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**A THEMATIC COGNITIVE BEHAVIOURAL INTERVENTION  
WITH DEPRESSED CHRONIC PAIN PATIENTS**

**BY**

**ELINOR KETER**

**A Practicum  
Submitted to the Faculty of Graduate Studies  
in Partial Fulfillment of the Requirements  
for the Degree of**

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**Faculty of Social Work  
University of Manitoba  
Winnipeg, Manitoba**

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**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University  
of Manitoba in partial fulfillment of the requirements of the degree**

**of**

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**ELINOR KETER      ©1998**

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## **PHENOMENON**

Individuals who experience serious chronic pain from injury or illness form a population whose medical needs are usually well served, but whose social and psychological needs often are not. Clinical intervention of a social and psychological nature addresses negative changes produced by chronic pain and disability, in particular depression, but also other, non-adaptive responses.

## **LITERATURE REVIEW**

Chronic pain is a profound personal burden to bear. When it is compounded by depression, an individual's distress becomes almost toxic. The admixture of physical, cognitive, and affective consequences for patients has interested practitioners and researchers, and a large body of literature has been produced. However, the foci and results of this study, mainly theoretical, have left the clinical side of the field parched.

A review of the research literature on chronic pain and depression reveals that although practitioners have observed association between these conditions, they generally do not treat both (Sullivan et al., 1992). Lack of treatment happens for different reasons: sometimes diagnostic omission, sometimes patient rejection of psychological labeling or intervention, and at other times, because of limitations in specialty programs. Missing a patient's depression can happen easily; the logical focus of treatment by family physicians and medical specialists for a (chronic) pain patient is initially and often permanently, the pain. If pain does not improve completely under medical care or becomes entrenched over time, other dynamics can come into play, including psychosocial problems and sometimes depression.

Depression in the chronic pain patient involves an complexly interrelated set of symptoms. These vary among individual patients as well as between populations of patients

with specific pain, such as arthritis sufferers or low back pain sufferers. The cognitive and affective reactions to chronic pain and their mutual exacerbation of and by the physical pain state pose a significant treatment challenge to the clinician. Work on this causal conundrum begins with diagnosis, made more difficult for the practitioner by having to choose from a wide array of assessment tools and criteria. Nevertheless, for treatment of depressed, chronic pain patients to be effective, their unique presentation must be recognized as a form of depression and must be accordingly treated (Roy et al., 1984; Sullivan et al., 1992). A clinical view of depression must appreciate the complicated symptoms which these patients display because that unique, individual variation of some common themes is key first, to understanding and diagnosing the patient's condition, and second, to determining appropriate treatment for the person's predicament.

Treatment is available from psychologists, psychiatrists, social workers, and their colleagues in medical and multidisciplinary pain clinics. However, in spite of pain clinics' de facto recognition of the complexities posed by chronic pain, they most often sidestep depression in work with patients (Sullivan, 1992). Commenting on this phenomenon in his review of the clinical literature for this special population, Sullivan noted that multidisciplinary clinics do offer patients help through behavioural techniques, but that they treat depressed chronic pain patients essentially the same as other chronic pain patients. The result is untreated depression which may or may not have been diagnosed, but which in any case, is usually not treated directly.

Failure to treat depression is so common a phenomenon that it often goes unnoticed by the practitioner and usually begs analysis by researchers. Research on the clinical treatment of depression in chronic pain patients is sparse (Sullivan et al., 1992), notwithstanding the careful research work to study prevalence, causes, and facets of depression in chronic pain. Contrasting the plethora of research on depression in this population with the paucity of

research about effective clinical treatment exposes an important area neglected by both the theoretical and research literature.

Apart from displaying a wide interest in the subject of depression in the chronic pain patient, the literature is distinguished by diverse and conflicting viewpoints (Sullivan, 1992). While literature reviews and research results concur that chronic pain and depression frequently co-exist (Geisser, 1994; Goldberg, 1993; Kuch, 1993; Magni, 1994; Roy, 1984, 1989, 1993; Skevington, 1983; Sullivan et al, 1992), the agreement ends at that point. Researchers and commentators' opinions diverge on almost every other aspect of that co-relationship: prevalence, diagnostic categories, causality, symptomatic presentation, and treatment. Sullivan's 1992 literature review, which comments on research in the area as "conceptually fragmented, with little cross-study consistency in theoretical frames", produced some useful distinctions. These help in looking at a complex phenomenon that encompasses special populations, various presentations, and refractory problems.

## **PREVALENCE**

Depression is not uncommon in the general population (Goldberg, Kerns, & Rosenberg, 1993; Magni, Moreschi, Rigatti, Luchini, 1994; Romano & Turner 1985; Roy et al. 1984; Sullivan et al., 1992). Numerical estimates of prevalence vary significantly. The American Psychiatric Association reported in the Diagnostic and Statistical Manual (1987, in Polatin, 1993) that clinical depression rates for the general population were between 5% and 26%. Polatin reports that when those clinical depression rates were combined with depressive symptoms (those not specifically classified as clinical depression) rates were at least 26% and in fact, higher.

When concurrent conditions of depression and chronic pain were examined together, Polatin found that 46% of patients had experienced the onset of depression after back pain.

He concluded that in those cases, depression was the consequence of chronic pain. Magni et al. (1994) presented findings with similar conclusions, reporting on studies in the United States by the National Centre of Health Statistics, which looked at the relationship between musculo-skeletal pain and depressive symptomatology. Over 2,000 subjects were followed up at two time periods, ten years apart. Among other findings, it was discovered that musculoskeletal pain predicted the development of depression; further, depression was sometimes secondary to chronic pain. However, this was true only for a cut-off of 16 on the CES-D scale; for more severe depressive symptoms (a cut-off of 20 or more on the CES-D scale), the relative importance of chronic pain as a predictor of depression was diminished.

Outside the United States and Canada, researchers (Mino et al., 1994) found rates of major and minor depression among medical clinic patients were similar to patients in U.S. clinics. However, in a finding similar yet more extreme than the U.S. findings, none of these patients had received a formal diagnosis of depression from their primary care doctor. Mino et al. explain the discrepancy between the negative diagnosis rates provided by treating Japanese physicians and the research findings of depression in the same patients, by assigning responsibility to the Japanese cultural stigma toward psychological problems. Although psychological distress is not broadly or culturally stigmatized in Canadian and American medical treatment, a mild prejudice was evident to some researchers (Korf, 1993; Sullivan, 1992); this suggests the possibility of under-reporting of depressive symptoms by patients who censor such feelings, or who fear disapproval or disbelief from treating physicians.

Chronic pain patients are often studied in populations whose members share a common site or type of pain, such as headache, backache, or arthritis pain. This convention of using a homogeneous pain population conveniences researchers, who often work with such specialized groups; also, the practice yields data which is more relevant for the specialized problems of certain groups. For example, some researchers have focused on back pain

(Holzberg, 1993), while others have worked only with arthritic patients. The incomparability of some pain groups to each other creates methodological difficulty in using their results to determine the general prevalence of depression among chronic pain patients. The two research examples above illustrate a difficulty in establishing prevalence rates. Results from studies are not easily comparable when there is variation in the type of pain studied, sample sizes, pain populations, duration of chronic pain, and methods of diagnosis.

Prevalence figures are significantly affected by these methodological issues, but also by mis-steps in the patient-physician relationship. The under-diagnosis mentioned above can be attributed in part, to under-reporting by patients, but it can also be attributed to diagnosis inconsistency by clinicians (Sullivan, 1992).

In a broad review of the clinical treatment of depression and chronic pain, Sullivan (1992) concluded that diagnostic inconsistencies for depression in chronic pain patients contributed to significant under-diagnosis. Such omission is both conceptual and clinical, and relates to patient reporting and practitioner inquiry. Patients and physicians alike may over-focus on somatic complaints, failing to explore the affective or psychological components of pain. Ironically, this "inattention" ( p. 13, Sullivan, 1992) to and thus, treatment of depression may have resulted from the notion that when pain and depression do co-exist, the depression is secondary to the pain. While perhaps chronologically true, that opinion of events discounts the pathological significance of depression as a separate, significant entity. It also presumes that treatment of depression may not succeed insofar as its believed cause (chronic pain) remains. Practitioners offering effective treatment to this population must be aware of the potential for patients' psychological distress and must refer them to mental health professionals for specific treatment for depression (Polatin 1993). Otherwise, the results are twofold: depression is left untreated or inappropriately treated, and prevalence figures are skewed.



Nevertheless, in spite of methodological differences, it can be said that depression is generalizable across nearly all chronic pain populations (Sullivan et al, 1992). Depression appears to afflict no group of chronic pain patients disproportionately; there appears to be a "universal fragility" (Askival' 1975) to developing the condition after certain types of events. In fact, analysis by some researchers (Sullivan, 1990) has shown that the association between depression and chronic pain was similar across pain types. Most of the quantitative research on chronic pain patients has been conducted within specialty pain clinics, and a lesser amount in medical clinics. A very small proportion of research has reviewed epidemiological data (Magni, 1994). These sources for information must be taken into account when drawing conclusions about the prevalence of depression in the chronic pain population. Psychiatrists and psychologists have headed most research studies, while medical doctors have initiated a minority. Commentators within the literature come from these professions, as well as from social work. Perspectives of these professionals vary from one speciality to another. Physicians usually focus on the somatic aspects of pain while psychologists and psychiatrists are concerned with mental and affective function. Social workers address some of the same issues as psychologists, and also become involved with the broader impacts of pain on an individual's life, roles and relationships.

Referral for psychiatric or psychological assessment of chronic pain patients typically takes place because non-somatic issues such as depression have slowed improvement from a painful condition or complicated the adjustment to chronic pain. Referrals are not necessarily accompanied by specific direction or treatment goals; in fact, it is a first task of the clinician to set these. Clinical objectives may or may not include treatment, depending upon the reasons for the referral, the interventions possible by a particular assessor, and the setting in which he or she works. Whoever is treating the patient at this stage shapes diagnosis and treatment (Bellisimo, Tunks, Roy, 1990) through their assumptions, concepts, and values. The

diagnoses that are made by psychologists and psychiatrists are largely a function of guiding conceptual models in their fields. The various conceptions of depression which are reflected in the literature can be seen most clearly in the diagnostic and measurement tools with which clinicians assess patient depression.

## **DIAGNOSIS OF DEPRESSION**

Diagnosis of depression commonly makes use of one of four main sources: the Diagnostic and Statistical Manual IV (DSM IV) of the American Psychiatric Association; the Research and Diagnostic Criteria (RDC, Spilzer, 1980); The Minnesota Multiphasic Personality Inventory (MMPI); and the Beck Depression Inventory (BDI). The former two guides are used most frequently by psychiatrists, the latter two by psychologists and non-psychologists. There are also numerous other guides and measures, but these four above are the most noted in the published literature. When other diagnostic tools are used, it is often in conjunction with these above, as they provide a definitive standard.

Descriptive labels for the presenting symptoms listed in these diagnostic guides and the extent to which patient conditions match those labels determine whether a diagnosis is applied, and thus, how patient-reported depression is viewed. Briefly, the descriptive categories within the first two guides include: major depression (without melancholia) (DSM IV) and major depressive disorder (RDC), which are largely comparable; major depression with melancholia (DSMIV), endogenous disorder (RDC), also comparable; and dysthymic disorder (DSM III) and intermittent depressive disorder (RDC) (Sullivan et al. 1990).

Most chronic pain patients' symptoms do not conform to a diagnosis of major depression or major depressive disorder, even though a significant minority do (Jensen et al. 1992; Romano & Turner, 1985); in fact, studies on chronic low back pain patients (Love, La Trobe, Bundoora, 1988) showed approximately one-third met the standard diagnostic criteria for major depression while another two-thirds were not clinically depressed, but nevertheless,

suffered depressive symptoms. Love's study, using the Beck Depression Inventory, illustrates a difficulty with the different, non-standardized criteria employed for diagnosing depression. Comparisons between studies are made difficult when clinicians or researchers have used different measurement techniques, such as the DSM in one case and the Beck Inventory in another. The measurement of depression is simply different. Also, the inclusive and exclusive criteria which distinguish major from minor depression or from a diagnosis of no depression at all, affect the prevalence picture of depression in chronic pain patients. Therefore, these criteria are important to examine.

In further discussion of the terminology above, Roy et al. (1984) noted in a literature review that even though consistent use of the DSM IV could resolve some diagnostic discrepancies, researchers nevertheless, continued to use different instruments and approaches, resulting in research descriptions which did not represent a single or distinct conceptualization of depression in chronic pain. This conclusion is also expressed by Sullivan et al. in a more recent review (1992). Those researchers observed that while the most used diagnostic tools in their review, the DSM III (then, now DSM IV) and the RDC, largely overlap in their categorization of, respectively, major depression and major depressive disorder, there are several other significant differences. First however, the similarities; symptoms listed in both guides include depressed mood, loss of pleasure or interest, appetite and sleep disturbance, loss of energy, psychomotor agitation or retardation, excessive guilt, concentration difficulties, suicidal ideation, depressed mood for at least two weeks. Differences between the guides relate to timing of symptoms. An RDC clinician might diagnose major depressive disorder after only one week of the above symptoms, and would require a greater number of symptoms, including vegetative signs, early morning waking, and presentation of diurnal mood variation. Clinicians using one of the other guides might make an equivalent diagnosis of major depression or depressive disorder, but could conceivably

formulate the same patient's condition differently, using a different time frame. In any given case, because of the exclusive and inclusive requirements of each diagnostic guide, the potential always exists for a patient to be diagnosed with major, minor, or no depression at all, but some other condition.

## DIAGNOSTIC NOMENCLATURE

A closer examination of the nosology of diagnostic criteria reveals further possibilities for digression among clinicians. In a much earlier review of the depression literature, Askival (1975) commented that clinicians varied in their interpretation of the "official nomenclature of depression diagnosis. For example, he comments that some diagnostic concepts are based on psycho-dynamic theorizing, which itself lacks empirical grounding. Further evidence of similar terminology possessing a theoretical basis but lacking empirical proof is the concept of alexithymia, a state in which a patient, "with no words for feelings" (p. 84, Sifreos in Joukaama, 1994), expresses little emotion, avoids conflict, and experiences diminished imagination or dreaming. Although he endorses the notion of alexithymia and the possibility that it may explain why "depression is masked in low back patients"(p. 84), Joukaama admits that measurement of the condition is difficult and that etiology is unclear. Without some standardized research confirmation which operationalizes the features and the reading of a syndrome like alexithymia, two potentials for misdiagnosis exist: firstly, there may be symptom overlap with other criteria for depression or other psychiatric problems; secondly, clinicians may interpret the reported symptoms differently and thus, diagnose differently.

Other labels for major depression include major depression with melancholia (DSM IV), endogenous depressive disorder (RSD), dysthymic (mental) disorder (DSM IV), and intermittent depressive disorder, including anhedonia, (depressed mood or loss of pleasure). These numerous diagnoses reflect diverse views of major, clinical depression; nevertheless, they reflect similarity insofar as they are similar to different photographic frames of the same

composition. Concerning less severe depression, the categories of minor depressive disorder, and depressed mood on the RSD parallel the additional DSM IV label of atypical depression.

While some chronic pain patients do develop major depression, many are diagnosed with minor depression according to psychological (including verbal, cognitive, experiential), somatic (physiological, biochemical), and psychomotor (motor-behavioural) symptoms (Askival, 1975). A lesser diagnosis (because it possesses some, but not all symptoms of depressed mood) is masked depression, meaning "hidden or smiling depression" (p. 84, Joukaama, 1994). Masked depression is equivalent to atypical depression. While some diagnostic labels describe different aspects of the same or a similar state, others do not, and clinical understanding is more obscured than it is benefited by this variety in diagnostic categories.

#### DIFFERENTIAL DIAGNOSIS

Depression in low back chronic pain patients is often irregular, does not conform to major depression, and sometimes possesses only some symptoms of minor, masked, or atypical depression (Joukaama, 1994). Similarly, Jensen's review reports on Love's 1987 and Turner's 1984 findings that the majority of chronic pain patients are not clinically depressed. However, these conclusions mislead because they refer to major but not minor, nor atypical depression, the latter arguably, the most common type of depression in chronic pain patients (Joukaama, 1994).

Joukaama states that "when all types of depression are taken into account, it may be that the total proportion of depressive cases in all . . . pain sufferers is quite high (p. 84)". Comparisons made by Sullivan (1992) add convincingly to Joukaama's contention. Citing the caveat that standardized diagnostic criteria do not exist to determine prevalence and that studies do not use a single disorder, Sullivan et al. (1992) nevertheless attempt to offer some prevalence estimates from their review of diagnostic and treatment literature; they report

epidemiological estimates of depression in the general population at 4% to 8%. However, in the chronic pain population, a single figure is more difficult to calculate. Sullivan et al.'s review article shows variations in diagnostic criteria, as well as the divergent prevalence figures (p. 6, 1992). If a prevalence estimate is not restricted to using a single disorder (such as major depression or major depressive disorder), but instead includes other forms of depression as well, and if the estimate also is weighted for sample size, then averaged, Sullivan et al.'s results show 62% of chronic pain patients presented with clinically significant depression. By this last phrase is meant depression which is significant to the clinician, but which is broadly enough defined to include major depression, dysthymic disorder, minor depression, and other types noted above in the discussion of minor depression.

Research from practitioners in pain clinics (Jensen, M.P. & Karoly, P., 1992) address the issue of differential diagnosis from a different viewpoint that also reveals in-built shortcomings. In their guide book for a multi-method assessment of pain, they note that the clinician must balance three exigencies: including all data in formulating a diagnosis; rejecting some data in formulating a diagnosis (in particular, some self-reported information by the patient); self-doubt of the clinician's own conclusions ("The interviewer is more prone to dissimulation than an MMPI, plus everyone knows the interviewer is soft-hearted") (p. 120).

The above criticisms and revisionary views of diagnosis and prevalence raise doubt about the even-handed application of diagnostic terms and criteria by clinicians in the field. The implications are huge of using similar yet different diagnostic labels and categories. If the nomenclature does not mean the same thing to different clinicians, or if it does mean the same thing but is being applied differently, then markedly different outcomes for the individual patient may occur. Knowledge of the true nature of a patient's condition is necessary to begin appropriate treatment and eventually, to achieve improvement. On a broader scale, inconsistencies in the application of diagnostic categories, both within and between

professions, significantly affects prevalence figures and the resources committed to treatment of those problems.

The above conclusions (Joukaama, 1994; Sullivan, 1992; Turner & Romano, 1985; Roy, 1984.) add an important footnote to any discussion of prevalence for depression in the chronic pain population. Fragmented by nosological, diagnostic and application differences, figures on this problem vary widely. In spite of a very large body of literature on pain and depression, few of the researchers or reviewers comment on prevalence. Of those who do, their findings suggest a much higher prevalence of depression in this population than available figures show.

If those higher prevalence estimate are accepted, it is abundantly clear that depression in chronic pain patients represents a serious problem. It is worthy of concerted attention from practitioners and researchers into causes and treatment. Much research, both broad and narrow, has been undertaken in recent years (Joukaama, 1994) to explore issues within the depression-chronic pain relationship. The question of causality is examined below, mainly from the psychosocial perspective. Observations are made about how the clinician's perspective of the patient is affected by answers found in the literature.

## CAUSALITY

The number of researchers who have studied the question(s) of what may cause depression in chronic pain patients is great. Sweeney et al. conducted a massive review of the literature on attributional style in depression. For this very specific topic alone, they reviewed over 250 references.

Researchers of depression alone and of depression and chronic pain together, have been unable to agree about its causes (Sweeney et al. 1986). None have concluded with reasonable certainty a cause or a complex of causes for the relationship between the two conditions.

Most research reports end with the suggestion for more study, methodological adjustments, or more careful statistical analysis.

First approaching the question of causality from a broad perspective, Magni et al. proposed three hypotheses about the relationship between depression and chronic pain: firstly, that chronic pain may be due to an underlying disorder, which is itself the primary disorder; secondly, that chronic pain causes depression; thirdly, that the two disorders share some pathogenic mechanism, but could equally well be distinctive, without interaction. Examining the first two possibilities, Magni et al. found that depression was sometimes secondary to chronic pain; however, they could not be more conclusive. It was suggested that in future research, a sooner follow-up of recent chronic pain and depression cases, perhaps those having only a six months to one year duration, might show stronger causal relations.

Joukaama, representing the broad spectrum school, concluded "no clear-cut linear causality between them" (depression and chronic pain), and endorsed Menges' 1983 analysis of depressed, chronic low back pain patients, whom it was proposed, fell into three different groupings. Each grouping shared different relative predominance of three components: somatic, social and depressive aspects. The population groups in which social or depressive aspects predominate, are the most frequently seen with issues of pain and depression at pain clinics. Menges' typology highlights an interesting fact: a portion of chronic pain patients do not develop depression. Their resistance to depression and the reasons for it may ultimately offer useful clues to researchers who are seeking to discover predictors or preventive measures to help chronic pain patients avoid depression. However, for those chronic pain patients who do develop depression, the causal question is important to answer.

In looking at causal issues, the literature can be roughly divided into two groupings, each having a different perspective on the causal agent(s); described simply, these viewpoints offer either a broad spectrum or a narrow spectrum focus. Either approach does not oppose



or exclude the other viewpoint, but each yields a different set of conclusions. Consequently, the clinical choice of one viewpoint over the other would certainly affect treatment and ultimately, outcome results for chronic pain patients.

## BROAD SPECTRUM IDEAS OF CAUSALITY

Joukaama and others (Askival, 1975; Jensen, 1992; Sullivan, 1990) have decided that the relationship between chronic pain and depression is complex and that causes of depression are multi-dimensional; further, they assert that on the basis of available empirical evidence, no specific causal connection can be concluded. Sullivan et al. (1992) refer to the "intuitive appeal" of concluding that depression results from "the chronic distress of chronic pain" but concludes that the idea is "tentative at best" (p. 12); the strongest association supported by empirical evidence is the co-existence of depression and chronic pain. The idea of stress as an inclusive cause appears elsewhere in the literature.

Von Korf (1993) posits a different but similarly broad relationship in the distinction between the functional disability of chronic pain and the distress of the pain itself. To be unable to engage in everyday activities stresses the chronic pain sufferer significantly. Von Korf, invoking the biopsychosocial model, comments that the distinction between chronic dysfunction and chronic pain is critical. In measuring the factors which bear on depression, it was discovered that the days which patients reported to be in pain were actually more strongly associated with disability from particular activity than with persistent or intense discomfort. In other words, the inability to perform certain activity was more distressing than the pain per se. By contrast, many patients with persistent pain were not dysfunctional. Thus, the level of (dys)function, according to von Korf, rather than the level of pain intensity, determined greater or lesser depression levels.

Roy (1992), reports on Turner and Romano's 1985 findings that for men in particular, disruption of customary activities was related to depression. A behavioural explanation (Fordyce, 1976), recapitulated by Turner (1985) maintains that the chronic pain sufferer becomes trapped in a cycle of increasing demoralization and depression because he or she is not able to engage in formerly active and positively reinforcing activities. When the patient does try to do so, he or she is negatively reinforced by pain. In a related finding, Magni reported that over time, a socio-demographic variable having predictive capacity for depression in men was employment status. Those men wishing but unable to work because of chronic pain experienced more depression than men with similar pain and working, or than those who did not wish to work. The predicament of disability from desired activity requires adjustments by the chronic pain sufferer and his or her family. This patient's adjustment and coping have formed the subject of considerable research, which either implies or states a narrow focus for causality. Many theories have been proposed, a large number of which fall into the cognitive, adjustment, or coping literature.

#### NARROW SPECTRUM IDEAS OF CAUSALITY

Magni and others (Gaskin et al., 1992; Geisser et al., 1994; Jensen et al.; Kuch, et al., 1993; Lindsey, 1992; Linton and Bradley, 1992; Love, 1988; Skevington, 1983; Toomey, 1993) believe that the mediation of specific causal agents can be identified. The formulation offered by Beck "posited that depression results from systematic negative distortions in cognitive processes, yielding a negative view of the self, the world, and the future"(in Romano & Turner, 1985, p. 30). This theory and related ideas about the significance of attributions has generated much theory and research in depression. Sweeney et al.'s meta-analytic review assessed over 250 studies in 1986, and they concluded on the basis of that review that a causal relation clearly did exist, although it could not be specified. Because so much research has

been done in this area of cognitions and their coping power, it is useful to acknowledge some of the common themes and findings in the literature. However, since the purpose of this review has been to elucidate a balanced clinical view of depression in chronic pain, only a brief summary of cognitive research will be provided.

The most striking fact about the body of research on cognitions and depression in chronic patients is that it is huge, dominating the discussion of coping and depression. A reviewer is met by a virtual cornucopia of ideas, theories, and interests. Several researchers (Jensen et al., 1992; Romano Turner, 1986; Roy, 1992; Sweeney, 1986) have classified this body of information into various schools, according to major theories such as the learned helplessness model.

Under the inclusive descriptor of attributional style in depression, Sweeney et al.'s (1986) meta-analytic review looks over the field of theory and research, beginning with Seligman and Abramson's model of learned helplessness, which "... suggested that the relationship between expectation of uncontrollability and depressive symptoms is mediated by an attribution of causality for the outcome that is perceived as uncontrollable" (p. 974). Revisions of this model according to locus of control, stability, and generality or globality of attributions added significantly to the study of cognitions and attributions in depression. Sweeney's discussion provides mainly methodological commentary and critique.

Jensen et al.'s review (1991) of the same literature takes a different approach, parsing the research into broad concepts such as beliefs, coping, and adjustment, and then discussing these in further subdivisions and greater detail. According to Jensen et al., beliefs explore the meaning of pain to the patient, as well as its effect on his or her own adjustment. The study of beliefs is categorized into: locus of control; belief in control over pain; attribution style; cognitive errors; "negative distorted beliefs" about oneself or one's situation; catastrophizing (misinterpreting events to be catastrophes); personalizing; self-efficacy beliefs, the opinions a

patient has about his or her ability to affect desired consequences. These concepts flow from the social learning theory model (Goldberg, 1993) and a related model, outcome expectations, referring to the extent that a person believes actions will result in successful outcomes, rather than disappointing outcomes. Numerous beliefs held by chronic pain patients, as well as clinicians, are also explored in Jensen's review; these include: belief in the right to solicitude from others; belief that one is disabled; belief that medication is appropriate for chronic pain; and belief that chronic pain impairs one's functional ability. These theoretical groupings, not exhaustive and mentioned only briefly here, nevertheless demonstrate the range of cognitive theories which have been examined by researchers, and whose efforts number in the hundreds.

#### **COMMENTARY ON THE RESEARCH LITERATURE**

The results from this research literature, unfortunately, have been inconsistent (Sullivan, 1992; Sweeney, 1986) and empirically inconclusive (Jensen, 1991). Although prolific, these mixed results offer limited utility for clinical work with depressed patients; at most, the results can help to suggest hypotheses, but can not give certainty. This limitation notwithstanding, the body of theory has been rich, interesting, and stimulating, providing a better understanding of an extremely complex and often confounding question: What causes depression in chronic pain patients? The study in this field has failed to answer that question; nevertheless, the theory and quantitative research together have generated insightful exploration. The resulting body of work has suggested some bases which are useful to clinicians for their own insights, hypotheses, and investigations with depressed clients. An example is evident in Goldberg et al.'s study of negative affect and the pain experience.

Goldberg et al. were unable to prove the degree of contributions by specific, discrete emotions to pain-proneness. Nevertheless, they discovered a distinction important to both diagnosis and understanding of causality: situational affect, not affective traits, predicted pain

levels. Thus, for example, state anxiety not trait anxiety affected depression, which in turn, affected pain. This finding about anxiety, that a transient mood affected by events could predict changes in depression, represents a significant departure from the research trend, which had emphasized personality. In other words, Goldberg et al.'s finding provides further support for the notion that depression is a response to the stress and debilitating consequences of chronic pain.

Another example of a specific situational affect which stood apart from other findings concerns anger. In Ham et al.'s research into psychopathology and pain (1994), state anger did not achieve statistical significance. Nevertheless, compared to other scale measures (somatization, obsession, compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation) state anger (distinct from trait anger, also measured) was the only significant result amongst many affects. To the extent that this finding about state anger is accepted, it offers the clinician possibilities to watch for or measure in clients. Also, this finding on anger shows how the broader notion of stress is given added meaning by more specific information about particular emotions which may be distressing the patient.

The (narrow) spectrum focus on specific cognitive and affective components in this causal literature provide the clinician with another tool to use with individual patients. The varied symptoms which individual patients present, and their sub-clinical issues (those which may have been undiscussed or as yet undiagnosed) are challenging to the chronic pain clinician. This research suggests additional information and new directions which should aid in the formulation of hypotheses at the beginning and throughout the course of treatment. It is also possible that treatment which selects and targets specific, affective symptoms may be more successful in the treatment of depression and chronic pain than other methods, since each affective or cognitive aspect makes a "unique contribution to the overall magnitude" (Wade et al., p. 310, 1990) of patient distress.

In evaluating the contributions of the cognitive and affective attributional literature to questions of causality, critical parameters must be clearly defined. If seeking empirical verification of the large body of theory, the research and reviews in the literature fail to provide proof. In their detailed review, Sweeney et al. concluded it was clear that attributional style was related to depression, but called for there to be no further causal studies, except to confirm causal direction or the influence of mediator variables. Further, they recommended that inconsistencies and differences in the findings of much of the attributional research be investigated.

Both broad spectrum and narrow spectrum viewpoints on the causal relationship between depression and chronic pain have merit. The first affirms the question of relationship. The second attempts to detail what constitutes the elements of that relationship or what mediates it. As noted above, some very useful findings have been produced, such as Kuch's ideas about anxiety or Ham's results about state anger. Affects like these suggest directions and checkpoints for the clinician to use in making his or her hypotheses and diagnosis. Jensen et al. have arrived at what may be an intermediate position or compromise. After delineating the strengths and weaknesses of the cognition research, they concluded that coping, adjustment, and appraisals mutually interact as a process for the chronic pain patient. The precise content of each patient's coping, adjustment and appraisal process are something which each clinician must elucidate with the best measurement tools available and with well-attuned listening skills. In fact, Sullivan, Reesor et al.(1992) point out that there is no substitute for well-developed listening in the diagnosis process.

## **CHANGE AND SUFFERING; KEYS TO BETTER UNDERSTANDING AND TREATMENT**

The diagnostic stage generates information for treatment, and thus, shapes clinical work with the patient; information collected or omitted foreshadows outcome possibilities. Two

major kinds of information which are largely missing from the literature discussion may have significance for clinicians and patients. These are: firstly, the elements of change in a patient's condition and how it affects long-term prognosis, as well as coping and adjustment; secondly, suffering, and how it simultaneously defines and obfuscates the state of depression in chronic pain.

### CHANGE

Von Korf et al. have produced a common-sensical but nevertheless, radical suggestion for the clinician, insofar as it is not expressed by other researchers or reviewers: "The term chronic pain has a tendency to conjure up ideas of stability and unchangeability . . . It is variation, not stability, that is in fact the dominant characteristic of most long-lived conditions" (p. 862, 1993).

Von Korf et al.'s position states firstly, that change is common in a chronic pain patient's condition, and secondly, that the variation which happens naturally can help the clinician working with a patient. Whatever state a patient is experiencing on a given day or period of time, probably does change at other times, thus allowing for new clinical readings on the problem or generating of new hypotheses for treatment. To the extent that the patient and the clinician can identify the nature and quality of these changes, and then utilize them with small or useful adjustments controllable by the patient, the variation in the chronic pain condition can foster adaptation rather than resignation. By contrast, the typical *modus operandi* of the chronic pain patient is to adjust to the worst variation of chronic pain, and to organize his or her life in response to that. To accept the worst extreme of a painful condition as the norm is understandable, since it does not risk disappointment. However, such an adaptation fails to take advantage of better states, to learn from and to use a temporary advantage. Following Korf et al.'s admonition requires more flexibility by the clinician, the patient, and his or her family, but yields potentially more benefit from the improved states of change. The

alternative, failing to notice or to use the potential benefits of variability in a chronic pain condition, misses a therapeutic opportunity. It is one which is best noticed by the clinician early in treatment but also monitored throughout.

These changes in a patient's condition, whether they occur from day to day, week to week, or month to month, are difficult to quantify in research. They constitute the one of the unique aspects of a patient's case. Different pain populations may exhibit similar change patterns, of which the clinician should be aware, but there will also be individual variation within that pattern, produced by a myriad of differences (overall health, family configuration and relationships, role responsibilities, employment status and duties, residential circumstances). The clinician working with a chronic pain patient is able to diagnose and prescribe more effective treatment strategies when circumstances such as those above are known. In addition, clinical effectiveness is improved by awareness of another major component of chronic pain depression, the experience of suffering.

## **SUFFERING**

Suffering, an aspect of depression addressed by some researchers (Fordyce et al., 1985; Joukaama, 1994; Roy, 1992), places a broad, personal imprint on each patient. It is an ambiguous experience for researchers to study, because it is ineffable. Suffering includes the subjective quality of pain alongside the physical experience, and is accompanied by tragic feelings such as sorrow, loss, anger, anxiety, and bitterness. Suffering, like depression, crosses over between cognitive, affective, behavioural, and physical pathways. (Askival, 1975). Personal strengths are often subverted and weaknesses exaggerated; the individual's personality can become distorted. Individual consciousness and the ability to relate to the world are fundamentally altered. Finally, chronic pain isolates the sufferer from others through his or her experience and (in)activity, imposing loneliness. Together, these consequences and the resulting cognitive-affective (mal)adjustments constitute suffering.



Fordyce (1985), in a defense of behavioural treatment methods, notes that they treat the behaviour of disability and the expressions of suffering, but not the sources of those; he states that there is no "modification of nociception" (p. 115), nor any "attention [paid] to the antecedents of nociception." Thus behaviourists, while acknowledging both the aspects and sources of suffering, do not attend to them. Pharmacological treatment of major depression is necessary and suitable, but sometimes not an appropriate intervention for the type(s) of depression, nor in particular, the suffering of chronic pain patients.

Analyzing chronic pain patients' suffering illuminates understanding of their situation, and should accompany any intervention. A few researchers (Roy, 1992; Wall & Jones, 1992) have touched on this very complicated aspect of the chronic pain patient's predicament. In a chapter eloquently titled "The Unanswered Cry", Jones and Wall trace the historical, social, and cultural antecedents of medical practitioners' disinclination to treat "psychological" aspects of pain in favour of treating its physical manifestation. They conclude that the usual diagnostic formulations of pain share in a myth of pain as a terrible but an ironically "ennobling" (p. 152) experience. Further, they submit that in spite of the advances made in the understanding and treatment of pain in recent decades, this myth persists, injecting the attitudes of clinical practitioners with approval or disapproval for patients who suffer bravely or not, respectively.

Roy (1992) delineates the multitude of a chronic pain patient's losses: "... futility, nihilism, helplessness, and hopelessness" and finally, their "demoralization" (p. 29). He concludes that this litany of noxious emotional reactions only begins to describe the quality of the depressed chronic pain patient's experience. The demoralization, in particular, is an aspect of experience which most clinicians are reluctant to actively treat, in spite of all the theoretical and empirical investigations into affective and cognitive components of chronic pain depression.

Why the reluctance to treat so significant a set of affects and cognitions and so needy a patient? The depressed chronic pain patient poses a huge challenge to all practitioners. The multi-layered condition is so complex and the patient's despair so profound that it can daunt the resources of competent professionals. Why? Explanation may lie in the fact that patient suffering on the order Roy described poses questions of meaning for the patient which are very difficult (for anyone) to answer. Assisting the chronic pain patient to answer those is a task with which clinicians have not been aided by the research or literature.

For the depressed chronic pain patient, his or her role(s) in life are uprooted, and fundamental feelings about the self and relationships to others are upturned. Nothing works as before. Practical aspects of living require specific practical, affective, and cognitive adjustments, as well as world-view adjustments. Ironically, it is specifically those kinds of adjustments and how to clinically effect them, which has received so little attention in the literature. Many researchers have studied specific questions about particular relationships between affect and depression, but few have addressed the issues from a clinical point of view. Separate findings such as those about anxiety (Kuch, 1993) or anger (Ham, 1994) and depression are useful particularities to investigate with patients; however, when viewed together, the set of affective and cognitive reactions create a broad, negative underpinning, in other words, suffering. The impact of this inclusive condition erodes patients' coping abilities and strains his or her family. Suffering and the questions it produces, require more attention from both researchers and clinicians.

In order to be ameliorated, suffering must be acknowledged as a component of chronic pain depression. Further, it is suggested that this inclusive condition should be treated early, since otherwise, its pervasive, corrosive effect may vitiate other therapeutic efforts. Patient losses range from employment, income and the (in)ability to fulfill family roles, to interpersonal and sexual relations, as well as to more general life satisfaction. The

combination and order of losses varies from patient to patient, but usually includes some or all of the above-noted. Helpless to reverse the chain of loss, the depressed chronic pain patient typically feels saddened, bereft, and alone. Feeling that they cannot help themselves, and importantly, that others may not be able to help either (Skevington, 1983), depressed chronic pain patients can, with appropriate intervention, achieve improvements in their situation, their outlook, or their reconciliation with what cannot be changed. Without appropriate intervention, powerful, negative emotions can overtake the consciousness of these patients, intensifying their suffering of what is already an unfortunate situation.

A companion concept to the notion of suffering is helplessness (Fordyce, 1985; Roy, 1992; Skevington, 1983). Associated with depressive suffering, feelings of helplessness subvert the individual's strengths and exaggerate weaknesses, compounding deficits imposed by the physical condition. Jensen and Karoly's research (1992) found that depressed chronic pain patients who felt less in control of their pain tended to make more negative appraisals of their own personality traits than patients who perceived that they had better control. In other words, a perceived inability to control pain undercut the individual's ability to problem-solve, and instead, encouraged negative self-perceptions. Not only could the patient not change events, but he or she also *felt* ineffective; both the state and the reaction contributed to demoralization. Jensen and Karoly found that negative appraisals intensified over time, such that patients who suffered chronic pain over a longer period (more than 11 years) were unable, even with help, to reverse negative thought patterns.

Further impairing the depressed chronic pain patient's ability to improve his or her situation is the belief that others can not help, that he or she is alone with the pain and the struggle to endure it (Skevington et al. 1983; Romano & Turner, 1985). This cognition isolates the sufferer psychologically and practically. In earlier research, Jensen et al. (1991) found that patients who had greater experience with severe pain were disinclined to seek

social support, a finding which raises the question of why family members generally fail to respond supportively. This finding supports an argument for a therapeutic approach which involves family members in making adjustments and finding solutions, along with the chronic pain sufferer.

Such social intervention, however, is rare. Roy (1989, 1992) reports that although families are frequently involved in the post-treatment and therapy of spouses with myocardial infarctions or chronically ill children, almost no studies exist which explore the positive involvement of family in therapy for chronic pain. Studies of the behavioural approach to chronic pain conclude that families frequently reinforce pain behaviour, whether advertently or inadvertently (Fordyce, 1976 in Roy, 1985; Fordyce, 1985). To the extent that this circumstance is true, families can also be helped to encourage and support positively adaptive behaviour.

This review of research and clinical literature for the depressed chronic pain patient found researchers made relatively few recommendations for devising or including social support for the individual in treatment. An exception, Herr (1992) recommends involving families and caregivers of depressed, elderly chronic pain patients in planning their interventions. Linton (1992) found in a post-program review of subject compliance with a back-pain recurrence prevention program that family support at home with the program corresponded with a relatively high (77% mean) maintenance of exercise-activity level, rest, and use of ergonomic recommendations. This aspect of clinical care, arranging for assistance with day-to-day living, simultaneously attends to objective needs, as well as to the subjective side of improvement, patient feelings of loneliness and hopelessness. Family members and others in the patient's environment can add powerful, consolidating support to clinical treatment. Even though the types, amount, and timing of spousal and family support must be carefully worked out, research (Goldberg, 1993) within the cognitive-behavioural model

shows some support for the beneficial support offered by spouses against the stress of depression and chronic pain. Most often, patients' families are a resource which is unused in chronic pain and depression therapy.

Whether patients' affective suffering is completely resolved or merely improved, practical steps such as those noted above help to diminish patient depression, and finally, to improve the individual and social "fallout" from chronic pain.

To summarize, the evidence in the chronic pain-depression literature shows a strong association between chronic pain and depression. Prevalence levels for this condition are significant, and if all types of depression are taken into account, the prevalence levels are high. The type of depression most common to chronic pain sufferers is classified by many researchers as minor or atypical. However, clinical diagnosis of depression is very uneven, perhaps because the symptoms of these patients vary, and do not fit a fixed or predictable diagnostic set. Also, change over time appears to be a common, potentially useful (for clinical treatment) aspect of the chronic pain-depression condition. Patients would be better helped if these facts about chronic pain and depression were better known to all practitioners.

The suffering which chronic pain imposes on the patient demeans his or her existence in a variety of ways (Wall & Jones, 1991). The reach of chronic pain and depression into the lives of sufferers is intense and epic. This sober fact and the catalogue of losses with which the depressed chronic pain patient lives define pressing individual needs, as well as important social needs, when the family and the network of a person's relationships are taken into account.

At the centre of this field is the patient and his or her suffering. The individual needs a central focus that the research and literature have not yet offered. Further, the emphasis of research needs to shift away from theoretical speculation on causality to clinical treatment (Sweeney et al. 1986), until now less studied. Such study would benefit sufferers and their

families if it included them both in the diagnostic and the treatment processes. The colours of a patient's emotional and social life create a picture "worth thousands" of research words. The whole composition offers clinicians an invaluable navigational guide for treatment.

### **A SUGGESTED APPROACH FOR CLINICAL TREATMENT**

In counselling these patients, the clinician works with the personal material that the client can relate about his or her suffering. Understanding of the individual's world is best provided by the his or her self-report through interview and inventories, even though there is some inevitable distortion (Jensen, 1996). The patient's story is after all, the best information that the clinician will get.

Client material that is useful for therapy includes the content of an individual's beliefs and attitudes relating to pain. A large part of the literature on pain and depression has studied affect and cognitions. In their review of the literature Jensen et al. (1992) concluded that appraisals, coping, and (mal)adjustment mutually interact as a dynamic process in the chronic pain patient. Degood and Shutty (1992) support this idea when they note that cognitive behavioural theory is helpful for the emphasis given to the "reciprocity" of cognitive, affective, and behavioural responses to pain. Particular emphasis in the literature is given to beliefs because they inform or mediate attitudes and feelings about pain. These cognitions present a logical starting point for working with clients on the problem of chronic pain.

Cognitive behavioural interventions orient to the "phenomenal world" of the patient and how he or she "construes a presenting problem (p.181, Turk et al., 1983)." An example is the theme of loss in many depressed patients' histories (Beck, 1976). Their conviction about loss(es) underscores respective thoughts and feelings. Even though some losses for the depressed chronic pain patient are both inevitable and significant, the near-total enervation and dysphoria associated with them can distort the patient's life. The total effect of negative

feelings is exponential: it is not simply that a patient like Edward (one of the practicum patients discussed below) who set inappropriately high performance standards for himself does fail to perform former tasks. Those performance standards and the resulting physical strain of his pain after trying, his disappointment, and his self-criticism thrust him into a welter of mostly negative experience.

In many chronic pain cases, the patients' beliefs and attitudes reflect pain-induced distortion. Beck notes that the depressed person exhibits a "cognitive triad [:] . . . a negative view of his world, a negative view of himself, and a negative view of his future" (p. 105 - 106, Beck, 1976). Therapy seeks to draw new baselines with the patient. Helpful questions to pose early in cognitive therapy might be : "What is reasonable activity for you now, when you almost always have pain?"; "What are fair family expectations of a person who is often exhausted by working with chronic pain?"; "If a certain level of activity and the pain that follows that activity demoralizes you, how sensible is the activity?"

Central to the individual's losses is the personal meaning or the weighting given to specific, real losses, and equally well, to symbolic investments or catastrophic fears. These meanings, expressed through social roles and activities, when explored with the clinician, contain valuable interpretative material for understanding patient beliefs and attitudes. The patient like Marion, who had always helped others but with chronic pain found herself feeling resentful towards them, engaged in several cognitive distortions. Marion had sympathy for others, but not for herself. Further, when burdened by her own physical needs, she also felt tremendous resentment and anger towards these same people. Learning about the backdrop of this type of personal meaning provides the therapist with data to formulate hypotheses and plan cognitive-behavioural interventions appropriate to the individual's situation. In Marion's case, this task included reviewing the client's obligations and activities in relation to others.

Adjusting her cognitions meant first, accepting that she should expect more help from her children and second, make herself less available to help extended family members.

Along with beliefs, emotions contribute to pain and depression so that "a variety of disturbing emotions typically co-exist with chronic pain" (p. 132, Price & Harkins, 1992). Depression, even if salient, is usually accompanied by other negative feelings. Cognitive behavioural therapy provides a rational ground on which to begin exploring with the client the connections between beliefs, feelings and problems. This understanding, in turn, provides a sound basis on which to begin problem-solving.

### **PRACTICUM OBJECTIVES AND AIMS**

This clinical social worker wished to broaden her own practical knowledge of the population of depressed chronic pain sufferers. Primary goals were to gain exposure to a variety of sufferers and then to learn and practise techniques for helping them adjust to a physical condition that was unlikely to improve. Time and selection constraints imposed certain limitations on exploring this clinician's interests.

In particular, this student clinician found it necessary to restrict therapy to the chronic pain sufferer alone, rather than extending it as well to the family of the primary client. Also, she used a broad working definition of depression that enabled a sooner start-up and a longer program of treatment than would have been the possible had she waited a necessarily longer time for clients who met research criteria for clinical depression yet also had no psychiatric complications.

In her clinical practicum for a Master's degree, this social work student proposed an intervention using cognitive behavioural techniques with chronic pain patients.

The first aim was to help these patients to modify thoughts or feelings related to their pain as well as to emotional and/or social relationships, in order to improve quality of life. In



cases where the individual's chronic pain was severe or had been long-term, it was recognized that changes to mood or function might be modest.

The second aim of this practicum was to acquire knowledge of and skill in using cognitive-behavioural techniques, a form of intervention having applicability with this special population and with others in the field of social work.

## **RATIONALE FOR INTERVENTION**

The importance of psychosocial factors in the complex phenomenon of chronic pain and disability has been clearly established in the literature:

Consideration of psychosocial factors has become a routine component of the assessment of chronic pain conditions. . . . to ignore the possible deleterious effects of chronic pain on the individual's life, or to fail to take into account possible psychological, interpersonal, and sociological contributors to the development and maintenance of the pain complaint leaves the clinician vulnerable to erroneous assumptions about the extent of the problem, its etiology, and possible solutions. (Kerns & Jacob, 1992, P. 245, 246)

Depression is so routinely a part of chronic pain that many clinicians (Waddell, & Turk, 1992) view it as a kind of distress that is not unexpected. Although realistic, a clinical expectation of finding depression in the chronic pain patient and description of it as understandable distress may miss for assessment or treatment important and unique aspects.

These conclusions notwithstanding, the actual treatment of depression in chronic pain is a less certain matter, as has already been discussed above. A variety of treatments may be prescribed for patients. For example, a frequently recommended treatment (Sullivan et al., 1992) for this population is with pharmaceuticals (tricyclic antidepressants) or through structured psychological interventions. Cognitive behavioural therapy, used in many chronic pain treatment programs in North America (Turner & Jensen, 1993), as well as with depressed persons (Beck, 1969, 1979, 1989; Fordyce et. al., 1985; Thompson & Campbell, 1992), offers

a standard, tested method that, if used with common themes and some individual tailoring, should offer benefit to this special population.

If treatment of depressed chronic pain patients is to be effective, their unique presentation must be recognized as a special form of depression and must be accordingly treated. The chronic pain patient who presents as deeply sad and unhappy may resemble the clinically depressed patient but may not meet some or even most of the standard tests for clinical depression. A clinical approach to depression or the appearance of depression for this population must appreciate the varied symptoms that these patients display. It must also take into account when planning and conducting treatment, the particular circumstances of each individual.

Any treatment intervention should possess the flexibility to acknowledge depression, in whatever forms it is found, and to select methods that will ameliorate the condition. Focusing on some common themes provides a helpful clinical entry to treatment. Knowing the aspects of chronic pain common to almost any patient's situation helps to create an etiological understanding for the clinician that in turn, facilitates early clinical rapport. Clinical intervention offering treatment that encompasses common themes, yet shapes to the individual's situation serves an identified need.

## **RATIONALE FOR COGNITIVE BEHAVIOURAL TREATMENT**

The research shows that pain coping is more or less effective according to various constellations of beliefs and attitudes individuals hold. The extent to which these are maladaptive affect clients' belief in such things as the mysteriousness or permanence of pain. These latter two ideas have been found to be negatively correlated with coping efforts. However, when clients' usual cultural coping beliefs (for example, common sentiments like : "You'll get better."; "Let's hope it improves.") fail, some sufferers develop different beliefs,

more compatible with their own experience, that help them to cope, more or less adaptively. This capacity by chronic pain patients to adopt new beliefs concerning their pain or its meaning permits a clinical opening for intervention. The change possible in attitudes or beliefs provides the grist for cognitive behavioural treatment.

Thinking and feeling, although complex processes that operate at conscious and less or un-conscious levels (Martin, 1983), are accessible to the clinician through clinical evocation via the client's memory and reflection. Cognitive behavioural therapy posits that emotions are shaped by thoughts and these can be consciously shaped by the subject him or herself, with therapeutic help. An individual can restructure thoughts relating to a problem, thus taking a first step toward feeling differently. Faulty thinking Beck (1976) usually means less effective adaptation by the depressed chronic pain patient to a predicament. The cognitive behavioural therapist works with the client to first identify negative thinking and then to shift ideas toward more positive thinking. Likewise, the dynamic that permitted self-defeating behaviour to pair with negative cognitions and negative emotions can shift to adaptive behaviour and adaptive cognitions.

A case example is seen in Alain (a pseudo-name), who had found most physical activity difficult because it aggravated his chronic pain. Alain thought he should be able to manage his former involvements and because he could not perform even modest activity, felt disappointed, guilty and anxious. Cognitive therapy with this client worked toward restructuring his thoughts so that he might accept more realistic standards for his own activity. Another goal of cognitive therapy was to have Alain consider and select some recreations which might relax and revivify him. However, this choice was complicated by the fact that the client's pre-pain activities, though they had required significant physical effort, had also produced social benefits. The physical effort Alain needed for these activities required energy which he did not now possess. Demonstrating a cognitive distortion, Alain's self-expectations

and his insistence on trying this roster of activities did not match his physical capacities. The clinical task was to have the client recognize that even though his capacities would not change, his world view could.

## **THE PRACTICUM EXPERIENCE**

### **THE INTERVENTION**

The primary purpose of this clinical intervention was to provide therapeutic help to chronic pain patients who were suffering from depression and possibly other negative affects. The intervention's secondary purpose was to provide a clinical learning opportunity for this social work student.

Clinical social work activities for the practicum were to assess and counsel through cognitive behavioural methods chronic pain patients with the above difficulties by focusing on four themes that the literature had identified as present in most patient histories: cognitive distortions, unsatisfying relationships, hopelessness, and negative affect. The themes were addressed in this order with all clients over a 10-session program that began after the first or second meeting.

The first or second meeting(s) were used to establish rapport with clients, to gather intake information, and to judge the clients' suitability for the cognitive behavioural program. Clients were given the free choice to participate in or to forego the program; alternate treatment was available if clients were not receptive. It was anticipated that realistically, treatment might need to continue beyond 10 sessions for some clients; however, that clinical judgment was to be made for each case by the clinician and her supervisor near formal completion of the intervention program. To maintain the integrity of judging change or

improvement, any extension of treatment would be considered as separate from this particular intervention.

## THE TREATMENT SITES

The primary site of treatment was the St. Boniface Hospital Pain Clinic, where medical treatment and psychological counselling are offered to chronic pain sufferers. The physicians working at the clinic offer a variety of treatments: acupuncture, acupressure, injections to painful areas, massage, relaxation, and heat treatments.

When one of the pain clinic doctors became concerned that issues such as stress, depression, family difficulties, or other personal matters were complicating recovery, they referred patients to the psychologist or social worker. These referrals took place simultaneously with or following medical treatment. Usually, counselling by the psychologist or social worker lasted for two to three months, although in a few cases it might continue for six months or longer.

The secondary site for treatment during the practicum was the Psychological Service Centre at the University of Manitoba. A training centre for clinical psychologists and social workers, it is accredited by the Canadian and the American Psychological Associations. The centre provides facilities for complete supervision of trainees who normally work with a variety of clients during training. In this clinician's case, clients were all chronic pain sufferers who had exhibited some signs of depression.

Both facilities were adequate for the therapy undertaken by this student. On-site supervision was available in both locations, and weekly supervision sessions took place with the student's practicum supervisor and advisor.

## THE CLIENTS

Six (6) clients were selected for this practicum. In this report, clients are referred to by pseudo-names, so that their identity is masked. With one exception, the individuals had been

referred to the psychologist by the St. Boniface Hospital Pain Clinic doctors. In the sixth case, the individual was referred for personal counselling by her family doctor to the University of Manitoba Psychological Service Centre; However, eventually, she was also seen by a pain physician at the Pain Clinic. Three men and three women comprised the client group, with ages that ranged from thirty-three (33), a woman, to fifty-nine (59), a man. All were married and currently living with their spouse.

Areas of chronic pain were different for all but two subjects who both had back pain; other subjects experienced chronic shoulder pain, post-surgical anal pain, fibro-myalgic pain in various locations, and frequent, recurrent migraine headache pain. The intensity and frequency of subjects' pain varied, from chronically uncomfortable to sometimes excruciating pain. This pain variability for some clients related to changed activity such as greater exertion at work or in home tasks that had precipitated temporarily intensified discomfort.

Often, individuals had no choice about changing their activity and knew that it would probably cause increased pain. An example is Edward, who was frequently required at work to repair heavier pieces of industrial machinery than he felt comfortable working on. These tasks required greater lifting or exertion than this client could perform without aggravating his chronic discomfort. He could predict that if he did this type of work, his shoulder would stiffen, pain would increase, and he would have difficulty moving and sleeping. It was clear that, for Edward, a substantial physical cost was attached to performing this type of work with his chronic pain.

## **METHODS**

The set of negative feelings that chronic pain sufferers experience impacts substantially on their practical and personal lives. For this practicum intervention, the student selected four areas that she considered were both common and important to most individuals: unrealistic or

distorted ideas about their disability, difficult personal relationships, hopelessness, and painful emotions. The student clinician planned to use these four, sequenced themes as a focus, addressing each with clients for approximately two sessions. As a priority, one or more of the four themes began each session. However, other personal material that patients presented also formed part of therapy content.

A protocol for ten (10) sessions was conceived, and the outline follows below. Topics and activities were broached similarly with every client.

### COGNITIVE BEHAVIOURAL THERAPY PROTOCOL

#### Session 1

- all measures (BDI, CIPI, SOPA)
- interview to assess chronic pain impact

#### Session 2 -Distortions

- review assessment results with client
- set realistic goals collaboratively for client-desired change
- choose interim steps to goals
- discuss tasks leading to goal achievement

#### Session 3 - Distortions

- review attitudes and goals; assess consistency and practicality
- review client self-talk; adjust to support goals
- discuss behaviour and attitudes which undercut goal and task achievement
- rehearse / role-play behaviour which relates to goals

#### Session 4 - Relationships

- monitor progress toward realistic cognitions

- discuss nature of client's expectations, engagement, and satisfaction in relationships
- ascertain areas of desired improvement
- select areas for improvement and tasks necessary to achieve changes

Session 5 - Relationships

- review client task performance on relationship issues
- adjust or add tasks, as appropriate
- review with client both intimate and social relationships
- have client select relationship(s ) to renew, initiate, or improve

Session 6 - Hope(lessness)

- discuss both short and long-range hopes and goals
- discuss negative versus reasonable predictions
- make action plans for reasonable goal achievement

Session 7 - Hope(lessness)

- review task accomplishment from action plans
- link some hope goals and tasks to personal relationships
- encourage small successes

Session 8 - Painful Affect

- discuss acknowledgment and acceptance of losses
- encourage positive appraisals and discourage negative outlook
- discuss humour and select exposure activities
- identify pleasure and mastery activities in client's life

Session 9 - Painful Affect

- continue encouragements from Session 8



- plan pleasure and mastery tasks
- Review humour homework
- Practising interpreting events positively with client

#### Session 10 - Reassessment

- Monitor success, pleasure and humour activities and homework
- Repeat assessments (BDI, CIPI, SOPA)

### ASSESSMENT INSTRUMENTS

Measurements of depression, pain-related problems, pain beliefs, affective distress & illness focus were taken, using the following instruments:

- Beck Depression Inventory (BDI)
- Chronic Illness Inventory (CIPI)
- Survey of Pain Attitudes (SOPA)

### TIMING OF MEASURES

- Pre-treatment: all above measures
- Post-treatment (session 10): all measures

### DURATION OF PRACTICUM

The practicum spanned the months between January 1997 and July, 1997, inclusive.

Treatment for each client covered 10 sessions, held at one or two-weekly intervals.

### RECORDING ASSESSMENT RESULTS

Client scores on assessment instruments and clinical notes were placed in individual client files, separate from pain clinic files, where a similar, independent record of visits and progress notes was also kept.

### CLINICIAN LEARNING

Development of clinical skills in cognitive-behavioural and other techniques were regularly reviewed by the student's supervisor during treatments and were evaluated at the conclusion of the program.

### PROGRESS OF CLIENTS

A formal intake report documented interview data and clinical impressions from the first meeting with each client.

Interview notes were made by the clinician after each therapy session about the progress and ongoing results of cognitive-behavioural treatments.

Client changes, treatment and progress were reported by clinician and regularly monitored by supervisor in weekly supervision sessions.

### ASSESSMENT

To assess clients' social and psychological status, a combined approach used clinical interview and patient self-report measures. When assessing some matters such as coping strategies, an area where research results are uneven (Degood & Shutty, 1992), interview remains the more effective tool; however, self-report instruments, which may measure subtle changes after treatment more precisely than clinical interview (Bradley et al., 1992; Jensen, 1996), were also chosen. As a standard clinical tool, the structured interview serves to provide the first and strongest observations for diagnosis and the formation of working hypotheses. Conversely, as a check to interview impressions, psychometric findings also

confirm or disconfirm the clinical judgment and, if carefully chosen, psychometric instruments may offer additional information for guiding treatment; most patients' answers in self-reports are accurate, trustworthy, and can be correlated with other measures of their distress (Jensen, M., 1996).

Modern psychometric practice recommends several measures of the same construct to produce a composite picture, which should come closer to accuracy than any single measure (Kazdin, 1992) and also, should predict response to treatment (Degood & Shutt, 1992). In accordance with these viewpoints, three different instruments were chosen for intake and outcome measures in this practicum.

## **INSTRUMENTS**

Formal assessment of clients for the practicum intervention included use of both interview and three self-report measures. In all cases, the student clinician met with the clients once before the beginning of the formal protocols described above. The purpose of the prior contact was to meet, explain the program of treatment, obtain a full history of pain-related problems, clinically judge for depression, and lastly, screen for any psychiatric problems that might complicate therapy.

Treatment was the primary aim of this intervention. The instruments described below provided a means to confirm clinical judgment, as well as to evaluate changes following treatment. In order to assess any changes after the cognitive behavioural intervention, these instruments were considered to provide a cross-check to clinical diagnosis of presenting problem(s) and the therapist's impressions of client response; also, the data from these instruments provided useful feedback to the student therapist who was developing her clinical assessment skills.

Because inventory information can help to direct client and clinician to problem areas or to suggest homework tasks and activities, it is possible to begin therapy with more focus. For example, personal beliefs and theories are critical for the clinician and the patient to make explicit in cognitive behavioural therapy because the degree to which those patient contents are realistic or distorted, affects the types of tasks on which the two work during therapy. Therefore, knowing more detailed information about client attitudes and values about pain offers a helpful point of departure from which to begin exploration of hope(lessness).

The three selected instruments varied in their scope. Broadly, they were used to measure pre-treatment status and post-treatment outcome. Specifically, the instruments measured depression, problems related to chronic pain, and beliefs about pain.

### Beck Depression Inventory

To assess patient depression, the revised Beck Depression Inventory (BDI) (Beck et al., 1979) was used. A 21-item inventory, the BDI presents four statements of increasing intensity for each item and asks the individual to choose a description which best represents how he or she has felt over the previous week.

Developed, tested, and used over a nearly 30-year period, the BDI is a well-vetted instrument for reliability and validity (Beck et al., 1988). It is frequently used with chronic pain patients (Hasenberg et al., 1994; Holzberg et al., 1993), in clinical and research settings. Reliability estimates in a meta-analysis (Beck et al., 1988) with both psychiatric and non-psychiatric samples showed co-efficient alphas of .86 and .81, respectively. High internal consistency was evident in both clinical and non-clinical populations. Good construct validity exists, as well as concurrent validity; a meta-analysis found a mean Pearson product-moment correlation of .72 between clinical ratings of depression and the BDI for psychiatric patients and .60 between the clinical ratings for depression and the BDI for non psychiatric patients.

Correlations of .55 or greater existed between the BDI and two other self-report scales for depression (Schaefer, 1985).

In this practicum, the BDI was used to determine depression levels and also served as an intake and outcome measure of treatment effectiveness. Analysis of any condition changes noted by the BDI which corresponded to the biopsychosocial profile differences seen on the CIPI (see below) were used to offer insights about possible reasons for change.

#### Chronic Illness Problem Inventory (CIPI)

From instruments which measure affective distress and environmental stressors in chronic pain patients, the Chronic Illness Problem Inventory (CIPI; Kames, Naliboff, Heinrich, & Schag, 1984) was chosen. It measures areas such as: sleep, eating, finances, employment, medications, cognitions, physical appearance, body deterioration, sex, activities of daily living, inactivity, social activity, assertiveness, medical interaction, marital difficulties, non-married relationships and illness focus.

Research on the CIPI (Turner et al., 1992), although not extensive, had shown the measure to be reliable. It also showed correlation between the CIPI and Sickness Impact Profile (SIP) total scores. These instruments both measure function in the areas of experience noted above. However, while the SIP, a behaviourally-based measure of illness dysfunction, had shown good reliability and validity, it was time-consuming for subjects to complete, and cumbersome to score. The CIPI, on the other hand, offered simple scoring and assessment of the specific problems associated with chronic illness. Total scores on both measures were correlated before ( $r(93) = 0.72, P < 0.001$ , 1-tailed test) and after ( $r(72) = 0.62, P < 0.001$ , 1-tailed test) treatment. Researchers concluded that these two measures were best used as complements to one another. The CIPI had also been shown to have 80% agreement between the inventory problem areas and those areas noted independently by a

clinical psychologist in a complete psychological evaluation at a pain centre (Kames et al., 1984).

#### Survey of Pain Attitudes (SOPA)

Finally, to assess patient beliefs, "at the heart of chronic pain problems" (p. 215, Degood & Shutty, 1992), the Survey of Pain Attitudes (Jensen, Karoly & Huger, 1989; Jensen & Karoly, 1989) was used (Appendix E). The SOPA has been correlated with patient pain coping responses and post-treatment attitude changes. Focused more specifically on the topic of pain than the other measures planned for this practicum, the SOPA also looks at self-efficacy and locus of control, issues which theoretically, play an important part in chronic pain control and coping (Jensen, Turner, Romano, Karoly, 1991).

A 57-item self-report scale, the SOPA has shown high internal consistency in its subscales and association with treatment response. As well, the SOPA has demonstrated stability over time and high face validity. Since the SOPA is still being refined in several of its sub scales, the creators have not yet offered overall, definitive measures of reliability and validity. Nevertheless, the scale's correspondence with existing cognitive behavioural theory and ongoing research recommend it.

Using the inventories was helpful at the outset of therapy. Clients were interested in seeing their and discussing their results. Some were surprised after use of the CIPI, to note the many ways in which chronic pain had impacted their lives. Realization of the full extent of their pain-related problem areas was a matter about which some individuals had not thought, yet instantly recognized on seeing their CIPI and SOPA results. In some cases, clients had simply not considered the changes that chronic pain had caused in their lives. In other cases, clients had actively suppressed consideration of these problems since they had felt troubled by their diminished capacities. Whichever the case for clients, the clinical process benefited. Completing and discussing the inventories kindled interest.

A secondary clinical benefit of using the inventories were the directions to which client results pointed or which they eliminated. When certain problems showed strongly on the CIPI or attitudes on the SOPA, the client and therapist could select which areas the client felt would be most beneficial on which to work. Identifying those problem areas facilitated selecting client goals, thus achieving two therapeutic steps: initially, the therapeutic process had directly engaged the client; next, active therapy could begin sooner, with less time spent exploring client background and desires for treatment.

Commentary on inventory use and the data that were collected follows in the "Results" and "Discussion" sections of this report.

## **USE OF HOMEWORK IN THERAPY**

Interview assessment and the results of the CIPI and the SOPA yielded a picture of each client's depression, beliefs, feelings and attitudes about his or her predicament. Clinical awareness of the combined emotions that each individual was experiencing helped patient and clinician to identify specific areas for problem-solving. In addressing those problems and choosing remedial activities, homework assignments were the tools.

The clinician and client collaboratively chose homework tasks and exercises that the client could perform at home and within his or her social relationships. Turk et al. have stated "homework is a key ingredient in diagnosing and dismantling problem-causing ideas, in strengthening problem-solving ideas, in assessing the sources of new problems and resistance . . . (p. 189-190, 1983)." This task-based process explored alternative ways of thinking, feeling, and doing things. Including the mutual evaluation of success by clinician and client, cognitive behavioural treatment's homework assignments modeled a strategic approach to living and coping with pain.

A caveat to the educative optimism of the cognitive behavioural approach with this population was that clinician and client might, in some cases, learn that mastery over a problem or feeling does not occur and that acceptance or retreat were the best or only response (Turk et al., 1983). Yet considered differently, a retreat with new attitude of acceptance represent cognitive change. Such a change in the individual's state of mind or feeling can be positively adaptive and therefore, represent net steps toward improvement of depression or distress.

Homework varied for each individual, according to his or her responsibilities, interests, schedule, and personal relationships. Because of the individual differences among clients, it was not possible to definitively plan sessions or homework before therapy with each individual. Homework was devised collaboratively by client and clinician. Thematic order of the intervention protocol was observed, but therapeutic content of sessions was unique. The protocol guided therapy to the extent that planned themes were introduced. However, each client's personal colouration of those themes or other predominant issues shaped sessions and prompted homework decisions.

A case in point is Janice, the client whose social relationships were poor. Her marital relationship, troubled to begin with, had worsened because of chronic pain. Also, friendships had not been maintained over the recent past. The client's social confidence had suffered, and she also felt awkward. This feeling further deterred her from making social overtures. One homework assignment for this client was to call one to two old friends each week and re-establish contact; another homework assignment was to use more constructive means of managing conflict with her husband. This approach to social relationships was opposite to one used with another client, Alain, who felt obligated to actively maintain a wide range of social relationships, at great cost to his physical comfort and peace of mind. Learning to



schedule less social time and more personal rest time was important for him. Thus, his homework tasks related to this goal of reducing social activity.

Unlike the individualized homework tasks described above, hypnosis was a technique used quite similarly with the clients who were interested in using it to change their awareness of pain quality or intensity.

### **HYPNOSIS AS A COGNITIVE BEHAVIOURAL THERAPY MODALITY**

Helping chronic pain patients to cope more effectively with their pain through cognitive behavioural methods includes cooperatively devising means for adjusting their existing thoughts, emotions and behaviour. It also includes an educational component of teaching clients about pain and of seeking with them new strategies which might change their experience of the pain. In the same way as external changes could be made to their routines and responsibilities of living, specific changes to their thoughts about activities and health, internal changes, could also be attempted. A metacognitive approach to pain through a technique like hypnosis offered the possibility of transforming pain or some aspects of life troubled by pain.

Barber (1996) advocates the benefits of educating the patient about pain and the connection between mind and body. He writes of their new awareness: " . . . the dramatic increase in confidence the first time a patient experiences hypnotic analgesia can be salutary (p. 5)." For treatment of the pain patient, Barber's operational definition of hypnosis is based upon assumptions that hypnosis results from social psychological forces. He considers hypnosis to be a complex, altered consciousness that includes increased receptivity to suggestions, potent, systematic control of usually involuntary functions. Of these significant changes, the most important transformations are altered physical function and perception.

Barber discusses the importance of distinguishing between relaxation and hypnotic induction, noting that the latter is sometimes mistakenly considered an exercise for the former. Although relaxation may be a part of some inductions, hypnosis differs because it shifts consciousness dramatically, and "this shift sub-serves the change in awareness of pain ( p. 6)." Some techniques of hypnotic analgesia include: anesthesia, direct diminution of sensation, sensory substitution, displacement, or dissociation. Choice of one or more of these techniques is determined sometimes by experimentation (what does or does not work for a patient), or at other times, by patient preference for a particular method.

For the six clients in this practicum, hypnosis was offered as one of the cognitive behavioural techniques for better managing their pain. If the patient were receptive to the technique after a therapist-induced session, hypnosis could be practised independently at home on an "as-needed" basis. The broad goal of using this technique was to foster more self-reliance in clients for pain control and perhaps less dependence on medication and doctors' visits. When part of a general treatment plan, hypnotic therapy can contribute yet another tool to patient self-control of pain (Barber, 1996). Thus, the process of hypnosis, therapeutic or patient induced, can be seen as both cognitive and behavioural: cognitive insofar as mental processes are used, and behavioural insofar as pain control and pain experiences are behaviours.

#### USE OF HYPNOSIS WITH CLIENTS

In the early stages of treatment planning and goal setting, hypnosis was broached as a possible pain reduction technique that clients might like to try using. If clients showed an interest, a "test-run" was done with them. For those clients who showed hypnotic receptivity during the induction, and an interest in trying the technique again, they were invited to bring an audio cassette tape to record an induction at the following session. Discussion took place

about a client's favourite retreat, location, or experience; if the individual had one, the imagery from this "place" was incorporated into the following visit's induction.

In length, the complete hypnotic session varied from thirty to fifty minutes, with the induction running fifteen or twenty minutes. Beginning with specific suggestions about breathing and physical relaxation, the induction proceeded through use of a client's personal imagery to a countdown at the end of which the client's awareness had become altered. At this point, the clinician moved onto making suggestions about pain quality, intensity, or location. This next part of the session might take ten to fifteen minutes and made use of information that had been related by the client in previous interviews. An example is provided by the client who offered an image she had found improved her headache pain.

Edythe had described in a previous session an image that had occurred to her spontaneously and which involved displacement of her pain. She related that in the midst of a severe headache she had imagined the pain as a red hot liquid inside her and that she had tried to transform this to a cool blue liquid. Using this imagery in preparation for the hypnotic session, the student clinician and the client discussed how the client might "see" and "sense" the transformed liquid coinciding with cooling, diminishing discomfort in her head and neck area, then moving into her shoulder, arm, and fingertips.

This "movement" of pain through hypnosis makes use of the fact that limb pain is less intense than head or trunk pain. The hypnotic suggestion thus has a realistic, and therefore, more convincing basis for the client to engage in the activity. Although it would be rare for severe pain to be entirely alleviated in this way, nevertheless, it is an achievable hypnotic strategy to "move" awareness of the pain to the body's margins.

Not all clients wished to try hypnosis. Two (men) were skeptical of the process, although one of these subsequently decided to try it. In all, four clients (two men and two women) tried hypnosis. Of those four, two clients (one man and a woman) experienced

reduced pain; the other two clients experienced little change in pain, but one of those two found the hypnosis relaxing and wanted to continue using it.

## **EVALUATION CRITERIA**

The following criteria were chosen to evaluate change in practicum clients after treatment concluded. These criteria also enabled this social work student to review her knowledge about chronic pain, as well as to evaluate her own developing clinical skill.

1. To measure the extent of change in chronic pain patients' psychological, and/or social experience following cognitive behavioural therapy.
2. To assess whether depression in particular, or other negative emotions, changed after treatment.
3. To assess specific psychosocial areas in which change may have occurred and note any correspondence to general treatment themes or to more specific therapeutic strategies.
4. To observe and report on other phenomena of interest.
5. To determine from supervisor's record of supervision, whether cognitive behavioural techniques were effectively learned by the student clinician over the course of the practicum.
6. To determine from supervisor's record of supervision sessions, whether other clinical skills had developed over the course of the practicum.

## **THE CLIENTS AND THEIR TREATMENT**

### **RECRUITMENT OF CLIENTS**

Clients for this practicum were selected from referrals made to the psychologist or social worker by the physicians at the St. Boniface Hospital Pain Clinic. The patients had come to

see these doctors via a typical pathway for chronic pain sufferers: referrals from their own family physician or treating specialist who had usually completed treatment. In some cases, patients' physicians expected that the Pain Clinic physicians might be able to help the patient achieve further medical improvement. In other cases, referring doctors did not consider medical improvement would occur, but did want help for the patient in managing the strains of living with chronic pain.

Selection of clients for this practicum were made from these Pain Clinic referrals to the psychologist or social worker. Patients who had reported having experienced depression or who were observed by pain clinic physicians to be depressed, were chosen for screening. Excluded were patients who had a prior psychiatric history of depressive or other psychiatric disorder as it was considered that their prospects for change or improvement would be at least complicated, and at most, dubious. A diagnostic impression of depression was formulated by the supervising psychologist, the student's advisor.

#### OPERATIONAL CRITERIA FOR DEPRESSION

Strict research criteria for depression were not used, mainly for practical reasons. Uncertain referral numbers from the Pain Clinic physicians made selection according to very specific criteria difficult; sufficient referrals for counselling also did not occur in the time frame with which the student had to work. Time constraints for the practicum and learning needs imposed other limitations. To have waited for sufficient numbers of clinically depressed would have been impracticable.

A second reason for choosing to use a diagnostic impression of depression relates to this student clinician's review of the literature and her clinical observations: unhappy, apparently depressed, chronic pain patients have been under-served by the little research on clinical intervention. These "depressed" chronic pain patients often did not meet standard research criteria for depression, such as the cut-off score of 21 on the B.D.I. Nonetheless,

this kind of patient did exhibit clinical signs of depression such as social withdrawal, loss of appetite, difficulty concentrating, feelings of worthlessness, guilt, thoughts of suicide, and other symptoms from the DSM IV. Using the clinical cut-off score on the BDI to screen potential clients for this practicum might have yielded clinically depressed candidates for therapy; however, at the same time, it might have screened out other candidates who, while not clinically depressed, were still unhappy and dysfunctional because of pain.

This particular population may constitute the class of chronic pain patients mentioned earlier in this paper, who are often diagnosed as suffering from "atypical depression", a variation that could benefit from more clinical study. These patients are a research anomaly, and the student clinician wished to learn more about them. She recognized that six clients provided insufficient numbers from which to draw any conclusions, and also, that insights gained from the practicum could be only suggestive.

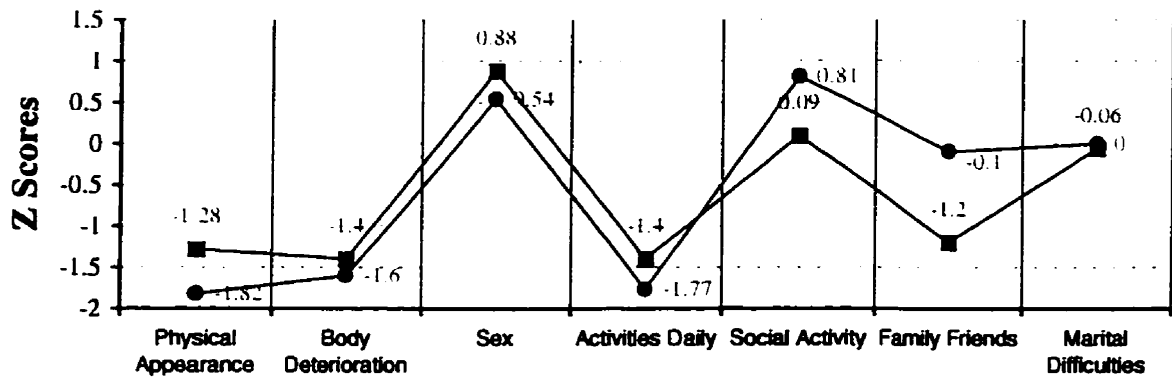
Nevertheless, the selection for this practicum of an apparently depressed, chronic pain population provided a learning opportunity in an area of professional interest. As well, it was believed that these distressed clients could benefit from the intervention, and therefore, their selection was judged to be appropriate and responsible.

A 44 year-old married, female computer programmer with severe migraine headaches.

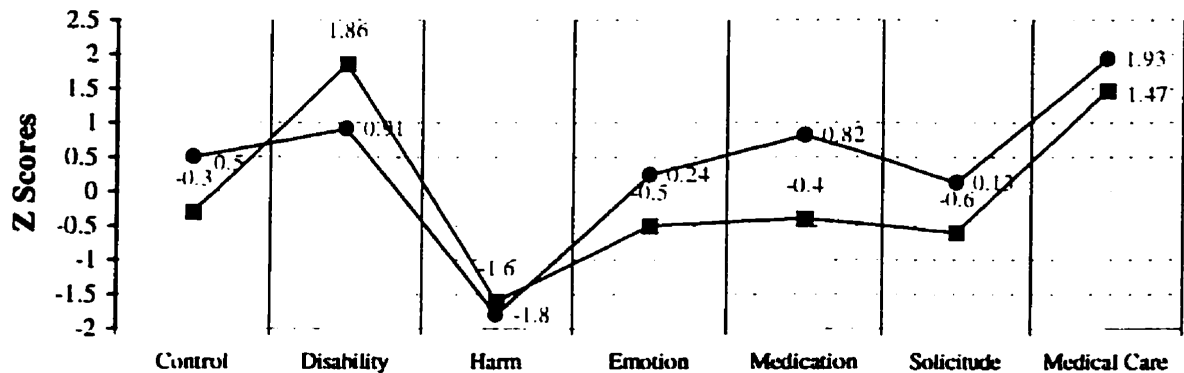
## Beck Depression Inventory (BDI)



## Chronic Illness Problem Inventory (CIPI)



## Survey of Pain Attitudes (SOPA)



● Pre-treatment      ■ Post-treatment

## INDIVIDUAL CASE PRESENTATIONS

### CASE # 1

**Name:** Edythe Lewis

**Period of treatment:** Client was seen for 10 visits on an almost weekly basis between February, 1997 and early May, 1997. The client extended the time between appointments to go on a one-week holiday and also, to fit in other medical care. On two occasions she missed appointments because of severe headaches.

**Reason for referral**

A forty-four-year-old, married woman, Edythe Lewis had been referred for counselling by her physician concerning her pain from severe, frequent migraine headaches. She and her doctors hoped that through counseling, Evelyn might learn some self-management techniques that could improve the patient's ability to manage her headache pain. Because Edythe had been away from work on long-term disability for more than six months while her family physician and specialist sought solutions to her condition, and because none had yet been found, the client expressed an urgent need for help.

**Background Information**

With moderate headaches, Edythe could work, but one to three times weekly, she experienced a headache so severe that she had to rest at home in bed while she endured blinding pain and nausea for eight to twelve hours and occasionally, for three to five days. This latter kind of episode sometimes ended with a trip to the emergency department of the hospital, where Edythe's husband took her. There, she received intravenous injections of



abortive pain medications. During bad bouts of headache, Edythe reported that she could not work, did not go out, and spent her waking hours lying down in a darkened room or on the couch. Sensitive to light and noise, the client could not distract herself with television or music.

Diagnosed in recent years as migraine headaches, Edythe's syndrome appeared to relate to her hormonal cycle. Some control over the incidence of headaches was being tried with medication. Evelyn had tried numerous medications both prophylactically and abortively, never with lasting success. At the time of her referral, her doctors were testing a new combination.

Edythe had been married for almost twenty-five years; she initially reported her marriage to be happy, although halfway through therapy she revealed that the marriage had begun to unravel. She and her husband were childless, apparently by choice. The couple had an active social life, although Edythe's headaches often forced them to reschedule or cancel arrangements. In early meetings, Edythe described blithely how she and her husband had adapted effectively to her health and associated problems. However, midway through treatment she revealed angrily how difficult she found her social relationships to maintain.

### **Clinical Impression:**

Edythe had prepared for her first interview, bringing with her a sheet of paper with typed information about prior treatments, medications, and personal adjustments for her condition. She appeared knowledgeable about her medical care and to want to give the impression of being a "good patient." However, in the process also appeared to be a demanding one. In addition, Edythe was tense, speaking quickly and then waiting with attentive impatience for response, suggesting not only that inner tension might contribute to her headaches, but also that it might affect the possible success of some treatments.

The Beck Depression Inventory showed a pre-treatment measure of 18, a score near the outside margins of "moderate" and nearing the clinical cut-off of 21. On the Chronic Illness Problem Inventory (CIPI), Edythe's scores were within the range shown for a pain population, excepting the measure of cognitive problems; here, Edythe showed concern that she had extraordinary problems with memory and other cognitive processes. On the Survey of Pain attitudes (SOPA), the client's scores showed strong belief in her own disability and a medical cure existing for her condition. These results were all below the research norms for a chronic pain population.

**Clinical Formulation:**

Edythe was an individual who regularly carried a heavy burden of debilitating pain. She might suffer more because of her demanding and impatient nature, but it was also those qualities that could give her the energy and commitment to experiment with some new treatment. Even so, it was considered necessary that Edythe relax sufficiently to give new treatments a chance to work. Also considered important were Edythe's beliefs and feelings about her headaches, content that was conspicuously missing from her positive presentation.

**Treatment Recommendations:**

The cognitive-behavioural treatment approach suggested for this patient was: exploration of (distorted ) thoughts about pain and illness that the clinician anticipated might reside in the patient's stoical attitudes, these expressed in breezy denials of difficulties from her pain; hypnosis and self-hypnosis that might offer tools of self-control; review of the client's significant relationships; exploration of feelings, particularly painful ones, again initially denied by the client, about her condition or related matters.

The clinician surmised that Edythe's inner tensions and presentation of global competency might pose some obstacle to treatment in the form of resistance.

**Course of Treatment:**

Initial impressions of Edythe as a "good patient" were demonstrated over the early course of therapy. These impressions were later replaced by the patient's more frank behaviour as she disclosed personal unhappiness about impacts of her pain, and marital problems.

The initial obfuscation by the client about all things going well reflected a set of cognitive distortions Edythe had about herself, her pain-related problems, and her emotional reactions to those difficulties. Early on, Edythe expressed beliefs about stalwart behaviour and carrying on her duties until she could not do so any longer. She also indicated her belief in the importance of not telling friends and associates about her health difficulties because "they might not understand" or because she ostensibly did not wish to burden them with concern. These beliefs and attitudes of self-reliance, of not wishing to appeal for understanding or sympathy, were explored with the client alongside the hard fact of her having such a serious and debilitating health condition.

Underlying Edythe's fear that others might not understand was her own, rather unsympathetic attitude that sickness and disability equated with character weakness and were therefore, reprehensible. Edythe, in spite of suffering so much with her migraine headaches, privately judged harshly others who were sick and unable to perform. Paradoxically, Edythe also felt a high need for solicitude from her husband, her extended family, and her co-workers when she was feeling sick.

This welter of inconsistent thoughts and feelings was explored with Edythe in discussion, leading to her recognizing some of the anger and disappointment she felt at being

so often decommissioned by headaches. For homework exercises, she decided to share more about her headache suffering in conversations with her sisters and a carefully chosen friend. These assignments were meant to achieve two purposes. First, Edythe would herself acknowledge the problems and disappointment associated with severe headaches and would accept those in herself, thus practising more immediate and general tolerance. Second, in sharing these problems with others, Edythe could cultivate some supportive understanding from members of her close social network.

Another cognitive therapy was hypnosis, which was practised on three occasions with the client. An audio tape was made, and Edythe seemed to like using it; two more tapes were made so that the client had three to choose for use: one for relaxing in general; one for transforming the quality and intensity of the pain; and one for moving the pain from her head to an extremity, thus diminishing the pain. Whether coincidental or a result of treatment, over the course of therapy, the client became more relaxed generally; she also began to introspect about and to diarize her feelings. She had earlier reported states of dissociation and loss of time sensitivity; this matter was discussed with the student's supervisor, and it was decided to encourage the client's greater awareness of her feelings at these times, which might represent Edythe's discomfort or unfamiliarity with relaxed, quiet feelings. For a tense individual like Edythe, taking steps to cultivate peaceful introspection and self-awareness were judged to likely have positive benefits on her pain management, and possibly also on her pain.

Relationship issues were addressed with the client at the same time as the cognitions discussed above. At approximately the midpoint of therapy, a dramatic change occurred. Edythe arrived one day, angry and swearing, behaviours that were very unlike her usual, self-controlled presentation. She expressed extreme irritation and frustration with everyone she knew, whom she claimed did not care sufficiently about her pain or burdens. Edythe's anger spilled onto the therapist, whom she charged, had not helped her enough. The student

clinician, although surprised to see such strong, direct feeling from a client who had until then behaved so differently, explored the resentments with the client. Edythe admitted for the first time during treatment that she was worn out and unhappy about her continuing headache condition and pain. Recognizing that this new behaviour might signal some inner change in the client, forward movement in her therapy, or perhaps resistance, the student clinician tried to productively use the client's affective momentum. The session was useful for revealing new feelings on which the two could work and for giving new energy to therapy.

This day marked a watershed for Edythe and for treatment; afterward, Edythe showed more readiness to explore her feelings, including her impatience and fears about such frequent, severe pain; for her part, the student clinician applied more emotional concentration to her contacts with the client, now knowing that more intense rapport was possible and that it had been associated with readiness for affective change. Cognitive behavioural therapy continued through rational discussion and some charting of homework about understandable and reasonable feelings in respect to Edythe's health problem. The client began to display more tolerance toward herself and less anxiety about the headaches.

In addition to energizing therapy, the day described above also marked a change in the rapport between the client and therapist, whose relationship had until then been amiable and polite, but by comparison, not close. After the angry session, a therapeutic connection had been struck, and could be more easily accessed at other moments. In fact, for the remainder of treatment, closer rapport became a state that client and therapist sought mutually to reach.

**Outcome:**

Edythe's response to therapy was generally positive, a clinical impression that was supported by the pre-treatment and post-treatment measures. The client displayed less distress and less intense self-control than she had before treatment, in fact, coming to view her pain problem more sympathetically than she had prior to treatment. The measures of depression on the BDI scale showed almost 6 points less. In relation to the other clients, depression diminished by 2.74 z-score points.

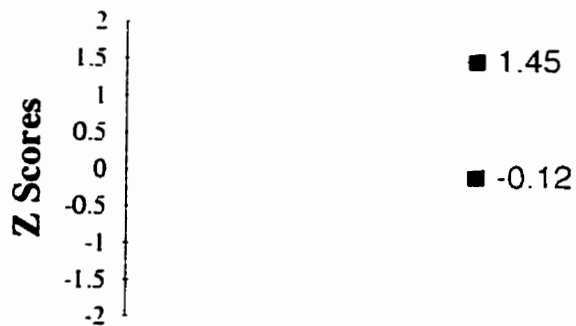
The CIPI showed improvement in the two problem areas of Social Activity and Family & Friends, with z-scores of nearly 0 and -1.2, from .81 and -.1, respectively. Other problem areas showed little change, or in the case of Sex, some deterioration.

The SOPA results are less obvious for interpreting improvement, but their change suggests developments which were positive, given Edythe's personality. After treatment, the client's sense of control dropped and her sense of her own disability increased. With another patient, these changes might have signaled deterioration in pain management. However, the student clinician interpreted these changes positively since before therapy, Edythe denied her own disability and its impact on her life. Also seen in SOPA results, were less belief in the importance of medication and less need for solicitude, both changes suggesting self-reliance that was realistic, instead of brittle, as was Edythe's at the start of therapy.

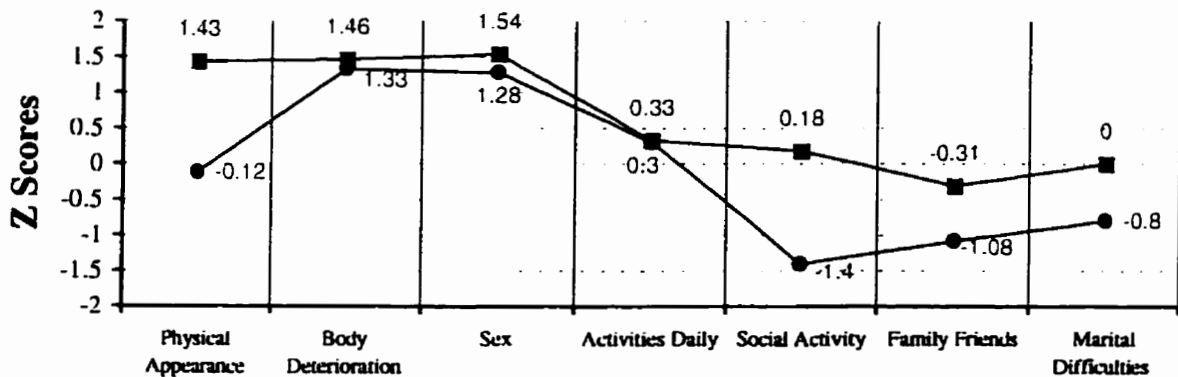
The treatment process of cognitive behavioural treatments, presented opportunity for considering and trying on other patterns of thought and behaviour. These appeared, from assessment measures and clinical judgment, to have helped this client.

A 55 year-old married, male heavy equipment repairman with shoulder and back pain.

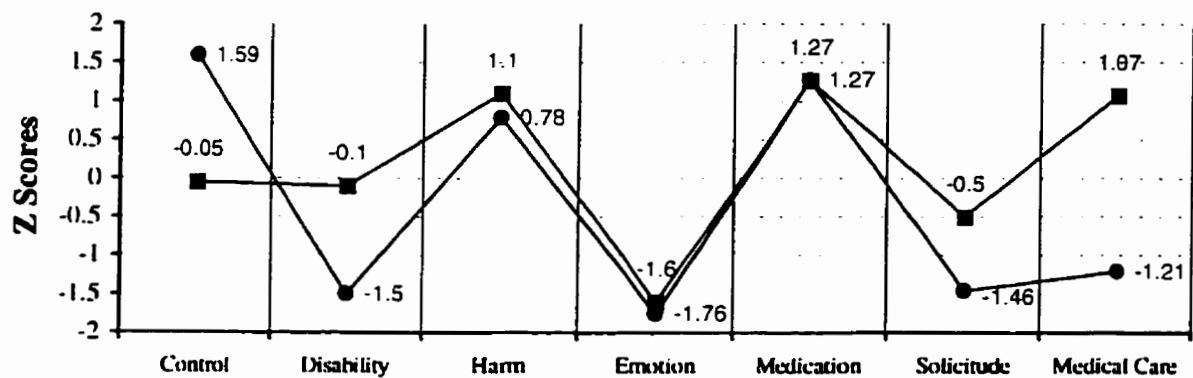
### Beck Depression Inventory (BDI)



### Chronic Illness Problem Inventory (CIPI)



### Survey of Pain Attitudes (SOPA)



● Pre-treatment

■ Post-treatment

**Case #2**

**Name:** Edward Mynarski

**Period of Treatment:**

Client was seen for 10 sessions, usually weekly, between February, 1997 and May, 1997. He returned to heavy, full-time work during this time. Visits were postponed on three occasions because of work commitments or sickness.

**Referral Information:**

Edward had been referred for counselling about pain management by the physician at the St. Boniface Hospital Pain Clinic because of a painful left shoulder and back that caused him considerable suffering. Treatments Edward had received, including an extended course of physiotherapy, were unlikely to bring further reduction of his pain. He experienced difficulty moving and sleeping because of the pain, and he was also troubled by intrusive flashbacks of the industrial accident event.

**Background Information:**

Mr. Mynarski was first seen by the supervising psychologist who referred him to this clinician for her program of cognitive-behavioural therapy.

A fifty-five year-old, heavy-duty mechanic, Edward had for thirty years spent regular, long hours at his work of repairing heavy industrial machinery for construction projects in and outside the city. He reported an active recreational life, hunting and fishing with family and friends in summers and ski-dooing in winters. He appeared to have enjoyed raising his family of three children, now grown. A daughter living elsewhere had two grandchildren, a second



daughter still lived at home, and a grown son, paraplegic from a sports accident, lived in his own apartment.

Two years earlier, Edward had been involved in a frightening accident at work when a failed safety attachment caused a large industrial bucket to swung full-force into him, injuring his back. One of his sons was working the machine at the time of the accident, but had since moved to a different company. Since the accident, excepting the two and a half years that he was disabled, Edward had worked with pain.

The client still experienced vivid flashbacks of the incident, usually concluding with the moment of impact after which he usually experienced a sharp awareness of his current, severe back pain. The patient expressed resigned disgust and resentment toward the employer whose error had apparently allowed the accident to happen.

Edward's continuing and current problems were the pain in his left upper back that radiated into his arm and lower neck area, as well as stiffness and pain in the low back region. The pain was always present, but was exacerbated by moderate to heavy physical effort. Nighttime sleep was often interrupted by pain, making it hard to return to sleep and also, lowering pain tolerance the following day because of fatigue.

Long work-days of 9 or 10 hours exacerbated this man's pain considerably, making almost any other activity or enjoyment impossible. Evenings after work were spent resting, trying to recover from the strain the heavy activity had imposed. Although Edward had requested that the employer arrange for lighter work or for a helper to do "bull work", the employer was unable to accommodate his request. The client exhibited a soldierly attitude toward his predicament, but the question remained whether he could continue.

Over time, there had been little amelioration of the continuing pain. It appeared that Edward was experiencing chronic pain of significant degree; as a result, he had a reduced ability to perform his work duties and little or no remaining capacity to engage in leisure or

social activities. Under these stressful conditions, the clinician was also uncertain whether Edward could continue to work full-time without further injury.

Social support for the client was apparently adequate. Edward believed that he had the love and concern of family members. He reported that those people were easily able to see when he needed help and did offer it. Unfortunately, they could do little about his pain or difficulty sleeping.

### **Clinical Impression:**

The client presented in a straight-forward and co-operative manner, sometimes demonstrating a sense of humour. In response to questions about his feelings, Edward appeared to respond candidly, but offered no elaboration. For example, when asked about the recurring flashbacks of the accident, Edward described the repeated ending, a splash of red (his own blood), and a simultaneous, searing pain, saying: "Yeah, I have them both almost all the time. That's just how it is."

The client felt quiet resentment toward his employer for their reported failure to properly check and service the bucket that caused his injuries. However, Edward neither blamed nor complained about anyone else in respect to his pain. He was undoubtedly suffering, to judge by his movements and description of limited activity. He felt unaware of what he might do to relieve those problems. By virtue of Edward's willing attendance at the psychologist and his open attitude, the student clinician considered that he would be motivated in therapy.

### **Clinical Formulation**

The student clinician considered that Edward's chronic pain might be exacerbated by two main issues. Firstly, he showed some signs of a post-traumatic stress syndrome: the

flashbacks, paired with increased awareness of his chronic pain. Secondly, his soldierly attitude and matter-of-fact personal acceptance of the pain's consequences, in spite of significant changes to quality of life, suggested that he might suppress negative or painful feelings about his predicament. Insofar as these feelings could be acknowledged and accommodations made, Edward's pain might also be somewhat relieved.

### **Treatment Recommendations:**

The treatment approach suggested for this patient was the thematic, cognitive-behavioural program that included: thought-stopping and/or thought-substitution exercises for the flashbacks; relaxation training and/or visualization; discussion of practical and interpersonal strategies to reduce some of the physical and other stress in his life which affected his pain; discussion of certain feelings related to the accident and Edward's pain.

Although the client was receptive to the idea of therapy, it was anticipated that some of his conventional and stoic attitudes about emotions might slow or impede progress in these matters.

### **Course of Treatment:**

Edward's treatment began when he was still off work, and continued during his difficult return. Heavy work's physical strain was punishing to Edward, and benefits that had developed from therapy were undone. The student clinician believed Edward was endangering his mental and physical health by continuing at heavy work, an opinion shared by her supervisor. Because of these events, the course of therapy was uneven.

Therapy began with the clinician offering feedback to the client about the inventory results. In the Chronic Illness Problem Inventory (CIPi) Edward's scores outstripped the means, normed for a pain population: the problem subscales of sleep, finances, work,

dependence on medications, and in particular, interactions with doctors. Thus, before even attempting his return to work, Edward felt stressed by the very practical difficulties of chronic pain. From the Survey of Pain Attitudes (SOPA), Edward's scores for Harm (the degree to which he believed the pain showed activity was harming him), and Medication (the degree to which he believed that medications were an appropriate treatment for pain) exceeded pain patient norms (Jensen & Karoly, 1994), indicating both anxiety about his condition, and a reliance on external means of pain control. The Beck Depression Inventory score of 21, just inside the research's clinical range, suggested the need to address depression issues specifically.

Edward's worry about harming himself and the post-traumatic flashbacks noted above offered substantial issues on which to work in therapy. He spoke readily about the flashback episodes, but appeared shaken by doing so. It was evident that during these episodes he relived the violent and terrifying aspects of the accident. Those corrosive feelings fused with his pain to create an obvious, unpleasant experience. Edward's discomfort evoked the therapist's sympathy and concern, accelerating the development of empathic rapport. Early sessions were devoted to practicing thought-stopping and thought substitution with Edward. He was also assigned practice with these activities as homework. Edward reported practising his homework sometimes, but not regularly.

Hypnosis was not tried initially as the client expressed skepticism and no interest. Relaxation was practised, and Edward found some benefit from it on days that his pain was moderate or minimal. When his pain was its most severe, little relaxation of any sort helped. Midway through the course of therapy, Edward decided to try hypnosis, so an induction was done and a tape made for home use. The client liked using the hypnosis tape and reported that if he had time and was in the right mood, he was able to relax effectively, and his pain diminished.

After five treatment sessions Edward returned to work. That strain worsened his pain, which then dominated his consciousness. Edward was able to focus only on getting through each work day, recovering from the increased pain he felt, and girding his physical and mental resources for the next day of work. The effort that work required of the client and the strain that it imposed on him etched visibly on his face and body. Increasingly, Edward appeared more reduced by his chronic pain.

Therapy sessions after Edward's return to work were devoted mainly to discussion of strategies to make the workdays more bearable and simultaneously, to explore other possibilities than working full-time at a heavy job. Financial need for the better pay of heavy work explained Edward's decision to return to strenuous work. However, by the end of therapy, he was beginning to question the long-term wisdom of that decision. The clinician encouraged those explorations since Edward's ability to tolerate work for much longer appeared dubious.

At the close of 10 sessions the signs in Edward's assessment measures had worsened disturbingly. Depression had increased from 21 to 29, entering the range for severe clinical depression. On the CIPI, the measure for Body Deterioration had doubled over Edward's pre-treatment measure and exceeded research pain population norms (Kames et al., 1984) by 2 points. Physical Appearance problems had likewise doubled and surpassed the same norms by the same margin. On the SOPA Edward's sense of disability had increased over pre-treatment measures, exceeding pain population norms. His score on Medication stayed high at an "abnormal" level, double the research means. Edward's post-treatment score on Harm dropped slightly from 3.8 to 3.1, yet still was higher than research norms of 2.6.

These rather dramatic changes alarmed the student clinician, who consulted her supervisor for advice. It was decided important to inform Edward of their joint concern for his physical and mental health. This was done in his last therapy session. In addition, a letter

that outlined their concerns was prepared for the St. Boniface Hospital Pain Clinic referring physician, and a copy was given to the client. If Edward chose to follow through on his stated plans to seek compensation for permanent disability, the letter of concern could buttress a claim that to continue at heavy work would probably be an unsafe course.

### **Outcome:**

Cognitive behaviour in the early sessions had begun to help Edward to experiment with and practise some strategies to reduce the emotionally-charged post-traumatic stress disorder flashbacks. Also, hypnosis and relaxation techniques were enjoyed by the client and did help to reduce his discomfort and suffering. It is reasonable to assume that the early, positive signs might have assisted some helpful change and offered the client some useful pain-management techniques that he did not previously have. The progress that had begun was stopped and perhaps lost once Edward returned to work. Healing momentum was reversed.

All instrument results, in nearly all sub scales, showed marked or serious deterioration. Depression on the Beck Depression Inventory (BDI) increased by 1.57 z-score points. All areas on the Survey of Pain Attitudes (SOPA), with one negligible change, showed worsening of attitude and affect. All sub scales on the Chronic Illness Problem Inventory (CIPI) showed increased problems.

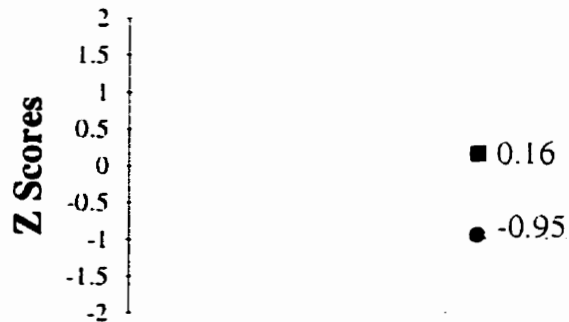
It became clear to this clinician that some stresses are too powerful for therapy to assuage. In this case, work that was unsuitable to the client's physical condition and therapy could do almost nothing to reverse that stress. In fact, in cases like Edward's, the type of therapeutic responsibility shifts altogether. It is arguable that the therapist should: first, help the client to continue to live more comfortably; second, assist the client to extricate himself from a dangerous work situation; third, advocate on the client's behalf, for appropriate

financial support. This clinician considered in retrospect, that she should have taken on a more activist role on Edward's behalf with his employer.

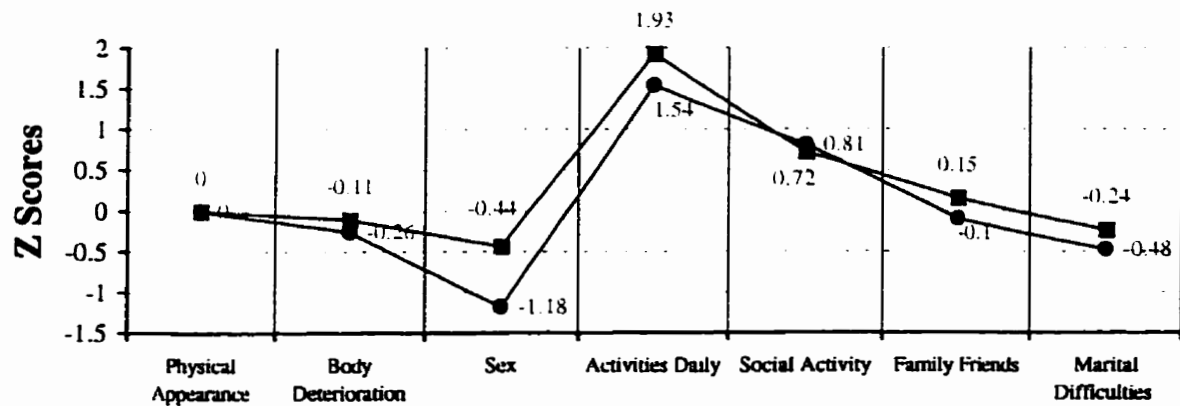
# ALAIN

A 52 year-old married, male civil servant with a post-surgical pain.

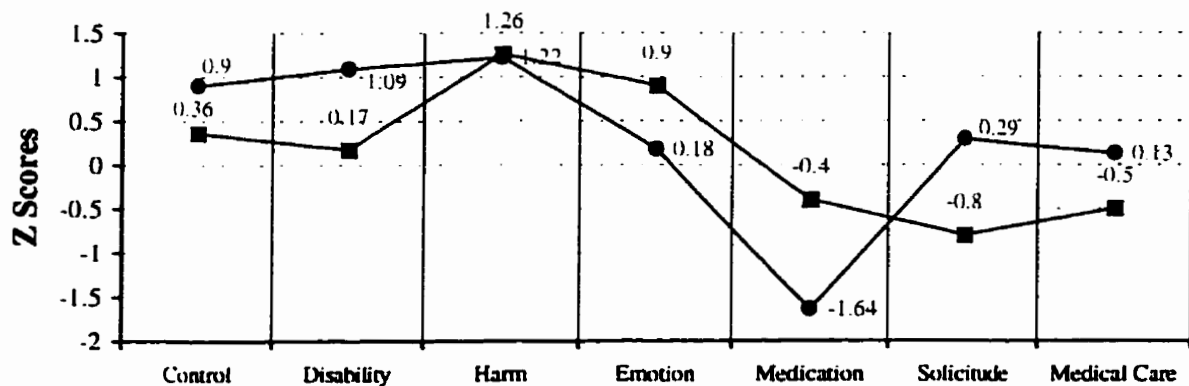
## Beck Depression Inventory (BDI)



## Chronic Illness Problem Inventory (CIPi)



## Survey of Pain Attitudes (SOPA)



● Pre-treatment

■ Post-treatment



### **CASE # 3**

**Name:** Alain Carriere

**Period of treatment:**

The client was seen for 10 visits between March, 1997 and July, 1997. He attended every second week. This arrangement inconvenienced Alain's work schedule, as he had returned to part-time work just before treatment started. The visit to the Pain Clinic involved at least a half day away from work to allow for return travel time from Alain's southern Manitoba community.

**Referral information:**

Alain Carriere was referred for counselling by the St. Boniface Hospital Pain Clinic physician who could offer no further beneficial medical treatment for post-surgical pain in the rectal area. He had undergone three surgeries to the area in the previous fourteen years, the most recent surgery, a rectal abscess drainage, having taken place a year earlier. Rectal electrode stimulation had given incomplete relief, and the doctor considered psychological issues were complicating Alain's pain.

**Background information:**

Alain, a 52 year-old civil servant, was married, with three children, two in their twenties, living independently, and a 16 year-old son living at home. Alain had worked in a senior capacity at the Unemployment Insurance Commission throughout his working career of thirty years. He stated that he liked his work. Alain had been receiving long-term disability support

for one and a half years since his 1995 surgery, during the period of his recovery and complications with chronic pain.

Since the surgery, Alain's activities around his home and property had been very limited by his pain; he was able to work carefully at chores until he felt pain and then he had to stop. However, Alain had found it easy to work too long when enthusiasm for a task was high. This choice would inevitably exacerbate his pain. Alain's wife had taken on more of the home care and maintenance tasks and he expressed concern that the extra work had placed a strain on her since she was also employed outside the home.

Alain reported that before his surgery and the onset of chronic pain, he had been a very active person. He had performed most of the repairs and improvements on his home and property. He sang regularly in his church choir as well as performing music at church-related events. He did wedding photography in the spring and summer months. He attended many of the social events for his large, extended family, and he also loved to dance at weddings. Since his 1995 surgery, Alain had dropped most of these activities as he could simply not be on his feet for very long.

Alain volunteered that he had always been a tense person and that his active lifestyle had served to utilize a lot of nervous energy. However, now that he could not be active, he reported that his natural tension worsened his rectal pain.. Alain acutely felt the irony that the things he used to do to relieve tension or anxiety, were the very things that caused more pain. Further irony, the only appropriate solution was to reduce activity still further.

Before entering this clinician's program of thematic cognitive behavioural treatment, Alain had attended therapy with another clinician at the Pain Clinic. Together, they had worked mainly on Alain's anxiety, using cognitive behavioural techniques to monitor his automatic thoughts and to practise thought substitution, as well as relaxation.

**Clinical Impression:**

Alain appeared in interview to be anxious and depressed. He was agitated in manner and shifted his position uncomfortably often during the meeting, grimacing in pain. However, the client's ready willingness to attend the therapy program this clinician proposed indicated some motivation toward improvement. Alain expressed hope that their work together would help him.

**Clinical Formulation:**

Alain was judged by all professionals who had worked with him to be a very anxious individual. His history of a nervous breakdown sixteen years earlier added evidence of a proclivity to excessive anxiety and in turn, did not auger well for a positive therapeutic outcome. Pre-treatment measures confirmed clinical impressions from the interview and patient history.

Depression on the BDI registered at 14, a score in the low end of the moderate range. CIPI sub scale results were all within the normal range for a pain population. However, the areas assessed by Alain as being the greatest pain-caused problem were activities of daily living, social activity, and employment. These three findings were all consistent with the client's interview history of having been an active, sociable person. SOPA results were, like the CIPI, within the normal range for a pain population, excepting the sub scale of Harm. Alain's score showed 50% higher than the research mean (Jensen, 1994) for pre-treatment measures of patients at a pain clinic. This worry about how his pain might be causing damage was consistent with his anxiety trait.

The client's pre-pain history showed an individual who lived actively and intensely, but who could become troubled by his emotional reactions. While a more rational approach to his problems might provide more balance, it also challenged Alain's natural inclinations and habits.

For example, reduced activity was necessary, but high levels of activity were what Alain wanted. The prospects for success of cognitive-behavioural treatment was uncertain because Alain knowingly resisted rational solutions.

**Course of treatment:**

Throughout the course of Alain's treatment, several issues dominated: generalized anxiety, difficulty with sleep, fear for the future, and sadness at his reduced activity levels. The planned cognitive behavioural protocols addressed these issues. For instance, the clinician viewed Alain's generalized anxiety as a cognitive habit that produced overly negative or catastrophic predictions; these, in turn, prohibited adaptive responses to his problems. The therapeutic response was to practise mental acts to stop the anxiety cycle and to replace negative predictions with rational responses.

Hypnosis was practised in two sessions as another technique to replace anxiety with peaceful feelings. Alain enjoyed these sessions, emerging more calm than before the therapy and pleased with the feelings he had experienced in the scene he chose for the hypnotic sessions. This scene was a rural winter location that Alain had regularly visited on weekends as a child and where he and a brother had played happily for long periods. In hypnosis, the therapist tried to evoke a strong sense of mood and place, using as a basis this beautiful scene Alain had described. An audio tape was made for home use and Alain reported enjoying using this at home

Difficulty with sleeping troubled Alain intermittently throughout treatment, and so time was devoted to exploring different strategies to improve his sleep. Alain also pursued medical and pharmaceutical options with his family doctor. Non-medical efforts included experimenting with the time of day that Alain worked his half-day, cultivation of more quiet and enjoyable evening pursuits such as listening to music and spending pleasurable time with

his wife; this latter strategy also involved discussion of how the chronic pain had impacted on sexual intimacy and other aspects of the marital relationship.

A stubborn problem that the therapist and Alain worked on together was his sadness over loss of activities he had enjoyed and which it seemed, partly defined him. A very sociable man, Alain talked at length of making and performing music, of dancing at numerous family weddings he attended each year. Chronic pain had sidelined Alain from those activities. While involvement at such events was possible in a different way, Alain had first to accept the fact that change was necessary, and then to find or choose new involvements. At the time of this treatment, Alain could not accept these losses; he oscillated between mourning the losses and accepting them. Alain's struggle was not concluded at the close of ten sessions.

Homework was another area where progress was uneven. After some sessions, Alain would do his assignments, and at other times, he would not. The reasons sometimes related to him having felt too anxious or at other times, having not felt sufficient motivation. Encouragement from the therapist would sometimes help and at other times, have no effect. Alain's motivation seemed sometimes to be undone by his anxiety and other times by his sadness.

### **Outcome:**

Throughout therapy, Alain seemed to the student clinician to be frequently, firmly in the grip of his anxiety. It suffused his other reactions, thoughts about his chronic pain, and related problems. To make progress with his anxious predisposition would take lengthy therapeutic effort, exceeding the brief period available to this clinician. Nevertheless, some positive results were evident by the close of therapy.

Hypnosis was a modality the clinician could not have predicted that the client would enjoy so much. In retrospect, the clinician considers that seeing this liking and progress, she

should have concentrated upon using more hypnosis with the client. To do so would have meant practising hypnosis in more sessions, perhaps using post-hypnotic suggestion for some of the anxiety or sadness issues. As it happened, the progress made with these affective areas was small and incremental, fluctuating between improvement and regression.

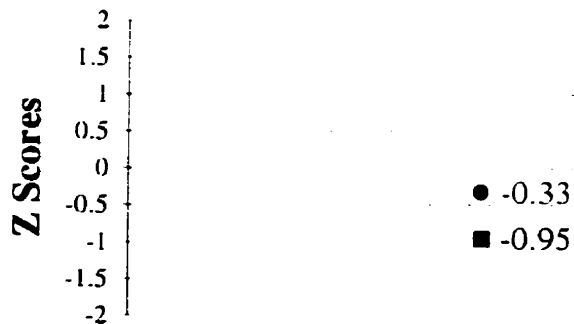
These limited and mixed results were reflected in post-treatment assessments that, with a few exceptions where they worsened, stayed very close to pre-treatment results. The BDI score for depression increased from 14 to 21, thus entering a zone of serious concern. Problems with daily activity and sex increased in those subscales of the CIPI. On the SOPA, emotional focus on the pain increased, as did perceived need for medication; on the positive side, Alain's sense of disability diminished, and so did his need for solicitude.

Alain's return to work, even at half-days, was a schedule that he found stressful, and like another client who had returned to work, he found those physical demands very wearing. This factor undoubtedly also affected Alain's ability to derive full benefit from therapy.

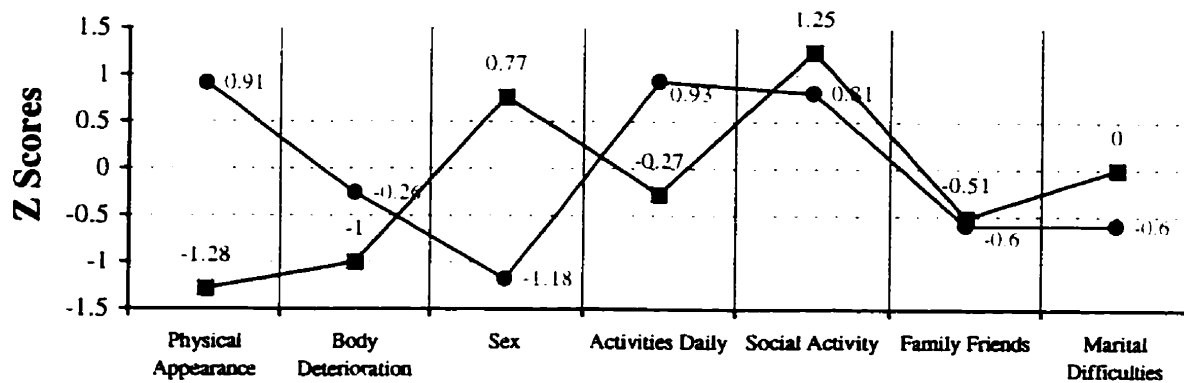
# MARION

A 36 year-old married, female, non-employed homemaker with fibromyalgia.

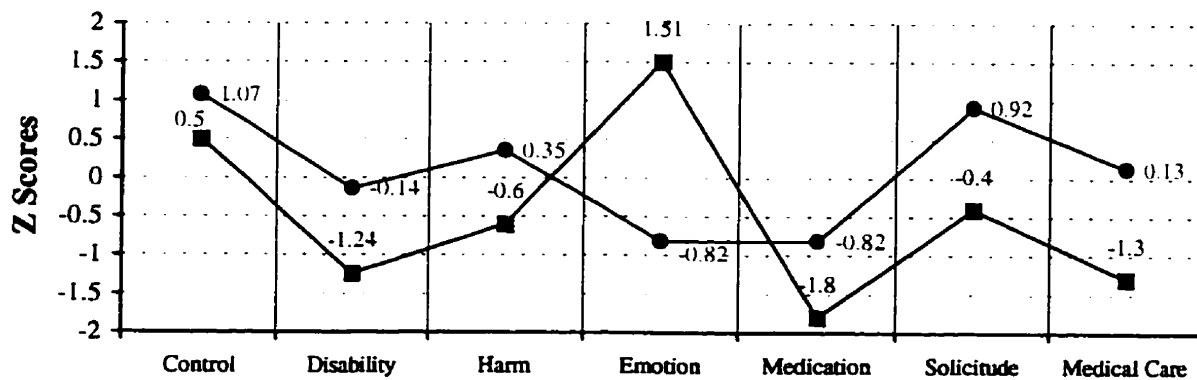
## Beck Depression Inventory (BDI)



## Chronic Illness Problem Inventory (CIPI)



## Survey of Pain Attitudes (SOPA)



● Pre-treatment

■ Post-treatment

**CASE # 4**

**Name:** Marion Bennett

**Period of Treatment:**

Client attended ten treatments between April, 1997 and July, 1997. Sessions were arranged on a weekly basis, although there were sometimes longer gaps between visits because the client rescheduled appointments. In general, reasons for missed appointments were weak, for example, the client reported having slept late or forgetting the appointment.

**Referral information:**

A St. Boniface Hospital Pain Clinic Physician referred Marion for training in relaxation techniques to help alleviate her pain in the neck and upper and mid-back areas. These symptoms had resulted from a motor vehicle accident several years earlier.

**Background information:**

This 36 year-old woman had suffered neck, upper and mid-back pain from motor vehicle accidents that took place eleven and twelve years earlier. Marion reported seeking medical attention from a variety of practitioners over the years, including orthopedic specialists, physiotherapists, chiropractors, and massage therapists. Marion also described holistic health regimes she had tried independently such as yoga, herbal remedies, and meditation. At this time she was seeking help from the clinician for any new strategies that might assist her with pain management.

The client also advised that she suffered from fibromyalgia, a diagnosis that had only recently been made. She described waking up many mornings with a pain that suffused her



whole body and which made it difficult to perform even light physical activity like washing dishes. Marion's method of coping with the pain and her household responsibilities was to slow down so that she did accomplish most tasks, but very slowly.

An aspect of her condition that Marion found very frustrating was its variability, in that on any given day, she might have greater or lesser physical capability; on "bad days" that meant that Marion could do very little, whereas on "good days" she felt few restrictions. The unpredictable nature of the condition made planning and seeking unemployment a difficult undertaking; because of her chronic pain, Marion did not consider herself reliable for any prospective employer.

Complicating the management of Marion's chronic pain over the years was the raising of her two daughters, at this time, seventeen and thirteen. When Marion was injured many years earlier, her daughters were young children who needed a lot of physical care. She described the difficulties and the pleasures in raising the girls and appeared to be a thoughtful and devoted parent. Child raising had been shared with Marion's second husband, whom she married when her first daughter was a toddler. He had fathered the second daughter.

Marion described the relationship with her husband as being very good. From the different anecdotes she related about their life, the picture emerged of a loving couple who made special efforts to spend time together in spite of Marion's husband working the graveyard shift. He had been very supportive when the eldest daughter had herself been involved in a motor vehicle accident a few years earlier than this, sustaining serious back and leg injuries. For approximately two years, the family was busy with many extra tasks to help the temporary invalid. However, at the time of treatment, this older daughter had largely recovered

The client's account of a happy, well-functioning family was severely at odds with the description Marion offered of her birth family; this, she volunteered, was extremely

"dysfunctional." She described the individuals in the family of origin as "losers", people who "drink too much, smoke too much, do too much of everything that's bad for you" and "never try to solve their problems." Marion had grown up in small rural communities in Manitoba and in disadvantaged neighbourhoods in Winnipeg's poor north end. Of six children, none had completed high school. Two had spent time in jail. Marion had run away from home at fourteen and lived on the streets for approximately two years, before going into foster care.

Marion wept when speaking of her mother, who she said was always under the influence of "some drug", whether liquor, illegal, or prescription drugs. Apparently her mother had been unable to manage household tasks or care for her children properly, and many of those tasks had devolved onto Marion, the eldest child. Marion's mother had suffered many undefined "illnesses" throughout her life, and Marion worried that she was becoming like the mother she resented and pitied. She tearfully lamented that because of her chronic pain, she felt like an old woman, even though only thirty-six years old.

A sequel to one aspect of the childhood that Marion resented was the dependence of her siblings on her. Because Marion had largely escaped the adult problems shared by her sisters and brothers, apparently they looked to her for guidance and tangible help. For example, the son (her nephew) of her jailed brother had lived with her family for a brief time before she had allowed him to be taken into foster care for serious behaviour problems. Marion felt guilty about those events, but felt she had few choices if she were to safeguard her own health and the integrity of her own family.

The consequence of Marion having a birth family with so many problems was that current sequelae inevitably involved her. These relatives created an emotional drain upon the client and brought a certain amount of chaos into her life that made managing her own difficulties even harder.

**Clinical Impressions:**

Marion presented as a passionate, intelligent, yet angry young woman who was actively seeking answers to many of her life's problems, including chronic pain. At the same time she appeared to be troubled by strong feelings of shame and regret regarding her birth family. Marion's impatience about her personal difficulties and her strong feelings were evidence that she possessed energy, which if engaged by therapy, might provide the motivation she needed to make some of the life changes she desired.

**Clinical Formulation:**

Marion was a young woman who had struggled and continued to struggle against patterns of behaviour originating with her birth family and related to her disadvantaged socio-economic background. Most pressing for her at this juncture was to learn some strategies to manage the chronic pain and the obvious family stress in her life.

It was considered that Marion's efforts might be undercut by feelings of low self-esteem and inadequacy, because apart from her marriage and two children, she did not recount other achievements. In shedding some of the self-defeating ideas and attitudes with which Marion grew up, she would also need to cultivate feelings of confidence and self-efficacy.

BDI results of 19 fell into the moderate range. CIPI results showed problems in the normal range of a chronic pain population (Kames et al., 1984). The most severe problems showed as Social Activity and Medical Interaction. These results, given Marion's interview history, confirmed the both imposition she felt her extended family to be and her own dissatisfaction with medical care. Marion considered that various practitioners she had seen had been unable to offer solutions to her medical problems. On the SOPA, Marion's feelings and attitudes ranked high on Disability and Emotion, with scores of 3.1 and 3.0 respectively,

compared to Jensen's ( 1989 ) research pre-treatment means of 2.73 and 1.94. The Emotion sub scale score, indicating the extent to which the subject believes emotions are involved in pain, was consistent with Marion's intense, affective presentation.

**Treatment recommendations:**

Treatment of painful emotions was considered necessary to the therapeutic plan, and formed a part of the clinician's thematic cognitive behavioural program. Cognitive distortions appeared evident in Marion's feelings of inadequacy and shame that were at odds with the stable marriage and family life she had built, as well as with the distance she had put between birth family patterns and her own life patterns. Hopelessness, seen in the fear Marion had of repeating some of her mother's frailties or mistakes, was another area that required particular therapeutic focus.

**Course of Treatment:**

The course of Marion's treatment was erratic; the client's motivation fluctuated and her emotions surged in unexpected directions. Marion had expressed strong interest in hypnosis, had appeared to experience benefit in the first induction, but did not practise with her audio tape at home. She wished to take steps towards employment, yet chose not to follow up on independent investigations that she had chosen in discussion with the clinician. Mood variation from one session to the other made follow-up on previously-discussed material and the continuity between sessions difficult. When invited to discuss these changes, the client either displayed a cavalier attitude or would demur.

In spite of these difficulties, cognitive behavioural work with Marion and the corresponding homework tasks did produce beneficial change. The clinician and Marion had discussed some changes that she might work on with her own family to divide the labour of

household tasks so that she was not doing most of them. As a responsible homemaker and a concerned parent, Marion had always done most of the household labour herself, not wishing to burden the children. This practice may have developed because of her intention to protect her own children from any loss of a carefree childhood, something she had experienced when as a youth, she assumed tasks her own mother had neglected. However, this protective behaviour was misplaced, given Marion's disability and the age of her children, who could perform some tasks. After experimenting with delegating certain chores at home, Marion found that she did experience beneficial relief.

Attendance at appointments throughout treatment was irregular, with inadequate explanations for missed or late arrivals. Rapport with the clinician, sometimes found in research to be a reason for these behaviours (Martin & Moore, 1994), appeared from the clinician's viewpoint, to be positive during sessions. In analyzing these matters of neglected homework or missed appointments with her supervisor, the clinician decided to relax pursuit of the goals the client had chosen. It was speculated that although Marion might desire change, she could be unfamiliar or uncomfortable with the direct pursuit of goals, and so feel unready to actively pursue them at the time of this treatment.

An interesting change occurred near the close of treatment. Marion arrived at therapy in a strikingly bright mood that coincided with warm, sunny weather and the beginning of the garden season in southern Manitoba. She spoke happily about activity in her garden even though in her case, the physical activity of that work required special care and very slow progress. The gardening had also stimulated plans she was developing for a possible small business. This unanticipated change in the client's outlook and its strong contrast with her prior moods raised questions about the nature of Marion's depression and whether she might also have been affected by Seasonal Affective Disorder. However, since this change occurred at the end of treatment, the question was not investigated.

**Outcome:**

Some of the post-treatment measures showed objective improvement. Depression, measured in the BDI, dropped from 19 to 14. The post-treatment CIPI sub scale of Daily Activities showed improvement from 2.3 to 3.4, but indicated problems with Sex. Marion's individual score in Sex problems increased only minimally, but in relation to the other clients in the program, increased dramatically, from a z-score of -1.18 to .77, almost a 2-point rise. However, the contents of therapy sessions offered no indication of difficulties with Marion's husband, nor their sexual relationship.

Post-treatment SOPA results show an improvement in Disability, Medication, and Solicitude sub scores; the first showed a 1.5-point improvement, and the latter two showed a 1-point improvement. Marion's Emotion sub scale score increased by 1 point compared with her pre-treatment measure, but by over 2 z-score points in the program group comparison.

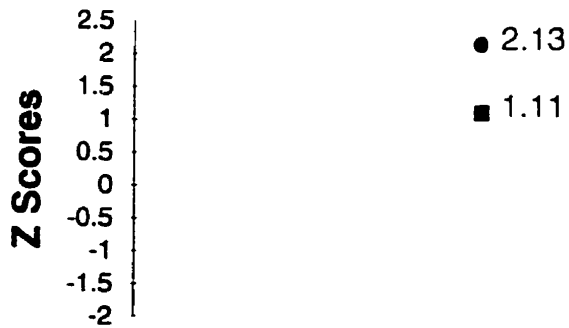
If one is to conclude from these results that cognitive behavioural treatment helped precipitate the above changes, it might be said that treatment helped the client to view her own disability more realistically and to reduce her dependence on external supports like medication or emotional support from others. These conclusions may or may not be correct; the therapist found it difficult to formulate firm clinical conclusions about this patient.

This clinician did form the impression over the course of treatment that Marion had traveled part way along a personal journey to reconstruct a life damaged by difficult, early experiences. The clinician predicted that the client would continue on this journey, but that certainly more support and possibly more therapy would be part of that process.

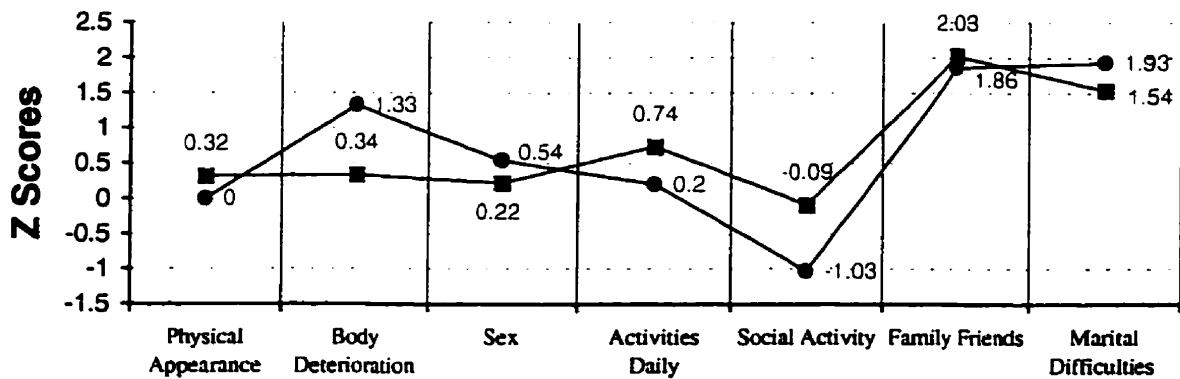
# JANICE

A 50 year-old married, female, former store security officer with fibromyalgia.

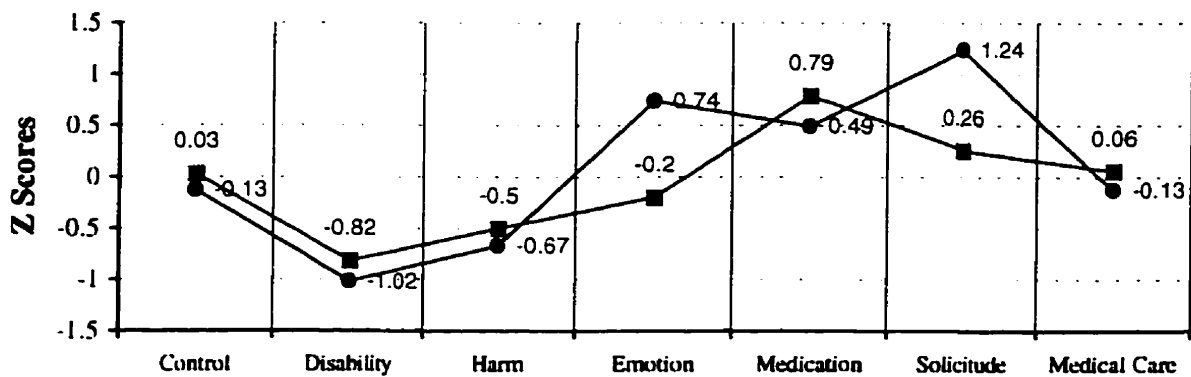
## Beck Depression Inventory (BDI)



## Chronic Illness Problem Inventory (CIPI)



## Survey of Pain Attitudes (SOPA)



● Pre-treatment

■ Post-treatment

## CASE # 5

**Name:** Janice Keith

**Period of Treatment:**

Client attended ten treatment sessions between April and July, 1997. Appointments were initially arranged on a weekly basis; that arrangement changed several times, making gaps of two or three weeks between visits because the client's married daughter gave birth to a second child during this time. Janice wished to help out her daughter by baby-sitting her three-year-old (grand)son and also by helping with the new baby. Since the daughter lived in another city, long drives and overnight visits were necessary.

**Referral Information:**

A physician at the Health Sciences Centre Pain Clinic referred this client for counselling of stress she had experienced from health problems related to neck problems from a motor vehicle injury, as well as generalized and chronic pain from fibromyalgia she subsequently developed.

**Background Information:**

This 50 year-old married woman worked as a store security guard prior to her injury. She reported enjoying the challenge of her work and the contact with co-workers. Janice had not worked for the past four years, at first due to her neck condition and then due to her fibromyalgia.

It appeared that the fibromyalgia was the more disabling condition at the time of the referral. Janice reported that the latter condition caused a variety of symptoms that were not



uniform or predictable from one day to the next. Sometimes she experienced pain all over, and at other times, the pain was in a specific location like her back or joints. Janice related that sexual intercourse was often uncomfortable for her, and also noted that her husband did not really understand her condition. The interruption of their sexual relations did not appear to trouble her.

Janice's thirty-year marriage was and had been unhappy for years. Janice described lengthily and bitterly how her husband was demanding, critical, and selfish. She related his propensity over the years to pursue his own interests and hobbies, in the process neglecting her and the family. Janice told how she had done most of the care and raising of their two children, a daughter, now married, and a son. Janice apparently believed that at this point in life, her husband regretted his disinterest in their children, who had a strong bond with her but not with him.

The client also complained about her husband's alcoholism, a problem for which she had little tolerance since she had successfully overcome personal alcoholism about twelve years earlier. Janice expressed resentment toward her husband's described lack of sympathy for her pain and disability. She related how he complained about her slow speed of walking and ridiculed her memory lapses, a change she believed was caused by the variety of medications she took for pain, blood-pressure, depression, and sleeping problems. Throughout the interview, the client returned to complaining about her husband and their conflict style of nasty sniping at one another.

The negative relations with Janice's husband contrasted with the positive relations with her daughter and son, both of whom she reported seeing regularly and for whom she appeared to have a lot of fondness. Janice worried that the conflict with her husband and the way she reported he criticized or ridiculed their children and grandchildren would alienate the younger

generation. The client also appeared to feel competitive with her husband for their children's affection and good opinion.

Janice related how stressful she found living with neck pain and fibromyalgia, as well as with the marital and family conflict she described. She raised the possibility of leaving her marriage in order to end an obviously unhappy situation. She also mentioned having contemplated suicide, although through further questioning, it became apparent that she had never seriously considered taking her life.

### **Clinical Impression:**

Janice presented as a distressed individual who felt overwhelmed by changes that had taken place in her life over the last few years. Her difficult marriage dominated numerous other concerns that she described in disjointed fashion. Although her conversational style was confused and distracted, Janice was able to attend to the clinician and focus on a particular issue when specifically asked to do so.

The client specifically requested that she be helped with stress that occasionally overwhelmed her. The stress apparently manifested in mainly affective reactions of anxiety and despair, as well as in some mental confusion. Janice also alluded to suicide, but when asked directly about her danger to herself, revealed that she was "not yet at that point." She did, however, worry about the future. The client's description of her mental and affective state was consistent with her self-presentation.

### **Clinical Formulation:**

Janice's chronic pain and the accompanying disability from a neck condition had changed the course of her working life, as well as her social life, creating a stressful burden of anxiety and hopelessness. These changes clearly distressed her, as did her troubled marriage.

However, difficult personal relationships appear to have been the long-standing pattern in this woman's life. It was considered that treatment would be helpful to address the acute distress this client was experiencing from life changes brought on by her chronic pain and disability.

**Treatment Recommendations:**

A brief program of cognitive behavioural treatments was recommended for this client to relieve stress and to begin to examine issues of problem-solving, relationship conflict, painful feelings and hope for the future.

Janice was receptive to undertaking treatment, and expressed hope for relief of stress. It was anticipated that the client's stress could be reduced; however, to achieve positive change in other areas of concern was considered more challenging and less probable, given the longevity of those problems.

**Course of Treatment:**

Janice's most distinguishing feature as a client was her apparent sincerity to work on the issues that she brought to sessions. A veteran of other treatment programs such as AA, Emotions Anonymous, and another substance abuse program, she showed familiarity with the process of examining her feelings and considering her behaviour. These experiences did not appear to have resolved the many personal and relationship issues that still troubled Janice. During the course of therapy, it became apparent that in addition to a long-term, troubled marriage, Janice had experienced a difficult childhood as well; she described harsh parenting by her mother and father, both alcoholics, and having grown up with very low self-esteem. These influences on her personality and her life were deleterious and doubtless diminished her. Nonetheless, she displayed a stalwart quality.

Poor communication skills made therapy difficult at first. As noted above, Janice was prone to lose track of her point in a narrative line and often switched without warning to a new topic; also, she interrupted frequently and did not listen well. The first session and part of the second were devoted to helping her notice these patterns and to practise stopping the habits. Homework was also arranged for monitoring Janice's conversations with others.

Another topic of early sessions was to address Janice's apparent cognitive distortion that her marriage was tolerable to leave unchanged or to live with. Janice's thoughts and feelings on this topic were confused; she certainly felt unhappy with her husband, but did not, it seemed, wish to leave him. The reasons for this gradually emerged over several sessions; they were both emotional and economic; Janice did not possess the resources to support herself into old age, nor the fortitude to make a break and then re-establish her home and family relations anew. This realization was bitter and sobering for Janice. However, it also gave new motivation to therapy, in causing her to consider how she might live tolerably with a husband that she disliked.

The marriage dominated the first half of the therapy program, after which other issues emerged and were addressed. These related to Janice's other relationships, as well as to her feelings about herself. Janice considered the relationships with her son and daughter and their partners to be important. She felt uneasy about discussing any matters on which she and the young couples disagreed, such as timing or length of visits, or in the recent past, her use, perhaps even abuse, of a strong medication that had adversely affected her behaviour. The reasons why this matter had taken place were not pursued because the client resisted discussion, always withdrawing or changing topics. The clinician and Janice discussed the natural occurrence of people in relationships having differing ideas. She then decided on some homework to explore conflict over differing values with her daughter and son-in-law. After a conversation with Janice, the couple apparently had formed a better understanding of

her overall health condition, medication needs, and the ways in which Janice was affected by the various prescriptions she had to take.

Unfortunately, the negative interaction habits between Janice and her husband complicated relations with others. For instance, Janice's husband ridiculed Janice's weight gain since her health had deteriorated and made fun of her speech habits in front of their children. This practice had been long-term, but Janice had little control over these matters. Although she asked her husband to stop, he did not. The natural consequences of hurt feelings, embarrassment, negative atmosphere, and conflict resulted. The clinician and her supervisor considered that some joint meetings with Janice and her husband would be helpful and suggested that he might attend one of the sessions with her. However, Janice's husband refused to come with her or alone. Therefore, although spousal therapy might have helped in this case, it was not possible. That stalemate required that the focus for Janice on marital matters became entirely her own. Treatment focused on how she might choose to conduct herself or to feel about a relationship that would probably always be difficult.

### **Outcome:**

Therapeutic outcome was limited by Janice's choice at that time to stay in her marriage. By making this choice the client exposed herself constantly to negative interactions and frequently difficult circumstances. Most of the treatment sessions returned to the topic of the marriage itself or issues related to Janice's husband's behaviour, her own reactions to him, or his impact on the family.

In spite of this impediment, some improvement was seen in Janice's demeanour, feelings and behaviour in the clinical setting. Changes were also evident in the post-treatment measures. As well, over the course of therapy Janice became calmer in manner and more constructive in attitude. She reported fighting less with her husband. Also, when conflict did

occur, Janice reported reacting to it differently; she was able to transform her formerly angry response into acceptance, and then was able to focus on what she might choose to do to feel better in that situation. Although it seemed sad to the clinician that Janice would elect to stay in such a relationship, the client appeared reconciled to the prospect.

Post-treatment measures showed a significant drop in the BDI measure of depression, from 40 to 27. CIPI results, however, displayed some increase in problems of Daily Activity and Social Activity, but these changes were still within the normal range of after-treatment results for a research pain population. A drop registered in Marital problems that even at pre-treatment, were well outside the above-noted research norms (Kames et al., 1984). These pre and post findings were certainly consistent with the client's history of unhappy marriage. SOPA scores stayed much the same as pre-treatment measures, except for Emotion and Solicitude that dropped after treatment by 1.0 and .5, respectively. The change in Janice's Emotion result brought it into the "normal" range (Jensen & Karoly, 1994) for a pain population, but the post-treatment result for Solicitude was still higher than the pain population mean. These findings suggest that treatment helped improve the emotional component of Janice's pain, but that she still had a strong need for supportive attention, not at all surprising, given the conflicted state of her marriage. Medication and the client's belief in it as an appropriate treatment for pain, was also outside the "normal" pain population range. Janice's dependence on medication, evident in both pre and post measures on the SOPA, was much higher than Jensen's research means and showed consistency with the patient's prior history of substance abuse.

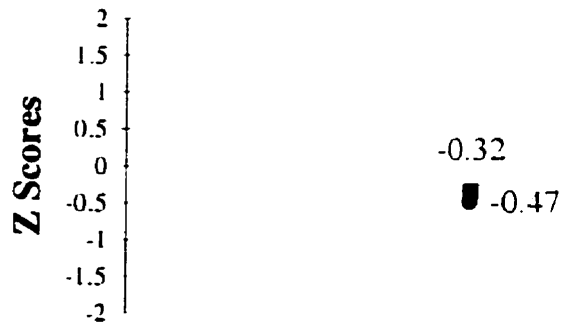
Cognitive behavioural therapy was not delivered precisely according to the protocols set out in this practicum proposal for reasons noted above in this history, but nevertheless, did deliver some benefit to this client. Clinical observation of Janice's functioning, a drop in her

depression levels, and reduced problems in her marriage, her emotionality, and her need for solicitude can be judged a therapeutic improvement.

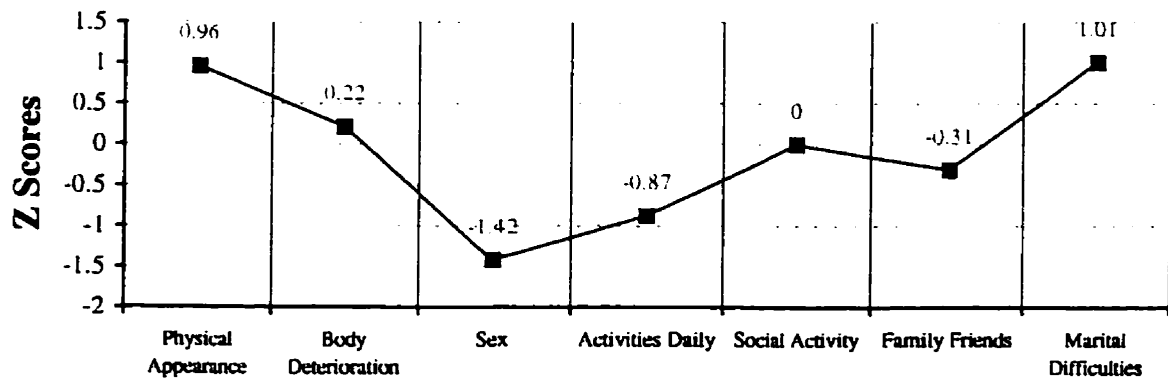
# WALTER

A 59 year-old married, male labourer, not working, with post-injury and post-surgical shoulder pain.

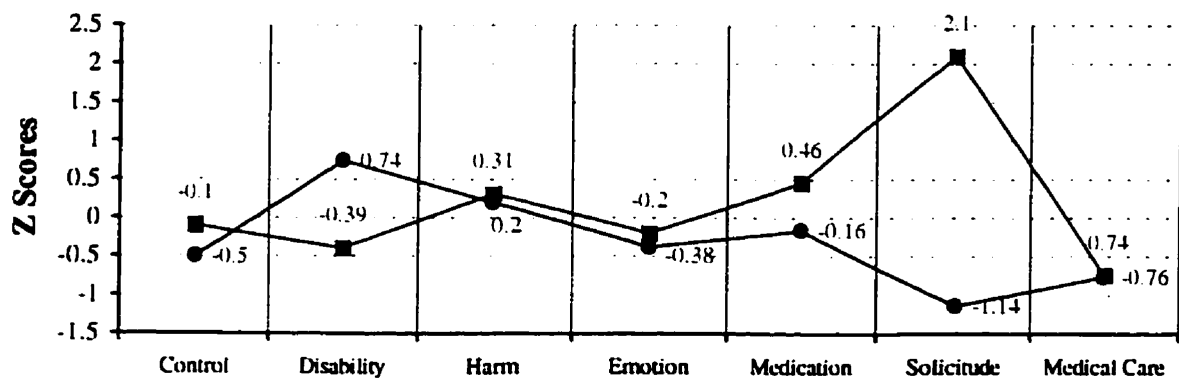
## Beck Depression Inventory (BDI)



## Chronic Illness Problem Inventory (CIPI)



## Survey of Pain Attitudes (SOPA)



● Pre-treatment      ■ Post-treatment



**CLIENT # 6**

**Name:** Walter Schultz

**Period of Treatment:** Client was seen for ten visits between May, 1997 to July, 1997. He attended all appointments punctually.

**Referral Information:**

A fifty-nine-year-old, married man, Walter Schultz was referred to the psychologist by a St. Boniface Hospital Pain Clinic physician for counseling about depression and stress that he had experienced since becoming disabled from work by a left shoulder injury and post-surgical restrictions on use of his joint and arm. Financial constraint added to Mr. Schultz's stress.

The student's supervisor first saw this patient and referred him to her for a program of cognitive-behavioural therapy.

**Background Information**

Mr. Schultz was one of several sons born in Germany. He had independently emigrated to Canada in his twenties; his parents, now no longer living, and his brothers had stayed in Germany. Walter arrived in Canada speaking no English and now spoke nearly flawlessly.

Since coming to Canada with a high school education and training in brick-laying, Walter had worked briefly as a brick-layer's helper, then a construction worker, and most recently, as a Winnipeg Hydro employee, doing various jobs. After a work-caused left shoulder injury and two surgical procedures, he found he could not continue in his repairman's job; lighter duties were tried for a period, and then Walter stopped work to undergo surgery to the other (right) shoulder. The client believed there to have been a relationship of the right shoulder problems to the left shoulder injury, but the Workers'

Compensation Board did not accept this. Consequently, Walter was awarded a disability pension for the left shoulder, but not for the right shoulder; at this point, both completely disabled him from working. A small pension was paid by his former employer.

Walter had been married twice; the first marriage, to a Canadian woman, ended in divorce; there were no children, and that wife had since died. The second marriage, fifteen years in length, had been difficult, involving separations, reconciliations, and at the time of treatment, an uneasy, unhappy accommodation. Walter had three step-children, also grown and with families, and Walter had mostly friendly relations with these relatives. Eleven grandchildren populated the youngest generation, and Walter expressed affection and pleasure for them.

The client's original injury had occurred in 1984 at work when he fell and dislocated the left shoulder. He had undergone a surgical fusion of the shoulder, returned to modified work duty, but experienced continuing pain, eventually necessitating a hemiarthroplasty. Walter again returned to work, but reported having had to guard the left shoulder and then developing problems in his right shoulder, for which he had also undergone surgery. At the time of the appointment, the client was left with limited movement bilaterally, so that he could not raise his arms above shoulder level. Unfortunately, there were no further treatments to be offered beyond the surgery and physiotherapy Walter had already received. He took medication regularly for pain. The client moved smoothly except for movements involving his shoulders; when turning in his chair to look at something, Walter would slowly turn his whole torso since torsion or neck movements appeared painful. Putting on his coat was a very awkward undertaking.

Recent cancer problems had been treated with chemotherapy, and Walter expressed no worries about this condition. His health otherwise was generally good; in fact, he appeared very fit, with upright carriage and no extra weight.

The loss of work and its regular income appeared to distress Walter for both financial and social reasons. He owned a small home which he and his wife had bought after their last reconciliation. Walter found that although he could do many of the basic maintenance chores, the progress was slow and the work was burdensome because of his shoulder limitations.

In social terms, Walter appeared to be very isolated. He first presented his marriage as satisfying and later, as extremely unhappy. Initially, the marriage was described as blissful, to "a wonderful woman" with whom he had shared fulfilling love over the previous fifteen years. Later on in the interview, Walter revealed that the marital relationship had been stormy in the past and now had deteriorated to the point where he and his wife almost never conversed. Also, no sexual relations had taken place for a few years.

Walter attributed this state of the relationship to several causes: an extended extra-marital affair in which his wife had been involved and for which she had left the marriage for approximately a year; his own wounded feelings and the fact that he had been unable to forgive his wife for the affair; his loss of work; and finally, his wife's reported suspicion that Walter had undergone surgery to avoid work.

As Walter described the situation at home, his wife was disinterested in sharing meals, company, recreation, and money with him; the couple apparently shared paying the bills but not the discretionary income. As a result, Walter had very little spending money; his wife did because of two part-time jobs she held.

A further complication to difficult marital relations was the fact that Walter's wife had multiple sclerosis. He reported that at the time she could do most things, but he believed that she worried about her future and dependence on him. The client gave history of his first wife being alcoholic, and his second wife also having excessive drinking patterns. He had not sought professional advice or help for this latter matter; however, he was urged to do so by the clinician.

Walter had not undergone any marital counseling, and he did not believe his wife would be willing to attend any. He alternated between hoping that relations between them might improve and feeling anger about the reported, long-ago affair, as well as about the disinterest with which his wife apparently now treated him. Walter stated that he did not understand why his marital relationship had deteriorated nor why there was no motivation on his wife's part to improve things.

The patient wanted to find some ways to reduce his stress, and appeared ready to undertake efforts to achieve that. He had not before been involved in counseling or therapy and expressed no preferences about the program of cognitive therapy when it was described to him other than a desire to try.

Walter did not have any regular social supports. His two natural children, for whom he expressed fondness, were "busy with their own families and making a living." He maintained telephone contact and visited several times a year. His three step-children, two of whom he apparently felt comfortable with, had similar frequency of contact; however, with one family he hosted the two adolescent grandchildren almost weekly even though he did not visit with their parents. Walter also described friendships with several men, some of whom he had worked with at his old job, but did not see these people socially; he explained that because of relations being strained with his wife, he could not host people at home; neither could he afford to go out with them. The result was that this gentleman was quite alone with his problems and worries.

**Clinical Impression:**

The client attended the interview dressed neatly in casual clothing. His manner was polite and pleasant; he answered questions in a ready but thoughtful manner. In regard to inquiries about his situation and relationships, the patient at first offered a positive description and

interpretation. Later in the interview, he revealed that several matters noted above were difficult for him and that his marriage seemed empty. When describing happier times with his second wife, Walter became first effusive and then tearful.

The patient changed topic several times from the matters being discussed, as thoughts or feelings overtook him; he gave the impression of someone confused by having several problems, but who was nevertheless, ready to unburden himself.

Walter's self-description of feeling very stressed was evidenced by his emotionality and the numerous, distressing events he reported from his recent past, some pre-existing his shoulder difficulties and some following the reduced function and chronic pain after shoulder surgeries. The clinician considered it probable that the client would be motivated to work toward making some adaptive changes, as well as reducing obvious stress.

### **Clinical Formulation:**

Considered alone, Walter's reduced physical function and chronic pain might have created problems for him, but the compounding effect of financial pressure, marital difficulties, and social isolation would certainly have intensified stress and depression. At intake, Walter had exhibited sadness about some of the irreversible losses in his life, such as his physical strength and full function. However, he showed acceptance of those changes. The areas in which the client demonstrated distress and cognitive distortions were his marriage, extended family, and social relationships. Also, Walter was living with essentially no social supports, a concern to the clinician because of his physical state and his age.

Whether his unhappy marital situation was sequel to his physical problems was unclear at this point; nevertheless, it appeared to be the most significant stressor in his life. As a broad therapeutic goal, the patient's need to reduce stress was selected, alongside review of cognitions regarding his marriage.

**Treatment Recommendations:**

The clinician considered that Walter would benefit from unburdening himself and having opportunity to explore some solutions to his problems. Cognitive-behavioural techniques were to: explore the realism of some of Walter's cognitions; investigate establishing more supportive social relationships; look at painful emotions and the development of hope. An unknown quantity in this process was the reason or reasons for Walter having so many relationships that were non-functional. It was considered that those factors might impact on the progress or success of therapy.

**Course of Treatment:**

Walter's cognitive behavioral treatments proceeded according to the protocol: all themes in the program outline were addressed, with approximately two sessions spent on each of the four themes. Discussion of the difficulties in Walter's marriage carried over into other sessions, not a surprise, considering the strong feelings he had expressed in the first clinical meeting. During treatment, additional aspects of the client's personality became more apparent and offered the clinician some understanding of his relationship difficulties. These relational issues were not resolved by treatment, but the client did feel both less stressed and less unhappy by the time treatment ended. As well, he appeared ready to approach decision-making about some long-term problems.

In treatment, Walter was responsive to alternative viewpoints. This was evident both during discussions about his situation and when he arrived at subsequent appointments; he often said, "I was thinking about what we talked about last week, and I've decided to start doing . . . ." He usually followed through on homework and plans made in sessions; however, if it happened that he did not complete homework assignments, he usually had a clear reason why. An example of Walter's willingness to try new experiences was his attendance at one of

the city's senior centres. Although it took a few weeks for him to make the decision to go, Walter did, despite some trepidations.

The client demonstrated throughout treatment that he had reflected little in the past about his life and the issues he discussed with the clinician. His attitudes, beliefs, and responses were largely unexamined. Upon thinking about and discussing these issues, he spontaneously drew conclusions that themselves incorporated cognitive distortions. For example, embroiled in distress and anger toward his wife, and disappointed in his two marriages, Walter carried several negative notions about women in general. After noticing this distorted generalization, he began to reflect on possibilities that more convivial female companionship might exist.

Treatment also uncovered some areas of strong, negative affect that might explain a personal factor contributing to Walter's unsatisfying or limited relationships. On a few occasions, Walter demonstrated aggressive anger as he recalled an unfortunate event from his past. For example, remembering his own sense of betrayal after discovering his second wife's extra-marital affair, Walter's behaviour and voice shifted dramatically. He started to shout that some women "just need to be shown who's in charge" and mimed striking someone with his fists; during this demonstration, Walter seemed unconscious of his behaviour shift or its effect. On other occasions, when describing a lawyer whose efforts had disappointed him, or some people he resented because of their association with his wife's paramour, Walter became caustically judgmental. The visceral quality and unpleasantness of his descriptions created a striking contrast to his behaviour moments earlier. While negative feelings about these people or events might have been predictable along some behavioural continuum, Walter's conduct had suggested angry, perhaps violent propensities. Asked about the latter possibility, Walter admitted some unfortunate episodes, but minimized the significance of them. He did not wish to discuss them further.

The client's behaviour in succeeding sessions became less emotional and less tense. He displayed no further angry outbursts nor tearful episodes after the third session. Although marital tension apparently continued, Walter did not become overwrought when contemplating his present or future situation. Efforts in treatment moved to examining the client's (non-existent) social network with him and discussing the benefits of more social interaction. Homework assignments involved Walter making contact for a walk and coffee with some former work associates he had enjoyed in the past. As well, visits were encouraged to a local senior's organization for some casual social contact. These visits also provided an opportunity for Walter to deploy some well-developed wood-working skills in the centre's workshop. The above activities offered the client several benefits: distraction from his problems at home, social interaction, the possibility of new friendship, and pleasure from working on a hobby in a well-equipped workshop. All of these experiences had been missing from Walter's life since he had become unemployed by virtue of his medical condition.

It became clear part-way through treatment that Walter's marriage was probably irretrievable. It also became evident that, in the short-term, he might be financially unable to leave the relationship. Discussions ensued about the limitations of this situation, and how Walter could maintain his own morale in an emotionally hostile environment. Some role-play was practised of difficult situations that tended to recur with his wife. Walter also listed activities in which he could reliably and affordably engage for his own pleasure. These activities and discussion of Walter's medium-range future (after age sixty-five) succeeded in encouraging some hope in the client.

At the conclusion of treatment, Walter's original goal of reducing his stress had been achieved. His state of mind when he came to sessions was relaxed and no longer distressed. Some steps toward establishing social support outside of Walter's estranged marriage had



been taken. Finances continued to be constrained, but special counselling on this matter had been suggested.

**Outcome:**

As noted above, in several respects, Walter's situation had improved by close of treatment. Post-treatment instrument measures on the Beck Depression Inventory (BDI) showed no positive change, and on the Survey of Pain Attitudes (SOPA) showed modest improvement in a few categories. Unfortunately, no pre to post comparisons were possible on the Chronic Illness Problem Inventory (CIPI) because the first measure, although taken, had been lost.

In depression, Walter's z-score on the BDI had increased .15 over the course of treatment. This change was not matched by clinical observation of mood deterioration. The recorded change was so slight as to be negligible.

On the SOPA, Walter exhibited a z-score increase of .4 for Control, representing the sense a client has that he can control his pain. This score change showed improvement insofar as increase means more control, a marker associated with better management of chronic pain. Also, Walter was one of only two clients whose Control sub scale score increased.

In Disability, measuring a client's appraisal of his own disability from pain, Walter's feeling of being disabled diminished by 1.13 z-score points. This change also represents improvement.

Emotion z-score change showed a shift upwards of .18, a modest improvement. This change indicates a client's increased awareness of how feelings affect his pain. For a client like Walter, who began treatment unaware and unreflective, this change represented improvement; to the extent that he could notice his emotional state, he might be better able to manage his pain or pain problems.

The most marked change was in Solicitude, the extent to which a client believed that intimates should be solicitous of his pain. Walter's score increased by 3.15 z-score points, by far the greatest change among the six clients. This change may not be surprising, considering that of all the clients, Walter had the least affective and social support. It is reasonable to conclude that the therapeutic relationship, with its exploration of relationship and affective issues, may have sensitized Walter to the fact that there was no solicitude in his life. To the extent that he had become aware of this, Walter might begin to engage in other relationships that could provide emotional support.

Other sub scale scores, such as Harm, the extent to which a patient believes pain is harming him, and Medical Cure, the belief a medical cure exists, showed little, negative, or negligible change, respectively. Medication, the belief in need for medicine for pain, increased .62 z-score points.

On balance, the clinician considers that clinical observation, as well as instrument score results, demonstrate that this client's attitudes and pain beliefs changed to be more positively adaptive after treatment. Depression, as for other males, was essentially unchanged by therapy.

## RESULTS

Results were mixed from the cognitive behavioural intervention with these six clients. Improvement took place in some areas for all clients except one, whose results will be discussed below. Areas of improvement were individual, differing from person to person; however, the clients who did improve the most also shared more common areas of change with one another. More positive change for more individuals took place in the sphere of attitudes and emotions, as measured by the Survey of Pain Attitudes (SOPA) than in practical problem areas, as measured by the Chronic Illness Problem Inventory (CIPI). These findings were confirmed by clinical observation that also offered interpretative perspective on client distress and problem-solving, areas not specifically measured by the formal instruments.

### INSTRUMENT MEASURES (BDI, SOPA AND CIPI )RESULTS

The most striking finding in client results was a split along gender lines in all three major areas assessed: depression, emotions and attitudes, and practical problem areas. The raw score results were converted to z-scores to permit comparisons between instruments.

Beck Depression Inventory (BDI) pre-treatment measures of depression showed two clients (Edward and Janice) to be within the range requiring clinical treatment. Other clients' results fell into the moderate range of depression. Compared to one another through z-scores, two females (Edythe and Janice) and two males ( Edward and Alain) ranked above normal (0) in depression. The remaining two clients (Marion and Walter) had z-scores slightly below normal.

In post-treatment measures, all female clients showed reduced depression. Reductions in depression among three female clients ranged from a drop of 1.75 z-score points through 1.38, to 1.01 z-score points. Conversely, all men's depression scores rose in post-treatment

measures; reasons for this opposite trend from the females are uncertain. Hypotheses to explain the contrast will be presented below in "Discussion of Results."

Echoing the depression results on the (BDI), Survey of Pain Attitudes (SOPA) pre and post measures showed greater improvement in a greater number of sub-scale categories among female clients than among male clients. Two females showed improvement in five and six of seven categories respectively, while the third female improved in only two categories. The three male clients showed improvement in four of seven, two of seven, and one of seven categories, respectively.

All females showed a need for less solicitude after treatment than male clients, the only category on the SOPA registering a unanimous drop among females in post-testing. In after-treatment results, two of the females showed reduced belief in the appropriateness of medication as a treatment for their pain. Two of three females showed a post-treatment reduction (.94 and .74 z-score drop) in Emotion, reflecting their view of how emotion was impacting their pain: less. The third female, Edythe, showed a 2.3 z-score rise in her awareness of emotion's effect on pain. Contrasting the direction of these changes, men's Emotion scores showed little change, in fact, a very slight rise in their belief of how feelings impacted their pain..

Solicitude was another area where men's change (two clients), opposite from women's and showing a stronger belief in their need for solicitude, may indicate a gender difference. This affective change is also consistent with men's unanimous, slightly higher measures of post-treatment belief in Emotion affecting their experience of pain. These two areas indicate emotional awareness for men intensifying after treatment and may require a different interpretation from that given to women's results. All pre-treatment measures of men's Solicitude and Emotion had shown lower than women's results in those categories.

The area of attitude change where male clients' improvement outstripped females appeared in the Disability sub-scale. Two male clients' sense of their own disability diminished, dropping 1.13 and .82 z-score points; the third male's Disability score actually increased, 1.4 z-score points, an unsurprising change since his return to work during the course of therapy was physically stressful. Female disability z-scores, on the other hand, increased by .20 and .75, although in the third case the z-score dropped 1.10 z-score points. These female score changes demonstrate opposite trends to male subject score changes.

Control scores on the SOPA, reflecting belief in ability to control pain, among four of six clients, dropped in post-treatment measures. The drop ranged from .54 z-score points (a man), through .51 and .80 (females) to 1.64 (a man). Therefore, in two-thirds of this small population, treatment did not affect this area of experience. In the two clients whose sense of control increased over the course of treatment, the rise was .50 z-score points.

Harm was a category showing almost no change from pre to post measures. In five of six cases, the change toward improvement (down) or deterioration (up) was minimal; at the most, harm moved down .2 z-score points. In one case, the change was .95 z-score points downwards; however, this particular client had also shown several other improvements in her SOPA scores, so that this relatively dramatic change was consistent with an overall improvement.

Medical Care results, those showing a belief in medicine as offering a solution to pain, crossed gender boundaries with half of clients (both men and women). Z-score points dropped for these clients by .46, .63, and 1.46. This change suggests improvement, insofar as it indicates less external dependence for pain relief; the result also suggests more self-reliance. Increased belief in Medical Care showed both less and more change, with z-score differences of .02, .19, and 2.28.

The Chronic Illness Problem Inventory (CIPI) results, measuring practical problem areas, showed considerably less change among clients than either the BDI or the SOPA results had displayed. Improvements were limited to fewer categories in CIPI problems and distributed among fewer subjects. However in one trend, the CIPI reflected a BDI and SOPA pattern: the split between gender. Female subject CIPI results showed improvement in a minimum of two categories for one female subject and a maximum of three categories for another. Male subjects showed either no improvement in problems (two men) or a worsening of problems (one man) when compared with pre-treatment CIPI measures.

In Physical Appearance, two female clients and all men felt the same or worse when post measures were compared with pre-treatment measures. Body Deterioration showed similar results, with all but one of six clients feeling the same or worse after treatment. The one client who improved on this measure presented a striking change with a difference of nearly 10 z-score points.

Sexual Problems results displayed a reduction of .32 and .34 z-score points for two females; however, problems with sex increased for all other clients, with those changes ranging from .26 to 1.95 z-score point differences.

Daily Activities problems showed clients considered that after treatment they had more difficulties in two cases (.39 and .54 z-score point increase) and essentially the same results in two others. Another client showed improvement of .66 z-score points in this category, while pre-treatment measures were not available for a sixth client.

Social Activity problems showed increased scores, thus greater problems for three clients; z-score point differences ranged from .09 through .36, to 1.56. A fourth client's pre-post scores stayed nearly the same, while a fifth showed improvement in problems of social activity, with a z-score point difference of .9. Pre-treatment measures were unavailable for a sixth client.

Family and Friends' problem results showed similar trends to Social Activity measure differences, with four clients finding that those problems had deteriorated further during the course of treatment. In contrast to those clients, the same client whose Social Activity problems had improved, also showed improvement in problems with family and friends.

Finally, post-treatment results for Marital Problems reflected the latter trends of increased problems for three clients (z-score increases of .24, .60, and .80), maintenance of status-quo for a fourth (.04 difference, a man), and improvement of .39 z-score points for one female. As noted already, pre-treatment results on the CIPI were unavailable for one male subject.

#### CLINICAL OBSERVATION OF CHANGE

Reflecting on the overall pattern of change during and after treatment, this clinician observed in five of six cases that clients exhibited comparatively calmer demeanour and less distress. These changes were evident in spite of many practical, pain-related problems that persisted after therapy. In one case (Edward) where the client's difficulties had worsened significantly after his return to work, it was observed that his attitude to his situation and his future was more realistic and calm, whereas it had been anxious and distressed before, based partly upon his previous experiences of working with pain. The student clinician considered that clients (with one exception) demonstrated less anxiety about their problems and a greater sense of general control over their lives, although not over their pain.

The clinician drew these conclusions from watching the clients display increasing rationality about pain-related issues in their lives. Having collaborated with the clinician in attempting some measures to reduce pain or other problems, the clients also appeared more inclined to problem-solve: through making decisions that they had long deferred; through

adopting a different attitude to a problem (such as accepting one's tendency to fatigue very quickly); or through making changes in how certain relationships were conducted.

An example of these kinds of observed changes can be seen in the case of Edward. In his case, all post-treatment instruments showed worsening of depression, of his general emotional state, and of practical problems. Yet in spite of all these difficulties that occurred after his stressful return to heavy work, Edward had decided that he and his family must gather to make some difficult decisions about his ability to continue working. Such decisions would certainly change the family's financial situation. Edward's willingness to consider these issues had not existed at the time therapy began. Further, although it is true that the difficulties associated with returning to work must also have influenced Edward developing more realistic attitudes, those same conditions had already existed for several years prior to therapy, including several periods of attempting to be back at work. Therefore, this particular working with pain episode was not unique. To conclude that therapy had produced some attitude change and an ability to make decisions long avoided, is reasonable.

All female clients displayed less distress and more willingness to look realistically at their life situations. During and after therapy, they were more willing to consider and to try alternative measures to managing pain-related problems. For example, after therapy, Edythe showed less irritability about her severe migraine condition, and more readiness to relax the rigid standards she held for herself. Simultaneously, a more subtle change also occurred. Edythe acknowledged that she felt depressed and angry about her frequent sickness. This information had not been volunteered early in therapy, nor would Edythe have admitted to it if asked, since her *modus operandi* was to live actively and cheerfully. Edythe's sickness, disability, and depression engaged feelings that violated the self-image that she had created for herself. To acknowledge these inconsistencies in her beliefs and attitudes and then to relax expectations for herself represented an adaptive change for Edythe. Superficially, the change



engaged negative emotions and so might have been interpreted as lack of therapeutic progress, when in fact for this client, it represented cognitive change that was useful to further therapy. The client's acceptance of her own unhappiness created a new departure point in therapy for other changes; Edythe began to more honestly explore her feelings about relations with others, including her husband. The coincidence of these changes with therapy suggests that the cognitive behavioural intervention must have been at least partly responsible.

Three other clients also demonstrated less distress and a new readiness to problem-solve that had not existed before treatment. Walter appeared less troubled about his unhappy marriage. Although he was unwilling or unable to leave the relationship, he displayed interest and pleasure in seeking sociability through a local senior's organization. Prior to treatment he had described the present state of his marriage in highly favourable but apparently inaccurate terms. However, as treatment progressed through early appointments, Walter had wept about his unhappiness over the marriage having soured. He had also indicated that he felt stressed by his personal circumstances, anxious, and was sleeping with difficulty. Walter had apparently been unable, before therapy began, to acknowledge that his wife was completely unresponsive to him and disinterested in improving the marriage. Toward the close of treatment, Walter expressed his intention to look at his marriage and situation differently, planning to adopt new behaviours and attitudes that would not hinge on the quality of relations with his wife. Previously, he had sought reconciliation with her, but almost always unsuccessfully. Following treatment, he had resolved to avoid this futility. Also after the cognitive-behavioural intervention, the client's non-verbal behaviour changed; he appeared less agitated; he no longer wept nor expressed nostalgic fantasies about his wife.

A female client, Janice, also experienced a troubled marriage and had exhibited signs of stress in pre-treatment and early interviews. In those visits, she had spoken at length about the negative patterns within her marriage relationship and about frequently feeling anxious. In

post-treatment measures, Janice's marital problem index dropped, as did signs of stress. She reported then that she had decided to no longer be upset by her husband's behaviour, as had been her habit in the past. Also, in mid-treatment, Janice related that she was feeling better about her social interactions. She had initially shown a lack of confidence about her self-presentation and had stated that she had felt this way since becoming chronically ill; loss of physical fitness, slowed movements and speech, both due to the effects of pain and medication, caused Janice to feel self-conscious. These changes, along with diminished memory, were the subject of family teasing, another matter about which Janice felt sensitive. In treatment, techniques were practised with Janice and given as homework to help her improve her communication skills. Practising assertiveness, more succinct story-telling, and more constructive responses to teasing enabled Janice to feel effective when conversing with family and friends.

These types of positive, adaptive changes in outlook, attitude, and sometimes behaviour were noted generally in all clients. Even though the various improvements were not universal, nor reflected in the instrumental measures of change for clients, the clinician's observation of improvement is nonetheless worthy. It should carry some weight in interpreting overall results. The student clinician believes that all clients felt less distressed after the intervention and were ready to make or, in some cases, had already begun to make adaptive changes in their circumstances because of treatment.

## **DISCUSSION OF RESULTS**

### **DEPRESSION AND NEGATIVE AFFECT (BDI and SOPA)**

Depression in chronic pain patients was the main focus of interest in this clinical intervention. It is also the area that has the most clearly demarcated results. As noted above, a split in depression findings occurs along gender lines; all females experienced reduced depression after the intervention and all males experienced increased depression from pre to post measures. The pre-intervention measures of female depression were in the moderate range, with one exception, showing Janice to be at a higher level, indicating clinical care was necessary. All female pre-treatment depression scores showed as positive z-scores, whereas male pre-treatment scores were minus z-scores. These findings show that females all started treatment with above-normal levels of depression (for this population) and so arguably, had more scope for change.

In seeking to explain the greater improvement of depression in females, individual situations of some clients may offer some insight. Two of the three men returned to work during treatment; one had returned just before intervention began, and the other returned approximately halfway through the treatment program. These two individuals experienced increased pain and significant fatigue from working. In contrast, none of the females was working before, during, or after clinical intervention, so were entirely free from that physical and mental stress.

Age differences between men and women were unlikely significant. Females were each and on average, younger than males. However, the average figures are distorted by the oldest client (a man, 59) and the youngest client (a woman, 36); most clients clustered within a nine-year middle-age range, from 46 to 55. Current literature on age and chronic pain (Helme, R.D. & Gibson, S.J., 1996) shows diminishing sensitivity to pain with advanced or elderly age. However, the findings for other age groups and pain types are inconsistent.

Personality measures were not taken of clients, so that data is unavailable. Clinical impression during treatment suggests that females did not possess a greater degree of optimism or self-reliance, traits that have been considered to positively affect depression levels. The presumption that certain personality traits assist in coping with chronic pain has been part of research into coping and personality. However, recent findings (Hagglund et al., 1991) confound that presumption. Research with chronic arthritis pain patients showed that those who exhibited optimistic cognitions did not have less pain or functional disability. Other literature offers findings which suggest possible explanations for females' greater improvement in depression.

In his extensive review of the cognitive behavioural literature, Jensen (1991) noted Buckelew et al.'s research discovery that female subjects showed stronger belief than males in controlling their pain and also, a greater inclination to engage in cognitive restructuring to cope with pain. This student clinician's more positive treatment results with females is consistent with Buckelew's findings. The three women clients in this intervention may have been more positively disposed than male clients to engage in cognitive behavioural strategies to reduce pain or to cope with associated problems. This speculation is made with full acknowledgment that the tiny sample of intervention clients is too small and biased by selection methods for results to have any authority. Nevertheless, Buckelew's research results with chronic pain patients may offer insight to this practice's results of male/female depression change and personal control differences in results.

Also from the same review (1991) and pertinent to this practice's results, is Jensen's report of Affleck's discovery of how personal control over treatment was positively associated with mood and global adjustment to pain. Affleck's finding also provides a possible explanation for the improvement in depression among females. The change may relate to

females' non-employed status, their freedom to engage in suitable remedial activity when it suited them. This freedom may have contributed to their sense of control.

Two of three male subjects with whom this clinician worked felt that they had little choice about returning to work, in spite of experiencing significant chronic pain. They provided the major income for their families, and their income was substantially better than the disability payments each man had received while totally unable to work. The third man, completely and permanently disabled, experienced severe financial stress and similar to the other two, felt he had no alternatives for improving his situation. Caught in this circumstance, Walter would have worked if he could have managed the physical demands. Nonetheless, Walter was acutely aware of and regretful about financial resources he could not provide.

By contrast, female clients were each supported by husbands and had no comparable pressure to return to work with pain. A second income that they could have provided might have improved their families' economic situations, but was not essential. However, because of the work environment demands for male clients, personal control over treatment or pain relief modalities, such as that found by Affleck, were simply not possible.

When at work, these men could not often arrange to perform calming or relaxing exercises if they felt a need. Furthermore, they could not rest or make small adjustments in their activities to accommodate their pain. The men's work demanded a consistent level of performance that had to be delivered. This problem was particularly keen for Edward, who repaired heavy-duty equipment. At home, each woman client could stop activities or rest when needed. If any wished to engage in a relaxation sequence or self-hypnosis, no other priorities prohibited doing so. In fact, each of the female clients did report often having taken the time to use different techniques that had been discussed and practised in therapy.

The male clients' greater need for solicitude and their higher evaluation of the impact of emotions on their pain poses an interesting causal question: Are these differences gender-

based, or are they related to differences in personality and individual situation? With a tiny, non-statistical sampling, these questions cannot be properly addressed. Nevertheless, having acknowledged that limitation, one can still speculate. The consistency of males' affective results suggests that emotions and how men handle them may be an important part of their pain experience. Men may suppress emotions relatively more than women and therefore, be less aware of pain's impact on their lives. Through an intervention like cognitive behavioural therapy, they may become more aware of those impacts and how they feel about pain's disruption of their lives. The post-treatment measures of Solicitude and Emotions suggest this process may have been at work. Likewise, the males' depression results could be explained similarly. If men's emotions and their readiness to examine them are slower than women's propensities, yet they are still responsive to treatment, then the timetable treatment should perhaps be planned differently for men. A longer period of treatment may be necessary, or even different methods of treatment.

The male clients' liking for hypnosis as a treatment modality supports this conclusion further. Hypnosis accesses areas of cognitive and affective experience not normally available to people. The fact that male clients liked the hypnotic experience in treatment, combined with the facts of their increased awareness of emotions, greater depression and need for solicitude during the intervention, supports this conclusion: treatment made men more aware of their thoughts and feelings about pain, and perhaps more ready to explore them; this readiness was evident from their receptivity to and subsequent use of self-hypnosis. Negative emotions like depression, as well as positive reactions such as increasing emotional awareness, were surfaced by treatment; this process was begun but incomplete by the close of the intervention. Continuation of the therapeutic process would have required more work with clients to adapt to or accept the losses brought on by chronic pain. In a non-practicum setting, therapy would have continued; however, in this situation, the terms of the practicum

intervention had been fulfilled. Continued treatment of these clients by this student clinician was not possible; their treatment needs were assessed and where indicated, clients were able to receive further therapy with a different practitioner at the respective centres.

Female clients improved more in depression and affective areas. However, one sub-category of the SOPA, the sense of control over pain, created an exception to that pattern. The clinician observed that over the course of therapy, all clients appeared to develop a more realistic, in some cases, fatalistic appraisal of how pain affected their physical capacities. Four clients (two women and two men) showed in post-treatment results that they felt they had less control of their pain compared with their pre-treatment belief. This finding of reduced belief in control appeared to represent a positive adaptation to chronic pain, rather than a negative one.

Through homework and actions that attempted to ameliorate their pain-related problems, clients were able to see more clearly what adaptations they could and could not accomplish. The clients had to accept certain circumstances that they did not wish and did not like; for example, Edythe decided to accept the illness-based necessity of sometimes defaulting on social obligations and adopted the new practice of advising her associates about the true reasons. Previously, she had not approved of reneging on arrangements, fearing an appearance of weakness. These thought processes involved Edythe confusing her illness and justified withdrawal from social obligations with irresponsibility and poor character, the latter two both distorted cognitions. A second example of client acceptance of difficult realities was Edward's recognition that he had less control over pain than he had previously believed. Prior to the intervention, Edward had insisted that he could handle the strain of returning to heavy-duty work by exerting a strong will and fortitude, as he had done in the past. However, these exertions were not sufficient this time to fortify him for the physical strain. When he resumed work, Edward reluctantly but realistically adopted new attitudes, concluding that he

should make a major change in his work or perhaps not work at all. That decision-making was not complete before the intervention concluded, but Edward had made some new personal choices. He needed to discuss these with his wife, an important step in itself and one with which the student clinician could have assisted if the client had wished and if treatment had continued.

While these kinds of realities were uncomfortable for clients and forced a pyrrhic sense of defeat in some cases, the discovery was nevertheless, therapeutically useful. Faced with an unchangeable circumstance, clients were forced, as in traveling down a dead-end road, to turn around and seek another way. The client's uncomfortable realization about ineffective thinking or personal arrangements marked a pre-cursor to change, as well as a potential watershed in treatment. Helping in this process, the clinician encouraged and supported. Thus, although superficially a negative change, the diminished sense of control because of pain in these four cases actually represented both clinical opportunity and clinical progress. This measure of progress could not be predicted nor scheduled within the protocols of the intervention. As an indicator of possible therapeutic opportunity, control is an area that clinicians could productively monitor during treatment.

#### CHRONIC ILLNESS PROBLEM INVENTORY (CIPI) RESULTS

CIPI results showed less change overall between pre and post treatment than did the Beck Depression Inventory (BDI) or the Survey of Pain Attitudes (SOPA) results. However, the general pattern of some change among female subjects and very little or no change among male subjects displayed in the SOPA findings was repeated in the CIPI. The direction of change in the CIPI that tends toward deterioration and the number of subjects that show this trend may indicate something different than the similar direction of trends in the SOPA results.



This clinician considers that the physical problem focus of the CIPI and the fact that clients showed either little change or deterioration may not reflect the effect of clinical intervention. Instead, results may reflect the nearly insoluble quality of some chronic pain problems and client recognition of those facts. This discouraging reality is something that chronic pain sufferers understandably do not wish to accept, and in a different way, neither do clinicians, whose professional *raison d'être* is to improve function. Physical limitations caused by pain and its new problems stagger, depress, and sometimes temporarily, defeat sufferers. Seeking help from psychologists and clinicians, patients hope for change in those problem areas. Yet often, the change that is sought is different from what is possible. Hence, the inherent paradox of chronic pain treatment: problems that cannot be removed must be accepted; other problems permit only modest improvements or accommodations; a few problems can, with the patient's effort and the collaboration of others, be overcome or improved upon.

Thus, the focus of the CIPI on problems may bias post-treatment results toward a "no-change" result or even deterioration. This clinician discovered that most of the clients' physically-based problems were not amenable to change through thinking or feeling differently about them. Unsurprising in areas like Physical Fitness, Body Deterioration, and Daily Activities, the no-improvement result repeated with Sex, Social Activity, and Family and Friends, interactive areas in which one might reasonably expect that changed attitudes would have some impact. These latter areas are nonetheless, mediated by physical performance or by physical participation. If the client's capacities and functions have changed because of pain, he or she may continue to perceive of the change(s) as a problem. Further, as long as the "problem" or pain-based change persists, the client defines it as problematic, even when he or she feels less distress about the difficulty.

Collaborative areas like sex, social activity, and family and friends reach into the heart of a person's self-image that in turn, connects closely to body image. Meaningful transformation of these psychic entities is not achieved quickly, via brief-focus therapy. Also, the dynamic quality of human sexual and social relationships necessarily involves change because of their interactive nature. To alter behaviour or feelings in these spheres would require more intensive personal therapy, more time, and some meetings with spouses and/or families. Intervention on those levels was beyond the scope of this practicum.

#### COMMENTARY ON USE OF INSTRUMENTS (BDI, SOPA, CIPI)

The instruments chosen for this practicum were all useful. They performed as expected in helping the student clinician to identify early and specifically, problem areas in the affective and instrumental domains. Also, the instruments provided a focus that the clients could see and understand. Providing information, the instruments helped to engage the client immediately in contributing to the therapeutic process: making choices and asserting direction. This involvement communicated subtly the patient's co-responsibility to therapy. In no case, did a client object to or resist completing the inventories; on the contrary, clients undertook the task willingly.

The self-reporting aspect of the inventories did not pose any difficulty. As noted in the "Rationale for Intervention" of this paper, research (Jensen, 1996) has suggested that self reports reflect patients' pain experiences most of the time. Self-report from clients is a defining feature of most therapeutic situations and alongside interview, provides important material for the practitioner.

The Beck Depression Inventory (BDI), measuring the most discrete content area of the three instruments used, was also the most sensitive to change. The fact that the BDI results

show the greatest degree of change reflects its favourable reputation for reliability and for content validity.

The Survey of Pain Attitudes (SOPA) showed more change than the other multi-dimensional instrument, the CIPI. Again, the SOPA's greater level of change was appropriate to the domains being measured. Insofar as individuals are able to exert more control over their beliefs and attitudes than they can over physical obstacles, these areas are ones where one would expect to see change. The gender-based change differences seen in the SOPA results were also seen with the BDI, thus giving the SOPA results more weight.

However, one aspect of the SOPA poses problems for interpreting findings and therefore, requires the clinician's or researcher's careful attention. Certain sub scales could reflect either positive or negative change, depending upon the subject's personality. For example, in the SOPA category of Emotion, the extent to which subjects believe that their emotions impact the experience of pain, two clients showed opposite directional results, yet both appeared to have improved in this area. One client (Janice) whose feelings of loss, embarrassment, and anger impacted her pain significantly, felt much better in these respects after realizing that her strong negative emotions about certain types of family dynamics increased her pain. When Janice adjusted her reactions to those events and began to feel calmer, her chronic pain improved somewhat. Also, her post-treatment SOPA measure for Emotion was nearly 1 z-score point lower, consistent with her brighter mood and improved confidence. Conversely, another client (Marion), who often suppressed her feelings about her pain and disability, became more aware of a greater range of emotions during therapy, giving more serious attention to them. For this particular client, depression and other measures improved, but this was alongside a higher post-treatment SOPA score for Emotion. Greater awareness of emotion in respect to her pain was a positive change for Marion. the opposite case was true for Janice, whose awareness of emotion needed to diminish to relieve anxiety

and unhappiness. These opposite-direction Emotion results for the two above clients were nevertheless, consistent with improvement for both.

These two cases illustrate how opposing results on the same measure of the SOPA represented improvement. The clinician must interpret these findings alongside clinical observations and in conjunction with other measures. Considered alone, without knowledge of clients' personal situations or personalities, an Emotions' result could mislead. This latter point raises the related matter of personality testing, which was not done in this program. Assessment of personality was accomplished through clinical observation and judgment. If additional rigour were desired for personality assessment in this type of program, a measure like the MMPI could be added to the initial assessment, along with the other instruments.

The CIPI produced post-treatment measures that showed less change in subjects than either the BDI or the SOPA. As already discussed, physically-based problems are significantly less amenable to amelioration than depression, cognitions or emotions, the domains examined by the BDI and the SOPA. Thus, clients' self-assessments of practical problems remained close to pre-treatment measurements. This finding provides hindsight that the CIPI may have been a poor instrument choice for use both before and after the intervention. As a pre-treatment measure, it offered benefits discussed above, to help identify problem areas for intervention and to engage the client in the goal-setting process for therapy. However, as a post-treatment measure, it offers little useful information that could not also be obtained through interview.

### **COMMENTARY ON STUDENT CLINICIAN LEARNING**

Cognitive behavioural techniques prescribe a method for facilitating rational change. The techniques of problem identification, goal-setting for problem-solving, homework assignments, and progress review offer structure to treatment. Although generally effective in

achieving aims, cognitive behavioural theory and method do not provide insight into the substance of therapy, nor its dynamic, interpersonal aspects. The content of therapy and the relationship between client and therapist involve clinical issues that are not addressed by the cognitive behavioural framework per se. Three psychodynamic features of clinical work were found to be significant in this practicum. First, some clients presented issues that did not fit the cognitive behavioural conception and intervention protocol. Second, transference may have injected elements into the midst of treatment that distracted from planned treatment. Third, countertransference could be said to have occurred, also affecting the process. A fourth aspect of clinician learning concerned the development of therapeutic skills.

During this practicum, in four of the six clients cases, the chosen themes were temporarily set aside or incompletely explored. For three (Edythe, Joanne and William) of the four, marital issues dominated therapy for several sessions, and to a lesser extent, for all meetings. For the fourth client of this group (Michelle), issues from her family of birth and her present family were asserted in every session. The above matters emerged independently of the protocols and were pressingly presented by the clients. These personal matters were important to the clients and therefore, required appropriate therapeutic response, that is, exploration with the client. Direction of therapy then shifted. The clients' new issues, although pertinent to at least one of the themes (relationships) that the student clinician had chosen in planning the practicum agenda, required therapeutic examination at a pace and in a way comfortable to the client. That shift meant in turn, that protocols were set aside.

The guiding principle for adjusting a plan and course of therapy is that the changes are made in the client's best interest. From a strictly cognitive behavioural view, the replacement by the client of treatment goals with secondary issues, might constitute one or both of two possibilities: first, resistance from the client (Burns, 1989) or second, perhaps an inadequate initial assessment by the clinician. However, a third alternative from the humanistic paradigm

(Martin, 1989) suggests that ultimately, the client does always present the issue that is most troubling to him or her. Further, it is not only appropriate but therapeutically necessary for the clinician to respond to the client's implicit message or need. In the case of these four clients, the secondary issues on which they wished to concentrate significant time were pivotal to their futures, suggesting support for Martin's (ibid) thesis. Three clients expressed uncertainty about continuing their marriages; the fourth client related dissatisfaction with the structure and pattern of most of her intimate relationships. For these people, it would not have been reasonable for the student clinician to ignore such life-altering concerns and to have pressed forward with a pre-arranged agenda.

Considering the above rationale for following the clients' lead, one must consider whether the need to deviate from planned themes in this practicum represents a deficit of the cognitive behavioural treatment methodology to choose and then follow an agenda. Alternatively, the need to deviate from the plan may indicate a weakness in the practicum project's conception and planning. If the need for agenda shifting is the former, then a cognitive behavioural clinician must also inform him or herself about other therapeutic philosophies and types of treatment for moments when the cognitive behavioural method or plan is inadequate to other therapeutic needs. However, if needing to change the treatment plan represents a rigid conception by this student clinician, a program that was too ambitious or too hasty, then adjustments would need to be made to future program planning. Scaling back the number of themes to be addressed might be tried, although the original themes were each considered important; alternatively, extending the number of treatment sessions might also help.

A fourth explanation for the strong assertion by clients of the marital or relational issues noted above may be a metaphoric representation of other troubling issues in an individual's or a family's life. This theory postulates that for involved family members, identification of certain problems is often too difficult. The distraction of coping with a matter like chronic

pain can provide a safer, acceptable focus. This student believes that Minuchin's theory (1981) might explain some clinical situations. Also reasonable is the conclusion that the very substantial difficulties of chronic pain merely coincide with other developmental factors or family dynamics to compound into more complicated problems, producing an exponential effect. The accumulation of new problems precipitated by a chronic pain condition in the family may tip the balance of life from functional to dysfunctional. For example, a family that is newly experiencing the strain of adolescent children asserting independence may be unable to cope with that natural change if there is also a parent with chronic pain who cannot participate in parenting or other duties.

The first two explanations above may best explain the difficulties this student clinician experienced with some of the clients in focusing the cognitive behavioural treatment on four themes. All four themes are relevant and bear consideration by pain clinicians working with any chronic pain client. Yet however relevant the four themes may be, the client's ability to work meaningfully on a given issue will be affected by its seriousness to the individual, in turn affecting the speed of treatment progress that is possible. Two clinical hours devoted to a given theme like a troubled marriage is a very modest time and probably inadequate. An overly ambitious time frame and the humanistic interpretation do not exclude one another as reasonable, possible explanations for the client's predominant interest in one theme like marriage. The idea of pain as a metaphor for other problems may offer explanation in Janice's case where an unhappy marriage and other personal difficulties like substance abuse had prevailed for years. Late middle life with grown children departed from the family home had left Janice and her husband alone with those serious problems. The timing of these events for the couple was even meaningful; the onset of Janice's disabling condition coincided with the summer of her daughter's marriage. Janice's pain may represent the pain of stage of life

changes in a family that already, had spousal problems. Stress theory may also be used to interpret many of these and other chronic pain cases.

In seeking to explain client behaviour in treatment or the interactions between client and clinician, clinical responsibility dictates that the practitioner carefully review the relevance of pertinent theory and possible explanations. Related to this responsibility is the clinician developing an appreciation of the therapeutic relationship itself. Transference, the use by the client of the therapist in navigating new relational patterns (Kernberg, 1979) may have effect on the treatment process. So also may counter transference, the projection of feelings by the clinician onto the client or the participation by the therapist in psychodynamic patterns with the client. Strong evidence does not exist of these phenomena taking place during this practicum. However, subtle observational evidence and reflection by the student clinician suggest that some degree of transference and counter-transference did enter the therapeutic relationships with clients in this intervention. To examine this possibility, object relations theory offers some insight.

Relational theory interprets events between a client and therapist as containing powerful transference and counter-transference elements; these elements may be present throughout the therapeutic relationship, or may develop at particular points or periods during treatment. In this clinician's case, inexperience overshadowed subtle dynamics of transference and counter-transference which may have been enacted throughout treatment, but of which she was unaware at the time.

Certain aspects of four clients' interactions shared one common pattern. Whether misplaced or not, these clients demonstrated belief that the clinician would be able to improve their pain or situation. At a surface level, the clients and student clinician enacted roles which preoccupied each person, but which proceeded from this belief. For her part, the student did not actively appreciate the therapeutic potential of these events, thus missing a clinical



opportunity. Also, application of ideas of transference and countertransference was not a part of the cognitive behavioural intervention. At this juncture after the project's end, reflecting on those events through a different conceptual lens can offer useful analysis.

Relational theory builds on an "interactive vision (p. 5, Mitchell, 1988)" that posits the existence of psychological meaning in all a client's relationships. In his discussion of relational theory, Mitchell also speaks of the clinician's necessity to resist the client's relational matrix and to offer other possibilities, to broaden or expand that matrix. Various theoretical explanations within the relational school compete with each other for influence about the genesis of psychological difficulty and the appropriate content focus of therapy. It is not the purpose of this discussion to present or debate those viewpoints, but only to offer an additional understanding of dynamics that may have been involved with four clients in this practicum.

Reflecting on observations of and interactions with the above four clients, the student clinician noticed that each person demonstrated strong faith in and dependence upon the clinician through most of the treatment sessions. These individuals frequently asked for advice, listened closely to the ensuing discussion, and followed very closely any homework arrangements made with the clinician. While this kind of behaviour might be exhibited with any practitioner, medical or pain clinician, it can indicate a certain "set." The clients appeared anxious to be "good patients." Their faith in this clinician's healing abilities took on aspects of dependence and automatic regard.

The student clinician's reaction was to accept the clients' faith. She felt flattered by their belief in her ability to help them improve and wanted to meet those expectations for healing. She hoped to be the individual who could make a significant difference to their chronic pain problems. This clinical vanity constituted countertransference, her part in the object relations.

The operation of dynamics in the transference-countertransference relationship can be examined in greater detail through the concepts of illusion and narcissism. Seeing clients' illusions about self and others as creations which work toward a balance between limitations and reality provides valuable clinical material. Mitchell concludes that "the key factor [about illusions and in therapy] resides in the interplay of illusion and reality in the character-forming relationships with significant others" (p.158, Mitchell, 1988). As psychological phenomena in therapy, illusions that are unchallenged perpetuate clients' relational matrices. However, when used actively in the therapeutic relationship, illusions offer potential for personal growth to both the client and the therapist. Narcissism, as Mitchell describes it, appears to offer insights to the therapeutic relationships in Edward's, Evelyn's, and Janice's cases.

In the situation of a depressed or problem-burdened client, narcissistic idealization of the therapist as all-knowing and the client as needy of his or her guidance creates a powerful transference-countertransference. This pattern constitutes a "subtle kind of seduction" (p.19. Mitchell, 1988) by the client and an acceptance by the therapist to engage in support of a weakness that may subtly subvert client function and coping. To accept and participate in the client's idealization of the therapist's abilities to offer answers can be variously viewed as a collusion with the patient, an over identification with the client's needs, or at the very least, a missed clinical opportunity to foster greater self-reliance in the client. The outcome of this shared illusion in the transference-countertransference relationship is to perpetuate in a certain sense, a client's maladaptive coping and limited personal relations.

In respect to Edward, Edythe, and Janice, the therapist's inner reactions and conduct can be seen as showing an over-identification with the clients' needs for support through the therapist's (felt) heroic role. To the extent that she accepted this role, consciously or unconsciously, the therapist became "locked into" saving the client. The therapist's acceptance of the illusion in this idealizing transference could be seen to derive from her own

countertransference with the illusory role of rescuer. Whether regarded as a client's idealizing illusion which the therapist accepted, or as a client need for intense attention and support to which the therapist responded, relational theory conceives of the interaction as an obvious transference-countertransference phenomenon.

The trap of feeling all-knowing and strong for a troubled individual is understandable and may be "part of the territory" with a clinical role. Many clients have not before received the kind of counselling that a pain clinician can offer. They exhibit relief, hope, and gratitude, all affirming emotions for a clinician to experience in treatment sessions. The disadvantage to accepting these illusions or client appraisals is that acceptance may undercut the therapist's objectivity and thus, her or his ability to meaningfully help clients.

The process of therapy benefits from the clinician maintaining a meta-awareness of these interactive matters in the therapeutic relationship. It is important to examine the events in treatment sessions for elements of transference or countertransference. When evidence of them is found, the matters should be explored with the client. Mitchell speaks of the clinical importance of using these transference-countertransference phenomena to actively and constructively assist the client to break free of fears, limiting relations, and self-limiting behaviours. With a shared awareness from that process, both client and clinician can work more effectively toward chosen goals.

This discussion of object relations has looked outside the scope of cognitive behavioural therapy. Nonetheless, the concepts and interpretation illuminate understanding of a challenge encountered in these types of clinical cases. This discussion may also point out a limitation of cognitive behavioural treatment; as a method, it can lead to desired actions and change. However, the vision and the conduct of cognitive behavioural therapy may miss some clinical elements that contribute to more deeply productive therapeutic results.

The inexperienced therapist lacks the benefit of prior exposure to similar clients and problems and usually, feels busy with competing concerns. She is simultaneously: observing psychological phenomena and accumulating personal data about the client; trying to maintain emotional openness to the client and awareness of her own reactions and feelings; making decisions about what to do next; attempting to engage genuinely with the client to produce and use those dynamics for moments of learning and change; in this practicum, also applying cognitive behavioural techniques with clients. These skills are gradually learned over time and integrated into seamless behaviour.

Learning the art of therapy progresses gradually, intertwined with the student's clinical exposure and experience. Different clients and different problems reveal aspects of the personal change process that can be possible in a therapeutic relationship such as: the rhythm of rapport between client and clinician that varies from close and sometimes dependent to independent; the need to encourage new action in clients, but according to their respective value systems; the swift change in some areas and the very slow movement in other matters like character, personality or complex relations. Also, sometimes the change that would be beneficial and toward which a client strives, may simply not happen.

## **EVALUATION OF THEMATIC COGNITIVE BEHAVIOURAL INTERVENTION**

The research literature has consistently shown that cognitive behavioural treatment is effective for chronic pain sufferers in an important way: it can enhance their sense of control over their pain even though it does not reduce the intensity or frequency of pain suffered (Jensen, 1983). Thus, their physical state may remain the same, yet not so distressing. For depression, cognitive behavioural therapy has also shown results, particularly when used in conjunction with anti-depressant medication.

As a treatment intervention for the clients who share both conditions, chronic pain and depression, cognitive behavioural therapy appears to achieve benefits. The unique aspects of cognitive behavioural treatment that this practicum's intervention attempted to explore were three: first, depression and chronic pain together were inclusion criteria in selecting clients; second, treatment was pursued along four themes according to a particular protocol; third, work with clients was clinical (little evident in research literature) rather than survey or statistical.

Choosing this kind of treatment also served the professional development needs of the student clinician. She gained practice in a clinical technique that has broad applications beyond this special population to other social work and clinical clientele. Cognitive behavioural therapy skills would offer long-term benefit insofar as these techniques could be adapted to many different programs and clients.

Six evaluation criteria had been chosen at the outset of the practicum to evaluate client change after the clinical intervention, as well as to assess student learning. A brief commentary on each criterion follows. Additional, detailed discussion can be found in the "Results" and "Discussion of Results" sections of this report.

1. To measure the extent of change in chronic pain patients' psychological, and/or social experience following cognitive behavioural therapy.

Measurements taken of depression (BDI), practical, pain-related problems (CPII), affective distress and illness focus (SOPA) at the beginning of this intervention were repeated at the close of treatment. Clinical observations were also made throughout the treatment process.

In the area of primary interest, depression, females' depression improved whereas males' did not. In respect to feelings about their pain, disability, or distress in general, some positive

change occurred for all clients. The areas of improvement were not uniform, and gender differences were still evident. Interestingly, even though women's affect appeared to be improved (less depression, less emotionality) after treatment, they assessed their physical disability as greater than men, whose appraisal of their own disability dropped.

Overall improvements in distress, morale, and decision-making were noted in clinical observations.

By contrast to these attitude and affect changes, social experience for these practicum clients had not changed positively after treatment according to CIPI results for three of six clients. This area remained the same for a fourth client and improved for the fifth (the sixth had not completed a pre-measure, so could not compare). Perhaps this finding of practical problems remaining static or even worsening, is not surprising insofar as joint or co-treatment was not offered to any person in a client's family or social sphere. Although intimate relations, especially marriages, were discussed with clients, no attention was directed in treatment to other relationships.

Considering that no treatment intervention was directed to social relationships of clients, the inclusion of social experience as an evaluation criteria was inappropriate. However, because clients did express sadness about changes in their intimate relations and their social lives, future treatment programs should plan to include exploration of this area with clients and where appropriate, extend treatment to involve persons who are important in the client's life.

## 2. To assess whether depression in particular, or other negative emotions changed after treatment.

Depression did improve for females, that is, half of the clients. All men's depression worsened after treatment. Speculation about possible reasons for this gender difference in depression results has already been presented above in the "Discussion" section.

To recapitulate briefly, this clinician considers that male clients did not show the positive change in depression that females did, for specific reasons relating to: first, men's greater psychological strain at the time of treatment; second, the accessibility of their emotions for self-examination; and third, the men's (un)readiness to explore emotional matters. Their need to work placed greater stress on their physical and personal resources, something to which females were not exposed. The clinician believes that if this stress had not been present, male depression also might have improved. As well, she considers that with more treatment time, improvement in men's depression might also have occurred.

As has already been discussed about results, male clients did show some favourable responses to treatment in lowered assessments of their disability and in their acknowledgment of emotion as a part of their chronic pain. Consistent with this last finding was their self-reported, higher need for solicitude. Men's receptivity to hypnosis may also have underscored a heightened awareness of affective states and pain. With more treatment time, depression results might have been more similar to females'.

Other negative emotions like anger changed positively for all three females (Edythe, Marion, and Janice) and one male client (William). The other two males had not demonstrated any anger during treatment sessions. Generalized distress improved for all but one client (Edward, Client # 2). As has already been discussed, reasons for Edward's swift and worrisome deterioration appeared to relate to his having returned to a heavy job.

### 3. To assess specific psychosocial areas in which change may have occurred and note any correspondence to general themes or to more specific therapeutic strategies.

The themes chosen for this practicum intervention were all pertinent: distorted cognitions, difficult relationships, hopelessness, and painful affect. Virtually all clients' thinking involved some distorted cognitions. In this report, "Individual Case Presentations"

detail these distortions. After treatment in all cases, clients had modified the most prominent distortions that had been identified and on which client and clinician had worked together.

"Difficult Relationships" was also a theme appropriately chosen by this student clinician. Both intimate relationships (marital and close family) and in some cases, other social relations, had become challenging in some way for these chronic pain clients. The range of relationship problems discussed with the student clinician varied from bitter marital discord, through general marital malaise, to clients' frustrated friendships or relationships in the community. A social work perspective might use the theory of social networks to examine the range of relationships that had become problematic for these clients. Within the individual's network are relationships and ties of greater or lesser prominence, as well as of greater or lesser support. Impacts by chronic pain on those attachments are inevitable; fortuitously, some of the solutions to the client's problems may also be found within the his or her affective and social involvements. This treatment possibility was not explored within this intervention, although could be in a more comprehensive program.

Involving members of a client's social network in a treatment plan could take different forms and might require the services of another clinician. Treatment on the order and intensity the client had been receiving in this intervention's cognitive behavioural scheme would be unlikely to be offered to new people brought into the treatment plan. However, the client and his or her family might benefit if principles of family therapy were used. Alternatively, some techniques from network therapy might be applied, drawing in a broader range of individuals with whom the client had significant relationships and from whom he or she might reasonably receive different or additional support. Expanding treatment through either family or network therapy models would naturally require the appropriate application of theory and methodology. Careful treatment planning and more clinical resources, both practical considerations, would need to be involved.



The help that might have been offered by persons in the client's network was unexplored in treatment. Time constraints did not permit such expansion, nor would it have met the original terms set for the practicum. The value of offering these types of collateral treatments are a matter that would bear further study and investigation.

All family members of a chronic pain patient are affected in some way by the common problems. Optimally, some families respond constructively to the challenges and their coping causes positive change and growth in family members. Other families are negatively impacted by the stressors. Any treatment intervention that expanded from the individual client to include family members would need to include some assessment of the impacts of chronic pain on these individual family members, as well as on the family as an entity. Necessarily, the paradigm for treatment would shift from an individual to a family or ecological approach. Issues such as problem-solving, communication, roles, affective responsiveness, affective involvement, and behavioural control (Epstein et al. 1981) would be assessed.

Hopelessness was certainly a relevant theme. The timing for discussion of this theme as third in the protocol was appropriate. By the sixth session therapeutic rapport was well-established, assessment had been completed and instrumental problems were at least initially addressed. The clients appeared "ready" to reflect on this abstract and often painful issue. All clients grappled with hopelessness. Related to issues of life's meaning for each client, thoughts and feelings about the future had been implicit in their seeking clinical help. To consider their future connected clients directly with powerful feelings about self, personal roles, affective relations, as well as the changes that had unsettled their lives. More detailed information about each case is contained in individual case histories in "The Clients" section of this report. These clients wanted to have hope, but many had lost it. As a topic in the treatment of chronic pain clients, hope is essential to any program.

Painful emotions were a theme choice that required no formal enunciation in the protocol. In a therapeutic context and relationship, clients' emotions are the stuff with which a clinician works. Whether expressed freely by the client or elicited by the clinician, painful emotions are a basic aspect of clinical work. Treatment of the male clients in this practicum demonstrated that fact; although they did not speak readily about their disappointments or sorrows, these matters were important, and the men's need for solicitude was high. Through the course of treatment, affective issues surfaced. Some of this practicum's clients suffered more than others because of their physical pain, yet all suffered emotionally. The variety of painful emotions extended across the full spectrum described in the "Suffering" section of this paper's literature review

For any clinician working with a chronic pain population, inquiring about the effects of pain on the client is a routine responsibility. So also should be gentle investigation of the individual's feelings regarding significant, inevitable changes in his or her life. Since obtaining this type of personal data early in the process is part of assessment, inclusion as a formal protocol theme is unnecessary.

#### 4. To observe and report on other phenomenon of interest.

During this practicum, three issues stood out prominently as matters that would require different strategy in future treatment: the necessity of returning to work for some chronic pain clients; previous psychopathology as a complication to treatment; the question of clients' sexual problems as an area for clinical attention in treatment.

Returning to work with chronic pain exacerbated difficulties for which two clients had sought treatment. Work largely reversed benefits of treatment for one client, Edward, and disrupted treatment for another client, Alain. In the first case, heavy physical work imposed a

visible strain on the client; in the second case, sedentary work caused a lesser physical strain, but was nevertheless difficult for the client.

The first client's case is clear-cut because he had to return to full-time duty, with no accommodations by the employer. The physical strain he endured and the increased pain was obvious to witness when he arrived for treatment sessions. The second client, Alain, presented a case that was less clear. Doctors believed that he could tolerate working at least half-time at his sedentary job. Also in Alain's case, anxiety, a long-time psychological problem, complicated his chronic pain. Other psychiatric issues may also have been involved.

The rapid psychological deterioration of Edward after he returned to work showed evidence in all measures (BDI, CIPI, SOPA), as well as visibly in treatment sessions. These outcomes convinced this student clinician that treatment for clients like these, who feel they must return to work, should include active intervention on their behalf by the clinician with the employer. Because the strain of performing work that was too heavy might further injure a client like Edward, or could cause a psychological crisis, a clinician must act to protect the client's mental (in this case) health. This clinician's supervisor believed that Edward was the type of individual, who because of his stoicism, would carry out his responsibilities until virtually unable, then might quietly commit suicide. Edward was a client who believed that one must "do what [he's] gotta do" and that a person should "carry his own water." To let a client like Edward follow through with this philosophy could mean physical harm or psychological disintegration.

Early intervention with an employer like this client's should be included as part of treatment efforts. If such action failed to secure suitable work arrangements, as was the case with Edward's employer, a "fall-back" intervention should be started. This might mean arranging for permanent, alternative compensation, and if there were time gaps in coverage, to arrange for "bridge" compensation so that financial need did not force unhealthful action..

In Edward's case, he did wish to attempt returning to work. However, on discovering the overbearing strain it caused, Edward was then willing to consider alternatives. As his period of cognitive behavioural treatment had concluded by this time, efforts were begun to arrange other means of support. However, the matter was not concluded by the treatment intervention had ended.

### Prior Psychiatric Conditions

Alain's case represents the clinical problem of prior psychopathology; his predisposition to anxiety complicated his coping with chronic pain. The client had experienced a nervous breakdown in the recent past for which he had received psychiatric care. According to the screening criteria devised for this practicum, which excluded clients with psychiatric conditions, Alain should not have been part of the treatment group. This aspect of his history was not learned until the cognitive behavioural treatment intervention had already begun. In reviewing the course of his treatment, it is evident that emotional complications of Alain's chronic pain might be attributed to his anxiety difficulties, which pre-existed his surgery. Without benefit of the psychiatric assessment he had undergone a few years earlier, it is only speculative to comment on the nature of Alain's prior condition.

Nonetheless, taking into account that information about this client's condition is incomplete, one could surmise that a prior condition like anxiety disorder might receive diagnosis under Axis I of the DSM IV, personality disorders. Most chronic pain patients, if viewed through a diagnostic tool like the DSM IV, would also receive diagnoses under at least two axes; having a serious medical condition, they would fit certain categories under Axis I; experiencing numerous non-medical problems from the chronic pain, they would also fit Axis II for psychosocial and environmental problems. The greater the number of negative factors affecting mental health, the more guarded the prognosis becomes (Carson et al., 1996). In chronic pain sufferers, pre-morbid psychopathology is negatively correlated with

affective coping (Swimmer, 1992.; Toomey et al., 1993). Thus, although cognitive behavioural treatment has been shown effective for conditions like chronic pain and for anxiety disorders, in Alain's more complicated case, expectations for improvement change. His prior history, combined with his current circumstances did not auger well for improvement.

It is possible that Alain or a similar client could benefit from cognitive behavioural intervention, but under different terms than were set out by this practicum. Knowing that outcomes can be dubious in these types of cases, future clinicians would need to plan treatment strategies and time frames accordingly. Furthermore, in cases like Alain's, psychiatric consultation should be considered at the outset.

#### Sexual Matters as a Pain-related Problem

An area where most clients experienced increased problems after treatment but on which they eschewed discussion was sexual difficulties. Two women recorded an improvement in sexual problems after treatment, but three other clients recorded the opposite result. One man had only completed a post-treatment questionnaire. Combining both affective and marital expression, sex was the only problem area that was kept discreet by clients.

No specific research had been done on this area in the student clinician's literature review or in planning the intervention. The finding of increased sexual problems raises the question of whether sex may represent a barometer of relationship intimacy or health. Alternatively, the finding may represent a coincidence or a sign of greater client honesty in reporting after experiencing rapport in the therapeutic relationship.

Because no work was done with clients on this intimate relationship problem, it is not possible to comment about the issue. Nevertheless, the subject bears some further examination in the clinical literature.

5. To determine from record of supervision, whether cognitive behavioural techniques were effectively learned by the student clinician over the course of the practicum.

During the course of the practicum, the student clinician met weekly and occasionally twice weekly with her clinical supervisor. Brief reports were given by the student on each client. Questions about treatment techniques, progress, or strategy, and client problems were asked. Suggestions were offered for adjusting treatment and recommendations were sometimes made for reading and resource material to use in building knowledge on a special topic. These sessions were invaluable to the student for the knowledgeable direction she received.

The student's own knowledge of cognitive behavioural techniques advanced as the practicum progressed, so that she experienced a diminishing need to ask questions and for direction. Her supervisor stated in evaluation: "She came prepared for supervision . . .[,] was non-defensive and made excellent use of consultation and supervision sessions".

6. To determine from the supervisor's record of supervision sessions, whether other clinical skills had developed over the course of the practicum.

The student's supervisor rated her clinical performance in general as exceptional, ranking "in the top 20% of all students at the same level of practicum". His general comments: "Ms. Keter is hard working and a conscientious therapist. She has developed good case management skills with very diverse and difficult pain clients. Her skills as a therapist continue to grow and develop."

Detailed ranking of competencies such as assessment, intervention, supervision, professional conduct, self-awareness and administration were reviewed according to the Practicum Evaluation Rating Form, a clinical performance evaluation. This report indicates superior or outstanding performance by the student clinician in all competencies.

## CONCLUSION

To conclude, the cognitive behavioural treatment used in this intervention with depressed, chronic pain patients can be judged as a qualified success. All female clients experienced reduced depression after treatment. While men's depression did not improve, two of three men experienced the sense of their disability being reduced. Men's depression actually increased over the course of treatment; on the other hand, awareness of how their emotions impacted their experience of pain and their felt need for solicitude also increased. These latter changes were interpreted for those two clients as positive steps toward developing personal pain management skills. Also significant is the fact that two of three men returned to work during the course of treatment, thus placing on themselves a burden that other clients did not have.

Treatment may have offered male clients better coping skills, inasmuch as they might better appreciate the personal experiences that affected their pain, they would probably be better able to control the pain in the future. The benefit of patients' belief in their own ability to control pain is a strongly consistent finding across the literature (Jensen et al., 1991; Turk et al., 1983; Hasenbring, 1994). According to the student clinician's observation, all clients experienced less distress and more readiness to make decisions about problems that their chronic pain had caused or highlighted.

A question of whether the cognitive behavioural treatment intervention offered better or sooner outcome possibilities to females, from the outset, is beyond the scope of this practicum. Certainly, some findings in the literature suggest that depressed men may acknowledge emotions less readily than women (Sargent, 1985), a finding similar to the results found of this intervention. The factor of social support was found by researchers to be associated with men's depression only where those men had low levels of instrumental activity (Zautra in Jensen, 1992).

Reflecting these findings from the literature, this treatment intervention would be best suited to individuals experiencing mild to moderate chronic pain who maintained some function and some ability to actively adjust aspects of living. The treatment would be contraindicated with client groups who had extremely serious pain, psychiatric pathology, or linguistic barriers.

Clients who experienced extremely severe chronic pain that was controllable only by medication would be unsuited to this form of treatment, since adjustments in thinking or behaving would have no impact on their situation. Jensen and Karoly (1985) found that cognitive coping techniques were associated positively with better psychological functioning and activity levels only for those patients reporting relatively low levels of pain severity. Supportive counselling to the individual or family might be appropriate, however.

Clients who had psychiatric pathology and thus, more complicated factors affecting their pain would also be unsuited to receiving cognitive behavioural treatment. The prognosis for improvement of their depression or other painful affect would be limited, and psychiatric assessment and perhaps intervention would be recommended.

Another type of client unsuited to this treatment intervention would be one who possessed language barriers to discussing thoughts and feelings. While the cognitive behavioural methods of the treatment might work well to ameliorate pain or problems, the initial phase of determining the beliefs significant to client pain would be difficult to carry out. Likewise, the treatment sessions, requiring verbal description and exchange, would also challenge or demand abilities that a non-verbal or second-language speaker did not possess.

In the intervention, cognitive behavioural treatment was a tool: to explore problem-solving strategies with clients; to practise new thoughts and behaviour; and finally, to transform troubling experiences. The treatment method provided a direct approach to these tasks and also, engaged the clients readily in the therapeutic process. The protocol of themes



(distorted cognitions, difficult relationships, hopelessness, and painful affect) chosen for the intervention was found to be relevant. However, the protocol's order of addressing themes was slowed, in some cases, by more pressing concerns that clients raised.

Hypnosis and self-hypnosis proved surprisingly helpful to half of the client group. In retrospect, the clinician considers that she should have encouraged and practised the techniques more with clients because they did work effectively. Hypnosis offered clients a very powerful tool to reduce their awareness of physical pain and to enhance feelings of control.

Cognitive behavioural treatment encouraged clients to experiment actively with possibilities. In practising techniques of problem identification, generating solutions, then trying out alternatives, clients found that some efforts succeeded and some failed to produce hoped-for changes. Nonetheless, the attempts themselves were worthwhile. Clients found persuasive evidence from trying; a new set of possibilities sometimes emerged that could show a better course of behaviour or feeling.

Beyond experimenting with possibilities, clients learned a psychological lesson. When trying out different approaches or activities, they felt sometimes disappointed but afterward, more sure. For example, attempting a former activity, even if unsuccessful, did encourage clients to try a different "tack." Experimenting demonstrated for clients, their own flexibility. It also helped to restore self-confidence. These experiences provided the "data" that Turk (1983) writes of clients needing in the present and over the long-term for chronic pain and other problems.

Developing flexibility was also an important trait for chronic pain sufferers to learn. For some clients, physical capacity varied from day to day or week to week. Learning from new experience that they could vary activities or behaviour, as well as thoughts and feelings, was useful knowledge. Turk reminds that "talk is not sufficient to persuade" (p. 185, 1983), and

experience provides explicit evidence that convinces in both a factual and a psychological sense. Cognitive behavioural treatment appears to deliver this persuasion.

The key to devising homework activities that provided convincing evidence was the client's personal meaning, which when uncovered, suggested to both client and clinician a way toward change. The symbolic and pragmatic significance of beliefs were necessary to understand before choosing areas for initiating changes. After these steps, the clinician had to accompany the client on a very personal journey. He or she had also to be mindful of the "passage" ahead.

Understanding that passage, the change process, and having knowledge of chronic pain patterns assists this navigation. The clinician must anticipate possible pitfalls as well as potential opportunities, always maintaining a broad perspective on the client's immediate experience. Shifting focus between narrow and wide perspectives at the same time as maintaining emotional acuity in the clinical moment presents challenge.

The chronic pain patient who has found incomplete relief with other practitioners is both skeptical and believing. He or she is simultaneously jaundiced and hopeful. Near-desperation predisposes the client's willingness to try treatment, creating vulnerability and readiness. This psychological juncture offers unique opportunity to both client and clinician.

At this juncture and throughout treatment, a central issue in chronic pain treatment is the need to encourage hopefulness in the face of suffering. Sufficient hope must catalyze new treatment efforts; on the other hand, inflated expectations may lead to disappointment that could intensify suffering. Therefore, the pain clinician must be especially careful in his or her work, to seek the best balance of hope and realism with each client.

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## APPENDIX A

TABLE I  
THE TARGET APPROACH TO DEPRESSION

Specific Problem Area (target)	Reasons Given by Patient	Therapeutic Approach
<b>I. Behavioral Symptoms</b>		
1. Inactivity	1. Too tired or weak	1. Probes
2. Withdrawal	2. Pointless to try	(a) What lost by trying?
3. Avoidance	3. Will feel worse if active	(b) Has passivity done any good?
	4. Will fail at anything I try	(c) Will feel worse if passive
		(d) How do you know?
		2. Activity schedule
		3. Graded task assignment
		4. Cognitive rehearsal
<b>II. Suicidal Wishes</b>		
	1. No point to living	1. Expose ambivalence
	2. Too miserable, need escape	(a) Question reasons for dying
	3. Burden to others	(b) List reasons for living
	4. Cannot cope with obligations/problems	2. Alternative therapy
		(a) Alternative views of problems
		(b) Alternative actions
		3. Reduce problem to manageable units
<b>III. Hopelessness</b>		
	1. Nothing will work out	1. Empirical demonstration of fallacy of negative predictions
	2. Same as suicidal "reasons"	2. Question "reasons"
<b>IV. Lack of Gratification</b>		
	1. Cannot enjoy anything	1. Remove "blindness"
	2. No satisfactions	2. M&P Therapy: Look for gratifications and label them
	3. Activities do not mean anything	3. Explore meaning of goals
		4. Counteract "killjoy thoughts"

## APPENDIX A

Table 1, continued

V. Self-criticisms Self-hate	1. Am defective, weak, etc. 2. I <i>should</i> be more adequate 3. Am responsible for problems	1. Identify and reason with self-criticisms 2. Role-play: self-sympathy 3. Discuss: "tyranny of shoulds" 4. Triple column technique
VI. Painful Affect	1. I can't stand the pain 2. Nothing can make me feel better	1. Distraction 2. Raise threshold by ignoring affect 3. Counteract with humor, anger 4. Induced imagery 5. Triple column technique
VII. Exaggeration of External Demands, Problems, Pressures	1. I am overwhelmed 2. There is so much to do, I can never do it	1. Problem resolution (a) List things to do (b) Set priorities (c) Check off accomplished tasks (d) Concretize and split up external problems 2. Cognitive rehearsal

## APPENDIX B

### Beck Depression Inventory

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the past week, including today. Circle the number besides the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

- 1     0 I do not feel sad  
      1 I feel sad  
      2 I am sad all the time and I can't snap out of it  
      3 I am so sad or unhappy that I can't stand it
  
- 2     0 I am not particularly discouraged about the future  
      1 I feel discouraged about the future  
      2 I feel I have nothing to look forward to  
      3 I feel that the future is hopeless and that things cannot improve
  
- 3     0 I do not feel like a failure  
      1 I feel that I have failed more than the average person  
      2 as I look back on my life, all I can see is a lot of failures  
      3 I feel I am a complete failure as a person
  
- 4     0 I get as much satisfaction out of things as I used to  
      1 I don't enjoy things the way I used to  
      2 I don't get real satisfaction out of anything anymore  
      3 I am dissatisfied or bored with everything
  
- 5     0 I don't feel particularly guilty  
      1 I feel guilty a good part of the time  
      2 I feel guilty most of the time  
      3 I feel guilty all of the time
  
- 6     0 I don't feel I am being punished  
      1 I feel I may be punished  
      2 I expect to be punished  
      3 I feel I am being punished
  
- 7     0 I don't feel disappointed in myself  
      1 I am disappointed in myself  
      2 I am disgusted with myself  
      3 I hate myself
  
- 8     0 I don't <sup>think</sup> I am any worse than anybody else  
      1 I am critical of myself for my weaknesses or mistakes  
      2 I blame myself all the time for my faults  
      3 I blame myself for everything bad that happens
  
- 9     0 I don't have any thoughts of killing myself  
      1 I have thoughts of killing myself, but I would never carry them out  
      2 I would like to kill myself  
      3 I would kill myself if I had the chance

## APPENDIX B (Continued)

- 10    0 I don't cry anymore than usual  
       1 I cry more now than I used to  
       2 I cry all the time now  
       3 I used to be able to cry, but now I can't cry even though I want to
- 11    0 I am no more irritated now than I ever am  
       1 I get annoyed or irritated more easily than I used to  
       2 I feel irritated all the time now  
       3 I don't get irritated at all by the things that used to irritate me
- 12    0 I have not lost interest in other people  
       1 I am less interested in other people than I used to be  
       2 I have lost most of my interest in other people  
       3 I have lost all of my interest in other people
- 13    0 I make decisions about as well as I ever could  
       1 I put off making decisions more than I used to  
       2 I have greater difficulty in making decisions than before  
       3 I can't make decisions at all anymore
- 14    0 I don't feel I look any worse than I used to  
       1 I am worried that I am looking old or unattractive  
       2 I feel that there are permanent changes in my appearance that make me look unattractive  
       3 I believe that I look ugly
- 15    0 I can work about as well as before  
       1 it takes an extra effort to get started at doing something  
       2 I have to push myself very hard to do anything  
       3 I can't do any work at all
- 16    0 I can sleep as well as usual  
       1 I don't sleep as well as I used to  
       2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep  
       3 I wake up several hours earlier than I used to and cannot get back to sleep
- 17    0 I don't get more tired than usual  
       1 I get tired more easily than I used to  
       2 I get tired from doing almost anything  
       3 I am too tired to do anything
- 18    0 my appetite is no worse than usual  
       1 my appetite is not as good as it used to be  
       2 my appetite is much worse now  
       3 I have no appetite at all anymore
- 19    0 I haven't lost much weight, if any lately  
       1 I have lost more than 5 pounds            I am purposely trying  
       2 I have lost more than 10 pounds          to lose weight by  
       3 I have lost more than 15 pounds          eating less - YES NO

APPENDIX B *(Continued)*

- 20    0 I am no more worried about my health than usual  
      1 I am worried about my physical problems such as aches and pains; or  
      upset stomach; or constipation  
      2 I am very worried about physical problems and it's hard to think of  
      much else  
      3 I am so worried about my physical problems, that I cannot think about  
      anything else
- 21    0 I have not noticed any recent change in my interest in sex  
      1 I am less interested in sex than I used to be  
      2 I am much less interested in sex now  
      3 I have lost interest in sex completely

# CHRONIC ILLNESS PROBLEM INVENTORY

Please indicate HOW MUCH EACH STATEMENT APPLIES TO YOU by entering the appropriate number in the box to the right of each statement. Select the number that best describes your experience during the PAST SEVERAL MONTHS.

HOW MUCH DOES IT APPLY TO YOU		HOW MUCH DOES IT APPLY TO YOU	
0 = NOT AT ALL		0 = NOT AT ALL	
1 = A LITTLE		1 = A LITTLE	
2 = A FAIR AMOUNT		2 = A FAIR AMOUNT	
3 = MUCH		3 = MUCH	
4 = VERY MUCH		4 = VERY MUCH	
1	I have difficulty falling asleep ( )	14	I have difficulty remembering ( )
2	I have difficulty staying asleep ( )	15	I have difficulty thinking clearly ( )
3	My appetite is poor ( )	16	I am uncomfortable with how I look ( )
4	I have difficulty maintaining proper weight ( )	17	I feel I am looked down upon because I look physically disabled ( )
5	I am unable to pay my bills ( )	18	I do not feel attractive ( )
6	I have some financial worries ( )	19	I feel my body is generally deteriorating ( )
7	I am not able to work ( )	20	I fear I will never be healthy again ( )
8	I lose too much work time because of my health ( )	21	I do not have confidence my body will work right when I need it to ( )
9	I have difficulty finding a new job ( )	22	I worry about not being able to care for myself ( )
10	I am not able to perform all of my duties at work because of my health ( )	23	I have no other problems beside my medical problem ( )
11	I need to use too many medications ( )	24	I do not have much interest in sex ( )
12	I am afraid I may become or already am dependent on medications ( )	25	My physical problem makes sex difficult and/or uncomfortable ( )
13	I have difficulty concentrating ( )		158 ( )



HOW MUCH DOES IT APPLY TO YOU		HOW MUCH DOES IT APPLY TO YOU	
0 = NOT AT ALL		0 = NOT AT ALL	
1 = A LITTLE		1 = A LITTLE	
2 = A FAIR AMOUNT		2 = A FAIR AMOUNT	
3 = MUCH		3 = MUCH	
4 = VERY MUCH		4 = VERY MUCH	
26	I do not often engage in sex ( )	39	I have difficulty going out to dinner, movies and other activities ( )
27	My partner and I do not often embrace, kiss or touch ( )	40	Family or friends do not come over to visit often ( )
28	I have difficulty bending, lifting or carrying ( )	41	I do not get along well with my family ( )
29	I have difficulty walking and/or moving around ( )	42	I do not have many close friends ( )
30	I have difficulty doing household chores ( )	43	It has been difficult to maintain old friendships ( )
31	I have difficulty with transportation ( )	44	I find it difficult to meet new friends ( )
32	It is hard for me to get out of the house very much ( )	45	It is difficult for me to ask family or friends for help when I need it ( )
33	My problem is more serious than others with a similar illness ( )	46	It is difficult for me to tell others when I am upset ( )
34	I have difficulty figuring out what to do each day ( )	47	It is difficult for me to tell others when I cannot do something ( )
35	I do not have enough activities to occupy my time ( )	48	No one believes my problem is real ( )
36	I am sitting or lying down most of the day ( )	49	I have difficulty getting information from my doctor about my illness ( )
37	I have difficulty enjoying time with relatives and/or friends ( )	50	I have difficulty telling doctors when I am dissatisfied ( )
38	I have problems in planning social activities because I do not know how I will feel ( )		

## APPENDIX C

## HOW MUCH DOES IT APPLY TO YOU

0 = NOT AT ALL

1 = A LITTLE

2 = A FAIR AMOUNT

3 = MUCH

4 = VERY MUCH

## HOW MUCH DOES IT APPLY TO YOU

0 = NOT AT ALL

1 = A LITTLE

2 = A FAIR AMOUNT

3 = MUCH

4 = VERY MUCH

51 I have had to see many doctors and try alot of different treatments for my problem ( )

52 I feel doctors have not taken my problem seriously ( )

53 I have never received the proper treatment for my problem ( )

54 No treatment has ever helped my problem ( )

The next eight questions (55-62) apply to individuals who are MARRIED or IN A SERIOUS RELATIONSHIP

If you are not married and/or do not have a steady ongoing relationship, please skip to question #63 and answer the remaining questions

55 My partner and I have difficulty talking about important matters ( )

56 My partner and I have difficulty talking about feelings ( )

57 My partner and I have so much time together that we get on each other's nerves ( )

58 My partner and I are not getting along as well as we used to ( )

59 My partner expects me to do more than I am capable of ( )

60 My partner won't let me do activities that I am capable of doing ( )

61 My partner spends too much time taking care of me ( )

62 My partner worries about me too much ( )

The remaining questions are for individuals who are NOT MARRIED or ARE NOT INVOLVED IN A STEADY ONGOING RELATIONSHIP

63 I have difficulty meeting opposite sex companions ( )

64 I have difficulty developing a close relationship with a person of the opposite sex ( )

65 I am afraid to initiate a sexual relationship with someone ( )

You are finished. Thank you.

## APPENDIX D

## CHRONIC ILLNESS PROBLEM INVENTORY

## Summary Sheet

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_

SCALE	SUM	MEAN	PROBLEM SEVERITY					
			0	1	2	3	4	
1. SLEEP	____/2= ____							
2. EATING	____/2= ____							
3. FINANCES	____/2= ____							
4. EMPLOYMENT	____/4= ____							
5. MEDICATIONS	____/2= ____							
6. COGNITIVE	____/3= ____							
7. PHYSICAL APPEARANCE	____/3= ____							
8. BODY DETERIORATION	____/4= ____							
9. SEX	____/4= ____							
10. ACTIVITIES OF DAILY LIVING	____/5= ____							
11. INACTIVITY	____/3= ____							
12. SOCIAL ACTIVITY	____/3= ____							
13. FAMILY/FRIENDS CONTACT	____/5= ____							
14. ASSERTION	____/3= ____							
15. MEDICAL INTERACTION	____/5= ____							
16. MARITAL DIFFICULTY	____/5= ____							
17. MARITAL OVERPROTECTION	____/3= ____							
18. NONMARRIED RELATIONSHIPS	____/3= ____							
19. ILLNESS FOCUS	____/4= ____							

## Survey of Pain Attitudes\*

*Instructions:* Please indicate how much you agree with each of the following statements about your pain problem by using the following scale:

- 0 = This is very untrue for me.  
 1 = This is somewhat untrue for me.  
 2 = This is neither true nor untrue for me (or it does not apply to me).  
 3 = This is somewhat true for me.  
 4 = This is very true for me.

1. There are many times when I can influence the amount of pain I feel	0	1	2	3	4
2. The pain I usually experience is a signal that damage is being done	0	1	2	3	4
3. I do not consider my pain to be a disability	0	1	2	3	4
4. Nothing but my pain really bothers me	0	1	2	3	4
5. Pain is a signal that I have not been exercising enough	0	1	2	3	4
6. My family does not understand how much pain I am in	0	1	2	3	4
7. I count more on my doctors to decrease my pain than I do on myself	0	1	2	3	4
8. I will probably always have to take pain medications	0	1	2	3	4
9. When I hurt, I want my family to treat me better	0	1	2	3	4
10. If my pain continues at its present level, I will be unable to work	0	1	2	3	4
11. The amount of pain I feel is completely out of my control	0	1	2	3	4
12. I do not expect a medical cure for my pain	0	1	2	3	4
13. Pain does not necessarily mean that my body is being harmed	0	1	2	3	4
14. I have had the most relief from the pain with the use of medications	0	1	2	3	4
15. Anxiety increases the pain I feel	0	1	2	3	4
16. There is little that I or anyone can do to ease the pain I feel	0	1	2	3	4
17. When I am hurting, people should treat me with care and concern	0	1	2	3	4
18. I pay doctors so they will cure me of my pain	0	1	2	3	4
19. My pain problem does not need to interfere with my activity level	0	1	2	3	4
20. My pain is not emotional, it is purely physical	0	1	2	3	4
21. I have given up my search for the complete elimination of my pain through the work of the medical profession	0	1	2	3	4
22. It is the responsibility of my loved ones to help me when I feel pain	0	1	2	3	4
23. Stress in my life increases my pain	0	1	2	3	4
24. Exercise and movement are good for my pain problem	0	1	2	3	4
25. Just by concentrating or relaxing, I can "take the edge" off my pain	0	1	2	3	4
26. I will get a job to earn money regardless of how much pain I feel	0	1	2	3	4
27. Medicine is one of the best treatments for chronic pain	0	1	2	3	4
28. I am unable to control a significant amount of pain	0	1	2	3	4
29. A doctor's job is to find effective pain treatments	0	1	2	3	4
30. My family needs to learn how to take better care of me when I am in pain	0	1	2	3	4
31. Depression increases the pain I feel	0	1	2	3	4
32. If I exercise, I could make my pain problem much worse	0	1	2	3	4
33. I believe that I can control how much pain I feel by changing my thoughts	0	1	2	3	4
34. Often I need more tender loving care than I am now getting when I am in pain	0	1	2	3	4
35. I consider myself to be disabled	0	1	2	3	4
36. I wish my doctor would stop prescribing pain medications for me	0	1	2	3	4
37. My pain is mostly emotional, and not so much a physical problem	0	1	2	3	4

## APPENDIX E

- 0 = This is very untrue for me.  
 1 = This is somewhat untrue for me.  
 2 = This is neither true nor untrue for me (or it does not apply to me).  
 3 = This is somewhat true for me.  
 4 = This is very true for me.

38. Something is wrong with my body which prevents much movement or exercise	0	1	2	3	4
39. I have learned to control my pain	0	1	2	3	4
40. I trust that the medical profession can cure my pain	0	1	2	3	4
41. I know for sure I can learn to manage my pain	0	1	2	3	4
42. My pain does not stop me from leading a physically active life	0	1	2	3	4
43. My physical pain will never be cured	0	1	2	3	4
44. There is a strong connection between my emotions and my pain level	0	1	2	3	4
45. I can do nearly everything as well as I could before I had a pain problem	0	1	2	3	4
46. If I do not exercise regularly, my pain problem will continue to get worse	0	1	2	3	4
47. I am not in control of my pain	0	1	2	3	4
48. No matter how I feel emotionally, my pain stays the same	0	1	2	3	4
49. Pain will never stop me from doing what I really want to do	0	1	2	3	4
50. When I find the right doctor, he or she will know how to reduce my pain	0	1	2	3	4
51. If my doctor prescribed pain medications for me, I would throw them away	0	1	2	3	4
52. Whether or not a person is disabled by pain depends more on your attitude than the pain itself	0	1	2	3	4
53. I have noticed that if I can change my emotions, I can influence my pain	0	1	2	3	4
54. I will never take pain medications again	0	1	2	3	4
55. Exercise can decrease the amount of pain I experience	0	1	2	3	4
56. I'm convinced that there is no medical procedure that will help my pain	0	1	2	3	4
57. My pain would stop anyone from leading an active life	0	1	2	3	4

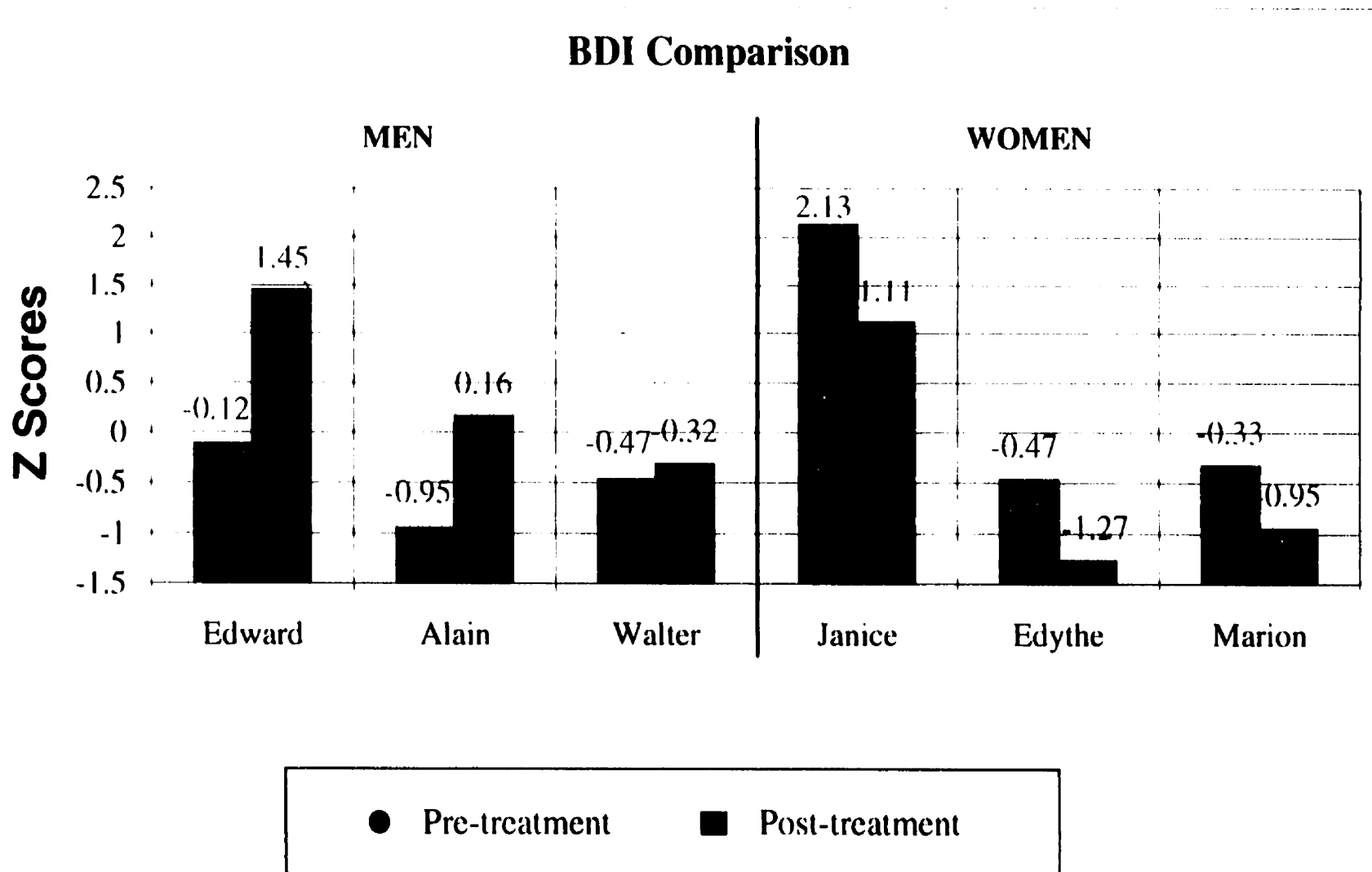
SOPA Scoring Key

Control: 1, 11<sup>\*</sup>, 16<sup>\*</sup>, 25, 28<sup>\*</sup>, 33, 39, 41, 47<sup>\*</sup>, 53  
 Disability: 3<sup>\*</sup>, 10, 19<sup>\*</sup>, 26<sup>\*</sup>, 35, 42<sup>\*</sup>, 45<sup>\*</sup>, 49<sup>\*</sup>, 52<sup>\*</sup>, 57  
 Harm: 2, 5<sup>\*</sup>, 13<sup>\*</sup>, 24<sup>\*</sup>, 32, 38, 46<sup>\*</sup>, 55<sup>\*</sup>  
 Emotion: 4<sup>\*</sup>, 15, 20<sup>\*</sup>, 23, 31, 37, 44, 48<sup>\*</sup>  
 Medication: 8, 14, 27, 36<sup>\*</sup>, 51<sup>\*</sup>, 54<sup>\*</sup>  
 Solicitude: 6, 9, 17, 22, 30, 34  
 Medical Cure: 7, 12<sup>\*</sup>, 18, 21<sup>\*</sup>, 29, 40, 43<sup>\*</sup>, 50, 56<sup>\*</sup>

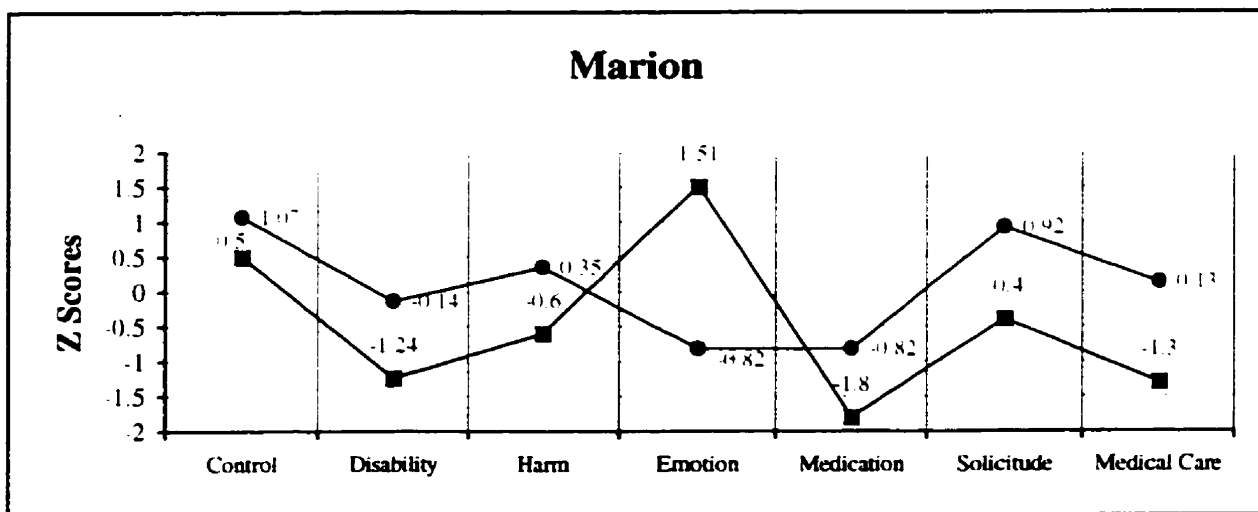
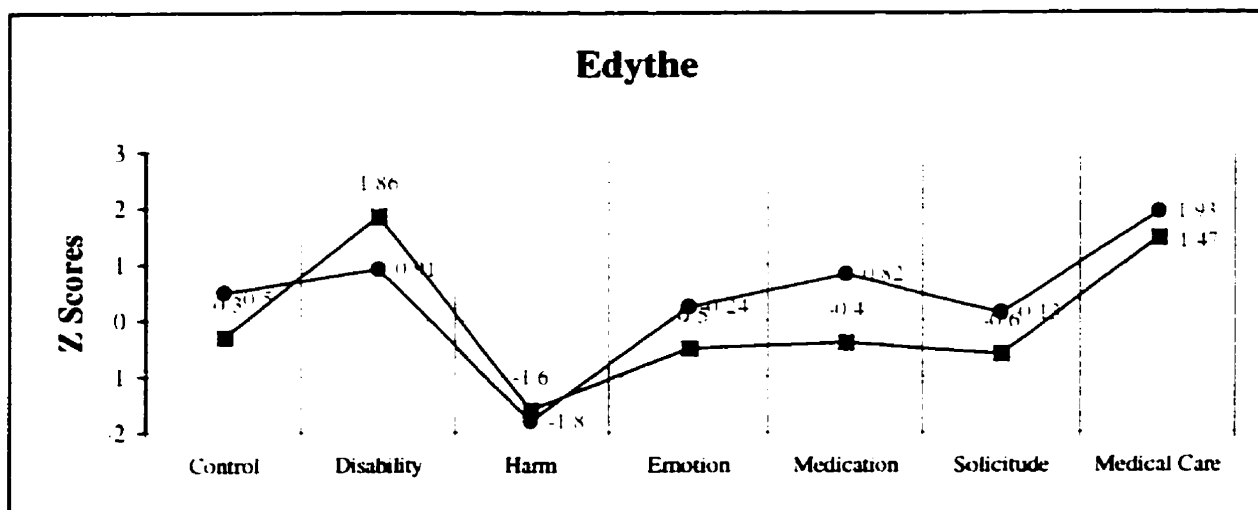
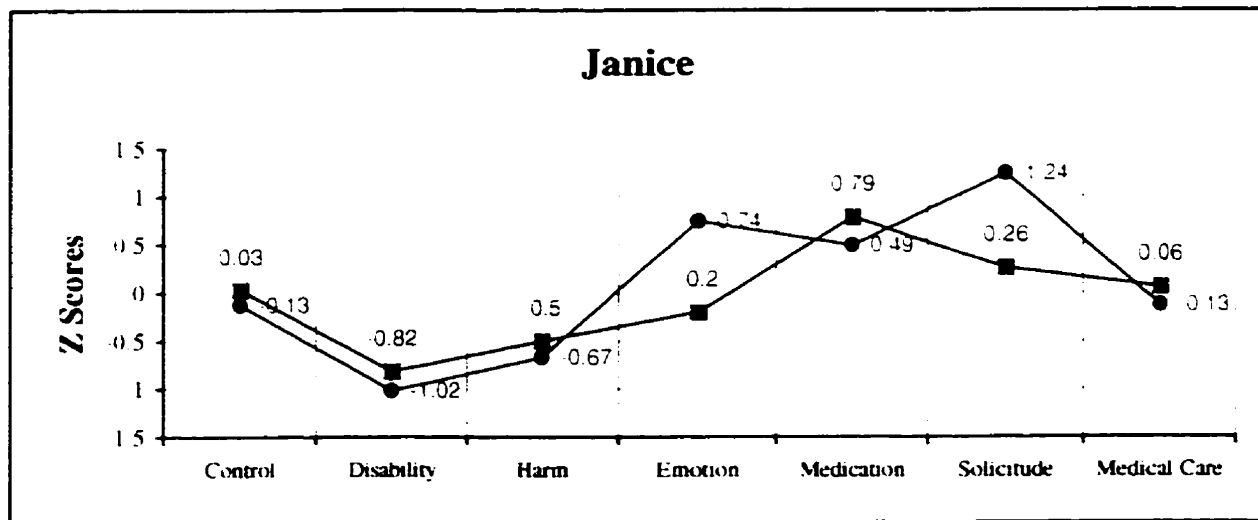
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<sup>\*</sup>Reverse-scored items. Transform these items (i.e., 4 minus rating given) before summing with other items.

## Beck Depression Inventory (BDI) Results



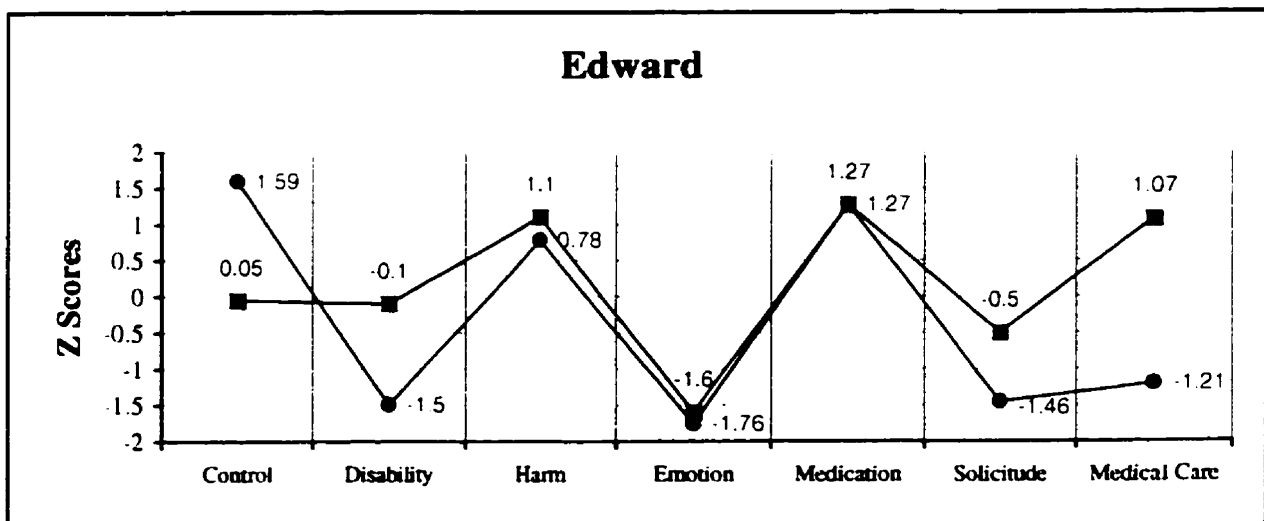
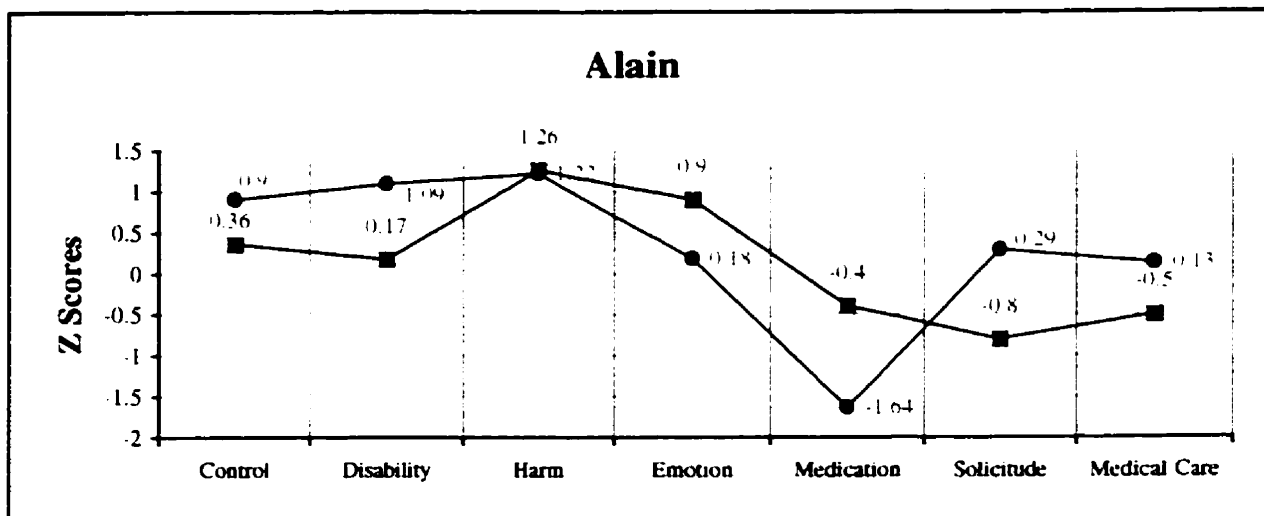
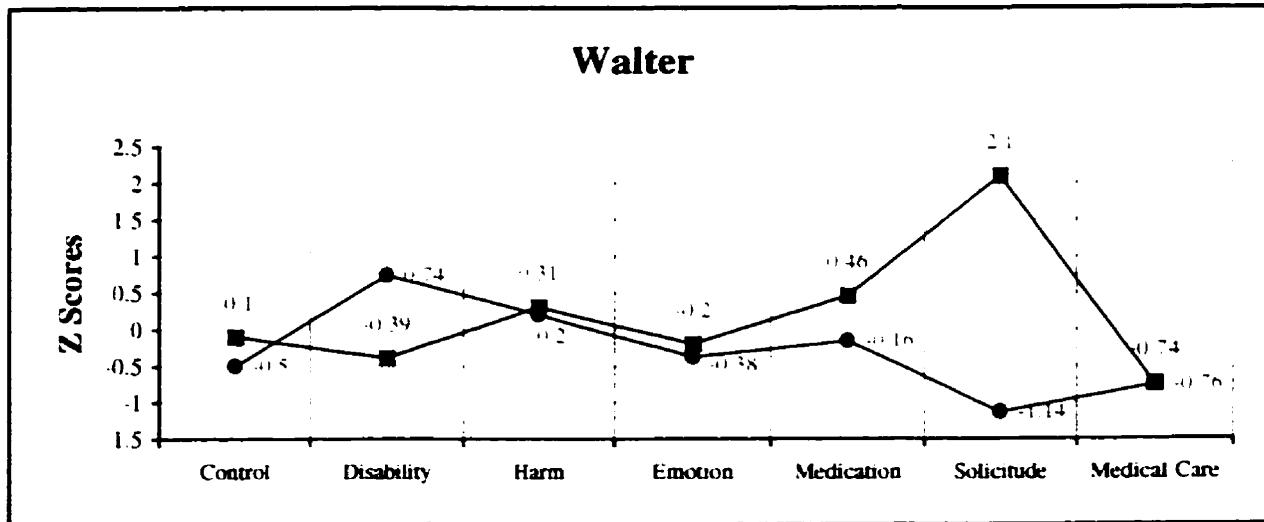
## Survey of Pain Attitudes (SOPA) - Females



● Pre-treatment

■ Post-treatment

## Survey of Pain Attitudes (SOPA) - Males

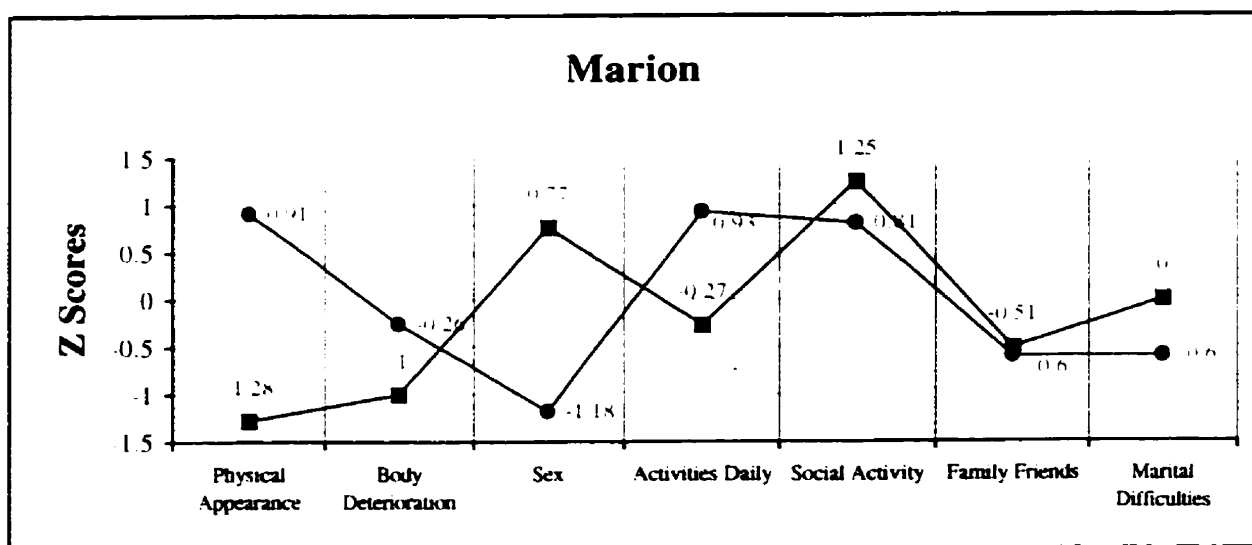
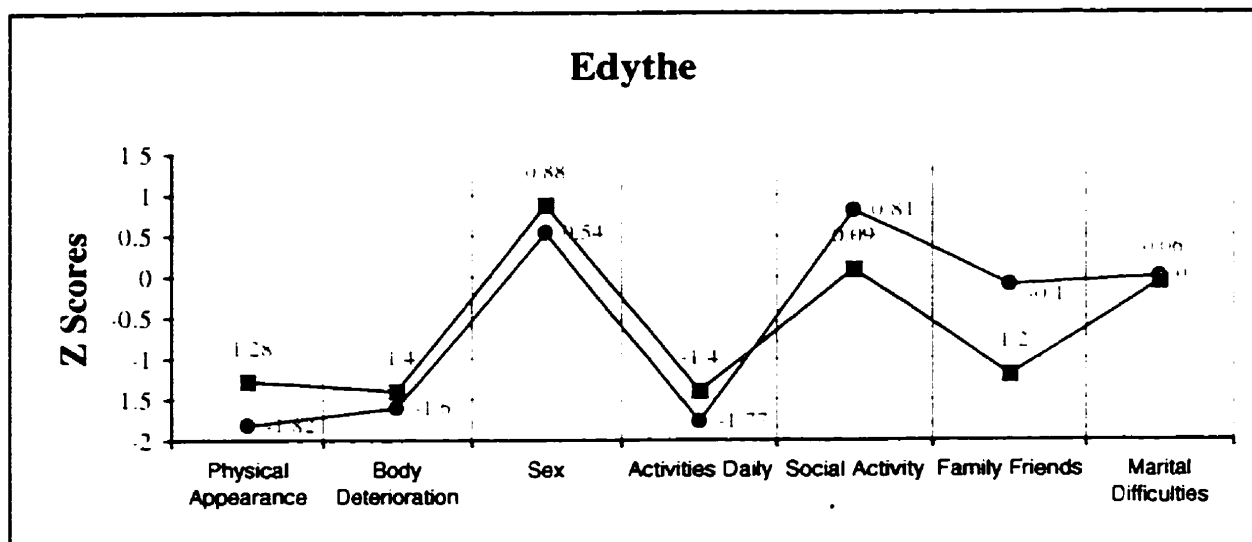
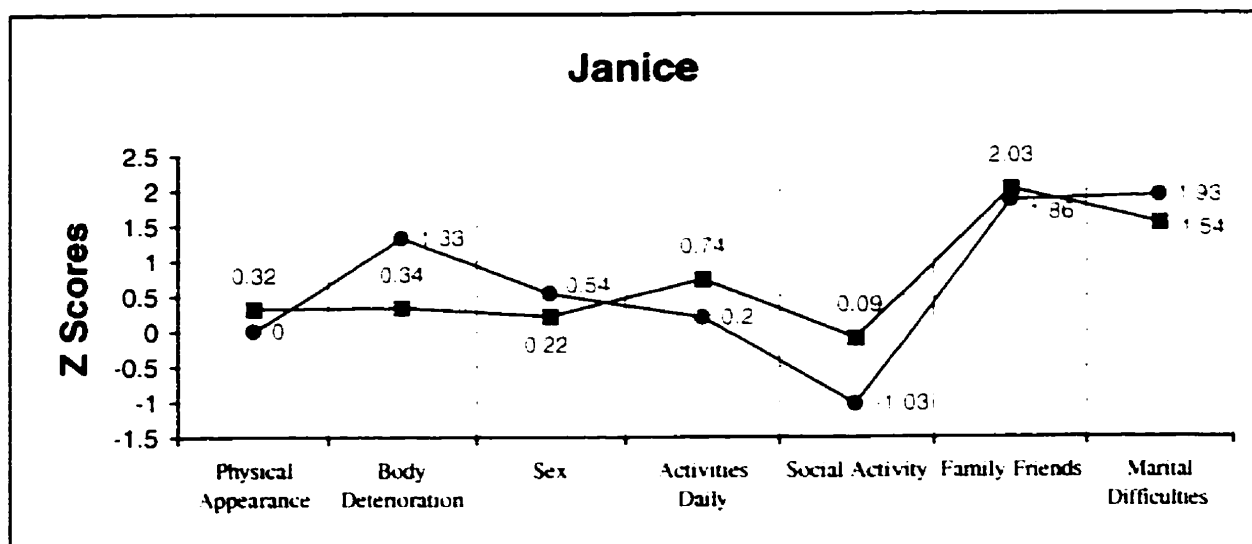


● Pre-treatment

■ Post-treatment



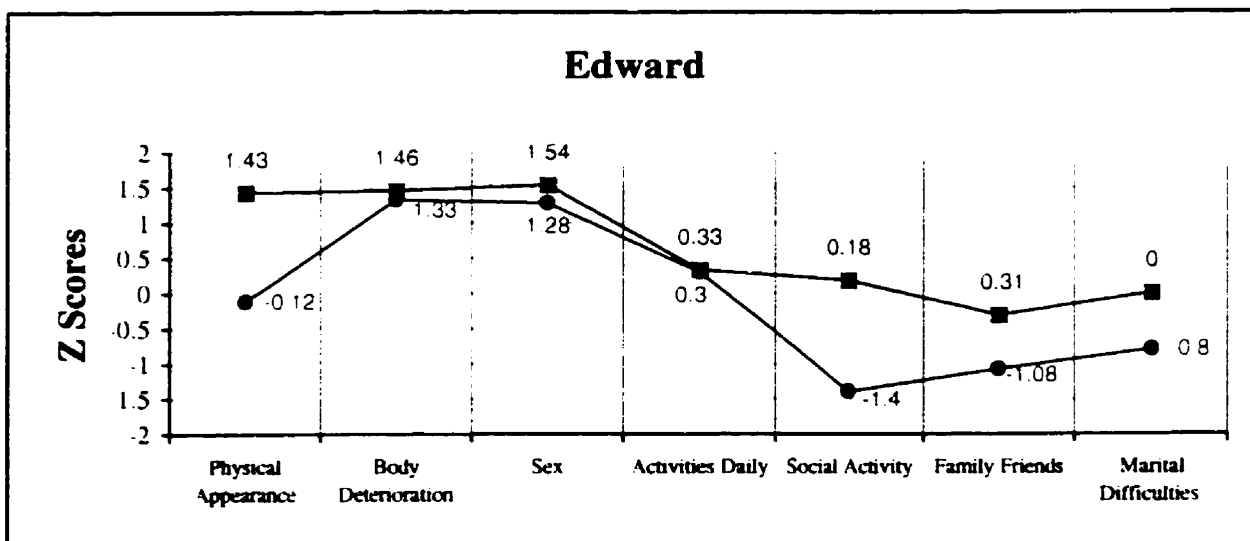
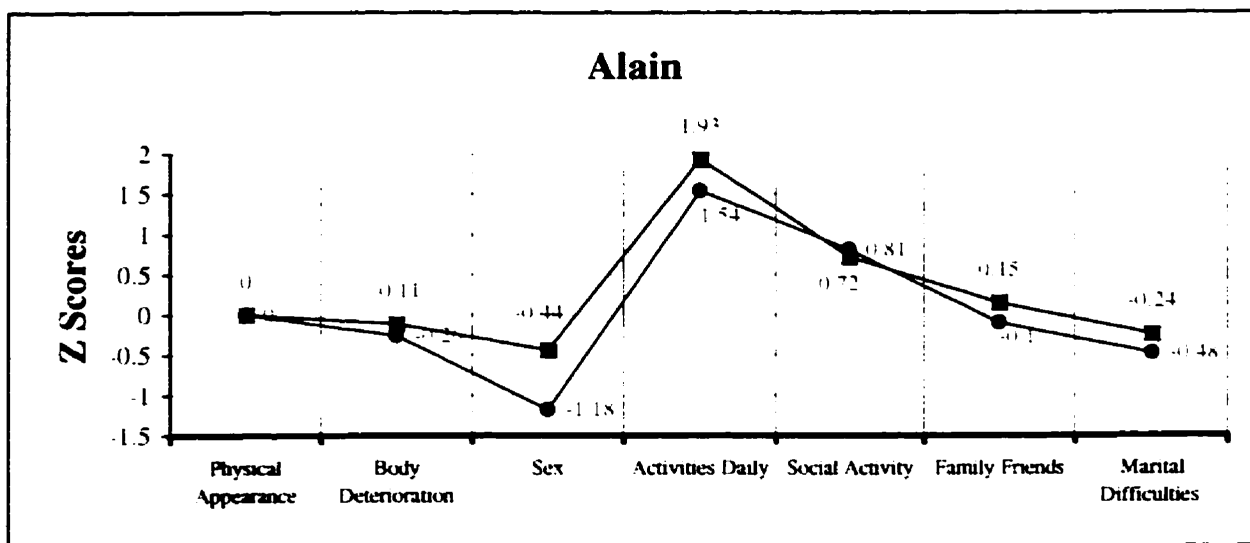
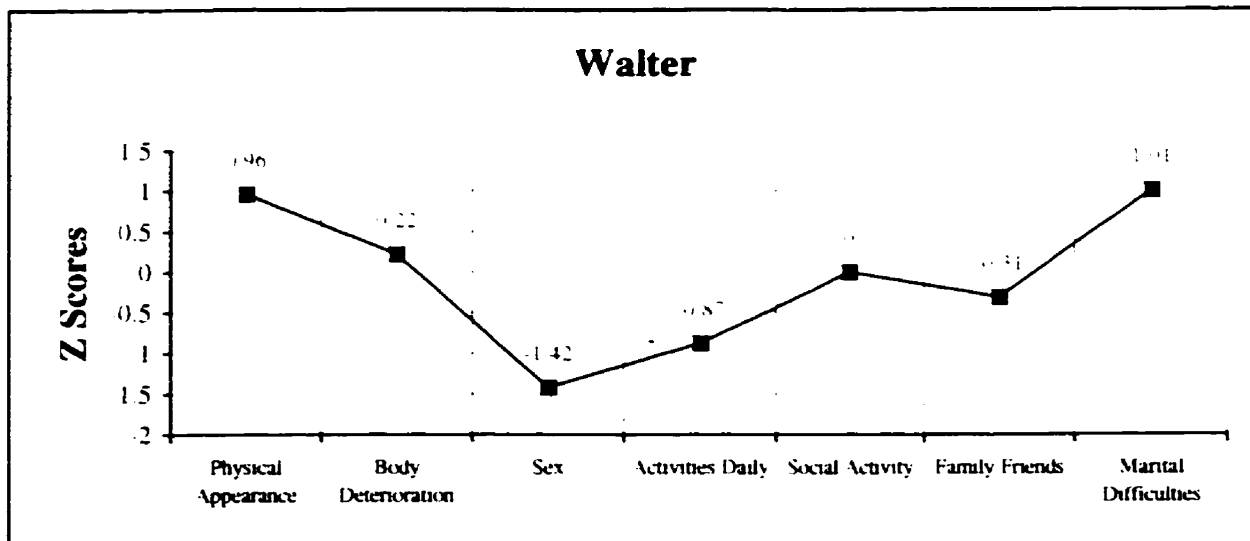
Thematic cognitive behavioural intervention  
Chronic Illness Problem Inventory (CIPI) - Females



● Pre-treatment

■ Post-treatment

## Chronic Illness Problem Inventory (CIPI) - Males



● Pre-treatment

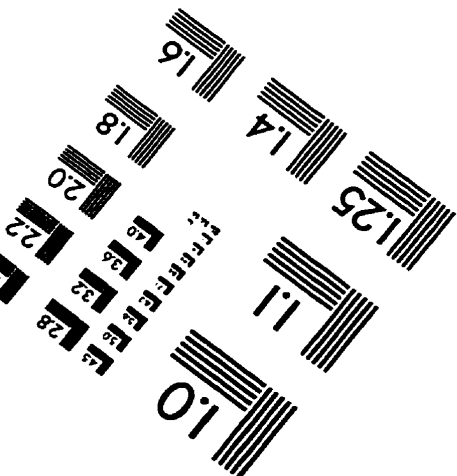
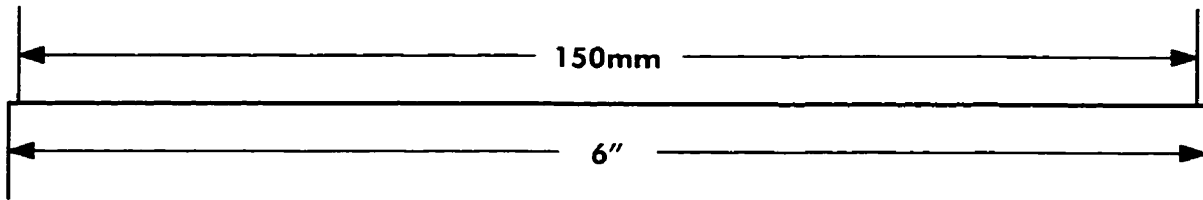
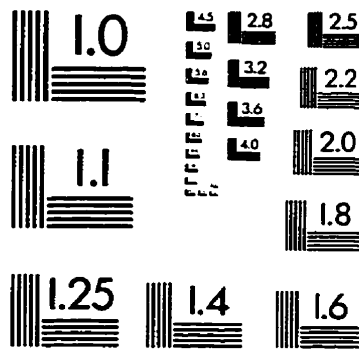
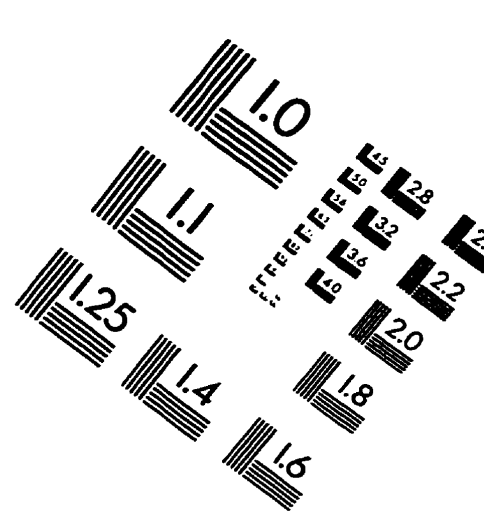
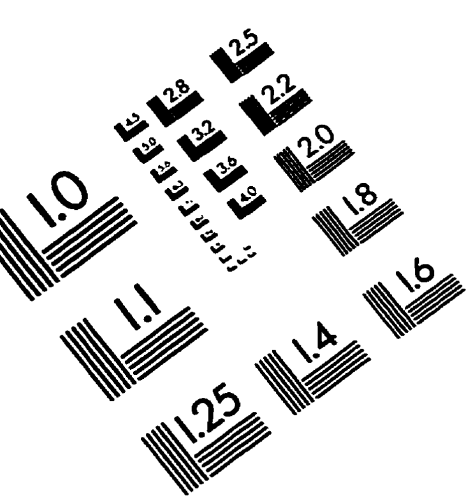
■ Post-treatment

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# IMAGE EVALUATION TEST TARGET (QA-3)



APPLIED IMAGE, Inc.  
1653 East Main Street  
Rochester, NY 14609 USA  
Phone: 716/482-0300  
Fax: 716/288-5989

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