BRIEF THERAPY WITH INDIVIDUALS LIVING WITH CHRONIC PAIN

BY

LISA SIGURDSON

A Practicum submitted to
The Faculty of Graduate Studies
In Partial Fulfillment of the Requirements for the Degree of

MASTER OF SOCIAL WORK

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University of Manitoba
Winnipeg, Manitoba

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THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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Acknowledgements

With my practicum now at a completion, as well as the required coursework for my Masters Degree in Social Work, I realize that I have many people to credit for helping me achieve this very significant goal. First, I wish to thank my advisor, Professor Ranjan Roy. You have helped me in so many ways, including narrowing the scope of my practicum placement, assisting me on site at the pain clinic, and providing continual guidance in the completion of this final report. Your knowledge, wisdom, and insight into not only the area of chronic pain, but in therapeutic intervention have helped me to acquire a foundation of skills and professional values that I will take with me wherever I go in my career. I would also like to thank my two practicum committee members, Professor Michael Thomas and Professor Tuula Heinonen. Professor Thomas, you as well provided me with information and knowledge regarding the area of chronic pain, but also assisted me in learning about the intervention technique of hypnosis, specific to the chronic pain population. I also appreciate your informal support on site at the pain clinic. Professor Heinonen, your recommendations and comments were always clear, helpful, and supportive. You always encouraged me, despite the seemingly long journey to finish this report. Thank you for taking the time in your very busy schedule to help me in this practicum project.

I would not have been able to complete this practicum, were it not for the wonderful staff at the Health Sciences Centre pain clinic that welcomed me and supported me in obtaining a client caseload. All of the attending doctors were helpful and more than willing to refer patients to me for therapy. I especially thank Dr. Mathieson, for your constant sharing of knowledge and ongoing support during my eight

months at the clinic. The nurses at the clinic are an integral part of the services and support provided there, and always helped me in whatever way they could. Finally, the administrative staff was especially accommodating in scheduling, typing reports, and organizing my appointments. I sincerely miss working with everyone I met at the pain clinic; you are a wonderful team.

Most importantly, where would I be without my clients? It is you who challenged, supported, and encouraged me to become a more knowledgeable and skilled clinician and social worker. Thank you for agreeing to work with a student therapist, and for allowing me to incorporate your cases into this final report. This practicum would not have been possible without the opportunity to work with such a unique client population. Thank you for sharing your stories with me, and having the courage to try new things in the hope of improving your life situations.

In order to complete this practicum report, I had to temporarily work a reduced schedule in my occupation with the Workers Compensation Board of Manitoba. I wish to thank my employer for accommodating my request in this manner, and supporting me over the past few years in completing this Master's degree. I feel that my role as a counselor with injured workers at the Workers Compensation Board and my experience in doing therapy with chronic pain clients at the pain clinic have been mutually beneficial and challenging. Both experiences will improve my overall skills as a social worker. I also wish to thank my co-workers who always asked about my progress in the practicum, as well as this report, and supported me in completing both.

Finally, I wish to acknowledge those people in my life who, on an almost daily basis, gave me love, support, and encouragement. Family, including mine and my husband's, were my cheerleading club on many occasions, especially when I seemed to need it the most. My biggest supporter though was, and is, my husband. John, your patience, love, and never ending support over these past few years have been an integral part of my ability to obtain my Master's degree. I really don't know how to properly give credit to what you have done for me in this process, only to say that my achievements in this degree reflect you and your part in my life. Thank you for everything you have done for me, and please know that I support you the same way you have me.

Introduction

Chronic Pain is pain that exists beyond the typical or expected time of healing (International Association for the Study of Pain, 1994). Though a range of one to six months has been recognized in terms of duration to define chronicity, a length of three months is considered "the most convenient point of division between acute and chronic pain" (International Association for the Study of Pain, 1994, p.*xi*). Therefore, this practicum will utilize a definition of chronic pain as pain that exists for three months or longer, despite medical treatment or expected recovery time.

Several authors have noted chronic pain as a growing health problem in North America, which continues to have adverse impact on society at large, specifically in terms of medical costs and lost work days (Brown, 1994; Gatchel, 2001; Sommer, 1998). Moreover, the impact of chronic pain on the person can be observed in terms of loss and grief associated with changes in personal, occupational, family, and social roles (Tunks & Roy, 1990). There is growing support in the literature for a multidisciplinary treatment approach that encompasses a bio-psychosocial model for assessing and treating chronic pain sufferers (Brown, 1994; McCarberg & Wolf, 1999; Pope, Frymoyer, Anderson, & Chaffin, 1991; Roy, 2001). Social work, by incorporating the ecological/systems approach, is regarded as a suitable discipline to play a valued role in assisting chronic pain clients to achieve an improved quality of life and increase in overall functioning.

This practicum explored the problem of chronic pain in a pain clinic setting, using an ecological/systems approach to assess and provide brief therapy as intervention with individuals living with chronic pain. The paper begins with a literature review citing articles and publications from 1980 to 2002, in order to present the psychosocial impact of chronic pain as well as suitable intervention methods relative to social work practice. The clinical setting, client population, and intervention methods will be provided, followed by the intervention and personal learning objectives. Case presentations will follow outlining the specifics of each case, the psychosocial issues, chosen intervention methods, and results from therapy. General findings/themes will be discussed, as well as challenges encountered in completing the practicum. The report will conclude with a review of my personal and professional learning objectives relative to the practium.

The Psychosocial Impact of Chronic Pain

The Psychosocial Model and Relevance to Social Work

Often the impact of chronic pain is reported in terms of health care and insurance costs to society however, these "numbers and statistics tend to mask great individual suffering and tragedy" (Roy, 2001, p. 15). This draws attention away from the impact of chronic pain on the individual sufferer and their family. Roy (1990a) has reported that "chronic pain sufferers are frequently sad, dependent on drugs, socially withdrawn, subject to multiple surgeries, and mentally and physically disabled" (p.789). "Chronic pain affects much more than somatic or bodily functions. It also has significant and enduring psychosocial effects" (Sieppert, 1996, p. 122). Turk (1996) also notes the role of psychological and social variables in the chronic pain experience. Given this, the model of interpreting chronic pain and implementing intervention must reflect all aspects of the pain experience, including medical, social, and psychological issues.

"Individuals suffering from long-lasting, or chronic, pain are of concern to social workers because such pain disrupts job, family, and social functioning and can lead to depression, excessive health concerns, and withdrawal from social activities" (Miller, 1993 in Kelley & Clifford, 1997). Roy (1981) indicates that "the essential element – and the special if not unique focus that social work can bring to bear on an assessment of a patient with chronic pain – is the understanding of the person-environment paradigm in all its complications" (p.56). The effect of chronic pain on the individual, the family, as well as within other social systems is considered in this regard. Because social workers are trained to understand and help with an ecological and holistic approach, they bring a wealth of knowledge and skill to the chronic pain arena with regard to assessment and intervention.

Social workers are often part of treatment teams in pain clinics, but others may work in hospitals, personal care homes, or rehabilitation services where the issue of chronic pain is a presenting factor. It is therefore important for social workers to acquire a satisfactory knowledge base of chronic pain in order to effectively provide service and support to this very specific client population. In a national survey of social workers employed in health or medical settings across Canada, Sieppert (1996) found that the attitudes of social workers toward being involved with chronic pain management was favorable and that social workers wanted to be part of the multidisciplinary treatment team. However, this study also revealed that social workers' exposure to, and knowledge of, relevant concepts and issues associated with chronic pain were limited (Sieppert, 1996). Moreover, social workers expressed a desire to be trained specifically in this problem area to develop a non-medical intervention approach when working with chronic pain clients. In the absence of appropriate training, "the clear implication is that a significant proportion of social services clients in both health and nonhealth settings are unlikely to have issues of chronic pain adequately addressed and treated" (Sieppert, 1996, p. 128).

Psychosocial Impact from a Roles Perspective

The impact of chronic pain will now be discussed in the manner that it disrupts and alters the various roles a person fulfills in terms of their personal, professional, family and social activities. "The consensus among clinicians, researchers, and patients is that chronic pain reduces patients' ability to perform their roles satisfactorily and treatment often fails to restore that ability" (Roy, 1981, p.55). This disruption is experienced not only by the chronic pain sufferer, but also impacts the marital and family environment, and other social relationships. Tunks and Roy (1990) have reviewed the relationship between altered roles and the person's environment and ecological system, recognizing that changes result in individual consequences which in turn can cause "...impairment of group functioning and adaptation, with consequent further effect on the index member" (p.59). In this respect, the impact of chronic pain becomes extremely complicated by the mutual influence and interconnectedness between the individual and their environment. Altered roles will be reviewed in terms of becoming a patient, occupational function, family and marital issues, as well as social relations. The psychological impact of chronic pain on the person will also be discussed.

The patient role. Injury or illness moves a person into the "sick or patient role" from a prior state of independent physical wellness and functioning (healthy role). For example, a person may not be able to carry out activities of daily living, thereby requiring the assistance of others. This can be humiliating for the client who must now rely on others to complete even the most routine of tasks (Wall & Jones, 1991). Though acceptable at first when in the acute pain or illness phase, in the case of chronic pain this situation is prolonged which perpetuates the sick role beyond typically acceptable timeframes, as associated with recovery or resumption of independent functioning. With chronic pain, "the patient may never be able to complete the move out of the sick role – resumption of roles would be impossible....this immediately puts this individual at odds with societal and individual expectations" (Tunks & Roy, 1990, p.62). This creates disruption within the individual as they have begun to assume an identity that is unbecoming to both their personal values and societal norms.

A further complication in the chronicity of the patient role involves the challenges in establishing medical support for the ongoing existence of debilitating pain. It is noted in the literature that there is often an absence of physical findings to support ongoing chronic pain (Turk, 1996). This requires the chronic pain client to undergo an array of medical treatments, often with minimal or no success, thereby resulting in "…anger and disappointment…" due to "…the inability to ameliorate the pain…" (Roy, 2001, p.132). This in turn can place a strain on the physician/patient relationship. As the chronic pain sufferer endures continued treatment failures, he/she maintains a belief that "…there is a surefire way of removing his pain and failure to achieve this must be ascribed to the incompetence or the indifference of the medical profession" (Wall & Jones, 1991, p.162). The patient/doctor system experiences "dissonance" from the physician's perspective as well in that, due to lack of treatment success, "… the physician questions the patient's motivation or even … sanity" (Tunks & Roy, 1990, p.68). Alternative labels suggesting faking or imagination of pain are often suggested, which results in continued physician/patient conflict. Unfortunately, this application of alternate labels or diagnoses tend to entrench the person further into the patient role, but with even less credibility than before, as they are now "…recategorized as a less desirable patient" (Tunks & Roy, 1990, p.69).

Occupational role. "The value of work is undeniable. Work is not only a means to an end, but not infrequently it is an end in itself" (Roy, 2001, p.101). Chronic pain often results in job loss or inability to perform one's occupation or profession, thus compromising a person's ability to fulfill a second life role. Roy (2001) describes this aspect of the chronic pain experience as having the greatest effect on an individual, as it brings with it not only financial consequences but is "…viewed as a matter of great personal failure…" (p. 110). The ability to perform one's work or occupation is highly regarded on both a personal and societal level. It is given the most weight and value and also tends to serve as the benchmark by which rehabilitation and recovery is measured.

In examining the impact of chronic pain on the loss of occupational roles, it is important to acknowledge the potential effects of unemployment as well as the combined impact of unemployment and having a chronic pain condition. Being unemployed has been associated with feelings of unhappiness, helplessness, and decreased self-confidence (Viney, 1983). Greater duration of unemployment has also been related to overall decreased mental health (Hepworth, 1980 in Viney, 1983). In a study comparing the effects of employment status on a chronic pain group and healthy comparison group, Jackson, Iezzi, and Lafreniere (1996) found that "participants experiencing both chronic pain and unemployment reported poorer adjustment than the other groups and more financial strain….and decreased social support than the employed chronic pain and healthy comparison groups" (p.354). These results speak to what Roy (2001) describes as the "…double jeopardy of chronic pain and unemployment…" (p. 22). Not only is the person unemployed, but they are absent from work "illegitimately", because of "…an elusive chronic pain condition…" (Roy, 2001, p. 110) which involves even greater stigma and social marginalization.

The results reported by Jackson et al. (1996) also indicated that the employed chronic pain group scored higher on emotional distress than the healthy employed group, thus suggesting that "...employment may only partially buffer the impact of chronic pain" (p.364). Unfortunately, the ability to successfully return to work, and thus resume one's occupational role, is typically the manner in which a chronic pain sufferer is assessed and evaluated. Incorrect assumptions are often made that because a person has returned to work, their chronic pain has resolved or been treated. Tunks and Roy (1990) report that part of the challenge in assessing the psychosocial aspects of chronic pain and treatment effectiveness "...comes from an inordinate concentration on the capacity for work as an essential criterion of outcome" (p.61). This ignores the relevance of family and social roles in the chronic pain experience.

It is likely that the occupational role is given the most attention and regard in terms of a chronic pain client's rehabilitation due to the "...social cost and because of special interest by insurance plans and Workmen's Compensation Boards and costs to industry..." (Tunks & Roy, 1990, p. 61). In the "occupational ecology", the injured worker, especially one with chronic pain, becomes a "financial liability to (their) company" as well as " a statistic" to be returned to work, thus lending even further credence to the occupational role (p.64). Given the manner in which satisfactory performance of one's occupational role is regarded in society, it is no wonder that the chronic pain client also assumes this perspective. Chronic pain clients have been noted to regard "...loss of the occupational role..." with "invalidism" (Roy, 1981, p.57). In summary, "loss of this role has very serious psychological and social consequences for the individual..." (Roy, 2001, p. 111).

Family roles. In viewing the family as an ecological system, "...the family members live in an interactional world in which they both act and react" (Roy, 1990b, p.

185). It is assumed that all family members are connected, affect one another, and change in the direction of homeostasis (Roy, 1990b). Having said this, "a chronic pain family's capacity to reorganize family life while making allowance for the patient is the real issue. This depends on several factors, a critical one being loss of roles" (Roy, 2001, p.40). Chronic pain can impact the degree to which a person is able to maintain their roles in the family, both within the marital relationship as well as the parental context.

Issues such as intimacy/sexual problems, marital distress, role changes, and spousal health issues have been identified in terms of the psychosocial impact of chronic pain in the spousal relationship (Roy, 1990b). Decreased sexual activity or intimacy levels are expected given the nature of many chronic pain conditions. However, in a review of the literature, Roy (1990b; 2001) noted mixed findings to empirically support this assumption. Nevertheless, this issue tends to present itself in clinical settings and requires appropriate attention. Role related problems have been observed in terms of the increased caregiver responsibilities on the part of the healthy spouse (Roy, 2001), as well as decreased problem solving and communication between partners (Roy, 1990b). Marital distress has been associated with a host of negative emotions on the part of the "healthy spouse" ranging from anger and grief to depression. Health problems have also been recognized in the healthy spouses of chronic pain clients, which further complicates the marital relationship (Roy, 2001). It is also noted that the reaction or altered role of the healthy spouse has been associated with the manner in which the chronic pain client adjusts and copes with their pain. For example, if the chronic pain patient perceives little or no support from their spouse, or receives negative feedback regarding their condition, the risk for the chronic pain client to develop depression increases (Kerns & Turk, 1984;

Zautra, Hamilton, & Burke, 1999). The mutual influence of spouses demonstrates the manner in which chronic pain becomes a very complex psychosocial experience in the familial network.

Family issues are in part related to changes in the marital relationship, but have also been linked to the impact of loss of the occupational role, specifically if the sufferer is the family provider. "The provider maintains his full spousal and parental role partly by virtue of the security that the occupational role brings. When the occupational role is dysfunctional or lost, there is a shift in expectations" (Tunks & Roy, 1990, p. 65). Spouses and often children may have to assume responsibility for functions previously performed by the chronic pain client, and the family may also disregard the client's place in the family, which casts them into a "...devitalized parental role..." (Tunks & Roy, 1990, p.65). This shift or change in the familial environment brings into question the impact of a parent's chronic pain on the child. Roy (2001) examined literature involving the impact of parental depression, chronic pain, and pain conditions on children. He concluded that overall the results were mixed, however, "there was some suggestion that the children showed more distress and behavioral problems compared to control groups" (p.55). This is not meant to imply that having a parent with chronic pain has no effect on the children, but that further examination is required in both the clinical and empirical realms. Particular attention should be given to factors such as the child's age, severity of illness, and gender of the parent and child "in predicting the vulnerability of the child" (Roy, 2001, p.55) in chronic pain families.

Social roles and support. By assuming the patient role and having a disrupted occupational role, the person with chronic pain often also finds him or herself removed from their livelihood and social network. This results in decreased sources of social support and validation, ingredients that can help a person to manage stressful life situations. This decrease in social support will often have negative psychosocial consequences for the chronic pain client, as adjustment to disability has been associated with social support (Li & Moore, 1998) and positive interactions with members of the social environment (Falvo, Allen, & Maki, 1982). Additionally, the absence of "…positive social interactions…" has been associated with "…resignation, passivity, and social isolation…" (Zautra et al., 1999, p.209) in the chronic pain client. In a review of the literature, Roy (2001) concluded that social support is thought to play "…a buffering role in moderating depression in Rheumatoid Arthritis", however, there is limited support for this same effect with regard to depression and pain in the chronic pain population (p.99). Despite these findings, Roy (2001) acknowledged that "…from a clinical perspective social support was an important dimension that ought to be investigated" (p.99).

As the chronic pain client experiences decreased contact with their immediate social network; it is often replaced with increased contact with larger systems, such as insurance companies. "It is undeniable that chronic illness alters the nature of social interaction. Informal and semiformal may shrink, while the interaction with the formal network is on the rise" (Roy, 2001, p.99). It is often reported that chronic pain clients find their relationships with these formal systems to be adversarial in large part due to companies that seem "…determined to deny their claim (s)" (Roy, 2001, p. 120). The questionable nature of many chronic pain conditions further complicates this process as insurance companies rely solely on medical information to substantiate ongoing payment of medical treatment or wage loss replacement benefits (Roy, 2001). Being disabled from pain alone unfortunately is not sufficient to support ongoing absence from the workforce when corresponding medical evidence is lacking. Thus, the chronic pain client is in continual conflict with the larger system.

Brown (1994) explored this adversarial and negative relationship between chronic pain clients and insurance companies in terms of impact on chronic pain clients. Many participants identified with a sociological meaning construct of "Agent's Disbelief" in terms of having to "prove" their situations to insurance companies. Brown concluded that insurance programs "...hold significant power in the lives of people with pain conditions and disbelief on the part of these institutions can create overwhelming dissonance between what the person with pain finds personally meaningful and the financial resource program's analysis" (p.108-9). Disbelief on the part of the insurance company can contribute to the chronic pain client's difficulty in "...resolving the pain experience..." , thus causing him or her to "...remain 'fixated' in a search mode – search for cure, search for meaning, search for validation" (Brown, 1994, p. 109). This type of psychosocial interaction between the chronic pain client and the larger, more formal social network contributes to the maintenance of the patient role and presents a barrier to resuming other roles, especially that of the occupational.

In chronic pain insurance cases, alternate reasons to explain ongoing disability are often explored by the insurance company, such as malingering (faking), psychiatric problems or lack of motivation to work (laziness). There appears to be general consensus in the literature that true malingering is very rare in the chronic pain population (Cailliet, 1981; Sommer, 1998). It is also noted that "...motive for litigation or financial compensation arising out of injury has very little, if any, negative consequences for treatment success or for rehabilitation…" (Roy, 2001, p.119). Furthermore, work ethic or laziness on the part of the chronic pain population was not supported in Jackson et al.'s study (1996), wherein the authors found that healthy and chronic pain unemployed and employed groups did not significantly differ in work ethic values. This invalidated the belief that "pain and/or unemployment" are "…directly related to the weakening of a desire or the orientation toward hard work" (p. 365).

Psychological issues with chronic pain. "There is evidence to suggest that because of the failure of attempts to alleviate their pain, chronic pain patients develop specific psychological problems that distinguish them from acute patients" (Gatchel, 1996, p. 33). These complications have a negative impact on the ability of a person to resume their various roles to a satisfactory or desirable level. Fear of re-injury produces avoidance on the part of the chronic pain client in both the physical and psychosocial contexts (Turk & Okifuji, 2002; Wallace & Wallace, 1999; Zautra et al., 1999). Issues of decreased self worth (Brown, 1994), hopelessness and frustration related to a desperate search for a "cure" (Johnson & Webster, 2002), and lack of personal control with low self-efficacy (Turk, 1996) are amongst the noted emotional and psychological consequences of chronic pain. Johnson and Webster (2002) have observed that in this regard, the chronic pain sufferer transforms "…from the person they used to be to someone they scarcely recognize or would want to know" (p.48). An overall "loss of self" is referenced as a common experience of the person living with chronic pain (Soderberg & Lundman, 2001).

Frequently, chronic pain sufferers deal with symptoms associated with depression (Roy, 2001; Gatchel, 1996; Kerns & Turk, 1984). This can become a complicated process in terms of assessment and diagnosis, given that some characteristics of chronic pain resemble those found in depression. For example, sleep disruption or disturbance is frequently observed as a neurovegetative symptom in depressed individuals, yet has been estimated to exist in approximately half of the chronic pain population which will interfere with daily functioning and cause increased pain (Currie, Wilson, Pontefract, & deLaplante, 2000). Issues of loss and grief are direct consequences as related to disrupted role functioning in the chronic pain client, yet should not be assumed to represent clinical depression in terms of a psychological diagnosis. The important issue is that, given the psychosocial consequences of living with chronic pain, it "…is capable of engendering or at least eliciting depressive symptoms" (Roy, 2001, p.16), and these factors must be taken into account in the clinical setting with regard to assessment and intervention. Gatchel (1996) has reported that as "…pain becomes chronic in nature, psychological changes begin to occur" which are "…likely caused by the trauma and stress associated with the chronic pain condition, and not stable psychological traits" (p.34). He further concludes that when "…the chronic pain is effectively treated, many of the problematic psychosocial symptoms tend to also be alleviated" (p.34).

Intervention with Chronic Pain Clients

Model of Interpreting Pain and Providing Treatment

The literature supports that a bio-psychosocial perspective is most appropriate when dealing with the chronic pain population because it acknowledges the very complex phenomenon of chronic pain that is a result of several interrelated factors (Gatchel, 2001). Medical, social, psychological, and occupational issues all play a part in a chronic pain situation and each should be considered when providing treatment (Guzman et al., 2001). Multidisciplinary programs are strongly emphasized in the literature as representing the optimum treatment program for this client population (Brown, 1994; McCarberg & Wolf, 1999; Pope et al., 1991; Roy, 2001). In this regard, patients may work with a range of professionals, including physicians, social workers, psychologists, and occupational therapists to reach treatment goals. "The social work profession offers theoretical foundations and skills that are valued by those who maintain multidisciplinary pain centers" (Sieppert, 1996, p.127). Furthermore, "the social worker is trained to determine the significance of the social, environmental, and emotional factors that, in many instances, emerge as the primary issues for these patients" (Roy, 1981, p.56). The social worker, in a therapeutic role, uses an ecological approach that considers these factors when determining intervention and support, within the multidisciplinary team setting.

Social Work and Therapy

"The practice of psychotherapy is certainly not the exclusive domain of social work, and is one of several intervention methods that social work has in common with psychology and psychiatry…historically, the social workers have engaged in psychotherapeutic activities…" (Roy, 1990a, p.797). Support for psychotherapy in general as a treatment modality is well documented in the literature (Lambert & Bergin, 1994; Stalker, Levene, & Coady, 1999) and has been applied in a variety of clinical settings with a range of client populations. As Roy (1990a) points out, social workers have traditionally been involved with the provision of psychotherapy or therapeutic intervention for several years. Current trends in clinical social work, as well as in other disciplines where psychotherapy is practiced, involves provision of short term, or what is commonly referred to as brief therapy. The practice of brief therapy will now be reviewed in terms of its primary principles/tenets as well as empirical findings regarding its efficacy.

Brief or Short Term Therapy

Hudson-Allez (1997) points out that brief therapy, also commonly referred to as time limited therapy, "...is not long term therapy cut short. It is a very specific way of working that integrates the traditional person-centered….and cognitive approaches and …and action models…" (p.34-35). Typically therapy is limited in terms of the length of time the therapist and client will work together or by the number of sessions that will be utilized to identify and achieve treatment goals. Most importantly, it is considered to possess distinct features and characteristics that can be observed regardless of the theoretical models used in treatment. Following is a combined list of basic principles of this type of therapy, as taken from two sources in the literature (Goldstein & Noonan, 2001, p.39; Hoyt, 2001, p. 229;):

1. Time sensitivity – conscious use of time
2. Quick and rapid engagement

3. Focus on specific achievable goals
4. Emphasis on patient's strengths and capacities/competencies
5. Flexibility in approach and technical interventions
6. Clear definition of patient and therapist responsibilities
7. Here and now orientation
8. Acceptance of limitations of treatment

These features form the structure or framework of short-term therapy in terms of engaging the client, assessment, identifying goals, and achieving desirable outcomes. "Forward movement and change…" is emphasized and key to achieving goals (Stalker et al., 1999, p. 473).

Interestingly, some authors suggest that basically all forms of therapy can be considered brief in nature, ranging from 1 to 25 sessions, with the average being approximately 6 (Hopwood & Taylor, 1993; Peake, Borduin, & Archer, 2000). The literature indicates that brief or short-term therapy is equally as effective as longer term therapy (Peake et al., 2000; Wolson, 2001) and that patients can make considerable therapeutic progress in a short amount of time (Cameron et al., 1999). Cognitive Behavioral therapy, a short-term therapy, has yielded significant results in treating depression, phobias, as well as "…various psychophysiological disorders, including chronic pain…" (Cameron et al., 1999, p.4). A recognized limitation of brief therapy entails yielding less effective outcomes with certain populations, for example clients with longstanding and severe psychological disorders, specifically in terms of risk for relapse (Cameron et al., 1999; Lambert & Bergin, 1994; Stalker et al., 1999). Stalker et al. (1999) point out that despite beliefs associated with the Solution Focused Brief Therapy model of "…more rapid and enduring client change….there is no empirical evidence of (its) superior effectiveness or brevity" (p. 471). However, Wolson (2001) postulates that brief therapy is an effective intervention strategy for a "…range of psychological and health-related problems, including severe and chronic problems" (p.11). Despite some debate regarding the effectiveness of briefer therapies with populations characterized by longstanding psychological problems, the general consensus appears to be that brief or short term therapy yields similar, if not in some cases greater, success as compared to long term therapy.

A significant trend in the psychotherapy literature, specifically with regard to brief/short term therapy, is that of "eclecticism" or the combined application of various models and approaches (Lambert & Bergin, 1994; Peake et al., 2000). "Our perceptions and practices have consequences. One implication is that, because all approaches are not equally effective, therapists need to find out and do what works best…" (Hoyt, 2001, p.233). This requires the clinician to continually assess the progress of the client and implement new or different techniques when required. This allows the practitioner to "…avoid the assumption of 'pain-patient homogeneity' in terms of response to treatment" (Gatchel, 2001, p. 193) by applying the same techniques with all individuals. Eclecticism is also "…in keeping with the theoretical openness that is endorsed by a generalist social work perspective" (Stalker et al., 1999, p.474).

Brief Therapy with the Chronic Pain Client

Roy (1981) indicates that "…if psychotherapy is viewed as a client-centered, short term, educational and problem-solving approach, then an argument can be made that patients with chronic pain do benefit from this kind of psychotherapeutic intervention" (p.60). In the assessment phase, the social worker should focus on etiological issues, the specific ways the pain is affecting the client's psychosocial functioning, and the relationship to medical information in terms of treatment formulation (Roy, 1981). The goals of therapy entail engendering change in various aspects of the client's life in order to decrease the impact of the chronic pain so the client can function at a more desirable level.

There appears to be general agreement amongst several authors in terms of therapeutic goals as related to this client population. Roy (1981) stated that "improved relationships in the family, improved self-image, and the reassumption of social, parental, and other roles are the major goals of this form of intervention" (p.60). Golden & Steiner (1981) identified "increasing the client's ability to manage the pain within the context of the vital adult roles", "working through any strains in interpersonal relationships…", and "…restructuring aspects of the environment…" as part of the treatment process (p.50). Christ, Sormanti and Oppenheim (2001) identify objectives of increasing the client's level of independence, working towards a positive identity for the client through the development of coping strategies and problem solving skills, as well as increasing the support within the client's social network.

Addressing the issue of altered roles appears to be an integral part of the therapeutic process with the chronic pain client. Identification of the roles most affected, acknowledging the grief experienced in relation to this, giving emphasis to roles still satisfactorily performed, and modifying role expectations, while ensuring the client's "…positive sense of identity…" are part of this process (Golden & Steiner, 1981, p.51). In achieving this, the client will experience less social isolation and greater interconnectedness to various aspects of their environment. Cognitive Behavioral techniques, such as relaxation strategies and cognitive reframing, have been found to be helpful in assisting the chronic pain client to manage pain symptoms by developing healthy coping skills (Burgess & Chalder, 2001; Currie et al., 2000; Turk & Rudy, 1986). Additionally, the Solution Focused approach has also been applied to working with this clientele as related to establishing progressive milestones toward larger treatment goals (Johnson & Webster, 2002). Given the frequent necessity for implementation of various techniques to assist the client, the current trend of "eclectic" practice is represented in providing brief therapy to chronic pain clients, similar to other brief therapy situations. "In the midst of such complexity, the psychotherapeutic operations involve more factors than can be accommodated within a single therapeutic model….no single technique appears to suffice" (Bellissimo & Tunks, 1990, p.104).

A final note related to doing therapy with the chronic pain client entails the key values or features of any therapeutic practice considered essential to effect change. "It is well recognized that within all forms of psychotherapy there are common features which provide a universal framework…" (Pilowsky & Bassett, 1990, p.123). Listening and communicating concern with the suspension of judgment are required to engage the client in the therapeutic process (Donovan & Laack, 1998; Pilowsky & Bassett, 1990).
The clinician who achieves this will assist the client in feeling validated, which is highly regarded in the clinician-client relationship, specifically when dealing with chronic pain problems (MacDonald, 2000). The nature of interaction between the therapist and client is highly regarded in terms of achieving goals and predicting treatment outcome (Peake et al., 2000; Stalker et al., 1999). "Both the relationship and the therapeutic techniques

serve as important instruments in the alteration of the patient's assumptive world (Peake et al., 2000, p.19). Therapeutic alliance should not be underrated as its absence can significantly challenge the effectiveness of various techniques and halt overall success in treatment.

Summary

The impact of chronic pain on an individual level has been reviewed from a traditional ecological social work perspective, giving special recognition to the manner in which various life roles are diminished or changed and the corresponding environmental figures interact and influence the entire system. Experiencing ongoing pain of a debilitating nature has been noted to permeate through all aspects of a person's environment, affecting their personal, occupational, family, and social roles. Factors such as psychological issues related to the pain experience have also been reviewed to demonstrate the complexity of these situations. The role of the social worker in a multidisciplinary setting, while endorsing the bio-psychosocial perspective of chronic pain is considered valuable in the provision of brief therapy to chronic pain clients. Brief therapy has gained empirical support over the years in terms of its effectiveness and is considered an appropriate intervention to this client population. An eclectic approach is typically required by implementing various techniques, however the establishment of a therapeutic alliance with the chronic pain client is essential in "…enabling clients and patients to regain a sense of congruence between themselves and their environment" (Roy, 1990a, p.801).

Practicum Placement

Clinical Setting

Clients seen throughout the practicum placement were all patients at the Pain Clinic, Department of Anesthesiology, Health Sciences Center in Winnipeg, Manitoba. This clinic primarily offers medical intervention to patients suffering with chronic pain. Patients must be referred by a general physician, or other medical specialist. The clinic offers a wide range of medical treatment, including pharmacological intervention, injections/blocks, and surgical procedures. All patients are followed by one of the attending anesthesiologists at the clinic. A Clinical Psychologist and Clinical Social Worker (both Professors at the University of Manitoba) are available on a part time (volunteer) basis. They provide psychological and social assessments, as well as therapeutic intervention to assist patients in dealing with the psychosocial impact of chronic pain. Psychology and Social Work students are able to complete placements in this setting, and I was able to see patients in this regard under the supervision of Professor Ranjan Roy, Practicum Advisor and Consulting Clinical Social Worker at the clinic. Clients were seen for therapy sessions either at the pain clinic or the Psychological Service Centre at the University of Manitoba, based on office space availability and convenience factors for the client.

Client Population & Recruitment

The clients I saw at the clinic were all considered to be disabled to various degrees due to chronic pain associated with various medical circumstances, for example automobile accident injuries or migraine headaches. All clients were patients of one of the pain clinic doctors and were not responding to medical interventions in terms of pain management. All clients were referred for an assessment by their pain clinic doctor, with a brief letter outlining their medical status, and at times, psychosocial situation. Referrals were pre-screened by Professor Roy to ensure each appeared suitable for my practicum placement. Additionally, due to my employment with the Workers Compensation Board (WCB), I did not accept any referrals wherein the client had a claim of that nature. This was to avoid any potential conflict of interest between my role as a student therapist at the pain clinic and as a counselor with the WCB of Manitoba.

When initially meeting with each client, I provided a brief overview of my status as a graduate student in Social Work at the University of Manitoba. A consent form (see Appendix A) was provided for the client's review and signature. The form outlined the purpose of my practicum and the requirement for my work to be evaluated as part of the education component. The form also requested that the client complete three measures and allow their results to be included in the final practicum report, with the understanding that confidentiality and anonymity would be respected. The client was also given the option to not agree to their personal results being reported in the final document even though they participated in therapy sessions.

Measures & Evaluation Methods

Measures. Each client was asked to complete the Pain Disability Index (PDI) as a pre and post measure, the Client Satisfaction Questionnaire (CSQ-8) post therapy, as well as a Client Self Rating Scale as a means of identifying and evaluating treatment goals throughout therapy. Each will be discussed in terms of its features and application to the chronic pain population.

Clients were asked to complete the PDI in the first or second therapy session as well as in the final therapy session. The PDI (see Appendix B) consists of a 10 point rating scale that represents the degree of interference patients believe their chronic pain has with their life, specific to seven areas/activities. Ratings range from 1, being "no disability" to 11, "total disability". Internal consistency for this measure is reported at .86 alpha, with statistically significant test-retest reliability (Kerns & Jacob, 1992). Its short format is considered a beneficial feature for this client completion. Scoring entails summing all ratings for the seven areas, with higher scores representing a greater degree or level of disability. By including various aspects of a person's life, the questionnaire also allows for the patient and therapist to identify which of the patient's life roles are most affected by their chronic pain based on the area that receives the higher ratings. This in turn can assist in establishing treatment goals at the outset of therapy. The PDI was to be completed both at the beginning and at the completion of therapy in order to compare overall disability scores as well as to evaluate whether disability ratings had changed for any of the seven domains/areas identified in the questionnaire throughout the course of therapy.

In addition to the PDI, clients were asked to complete a Client Self-Rating Scale (see Appendix C) in the first or second session. In most cases, the client and I completed this together to establish goals for therapy. One to two goals/objectives were considered appropriate at the initial commencement of therapy with the agreement that these could be modified, abandoned, or added to throughout the process, depending on how therapy progressed. We attempted to identify, and term, goals in terms of positive change wherever possible. We also identified the client's level of functioning with respect to each goal at the beginning of therapy, based on a rating scale, where 1 represented "minimal to no achievement of the goal" and 10 represented "maximum achievement of the goal". We then attempted to identify/negotiate the desired rating (out of 10) for each goal when therapy would conclude (for example to increase the rating by a certain number of points on the scale to represent improvement and a higher level of achievement). The clients and I also discussed how the ratings could be defined, in terms of what they would or would not be doing, in order that there was some mutual understanding of the goals and the assigned ratings. It was also hoped that by negotiating a rating for each goal for the conclusion of therapy, more realistic and attainable goals would be identified. The Client Self Rating Scale was also utilized as a reference tool throughout the course of therapy with the clients in terms of reviewing progress and determining whether the goals remained appropriate or required modification. It was also referenced when completing therapy, as another means of evaluating the achievement of goals or whether some change had occurred, and to what degree.

As a final measure, clients were asked to complete the Client Satisfaction Questionnaire (CSQ-8) in the final therapy session as a means of measuring their satisfaction with the therapy/treatment process (see Appendix D). The CSQ-8 contains eight items considered representative of client satisfaction with services received in a program or agency. It is not a measure of direct gain from treatment, however, attempts to quantify "...the client's perspective on the value of services received" (Corcoran & Fischer, 2000, p. 174). The CSQ-8 has been reported as having internal consistency measures of .86 to .94 alpha and good concurrent validity, with scores being related to client and therapist ratings of overall improvement. It has been used with a variety of populations and is considered especially applicable in mental health settings and programs (Corcoran & Fischer, 2000; Mitchell, 1998). To score the CSQ-8, all scores for each of the eight items are summed, resulting in a total score, which can range from 8 to 32. Higher scores represent a stronger degree or level of satisfaction with the service.

Of note, "the literature provides some indication that client satisfaction is a worthwhile and valid construct to consider in evaluating treatment outcome" (LaSala, 1997, p. 55). It is possible that client satisfaction may be more linked to characteristics of the therapeutic relationship, such as empathy or perceived support on the part of the therapist, which is not always directly correlated with goal attainment or treatment outcome. It is important to evaluate this aspect of the treatment process, as the clients involved with this practicum presented with chronic pain, a problem area that often challenges the achievement of goals and requires support, validation, and empathy from the therapist on an ongoing basis. Client satisfaction with the treatment process may be possible due to the qualities of the service received from the therapist which may not be necessarily captured in the scale for goal achievement or the PDI (disability level).

The CSQ-8 measured the nature of the therapeutic alliance between me and the client as well as the client's satisfaction with this aspect of therapy. In a study involving a comparison of two mental health treatment programs/formats, Mitchell (1998) found that despite the type of therapy that is provided, "…clients place a high value on the social worker's expressions of empathy and, …clients are more satisfied when such empathy is conveyed" (p. 409). The CSQ-8 specifically asks whether the client would refer a friend to the service/program if he or she were in a similar situation. "Whether a client states that services would be recommended appears to be a good sign that he or she is happy with treatment" (LaSala, 1997, p. 62). Having the clients complete this last measure was seen as representing satisfaction experienced in the therapeutic process and perceived support of the therapist, which is distinct from measures directed at treatment outcome or results.

Evaluation of practicum progress. Aside from the measures utilized to evaluate goal achievement and client satisfaction, I was involved with an evaluation process throughout the practicum specific to monitoring my learning and development as a student therapist. I maintained a journal/log of sessions with clients that identified issues discussed in therapy, as well as therapeutic issues to be reviewed with my advisor, Professor Roy. Professor Roy and I met on a regular basis to discuss each case, review issues/goals, and identify appropriate interventions. Professor Roy was familiar with all the cases and was kept up to date through our supervision sessions as well as written documentation/updates that I provided to the referring physicians at the pain clinic. Supervision sessions also allowed for discussion around my personal challenges in doing therapy, and ways to develop further skills and overcome anxiety I may have experienced around various issues.

Another aspect of evaluation entailed the review of videotaped sessions with one particular client that I met with at the University of Manitoba Psychological Services Centre. Unfortunately, the pain clinic did not allow for videotaping of sessions due to the limited space and lack of appropriate equipment. However, in continually reviewing one case in this manner independently, and with Professor Roy, I was able to observe myself as the therapist, the client's reactions, and our interaction as a system. With Professor Roy, therapeutic issues were reviewed, hypotheses were formulated about the case, and my behavior as a therapist could be observed and critiqued for further learning. This was transferable to other cases and benefited me to some degree in working with all clients. The review of videotapes was one of the most valuable evaluation methods of the practicum as in observing the videotape; the therapy session could be "stopped", discussed, and continued. Review of subsequent sessions on the tape also allowed for a thorough process in identifying themes, goals, and direction for future sessions.

Client feedback was another source of informal evaluation utilized during the practicum to gauge my development as a therapist. At various points in therapy, questions such as "What has been helpful so far in our work together?" and "How are things better?" were presented to each client. It was hoped that these questions would not only prompt client feedback on therapeutic techniques or interventions, but also other aspects of our relationship, such as sense of trust, empathy, or support felt by the client. This information was used in conjunction with that obtained in having clients complete the CSQ-8.

Therapy Objectives

The objectives of this practicum were categorized in terms of goals related to intervention with the client population and learning objectives I identified with regard to my skills as a social worker in a clinical setting.

Intervention objectives. The goals related to the intervention provided to the clients were as follows:

1. To assist clients with chronic pain in understanding their pain experience from a psychosocial perspective, by identifying affected life roles and areas of functioning.

2. To assist clients with chronic pain in developing techniques and coping skills that would enhance their ability to manage pain.
3. To assist clients with chronic pain improve those relationships most affected by the chronic pain experience.
4. To assist clients with chronic pain in achieving an increased sense of life mastery and autonomy.

As described in the measures and evaluation section, each client and I individually identified treatment goals at the outset of therapy. The Client Self Rating Scale (see Appendix C) was utilized to identify goals, achievement of each goal as perceived by the client at the outset of therapy, and to negotiate a realistic achievement level for the completion of therapy. Individual client goals will be discussed in each client/case write up in the following section.

Practicum/learning objectives. To enhance my skills and knowledge as a clinician/therapist, the following goals were identified:

1. To enhance my knowledge base of the etiology and prevalence of chronic pain.
2. To increase my knowledge and understanding of chronic pain from a social work perspective, employing an ecological/systems approach.
3. To develop my skills as a clinician specific to assessment and identification of relevant issues related to the psychosocial impact of chronic pain on each individual client.
4. To develop my skills as a clinician in the application of various brief therapy techniques, such as Cognitive Behavioral or Problem Solving.

5. To develop my skills as a clinician in terms of establishing therapeutic relationships with clients, inherent with trust, validation, and support.

These goals will be reviewed further in the discussion section regarding my development and learning throughout the practicum experience.

Case Presentations

I saw a total of seven clients for individual therapy during my practicum at the pain clinic (April to December 2003). In addition to having my own caseload, I occasionally joined Professor Roy, to observe and participate in therapy sessions with his clients. However, I did not collect any data on these individuals, nor did I work with them individually.

Prior to reviewing each case individually, it is important to note the complexity of the cases, and the need for various treatment modalities in each case. Though all were patients of the pain clinic for a chronic pain problem, the issues that these individuals raised in therapy could not be predicted on that characteristic alone. In keeping with the psychosocial paradigm of chronic pain, it is understandable that the problems raised by these clients were not simply just about pain management. Rather, the many ways the pain was impacting a person's life and their relationship with their environment produced numerous related and yet unique problems. An open mind was essential in working with each client, as often a panacea of problems/issues would be identified by the client that went far beyond pain management issues.

This type of clinical situation was most ideal for my training in social work because of the discipline's particular attention to the person-environment paradigm that respects a multi-faceted approach to assessment and treatment of problems. Therefore, a restricted approach of one type of therapy, such as Cognitive Behavioral, did not suffice, but rather a multi-modal approach was often required. In general, it included helping clients explore all issues and develop interventions, while providing a supportive and empathic environment for clients to discuss their thoughts and fears. Particular attention was also paid to helping clients increase their social network and support system to better cope with their chronic pain (Devins & Binik, 1996). The cases will now be discussed individually, outlining the prevalent issues, chosen intervention/treatment methods, as well as the results and outcome from therapy.

Client #1: Mrs. A.

Case description. Mrs. A., a middle-aged woman, was the victim of a dominant arm injury several years earlier, and had undergone various medical interventions with minimal to no success. There was substantial physical evidence to support Mrs. A.'s level of reported pain and disability and her doctors were quickly exhausting treatment options available to her. Mrs. A. was advised that her medical condition had reached a "plateau" but that she should use her arm as much as possible to prevent deterioration. At the time of being referred for therapy, Mrs. A. was being tried on various pain medications, some of which produced negative side effects.

Psychosocial information. Mrs. A. was married and had two children in their late teens. This was Mrs. A's second marriage and she described her husband as loving and supportive, though acknowledged their relationship had changed due to her chronic pain problem. She reported going through a terrible divorce from her first husband which left her to raise and support her two children independently for many years before marrying her current partner. Mrs. A.'s children were very helpful around the house and contributed financially by working part time while going to school.

Mrs. A. had enjoyed a career in the customer service industry for several years, winning service awards and progressing to a supervisor position. Her career was initially interrupted several years earlier when she was diagnosed with a serious health problem, for which she required surgery and medical treatment. Mrs. A. made a complete recovery from this problem and returned to work on a full time basis. She continued working until she had to leave work altogether due to her arm injury. Mrs. A. was applying for disability benefits when she was referred for therapy. This proved to be a taxing and grueling process in light of the many roadblocks she met from the insurance company and medical system. Mrs. A.'s family experienced a great deal of financial distress as a result of her not working and waiting several months to receive a disability income.

Mrs. A. experienced continuous arm pain, along with functional limitation when performing any activity or task. She was very resourceful in obtaining help from friends to accomplish household work, and demonstrated an incredible ability to figure out ways for her family to meet their financial obligations. Nevertheless, Mrs. A. had feelings of sadness, loss, hopelessness, and worry regarding her situation. When she was referred for therapy, Mrs. A. was being treated for depression with medication by her family doctor. Mrs. A. struggled with social isolation, aside from the times friends would help her around the house. She found her pain and medication side effects causing increasing levels of fatigue and poor concentration, which made it difficult for her to socialize with anyone. Mrs. A. found herself spending more and more time alone and feeling worse about her current situation.

Case formulation. Mrs. A.'s case is one that represents loss of roles brought on by a chronic pain condition, and the grief associated with this painful process. Mrs. A. was immersed in the chronic "sick role" from her former, healthy state with no hope for medical improvement. The reality of her situation was that she no longer was a "well and healthy" person and her identity as such had been destroyed. She lost her ability to function in many ways, and it was unlikely she would regain this in the future.

Mrs. A.'s chronic pain problem alone was significant but her experience with a prior medical problem likely compounded her situation further. Mrs. A. struggled previously with a life threatening condition that posed greater danger to her than her presenting arm condition. She was successful in overcoming her prior illness, and in so doing, developed a sense of strength in times of medical/physical adversity. This in turn likely allowed Mrs. A. to establish high expectations around recovery when sick or ill. Mrs. A. likely applied these same expectations to her ability to cope with her arm problems and chronic pain. Because her arm condition was of a chronic nature, she could not "recover" and her expectations were thus inherently flawed. Mrs. A.'s perspective not only supported an unrealistic goal around coping with her pain, but also prevented her from facing her loss and the grief associated with it.

Mrs. A. encountered further loss with regard to her inability to work and maintain her successful career. This aspect of her situation was considered significant, in light of the many functions work played in Mrs. A.'s life. First, it provided her with financial support and stability both currently and previously when she supported her two children by herself. This in turn nurtured a sense of accomplishment and strength for Mrs. A. Her inability to work challenged her sense of identity in this regard, and also resulted in financial hardship for Mrs. A.'s family. She was dislocated in the family from contributor to dependent. In addition, being absent from the workforce automatically decreased Mrs. A.'s interaction with her informal social network, which contributed to her sadness and social withdrawal. Finally, not being able to work introduced Mrs. A. to the challenging process of applying for and receiving insurance benefits. She experienced feelings of loss of control with regard to the insurance and medical systems, which largely controlled her financial situation.

In summary, Mrs. A. was viewed as experiencing loss of health, occupational functioning, and family, and social roles. This resulted in grief and some denial in processing her new reality. Mrs. A. was also considered as postulating unrealistic self-expectations in terms of coping and functioning which endorsed her sense of hopelessness. An overall loss of mastery and control permeated Mrs. A.'s entire situation and brought with it feelings of sadness, depression, and a declining sense of self-worth.

Goals. In order to assist with identifying treatment goals, Mrs. A. completed the PDI, as well as the Client Self-Rating Scale. Mrs. A. obtained a total score of 59/77 on the PDI, representing a moderate to high level of pain interference. In reviewing specific life areas with Mrs. A., she identified various arenas wherein she wanted to increase her functioning and pain control. The following goals were identified:

1. Increase the frequency and quantity of self-care activities performed by Mrs. A. Mrs. A. identified increasing self-care tasks as a means to help her low self-esteem. In completing the Client Self-Rating Scale, it was determined her current activity level in this area was 4/10, which would be increased to 7/10 through therapy.

2. Increase Mrs. A.'s completion, or participation in, household tasks.

Mrs. A. acknowledged it being premature to identify a goal around her occupational role, so chose to focus on her activity at home in terms of household responsibilities that she could take part in, keeping in mind her physical limitations. A rating of 3/10 was assigned to this goal on the Client Self-Rating Scale, with a goal of increasing Mrs. A.'s level of activity in this area to 6/10 through therapy.

3. Develop pain management techniques and coping strategies to minimize pain interference. Mrs. A. identified a strong desire to learn any coping strategies or techniques to help control her pain levels. No rating was assigned to this goal on the Client Self-Rating Scale, however Mrs. A. felt she possessed minimal skills in this area and anything she could learn would only improve her situation.

Intervention. Various interventions were implemented in working with Mrs. A. in order to help her achieve the various goals she identified. The following are the main approaches incorporated in this case:

1. Hypnosis was introduced when initially working with Mrs. A. as she identified a desire to try this particular technique. "In the last 50 years...this treatment modality has made significant strides in its acceptance and utilization in the treatment of individuals suffering with chronic pain..." (Johnson & Webster, 2002, p. 177). Hypnosis has a longstanding and somewhat complex history. Because this technique was only implemented for a short period with one client, a comprehensive description of the

technique's characteristics will not be provided. However, it is noted that, from a traditional perspective, hypnosis is described as "a special nonordinary state that is noticeably different from normal waking experience" (Johnson & Webster, 2002, p. 180). Alternatively, "a more recent…perspective contends that the psychological and physical phenomena created through hypnosis are the product of commonly definable psychological, cognitive, and social variables" (Chaves, 1997 in Johnson & Webster, 2002, p. 180). The function of hypnosis in working with a chronic pain client entails helping the client to experience "…an identifiable shift in consciousness to a different state…instead of the painful symptoms" (Johnson & Webster, 2002, p. 187). Stated more specifically, it is a pain management tool that can help an individual experience an alternative state of awareness from the regular, pain-filled one they endure on a daily basis.

The format of this intervention entailed me initially working with the Clinic's Consulting Psychologist in order to learn how to perform an induction. I observed the Psychologist on two occasions, wherein he assisted Mrs. A. in achieving a relaxed state to decrease her pain and discomfort. I gradually assumed responsibility for the hypnosis, and carried out an induction with Mrs. A. in subsequent sessions by following variations of a script located in Reynold's (1990) social work practicum report (see Appendix E). The induction was comprised of deep relaxation, imagery, and replacement of pain symptoms with those associated with relief and comfort. Mrs. A. was asked to regularly practice this technique on her own, to gradually improve her ability to control her pain. The hypnosis was shortly thereafter replaced by other interventions, as per Mrs. A.'s request to try other pain management techniques.

2. Cognitive Behavioral therapy was chosen to assist Mrs. A. in developing relaxation strategies and positive coping statements aimed at reducing the level of negative impact her pain had on her life. The Chronic Pain Control Workbook, by Catalano and Hardin (1996) served as a great resource in working with Mrs. A. from a cognitive behavioral perspective as it outlined many activities relevant to aspects of this model. This approach included an educational component in terms of Mrs. A. learning about the physiological effects of enduring long periods of pain. This formed the foundation for learning relaxation methods such as deep breathing and imagery. Mrs. A. was also asked to keep a pain log/diary (see Appendix F) as a way to measure overall pain levels but also to identify any situational pain patterns. Mrs. A. applied the relaxation strategies at regular daily intervals and also when she had episodes of increased pain.

Mrs. A. engaged in self-talk that was felt to be defeating and damaging from a pain control perspective. In the cognitive behavioral model, this behavior is felt to elicit negative emotions in an individual which in turn decreases self-confidence and esteem (Borcherdt, 1996; Catalano & Hardin, 1996). The model also indicates that new, positive thoughts/statements must be identified to replace the negative ones in order to change a person's feelings and emotional status. Despite Mrs. A.'s success in achieving a specific task/goal, she told herself she was much slower and weaker than before her arm was injured. This thought pattern perpetuated Mrs. A.'s sense of loss and resulted in her feeling more sad and hopeless about her situation. Though this way of thinking reinforced Mrs. A.'s sense of loss, it also prevented her from truly acknowledging and processing the grief around her losses. Her ability to modify her activity levels was inhibited due to her denial of the grief around her situation. In addition to replacing her negative self-statements with more positive, encouraging ones, Mrs. A. was encouraged to acknowledge the grief around her chronic pain situation so she could move forward with building on her strengths and increasing her role participation in various areas of her life.

Results. Mrs. A. and I engaged in an informal review process throughout the course of therapy to ensure goals remained accurate and appropriate. At the conclusion of therapy, Mrs. A. completed the following activities in order to obtain more formal feedback:

1. In completing the PDI to obtain a post-therapy measure, Mrs. A. yielded a total score of 60/77, one point higher than her pre-therapy score of 59/77. This suggested Mrs. A. perceived her pain as still having significant interference with her life, with no change in this aspect of her chronic pain situation when compared to her score when she started therapy.

2. In completing the CSQ-8 to measure her satisfaction with the therapy process, Mrs. A. yielded a score of 30/32, representing a very high level of client satisfaction. Mrs. A. qualified this score by offering she found the therapy supportive and helpful in learning pain management techniques and feeling understood.

3. Mrs. A. did not formally complete the Client Self-Rating Scale to review her progress in identified goals, but throughout therapy Mrs. A. accomplished several interim goals related to household task completion/participation and self-care. Mrs. A. was

able to acknowledge her achievements, but struggled with internal negative statements and thoughts that prevented her from feeling good about her progress.

It appeared Mrs. A.'s pain continued to exert a great deal of control over her life, though she did partially accomplish the goals identified at the outset of therapy. Mrs. A.'s score on the CSQ-8 indicated strong client satisfaction with the therapy process, which could not have been predicted on the basis of her PDI score alone. It appeared that Mrs. A. was satisfied with the treatment received in light of her CSQ-8 score, but continued to struggle with the impact her chronic pain had in her life (reflected in her PDI post-treatment score).

Two challenges Mrs. A. faced throughout therapy entailed the application process for insurance benefits and the side effects from her pain medication. At times Mrs. A. missed appointments due to illness from her medications, causing an interruption in the therapeutic process. The battle with her insurance company often consumed Mrs. A.'s time and energy to the point where it became a fulltime job. This robbed Mrs. A. of any sense of control or mastery and also prevented her from working on her personal pain-related goals. At the end of the therapy process, she was successful in obtaining the insurance benefit, which engendered some sense of control in Mrs. A. and allowed her to re-focus on other issues.

At the conclusion of my practicum, Mrs. A. requested she be transferred to another therapist, in order to continue working on her negative self-talk. Mrs. A.'s case was referred for ongoing therapy for this purpose. Mrs. A. did learn and apply various relaxation strategies, and also achieved some of the goals she identified in therapy.

However, she was faced with many losses due to her pain problem and struggled to realize her new identity as a person living with chronic pain.

Client #2: Ms. B.

Case description. Ms. B. was a young woman suffering with chronic hip, pelvic, and bilateral leg pain. She had not incurred a specific injury, but rather her pain problems developed gradually over time to the point where she utilized crutches or a wheelchair for mobility and support. Ms. B. was being treated with various pain medications through the clinic, none of which seemed to provide her with any relief. The staff at the pain clinic could not understand Ms. B.'s level of disability given the absence of physical/medical evidence.

Psychosocial information. Ms. B. was residing with her mother when referred for therapy. Ms. B. did not know her father, and had been raised by her mother, who had longstanding alcohol and drug problems. She had two half siblings, and was not close to either of them. Ms. B. described being physically and verbally abused by her mother most of her life. She also described one incident in her pre-teen years where she was sexually violated by one of her mother's male friends.

Ms. B.'s relationships with her mother and siblings were always destructive and unproductive. As a child, she thought this was "normal" for a family, until she disclosed this information to a close friend. When Ms. B. told the school social worker and one of her teachers about the abuse, they initially did not believe her. Eventually, her story was accepted and Ms. B. lived in various foster homes for a good portion of her adolescence.

Ms. B. moved to another city once she graduated from high school and then completed training at a technical school. She found work and established her independence. Though she struggled with trusting people, Ms. B. was able to form some friendships when living in a different city. Ms. B. worked full time until her chronic pain condition forced her to stop working and go on disability benefits. She then moved back to her birthplace and in with her mother for financial and daily living support. At the time of her referral to the clinic, Ms. B. had one close friend from school, and was maintaining a long distance relationship with a man who resided in the city where she lived temporarily.

Ms. B.'s medical history included the onset of pelvic pain in her late teens followed by hip and leg pain in early adulthood. Ms. B.'s mother did not abuse her when she was ill as a young child. However, as she grew older, the abuse took place regardless of Ms. B.'s health situation. Ms. B. had virtually no self esteem, and felt the years of her mother's abuse had significantly affected her ability to form relationships with others. She was overwhelmed with her pain, and was frustrated that medical treatment had been unable to alleviate it. Ms. B.'s living situation at the time of the referral resembled her younger years in terms of ongoing abuse from her mother. She often presented at hospital emergency wards with overwhelming episodes of pain, demanding medical attention.

Case formulation. Ms. B.'s case is representative of the relationship that is sometimes observed in clinical settings between childhood abuse and adult chronic pain. Ms. B. was a pain client wherein "...pain was a means of communicating emotional distress" (Roy, 1998, p. 37). Ms. B. had endured years of physical and verbal abuse from her mother and in her own words, "had not truly dealt with it". The evolution of her somewhat curious chronic pain condition, from a medical perspective, portrayed her helpless and victimized identity.

Ms. B.'s chronic pain can be considered against her abuse history, in light of what is known as Engel's pain prone disorder (1959, in Roy, 1998). This condition recognizes the relationship between childhood abuse and chronic pain as an adult, which may or may not be supported with medical evidence (Engel, 1959 in Roy, 1998). The experience of pain resulting from abuse of any form is associated with retribution for mistakes and wrongdoings as a child. This transfers into the expression of psychological suffering or pain in adulthood (Roy, 1998). Often this expression of pain takes on a somatic (physical) form as a means of communicating an individual's helplessness as well as to "…eliminate profound feelings of sadness" (Roy, 1998, p. 57). Ms. B.'s increasing pain levels were representative of her increased emotional distress. "The literature, which may be considered impressive, does point in the direction of an association between childhood abuse and adult chronic pain" (Roy, 1998, p. 31).

The fact that Ms. B.'s initial disclosure of her abuse to adult caregivers was met with disbelief was also considered significant. As a child, Ms. B. had the task of "proving" her abuse. Ms. B.'s pain levels and increasing disability as an adult could not be explained with medical findings and therefore was questioned by the medical profession. This created a similar and parallel experience for Ms. B. as an adult, in terms of proving her distress and helplessness to caregivers. It is likely that Ms. B.'s sense of helplessness and even "badness" as a child was reinforced when no one believed her story of abuse. Her chronic pain as an adult can be viewed as a means of communicating this psychological damage, only this time she felt compelled to "prove" the existence of her pain just as she had her childhood abuse experience so many years ago.

Ms. B. was successful in overcoming her childhood abuse to some extent by successfully completing high school and establishing a career with physical distance from her mother. She also made some supportive social connections. These were considered significant achievements for Ms. B. and representative of her strength as an individual that would serve as a foundation for future growth and change. Despite this, Ms. B. likely continued to suffer from the emotional and psychological effects from years of abuse. Ms. B. experienced some positive relationships which likely helped her overcome in part her childhood abuse, but they "...did not fully counteract the damaging effects," and "...presumably those effects were (only) modified..." (Roy, 1998, p. 56) rather than completely alleviated. Her immersion into the sick role, with its concurrent losses, likely triggered the emergence of feelings similar to that which she experienced when she was abused. These feelings of sadness, shame, guilt, and victimization were at the center of Ms. B.'s identity and reinforced the role of, and need for, physical pain in her life.

Ms. B.'s return to her abusive mother is a curious phenomenon, especially in light of her vulnerability to physical and emotional problems due to her chronic pain. Ms. B. explained the move home to her mother in terms of requiring financial support, yet her mother did not offer her much help in this regard. Ms. B.'s abuse as a child in part explains her return to this situation. Ms. B.'s developmental and social learning experiences were centered on physical and emotional abuse, which formed the foundation of her identity as a victim, inherent with low self esteem, anger, resentment, helplessness, fear, shame, and guilt (Roth & Batson, 1997). As an adult, Ms. B. was therefore likely ill equipped to effectively deal with her mounting chronic pain. This reinforced her victim role, but also gave new meaning and purpose to her chronic pain experience. From a systems/family role perspective, Ms. B. served as the scapegoat who was blamed, punished, and criticized for all things systemically dysfunctional and problematic. Her role as a chronic pain patient was intertwined with this family role, in that her sense of helplessness and sadness continued to be supported. Finally, in returning to her mother, it is possible Ms. B. hoped to receive love, support, or even approval from her mother, stemming back to her childhood abuse. Often children maintain a sense of loyalty to their abusive parents, and even look for ways to please them (Gelinas, 1993). Perhaps Ms. B. hoped her mother would accept her with love in light of her chronic pain. This wish was eliminated, as Ms. B.'s mother continued to mistreat her which only enhanced her feelings of victimization and helplessness.

Goals. Ms. B. completed the PDI and yielded a total score of 55/66 (one category worth a possible 11 points was removed). This was interpreted as Ms. B.'s pain having significant interference in almost all areas of her life. Though Ms. B. was introduced to the Client Self-Rating Scale on two occasions, she was not able to use this tool to identify treatment goals. However, Ms. B. did articulate the following hopes in doing therapy:

1. Develop pain management skills that would help her to deal with ongoing chronic pain and episodes of increased pain.

Though Ms. B. did not complete the Client Scale with respect to this goal, she rated her overall pain level as 6/10, with frequent increases to 8/10. She felt that any decrease in pain levels would represent progress in developing pain coping strategies.

2. Minimize the negative impact of Ms. B.'s childhood abuse on her functioning as an adult.

Ms. B. felt her abuse history prevented her from developing self esteem or confidence, and also impacted on her ability to form relationships. She was not able to assign a rating to this goal, in terms of present functioning versus desired functioning, nor was she able to assign benchmarks, or objective measures to evaluate progress in this area. However, given the gravity of Ms. B.'s childhood abuse, and the ongoing negative relationship with her mother, we agreed to work on this goal as it was considered important to her well being and potential therapeutic progress.

Intervention. A combination of therapeutic interventions was applied to Ms. B.'s case to help her achieve the identified goals. The main approaches were as follows:

1. A central focus on Ms. B.'s childhood abuse, in a therapeutically conducive environment. Her abuse was seen as an integral factor in her chronic pain experience that required exploration and intervention. Ms. B. was asked to recount her abuse experience, paying specific attention to her emotions, thoughts, and beliefs, both as a child and as a reflecting adult. The psychotherapy literature reports that the recounting and exploration of past abuse helps survivors to "…foster catharsis and abreaction to the trauma" (Sanderson, 1990 in Roy, 1998, p. 104). A crucial element of this therapeutic process

entailed the development of an empathic and trusting relationship with Ms. B. such that she would feel safe and secure in sharing this part of her past. "...a survivor is *permitted*, perhaps for the first time, to recognize and accept the intensity of painful feelings and self-defining constructs associated with the ...abuse..." (Roth & Batson, 1997, p. 48). This was a delicate aspect of therapy in light of Ms. B.'s past experience with caregivers, in particular social workers, not believing her story of abuse. Therefore, the traditional non-judgmental and supportive approach became even more significant in achieving a therapeutic alliance with Ms. B. to help her deal with her abuse. "To regard survivors with respect...requires that the therapist adopt, and communicate to the survivor, the notion that she is a worthy, agentic person" (Roth & Batson, 1997, p. 52).

2. Cognitive Behavioral therapy was primarily utilized to assist Ms. B. in developing pain management techniques. As in working with Mrs. A., in large part Catalano & Hardin's workbook (1996) served as a guide in this process. Ms. B. and I began reviewing the physiological stress response, followed by developing relaxation and imagery techniques she could utilize on a regular basis as well as in times of extreme pain. Though it was recommended to Ms. B. that she maintain a journal of her pain levels (see Appendix F), she did not feel this would be helpful and chose to abandon this exercise shortly after it was introduced. A Cognitive Behavioral approach was also applied when addressing Ms. B.'s low self-esteem, fueled by negative thoughts/self-talk that was grounded in years of abuse. Reality testing of the negative statements, followed by the identification of alternate, positive, and encouraging statements formed the main process in this aspect of therapy (Borcherdt, 1996; Catalano & Hardin, 1996).

3. Crisis Intervention and Problem Solving approaches were utilized at one point throughout the therapeutic process to address the escalating situation between Ms. B. and her mother. Ms. B. initially rejected suggestions by the clinic staff that she move out of her mother's home and away from the abusive relationship. However, as her home situation worsened, she eventually reached the decision to secure alternate living arrangements. Ms. B. presented in therapy in a "crisis" state, indicating her mother's behavior was becoming more abusive and dangerous. Therapy consisted of identifying temporary safety plans for Ms. B. until a longer-term residence was located for her, as well as exploring various resident options available to her. Ms. B. and I were eventually able to secure her a room in a local community residence. She moved out of her mother's home into her own place, though Ms. B. had to once again financially support herself as well as independently complete activities of daily living. In helping Ms. B. achieve this goal, a strong emphasis on her past achievements and strengths was required as "evidence" of her ability to overcome problems and be independent. This perspective was applied in conjunction with the cognitive behavioral approach described earlier in terms of assisting Ms. B. establish positive coping statements.

Results. Informal feedback was sought from Ms. B. throughout the course of therapy as a means of evaluating the helpfulness of therapy from the client's perspective. To obtain a formal/objective measure, Ms. B completed the following:

1. Ms. B. yielded a post-therapy PDI score of 44/66. Though ten points lower than her pre-therapy score of 55/66 and representative of some improvement, the post therapy score still reflected a moderate level of pain interference. Interestingly, Ms. B.

informally reported a rise in pain levels throughout the course of therapy despite the slight improvement suggested by the lower post-therapy PDI score. Clinically, Ms. B. presented as having greater pain interference than when initially staring therapy, yet her score on the PDI suggested otherwise. Possible explanations for this may include Ms. B. not accurately completing the PDI at post therapy, thus generating an inaccurate or misrepresentative score. Alternatively, the PDI may not have been the most suitable assessment tool to measure Ms. B.'s distress. Ms. B. continued to present in significant chronic pain, thus communicating her emotional pain, which is not automatically captured when measuring level of physical functioning. Her deeper problems from her childhood abuse may still have required addressing, therefore, she continued to communicate this with reports of high pain levels, when attending the clinic for treatment.

2. Ms. B. completed the CSQ-8 to measure her level of satisfaction with services received in therapy. Ms. B. yielded a score of 25/32, representing a moderate to high level of client satisfaction. Qualifying information included Ms. B. stating she found the therapy relationship supportive and understanding of her past and current problems. She indicated she would definitely refer a friend in need of similar help to this service.

3. Ms. B. did not complete the Client Self-Rating Scale at the outset or completion of therapy. In reviewing with her any change in pain levels, Ms. B. reported a constant level of 7/10, thus suggesting her pain levels, or ability to manage pain, remained

unchanged. With regard to her goal around abuse issues, Ms. B. was successful in removing herself from an immediately abusive situation with her mother, though she continued to suffer the long term psychological consequences of many years of abuse. In this respect, Ms. B.'s childhood abuse continued to play a negative role in her life.

Ms. B.'s history of childhood abuse introduced a key challenge in this case. Her chronic pain was viewed as a means of communicating to the world her helpless, powerless, and damaged identity. Her struggle with the clinic staff to prove the extent of her pain was felt to be reflective of her need to have others understand her emotional distress and sadness resulting from her mother's abuse. Though Ms. B. indicated a desire to address her abuse issues, often she attempted to refocus the therapy sessions away from this topic, thus making it difficult to explore her experience and resulting emotions.

At the conclusion of my practicum, Ms. B. requested to be transferred to another clinic therapist for further support. I felt Ms. B. required further therapeutic intervention, and followed through on her request. As a child, Ms. B. suffered much emotional and physical abuse, thus resulting in her having minimal self-esteem as an adult. Her ability to remove herself from her terrible living situation was seen as an accomplishment, though in many ways Ms. B.'s abuse and chronic pain remained intertwined to represent her struggle with sadness, helplessness, and a negative self-image. The treatment focused on helping Ms. B. manage her pain, but also to understand the pain resulting from her childhood abuse. Roy (1998) indicates that empirically, there appear to be "...a wide variety of treatment methods" and there is "...not much outcome research...to guide the therapist about the choice of treatment" (p. 125) for treating childhood abuse survivors.

Nevertheless, cases of past childhood abuse and adult chronic pain are seen in the medical and therapeutic setttings. Though further research is required in this area, "...pain clinic clinicians have to operate on the basis of the postulate that if abuse in some ways contributed to the formation of the pain, treating those issues may indeed be beneficial" (Roy, 1998, p. 141).

Client #3: Mrs. C.

Case description. Mrs. C. was originally referred to the pain clinic because of a knee injury several years earlier. This had more or less resolved itself at the time of being referred to me for therapy. More recently, she had incurred an injury to her dominant arm. The chosen course of treatment for her arm pain was medication. The doctors at the pain clinic had advised Mrs. C. that her condition would likely last to some degree for the rest of her life, but encouraged her to use her arm as much as possible.

Psychosocial information. Mrs. C.'s family had immigrated to Canada several years earlier. English being her second language, Mrs. C. had a limited educational background. A family friend, along with one of her brothers, sexually abused Mrs. C. as a young girl. When Mrs. C. initially disclosed this information to her parents, they did not believe her nor did they secure any type of help or support for her. Mrs. C.'s parents eventually accepted her story, but they remained unloving and critical of her, even once she became an adult.

Mrs. C. met her husband in Canada and they eventually married. Her parents were not supportive of her marriage, though they did accept their young grandchild. Mrs. C.

and her husband worked at the same company, in manual-laboring positions. Their relationship was very loving and supportive, though Mrs. C.'s childhood sexual abuse had a negative impact on her. As a patient at the pain clinic, Mrs. C. and her husband attended therapy sessions with a clinic therapist, in order to address her past abuse and minimize its effect on her as an individual and the marital relationship. The therapy was helpful to Mrs. C. in this regard and she and her husband enjoyed quite a few happy years together. Even when her arm became injured, Mrs. C. was able to cope with her pain, and relied extensively on her husband's support to do this.

When referred for therapy a second time, Mrs. C. was not working due to her arm problems. She was in receipt of insurance/disability benefits, and was being considered for a retraining program to return to work in a sedentary occupation. Additionally, Mrs. C.'s husband had recently become seriously ill to the point where he had to stop working. Mrs. C. described significant negative physical and emotional changes in her husband as a result of his health problems. Mr. C. was applying for disability benefits, but due to waiting periods, and Mrs. C.'s reduced insurance income, the family was facing financial strain.

Mrs. C. presented in therapy as extremely emotional and weepy. She was very sad, depressed, and overwhelmed with the impact of her husband's medical problems on her family situation. She often spoke of her failure as a wife and mother. Mrs. C. began to express an increase in pain symptoms, and regressed in her behavior and thinking patterns. This was most evident around the issue of her daughter's safety, which she constantly worried about in light of her own abuse experience as a child. She was terribly frightened that her own child would suffer the way she had, and at times did not want her daughter to attend play groups or daycare functions, and reported episodes of people watching or following her daughter. Mrs. C. had previously gained control of these worries when she underwent therapy years ago, but with the onset of her husband's illness, her coping mechanisms deteriorated to the point where she engaged in prior maladaptive behavior and thinking. Mrs. C.'s situation worsened over the several months we worked together, to the point of a suicide attempt, and resulting hospitalization. Mrs. C. was eventually discharged, and continued to follow up with a psychiatrist from an outpatient program, for monitoring of her medications. Mr. C.'s health continued to deteriorate during this time and Mrs. C.'s mental health remained vulnerable and fragile.

Case formulation. Mrs. C.'s case demonstrates a chronic pain patient's relapse into depression and crisis as a result of spousal illness and decreased family (social) support. "It is now generally accepted and is supported by research literature, that social support acts as a buffer against the vicissitudes of life.... In simple terms, intimate and reciprocal relationships seemingly have the power of protecting individuals from succumbing to illness, or, coping with it more effectively" (Roy, 2001, p. 87). DiMatteo and Hays (1981) indicate that "...research suggests that social support may in fact, be associated with recovery, and coping with serious physical illness and injury" (p. 121). Mrs. C.'s chronic pain undoubtedly resulted in loss and grief for her. However, it was her husband's love and support, and Mrs. C.'s value of this relationship that enabled her to endure her chronic pain and past abuse. Her husband functioned not only as her own micro-support system, but also her entire social support network. Mr. C.'s sudden serious (and somewhat uncertain) illness radically changed Mrs. C.'s assumptive world and robbed her of her only source of emotional support, causing a return to former, unhealthy coping behavior of crisis proportions.

Three levels, or elements of social support, are identified in the literature, including perceived social support, supportive relationships, and supportive networks (Pierce, Sarason, & Sarason, 1996). Other than her husband and family, Mrs. C. did not possess any other supportive relationships (not including therapeutic), nor was she a part of any larger social network that could provide her with resources. All three aspects of social support were drawn from her relationship with her husband. The significant and negative impact of Mr. C's illness eliminated any source of coping and support for Mrs. C. The onset of Mr. C.'s medical problems was a pivotal life event that caused serious demise to Mrs. C's "...physical and mental health" (Eckenrode & Gore, 1981, p. 43), erupting any prior sense of control or autonomy she may have experienced.

Mrs. C.'s declining mental health eventually resulted in suicidal ideation and behavior. Suicide is a serious problem and source of death amongst individuals in North America, and is pre-empted by a crisis situation. Hoff (2001) defines crisis as "...an acute emotional upset arising from situational, developmental, or socio-cultural sources and resulting in a temporary inability to cope by means of one's usual problem-solving devices" (p.4). Mrs. C.'s crisis and suicide attempt were not disproportionate to the problems she was experiencing in light of this definition. Her husband's sudden deteriorating health and uncertain diagnosis caused a crisis for Mrs. C. that challenged any previously employed positive coping strategies. Suicide eventually became an option for Mrs. C. to escape the plight her husband's illness had bestowed on their life situation.

Goals. Mrs. C. completed the PDI to obtain a measure of the degree of pain interference in her life. She obtained an overall score of 44/66 (one category worth a potential 11 points was removed). Mrs. C's score represented moderate to high levels of pain interference in almost all aspects of her life. The Client Self Rating Scale was not considered an appropriate instrument to use in light of the pressing crisis issues and suicidal ideation. The uncertainty around Mr. C's illness and Mrs. C.'s regression into depression complicated this case beyond teaching pain coping methods. Serious situational factors were involved; leaving Mrs. C. feeling helpless and unable to cope. Given this, therapy with Mrs. C. was quite different from other cases, which is articulated in the following goals/tenets:

1. Develop coping strategies and safety contracts specific to crisis situations and suicidal ideation.

   This goal was aimed at addressing Mrs. C.'s thoughts leading up to her suicide attempt and the ideation that persisted, though to a lesser degree, thereafter given the ongoing crisis situation at home. Part of this goal included identifying social supports that could be a resource to Mrs. C.

2. Identify ways in which Mrs. C. could be most helpful and supportive to her husband, with respect to his health problems.

   Mrs. C. felt she had failed in this life role, due to her arm pain that prevented her from completing extra household chores on behalf of her husband. This goal entailed assisting Mrs. C. in recognizing the ways she could fulfill her role as wife/mother by providing emotional support to her husband, including maintaining her own emotional stability.

3. Maintain current (productive) pain management techniques and eliminate maladaptive patterns that recently resurfaced when her husband became ill. Mrs. C. had been living with chronic arm pain for some time, and had been employing various coping methods on a daily basis, whether she acknowledged this or not. This goal entailed identifying those methods that were most helpful, and ensuring Mrs. C. continued to apply them in her difficult situation. Additionally, recognizing her regression into former, unhealthy coping behavior, a related focus was to address this behavior and minimize, or where possible, eliminate it altogether.

Intervention. Given the complexity of Mrs. C.'s situation, a multi-modal approach to therapy was required to address the presenting issues. The main approaches were:

1. In light of Mrs. C.'s very complex and chronic life situation, a general, supportive approach was required aimed at stabilizing her mental health such that hospitalization was no longer required. The therapy sessions served as a platform for Mrs. C. to discuss her husband's health problems, specifically her fears and grief around the losses related to his illness. Though it remained unclear the exact nature of Mr. C.'s condition, it was evident that he was deteriorating and Mrs. C. was dealing with significant stress and anxiety related to this issue. The clinical setting was an arena for Mrs. C. to vent her worries and frustrations not only about her own chronic pain, but also her spouse's condition. In doing this, and by reaffirming her strength, it was hoped Mrs. C. would be

able to cope with her stressful situation at a level where she maintained her role as mother and as a supportive spouse to her husband. A final aspect entailed recognizing the social isolation experienced by Mrs. C. and exploring community supports, such as groups available through her local church or community centre. Mrs. C. eventually secured the assistance of her sister to help with housework and meals, which indirectly increased her element of social/family support, albeit to a lesser degree than she previously shared with her husband. Mrs. C. was encouraged to join a community group, to create a network of support and friends that could help her cope with her very difficult situation.

2. A Cognitive Behavioral approach was utilized with Mrs. C. to achieve various tasks. First, Mrs. C. and I explored those techniques that she used which were successful in helping her to manage her chronic pain and anxiety. Mrs. C. regularly applied deep breathing and rehearsed encouraging/coping statements to help her through a pain episode or time of significant stress. Mrs. C. was encouraged to continue those methods that were most helpful to her. In keeping with the tenets of social work practice and the cognitive model, I continually reinforced Mrs. C.'s past accomplishments to challenge her negative thoughts about failing in her role as wife and mother. Mrs. C. had overcome many difficulties in her life, and in continually pointing this out to her, her negative and damaging thoughts were alleviated to some degree. Mrs. C. was asked to complete homework assignments wherein she was required to list/identify past successes and current traits that defined her as a good person/mother, as a means of counteracting her negative thought patterns.

3. Crisis Intervention was employed when Mrs. C. presented in significant distress, and in particular, when she revealed her suicide attempt. A risk assessment was immediately completed in terms of exploring with Mrs. C. the events leading up to her attempt, factors that prevented suicide completion, ongoing suicidal ideation, available resources, and safety plans/contracts. Mrs. C.'s ambivalence towards suicide and her adherence to contracting were reinforced throughout this process in order to counteract her ongoing suicidal ideation (Aguilera, 1990; Hoff, 2001). Mrs. C.'s husband was involved with the safety contract and ongoing risk assessment. Eventually, Mrs. C. was taken to the hospital by her husband, and was admitted for psychiatric care.

Mrs. C. was discharged after several weeks, and continued with weekly therapy sessions. Though she met with a psychiatrist from a local day program, Mrs. C. had not been accepted into the day program itself, and required ongoing monitoring and support from a therapeutic perspective. Hoff (2001) emphasizes that crisis should be viewed as an opportunity for change and growth for a client. In this respect, Mrs. C. and I worked on reinforcing her strength as an individual, and increasing her confidence in her ability to raise her daughter and support her ailing husband.

Results. Mrs. C.'s situation, inherent with suicide ideation and an attempt, was subject to ongoing monitoring and informal assessment to ensure appropriate interventions were implemented. Mrs. C. did not complete the PDI a second time, nor did she complete the CSQ-8. In large part, this was due to her chronic situation that required very close monitoring and immediate transition to another therapist upon the completion of my practicum.

It is likely that Mrs. C.'s second PDI score would have been consistent, or possibly even higher, than her pre-therapy score in light of her chronic and stressful situation. Though Mrs. C. did not formally identify, or evaluate therapy goals, she did accomplish the following:

1. Despite her suicide attempt, Mrs. C.'s depression improved from the level that had originally landed her in the hospital. She did resume some tasks as a wife and mother.

2. Mrs. C. began to provide some emotional support to her husband, despite her fears about his prognosis. In spite of her physical limitations, Mrs. C. continued to care for her daughter, with newly secured assistance from her sister in completing major household tasks.

In summary, Mrs. C.'s overall situation did not change much from when she first began therapy, in that her husband's health continued to fail and she continued to deal with depression. It was expected that Mrs. C would require long-term therapeutic support due to the bleak and chronic reality she faced. Though she was struggling with her own medical issues, the onset of her husband's illness was considered the most significant and contributory factor in Mrs. C.'s ongoing crisis and emotional struggles. With no reprieve in sight for Mrs. C., it is likely that all her problems cannot be addressed in therapy. However, therapy does have a role to play by mobilizing social support for Mrs. C, monitoring her very fragile mental health status, and controlling her regression into prior unhealthy coping methods. Were it not for her husband's illness, Mrs. C. would likely have not required therapy a second time. Because her husband's health continued to deteriorate, Mrs. C.'s problems escalated to a level requiring continual therapeutic and psychiatric intervention.

Case #4: Ms. D.

Case description. Ms. D., a young woman in her early twenties, was suffering with an abdominal condition that resulted in significant chronic pain. Ms. D. had two other longstanding health problems; however these were well controlled with medications and diet adherence. Diagnosing Ms. D.'s most recent medical condition took almost two years and involved several visits to other medical centres. When referred for therapy, Ms. D. was being treated with medication and nerve block injections.

Psychosocial information. Ms. D.'s first medical issue emerged when she was a young girl, yet she immediately took on a large role in managing her medication and treatment. Ms. D.'s second condition was diagnosed when she was a teenager, yet she maintained her school and extra curricular activities. Ms. D. was a successful student and was awarded scholarships to attend post-secondary training, based on her grades as well as her volunteer activities. Despite her many medical problems, she continued to be involved with clubs, and traveled extensively with one of them. Ms. D. advised that despite her health problems, she had a "normal" childhood and adolescence.

Ms. D. was in a long-term relationship with a young man, with whom she had plans for the future. He was a significant source of strength and support for her. Ms. D. lived with her parents and one younger sibling. She described her family as supportive and helpful, though the pain clinic staff witnessed many conflicts between Ms. D. and her mother. She regarded her relationship with her father as "normal", but struggled to define the one she shared with her mother. Ms. D. indicated that recently her mother was becoming more controlling of her, which resulted in frequent conflict and arguments. Ms. D. acknowledged that her mother was concerned about her well being, in light of her medical status. However, Ms. D. also resented her mother's actions and behavior toward her. Ms. D believed that some relationship existed between her pain levels and the problems with her mother.

Ms. D. expressed fears related to her pain that centered on potential scholastic failure and loss of scholarships and long term career goals. At the time of being referred for therapy, Ms. D. was enrolled in a university program. However, this was her second and last attempt, in being funded by scholarships through school. She experienced poor concentration and extreme fatigue from her medication, which also threatened her ability to attend classes and maintain a rigorous schedule. The year prior, Ms. D. had to withdraw entirely from her school program due to her medical problems and chronic pain. Because of her disappointment and ongoing problems, Ms. D. began to struggle with thoughts of self-harm.

Case formulation. Ms. D. is an example of how loss of autonomy/mastery in one's life due to chronic pain can manifest itself in relationship conflict and breakdown.

In reviewing Ms. D.'s situation, it is important to consider her other medical problems that were present early on in her life. Though Ms. D. recounted a "normal" experience as a child and teenager, despite her medical issues, it is likely she missed or altered her activities to a certain degree. In Ms. D.'s opinion though, she had a regular childhood and adolescence. By traditional markers, such as successful completion of high school and participation in various hobbies/activities, Ms. D's opinion was reinforced. Winning a scholarship was especially significant to Ms. D.'s progress in life despite her medical setbacks. The fact is Ms. D. achieved many goals and life benchmarks, which confirmed her belief that her life progress and development should not be altered by her health status.

Ms. D. maintained her expectations for achievement and progress despite her more serious and recent abdominal problem which brought her to the pain clinic. However, this condition imposed greater pain and limitation on her than she had previously experienced, and seriously threatened her ability to continue functioning at her desired level. Ms. D. strongly identified with being a successful student, which functioned as her career given her stage in life. Her confidence, self-esteem, and autonomy were directly linked to this aspect of her life. When her academic performance began to decline, and her future vocational goals were threatened, her sense of control and life mastery seriously deteriorated. Her current and future identities were threatened to a significant degree.

As a result of her chronic pain, Ms. D. struggled with many (drastic) life changes, including:

1. Decreased overall physical activity.
2. Decreased academic activity, and poorer performance.
3. Potential loss of scholarships and long term academic/vocational goals.
4. Decreased social activity.

5. Decreased extra-curricular activity.
6. Increased conflict and interpersonal problems with her mother.

Her mother tried to help Ms. D. cope with her health problems, which Ms. D. resented on many occasions. The help and assistance offered by her mother may have been entirely appropriate in light of Ms. D.'s pain levels, medication side effects, and overall situation. Unfortunately, Ms. D.'s lack of autonomy or control due to her chronic pain may have been reinforced when her mother continually helped her, despite the fact that she often needed it. Her mother's help was a reminder of her functional limitations, and many losses brought on by her medical condition.

Because her mother's help was very difficult for Ms. D. to accept, she rejected her mother altogether, and thus conflict and arguments ensued. These relationship problems were considered reflective of Ms. D.'s denial of, and internal struggle to acknowledge her medical issues and modify her life as required. It was also possible that due to Ms. D.'s many problems, her parents, more specifically her mother, became increasingly protective out of worry and concern. This would have compounded the problems further, creating further struggle for autonomy on Ms. D.'s part. It should be noted that because Ms. D. was never seen in therapy with any of her family members, particularly her mother, it was difficult to ascertain the exact nature of Ms. D. and her mother's interaction. This also meant that Ms. D.'s report was relied on for information about her and her mother's relationship.

Another important aspect of Ms. D's conflict with her mother was related to her development into an adult, wherein she was becoming more independent and self-reliant. In many families, this normal process can elicit disruption, and even conflict, amongst the family members, especially parent and child (Nichols & Schwartz, 1998). The homeostasis and balance in the family system was likely interrupted in this regard even without the influence of Ms. D.'s chronic pain condition. Subsequently, Ms. D's mother may in part have been responding to her daughter's assertion for independence, in addition to having concern for her health status. Moreover, Ms. D's progress in this developmental process was challenged because of her chronic pain, which actually made her less independent and autonomous. Therefore, the issues between Ms. D. and her mother were complex; including Ms. D.'s assertion for independence, her mother's adjustment to this, and Ms. D.'s chronic pain condition that left her without a sense of mastery and being dependent on others.

Goals. Ms. D. completed the PDI to obtain a pre-therapy measure of the degree of interference by her chronic pain in various aspects of her life. Her total score was 40/77, thus suggesting a moderate degree of pain interference. Areas of occupation, family responsibilities, and recreation received the highest ratings for pain impact. In reviewing the PDI as well as her overall situation, the following therapy goals were identified with Ms. D.:

1. Improve Ms. D.'s ability to handle stress as related to pain episodes and academic assignments.

   Ms. D.'s focus was academic success; therefore, her pain levels were known to flare when she was under stress related to this aspect of her life. Ms. D. experienced situations of anxiety and moodiness when under school induced pressure. On the Client Self-Rating Scale, Ms. D. rated her pre-therapy level of functioning/achievement in this area as 4/10, with a desire to improve this to 7/10. Success was defined as fewer anxiety-ridden feelings, especially when taking an exam or studying.

2. Experience fewer arguments with her mother.

   Though Ms. D. did not place as much value on this as the first goal, she acknowledged the distress from her conflict with her mother. She wanted to improve their relationship and decrease the arguing and conflict between them. On the Client Self-Rating Scale, Ms. D. identified a pre-therapy level of achievement in this area as 4/10, with a desire to increase this to 8/10 by the completion of therapy.

Intervention. In order to address Ms. D.'s presenting issues in therapy, and help her to achieve her goals, a multi-modal approach was implemented. This consisted of the following:

1. Cognitive Behavioral therapy was performed with Ms. D. relative to helping her develop pain and stress management skills. Ms. D. agreed to keep a pain diary/log (see Appendix F) which helped her identify trends in her pain levels based on various situations or activities. Ms. D. and I explored various relaxation strategies including deep breathing, which she performed on a regular basis and before exams. Ms. D. was provided with information from The Chronic Pain Control Workbook (Catalano & Hardin, 1996) in order to understand her chronic pain situation more fully and learn various coping techniques.

Cognitive strategies were employed with Ms. D. to address her tendency to engage in self-defeating thought processes, such as catastrophizing and rigid thinking. The literature identifies negative self-talk as being extremely damaging to a person's self esteem and emotional well being, and therefore requires attention in the therapeutic process (Peake et al., 2000). In this regard, Ms. D. was directed to identify her most common negative statements and develop alternative, positive, and encouraging ones to replace them. Ms. D. often engaged in damaging self-talk when writing exams or under academic stress, which undermined her potential for success and achievement. In this regard, situation specific cognitive strategies were developed with Ms. D. to address the symptoms associated with her most troubling situations. Ms. D. was encouraged to use both her relaxation techniques as well as positive self talk to cope with pain and/or stress.

2. A Problem Solving approach was used when working with Ms. D. on improving her relationship with her mother. The literature cites the following steps to form the traditional problem solving model:

- General orientation about the model and how it can be effective.
- Defining the problem.
- Brainstorm potential solutions.
- Systematic evaluation of potential solutions.
- Confirm and test out solution to determine if further alternatives are required. (Peake et al., 2000).

Ms. D. and I examined the various ways she had chosen to deal with her mother in the past and what consequences resulted from this. She then was able to develop a plan or strategy to interact with her mother when she would become annoyed, in order to yield a more desirable result. After employing a certain plan with her mother, Ms. D. and I would review the outcome to refine and modify her plan for the future. A recommendation was made to Ms. D. that family therapy be sought to more comprehensively address the problems that existed between her and her mother, however Ms. D. resisted this offer.

In working with Ms. D. on defining the problem between her and her mother, Ms. D.'s own internal struggle with her pain and lack of control were explored. As indicated in the case formulation, part of Ms. D.'s issues with her mother were considered reflective of her own issues related to the loss and limitations brought on by her chronic pain. In probing this issue further with Ms. D., it was hoped that some discussion could take place around her struggle to regain some sense of mastery in her life and her tendency to do this by defying her mother. By doing this, she may have better understood her pattern of interaction with her mother, or perhaps others, when issues of control or autonomy were involved. This therapeutic process may have helped to alleviate some of the conflict in the daughter-mother relationship, in conjunction with the problem solving approach used to help Ms. D. develop more favorable interaction methods with her mother. Unfortunately, Ms. D. and I did not have an opportunity to conduct a thorough exploration of her own struggles, primarily because of the need to address more immediate situations in each therapy session, such as panic attacks or upcoming exams.

Ms. D.'s suicidal ideation became evident at a time when she was hospitalized for medical reasons. This situation allowed for a psychiatric consultation and assessment of

Ms. D. by hospital staff. This issue did not require direct addressing in the pain clinic setting, as any immediate concerns were dealt with during Ms. D.'s hospital stay. It was eventually determined that Ms.D. was at a very low risk for self-harm and ongoing psychiatric care was not required.

Results. After her hospitalization, Ms. D. did not return for therapy due to academic demands and increased pain. It was also nearing the completion of my practicum at the clinic. Therefore, Ms. D. was unfortunately unavailable to complete the PDI a second time, and complete the CSQ-8. In reviewing this case, the following goals were found to be achieved by Ms. D.:

1. Development of a relaxation strategy that was found helpful when Ms. D. was enduring increased pain or academic stress. Ms. D. reported to me on a few occasions that deep breathing helped to calm her anxiety and reduce feelings of panic.

2. Identification of positive coping statements to be employed when in stressful situations. Ms. D. engaged very well in the cognitive process around identifying her damaging thoughts and developing alternative positive ones. At time, she struggled with defaulting to her negative, catastrophizing ones when under stress.

3. Some improvement occurred in the relationship with her mother, based on Ms. D.'s own reports in therapy. However, due to the inability to see Ms. D. and her mother together, a true picture of the situation was not obtained. This problem was dealt with from an individual therapy perspective only.

At the conclusion of my practicum, I recommended that Ms. D. be considered for future therapy services, should she indicate a desire to pursue this again. Ms. D. was undeniably an intelligent and potentially successful young woman who was plagued with a chronic and painful health problem. This problem threatened her ability to fulfill many academic, career, and personal goals. Ms. D.'s illness caused a loss of control in many aspects of her life, as is very common in chronic pain clients. Ms. D. engaged in conflict and negative interaction with her mother, which was considered in some way to be related to her struggle to accept her new identity as a person living with chronic pain. Ms. D. embraced many of the pain management strategies and applied them in everyday life with encouraging results. However, Ms. D.'s struggle with her mother continued and her life goals remained uncertain in light of her ongoing medical problems and the evolving psychiatric complications that were revealed when she was in the hospital for medical treatment.

Additional Cases: Clients #5, 6, 7

In addition to the four cases discussed, I worked with three additional clients. All three clients did not provide consent to have their cases or therapy results included in the practicum report and therefore they will not be presented. It will be noted that all three suffered with chronic pain, and one was additionally dealing with significant loss/grief due to the sudden death of a life partner. Though part of my practicum was dedicated to working with these three clients, and their cases were regularly reviewed with Professor Roy, they will not be discussed here in any detail. This completes the case discussion chapter of the report.

Discussion

Themes

Though each case has been reviewed individually to appreciate their respective characteristics, some themes will now be discussed with regard to issues faced by clients, and the manner in which these issues were addressed in therapy. A brief overview will now take place regarding the more prominent themes that emerged during my practical experience at the pain clinic.

Grief/loss of roles. The preceding case reviews noted the many levels on which chronic pain clients experienced loss and associated grief due to their medical problems. Chronic immersion into the sick/patient role, loss of occupational role, and significant change in marital/family roles were all characteristics of each case. Golden and Steiner (1981) reinforce the task of acknowledging grief and loss due to a chronic pain condition as a fundamental part of the therapeutic process. As seen in each of the individual cases, several adult roles were afflicted by chronic pain in terms of loss and deterioration of self-identity.

Many clients struggled with grief from losses induced by their chronic pain and health problems. In therapy, any discussion around loss of roles was carried out in a empathic, yet pragmatic fashion as a means of assisting clients in developing a sense of reality of their respective situations while allowing an opportunity to grieve the associated losses. This was an issue that arose time and time again in therapy, and required due attention and exploration. A key feature in discussing grief around chronic pain was also to emphasize to clients the continual process of accepting their limitations and modifying their activities depending on each situation they faced.

Equally important as acknowledging role loss/change relating to chronic pain, was the task of assisting clients in identifying those roles they were able to still fulfill/accomplish. Once identified, the reinforcement of these abilities and role continuities was central in working with clients to identify and achieve treatment goals. This approach incorporated a strengths perspective, inherent to social work practice, and key to validating and supporting the client. The literature on working with chronic pain clients supports this as being integral to therapeutic gains, by increasing the client's existing sense of control and autonomy, reinforcing a positive self-identity, and allowing for growth and change (Stalker et. al., 1996). I found myself continually asking clients to identify things/tasks they were still able to perform, or provide examples of situations wherein their chronic pain did not have a negative impact. The purpose of this was to assist clients in seeing their existing ability to control their pain and also identify aspects of their lives that were unchanged because of the pain. In doing this, it seemed clients were able to understand more fully the complexity of their situations and the many factors affecting their pain levels, through their own assessment and observation.

To assist clients in dealing with family roles and functions most affected by their chronic pain, a similar approach was incorporated as described in the preceding paragraph in terms of reinforcing existing connections and aspects of various relationships. Emphasis was given to ways in which a particular relationship could still function, despite the client's chronic pain, as a means of increasing family and social support, as well as the client's self-esteem. Clients were also exposed to the idea that relationship issues were a result of, as well as a potential factor in, the experience of chronic pain. This was to appreciate the complex psychosocial phenomenon of chronic pain as well as the need for positive family and social support (Roy, 2001).

Clients identified difficulties in sharing thoughts and feelings about their chronic pain with spouses or family members, which increased social isolation and feelings of depression. Attempts were made, where necessary, to carry out sessions with family members, in keeping with an individual therapy approach, to gain a better understanding of relationship dynamics and to educate the family member(s) on the client's chronic pain and psychosocial issues. In some cases, recommendations were made to clients to consider concurrent family and/or marital therapy due to the limits of individual therapy in comprehensively addressing relationship issues. Largely a Problem Solving approach was implemented to develop appropriate plans for improved interaction with various members of clients' environments (Hudson-Allez, 1997).

Control/autonomy. Building on the losses described earlier that were experienced by many of the clients, it followed that an overall loss of mastery and control permeated every aspect of their situations. First and foremost, many clients endured a loss of control around their physical functioning and ability to manage increasing pain levels. Second, the medical treatment sought and received through the pain clinic often did not alleviate their symptoms to any significant degree. In cases where there were minimal medical findings to support the level of pain experienced by the client, or where no alternative treatments were available, the client's feelings of helplessness reached significant proportions. Many of the cases involved the introduction of cognitive behavioral pain management strategies to decrease the influence of chronic pain in various life situations. The Chronic Pain Control Workbook (Catalono & Hardin, 1996) was instrumental in explaining the stress response to clients, the importance of identifying variation in pain levels, the development of relaxation techniques, and facilitating cognitive restructuring to elicit positive coping thoughts and feelings within clients. The majority of clients were able to identify situations in which their pain did not control or circumvent their participation, which served as a foundation to explore their coping techniques that had proved somewhat successful. Additionally, clients employed deep breathing, imagery, and muscle relaxation to counteract the effects of pain episodes as well as to foster an overall decrease in their chronic pain. Client feedback indicated these strategies were helpful in "gaining control" and decreasing stress levels.

Along with experiencing no control over pain levels, clients often reported their emotions as "being out of control" or unmanageable. Depressive symptoms such as sadness and isolation were found to be present in many of the cases. A measure aimed at improving clients' ability to manage their emotions and thoughts entailed cognitive restructuring. For example, often a client would report success in fulfilling a behavioral goal (such as cleaning the house), but would not experience any satisfaction or positive feelings about this. Further exploration would often reveal negative thinking, self-defeating statements, and cognitive processes that produced feelings of sadness, failure, and hopelessness for the client. Thus, negative thoughts that centered on their inability and loss, rather than ability and accomplishment, produced negative feelings and emotions. Strategies to invoke cognitive restructuring were applied, including helping the clients to identify various thought processes, their potential consequences, and alternate, positive coping statements (Catalano & Hardin, 1996; Hudson-Allez, 1997). Clients reported this to be one of the most difficult processes as each new situation brought reminders of loss, and any related grief, about their pain. This in turn had the potential to yield negative thoughts and feelings about the need to modify goals to reflect their current levels of functioning. Because there was always a tendency for clients to compare their present performance with that which took place before their chronic pain developed, the loss of their situation would be reinforced and accompanying depressive thoughts and feelings would flourish.

Continual efforts were made in therapy, and in homework assignments, to assist clients in employing cognitive strategies to increase self-esteem and positive feelings. Clinical observation suggested that when clients set realistic goals, employed relaxation techniques, and were able to engage in positive, helpful coping statements, they presented in a less helpless and deteriorating fashion. The reinforcement of choices, decisions, and the ability to control thoughts and feelings underscored the therapeutic setting, though clients often struggled with these ideas, in light of their pain levels and associated losses.

Challenges

In completing this practicum over an eight-month period, some challenges and difficulties associated with various aspects of the placement came to light. Each will be reviewed in conjunction with some recommendations or suggestions, based on my experience as well as information found in the literature.

Pain clinic setting. The pain clinic where I completed the practicum is primarily a medical clinic, run by anesthesiologists who act as the patients' primary care physicians in this setting. In this regard, treatment is comprised of medical intervention, with the physicians largely viewing patients' chronic pain in terms of their own training and knowledge. This was especially true in situations where the client's pain did not match up with the medical findings/evidence. However, the clinic doctors demonstrated an ability to recognize when a psychological/social assessment was warranted for patients, and thus triaged them to other disciplines. In this regard, they appeared to appreciate the need for a comprehensive psychosocial assessment in many cases.

In addition to the impact the medical setting had on the view/assessment of chronic pain patients, it also influenced the perceived role of therapy in treating the chronic pain, specifically from a client perspective. Because the clients were patients in a medical clinic, where treatment was primarily of this form, they may have often viewed therapy as a secondary or supportive resource rather than a primary intervention to help them deal with their pain. Though this was not true in all client situations, my experience did include working with clients who perceived missing therapy appointments as insignificant, though these individuals would never consider canceling appointments with their clinic doctor or one of the staff nurses to discuss their medical treatment. If the clinic were truly multidisciplinary in nature, regularly involving various disciplines such as medicine, social work, psychology, physiotherapy, and occupational therapy, clients might appreciate the psychosocial aspects of their pain to a greater degree, as well as the need for a treatment plan involving many forms of intervention.

As reported in chapter one, the literature reinforces the psychosocial concept/model of chronic pain. "A pain clinic should recognize the complexity of chronic pain…" and thereby offer "…a comprehensive therapeutic program, combining medical and psychosocial methods…" (Catalano & Hardin, 1996, p. 106). In doing this, a collaborative approach can be implemented which assists clients in viewing their pain as having many contributing factors, which can only be treated with multi-modal methods and supports (Hudson-Allez, 1997). Again, the profession of social work is a valuable resource in the treatment of chronic pain given our training in an ecological/psychosocial model. However, a program must reflect this model in terms of assessment and treatment in order for it to yield the greatest results, by addressing all aspects of the chronic pain experience.

Data collection. There were some challenges in collecting data from clients in this setting. The first challenge involved incomplete questionnaire packages. Two clients did not agree to complete the questionnaire package, and therefore no measures were obtained on these two cases. Additionally, for the clients that did complete the pre-therapy measures, other factors, such as medical issues, interfered with my ability to obtain post-therapy measures from some of them. This prevented the comparison of client functioning, with respect to pain issues, before and after therapy, and therefore the evaluation of the potential effectiveness of the intervention was not possible from a more research based perspective. Though client feedback and my own assessment of observed change in the client's situation assisted in the evaluation process, the absence of objective information significantly affects the type of conclusions that can be made with regard to results and treatment success.

In applying the cognitive behavioral model, clients were asked to journal or keep a diary of their pain levels in order to gather information around pain trends and situational factors. Many clients resisted following through on this request, stating that they did not have the time or energy to record their pain levels and felt they knew when their pain was at its worst. The chronic pain literature points out various advantages to having clients keep journals; however, it also recognizes the challenge in getting clients to recognize the potential benefits. Some authors suggest that the act of recording pain can interfere with a pain coping mechanism, specifically avoidance/distraction because it forces the client to focus on their pain in a detailed fashion (Tennen & Affleck, 1996). Conversely though, it can also help clients to recognize times when they have lower pain, thus reinforcing their ability to control pain to a certain degree, as well as identify patterns or trends in their pain levels. In my practicum, I provided a pre-constructed log to the clients to prevent them from having to organize the journal themselves. However, it may have been that the log did not allow for capturing of necessary information (from the client's perspective) or seemed too overwhelming. The issues recognized in the literature may have also been present, but clients did not articulate them to me. Overall, minimal objective data was gathered for clients' pain levels during the placement.

A final difficulty I encountered included identifying an appropriate measure to capture treatment effectiveness in light of the presenting problem of chronic pain. Many measures are referenced in the literature, with much support for the PDI in terms of measuring pain influence over aspects of daily living. Measuring for pain influence would seem correlated to typical treatment goals and overall success. However, situations occurred where a PDI score remained relatively unchanged, yet scores of the CSQ-8 suggested client satisfaction and perceived benefit from therapy. In these cases, the scores in isolation of each other represent two very different conclusions. Taken together, one might wonder in what way the client was satisfied, especially if PDI scores suggested their level of functioning remained low because of high pain levels. If the CSQ-8 scores are assumed to be valid, the role of therapy with this presenting problem requires evaluation. Given the therapy goals of improving clients' functioning and their ability to manage pain, it would be expected that lower scores on the PDI, taken at post-therapy incidents would reflect this change. Given this was not the case, though one client's scores on the PDI did decrease somewhat, how is it that clients' scores on the CSQ-8 suggested client satisfaction? There are several possible answers here. One is that the CSQ-8 scores were not valid, and perhaps biased to avoid disappointing me as a student therapist. Another possibility is that clients were looking for other results from therapy other than those identified around physical functioning. This brings into question the value of the therapist's support, validation and empathy as perceived by the client in relation to treatment effectiveness. Finally, in light of the chronic medical problems many of these clients were facing, utilizing a measure that assessed physical functioning may have been inappropriate due to the chronic nature of their situations. The important issue appears to be that evaluation should include a combination of therapist observations, client feedback, more than one objective measure, and feedback from other clinic staff.

Limits of therapy. Individual brief therapy is supported in the literature as an appropriate method for treating chronic pain. Benefits specific to this intervention include helping a client learn pain management techniques, address the grief and loss associated with the chronic pain's impact on his/her life roles, and resume/modify affected life roles to minimize the deterioration of relationships with other systems.
In spite of this, one cannot ignore the need in many cases for family or marital therapy as an intervention. In light of the psychosocial view of chronic pain, the role of family therapy in addressing relationship and family system issues is likely the better method to improve this aspect of the chronic pain experience.

Relationship/family issues not only arise out of the chronic pain problems, but also can affect the client's ability to manage pain (Catalano & Hardin, 1996). In this regard, therapy with a chronic pain client and their partners/family members may prove beneficial in terms of educating the family, changing negative relationship issues, and facilitating increased support in the client's personal and natural environment. "Incorporating the spouse and other solicitous family members into the treatment regimen may prove helpful…and increase the likelihood that positive treatment effects are maintained and generalized outside and beyond the treatment context" (Katz, Ritvo, Irvine, & Jackson, 1996, p. 265-6). Because of the benefits associated with individual therapy and family/marital intervention, the administration of both would likely be required throughout a treatment process, depending on a client's individual circumstances. This would enhance the multidisciplinary approach required when treating chronic pain clients, from both a social work/therapy perspective as well as global treatment process.

Personal and Professional Development

Knowledge acquisition of problem area. Completing this practicum allowed me the opportunity to acquire knowledge and develop further skills in the areas of social work practice and therapy. First and foremost, I learned about chronic pain from a medical perspective, and the various treatments offered through pain clinic centres. In completing a comprehensive literature review for this report, I was able to learn about the etiology of chronic pain, the importance of viewing if from a psychosocial perspective, as well as its effects on the individual, family, and society. The literature reports generalities or common features associated with this specific client population. I found that the literature findings were reinforced in the clinical setting in terms of issues around autonomy, role change/loss, and psychological effects from chronic pain. These tended to be present in each case to varying degrees.

Despite the commonalties found in this client population, working with individual clients enabled me to observe firsthand the uniqueness of each situation. Though all clients shared the plight of chronic pain, which enabled their treatment through the pain clinic, their situations still contrasted against one another. Thus, it was very important to avoid making assumptions regarding therapeutic issues and applying them to all situations. In this regard, the heterogeneous quality of this client population was respected and considered. Though it appears that general themes characterize the chronic pain population from a psychosocial perspective, each case remains unique and presents specific issues in the therapeutic setting. A psychosocial model was required for each assessment and intervention, in order to ensure the client's relevant issues were considered.

Development of assessment skills. "Chronic pain is influenced by your environment.... chronic pain can be affected adversely or positively by your family, your job, and your world in general" (Catalano & Hardin, 1996, p. 14). This statement reinforces the need to assess each client situation with a traditional person-environment perspective that serves as the unique quality of social work practice. In applying the traditional ecological model to my cases, I was able to better understand the impact of the chronic pain experience with respect to a person's life roles. By examining the many ways in which a person had lost roles altogether, decreased specific roles, or assumed new and unwanted roles, the many ways in which the chronic pain affected a client's life situation was demonstrated. It also served to understand the client's overall decrease in autonomy and control. It was evident that in every case, the client was dislocated from many roles, thus making their chronic pain a psychosocial experience.

Sieppert (1996) and Roy (1981) reinforce the need for the completion of a traditional social work assessment to identify psychosocial issues in a chronic pain situation. When initially meeting a client, I attempted to explore with them all aspects of their life, including the nature of family and social support they were receiving, and all relevant psychosocial data including medical, social, and family history. Past psychological or mental health issues were also investigated, as the presence of these was felt to significantly increase a person's vulnerability to the development of psychological conditions such as depression. The Client Self Rating Scale and PDI (pre therapy completion) also assisted in gathering information to formulate impressions regarding a new referral.

Assessment was a continual part of therapy, as the need to re-evaluate goals was continually part of the intervention process. In this regard, I quickly became aware of the importance of assessing chronic pain clients for the potential presence of a psychological condition, such as depression. The literature identifies the overlapping features of chronic pain and depression, as well as the presence of depressive symptoms in chronic pain clients (Gatchel, 1996; Roy 2001). Completion of a (mini) mental status examination, either in the initial session, or during therapy when psychological symptoms appeared to escalate, was helpful to tease out potential diagnoses of depression. Features such as a client's presentation, behavior, speech, orientation, mood/affect, and alertness were assessed to determine signs/symptoms of depression or suicidal ideation/crisis (Berger, 2002).

An additional, and somewhat complimentary assessment tool, was the risk assessment in terms of addressing a client's expressed suicidal ideation and potential plan. During my practicum experience, one client made a suicide attempt, and required hospitalization for psychiatric care, while another client expressed thoughts of suicide, but had no identified plan. Chronic pain clients are at risk for crisis situations, often characterized by some degree of suicidal ideation. When a crisis was identified in a particular case, and a risk assessment completed, the crisis intervention model was implemented as a means of alleviating the risk and supporting the client. Because of the chronic nature of many of the cases with which I worked, it was crucial to always be cognizant of any signs of psychological distress and/or suicidal behavior. Thus, assessment and evaluation occurred throughout the treatment process in many of the cases.

Development of intervention and therapeutic skills. The literature supports the application of various brief therapy models in working with chronic pain clients, recognizing that often an eclectic approach is required to adequately address client needs through intervention. I found this to be true in working with clients who attended the pain clinic. Each case presented me with the opportunity to implement various approaches, thus allowing me the chance to develop skills and techniques from various therapy models.

In the case of Mrs. A., I worked with Professor Thomas in developing skills related to carrying out a hypnotic induction. This was unique to her case, and was carried out for only a short time; however, I performed this type of intervention on approximately three successive occasions. Cognitive Behavioral therapy proved to be useful in terms of teaching all clients relaxation strategies, such as deep breathing or imagery. Expressed negative thinking patterns called for cognitive restructuring which allowed me the opportunity to implement various strategies to help clients eliminate potentially damaging self-talk. The Problem Solving approach proved to be applicable when helping clients address relationship issues. Solution-focused methods, such as identifying interim goals for clients, and using a ten-point scale to determine gradual change and improvement, was helpful in evaluating progress and modifying therapeutic approaches. The Crisis Intervention approach was required for a significant period of time with one case, with regard to suicidal ideation and an attempt, and to a lesser degree, with a second case. In summary, the chronic pain clients I worked with at the pain clinic presented with a variety of issues, in the context of their chronic pain, which called for a mulit-model approach to adequately address issues while maintaining a traditional social work perspective (Stalker et al., 1999).

Development of skills to establish therapeutic relationships with clients. Fostering relationships with clients that are characterized by trust, support, and validation is not only paramount in doing therapy, but is a tenet of general social work practice. A non-judgmental and empathic approach was found to be helpful as an initial step in the process of allowing clients the opportunity to share their stories and very personal chronic pain experiences. This approach was also significant in light of the medical "illegitimacy" surrounding many of the clients' circumstances wherein medical findings did not substantiate the reported levels of pain and disability. Roy (1998) identifies the requirement for a trusting and supportive therapeutic relationship in order for a client to disclose issues of childhood abuse in a pain clinic/treatment setting. Two clients did not initially disclose to me but quite openly discussed their past abuse situations in therapy which suggested some level of trust was present in our relationships. The abuse issues were relevant in working with the clients to address their present day chronic pain levels. The case where one client disclosed to me her suicide attempt, and openly discussed her ongoing suicidal ideation suggests that trust and support were features of that relationship as well.

I underscored therapy sessions with client validation and positive reinforcement in order to maintain a social work, strengths perspective and foster increased self-esteem and self-confidence within each client. Validation is recognized in the therapy literature as key to working with all client populations, especially if anger or resentment is present in an individual (Leahy, 2001). In consulting with Professor Roy, the importance of validation and a positive-challenging approach was continually reinforced as a requirement for doing therapy with the pain clinic clients.

Despite best efforts to form positive therapeutic relationships, and assist clients in identifying realistic goals, I faced situations that were characterized by some form and degree of resistance. Leahy (2001) describes resistance as "…anything in the patient's behavior, thinking, affective response, and interpersonal style that interferes with the ability of that patient to utilize the treatment and to acquire the ability to handle problems outside of therapy and after therapy has terminated" (p. 11). This author also offers a comprehensive approach for dealing with resistance in therapy, depending on the form of resistance (behavior/thinking/style) encountered. Catalano and Hardin (1996) identify several forms of resistance specific to pain management therapy or in working with chronic pain clients. Examples of resistance relative to my experience in the practicum included clients missing/canceling appointments, not completing homework, and expecting the therapist to "do all the work" and "solve all the problems". Though Leahy (2001) offers a plethora of options to deal with resistance in therapy, the general theme includes directly and openly challenging the client, while utilizing a positive, non-defensive approach. In other words, the resistance issue, such as missing appointments or not completing homework, should be the focus for the next therapy session. In doing this, it is hoped that further issues and information will be revealed by the client, which will be incorporated into the overall treatment and intervention. Though this is a somewhat daunting task for a student therapist, avoiding direct discussion on these issues with the client is likely to only reinforce the behaviors and prevent therapeutic progress (Leahy, 2001).

During the practicum, I found dealing with resistance somewhat difficult, especially in light of my status as a student therapist, wherein I was learning a new skill and practice, and was therefore vulnerable to scrutiny by superiors, clients, and myself. Additionally, issues of transference and countertransference in some of the cases could not be ignored given their contribution to, and impact on, the overall intervention process. Leahy (2001) speaks to these issues by suggesting that "…countertransference can be one of the most useful tools in helping patients – it can provide a window into the 'real-world effects' that the patient has outside of therapy" (p. 241). Given this, the therapist can utilize the countertransference to understand his/her own interaction with the client and secondly, how to help the client in light of this information (Leahy, 2001). Leahy also offers a set of guidelines for the therapist in this regard, including a questionnaire posited to be helpful in identifying one's own therapeutic "schema" or world view as a therapist and how this would impact, and more importantly, be helpful in the therapeutic process.

Throughout the practicum, I utilized the following methods to examine my therapeutic style and client interaction:

- Completion of journal notes from case sessions
- Review of session videotapes from one case with Professor Roy
- Ongoing consultation/supervision with Professor Roy regarding all cases
- Review of literature on therapeutic skills and issues

I found that the most difficult aspects of therapy entailed dealing with resistance from a client, primarily due to my learning curve as a therapist with challenged my confidence in this area. This is a goal for my ongoing learning and development as a social work clinician. As my experience grows in this field, I anticipate developing more techniques in this area of clinical practice. Overall, I found the clients formed alliances with me in therapy such that we could work together on achieving their goals. Post therapy CSQ-8 scores suggested that, for those that completed it, clients were relatively satisfied with the treatment received through therapy. This can be interpreted to mean that elements of the client-therapist relationship, such as trust, support, and empathy, were present in the various clinical situations I experienced.

Conclusion

Chronic pain is a condition that has been found to plague a large portion of the population. The definition of chronic pain varies in the literature, though commonalties exist in terms of duration, the disabling impact, and the frequent incongruity between reported pain levels and medical findings. The impact of chronic pain is evident on a micro, meso, and macro systems level in terms of its significant effect on the individual sufferer, his/her family, and larger, social system. "Chronic, intractable pain interferes with all aspects of living. It demands attention, impairs concentration, and drains the individual of energy" (Katz et al., 1996, p. 252). Due to the nature of this practicum, the influence of chronic pain was discussed from an individual or micro-system perspective, with an examination of role change and loss for the chronic pain client. In doing this, an ecological/person-environment paradigm was implemented, to not only respect the values and tenets of social work practice, but also to articulate the effect of chronic pain on the individual person as a psychosocial experience.

By incorporating a psychosocial model when working with a client suffering with chronic pain, the role of social work as a discipline becomes invaluable to the entire process. The literature supports provision of multidisciplinary intervention to this client population, of which a clinical social worker is a major team member. The function of a social worker in the treatment setting includes therapy aimed at improving clients' overall situations. The practice of brief therapy is a growing treatment that has been found to benefit many client populations, including those suffering with a chronic pain condition. Clinical social workers can deliver this service, using the psychosocial model, to help clients living with chronic pain improve their quality of life and overall functioning. The trend and growing support for use of an eclectic approach in therapy, by combining elements of several models, allows the clinical social worker to address the various problems presented in therapy in a flexible and creative manner that is sensitive to client response and treatment progress.

My practicum entailed working with chronic pain clients who were patients at a local pain clinic. I provided brief, individual therapy as an intervention to help alleviate the negative impact of chronic pain on the clients' lives, as well as to help them gain skills that would increase their pain management abilities. I worked in conjunction with my advisor, Professor Roy, and the pain clinic staff to provide treatment to various clients. For a period of approximately eight months, I was able to acquire seven cases, wherein I worked with each individually to establish treatment goals based on their own unique situations. This report included case presentations, noting the psychosocial situation of each client, identified goals, therapeutic interventions, and individual outcomes. Two measures, the Pain Disability Index, and the Client Satisfaction Questionnaire were utilized in order to obtain objective data related to progress and the helpfulness of therapy. Subjective measures included the use of a Client Self-Rating Scale and indirect feedback from clients during our sessions.

Completing this practicum allowed me to experience firsthand the relationship between information found in the literature and that observed in clinical practice. The need to address the grief and loss associated with the chronic pain's impact on a person's life roles was reinforced in all the cases as paramount to moving forward with goals such as learning pain management skills. The loss of identity, self, and autonomy in one's life was observed in all situations and required due acknowledgement by me as the therapist.

In addition to this, reinforcement of the roles a client was still able to partially or completely perform, was required as a follow up item in therapy sessions to identify areas where the client still exhibited control and mastery. In doing this, new skills and techniques could be taught to the client around pain management and coping. The need for elements of various models was evident in my work with clients, including those of the Cognitive Behavioral, Solution Focused, Problem Solving, and Crisis Intervention. Continual assessment and appropriate intervention was required in order to adequately address problems.

I accomplished several goals related to my personal learning and development as a social work clinician. I learned about chronic pain conditions and medical treatments. Additionally, by utilizing an ecological framework in assessment and treatment, I was able to better appreciate the psychosocial impact of chronic pain on an individual client. By working with different cases, I also had the opportunity to implement general assessment interviews, conduct risk assessments on clients presenting with suicidal ideation/crisis, as well as complete mini mental status examinations due to potential complicating psychological factors in various cases. Finally, because of the individual issues, I was required to implement various models and techniques, while assessing my development as a therapist. In doing this evaluation, I was able to examine any transference and countertransference issues, and learn about my therapist style and ways to improve my interaction with clients. This will assist me in future cases, specifically where resistant behavior is observed and requires attention.

Some difficulties/challenges were encountered in completing the practicum. These were related to the pain clinic's medical setting, difficulty in collecting data from clients, and the limits of individual therapy in addressing various client issues, in particular those related to personal relationships. Recommendations around these findings included the need for a multidisciplinary program for treating the chronic pain client, identification or development of an objective measure specific to the chronic pain population to better assess outcome, and concurrent individual and family therapy to address all client needs.

With my practicum now complete, I am significantly more aware of the impact a chronic pain condition can have on an individual's life roles, and the corresponding decrease in self-esteem and sense of autonomy and mastery. With this in mind, I am particularly sensitive to the need for a multidisciplinary treatment program wherein all aspects of the person's life and immediate environment are considered and addressed. The psychosocial phenomenon of chronic pain is complex and requires more than medical treatment. Grief and loss were central themes in my work with clients, and a loss of control was at the core of every case. By appreciating this, and acknowledging these issues with clients, I was able to help some move forward in learning new skills and implementing various coping strategies. The cost to the individual sufferer, their family, and society is paramount with chronic pain, and demands our attention as social workers and treatment providers. The knowledge and practical experience I have gained through this practicum will be instrumental in my future work as a clinical social worker with not only the chronic pain population, but also other clients presenting for therapeutic intervention and support.

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Appendix A

Consent Form

I, ______________________________, agree to participate in therapy sessions with Lisa Sigurdson, graduate student in the Faculty of Social Work at the University of Manitoba, supervised by Professor Ranjan Roy, Professor of Social Work and Clinical Health Psychology at the University of Manitoba. I understand that all information will be recorded in my hospital/clinic chart and remain in the clinic setting. I understand that the service provided will be evaluated for educational purposes by way of a final report submitted to the University of Manitoba as part of the requirements for the Masters Degree. The purpose of the evaluation is to assess Lisa's work and development as a counselor in the clinical setting. As part of this assessment, I agree to complete two standard questionnaires as well as a self-rating scale with respect to my goals in therapy and progress made in each area at the point of termination of treatment. The results included in the final report to the University will be done in an anonymous manner with no personal or confidential information included. I understand that I may withdraw from therapy at any time without prejudice, as well as may request that my results not be included in the final report. I understand that the strictest of confidentiality will be used at all times to respect my privacy and personal information.

________________________________ ____________________

Signature Date

Appendix B

Pain Disability Index (PDI)

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is the worst.

For each of the 7 categories of life activity listed, please circle the number on the scale which describes the level of disability you typically experience. A score of 1 means no disability at all, and a score of 11 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

1. Family/Home Responsibilities

This category refers to activities related to the home or family. It includes chores or duties performed around the house (eg. yard work) and errands or favors for other family members (eg. driving the children to school).

1 2 3 4 5 6 7 8 9 10 11

2. Recreation

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

1 2 3 4 5 6 7 8 9 10 11

3. Social Activity

This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theatre, concerts, dining out, and other social functions.

1 2 3 4 5 6 7 8 9 10 11

4. Occupation

This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs/roles as well, such as a stay at home parent, or volunteer work.

1 2 3 4 5 6 7 8 9 10 11

5. Sexual Behaviour

This category refers to the frequency and quality of one's sex life.

1 2 3 4 5 6 7 8 9 10 11

6. Self-Care

This category includes activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.).

1 2 3 4 5 6 7 8 9 10 11

7. Life Support Activity

This category refers to the basic life supporting behaviours such as eating, sleeping, and breathing.

1 2 3 4 5 6 7 8 9 10 11

Appendix C

Client Self Rating Scale

Goal # (1, 2, 3): ____

____

On the following scale (1 representing minimal to no achievement in this area and 10 representing maximum achievement), please indicate where you feel you are presently functioning with respect to the above goal:

____

1 2 3 4 5 6 7 8 9 10

On the next scale, using the same system of number representation (1 is minimal and 10 is maximum achievement), please indicate where you feel you would like to be functioning in this area by the time therapy concludes:

____

1 2 3 4 5 6 7 8 9 10

Notes: ____

____

____

Appendix D

Client Satisfaction Questionnaire (CSQ-8)

Please answer the following questions about the service you have received through therapy. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. The questions are related to the therapy/counseling services received at this clinic only, and not the medical aspect of treatment. Thank you very much for your help.

Circle your answer:

1. How would you rate the quality of service you received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	2	3	4
Definitely no	Not really	Yes, generally	Definitely Yes

3. To what extent has the service met your needs?

4	3	2	1
All needs met	Most needs met	A few needs met	No needs met

4. If a friend were in need of similar help, would you recommend this service to him or her?

1	2	3	4
Definitely not	I don’t think so	Yes, I think so	Definitely yes

5. How satisfied are you with the amount of help you have received?

4	3	2	1
Very satisfied	mostly satisfied	mildly dissatisfied	Quite dissatisfied

6. Has the service you received helped you to deal more effectively with your problems?

4	3	2	1
Yes, it helped a great deal	Yes, it helped	No, it really didn't help	No, it seemed to make things worse

7. In an overall, general sense, how satisfied are you with the service you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to this service?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

Appendix E

Hypnotic Induction

"Now what I would like you to do as we begin…is to begin to relax. Make yourself as comfortable as possible. If you are wearing glasses, contact lenses, or jewelry I would recommend that you remove them…that's good. You may feel more comfortable by loosening any tight clothing and removing your shoes if you wish. You may sit comfortably with your hands, palm down on your thigh…that's good. Allow yourself to relax…feel yourself sink into the chair. As you begin to relax I'd also like you to be aware of your breathing (in co-ordination with the client's breathing)..in..and..out…in… and …out. That's it. Very good.

As you are aware of your breathing in and out…I want you to concentrate on this object that I'll place here (any simple object, I used a gold broach). Focus very carefully on this object…notice it's shape..it's color…it's contours…it's boundaries…it's center…that's very good…very good. Now, I would like you to continue concentrating on the object…and as you continue concentrating on the object I would like you to be aware of your relaxed…slow…breathing..in..and…out..in…and…out..Very good. Now as you breathe, I want you to imagine that you are breathing in and out a special gas that will make you feel relaxed and sleepy. As you breathe in and out you will begin to feel more relaxed…more sleepy…more relaxed…more sleepy.

What I will do is count down from 10 to 1. As I count down, you will feel more and more relaxed…more and more sleepy. Very soon your eyes will feel so heavy…very heavy.. that you will not be able to resist closing them. And as you feel more and more relaxed…more and more sleepy…and you close your eyes..you will become hypnotized. (at a pace slightly slower than the client's breathing) <u>Ten</u> … eyes heavier.. and heavier…<u>Nine</u>…heavier..heavier…<u>Eight</u>…more relaxed..sleepy…heavy…<u>Seven</u> …your eyes are closing..more and more relaxed …<u>Six</u>… deeper… heavier.. <u>Five</u>…relaxed… sleepy… <u>Four</u>…deeper… <u>Three</u> … feeling very relaxed…<u>Two</u> …deeper and deeper… <u>One</u>…very good.

Very good. Very relaxed. Now, as you closed your eyes, you will have been aware of a particular sensation around your eyes. This was the feeling of profoundly deep relaxation. It may have been a warm flowing feeling… or a cool comfortable feeling. I want you to be aware of that feeling, whatever it was. Now I would like you to imagine this feeling of relaxation is spreading from your eyes to the other parts of your body…back across your temples to the back of your head … to your crown… forehead … cheeks … jaw…chin… down to your neck…. shoulders … flowing down to your arms …forearms… wrists … hands… fingers… down from your shoulders to your upper back … across your rib cage to your chest … abdomen … lower back… hips … thighs, top and bottom…knees …calves and shins … ankles … feet… toes. Very good. Now as you are feeling very relaxed… I am going to count down again from 10 to 1. As I approach one you will become even more hypnotized. <u>Ten</u> … deeper and deeper … <u>Nine</u> … more and more hypnotized … <u>Eight</u>… so relaxed and hypnotized … <u>Seven</u> … deeper and deeper ... <u>Six</u> ...<u>Five</u> ....deeper and deeper... <u>Four</u> .... <u>Three</u> ...<u>Two</u> ...<u>One</u>...very hypnotized.

Very good, that's it. Now, as you are very hypnotized I would like you to imagine the object I had you concentrate on as we began. What I would like you to do is imagine the object as if it was in front of you right now and you were looking at it. As you imagine it notice it's shape... it's color ...it's contours... it's boundaries ...it's center...that's good...very good. When you have a clear image of the object I would like you to let me know by simply lifting your right pointing finger... that's it ...very good. Allow the image to go away and just be aware of what a pleasant and relaxing experience hypnosis is ...that's it.

Now I would like you to imagine something very enjoyable and very pleasant. I would like you to imagine a very special place where you feel completely relaxed ... completely at ease .. happy .. and content ... and healthy. This place may be a park ... beach ...wherever. It's a special place where you felt just right and away from all worries. Imagine this place ... what would it feel like if you were there right now? ...Imagine what you might see ... touch ...hear ... smell ... possibly taste .. create as full an image as you can ... experience the feelings of comfort, safety, and relaxation. When you are fully in your special place, I would like to know. When you are there simply lift your right pointing finger again ... that's it ..very good. Now take a few moments to enjoy your special place (minute or so passes).

Ok, I'd like you to leave your special place. That's it ... continue to feel very hypnotized ... very hypnotized. Now, anytime you wish to be hypnotized and access your special place, all you have to do is on your own, count down from 10 to 1. This will bring you to the very hypnotized state you are in now. As all along, you will have complete control. You may do this on your own to practice hypnosis. You will find that the more often you practice, the stronger and more effective the hypnosis will become. When you are complete, and it is time to return to your normal waking state, you will do as we will now, count up from 1 to 10. As we reach five your eyes will open, yet you will still be hypnotized. When ten is reached you will be completely awake. In fact you will feel refreshed, rested, and enthusiastic for the rest of the day. (at a pace slightly faster than the client's breathing) <u>One</u>... waking up... <u>Two</u> ... more and more awake ... <u>Three</u> ... <u>Four</u> ....<u>Five</u> ...eyes beginning to open ... <u>Six</u> ..eyes open ... more awake... <u>Seven</u> ...<u>Eight</u> ... <u>Nine</u> ...<u>Ten</u>. Any sleepiness or grogginess will soon be gone and you will be left feeling completely awake and refreshed!"

Appendix F

Pain Log

Date/Day of the Week:______________________________

Pain Level in the Morning (1 to 10; 10 being the worst):__________

Any relaxation/coping strategies performed?_____________

Activities/tasks throughout the day (note any significant variation in pain levels):

____

____

____

____

____

List coping techniques used throughout the day (and outcome):

____

____

____

____

Pain level at conclusion of the day (use same scale as for morning):____________

Notes: