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Abstract: Aim: This article explores factors that contribute to clients' chronic pain management from an occupational therapy perspective. Method: Nine occupational therapists from Australia and New Zealand who worked in this practice area were interviewed. Qualitative method of narrative inquiry was used to analyse the therapists' practice narratives to determine their view of how clients manage their chronic pain. Results/Conclusions: Among many themes, significant agentic (positive management) them ...

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Aim: This article explores factors that contribute to clients' chronic pain management from an occupational therapy perspective.

Method: Nine occupational therapists from Australia and New Zealand who worked in this practice area were interviewed. Qualitative method of narrative inquiry was used to analyse the therapists' practice narratives to determine their view of how clients manage their chronic pain.

Results/Conclusions: Among many themes, significant *agentic* (positive management) themes and *victimic* (negative themes related to non-management) emerged. Agentic themes were related to conceptual categories of *being*: the importance of maintaining valued roles and having good social support; to *knowing*: accepting the long-term nature of pain and being ready to change thinking about pain, and to *doing*. These categories included strategies such as setting realistic goals, pacing activity and using relaxation. Victimic themes were also related to *being*: losing valued roles, having depression and receiving compensation and to *knowing*: being fearful, looking for a cure or not knowing what to expect. Victimic *doing* themes related to: being unable to set goals and being unable to use strategies. These themes and categories form the basis of proposed agentic and victimic conceptual models of factors for occupational therapists to address in pain management programs. As acceptance and readiness for change were consistently mentioned in all narratives, the place of contextual cognitive-behavioural approaches to pain management is also raised as a viable alternative to standard cognitive-behavioural therapy (CBT), currently used in most chronic pain practice.

KEY WORDS: *chronic pain management, occupational therapy, practice narratives.*

Introduction

In 2007, the prevalence of chronic pain in Australia was estimated at approximately 3.2 million people, with 1.4 million males and 1.7 million females (Access Economics, 2007). The economic impact of having chronic pain in terms of reduced productivity, caregiver burden and decreased quality of life was estimated at a gross cost of \$34.3 billion Australian dollars in 2007. The majority of this was taken up by reduced work performance, loss of employment, burden of disease, and health system costs (Access Economics, 2007). Many quantitative studies exist that explore factors influencing pain management. However there is limited research into what enables people to manage their pain in the long term (I. B. Jensen, Bergström, Ljungquist, & Bodin, 2005; M. P. Jensen, Hoffman, & Cardenas, 2005). Research specific to occupational therapy and pain management is scarce although occupational therapists commonly work with people who have chronic pain in practice (Brown & Pinnington, 2007; Robinson, Kennedy, & Harmon, 2011; van Huet, Innes, & Whiteford, 2009)

Occupational therapy approaches to pain management

The International Association for the Study of Pain recommends inclusion of occupational therapists in multi-disciplinary health care teams within pain programs (Shannon, 2002). The role of the occupational therapist varies according to type of program (in/out patient), health care setting (hospital or community based), and funding model (private or public), but it is primarily involved with enabling people to participate in their daily occupations. For occupational therapists who work in chronic pain management, meeting the diverse needs of people with chronic pain is acknowledged as challenging, however enabling active participation in pain management programs has been shown to enable the person to have "autonomy, control and responsibility" (Strong, 2002, p. 301).

More specifically the role of the occupational therapist in chronic pain management may include any/all of the following: a) education on activity pacing, correct body mechanics and manual handling procedures; b) energy conservation and work simplification strategies; c) goal setting; d) home and work assessment; e) prescription of assistive devices; f) relaxation and stress management. (Robinson, et al., 2011; Shannon, 2002; Strong & Unruh, 2002)

The strategies utilised in therapy, aim to address both the physical and psychological aspects of chronic pain.

Psychological approaches to pain management

Occupational therapists also borrow from psychological approaches in chronic pain management. The most common approach used is cognitive-behavioural therapy (CBT) (Turk, Meichenbaum, & Genest, 1983). CBT consists of “learning new behaviours... and challenging and changing unhelpful or negative ways of interpreting and constructing their [pain] experience” (Curran, Williams, & Potts, 2009, p. 178). Turk and colleagues first applied CBT to pain treatment in the 1980s and it is now the most widely used behavioural method in interdisciplinary pain management programs (Curran, *et al.*, 2009).

The effectiveness of cognitive-behavioural interventions has been subject to significant research. Positive impacts have been noted in depression alleviation, pain coping and reduced pain behaviours. There is, however, limited evidence for the actual relationship to improved functioning (Morley, Eccleston, & Williams, 1999; Vowles & McCracken, 2010). There is little available evidence on the use of CBT and its efficacy specific to occupational therapy in chronic pain practice. This could be attributed to the fact that psychologists traditionally provide the CBT component in pain management programs or, if aspects of CBT are used by therapists it is difficult “to isolate individual components of psychological interventions” or compare “specific treatment components delivered in highly variable and complex treatment designs” (Brown & Pinnington 2007, p. 53).

Recent psychological approaches in chronic pain are based on methods of “mindfulness” (McCracken & Thompson, 2009, p. 75). One of these mindfulness methods is Acceptance and Commitment Therapy (ACT) (Hayes, 2004). Whereas CBT is aimed at challenging, changing and restructuring thoughts, ACT is aimed at accepting thoughts and feelings. Vowles and McCracken (2008, p. 398) see acceptance as the “willingness to experience pain or other distressing events without attempts to control them, and aligning of actions with desired, personally meaningful purposes rather than with the elimination of unwanted experiences”.

Research using ACT is supportive of its use with people who have chronic pain and has shown improvement in physical and emotional functioning, as well as reduction in health-care visits and medication use (Vowles & McCracken, 2008). Although this method is emerging as an alternative to traditional CBT, it has yet to be widely adopted into chronic pain management programs in Australia.

Method

The study design was qualitative using narrative inquiry. As described by DePoy and Gitlin (2005), there are many approaches to narrative inquiry; however, all of these centre around storytelling. Narrative inquiry uses people’s stories about a particular experience as data. A

central concern of narrative research is how the person's (participant's) story is represented and interpreted.

Questions asked in the research were aimed at gaining narrative accounts that focussed on the therapist-participants' area of chronic pain practice and their opinion of what influenced successful chronic pain management (see Appendix). This included recalling practice case scenarios therapists saw as significant. All therapists were interviewed once or twice between 2007-2008 with interviews lasting from 2-3 ½ hours. Repeat interviews were aimed at either expert therapist-participants in chronic pain management or clarifying information from previous interviews.

Participants

Participants were recruited from various states of Australia and New Zealand, following expressions of interest at the 10th World Federation of Occupational Therapy Congress (WFOT July, 2006) in Sydney and at the OT Australia (Victoria) Pain Special Interest Group (November, 2006). Nine therapists provided informed consent. Ethical approval for the research was obtained from The University of Sydney prior to recruitment.

Demographics of participants are included in Table 1.

Procedure

Therapists-participants were interviewed at a nominated venue, by the first author and all interviews were tape recorded, with permission of participants. Interviews were transcribed verbatim and subjected to the following to ensure authenticity.

Summaries of interviews were provided to therapist-participants for comment and amendment if required. This ensured that the data gathered were representative of the actual interviews. Theoretical rigour was applied by ensuring the method used was consistent with the research purpose, based on existing research (Liamputtong & Ezzy, 2005). Interpretive rigour involved a clear demonstration of how the interpretation of themes was achieved, by accurately representing the data within the selected methodology. This was achieved by in-depth thematic analysis and interpretation relative to conceptual models created during analysis (Liamputtong & Ezzy, 2005). Methodological rigour was achieved by keeping detailed documentation of the research process by maintaining an audit trail that considered how participants were accessed, how trust was developed with participants and how data were collected and recorded (Liamputtong & Ezzy, 2005).

Reflexivity refers to a process of reflecting critically on the self as researcher, as one way of acknowledging the subjectivity of the research process (Curtin & Fossey, 2007). This occurred by continual evaluation of thinking and reasoning behind interpretation of data as recorded in a reflective journal. Discussions with research advisors were minuted in the journal to provide a developmental pathway of collaborative research ideas, and thematic development.

Data analysis

Analysis of therapist-participant interviews consisted of, discovering the predominant themes; interpreting the stories and using reflexivity. Initial analysis used a process of open coding (DePoy & Gitlin, 2005). A comparison of key themes, words and phrases using the *in-vivo* language of participants was made within and between transcripts. Copies of transcripts and emerging analysis were provided for review by the research team. A process of triangulation (Liamputtong & Ezzy, 2005) was used with other members of the team to ensure that research bias was limited, and data analysis and interpretation was inclusive of a range of views.

The initial analysis of findings resulted in the creation of four key overarching themes to guide further analysis. These key areas identified were:

- About the ‘person’ (self) – referred to how therapists saw their clients gave importance to life roles, viewed themselves as clients and how depression and compensation impacted on their clients’ view of self;
- Meaning ascriptions – how therapists interpreted the meanings ascribed to pain by their clients and how these impacted on clients’ self-management;
- Adopting and using strategies – therapists discussed strategies and methods they advocated as useful for clients and those that their clients continued to use; and
- External/Social world influences – impact of client’s family, of the pain intervention or program used, and the ongoing social support available to the person.

When interpreting the stories, factors emerged that therapists considered either agentic or victimic to managing pain in the long term. Polkinghorne (1995) described how people with chronic pain, may manifest one of two narrative types; “agentic” or “victimic” (pp. 301-302). Agentic narratives are characterised by action or ‘doing’, motivation and persistence in developing skills in problem solving around chronic pain. Conversely, victimic narratives are characterised by passivity, ‘not doing’, with the person seeing others as controlling life events and being unable to move forward towards personal agency. This framework was applied to the key overarching themes based on therapist-participant perceptions of whether something was related to their clients being active or being passive in their approach to pain management.

Findings

Finding from the research centred on the key thematic areas of person (self), meaning ascriptions, strategies used and social world influences. These were later synthesised and conceptualised into proposed models related to agentic and victimic factors of chronic pain management that are outlined in the discussion.

Agentic Person (self) themes/Social World themes

These themes were considered relative to each other, as therapist-participants found they informed their client’s identity and influenced how their client’s saw themselves in the world and in relationship to others.

Having valued roles.

Having valued roles was identified in all therapist-participant narratives as being important for their clients. Marie found people preferred to devote more time and energy to familial role enactment in preference to work and other roles:

By the time we get them I think work is often a lower kind of priority, in terms of all the things that they've lost. You know, worker role is one thing but being able to tie my shoe laces, and run around after my kids, and cook the dinner, I think people tend to look closer to home first

In relation to having valued roles, how these were supported and enacted within the social world was seen as critical by therapist-participants for their clients.

Having good social support

Alison summed up the benefits of having “good appropriate family support” as being important to successfully managing pain. Patricia spoke about the importance of family involvement in a person’s pain management.

I think it's really important that families are bought along in the process. And I just think that other family members can be so powerful. One could be reinforcing appropriate behaviour, but certainly really punishing people, too. I see pain behaviour and activity performances very influenced by the responses – what happens in the family.

Victimic Person (self) themes/Social World themes

Many personal and social factors were recognised by therapist-participants as negatively influencing pain management. These included; losing valued roles, having depression, receiving compensation and lacking good social support.

Losing valued roles

For most clients that therapist-participants saw, having chronic pain meant the loss of valued life roles. Marie described the impact of role loss for people she saw and how they found “life just feels like it’s really not worth living.” Patricia also noted how chronic pain impacted on some of her male clients in particular:

Most of them felt like failures in terms of their male role; their role of being provider and care giver for their family. Most of them felt sexually they felt de-masculinised because usually their sexual relationship with their partner was limited or defunct.

Being severely depressed

The high incidence of depression and the effect on activity participation was reported by clients to all therapist-participants. Liz saw depression as “a huge issue”. Patricia described how her awareness of the severity and impact of depression had developed over her years in chronic pain practice.

But another factor that's really important in change, I think, is how depressed people are. I guess I didn't recognise this when I first started working in this area, and I think it's incredibly underestimated, the effect of how moderate to severe depression really affects people's ability to make change and to work on the sort of pain management strategies we're talking about.

Receiving compensation

The personal effect of being within a compensation system often impacted on people's sense of who they were and the way they approached chronic pain management. This was a particular issue where financial gain was dependent on having chronic pain. Alison saw this as the "number one barrier":

I can see that it's really not in their best interest to improve. Particularly if they have a comp[ensation] claim in and they're waiting for a pay-out. As the OT I would say that is the number one barrier that I find to good management of chronic pain. And some people actively come out and say that.

Lack of social support

Matt saw social and environmental factors as being significant. This could involve family, health professionals and even where the person resided:

So going back to a non-supportive environment. So, for instance they went back to a GP who is very physically focused, and medication focused and isn't supportive of, you know, a self-management type approach. Probably also... whether their family was supportive or not. Probably access, as well. So if they're really isolated geographically; I think that's tough.

Agentic Meaning Ascription themes

Meaning ascriptions were the thoughts and beliefs about pain that influenced clients' pain management. Therapist-participants recounted common themes related to their clients' acceptance of pain and being ready to change thinking and behaviour around pain.

Acceptance and readiness for change

Most pain programs that therapist-participants worked in recognised the concepts of acceptance and readiness for change as important factors in pain management. Elizabeth described this as a time contingent process:

Well first of all – acceptance that they have problems and that it's not going to go away easily and the responsibility is in their hands. I think that's important... You know, sometimes you meet people 4 years down the track and they're doing really well, it just took them a long time to get there. I mean, that whole readiness to hear what's being said, and then to be able to do it. (laugh) It's a big challenge.

Patricia similarly acknowledged that "in essence what you're asking the person to come to terms with is that changes for the future need to have pain, as an ongoing factor, factored in to it."

Victimic Meaning Ascription themes

Therapist-participants practice narratives revealed that lack of acceptance and readiness to change was common in pain non-management. They additionally identified that fear avoidance of activity, looking for a cure and not knowing what to expect in the future had a negative impact.

Being fearful

Several therapists such as Marie saw clients avoiding activity due to fear of exacerbating their pain. She saw this as an important barrier, especially to pain self-management.

Don't underestimate the value of fear avoidance in stopping people from doing things, and your ability to challenge that. Knowing that... we need to look at other ways of doing this so you can still be functional, you can still achieve your goals and you can still have the roles that you want.

Leah also noted fear avoidance in her practice and described how this became entrenched over time into “patterns of thinking... based around grief and fear” that were challenging to work with.

Looking for a cure

Patricia noted that “sometimes when we see people and they're very fixed on the idea that they just want, and need a cure, it is more useful to allow them to go off and look for cures,” rather than engage them in a pain management program.

Not knowing what to expect

Matt saw that his clients tended to view the future negatively in terms of deterioration in their pain condition due to not knowing what the future would hold:

They idealise their past, but they have a negative feeling about their present. Whereas, about their future, we always knew that when patients would come in and they'd mention a wheelchair during their first interview, that you're going to have to really work to change some cognitions there. Because their view of the future is very negative.

Agentic themes around using strategies

Strategies were the practical aspects of the various pain programs that therapist-participants used with their clients. The main strategies, common to pain programs were; goal setting, pacing, relaxation and using CBT (cognitive-behavioural therapy). Some therapists were critical of the use of strategies that had a limited research base or were applied ad hoc to pain programs.

Setting goals

Goal setting was a common strategy taught across programs. Goal setting could be related to increasing activity tolerances, such as walking, or reengaging in valued activity. Elizabeth saw that goal setting could involve a number of different areas:

And the sort of goals vary... it could be any one of a number of things like 'well, I want to finish painting the bathroom' to 'I want to take my dog for a walk' or 'I

want to take the kids to the park' or 'I want to be able to time-table ½ an hour a day for my relaxation' or 'I want to bake a cake' or 'I'd like to invite friends for dinner'.

Pacing

The use of pacing was a universal strategy employed across all therapist-participant programs. Although the way pacing was taught varied (time contingent/quota contingent), all therapist-participants agreed that it was a useful concept. Matt used pacing in practice but was aware that there was limited research evidence advocating its use:

I think it's really important, but if we can find out what they want to do first and then make it very contextualised, I think that process would be a whole lot more effective. And pacing it's just like CBT, everybody teaches people how to pace. But, you know, where's the evidence to say that that's any better than anything else? I just think you need to have a life to apply the pacing to.

Relaxation

Relaxation techniques were utilised in many therapist-participant's pain programs. Louise routinely would "start off with diaphragmatic breathing" or deep regular breathing as an easy technique people could "do throughout the day." Marie advocated its use as being an easy strategy to teach and practise to control pain and emotions:

I think controlled breathing is something that they tend to carry over really well. Now... whether it's an easier strategy to get your head around, or whether it's because we practise it so much... it's good for your high pain, it's good with anger; it's good with quite a few sort of different things.

The actual types of relaxation taught and the perceived merits of the various techniques differed across participants.

Using CBT

Using CBT was also a common method underpinning therapist participant pain programs. By using this approach Louise found, clients could be encouraged to re-engage in activity particularly if they were fearful of movement.

I think having a different understanding of what their pain is signifying. And that sort of hurt doesn't mean harm sort of idea. And that they can experience a sense of control while they're participating in activities. Changing the way they conceptualise pain, and their cognitions around that and their experience of it.

Victimic themes around using strategies

Therapist-participants found clients who were unable to using strategies. Another difficulty reported was getting clients to continue strategy use in the long term to assist ongoing pain management.

Being unable to set goals

Leah described a client who had "no goals at all, didn't have a clue, couldn't do half the things he wanted to do... And so trying to find something for him to do that was

meaningful... was really very difficult.” This was a major barrier to the client moving forward in pain management.

Being unable to use strategies

Elizabeth saw clients at follow-up who had difficulty applying strategies to everyday life. Adherence to strategy use proved a major barrier to some clients:

I mean you can see it when they come back to follow-up and they're saying 'Oh, nothing's got any better' and then you say 'well, what are you doing?' 'Oh, well I haven't done any exercise for 3 weeks,' and 'No, I stay in bed in the morning and I'm not doing my relaxation – I haven't got time.' And you think 'well... Okay, you're not doing anything. You're not actually applying the stuff.'

Using CBT “meeting a force with a force”.

Leah did not advocate the routine use of CBT. Over her years of experience she had found that challenging people on their thinking when they were vulnerable was like meeting “a force with a force.”

And the one thing that a cognitive approach, if you like, the challenging approach does, is say to people 'This is irrational – you're wrong.' So... what does 'you're wrong' elicit from someone? Especially when they're confused, because they haven't got a bloody clue what's right... I'm not saying that CBT is wrong - at all, but I think, as a singular approach – it's flawed. And it doesn't allow enough creativity from people, it sort of like tramples on the defenceless. You know, as far as I'm concerned, it's very unintelligent to meet a force with a force.

Discussion

The importance of roles and occupations of meaning in the construction and maintenance of identity is noted in several chronic pain studies (Alsaker & Josephsson, 2003; Townsend, Wyke, & Hunt, 2006). Townsend *et al.* (2006) saw that negotiating illness and fostering actions that affirmed valued roles such as parenting, allowed their study participants to assert control over their lives. Research of role participation following stroke, found that having more roles was correlated with greater life satisfaction (McKenna, *et al.*, 2009). Thus loss of roles could impact on perceived quality of life. These findings are consistent with those described in the practice narratives of therapist-participants.

Therapist-participants noted that clients with depression often had more complex needs than those without. Extensive literature has identified mental disorders such as depression as being an “antecedent, a consequence of or a common co-morbid complication of chronic pain” (Nicholas, 2007, p. 231). A prevalence study of chronic pain in Australia noted that chronic pain was associated with high levels of psychological distress (Blyth *et al.*, 2001).

Nicholas (2007) recommended treating both chronic pain and depression within pain management programs. This was supported by therapist-participants who reported using various psychological and activity-based strategies to assist their clients manage pain and depression.

Therapist-participants such as Alison found that receiving compensation was the “number one barrier to change” in clients she saw. She reasoned that it was difficult for people to

move forward in the pain management process while they had a chance of being financially compensated by remaining in high levels of pain. Research has identified the perceived barriers of negotiating a compensation system following workplace injury and the tension experienced by workers when trying to return to work and continuing to access health care (Korzycki & Shaw, 2008).

The interwoven nature of acceptance of long-term chronic pain and readiness to change thinking about pain was a recurrent theme in therapist-participant narratives. Acceptance that pain would be an ongoing factor in a person's life was required before change could be actioned. Research supports that pain coping and self-management are best predicted by individual's being ready to action change in their lives as these show the most promise in the prediction of positive treatment outcomes (Hadjistavropoulos & Shymkiw, 2007). Therapist-participants in the main supported the importance of the individual taking responsibility for change but acknowledged that this was difficult and time contingent.

Occupational therapists utilised strategies that were inherent to chronic pain practice and were relatively uniform across Western chronic pain programs. However, it was acknowledged that the effectiveness of these strategies had often not been evaluated by therapists and indeed, often did not have an evidence base.

Goal setting was a commonly used strategy across therapist-participants' programs. The variety of different methods of goal setting used across programs and in practice made judging successful outcomes difficult even when using goal-specific outcome measures such as the Canadian Occupational Performance Measure (COPM) (Law et al., 1994) and the Goal Attainment Scale (GAS) (Kiresuk, Smith, & Cardillo, 1994). Whilst goal setting had been utilised by all therapist-participants, its effectiveness varied dependent on the person and the program. Overall findings from this research support the use of client-centred, activity-based goal setting.

Pacing as a pain management strategy was mentioned in every therapist-participant's narrative account of their pain practice. Therapist-participants in general promoted between 15-30 minute blocks of time for people to be engaged in activity before having a break or moving on to another task. Research has found that pacing was the strategy patients used most consistently at follow-up (Curran, *et al.*, 2009) This concurred with the findings for therapist-participants in the current study. However a structured review of the evidence for pacing, noted that it was an "ill-or undefined construct" (Gill & Brown, 2009, p. 214). After extensive searching of the available literature, they found no outcome studies "specific to pacing as an intervention for chronic pain" (p. 215). Discrepancies in the mode and application of pacing in therapist-participant narratives are reflective of the current literature.

Relaxation in some form was presented in all therapist-participants' pain programs or practice. Although relaxation methods are routinely present in chronic pain management programs and often administered by occupational therapists, there is limited evidence supporting their use. Research has noted the lack of agreement between occupational therapists and service users as to the effectiveness of relaxation (Brown, 2003). Brown and Pinnington (2007) found a paucity of evidence for the use of relaxation methods, however 89% of occupational therapists endorsed its use in chronic pain management. It appears based on therapist-participant narratives, that although not fully supported by evidence, relaxation methods continue to be taught on pain programs and used on an ongoing basis by some of their clients.

Cognitive behavioural methods, i.e., challenging negative thinking, talking about pain, thought stopping and distraction were integral in many therapist-participants' pain programs and practice. A recent study has suggested that being flexible in the use of behavioural methods may be more advantageous to pain program treatment outcomes (Vowles & McCracken, 2010). It compared traditional treatment methods such as pacing, relaxation and CBT to psychological flexibility methods, including acceptance and value-based action consistent with an ACT (Hayes, 2004) approach. The study proposed that behaviour "positively directed toward the achievement of meaningful and successful daily activity" would counter the need for methods aimed at avoiding pain and negative experiences of activity (Vowles & McCracken, 2010, p. 144). Therapist-participant narratives supported acceptance and readiness for change as critical indicators of their clients' ongoing pain management.

Proposed conceptual models for factors influencing chronic pain management

The themes from therapist-participant narratives and those from people with chronic pain (van Huet, Innes & Whiteford, 2009) were compared and contrasted to create conceptual models. Consensus on a number of themes was evident and the effect these had on ongoing management was affirmed. These themes were embedded into proposed conceptual models of agentic (active) and victimic (passive) approaches to chronic pain management or non-management (Figures 1.1 & 1.2).

These proposed conceptual models borrow and build upon theoretical perspectives existing in occupational therapy literature. They differ from existing concepts in that they are specific to chronic pain management and arose from the findings of this research. Wilcock (1999) proposed that occupation as a term could be seen as a "synthesis of doing, being and becoming" (p.1). *Doing* could be seen as "the active part of occupation that is readily observable" (Lyons, Orozovic, Davis, & Newman, 2002, p. 287). *Being* encapsulates individuality, certain personal abilities and being "true to oneself" (Wilcock, 1999, p. 1). *Becoming* describes the ability to change and grow into the future to achieve "self-actualization" (Wilcock, 1999, p. 1). Within this research, it is proposed that aspects of 'being', 'knowing', 'doing' and 'managing' were representative of the themes and findings that emerged.

Being: This represents the 'self/identity' characteristics of the clients therapist-participants saw in practice. It also acknowledges how therapists' clients saw themselves within the social world.

Knowing: Signifies the meaning ascriptions applied to chronic pain. These meanings were derived over time and therapists' practice experience of how clients viewed living with chronic pain

Doing: Symbolises the active use of strategies, adaptations and techniques that therapists saw enable their clients to engage in their life world.

Managing: Denotes the reciprocal characteristics of the above aspects. These elements interact with each other over time to influence management/non-management.

Insert **FIGURE 1.1**

Insert **FIGURE 1.2**

Limitations of the research

Conceptual limitations within qualitative research centre on issues of representation, trustworthiness of data gathered and interpreted, and power within research relationships (Cohn & Lyons, 2003; Curtin & Fossey, 2007). In terms of representation the range of therapist-participants interviewed included therapists considered early-career practitioners and elite in terms of years of experience. Their perspectives could differ appreciably depending on knowledge acquired and practice experience. Trustworthiness was addressed by the use of triangulation and member checking (multiple transcript analysis and sending summaries to participants), however misinterpretation could remain. Power relates to being heard, and to have one's contribution represented in the research process. Therapist-participants might have felt that their programs required justification in their approach and strategies used. This could have influenced their answers, as most saw few limitations within their current practice.

Conclusion/future research:

To be cost effective many chronic pain programs are delivered in a group context. The majority of these programs use cognitive behavioural interventions to change people's thinking about chronic pain and coping (I. B. Jensen, et al., 2005). The effectiveness of these programs has been demonstrated in domains such as depression (Vowles & McCracken, 2010), however aspects such as pain severity have equivocal findings (Morley *et al.*, 1999). Chronic pain is a subjective experience that is mitigated by a multitude of factors including personality, gender, social support and the influence of health care interventions (I. B. Jensen, *et.al.*, 2005; Richardson, Ong, & Sim, 2007). Therefore future research should focus on examining the benefits of individual and group-based programs, the efficacy of strategies and methods provided by occupational therapist and longer-term outcomes.

Examining the narratives of therapist-participants adds to knowledge about chronic pain management. This research has resulted in conceptual models of agentic and victimic factors that influence management. Based on prevalence and health care costs alone, occupational therapists require current pain knowledge to practice in an evidence-based way and this research adds to that evidence base.

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Appendix

Questions asked of therapist-participants

The key question asked was:

- What factors do you believe influence successful chronic pain management?

As this question was considered complex, especially within the therapist's given context, background information was gained prior to this question being presented. This included:

- Could you tell me about the chronic pain program/practice you are involved with?
- Could you tell me about your role within the program?
- What is the psychological approach used in the program/practice?
- Could you describe the overarching message that the program provides to clients about pain management?
- What is your opinion about the methods/strategies used in the program/practice?
- In your opinion what factors influence successful chronic pain management?
- In your opinion what factors limit successful pain management?
- Could you provide an example of a case that made a significant impact on your thoughts about pain management or your practice?