table 4*Pain Resilience, Grief, and Pain Interference Correlation*

		Pain Resilience	Grief	Pain interference
Pain resilience	Pearson r	1	-.48**	-.20*
	p		.00	.05
	N	95	95	95
Grief	Pearson r	-.48**	1	.55**
	p	.00		.00
	N	95	95	95
Pain interference	Pearson r	-.20*	.55**	1
	p	.05	.00	
	N	95	95	95

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

Pain Resilience Factors and Grief Factors

A correlation was used to compare the relationship between the cognitive affective positivity subscale of the PRS with the thoughts and emotional responses subscales of the TRIG.

A correlation will be used to compare the relationship between the behavioral perseverance

subscale of the PRS to the non-acceptance subscale of the TRIG. Participant's responses revealed a statistically significant negative correlation between cognitive and affective positivity and emotional responses ($r(93) = -.50, p < .001$). Participant's responses revealed a statistically significant negative correlation between cognitive and affective positivity and thoughts ($r(93) = -.45, p < .001$). Participant's results did not reveal a statistical significance between behavioral perseverance and non-acceptance ($r(93) = -.08, p = .45$). See Table 5.

Table 5*Pain Resilience and Grief Factors Correlation*

		Cognitive affective positivity	Emotional response	Thoughts	Non- Acceptance	Behavioral perseverance
Cognitive affective positivity	Pearson r	1	-.50**	-.45**	-.48**	.36**
	p		.00	.00	.00	.00
	N	95	95	95	95	95
Emotional response	Pearson r	-.50**	1	.82**	.69**	-.22*
	p	.00		.00	.00	.04
	N	95	95	95	95	95
Thoughts	Pearson r	-.45**	.82**	1	.74**	-.27**
	p	.00	.00		.00	.01
	N	95	95	95	95	95
Non-acceptance	Pearson r	-.48**	.69**	.74**	1	-.08
	p	.00	.00	.00		.45
	N	95	95	95	95	95
Behavioral perseverance	Pearson r	.36**	-.22*	-.27**	-.08	1
	p	.00	.04	.01	.45	
	N	95	95	95	95	95

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

Chapter 4

Discussion

Summary

While previous qualitative studies indicate that individuals with chronic pain were describing the experience of grief or loss, this is the first study to quantitatively examine the experiences depicted in qualitative studies (Walker et al., 2005). Results support the qualitative research and suggest that individuals who experience chronic pain experience a grief process that can be evaluated in a quantitative manner. Additionally, the prevalence of grief associated with these losses is astounding indicating that people with chronic pain do experience their losses as grief.

In comparison to bereaved individuals, people who experience chronic pain are similarly grieving; however, their grief is more consistent with losses of identity, abilities, and the self rather than the loss of a loved one. The adapted version of the TRIG appeared to be an effective measure as individuals with chronic pain scored similarly to bereaved individuals on the TRIG. Individuals' scores on the TRIG were comparable to their scores on the ADIQ, which is a measurement of disease impairment acceptance. This relationship suggests that the adapted TRIG may be a valid measurement of grief related to chronic pain. It is important to note that the acceptance component of grief is not measured by the TRIG and therefore there was no relationship between the acceptance factor of the ADIQ and factors of the TRIG.

Prior research revealed that pain resilience appears to be a strong protective factor for people with chronic pain and often determines better treatment outcomes (Goubert &

Trompetter, 2017). There had not previously been research regarding the relationship between pain resilience and grief. In this study, those who endorsed a greater number of pain resilience traits endorsed lower levels of grief. These results appear to align with previous research that indicated better psychosocial adaptation to pain in individuals with greater pain resiliency factors (Goubert & Trompetter, 2017). This might indicate that helping increase pain resilience not only supports treating other psychosocial stressors related to pain but also helps alleviate grief symptoms as well. It also suggests that it is important in therapeutic work to identify resiliency traits and work to help people strengthen these traits in a strengths-based approach to decrease distress related to grief, just as clinicians would to decrease other psychosocial stressors.

The relationship between pain interference and pain resilience and grief was additionally intriguing. While pain interference had a significant, small, negative correlation to pain resilience, it had a significant, large, positive correlation to grief. This suggests the level that pain interferes with one's life may not be as pertinent in determining an individual's pain resilience. However, the results suggest that pain interference is more indicative of predicting the prevalence of pain related grief. This may indicate that the level of interference that pain has in a person's life may implicate a greater degree of grief, but an individual's resilience is not as related to the degree that pain interferes with one's life. A person may have a significant degree of pain interference and be highly resilient.

This study also sought to dissect the factors of grief and pain resilience further to identify whether there was a direct correlation between them. The cognitive and affective positivity factor of pain resilience had a strong, negative, relationship to the emotional responsiveness of grief. This may indicate that the positive emotions involved in resiliency may counter the negative emotional responses often associated with grief such as depression, anxiety, or anger. Cognitive

and affective positivity was also strongly, negatively, correlated to grief related thoughts indicating that a person who possesses more traits related to positivity may experience less thoughts about grief and losses related to their chronic pain because of their positive cognitive and emotional outlook. Interestingly, there was no relationship between non-acceptance of grief and behavioral perseverance of pain resiliency. This may suggest that although someone may not accept their chronic pain or the impact of chronic pain on their life, they may still possess behavioral perseverance in that they are still trying to do all that they can to stay functional, mobile, and endure the pain.

Limitations

There were some limitations to this study. The participants who completed the survey were disproportionately white and female, which is not an accurate depiction of the broad array of demographics of people living with chronic pain and therefore cannot be extrapolated to the entire population. The listservs that were outreached to disseminate the survey declined to post the survey and many of the social media groups of people living with pain conditions did not respond to outreach messages. This limited the number of people who had access to complete the survey as it was predominately passed through word of mouth and shared on people's personal social media accounts.

Additionally, there is not currently a psychometrically valid way to measure the impact of grief in individuals with chronic pain. While the TRIG was able to be altered and compared to the ADIQ and a non-adapted version of the TRIG, there would need to be more studies run to determine if the adapted version is psychometrically valid.

Implications

The results of this study suggest that people with chronic pain experience grief to similar levels as bereaved people. While the actual loss is different for the groups, this study suggests that the degree of grief people feel related to their chronic pain experience is comparable to the loss of a loved one. This suggests we should be attending to a person's grief process as a component of treatment. It may also indicate that individuals with chronic pain who have multiple *DSM-5* (American Psychiatric Association, 2013) diagnoses of depression and anxiety may have their symptoms be better explained by a grief process. This may also help inform treatment as often the initial shock of a grief requires that a clinician not move too quickly into a CBT solution-focused mindset. As pain-CBT is the evidence based best treatment for chronic pain, this study suggests that clinicians may need to evaluate where a client with chronic pain is at in their grief process when determining interventions. As disenfranchised grief may exacerbate the pain of grief, clinicians may need to evaluate whether some of the interventions utilized may be minimizing the grief that an individual with chronic pain is experiencing and may unintentionally exacerbate feelings of disenfranchisement.

Pain resilience is a protective factor for individuals experiencing pain related grief therefore, clinically it could be important to work with people on building resiliency factors along with acknowledging and naming the grief process. Prior studies suggest that working to increase pain resiliency improves treatment outcomes and quality of life. It might be extrapolated from this study that building pain resiliency may help mitigate grief if the individual is at a place in their grief process that they are willing and able to incorporate resiliency building strategies such as engaging more with their health care team, building social support systems, and pursuing meaningful activities that promote mobility.

Future Directions

Further research should be done to determine the validity and reliability of the adapted TRIG to more definitively confirm that it is an appropriate measure to examine pain related grief. The findings of this study suggest that it could be a psychometrically valid adaptation as individuals scored similarly on the ADIQ. It would also be interesting in the future to determine whether grief in individuals with chronic pain is stagnant or fluid. People with chronic pain often have fluctuating pain levels and days where they experience more or less pain interference. It would be interesting to complete a longitudinal study to evaluate levels of grief over time to determine if it fluctuates depending on the individual's level of pain interference at the time of completing the measure.

Because there is a relationship between pain resilience and grief, a future study could examine further whether interventions that target increasing pain resilience might lower an individual's experience of grief related to chronic pain. It would be important to know clinically whether there are specific interventions for pain related grief that are more efficacious than other interventions or if interventions for pain related grief would differ from interventions for bereavement.

Current research suggests that disenfranchised feelings can occur in people chronic pain who have their pain experiences minimized or dismissed (Curtis & Pirie, 2018). As this study revealed that pain related grief exists in individuals with chronic pain, it would be interesting to further explore the prevalence of disenfranchised grief in this population and whether those feelings are experienced in therapeutic relationships. Future studies could evaluate the prevalence of disenfranchised grief and the impact on treatment outcomes and potentially interventions that may be protective against disenfranchisement.

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Appendix A
Consent Form

This study has been created to assess the relationship between losses experienced related to chronic pain and resilience. If you feel uncomfortable at any time during this survey, you are free to discontinue. Your participation and answers will remain entirely anonymous throughout the course of this study and after the completion of this study, meaning that no one will ever know your survey was yours. The survey will take an approximate 15-30 minutes of your time to complete. Your participation in this study is beneficial for the future of pain treatment. You are helping researchers better understand the experience of loss and degrees of resilience that individuals with chronic pain experience. By beginning this survey, you consent your answers are truthful and are your own experience(s). Further, by completing this survey and subsequently submitting it, you consent your answers may be used for research purposes.

If you have any questions, comments, or concerns regarding this research, please contact the lead investigator, Lauren Abshire, MA at labshire13@georgefox.edu or the faculty supervisor, Marie-Christine Goodworth, PhD at mgoodworth@goergefox.edu at George Fox University Graduate School of Clinical Psychology, 414 N Meridian St. V104, Newberg, OR, 97123.

Appendix B**Demographics**

1. Do you experience chronic pain?
 - a. Yes
 - b. No

2. Are you over 18?
 - a. Yes
 - b. No

3. Age: _____

4. Gender:
 - a. Male
 - b. Female
 - c. Gender Queer
 - d. Transgender Male/Transwoman/FTM
 - e. Transgender Female/Transwoman/MTF
 - f. Other (please specify _____)
 - g. Prefer not to say

5. Ethnicity:
 - a. White
 - b. African American
 - c. Latino or Hispanic
 - d. Asian
 - e. American Indian or Alaska Native
 - f. Native Hawaiian or Pacific Islander
 - g. Middle Eastern/Arabic
 - h. Unknown
 - i. Prefer not to say
 - j. Other (please specify) _____

6. Do you have a pain diagnosis? If so, please specify _____

7. How long ago did your pain start? (Please approximate number of years) _____

8. Did your chronic pain begin suddenly or was it gradual?
 - a. Sudden
 - b. Gradual

9. What is your current employment status?
 - a. Unemployed

- b. Unemployed due to disability
 - c. Part-time
 - d. Full-time
 - e. Prefer not to say
10. Do you feel like those who are closest to you are supportive of you?
- a. Yes
 - b. No
 - c. Somewhat
11. Approximately how well do you feel that those closest to you understand your experience of loss related to chronic pain?
Excellent --- Good --- Fair --- Poor --- Very poor
12. To what degree do you grieve the loss of your self-identity due to chronic pain?
Always --- often --- sometimes --- rarely --- never
13. To what degree do you grieve the loss of your roles in your life due to chronic pain?
Always --- often --- sometimes --- rarely --- never
14. To what degree do you grieve the loss of your physical abilities due to chronic pain?
Always --- often --- sometimes --- rarely --- never
15. To what degree do you grieve the loss of your social life due to chronic pain?
Always --- often --- sometimes --- rarely --- never
16. To what degree do you grieve the loss of your job due to chronic pain?
Always --- often --- sometimes --- rarely --- never
17. To what degree do you grieve the loss of your goals and dreams due to chronic pain?
Always --- often --- sometimes --- rarely --- never

Appendix C

Brief Pain Inventory

Subscale: Pain Severity

3. Please rate your pain by marking the box beside the number that best describes your pain at its **worst** in the last 24 hours.

0 (no pain)---1---2---3---4---5---6---7---8---9---10 (pain as bad as you can imagine)

4. Please rate your pain by marking the box beside the number that best describes your pain at its **least** in the last 24 hours.

0 (no pain)---1---2---3---4---5---6---7---8---9---10 (pain as bad as you can imagine)

5. Please rate your pain by marking the box beside the number that best describes your pain on the **average**.

0 (no pain)---1---2---3---4---5---6---7---8---9---10 (pain as bad as you can imagine)

6. Please rate your pain by marking the box beside the number that best describes your pain you have **right now**.

0 (no pain)---1---2---3---4---5---6---7---8---9---10 (pain as bad as you can imagine)

Subscale: Pain Interference

9. Mark the box beside the number that describes how, during the past 24 hours, the pain has interfered with your:

A. General Activity

0 (Does not interfere)---1---2---3---4---5---6---7---8---9---10 (Completely interferes)

B. Mood

0 (Does not interfere)---1---2---3---4---5---6---7---8---9---10 (Completely interferes)

C. Walking Ability

0 (Does not interfere)---1---2---3---4---5---6---7---8---9---10 (Completely interferes)

D. Normal Work (includes both work outside the home and housework)

0 (Does not interfere)---1---2---3---4---5---6---7---8---9---10 (Completely interferes)

E. Relations with other people

0 (Does not interfere)---1---2---3---4---5---6---7---8---9---10 (Completely interferes)

F. Sleep

0 (Does not interfere)---1---2---3---4---5---6---7---8---9---10 (Completely interferes)

G. Enjoyment of life

0 (Does not interfere)---1---2---3---4---5---6---7---8---9---10 (Completely interferes)

Appendix D

Acceptance of Disease and Impairments Questionnaire (ADIQ)

To what level do you agree with the following statements?

	Disagree	Slightly Agree	Strongly Agree	Entirely Agree
I sometimes pretend that I do not have any impairments				
I do not want to be confronted with my impairments				
I try to ignore my impairments				
I try to forget my impairments as much as possible				
I become angry when I notice that I cannot do something anymore				
I feel frustrated by my impairments				
I become angry when I experience an impairment				
I become sad when I notice that I cannot do something anymore				
I become sad when I think about my impairments				
I become sad when I experience an impairment				
I have learned to live with my illness				
I can accept my illness				

I can accept my impairments				
I have learned to live with my impairments				

Appendix E**Texas Revised Inventory of Grief**

TRIG	TRIG adapted for chronic pain
I still cry when I think of the person who died	I still cry when I think of the person I was before chronic pain
I still get upset when I think about the person who died	I still get upset when I think about the person I was before chronic pain
I cannot accept this person's death	I cannot accept this chronic pain
Sometimes I very much miss the person who died	Sometimes I very much miss the person I was before chronic pain
Even now it is painful to recall memories of the person who died	Even now it is painful to recall memories of the person I was before chronic pain
I often think about the person who died	I often think about the person I was before chronic pain
I hide my tears when I think about the person who died	I hide my tears when I think about the person who I was before chronic pain
No one will ever take place in my life of the person who died	I will never have the life I had before the chronic pain
I cannot avoid thinking about the person who died	I cannot avoid thinking about the person I was before chronic pain
I feel it is unfair that this person died	I feel it is unfair that I have chronic pain
Things and people around me still remind me of the person who died	Things and people around me still remind me of the person I was before chronic pain
I am unable to accept the death of the person who died	I am unable to accept how my life is now
At times I still feel the need to cry for the person who died	At times I still feel the need to cry for the person I was before chronic pain

Appendix F**Pain Resilience Scale**

Directions: We are interested in the different ways that people respond to intense or prolonged pain (toothache, muscle strain, headache). Using a 0 (“Not at all”) to 4 (“All the time”) scale, please rate how much each of the following items describe how you respond when faced with intense or prolonged pain.

When faced with intense or prolonged pain...		Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
1	I get back out there	0	1	2	3	4
2	I still work to accomplish my goals	0	1	2	3	4
3	I push through it	0	1	2	3	4
4	I try to continue working	0	1	2	3	4
5	I like to stay active	0	1	2	3	4
6	I focus on positive thoughts	0	1	2	3	4
7	I keep a positive attitude	0	1	2	3	4

8	It does not affect my happiness	0	1	2	3	4
9	I still find joy in my life	0	1	2	3	4
10	I keep a hopeful attitude	0	1	2	3	4
11	I do not let it get me down	0	1	2	3	4
12	I do not let it upset me	0	1	2	3	4
13	I avoid negative thoughts	0	1	2	3	4
14	I try to stay relaxed	0	1	2	3	4

Total = sum of all items

Subscale Scores:

Behavioral Perseverance = sum of items 1 through 5

Cognitive/ Affective Positivity = sum of items 6 through 14

Appendix G

Curriculum Vitae

Lauren Abshire

(916) 501-0601

Labshire13@georgefox.edu

Pronouns: she/her/hers

EDUCATION

Present	<p>Doctor of Psychology in Clinical Psychology (<i>APA Accredited</i>) Anticipated Graduation April 2022 George Fox University, Newberg, OR Academic Advisor: Marie-Christine Goodworth, PhD Dissertation Title: <i>Experience of loss and resilience in persons with chronic pain</i></p>
2019	<p>Master of Arts in Clinical Psychology (<i>APA Accredited</i>) George Fox University, Newberg, OR Academic Advisor: Marie-Christine Goodworth, PhD</p>
2017	<p>Bachelor of Arts in Psychology George Fox University, Newberg, OR Academic Advisor: Kelly Chang, PhD</p>
2017	<p>Bachelor of Science in Exercise Science George Fox University, Newberg, OR Academic Advisor: Steve Grant, MA</p>

SUPERVISED CLINICAL EXPERIENCE

Oct 2020-May 2021	<p><i>Pre-Intern: Behavioral Health Provider</i> Providence Medical Group- Cedar Mill, Portland, OR Supervisor: Katherine Sluys, PsyD <u>Description:</u></p> <ul style="list-style-type: none"> • Provide therapy and behavioral health support in a primary care medical center for individuals across the lifespan • Utilized CBT and ACT modalities on a wide array of individuals with complex medical, mental health and chemical-dependency concerns
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- Actively communicate and collaborate within an interdisciplinary team of medical doctors, psychologists, psychiatrists, social workers, case managers, nurses, physical therapists, and support staff
- Utilize telehealth platforms to support patient care due to COVID-19
- Assist in the incorporation of behavioral health integration into a primary care clinic that has not previously had behavioral health services
- Attend weekly didactic trainings with an Addictions Psychiatrist for consultation and education on patients presenting with dependence or addiction related concerns.

July 2019- Sept 2020

Practicum II & Pre-Intern: Behavioral Health Provider

Providence Medical Group- Newberg, Newberg, OR

Supervisor: Jeri Turgesen, PsyD, ABPP, MSCP

Description:

- Provided therapy and behavioral health support in a primary care medical center for individuals across the lifespan
- Utilized CBT and ACT modalities on a wide array of individuals with complicated medical and mental health concerns
- Communicated and collaborated in an interdisciplinary team of medical doctors, psychologists, psychiatrists, case managers, nurses, physical therapists, community outreach specialists, and support staff
- Facilitated 6-week psychoeducation and processing groups for pain management
- Developed skills in telehealth as the facility rapidly adapted to COVID-19 precautions
- Provided supervised oversight training and onboarding for new practicum students including supervised supervision of their intervention and assessment planning

Jan 2019-May 2021

Supplemental Practicum: Behavioral Health Consultant

Providence Medical Group- Newberg, Newberg, OR

Willamette Valley Medical Center, McMinnville, OR

Supervisors: Luann Foster, PsyD, Mary Peterson, PhD, ABPP/CL, Bill Buhrow, PsyD

Description:

- Provide crisis mental health assessments addressing suicidality, homicidal ideation, psychosis and/or ability to care for self for

individuals in emergency departments settings in order to determine the appropriate level of care.

- Consult and collaborate with medical staff and other integrated health professionals to address potential treatment recommendations
- Collaborate with supervisors to consult on hospitalization criteria for crisis patients
- Engage in risk mitigation, safety planning and development of appropriate discharge plans for patients in emergency departments who are stable to return home or to be discharged to respite care

July 2018- June 2019

Practicum I: Therapist

Cedar Hills Psychiatric Inpatient Hospital and Intensive Outpatient Services, Cedar Hills, OR

Supervisors: Jory Smith, PsyD, Larry Jasper, PsyD, Resident Psychologist, Leonard Kaufman, PhD

Description:

- Provided inpatient and intensive outpatient, group therapy to patients with suicidal ideation, psychosis, and/or detoxification from substances
- Provided individual, inpatient and outpatient therapy and crisis interventions to patients with suicidal ideation, psychosis, and/or detoxification from substances
- Consulted and collaborated with hospital staff including other therapists, psychiatrists, social workers, nurses, mental health technicians and utilization review personnel
- Provided intake assessments for patients in order to appropriately diagnose and identify level of care

Jan 2018- April 2018

Pre-Practicum: Student Therapist

George Fox University, Newberg, OR

Supervisors: Glenna Andrews, PhD, ABPP, Andrew Summerer, MA

Description:

- Provided outpatient, individual, client-centered psychotherapy services to volunteer undergraduate students
- Conducted intake interviews, write treatment plans, make diagnoses, write professional reports, and make case presentations
- Consulted with supervisors and members of clinical team
- All sessions were video-taped, reviewed extensively, and discussed in individual and group supervision

Sept 2017- Nov 2017

Supplemental Practicum: Depression and Anxiety Support Group Therapist

Providence Medical Group- Newberg, Newberg, OR

Supervisors: Tami Rogers, MD; Courtney Chapin

Description:

- Co-facilitated an 8-week therapy group focusing on anxiety and depression management skills.

RELATED PROFESSIONAL EXPERIENCE

June 2019- August 2019

Intake Specialist

Cedar Hills Intensive Outpatient Program, Cedar Hills, OR

Supervisor: Leonard Kaufman, PhD

Description:

- Completed intakes, diagnosed, and made level of care recommendations for individuals admitting into either intensive outpatient or partial hospitalization programs
- Consulted and collaborated with group therapists after assigning a patient to their group
- Called insurance companies for authorization of services

Jan 2017- April 2017

Assistant Recreation Intern

Friendsview Retirement Community, Newberg, OR

Supervisor: Judie Lawrence, Director of Recreation

Description:

- Facilitated recreation activities in a memory care unit and health care unit in an assistant living facility.
- Met individually with residents in a memory care unit needing socialization and conversation.
- Taught fitness classes with adaptive activities for individuals with limited mobility.

PROGRAM DEVELOPMENT & EVALUATION

June 2019-Present

Behavioral Health Crisis Consultation Training Coordinator

Providence Medical Group- Newberg, Newberg, OR

Willamette Valley Medical Center, McMinnville, OR

George Fox University, Newberg, OR

Supervisors: Luann Foster, PsyD, Mary Peterson, PhD, ABPP, Bill

Buhrow, PsyD

Description:

- Serve as a liaison between student needs in the emergency department and supervisors to create system improvements
- Participate in bi-weekly meetings to discuss program development with supervisors
- Assist in developing and facilitating training of new team members in emergent, crisis risk assessment for suicidal and homicidal ideation, psychosis, and ability to care for self.
- Maintain records of progression and skill development of new team members, identifying areas of growth for training purposes

CONSULTATIONS & SPEAKING ENGAGEMENTS

Mar 11, 2021

Guest Lecturer

Topic: Risk Assessments for people with chronic pain in the emergency department

PSYD585 2: Risk Assessment

Faculty: Luann Foster, PsyD

Graduate School of Clinical Psychology

George Fox University, Newberg, OR

Oct 7, 2020

Didactic Presenter

Topic: Managing personal activation in interprofessional relationships

Behavioral Health Crisis Consultation Team

Yamhill County Mental Health

Graduate School of Clinical Psychology

George Fox University, Newberg, OR

Sept 30, 2020

Presenter with Maria Lytle, MA

Topic: Ableism and disability

Multicultural Community

Graduate School of Clinical Psychology

George Fox University, Newberg, OR

Sept 2019- May 2020

Consultant with Elisabeth Owen, MA, Colten Larsen, MA

Topic: Transgender healthcare/working with transgender clients in the judicial system

Supervisor(s): Marie-Christine Goodworth, PhD; Mary Peterson, PhD; Amber Nelson, PsyD

Supplemental supervisor(s): Jeri Turgesen, PsyD; Patricia Warford, PsyD

In consultation with:

- Providence Newberg Medical Center, Internal Medicine

- Providence Newberg Medical Center, Family Medicine
- Metropolitan Public Defender, Hillsboro, OR Law Office
- Metropolitan Public Defender, Portland, OR Law Office

Nov 6, 2019

Panelist

Topic: Student experiences in primary care
Health Psychology Student Interest Group
Graduate School of Clinical Psychology
George Fox University, Newberg, OR

Oct 14, 2019

Interviewee

Topic: George Fox University receives federal HRSA grant to treat opioid use disorders in rural underserved communities utilizing primary care and telehealth systems
KOIN 6 News
Graduate School of Clinical Psychology
George Fox University
Providence Medical Group- Newberg, Newberg, OR
Chemawa Indian School, Salem, OR

Oct 2, 2019

Panelist

Topic: Intercultural dialogue on spiritual diversity
Multicultural Community
Graduate School of Clinical Psychology
George Fox University, Newberg, OR

RESEARCH EXPERIENCE

2018-2021

Dissertation Research

Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Committee Chair: Marie-Christine Goodworth, PhD
Other Committee Members: Mary Peterson, PhD, ABPP, Kristie Knows His Gun, PsyD

Title: Experience of loss and resilience in persons with chronic pain

Topic: Exploratory study evaluating whether grief exists in individuals with chronic pain at equivalent levels of individuals who lost a loved one. Exploring the relationship between grief in individuals with chronic pain and pain resilience to guide clinical treatment.

Preliminary proposal defense completed: September 16, 2020

Successfully defended: April 28, 2021

June 2019

Research Assistant

Salem Health Rehabilitation Center, Salem, OR

Supervisor: Carilyn Ellis, PsyD

Research: Compiling and analyzing a data set related to chronic pain, opiate tapering, quality of life, and pain catastrophizing.

2018-2021

Research Vertical Team Member

George Fox University, Newberg, OR

Chair: Marie-Christine Goodworth, PsyD

Research: Bi-monthly meetings to discuss research projects of team members related to health psychology.

ASSESSMENT COMPETENCIES, EXPERIENCE & EXPOSURE

Cognitive Assessment

- Comprehensive Test of Nonverbal Intelligence—Second Edition*
- Wechsler Adult Intelligence Scale—Fourth Edition
- Wechsler Intelligence Scale for Children—Fifth Edition
- Wechsler Memory Scale—Fourth Edition

Achievement and Academic Assessment

- Wechsler Individual Achievement Test—Third Edition

Behavioral and Diagnostic Assessment

- Adult ADHD Self-Report
- Adult Behavior Checklist for Ages 18-59
- Adult Self-Report for Ages 18-59
- Beck Anxiety Inventory*
- Beck Depression Inventory
- Behavioral Assessment System of Children—Third Edition
- Brief Pain Inventory
- Conners—Third Edition
- Generalized Anxiety Disorder 7-Item Scale
- Geriatric Depression Scale
- Life Events Checklist
- Patient Health Questionnaire-9
- Patient Health Questionnaire- extended version
- Patient Activation Measure
- PTSD Checklist
- Weiss Functional Impairment Rating Scale
- Wender Utah Rating Scale

Neuropsychological Assessment

- Booklet Categories*
- Boston Aphasia Test*
- Boston Naming Test*
- California Verbal Learning Test—Third Edition*
- Delis—Kaplan Executive Function System
- Grooved Pegboard*
- Modified—Wisconsin Card Sorting Test*
- Montreal Cognitive Assessment
- Rey-Osterrieth Complex Figure Test and Recognition*
- Tactual Performance Test*
- Test of Memory Malingering
- Wisconsin Card Sorting Test*

Personality Assessment

- Millon Clinical Multiaxial Inventory—Fourth Edition*
- Millon Behavioral Medicine Diagnostic
- Minnesota Multiphasic Personality Inventory—2*
- Minnesota Multiphasic Personality Inventory—2—Restructured Form
- Minnesota Multiphasic Personality Inventory—Adolescent*
- Personality Assessment Inventory*
- Sixteen Personality Factor Questionnaire*

Risk Assessment

- Columbia-Suicide Severity Rating Scale

(*Trained-in/practiced without formal clinical administration)

GRANTS, AWARDS & HONORS

Aug 2019-May 2021 Health Resources and Service Administration (HRSA) Grant Recipient
Topic: Integrated care models for practicum training in addictions and culturally congruent treatment using tele-behavioral health (IMPACT)
 George Fox University, Newberg, OR

PROFESSIONAL AFFILIATIONS

2018- Present	Division 22, American Psychology- Rehabilitation Psychology
2017-Present	Division 38, American Psychology- Health Psychology
2017- Present	American Psychology Association (Graduate Student Affiliate)

RELEVANT MEMBERSHIPS & PARTICIPATION

- Aug 2020- Apr 2021 Graduate School of Clinical Psychology (Fourth Year Mentor)
George Fox University, Newberg, OR
- 2019- 2020 Multicultural Community (Student Leadership Member)
George Fox University, Newberg, OR
- 2018- 2019 Graduate School of Clinical Psychology (Second Year Mentor)
George Fox University, Newberg, OR
- 2017-2020 Health Psychology Student Interest Group (Member)
George Fox University, Newberg, OR

ATTENDED COLLOQUIUM & GRAND ROUNDS

- Chloe Ackerman, PsyD. *Gender diverse clients: Therapy and intervention readiness assessments*. Grand Rounds, George Fox University, Newberg, OR. March 10, 2021.
- Janelle Kwee, PhD. *Saying 'yes' to your embodied life: An invitation for psychotherapy*. Colloquium, George Fox University, Newberg, OR. February 3, 2021.
- Jason Steward, PhD. *Complex PTSD: Advanced case conceptualization, assessment, and treatment approaches in trauma populations*. Colloquium, George Fox University, Newberg, OR. November 4, 2020.
- Justin Lee, PhD. *Pediatric cancer and epilepsy*. Grand Rounds, George Fox University, Newberg, OR. October 14, 2020.
- Amy Stoeber, PhD. *Child adverse events to adults with substance use problems*. Colloquium, George Fox University, Newberg, OR. February 12, 2020.
- Cheryl Forster, PsyD. *Intercultural communication*. Colloquium, George Fox University, Newberg, OR. October 16, 2019.
- Worthington Jr. Everett, PhD. *Promoting forgiveness*. Colloquium, George Fox University, Newberg, OR. September 25, 2019.
- Douglas Marlow, PhD. *Foundations of relationships Therapy-The Gottman Model*. Grand Rounds, George Fox University, Newberg, OR. March 20, 2019.
- Diomaris Safi, PsyD & Alex Millkey, PsyD. *Opportunities in forensic psychology*. Colloquium, George Fox University, Newberg, OR. February 13, 2019.
- Scott Pengelly, PhD. *Old pain in new brains*. Grand Rounds, George Fox University, Newberg, OR. October 10, 2018.

Lisa McMinn, PhD & Mark McMinn, PhD. *Spiritual formation and the life of a psychologist: Looking closer to soul-care*. Colloquium, George Fox University, Newberg, OR. September 26, 2018.

Michael Vogle, PsyD. *Integration and ekklesia*. Colloquium, George Fox University, Newberg, OR. March 14, 2018.

Carlos Taloyo, PsyD. *The history and application of interpersonal psychotherapy*. Grand Rounds, George Fox University. February 14, 2018.

Jeffery Sordahl, PsyD. *Telehealth*. Colloquium, George Fox University. November 8, 2017.

Eleanor Gil-Kashiwabara, PsyD. *Community based participatory research and tribal participatory research with Indian American/Alaskan Natives*. Grand Rounds, George Fox University. October 11, 2017.

ADDITIONAL PROFESSIONAL TRAINING & EDUCATION

Brett Kaylor, DO. *Addiction psychiatry*. Weekly hour-long didactics. Providence Medical Group, Newberg, OR. September 2020-March 2021.

Andrea Alexander, FNP; Paul Coelho, MD; Nora Stern, MS, PT; Julie Oyemaja, PsyD; Joan Fleishman, PsyD; Patti Robinson, PhD ; Daniel Kang, DPT, PT; Jeff Houck, PT, PhD; Florence Gerber, MBA. *Interprofessional solutions for high-impact chronic pain*. Interprofessional Primary Care Institute. George Fox University, Newberg, OR. July 18, 2020.

Amy Stoeber, PhD. *Primary care trauma informed training*. George Fox University, Newberg, OR. February 21, 2020.

Kirk Strohsal, PhD. *FACT case consultation*. George Fox University, Newberg, OR. February 2020.

Kirk Strohsal, PhD. *Focused acceptance and commitment therapy*. George Fox University, Newberg, OR. December 12-13, 2019.

Chloe Ackerman, PsyD. *Transgender health and care*. Diversity of Gender and Sexuality Student Interest Group, Graduate School of Clinical Psychology, George Fox University, Newberg, OR. April 17, 2019.

APA. *Annual American Psychological Association Convention 2018*. August 9-12, 2018. San Francisco, CA.

Attended symposium topics include:

- CBT and Beyond—An Overview of Evidence-Based Interventions for Chronic Pain
- Concussion-Reporting Behavior and Culture in Collegiate, Military, and Youth Samples

- Clinical Responses to the Opioid Crisis—A Cross-Divisional Task Force
- Minimizing Opioid Use by Optimizing Pain Psychology
- Cannabis—An Alternative to Opioids for the Treatment of Chronic Pain in Our Military Veterans?
- Untold Truths of Trainees—Minority Intragroup Discrimination Effects on Graduate Clinical Training

Deborah Dunn, PhD. *Leadership development workshop*. George Fox University, Newberg, OR. September 2017.