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**Using an Integrative Psychotherapeutic Approach to Help Adults Cope with
Chronic Pain**

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University – University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Chronic pain is a complex and costly condition that impacts many American's lives. While there are medical interventions available, individuals may continue to experience some level of chronic pain. Therefore, the efficacy of psychotherapeutic techniques should be explored. The purpose of this qualitative study was to determine how to use an integrative psychotherapeutic approach to help adults cope with chronic pain. Seven interviews with psychotherapists serving the chronic pain community in multidisciplinary or interdisciplinary medical settings were analyzed. Results showed the important roles that psychoeducation and a strong therapeutic relationship had when it came to implementing a variety of psychotherapeutic techniques. Those working with this population need to have a high level of empathy, a commitment to client-centered care, and an understanding of psychotherapeutic approaches that enhance the mind-body connection.

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Using an Integrative Psychotherapeutic Approach to Help Adults Cope with Chronic Pain

What is chronic pain? To be precise, Burns (2010) defines it as “pain without apparent biological value that has persisted beyond the normal tissue healing time of three months” (p. 483). It differs from acute pain, in that acute pain lasts three or fewer months, has an easily attributable cause, and persists to let an individual know that they need to be careful to not cause further harm to their injury (Burns, 2010; NIH, 2011). Examples of chronic pain conditions include: low-back pain, arthritis, migraine headaches, carpal tunnel syndrome, fibromyalgia, and complex chronic pain syndromes (Brown, Dick, & Berry, 2010; Goosby, 2013; Gardner-Nix, Barbati, Grummit, Pukal, & Newton, 2012; Gharaee-Adarkani, Azadfallah, Eydi-Baygi, Zafarizade, & Tork, 2017; Mille & Bernal, 2014; U.S. Department of Health & Human Services [HHS], 2013; National Institutes of Health [NIH], 2011; National Center for Complementary and Integrative Health [NCCIH], 2015). In addition to these conditions, chronic pain can manifest as a result of “physical trauma, emotional trauma, sexual abuse, physical abuse, illness, genetics, and surgery” (Burns, 2010, p. 488).

Chronic pain is a pervasive and detrimental condition that is in need of a solution. “[It] affects more Americans than diabetes, heart disease, and cancer combined . . . [impacting] 70-80% of adults at some time in their lives” (Mille & Bernal, 2014, p. 318; HHS, NIH, 2013). This rate of prevalence puts an incredible financial burden on the American people. The yearly cost for medical care for this population combined with the impact on the work market could be up to \$635 billion (HHS, NIH, NCCIH, 2015). These costs are exacerbated by the desire of chronic pain patients to find a permanent, medical solution to their problem where often times, none exists (Burns, 2010; Ciccone & Grzesiak, 1984; Doran, 2014; Grant & Haverkamp, 1995; Linssen & Zitman, 1984). Nonetheless, many will try “electrical stimulation [devices], nerve

blocks, or surgery” to alleviate their pain (NIH, 2011, p. 6). It is difficult for individuals with chronic pain to abandon efforts toward achieving a medical cure. When medical treatments are ineffective, it is not unusual for those with chronic pain to be prescribed medication (Thorn & Kuhajda, 2006). However, this method has problems of its own, since opiates are commonly prescribed and issues of both tolerance and dependence are interwoven with their use (Barlas, 2017; Burns, 2010; Dickinson, Altman, Nielsen, & Williams, 2000; Ling, 2017; Tompkins, Hobelmann, & Compton, 2017).

One of the results of dependence and addiction issues related to opiates being prescribed for chronic pain conditions, is that opiates (prescribed e.g. oxycodone, hydrocodone and illegal e.g. heroin, fentanyl) have become the number one source of drug overdose fatalities (Barlas, 2017). Because of the expense and current difficulty in obtaining prescription narcotics, those who are addicted find illicit ways of acquiring it (Barlas, 2017; Ling, 2017). What was marketed as “safe” for mass use, and further motivated by fears of lawsuits as a result of certain patients experiencing negligent levels of pain, has ended up significantly contributing to one of the most pervasive health crises in modern U.S. history. Clearly, with the high risk now associated with opioid use (more than 25% of people prescribed become dependent in a mere 4-6 weeks), reliance on their treatment for chronic pain must be reevaluated (Barlas, 2017; Ling, 2017; Tompkins et al., 2017).

Because the medical community has limited means of managing many forms of chronic pain, other avenues need to be explored (Burns, 2010; Ciccone & Grzesiak, 1984; Doran, 2014; Grant & Haverkamp, 1995; Linssen & Zitman, 1984). This is why Clifford and Kelley (1997) contend “it is important for social workers to understand the experiences of people suffering from chronic pain and to develop and test useful interventions for aiding them” (p. 266). Though

individuals with chronic pain often have doubts about the ameliorative effects of psychotherapy – they feel that acquiescing to psychotherapy is tantamount to agreeing the pain is all “in the[ir] . . . head” (Grant & Haverkamp, 1995, p. 27; Pavlek, 2008, p. 387) – some of them are “at a complete loss and . . . desperate for help” (Thorn & Kuhajda, 2006, p. 1359).

The purpose of this study was to identify the benefits of using an integrative psychotherapeutic approach over a singular theoretical orientation. Interviews were conducted with psychotherapists who work in the chronic pain community. They were asked questions concerning the psychotherapeutic techniques they employ, and how they felt those methods impacted the clients with chronic pain they served. This study contributed to the qualitative research concerned with the utilization of integrative psychotherapeutic approaches for the treatment of chronic pain, and thus filled a gap that existed within the literature (Kelley & Clifford, 1997; Mille & Bernal, 2014; Pavlek, 2008).

Literature Review

Chronic pain affects a wide array of individuals. It is not a respecter of age, gender, socioeconomic status, or race. It is not hard to conceive that the debilitating effects of many chronic pain conditions often go beyond the individual who is suffering; they create a ripple effect. When a source of pain that was thought to be curable turns into the possibility of a lifetime diagnosis, the impact will be felt deeply by the sufferer and anyone in close relationship with him or her. It is hard to cope with both the psychological knowledge that this pain may never end or lessen, along with the physical reality of the pain. These realities forever change the dynamic of the relationships individuals with chronic pain have with their family, friends, and workplace (Coren, 2016; Currow et al., 2010; Dewar et al., 2003; Doran, 2014; Grant & Haverkamp, 1995; Ling, 2017; Phillips, 2017; Roy & Thomas, 1989).

Relationships Affected by Pain

Family. Family relationships are negatively affected by the chronic pain experience (Brown et al., 2010; Coren, 2016; Dewar et al., 2003; Grant & Haverkamp, 1995; Kelley & Clifford, 1997; Ling, 2017; Mille & Bernal, 2014; Phillips, 2017; Roy & Thomas, 1989; Thorn & Kuhajda, 2006). One reason for this is that those suffering from chronic pain are not able to participate in family activities at the same level they used to (Brown et al., 2010; Coren, 2016; Dewar et al., 2003; Mille & Bernal, 2014; Phillips, 2017; Thorn & Kuhajda, 2006). Those who experience chronic pain also face “a lack of empathy” from family members, which creates stress and conflict (Brown et al., 2010; Coren, 2016, p. 397; Kelley & Clifford, 1997; Mille & Bernal, 2014; Thorn & Kuhajda, 2006). In addition, individuals with chronic pain feel that they cannot fulfill their familial role properly, thus creating an imbalance in the family ecosystem (Brown et al., 2010; Grant & Haverkamp, 1995; Mille & Bernal, 2014; Roy & Thomas, 1989; Thorn & Kuhajda, 2006).

Friends. Chronic pain often isolates individuals from their social network both as a result of fatigue from pain, and feelings of alienation because of inability to fully take part (Coren, 2016; Dewar et al., 2003; Doran, 2014; Kelley & Clifford, 1997; Phillips, 2017). Because chronic pain “has no visible symptoms,” and sufferers struggle with how to properly verbalize what they are going through, and they often feel that their friends misunderstand the reasons behind their lack of engagement (Coren, 2016; Dewar et al., 2003; Kelley & Clifford, 1997, p. 267). What those suffering from chronic pain most desired from their friends was genuine empathy and support (Brown et al., 2010; Kelley & Clifford, 1997).

Work. It is not uncommon for individuals with chronic pain to lose their jobs or need to discontinue working because of the severity of their pain (Currow et al., 2010; Dewar et al.,

2003; Goosby, 2013; McCracken & Thompson, 2009; Mille & Bernal, 2014; Thorn & Kuhajda, 2006). This often led to feelings of loss and a lack of self-worth (Kelley & Clifford, 1997; Thorn & Kuhajda, 2006). If they choose to remain employed, they feel that their pain is being looked at with skepticism from their employers, which creates injury on an emotional level (Brown et al., 2010; Kelley & Clifford, 1997).

Comorbidity

It is not uncommon for those suffering from chronic pain to be concomitantly dealing with depression and/or anxiety (Brown et al., 2010; Burns, 2010; Circone & Grzesiak, 1984; Coren, 2016; Dewar et al., 2003; Goosby, 2013; Grant & Haverkamp, 1995; Herbert et al., 2017; Kelley & Clifford, 1997; Ling, 2017; McCracken & Thompson, 2009; Mille & Bernal, 2014; National Institutes of Health, 2015; Pavlek, 2008; Thorn & Kuhajda, 2006; Tompkins et al., 2017). Post Traumatic Stress Disorder (PTSD) was another frequent mental health diagnosis found alongside chronic pain (Herbert et al., 2017; Mille & Bernal, 2014; Pavlek, 2007; Phillips, 2017). Psychological symptomology is the initial reason some individuals with chronic pain seek out therapy (Kelley & Clifford, 1997; Mille & Bernal, 2014; Thorn & Kuhajda, 2006). Regardless of the reason chronic pain patients engage in therapy, it is likely to be to their benefit, as many report that their psychological symptoms worsen their level of manifested pain (Brown et al., 2010; Coren, 2016; Grant & Haverkamp, 1995; Mille & Bernal, 2014; Phillips, 2017).

Psychotherapists use a variety of psychotherapeutic techniques for treating individuals suffering from chronic pain. Some psychotherapists choose to draw from multiple techniques rather than adhering to a single method. The next section will explore the various psychotherapeutic techniques for treating chronic pain that were found in the literature.

Psychotherapeutic Approaches

Mindfulness. Mindfulness techniques are explored in the literature as a means to cope with chronic pain (Coren, 2016; Doran, 2014; Gardner-Nix et al., 2012; McCracken & Thompson, 2009; Thompkins et al., 2017). The object of mindfulness is to stay present with the pain experience in order to learn how the body responds to it; thus making pain a known process rather than an impenetrable adversary (Coren, 2016; Doran, 2014; Gardner-Nix et al., 2012; McCracken & Thompson, 2009). Individuals stay present with their pain through meditative practice by which they master observing their pain nonjudgmentally (Doran, 2014; Gardner-Nix et al., 2012, McCracken & Thompson, 2009). Through reconciling with their pain, those suffering from chronic pain are able to see their condition as a part of their identity without it encompassing who they are (Doran, 2014; Gardner-Nix et al., 2012). The pain that was once unrelenting is able to be compartmentalized and managed (Coren, 2016; Doran, 2014; Gardner-Nix et al., 2012). Through this technique, chronic pain patients experience a sense of well-being, even when the pain is not diminished (Doran, 2014; Gardner-Nix et al., 2012).

Cognitive Behavioral Therapy. Cognitive behavioral therapy is used to help chronic pain patients reframe harmful automatic thoughts that have a tendency to trigger or aggravate pain (Burns, 2010; Coren, 2016; Grant & Haverkamp, 1995; Thorn & Kuhajda, 2006). Those suffering from chronic pain are empowered to take charge of their pain management, making goals surrounding increasing levels of daily activity, gaining autonomy, and managing how they spend their energy (Burns, 2010; Ciccone & Grzesiak, 1984; Coren, 2016; Grant & Haverkamp, 1995; Thompkins et al., 2017; Thorn & Kuhajda, 2006). A significant portion of the cognitive behavioral technique deals with its psychoeducational component (Burns, 2010; Ciccone & Grzesiak, 1984; Coren, 2016; Grant & Havercamp, 1995; Linssen & Zitman, 1984; Thorn & Kuhajda, 2006). By learning that their thoughts are a version of the truth instead of absolute truth, individuals suffering

from chronic pain are able to reduce their reactivity to potentially threatening thoughts and look at them objectively (Burns, 2010; Ciccone & Grzesiak, 1984; Coren, 2016; Grant & Haverkamp, 1995; Kelley & Clifford, 1997; Linssen & Zitman, 1984; Thorn & Kuhajda, 2006).

Acceptance and Commitment Therapy. Acceptance and Commitment Therapy (ACT) is another modality that is used when working with clients who face chronic pain (Gharaee-Ardakani et al., 2017; Herbert et al., 2017). One of the core components of ACT is “psychological flexibility – the ability to contact the present moment more fully as a conscious human being and to change or persist in behavior when doing so serves valued ends” (Hayes, Luoma, Bond, Masuda, & Lillis, 2006, p. 7). ACT teaches individuals with chronic pain to look at their thoughts nonjudgmentally, relax through them, and to not avoid them (Gharaee-Ardakani et al., 2017; Hayes et al., 2006). Being in the present moment is important so a person can acknowledge what they’re thinking and feeling, but as more of an observer than a direct experiencer (Gharaee-Ardakani, et al., 2017; Hayes et al., 2006). ACT helps those suffering from chronic pain to recognize what they value in life, and to make goals for themselves accordingly, in order to remain connected to activities that give them meaning (Gharaee-Ardakani et al., 2017; Hayes et al., 2006; Herbert et al., 2017).

Narrative Therapy. Narrative therapy is used to help make chronic pain something that is accessible and understandable to those affected, by having them put it in their own words (Brown et al., 2010; Kelley & Clifford, 1997; Pavlek, 2008). When individuals with chronic pain are able to tell or write their own stories, it helps them assign meaning to what they are going through (Brown et al., 2010; Kelley & Clifford, 1997; Phillips, 2017). The use of metaphor is particularly illuminating as individuals wrestle with the way pain affects their lives. In addition, narrative

therapy reveals ways of coping that brought hope to those suffering from chronic pain (Brown et al., 2010; Kelley & Clifford, 1997; Pavlek, 2008; Phillips, 2017).

Group Therapy. Various studies tout the benefits of using a group therapy format for individuals with chronic pain (Burns, 2010; Kelley & Clifford, 1997; Linssen & Zitman, 1984; Pavlek, 2008; Phillips, 2017; Thorn & Kuhajda, 2006). One of the reasons for this was that group members are able to bond over their shared experiences – the chronic pain that had created isolation in many areas of their lives now brings a sense of cohesion and inclusion (Pavlek, 2008; Phillips, 2017; Thorn & Kuhajda, 2006). Additionally, group members are able to see unhelpful thought patterns and behaviors displayed by their peers, and hold each other accountable – what spurs resentment when said by a loved one, is accepted because the participants were all going through a similar experience (Kelley & Clifford, 1997; Pavlek, 2008; Thorn & Kuhajda, 2006). Two of the studies on group work with a chronic pain population used an eight week time frame (Kelley & Clifford, 1997; Linssen & Zitman, 1984), and two additional studies that used a group framework met for ten weeks (Pavlek, 2008; Thorn & Kuhajda). Pavlek (2008) and Thorn & Kuhajda (2006) recommend that individuals involved with chronic pain group work be mentally fit, and not have diagnoses or qualities that might hamper the function of the group. It is worth noting that the individuals who participated in group therapy had a desire for their groups to continue, and/or chose to pursue an individual form of therapy (Kelley & Clifford, 1997; Pavlek, 2008; Thorn & Kuhajda, 2006).

Integrative Therapy.

Defining integrative. “Integrative” in word and concept is defined different ways in different sciences and among the literature, therefore it is important to describe the intended meaning used here. The word “integrative” means using a variety of psychotherapeutic techniques

(Burns, 2010; Coren, 2016; Ciccone & Grzesiak, 1984; Linssen & Zitman, 1984; McCracken & Thompson, 2008; Pavlek, 2007). One such example of this would be utilizing elements of cognitive-behavioral therapy, mindfulness, sensory awareness, exposure therapy, art therapy, and clinical hypnosis (Burns, 2010; Coren, 2016; Ciccone & Grzesiak, 1984; Linssen & Zitman, 1984; McCracken & Thompson, 2008; Pavlek, 2007). A psychotherapist can learn to “integrate” multiple techniques into client sessions.

Many of the studies support using an integrative approach to combat chronic pain and its various comorbidities (Burns, 2010; Coren, 2016; McCracken & Thompson, 2009; Mille & Bernal, 2014; Pavlek, 2008). The literature suggests that using an integrative approach is best for the complex issues those impacted by chronic pain face, because it gives them a more diverse palette of coping options than a single approach offers (Burns, 2010; Coren, 2016; Grant & Haverkamp, 1995; Mille & Bernal, 2014; Pavlek, 2008; Thorn & Kuhajda, 2006) Although none of the integrative approaches use exactly the same model, many of them employ a cognitive behavioral element (Burns, 2010; Ciccone & Grzesiak, 1984; Coren, 2016; Linssen & Zitman, 1984; Pavlek, 2008; Thorn & Kuhajda, 2006).

In summary, it is clear that individuals suffering from chronic pain conditions can look to therapy with a sense of hopefulness. Whether relief is brought through the learning of coping skills or the lessening of pain, psychotherapy has something to offer. In the literature surveyed, there were no studies that interviewed psychotherapists about their modes of treating individuals who have chronic pain. Therefore, this qualitative research project will explore the methods of various psychotherapists who serve the chronic pain community. Specifically, this study will endeavor to discover how practitioners use an integrative psychotherapeutic approach to help adults with chronic pain more effectively cope. An integrative psychotherapeutic approach was

chosen to be the framework, as much of the literature suggested it would be the preferred method to untangle the intricacies of chronic pain (Burns, 2010; Coren, 2016; Grant & Haverkamp, 1995; Mille & Bernal, 2014; Pavlek, 2008; Thorn & Kuhajda, 2006).

Conceptual Framework

Everyone has biases from which they construct their perception of reality. These biases are often informed by experience, study, and other such forms of knowledge acquisition. It is important for researchers to identify and describe their views of the world and human behavior in the interest of transparency, as it colors the way they analyze data. The following concepts are relevant in understanding the way I perceive the chronic pain experience and the need for an integrative psychotherapeutic approach.

Social Constructionism

Language is a very powerful tool by which meaning is relayed. This meaning takes on depth in the context of relationships. Social constructionism explores the dynamics by which this meaning is formed, and the implications it has on society and the individual (Gergen, 1985).

Through this lens, I contend integrative psychotherapeutic techniques are essential, as each individual's construction of the world is unique, and each individual has been impacted by the constructions society has placed upon them in unique ways (Gergen, 1985). Some individuals who have chronic pain may see themselves as "disabled" because that is how they feel they have been labeled. Others may view themselves as victims of their situation because of the nature of its perceived cause. Still others may view themselves as proactive, determined, or committed to finding a way to overcome or live with their pain. When a therapist has limited options in terms of approach, they risk being unable to find a treatment that aligns with the individual's conception of reality. If a psychotherapist can offer an assortment of treatment

options, they honor the individuality of contexts their clients come from, and improve the chances of finding a technique that is effective.

Because language is used to convey meaning, it is important for the psychotherapist to be tuned-in to the client's meaning of the way they define themselves and their pain experience, while understanding how cultural constructs may have shaped that perception (Gergen, 1985). Through the strength of the therapeutic relationship, the therapist can then suggest different ways of looking at their condition. This is the natural consequence of having a variety of techniques to choose from. Helping those suffering from chronic pain to expand their ideas about who they are and what is achievable serves to benefit them and society as a whole.

The Eight Dimensions of Wellness

The Substance Abuse and Mental Health Services Administration [SAMHSA] identifies eight dimensions of wellness (2017). The first dimension is emotional wellness. This is defined as the ability to manage one's life in spite of stressors, and building fulfilling relationships. The second dimension is environmental wellness. This includes healthy living which is facilitated by living in well-kept and enriching environments that uphold well-being. The third dimension is financial wellness. This entails feeling content with one's present day and forecasted financial prospects. The fourth dimension is intellectual wellness. This involves knowing one's innovative skills and being aware of how to improve upon them. The fifth dimension is occupational wellness. This means deriving purpose and growth from one's work experience. The sixth dimension is physical wellness. This necessitates self-awareness around needed exercise, nutrition, and sleep behaviors. The seventh dimension is social wellness. This is about feeling connected as a member of a healthy and strong community. The eighth dimension is spiritual wellness. This is exemplified by finding a reason for living (SAMHSA, 2017).

The eight dimensions of wellness are intricately connected to the impact of chronic pain on a person's life. Every single dimension is affected. What does this mean for those who are suffering from chronic pain? It often means, as a review of the literature indicates, that these individual's livelihoods are significantly diminished.

When looking at the eight dimensions of wellness in the context of the complexity of chronic pain and its multidimensional impact, it's clear that using an integrative approach is the most appropriate solution. For example, the spiritual dimension could be aided by existential therapy, mindfulness, and/or meditation (prayer). Physical wellness could be positively impacted through psychoeducation, cognitive behavioral therapy, and/or progressive relaxation. The emotional component could be helped by supportive psychotherapy, trauma therapy (Eye Movement Desensitization and Reprocessing therapy [EMDR]), mindfulness, and/or diaphragmatic breathing. Utilizing multiple techniques increases the ability to achieve more satisfying patient outcomes.

Personal Lens

Death of a friend. A very close friend of mine died as a result of his struggle with intense chronic pain and depression. Before he died, I knew about his struggle with suicidal ideation, and that much of this contention was related to his perceived inability to participate in the activities from which he drew his identity. He was a black belt in jiu-jitsu, and the nerve damage he had received as the result of a botched hernia surgery left him in excruciating pain. It was very challenging for him to engage in daily life without an unsustainably high dose of opiates. I began my investigation into alternative therapies when he was alive, and discovered pain rehabilitation clinics that used cognitive behavioral therapy and an array of additional techniques to help individuals suffering from chronic pain discontinue their use of opiates. I told

him about the treatment. He decided to utilize psychotherapy from an individual in private practice, and was left feeling underwhelmed with the results. After a couple months without hearing from him, I received an e-mail from his father letting me know that he had taken his own life. Even though I knew this was possible, I was shocked and immensely grieved that he reached the level of desperation where he saw no solution but death.

The psychological treatment of people experiencing “incurable” chronic pain conditions is important to me because I know there are many individuals like my friend, who feel hopeless after many medical interventions have been attempted and have failed. These psychotherapeutic approaches can offer hope for a quality of life that those suffering from chronic pain had no longer considered achievable. Through these techniques, these individuals can live lives they consider to be meaningful in spite of their condition. Some may even experience partial or total pain relief as a result of psychological treatment.

Social work values. As a social worker, I consider it imperative to help clients attain a life they feel is worth living. This value is in congruence with the Ethical Standards of “Commitment to Clients” and “Self-Determination” as put forth by the National Association of Social Workers [NASW] (2017). These tenets state that the well-being of the client is always put first, the client gets to determine what well-being means to them, and they get to choose the route they want to take in pursuit of achieving that goal (NASW, 2017). When the social worker’s approach is client-centered, chances of success and the client’s satisfaction with the process are more likely to be realized.

Method

Design

The grounded theory approach was the format used for collecting the data for this study.

This qualitative method first involved analyzing the literature to determine the formulation of interview questions. After this task had been completed, the researcher interviewed respondents, transcribed the interviews, and coded the transcriptions to locate the themes within them. Next, the researcher went back to the literature and compared and contrasted the themes to what was already known and acknowledged within the research (Charmaz, 2015).

This design is being used because of its exploratory nature. Though there have been many studies conducted regarding chronic pain, more could be done on the topic of integrative psychotherapeutic approaches. It is the researcher's hope that this study will encourage further innovation and theory-building within the field of chronic pain to create more comprehensive psychotherapeutic treatment strategies.

Sampling Procedures

The researcher used purposive sampling to find her participants. Purposive sampling involves choosing individuals within a specific group of people rather than having them be selected at random (Elliot, Fairweather, Olsen, & Pampaka, 2016). Participants in the study had to meet some key requirements: They had to be a licensed mental health practitioner, they had to work with the adult chronic pain population, and they had to employ a variety of psychotherapeutic approaches in their practice. Eligible participants were recommended by an advisor who had colleagues working within the chronic pain field. They were invited via email by the advisor to obtain their level of interest in participating in the study. The emails of those who were interested in participating were given to the researcher, who then contacted the interested participants individually via email to confirm their interest in being a part of the study. Those who replied favorably were followed up with by the researcher to arrange an interview.

This method of sampling was chosen due its practicality and as a result of

opportunity. Knowing an individual who works in the field of chronic pain was helpful in sorting out those clinicians who use an integrative psychotherapeutic approach from those who do not. In addition, there was no conflict of interest due to the lack of a supervisory relationship between my advisor and his colleagues, removing the possibility for repercussions – good or bad – if therapists consented or declined to participate. Not to mention, confidentiality would protect the participants from anyone’s knowledge of their involvement with the study.

Protection of Human Subjects

Any study that involves human subjects must consider the protection of those subjects to be a primary ethical concern. With this understanding, all research containing a human component that is done by students in the Masters of Social Work program at the University of St. Thomas/St. Catherine University, must obtain approval from the University of St. Thomas Institutional Review Board. Since approval was granted for this research project, the researcher proceeded according to the accepted plans, and made every effort to ensure the participants in this study did not endure harm.

Recruitment Process

Once individuals were identified as eligible and were confirmed as willing by an advisor, an email was sent to them describing who the researcher was, the nature of the study, who connected the researcher to the potential respondent, the professional requirements for being a participant, and what the study entailed in terms of time commitment and the necessity for consent. Those who responded favorably were asked to choose a day and time to be interviewed for approximately one hour at a private, quiet, and convenient location left up to the participants’ discretion. They were sent a copy of the consent form (Appendix B) and the interview questions (Appendix C) to look over. The researcher’s goal was to recruit between five to ten individuals

to interview for the study. Seven participants were found to be willing and eligible, and all seven agreed to be interviewed.

Confidentiality and Anonymity

Confidentiality was a priority throughout the research process. Though anonymity could not be granted as the researcher knew the participants' identities, anonymity was maintained within the published study, as the individuals who chose to participate were assigned pseudonyms. No one was told of their participation unless they themselves revealed it, and the interview took place at the location of their choice at their discretion. The researcher made efforts at maintaining confidentiality, by having all the records of participants' interviews stored on devices that were password protected and for the researcher's sole use. The recordings and transcripts will be destroyed upon the project's completion on May 14, 2018.

Informed Consent

All measures were taken to ensure consent was willingly granted before the data collection process began. As aforementioned, the participant was given an electronic copy of the consent form (Appendix B) prior to the meeting. At the time of the interview, the researcher again reviewed the consent form and asked questions to affirm the participant understood the risks involved, the voluntary nature of the study, that they could choose to leave the study at any time, and that if they chose to do so, their data would be destroyed. The consent form was signed before the interview proceeds.

Data Collection

Data was collected using a set of interview questions (Appendix C) based on the topic of integrative psychotherapeutic techniques. A list of these questions was emailed prior to the interview date to better prepare the participant for the interview. Each interview session was

recorded using the Voice Memo application on the researcher's smart phone. The interview commenced using a semi-structured format. The designated questions took priority, and additional questions were asked according to time and relevance.

Data Analysis

The researcher used grounded theory methodology. Therefore, the first step of data analysis was to transcribe the interviews. Upon transcription, the researcher coded the transcript line-by-line. After the coding was complete, the transcripts were divided according to each individual question. It was in this format that the data was analyzed for themes. Quotes and data from participants that delineated particular themes within each question were grouped together, and comprised the findings of the study. These findings were compared and contrasted with the literature concerning psychotherapeutic approaches for treatment of chronic pain. This led to support and lack of support for the literature, and/or areas where more research could be done to advance the care of those who have suffered from chronic pain (Charmaz, 2015).

Results

Results were organized according to the order the interview questions were asked to the participants. The experience of the seven participants ranged from one to over 20 years. All of the participants were trained in health or medical psychology, and worked in medical settings. Four participants earned a PhD and three earned a PsyD. There were six women and one man interviewed. All were European-American.

Approach for Providing Treatment for Clients with Chronic Pain

Psychotherapists use a client-centered approach with those who are suffering from chronic pain. Using a biopsychosocial framework, they assess where their clients are psychotherapeutically, and discover their strengths and goals. They utilize psychoeducation,

both in telling clients about the role of a pain psychologist, as well as informing them about their specific chronic condition, and how the mind-body connection can be used to improve their functioning. Their approaches are research-based and multidisciplinary – they work in conjunction with several providers: pain doctors, interventionalists, physical therapists, occupational therapists, pharmacists, addictionologists, and occasionally primary care doctors. Psychotherapists who work in the chronic pain field prefer a team approach to treatment. They work hard to be non-threatening and empathetic toward those in chronic pain, though opiate-reduction and eventually extinction is typically a treatment goal. In addition, they incorporate a holistic approach, informing their clients about the impact of exercise, diet, and sleep on their pain.

Specific Models Used in Treatment of Chronic Pain

Psychotherapists use a wide variety of treatment modalities to combat the negative impacts of chronic pain. All respondents reported using cognitive behavioral therapy – two within that group stated they used the cognitive behavioral therapy for chronic pain protocol, and one reported using the cognitive behavioral therapy – TEAM (Testing, Empathy, Agenda Setting, Methods) technique. Psychoeducation was also utilized by all the study participants. Modalities used by most psychotherapists included: biofeedback, EMDR, mindfulness, and meditation. Other therapies mentioned were: hypnosis, supportive psychotherapy, psychodynamic therapy, relaxation, visualization, diaphragmatic breathing, guided imagery, behavioral therapy, acceptance and commitment therapy, principles of dialectical behavioral therapy, and motivational interviewing.

Frequency of Use According to Modality

The treatment modalities that were used by all or most of the participants were also

those that were utilized most frequently during sessions with their clients. Therefore, the respondents reported using psychoeducation with all of their clients, and elements of cognitive behavioral therapy with all or most of their clients. EMDR was used anywhere from with half of clients to with nearly every client, with one participant reporting they would only use it if a client was available to meet several weeks in a row. In most cases, psychotherapists that used mindfulness and/or relaxation techniques said they used them heavily, and in two cases, stated they used them as a supplement. In addition, those who utilized biofeedback used it with most of their clients.

Components of Psychotherapy that Elicit a Response

Respondents noted many different aspects of psychotherapy individuals in chronic pain responded to and several stood out as unified themes. People in chronic pain respond to being heard. They respond to telling their story, whether it is their initial pain story or the story of the week(s) they experienced between their appointments. These individuals are also impacted by the empathy and support they receive from their psychotherapists. Performing relaxation techniques also noticeably affects clients. Additionally, psychoeducation has a profound impact on this population. The level of “buy-in” also affects client response. Finally, cognitive behavioral therapy elicits a response from individuals suffering from chronic pain.

Various Responses to Components of Psychotherapy

The consensus among study participants was that most individuals impacted by chronic pain had an overwhelmingly positive response to the aspects mentioned above, and generally had a positive response to psychotherapy altogether. However, there were a few negative and/or mixed responses. One participant noted that individuals in chronic pain can become more depressed when talking about their pain. Two participants mentioned negative responses to

cognitive behavioral therapy, when clients' pain beliefs are challenged. This refers to the idea that those in chronic pain can do certain activities despite being in pain. One respondent also stated that during a relaxation exercise, a client had a flashback. Lastly, respondents noted that when they had a high level of "buy-in," the response to psychotherapy was positive. When the level of "buy-in" was low or the client was skeptical, the response to psychotherapy was ambivalent, neutral, or negative.

Implementing Chronic Pain Strategies

There are a few key components for implementing chronic pain strategies. The first component is psychoeducation. Respondents educate their clients about the mind-body connection, how their behavior can activate pain, what the research says about their chronic pain condition and how to manage it through certain psychotherapeutic techniques, and how contributing factors (e.g. cognitions, emotions, and family dynamics) impact their pain. The second component is treatment planning. This includes determining what the client's goals are and the methods they are comfortable with pursuing. Homework, such as activity pacing, journaling, or relaxation exercises is assigned, though relaxation techniques are often practiced first in-session. Finally, for those respondents who practice EMDR, the therapy is done in-session, and is helpful in shifting the client's experience of the pain incidence(s).

Client Attitude at Onset of Psychotherapy

All the participants stated that the client's attitude at the beginning of their relationship was variable, dependent upon a few factors. First, the source of the referral had an impact on the client's attitude. If the individual suffering from chronic pain was referred by a member of a multidisciplinary or interdisciplinary pain team or by a doctor who understood the role of the pain psychologist, the response tended to be overwhelmingly positive. If there was ambiguity

about why the person in chronic pain was going to see a psychologist, it was typically remedied by the psychotherapist explaining that it was not because the client was deemed “crazy” by the doctor, or that the doctor thought the pain was “all in their head” – it was instead as a result of their pain diagnosis, and education about the services they offered would ensue. Second, if the individual in chronic pain had previous experience with psychotherapy, it had an impact on their initial perception. If their experience was positive, they were more open. If their experience was negative, they were more guarded or skeptical. Last, the client’s motivation for being at the pain clinic had an impact on their attitude. When those in chronic pain had to see a pain psychologist as a condition of getting prescribed opiates, or if they found out that the psychologist would be a barrier to them being able to access opiates, it created a lot of resentment and anger.

Client Attitude at Termination of Psychotherapy

Three main responses emerged with regard to the individual in chronic pain’s attitude at their final session. The first response was that those experiencing chronic pain were pleasantly surprised at the results of the psychotherapeutic process. Another theme was an attitude of gratefulness and appreciation toward the psychotherapist. The last theme dealt with the uncommon, but occasional, negative response. These clients’ first appointment was often their last, and their attitude ranged from hopeless to angry, either because they were unconvinced they could be helped through psychotherapeutic methods, or because they found out the goal of the program was opiate termination. It is also worth mentioning that in the majority of cases when psychotherapy was a positive experience, though therapy was “ending,” it was always left open-ended by the psychotherapist if the individual felt they needed to return.

How Collaboration with Various Medical Professionals is Achieved

When pain psychologists are collaborating with medical professionals within their

system, they are able to do so through multiple mediums. Respondents mentioned to use of electronic medical records which allowed for digital communication either with specific individuals or with all other treatment providers stored in the client's chart. Most psychotherapists also reported being able to "walk around the corner" to consult with pain doctors, physical therapists, occupational therapists, psychologists, psychiatrists, pharmacists, and addictionologists when they are "in-house." Three respondents mentioned having case consultation meetings between members of the care team. When applicable, participants will contact their client's outside psychologist or substance abuse counselor, providing the individual in chronic pain signs a release of information.

Medical Professionals' Support and Investment in the Collaborative Approach

The prevailing consensus among participants was that the medical professions they worked with were on board with the collaborative care model. One respondent reported that not everyone was supportive of the model, but those individuals were in the minority. Three participants spoke of the drawback of reimbursement systems which pay only for direct patient contact, and how this financial incentive dis-incentivized case consultation among team members versus other reimbursement methods such as being salaried. Two participants mentioned that collaboration with their team was not as close as they would like. Four respondents stated that while they felt everyone in their setting was in favor of collaboration, it was not the case among all medical professionals across the board, though they believe the trend is shifting toward the collaborative model due to emerging research.

Positive or Negative Biases With Regard to the Collaborative Approach

The data showed that the bias in these settings was in favor of using a collaborative approach. Only two respondents reported anomalies within this bias. One such outlier was

stated by the participant to not be against the psychological aspect of collaboration, but against another therapeutic component on the collaborative team. The other instance of negative bias was against the psychological aspect, on the basis of its perceived credibility. However, these circumstances were based upon a select few of the medical professionals, and were not the overall bias of the care teams.

Impact of Therapeutic Relationship

Respondents reported the health of the therapeutic relationship was the central component to the success of the therapeutic process. When individuals in chronic pain do not feel appropriately supported by and comfortable with their provider, their willingness to engage in psychotherapeutic strategies is inhibited. Two participants noted the lack of healthy social support individuals in chronic pain experience, and stated their belief that the therapeutic relationship can serve as a metric for correcting those unhealthy relationships. Three respondents also mentioned the role of humor in building therapeutic rapport. Those suffering from chronic pain experience a lot of bleak, emotionally heavy circumstances for which humor can be a balm.

Emotional Range of Clients Throughout Psychotherapy

The consensus among participants was that individuals experiencing chronic pain display a wide range of emotions during psychotherapy sessions. Common emotions expressed during appointments include: grief and loss, anxiety, fear, loneliness, loss of hope, and sadness. Respondents also noted when breakthroughs occur during sessions their clients feel happy, hopeful, and have an attitude of acceptance. Crying occurs regularly, and while yelling may not happen frequently, it is no stranger to the pain psychologist's office.

Issues that Impacted Emotional Responses

Several proponents emerged from the data regarding issues that impacted emotional responses. When some individuals experiencing chronic pain come to find they will be tapered off prescribed opiates, they often encounter anxiety, fear, and anger due to their lack of control, and anticipate that their pain will be overwhelming. Another reported aspect of minimizing opioid dosage is clients begin to feel emotions that have been dulled by opiate use. External factors, such as strained family or support relationships, financial hardship, job loss, etc., have an impact on emotional responses as well. The client's relationships and experiences with their various medical providers also affects their emotions. When people going through chronic pain feel supported by their chronic pain management team, it diminishes their anxiety, fear, and shame. When those in chronic pain come to realize that there is likely no "fix" for their pain, they become very disheartened. This is especially the case when doctors and/or surgeons have not been forthcoming about the very minimal chances of a cure, and the client's pain psychologist reveals that management of pain is the goal at this point. Last, challenging the client's pain beliefs has the tendency to bring out anger and resistance as they struggle to accept that they have the ability to lead a fulfilling life in spite of their pain.

Ability for the Therapeutic Relationship to be a Hindrance

All but one participant offered that the therapeutic relationship could hinder a client's progress if the relationship was unhealthy. Respondents explained that if the relationship did not have a foundation of trust, or if either the individual in chronic pain or the psychotherapist felt uncomfortable, it would hinder the progress of treatment. Participants placed the responsibility upon themselves to address this issue with their clients, letting them know that if they felt uncomfortable or wanted to see a different psychotherapist, it was perfectly acceptable. In conjunction, the psychotherapist would facilitate the change if their client so desired.

Factors that Inhibit or Promote Success with Chronic Pain Population

Factors that Inhibit Success. Many factors were reported to inhibit success. When the client was receiving opiates, motivation to engage in the work of implementing strategies was inhibited. Also, if substance abuse was an issue for the individual in chronic pain, it counteracted the psychotherapeutic process. Motivation to change was also reported to be hampered as a result of secondary gain issues such as: ongoing litigation, social security disability insurance claims, and benefits received from friends and/or family members (e.g. special attention, increased affection, getting out of household responsibilities). Another inhibiting factor mentioned by respondents was that if people suffering from chronic pain had poor experiences with their medical providers, building trust was difficult, which compromised the therapeutic relationship. Lastly, barriers to care due to inadequate finances, transportation, and availability of the pain psychologists were noted issues.

Factors that Promote Success. There were three strong themes found in the data that participants suggested promoted success. Participants had a strong belief in the benefit of collaborative care with a pain management team. In addition, when individuals in chronic pain experienced the efficacy of working through the psychotherapeutic approaches, it motivated them to stay engaged in the treatment process. Finally, as clients tapered off opiates successfully, they became more open and receptive to utilizing the pain psychologist as a partner in their journey of well-being.

How Psychotherapists Adjust when Clients' Success Appears Inhibited

There are times during treatment when the success of an individual experiencing chronic pain may begin to stagnate or regress. When this occurs, psychotherapists said they collaborate with one another, and/or with their pain management team. Three respondents stated that when a

client's success seemed inhibited, they addressed it with the client directly. The psychotherapist would ask the individual in chronic pain what they felt was contributing to their difficulty in achieving success. Goals may be reassessed. A different psychotherapeutic technique may be employed. The pain psychologist may refer if it is clear headway is not being made, and the client consents to it. Two respondents mentioned the idea of the individual experiencing chronic pain bringing a family member or close friend into the psychotherapy session. This can add a fresh perspective and increased knowledge that has the ability to bring clarity to issues when the client or psychotherapist is feeling stuck.

Specific Patient Factors that Support an Integrative Psychotherapeutic Approach

The indisputable preference of the participants was one of using an integrative psychotherapeutic approach. The main reason participants gave for this perspective was the complexity of the individuals they were treating, as a result of the complexity of chronic pain and all its contributing factors. There were also two respondents who noted that language and hearing barriers made some psychotherapeutic techniques harder to implement. Therefore, having a greater variety of modalities to choose from allowed them to serve their clients with greater satisfaction.

Specific Patient Factors that Proved to be Challenging

Participants had clear ideas of the factors that made some patients more challenging to work with than others. First, if individuals in chronic pain had more complex mental health diagnoses, including personality disorders, severe anxiety or depression, or current or past trauma history, it complicated treatment. Second, if there was anything impairing the clarity of the client's mind, such as substance abuse, opiate use, developmental or cognitive delays or disabilities, or an organic disease process, this made psychotherapy more challenging. Third,

secondary gain issues that created motivational difficulties were reported as an obstacle to care. Last, if individuals in chronic pain had significant distrust of the medical profession as a result of previous negative experiences, this created an impediment that was difficult to overcome.

Discussion

Interpretation of Results

The purpose of this study was to explore how practitioners used an integrative psychotherapeutic approach to help individuals in chronic pain cope. Inherent to this objective was the idea that psychotherapists were trained in multiple modalities. While all of the participants supported using a cognitive behavioral framework for most clients, many of them stated having the flexibility to weave additional approaches into psychotherapy sessions was essential to the improvement of many individuals in chronic pain. Pain psychologists expressed the importance of implementing methods that the client was comfortable with, and that were consistent with their treatment goals. Informing those in chronic pain about treatment methods for managing pain was often accomplished through psychoeducation about the mind-body connection, and the affects that certain strategies had the potential to achieve. Each individual's chronic pain and life circumstances were unique, therefore their selection of pain management tools was unique. Acquiring the client's trust both through building the therapeutic relationship and giving them access to various avenues of treatment that had a strong evidence-based foundation, led many of those experiencing chronic pain to be open to trying as many techniques as they were offered.

An important finding from this study was the emphasis respondents placed on the significance of multidisciplinary or interdisciplinary collaborative pain management teams. Participants strongly felt that this factor contributed to better results for patients. When

collaborative case conceptualization meetings were involved, the benefits were even greater, especially for those suffering from chronic pain who had exceptionally complex cases. The enhanced relationships between providers and an accurate understanding about the role of each provider, created an environment where the individual in chronic pain was receiving consistent information, which increased feelings of support and trust that their needs would be met.

Intersection of Results and Literature

Commonalities.

Psychotherapeutic approach. It is clear that the results of this study coincide with the literature with regard to the efficacy of using an integrative psychotherapeutic approach that utilizes a cognitive behavioral framework as its foundation (Burns, 2010; Ciccone & Grzesiak, 1984; Grant & Haverkamp, 1995; Thorn & Kuhajda, 2006). The participants also advocated for the use of acceptance and commitment therapy (Gharaee-Ardakani et al., 2017; Hayes et al., 2006; Herbert et al., 2017), and mindfulness (Coren, 2016; Doran, 2014; Gardner-Nix et al., 2012; McCracken & Thompson, 2009). The role of psychoeducation also found support in the literature (Burns, 2010; Ciccone & Grzesiak, 1984; Linssen & Zitman, 1984; Pavlek, 2008).

Positive Results of Pursuing Psychotherapy. The literature and this study agreed that those suffering from chronic pain who were willing to invest their time and energy into pursuing their well-being, were often rewarded for their efforts with positive results (Pavlek, 2008; Thorn & Kuhajda, 2006). Though the pain may not diminish or go away completely, the impact of the pain on an individual's life was mitigated through psychotherapeutic techniques and support (Coren, 2016; Kelley & Clifford, 1997; Phillips, 2017). Those suffering from chronic pain had regained some level of employment, became more involved with family and friends, and felt a sense of hope for their present and future (Thorn & Kuhajda, 2006; Phillips, 2017).

Differences.

Psychotherapeutic approach. There were a few psychotherapeutic approaches found in the research that the clinicians did not report utilizing themselves, or vice versa. One notable technique that was absent from the surveyed literature was EMDR, which was surprising considering the comorbidity between PTSD and chronic pain (Herbert et al., 2017; Mille & Bernal, 2014; Pavlek, 2008; Phillips, 2017). In addition, while narrative and group therapy were present in the literature, they were not utilized by the clinicians in this study. However, it should be noted that multiple study participants stated that they referred more complex individuals to dialectical behavior therapy groups.

Clients' attitude at onset of therapy. Another difference between the literature and what the participants reported was the individual in chronic pain's attitude at the onset of therapy. While the respondents reported that clients were generally open and receptive, the literature noted several examples where individuals experiencing chronic pain were very unhappy about being referred to a psychotherapist (Dewar et al., 2008; Grant & Haverkamp, 1995; Ling 2017; Linssen & Zitman, 1984; Pavlek, 2008). Perhaps this was a result of the referring medical professional not explaining the role of the pain psychologist, or the doctor's lack of belief in the reality of the pain the individual was dealing with. Either way, the two view of client perspectives seemed to be divergent.

Strengths and Limitations

Strengths. One strength of using this method is that it is exploratory, so it has the potential to create new theories and ask questions that spur on further research (Charmaz, 2015). This is important because regardless of how much is known about a particular topic, there is always more that can be discovered. This is the beauty of qualitative research: It allows for

flexibility and nuance in a way that promotes creative thinking about problems and solutions.

Another strength of this study is its uniqueness. In all the reviewed literature, there were no studies that focused on multiple psychotherapists' professional experiences of using a variety of psychotherapeutic techniques to help adults suffering from chronic pain better cope with their pain, and the way it affects their lives. Therefore, this research has the capacity to expand on the salient issue of psychological treatments for chronic pain in a meaningful way.

Limitations. One limitation of this study was that it used a purposive sampling method. As a result of using this technique, the researcher had a lack of diversity among the sample with regard to gender and racial/ethnic background. In addition, many of the participants were from the same or similar organizations, which could skew the data toward the techniques and practices employed at those particular organizations. All of the participants interviewed worked in healthcare settings, and none were involved in private practice.

Another limitation of this study is the researcher's bias toward integrative psychotherapeutic approaches. This bias may have caused the researcher to discount the validity of using a single approach, when a thoroughly-known single approach could be used very effectively with this population. This belief also definitely shaped the desire to have the bias confirmed both by literature and by the participants involved.

The disadvantage of using qualitative methods is that they are non-generalizable. Therefore, even though the results of this study point to the strong preference among practitioners for using an integrative psychotherapeutic approach, it does not mean that practitioners who operate differently will find their technique to be ineffective. However, the results of this research have the ability to guide future research in directions that lay the foundation for theory and evidence-based practice (Charmaz, 2015).

Implications for Social Work Practice

Chronic pain is a complex issue that requires innovative treatment methods. The individuals who suffer from chronic pain require empathic, dedicated clinicians who are knowledgeable about the issues they face, and are educated in evidence-based psychotherapeutic techniques. More clinical social workers are needed in this field of practice, as participants stated it can sometimes take weeks or months for individuals in chronic pain to get an appointment.

It is important for clinical social workers to be aware of the comorbidity between PTSD and chronic pain, so when PTSD is diagnosed, they know to inquire about possible chronic pain issues and medical interventions that have been explored. If it becomes clear that a chronic pain issue is present and the client is in need of a psychotherapist more informed on ameliorative psychotherapeutic techniques, that a referral to a pain psychologist is made.

When deciding to work with an individual dealing with chronic pain, whether in a medical setting or private practice, the clinical social worker should focus on securing a healthy and meaningful therapeutic alliance with the client. This will be the basis upon which psychotherapeutic interventions will succeed. Staying client-centered and compassionate is essential, as the individual in chronic pain experiences the victories and setbacks endemic to this condition.

Policy Implications

Individuals seeking treatment for chronic pain are often long-term clients for their medical and mental health providers. Therefore, universal healthcare is a necessity. These individuals should not have to worry about the financial strain of receiving necessary medical and mental health interventions, when their lives already hold so many complications due to their

condition.

Because of the devastating seriousness of the opioid crisis, individuals who do not have cancer or a terminal illness (i.e. individuals in chronic pain) should be prescribed opiates very sparingly and under close supervision. This policy has the potential to have a huge impact on overdose rates due to the addictive nature of opiates. Perhaps having very limited access to prescription opioids in the first place would diminish the use of heroin as a cheaper alternative if and/or when prescription opioids became too expensive to refill, or doctors cut patients off.

Further Research

More research should be done that looks into the efficacy of multidisciplinary and/or interdisciplinary collaborative care teams for treating those suffering from chronic pain. Perhaps the results of these studies would spur the resurgence of chronic pain clinics back to the level they once were. Obtaining client perspectives on their experience of that type of holistic care would be valuable, alongside the results of an improved sense of wellness and ability to better cope with their pain – if that is indeed what the studies yield.

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Appendix B. Letter of Informed Consent

**Consent Form****1139576-1 How to use an Integrative Psychotherapeutic Approach to Help Adults With Chronic Pain More Effectively Cope.**

You are invited to participate in a research study about using an integrative psychotherapeutic approach to help adults with chronic pain more effectively cope. You were selected as a possible participant because your colleague, Ben Greenberg, communicated to me that you might be willing to engage in the research process. You are eligible to participate in this study because you utilize integrative psychotherapeutic techniques with the chronic pain population. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Bethany K. Miletich, Courtney K. Wells, PhD, and St. Catherine University/University of St. Thomas. This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information

The purpose of this study is to discover how mental health practitioners use an integrative psychotherapeutic approach to help adults with chronic pain more effectively cope. In doing this, I will be adding to the research that supports using multiple psychotherapeutic approaches, rather than focusing on one approach, such as cognitive behavioral therapy, hypnosis, acceptance and commitment therapy, or narrative therapy. While there is some research that focuses on an integrative psychotherapeutic approach for treating chronic pain, it is by no means exhaustive, therefore more research on this topic is completely warranted. Additionally, there were no studies I found where the researcher interviewed therapists to determine how and why they used the psychotherapeutic techniques they used, so this research will be unique in that manner.

Procedures

If you agree to participate in this study, I will ask you to do the following things: Consent to meeting at a private, convenient place of your choosing for a time period of no more than one hour,

during which a recorded interview will take place. There will be approximately five to ten participants in this study. No contact will be required after the interview is completed.

Risks and Benefits of Being in the Study

This study has a minimal risk of confidentiality being broken in the event that the researcher's laptop or phone gets stolen. This will be mitigated by the use of a pseudonym for all data that is related to your interview.

There are no direct benefits for participating in this study.

Privacy

Your privacy will be protected while you participate in this study. Interviews will take place at your office on the date and time of your choosing. You will choose the circumstances under which your participation in this study will be shared.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include a Voice Memo recording of our interview, a typed transcript of our interview, coding notes of the transcript, and additional notes as necessary. The recording will be taken and stored on my smart phone until the project has been completed. The notes, including the transcript will be stored on my personal laptop computer until the completion of the project. Both my phone and laptop are password protected and for my sole use. All signed consent forms will be kept for a minimum of three years upon completion of the study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with Benjamin Greenberg, your workplace, or the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will be erased. You can withdraw by e-mailing me to inform me that you no longer wish your contribution to be a part of the study. You are also free to skip any questions I may ask.

Contacts and Questions

My name is Bethany K. Miletich. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me at 612-876-8667 and/or mile3290@stthomas.edu. My advisor's name is Courtney K. Wells, and her contact information is 651-373-6651 and/or Well7613@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study.

You will be given a copy of this form to keep for your records.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix C. Interview Guide

GRSW 682 Qualitative Research Questions

Research Question: How does a practitioner use an integrative psychotherapeutic approach to help patients with chronic pain more effectively cope?

1. What is your approach for providing treatment for clients with chronic pain?
 - a. Which specific models do you use?
 - b. How much do you use of each of the models?
2. Are chronic pain patients referred to you or do they seek you out?
 - a. In what way does the referral process make a difference with the therapy experience, both for you and for the person suffering from chronic pain?
3. Which portions of therapy do you notice your clients respond to?
 - a. Is the response generally negative or positive or a mixture of the two?
 - b. How do you implement the parts of therapy that specifically target chronic pain?
4. What is the client's demeanor at the beginning of therapy versus the end in terms of what they believe therapy has to offer them?
5. Do you often collaborate with other medical professionals in the clients' life to coordinate care?
 - a. Why or why not?
 - b. Do you think that biases from the medical community against therapy to treat chronic pain contributes to this?
6. How do you think the therapeutic relationship affects success with a chronic pain patient, specifically?
 - a. Is there a sense of skepticism or helplessness from clients throughout the therapy process?
 - b. If so, how do you maintain the relationship with them, while also trying to help them progress?
7. What inhibits or promotes success in therapy with a chronic pain patient?
 - a. How do you adjust your approach when you find that a client's success seems inhibited?