An Interpretative Phenomenological Analysis of the Lived Experiences of Receiving Cognitive Behavioural Therapy Interventions for Chronic Pain by Individuals Living with Chronic Primary Pain Conditions

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Abstract

Background

Chronic Pain is a debilitating condition affecting billions worldwide with devastating consequences for the individual with chronic pain and those around them. Chronic Pain can be experienced as part of an underlying condition such as cancer (chronic secondary pain) or as ‘a disease’ in its own right (chronic primary pain). With chronic pain being a dynamic interplay between biological, social, and psychological factors, it is imperative for psychological treatments to be adequate in meeting the psychological needs of individuals with chronic pain. To date, Cognitive Behavioural Therapy (CBT) is the most commonly offered form of psychological therapy for chronic pain. This thesis sought to investigate how CBT interventions making up CBT treatment packages for chronic pain were experienced by participants with chronic primary pain conditions.

Method

An Interpretative Phenomenological Analytical approach was chosen as the most suitable theoretical framework aligned to the aims of this thesis. Seven participants who were living with chronic primary pain conditions based on the ICD-11 classifications and had received CBT treatment for chronic pain were recruited for participation. Through semi-structured interviews, participants shared their experiences of each CBT intervention making up their course of treatment. In keeping with IPA methodology, a case-by-case idiographic analysis was conducted followed by cross cases analysis.

Findings

Five CBT interventions for chronic pain were identified within the data set. Participants shared their experiences of 1) Behavioural Activation, also known as activity scheduling, 2)

Problem Solving, 3) Graded Exposure, 4) Thought Challenging and 5) Pacing. Five Group Experiential Themes (GETs) representing participants' subjective experiences of these CBT interventions were developed. The first, '*Regained Autonomy'* highlighted positive gains attributed to the CBT interventions graded exposure, problem solving and behavioural activation by participants. These gains include improvements to sense of agency, power of choice and independence. The second, *'A changed Pain Mindset'* described participants' experiences of thought challenging whilst the third GET, '*The Pain in Pacing'* highlighted cognitive and emotional barriers to pacing as reported by participants. The fourth GET, '*Indirect Interventions'* presented factors (therapist style and the support of loved ones) participants reported to have contributed to their experience of CBT interventions whilst the fifth GET, '*CBT did not cure my Pain'* addressed participants' views on labelling CBT as a treatment for chronic primary pain.

Conclusions

The results provide insights into how specific cognitive behavioural interventions are experienced by patients with chronic primary pain and why they were experienced in that manner. Participants' experiences of CBT interventions highlighted an interplay between the meaning assigned to the doing encompassing each intervention and the personal fight to preserve self-identity not just pain. Participants favoured CBT interventions with procedures that were additive to their behavioural repertoire, with such interventions being experienced as allies in their fight to reclaim their self-identity. These insights are useful in both research and clinical spheres with the potential to improve patient clinical outcomes.

Chapter 1 Thesis Introduction

Chapter Introduction

This chapter presents an introduction to the thesis. The researcher's motivation for the current study is presented within the chapter, which is concluded by a presentation of the current study aims and objectives. A summary of the thesis chapters is provided to orient the reader to this thesis.

Personal Motivation

After a few years of working as a Cognitive Behavioural Therapist as part of a large organisation, I was promoted to the position of Clinical Lead. I was given the responsibility to operationalise an integrated pathway between our Talking Therapies service and local pain clinics as part of the service's implementation plan of the then Five Year Forward View of Mental Health (NHS England, 2018). I eagerly accepted the challenge with a lot of hope and enthusiasm. Together with all stakeholders, we agreed an action plan. As the lead clinician, I was responsible for providing the clinical oversight for the implementation of CBT groups for chronic pain. Once the groups were set up, I co-facilitated the groups with another CBT Therapist as well as providing clinical supervision and training for CBT therapists on working therapeutically with chronic pain.

Despite these best efforts, the groups suffered from high dropout rates ranging from 40% to 65%. Moreover, the CBT therapists assigned to the groups started complaining of poor performance scores on their individual key performance indicator scales due to the outcome measures from chronic pain patients indicating a lack of clinical improvement on outcome measures such as the patient health questionnaire (Kroenke et al., 2001) and generalised anxiety scales (Spitzer et al., 2006) together with the work and social adjustment scales (Mundt et al., 2002).

In target driven environment as in NHS Talking Therapies services, this would reflect negatively on the clinician's statistics and affect their yearly targets. These issues highlighted to me that although clinically sound on paper, there was something about our provision that was lacking. Although many patients who dropped out did not complete end of therapy feedback, those that did increased my sense of awareness on the debilitating nature of chronic pain and the toll it has, not only on the individual but also their families. I began to question how much of this lived experience is addressed in CBT. It was at this point I developed authentic empathy towards the experience of chronic pain. I developed a 'real therapeutic relationship' as coined by Gelso (2009, p. 119) to mean "the personal relationship between therapist and patient marked by the extent to which each is genuine with the other and perceives/experiences the other in ways that befit the other" with chronic pain patients. Through this, a passion to better understand the lived experience of chronic pain and how CBT is experienced by individuals with chronic pain was ignited. Due to my role as a Clinical Lead at this time, I started researching into potential improvements within existing literature and soon identified the main improvements focused more on improving access and practical modifications such as session length rather than offers of in-depth clinical considerations that pay respect to the complexities of chronic pain as experienced by patients. In a field where the efficacy of CBT for chronic pain backed by a plethora of randomised control trials, I reasoned that the need wasn't that of re-examining the efficacy of CBT, but that of investigating how CBT is experienced from the perspective of those receiving CBT for various forms of chronic pain conditions with the goal of better informing current CBT clinical practice and improving clinical outcomes for patients.

Literature searches soon revealed a limited number of qualitative inquiries devoted to not only investigating the experience of receiving CBT from the perspective of patients but also generating actionable clinical contributions to CBT clinical practice beyond generic modifications to improve accessibility.

Although I am an outsider to the chronic pain group, I see my position as an ally. I believe my unique position as a CBT Therapist who on her journey unexpectedly became more conscious to the plight of chronic pain patients puts me in a unique position in that I am not seeking to defend my core profession, neither am I seeking to bash it, rather I am seeking to bridge the gap between my commitment to delivering evidence based CBT therapies and meeting the needs of individuals who for many years have reported not being seen or heard and experiencing psychological therapies as a fob off and evidence of their pain experience being invalidated by healthcare professionals (Bee et al., 2016; Wallace et al., 2014).

Advancements in the classification of Chronic Pain

More recently, in their update of the International Statistical Classification of Diseases and related health problems (ICD-11), the World Health Organisation included chronic pain (World Health Organisation, 2019/2021). This is an important first step in fully acknowledging the debilitating nature of chronic pain as a standalone condition with a life of its own (Treede et al., 2019). Furthermore, chronic pain was classified under two distinguishable clusters of chronic primary pain and chronic secondary pain. A distinction which arguably implicates both research and clinical approaches. Chronic primary pain includes pain conditions for which there is a continuous pain lasting for a period longer than 12 weeks and lacking in identifiable underlying cause, such as fibromyalgia and musculoskeletal pain, while the chronic secondary pain (CSP) includes pain conditions for which causes are known such as chronic cancer related pain and neuropathic pain. A succinct summation of these advancements might simply be, “pain as a disease in its own right vs. pain as a symptom” as postulated by Treede et al. (2019, p. 109).

Why Chronic Primary Pain?

Chronic Primary Pain can be described as when “pain itself is the disease” (Treede et al., 2019, p. 20). Simply put, the chronic pain an individual fitting the chronic primary pain classification may be experiencing is causing significant distress and disability, yet it cannot be adequately medically explained or attributed to another primary disease such as cancer or arthritis. Chronic pain conditions fitting the chronic primary pain cluster include fibromyalgia, chronic widespread pain, chronic headaches, and chronic regional pain. A key observation made within the feedback provided by patients post the CBT for chronic pain group was the presence of subtle but noteworthy differences in the emotional and psychological experiences based on pain condition. Patients whose chronic pain was not medically explained appeared to struggle more with acceptance and often reported the need to continue fighting to get back their old selves. This finding is not surprising, however what this finding led to was a genuine curiosity to understand how CBT interventions are experienced by individuals whose chronic pain condition may be further complicated by the emotional and psychological complexities accompanying living with chronic pain that is not medically adequately explainable.

Research Question

This thesis sought to respond to the question, “How are CBT interventions for chronic pain experienced by individuals living with chronic primary pain?” A sub question was, “How can the findings inform current CBT clinical practice for chronic primary pain patients”?

The goal was to make novel and meaningful contributions to the existing body of knowledge pertaining to how cognitive behavioural interventions can be best utilised therapeutically when working with clients whose chronic pain condition cannot be medically explained based on the lived experiences of participants.

Research Aim and Objectives

The current study aims to provide an in-depth understanding and exploration of how CBT treatment interventions utilised in the management of chronic pain are experienced by individuals with chronic primary pain conditions.

The current study carries three objectives presented below:

1. To investigate specific benefits and challenges attributed to each CBT intervention making up the course of CBT treatment by participants with chronic primary pain conditions.
2. To identify potential implications of the findings in (1) to current clinical CBT practice for chronic primary pain.
3. To make clinically relevant contributions in the form of modifications to CBT treatment formulations and protocols for clinicians working with chronic primary pain.

Overview of Thesis Chapters

To orient the reader to the organisation of this thesis brief descriptions of each chapter will now be presented.

Chapter one provided the reader with an introduction to the thesis and its origins. The personal motivation that led the researcher to embark on the journey of exploring CBT for chronic pain was shared. The key research question, aims and objectives shaping the current study were presented.

Chapter two discusses the psychology of chronic pain. Particular attention is paid to how chronic pain is understood and the psychological factors accompanying the experience of chronic pain. This chapter also discusses how cognitive behavioural therapy addresses the psychological factors accompanying chronic pain as well as a critical discussion on the efficacy of CBT as a psychological intervention for chronic pain.

Chapter three presents a thematic synthesis of qualitative studies on patient experiences of cognitive behavioural therapy treatment for chronic pain. This chapter presents the identified research gaps the current study seeks to investigate. Chapter 3 concludes with a case for the current study.

Chapter four presents the chosen methodology for the current study, highlighting the theoretical underpinnings of the methodology as well as a strong defence for the suitability of this methodology for the current study.

Chapter five sets out the methods adopted in the current study. Methods adopted are critically evaluated, and ethical dilemmas and actions taken to mitigate dilemmas critically discussed.

Chapter six provides a presentation of the findings emanating from the current study in line with research questions, aims and objectives. The extracts from interviews are used in evidencing and supporting the themes developed from the data analysis.

Chapter seven is a critical discussion of key findings in line with existing research, policy, and clinical practice. The contributions made to the existing body of knowledge pertaining to CBT for chronic primary pain are presented and discussed.

Chapter eight highlights the proposed pain specific CBT formulation developed through the findings of the current study and discusses its potential utility in clinical practice. The chapter also lays out the training implications of the current study.

Chapter nine concludes this thesis with a presentation of the dissemination strategy for the current study findings.

Chapter Summary

This chapter sought to introduce the current study, taking the reader through the motivations for the current study, the study aims and objectives. The following chapter will commence the presentation of the current chronic pain landscape.

Chapter 2 The Psychology of Chronic Pain

Chapter Introduction

The focus of this chapter is to orient the reader to the current picture of chronic pain within psychological therapies followed by a discussion of how Cognitive Behavioural Therapy attends to the psychological facets of chronic pain. CBT as a psychological treatment for chronic pain will be critically appraised.

Making sense of chronic pain

Chronic pain is a debilitating condition with a global prevalence of an estimated 1.5 billion (Zimmer et al., 2022). Dubbed the “silent epidemic” (Davies, 2016) chronic pain was estimated to affect at least two thirds of the UK population in 2016 with the figures projected to rise (Fayaz et al., 2016). Chronic pain is not just a personal problem, the effects of chronic pain have a ripple effect, destabilising interpersonal relationships, employment opportunities and the social fabric within the communities the individual sufferer belongs to (Dydyk & Conermann, 2024).

Chronic pain is not simply acute pain that has not gone away after a period of time, rather it is a pain with a life of its own, characterised by continuous pain persisting for a period longer than 12 weeks and over a precipitating underlying injury or illness (World Health Organisation, 2019).

Theories and Models of chronic pain

Historically, theories of pain such as the pattern and specificity theories made sense of pain primarily from a biological perspective. Drawing from both pattern and specificity theories, Melzack and Wall (1965) developed the Gate Control Theory of pain which made key contributions to the theoretical understanding of the pain experience. The Gate Control Theory postulates that when injury occurs on or within the body, pain signals pass through key locations within the spinal cord before being transmitted to the brain (Trachsel et al., 2025). The substantia gelatinosa, which is located within the dorsal horn of the spinal cord was characterised by Melzack and Wall (1965) as functioning in a gate like manner, controlling the going in and out of pain signals to the brain. As with any gate, when open, there is passageway to and from and when the gate is closed, access is prohibited. According to Melzack and Wall (1965), the gates within the substantia gelatinosa open in response to pain intensity. When certain pain levels are reached, the gates are prompted to open (Melzack & Wall, 1996). However, what was lacking was an adequate explanation on how this was determined by the body (Trachsel et al., 2025). Melzack and Wall (1965) pointed to further mechanisms located within the brain they deemed to be playing a cognitive and emotional part in the pain experience. Although this earlier work of Melzack and Wall (1965) did not put forward psychological theories to pain despite suggesting a cognitive and emotional element to the pain experience, the Gate Control Theory has made important contributions to the understanding of pain. The Gate Control Theory played a pivotal role of suggesting a mind-body connection at a time where pain theories were primarily biological in nature.

Almost 30 years later, following exposure to the experiences of amputees who reported pain sensation in areas where they had lost limbs, Melzack updated their earlier work, putting forward the neuromatrix model of pain (Melzack, 2001). Unlike the Gate Control Theory in which pain signals were seen as passing from the spinal cord to the brain, the Neuromatrix

Model postulated that pain is given rise by the central nervous system (Melzack, 2001). The Neuromatrix Model pointed the complex and dynamic engagement of key areas within the brain (cortex, sensory motor cortex, thalamus and limbic system) as ultimately shaping the pain experience (Melzack, 2005). The Neuromatrix Model of pain displays an interaction of both genetics and a person's experience in the shaping of their pain experience. Melzack (2001) asserted that it was the combined action of both genetic determination and experiences such as past pain experiences and the meanings made, sensory inputs and stressors that led to the formation of an individual's pain neurosigniture (Melzack, 2001). This neurosigniture is unique to an individual and modulates an individual's pain experience including the intensity and characteristics of their pain experience (Trachsel et al., 2025). This latter work of Melzack (2001) is important in highlighting the individuality and complexity of the pain experience. A succinct summation of this contribution to understanding pain and its implication is that pain is a multifaceted and complex experience made up of sensory, affective and cognitive elements that cannot be adequately explained through the biological lens alone.

Subsequently, the Biopsychosocial Model of pain, which puts strong emphasis on the dynamic interaction between biological, psychological, and social facets of chronic pain has become the most commonly utilised model and approach to understanding and treating chronic pain (Gatchel et al., 2007). The Biopsychosocial Model posits that as medical illness transcends into the realm of chronicity, multiple layers of complexity within the aforementioned facets are inevitable add-ons to suffering (Gatchel et al., 2007). Thus, effective treatment for chronic pain must respond to biological, psychological and social facets and the interplay between them (Nicholas, 2022).

Psychological Theories and Models of chronic pain

Decades of research have helped shed light on psychological hallmarks of chronic pain such as pain-related catastrophising and pain related disability. The Fear-Avoidance Model of exaggerated pain perception introduced by Lethem et al. (1983) is arguably one of the most influential psychological models in understanding the psychology of chronic pain. According to the Fear-Avoidance Model, pain perception is made up of two key elements, the sensory and the emotional reaction elements (Lethem et al., 1983). Whilst the sensory element focuses on the physiology of pain, the emotional reaction element is psychological in nature. The emotional reaction element was said to be encompassing three sub-components, "the pain experience, pain behaviour and physiological responses to pain stimulation" (Lethem et al., 1983, p. 402). Lethem and colleagues argued that there were individual variations in the extent to which psychological and physiological elements of pain dynamically interacted and they were interested in making sense of how and why this was so (Lethem et al., 1983). They centrally positioned the fear of pain and the response to the fear of pain in explaining the variation among individuals.

The Fear-Avoidance Model asserted that individuals whose chosen response was to confront rather than avoid fared better and were more likely to test the factual reality of their pain experience through doing. Contrastingly, individuals who avoided the pain experience and painful activities were at risk of developing an exaggerated pain perception (Lethem et al., 1983). A definition for an exaggerated pain perception being a "pain experience and/or pain behaviour (and/or physiological responses to pain stimulation) which are (is) out of all proportion to demonstrable organic pathology or current levels of nociceptive stimulation" (Lethem et al., 1983, p. 402). An exaggerated pain perception lends itself to both physiological and psychological costs for the individual. The Fear-Avoidance Model of exaggerated pain perception has evolved and continues to do so as revisions to its original state have been made and continue to be made in response to research findings. For example, Leeuw et al. (2007) incorporated pain intensity to the Fear-Avoidance Model as they found the greater the pain, the less likely an individual would be motivated to confront instead of avoiding activities. The Fear Avoidance Model continues to be a useful psychological framework in understanding chronic pain and informing pain management interventions (Leeuw et al., 2007).

The Misdirected Problem-Solving Model (Eccleston & Crombez, 2007) also provides useful insights into the psychology of chronic pain. This model places strong emphasis on the role of worry and problem framing in chronic pain. Worry is a natural response to perceived danger or threat. Worry can be described as an internal risk management process characterised by an individual attempting to generate possible solutions to the imagined often future focused threats (Brosschot & Verkuil, 2013). In relation to pain, when an individual experiences pain, the natural response to this is that of finding ways to extinguish this pain, often relying on biomedical solutions such as pain medications. Should pain subside, worry is extinguished. However, should pain persist, worry also increases, with the individual becoming more concerned about the pain and why it has not been solvable. This worrying is accompanied by additional challenges such as hypervigilance and hyperawareness to pain related cues (De Vlieger et al., 2006). The insolvable pain continues to have a hold on attention, consequently fuelling worry (Eccleston & Crombez, 2007). Despite the fruitlessness of the solutions the individual may have attempted to implement, the individual continues their quest to find a solution. Eccleston and Crombez (2007) referred to this as the perseverance loop. It is this loop that often keeps people with chronic pain stuck. According to the misdirected problem-solving model, when an individual with chronic pain is within the perseverance loop, they are often unable to reframe the problem from a non-biomedical frame, as such they continue persevering for a solution that does not materialise. Consequentially the individual's physical and mental health suffers. As aptly put by Eccleston and Crombez (2007, p. 235) "how one frames the problem is more important than their ability to problem solve". Therefore, individuals need to be able to reframe their pain perspectives to make way for alternative explanations and solutions to managing and living with persistent pain.

The models of pain presented within this section amplify the need for psychological interventions that can aptly respond to psychological factors accompanying the chronic pain experience. A number of psychological interventions have been heavily influenced by the presented models, for example graded exposure therapy (Vlaeyen et al., 2001).

Psychological Therapies for Chronic pain

The National Institute for Health and Care Excellence (NICE) in the UK provided guidance on the assessment and treatment of chronic pain that includes psychological therapies. In 2021, NICE published guidance titled, "Chronic pain (Primary and Secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain" in which Acceptance and Commitment Therapy (ACT) or Cognitive Behavioural Therapy (CBT) were recommended as effective psychological therapies for chronic pain (NICE, 2021). ACT has long been considered as part of a group of approaches classified as third wave CBT, however ACT is fast becoming a well-established approach in its own right (McCracken et al., 2013). Despite these advancements within ACT, CBT which is an amalgamation of behavioural and cognitive approaches is still the more commonly offered psychological therapy in the treatment of chronic pain (Lim et al., 2018).

Definition of CBT

Due to the broad application of the CBT treatment label, it is critical for studies to be explicit on what their adoption of the label 'CBT' is referring to. The label of CBT has been applied as an umbrella term representing an array of approaches including but not limited to Cognitive Behaviour Therapy, Cognitive Therapy, Behavioural Therapy, Acceptance and Commitment Therapy and Schema Therapy (David et al., 2018). However, the most common definition of CBT is an amalgamation of behavioural and cognitive therapy principles (Blackwell & Heidenreich, 2021). The current study adopts the latter definition of CBT as represented within the British Association of Behavioural and Cognitive Psychotherapists (BABCP) minimum training standards (BABCP, 2012) and core training curriculum (BABCP, 2021).

CBT for chronic pain

The focus of CBT treatment for chronic pain is that of helping an individual identify their own maladaptive thinking and behaving patterns that may be serving to maintain or exacerbate emotional distress, pain related disability, pain catastrophising, hypervigilance, rumination and pain intensity (Knoerl et al., 2016).

The evidence for CBT

There is a plethora of randomised control trial studies lending support to the efficacy of CBT in the psychological treatment of chronic pain (Eccleston et al., 2009; Morley, 2011; J. W. Vlaeyen & S. Morley, 2005). In 2012, Williams and colleagues conducted the largest Cochrane review of psychological therapies for chronic pain at the time. The key objective was that of investigating the effectiveness of psychological therapies when compared with non-active placebo treatment, waiting list control as well as treatment as usual in tackling pain related psychological difficulties (Williams et al., 2012). In 2020, Williams and colleagues updated their review, conducting new searches that led to a total of 75 studies (9401 participants with fibromyalgia, chronic low back pain, arthritis and mixed chronic pain). The largest evidence base was for CBT which made up 59 of the 75 studies. The remaining studies were made up of a mixture of behavioural therapy and ACT. When compared to an active control, CBT was found to have a very small benefit (standard mean difference -0.09, 95% confidence interval -0.17 to -0.01) at the end of treatment for pain. When compared to treatment as usual the benefits for CBT for pain at the end of treatment were also found to be small standard mean difference -0.22, 95% confidence interval -0.33 to -0.10). Williams et al. (2020) also found very small benefits on disability and distress when CBT was compared to both active treatment and treatment as usual. Williams et al. (2020) concluded that CBT beneficial in reducing pain, disability and distress however the benefits range from small to very small. This conclusion warrants the necessity for further primary research efforts into chronic pain and psychological therapies provision as the field continues working towards improving clinical outcomes.

In applying a closer critical lens to the methods adopted within empirical CBT studies included in reviews such as that by Williams and colleagues, it becomes evident that despite the shared CBT label on treatment, wide across study variations exist in relation to the CBT interventions making up the course of treatment. Although it is not entirely uncommon for a course of CBT to involve one CBT intervention, for example pacing or graded exposure, most courses of CBT for chronic pain are made up of a blend of multiple CBT interventions. There is an abundance of CBT for chronic pain treatment manuals and protocols combining various CBT interventions such as Thorn’s (2017) step by step guide for working with chronic pain that includes a mixture of cognitive restructuring techniques and relaxation and

Beehler et al.'s (2021) brief CBT manual for chronic pain which includes exercise, pacing, relaxation training, cognitive restructuring and behavioural activation. Similarly, Taguchi et al. (2021) developed a treatment protocol for chronic pain which includes relaxation, pacing, cognitive restructuring and attention training as CBT interventions. Whilst empirically supported treatment manuals and protocols can be beneficial in providing standardisation of treatment in clinical practice (Wislocki et al., 2023) in the absence of consensus within the field of the key 'ingredients' in the form of CBT interventions necessary for positive outcomes to be actualised, the plethora of treatment manuals with wide variations in the blend of interventions, delivery mode, duration of sessions and length of treatment can potentially push the field further away from the goal of better understanding what about CBT 'works' for chronic pain and how clinical outcomes can be improved (Ehde et al., 2014; Lim et al., 2018; J. W. Vlaeyen & S. Morley, 2005).

Agreeing on the CBT interventions necessary for positive outcomes for chronic pain is a complex task owing to a number of factors. One of the key complicating factors is the nature of chronic pain itself. Not only is the chronic pain experience debilitating and affecting how one engages in activities of daily living, it also brings with it a myriad of complex individual emotions and psychological factors such as mental defeat (Tang et al., 2007), grief (Furnes & Dysvik, 2010) and internalised stigmatisation (Waugh et al., 2014). The complexity of the chronic pain experience is spotlighted by the results yielded from large qualitative data syntheses by Toye and colleagues (Toye et al., 2013; Toye et al., 2017).

Toye et al. (2013) synthesised qualitative research that explored the lived experiences of individuals with chronic musculoskeletal pain. The emotional and psychological costs of chronic pain are reflected through the themes developed from the qualitative data syntheses. Through the use of a meta-ethnography method, Toye and colleagues (2013) synthesised 77 papers that had been generated from 60 studies on the experience of chronic pain, chronic musculoskeletal pain and fibromyalgia. A total of 1168 adults whose ages ranged from 18 to 91 years were represented within the data. The findings spotlighted the ongoing intense conflict between pain and self, a conflict Toye et al. (2013) referred to as the “adversarial struggle” (p.30). The adversarial struggle ensues as an individual desperately fights to keep hold of their life as they know it, including their sense of body, self, roles and relationships (Toye et al., 2013). These findings were updated through a mega-ethnographic study (Toye et al., 2017). A total of 5000 participants from 187 included studies were represented within this larger study. The findings corroborated their earlier findings and enhanced understanding of the pain experience. Seven concepts emanated from the larger study namely, 1) my life is impoverished and confined, 2) struggling against my body to be me, 3) the quest for the diagnostic ‘holy grail’, 4) lost personal credibility, 5) trying to keep up appearances, 6) the need to be treated with dignity and 7) deciding to end the quest for the holy grail is not easy. These concepts provide useful insights into some of the internal and external biological, social and psychological complexities accompanying the chronic pain experience and how these experiences may implicate the experience of healthcare. It is plausible to assert that many CBT treatment manuals and the conventional outcome measures are over simplified as they focus on tackling and measuring pain levels, pain related disability, catastrophising and hypervigilance, whilst missing the complex emotions and psychological factors such as those reflected by Toye and colleagues.

van Rysewyk and colleagues (2023) conducted an updated systematic review and synthesis following on from the work of Toye et al. (2017). Not only did the findings corroborate Toye et al. (2017), van Rysewyk et al. (2023) validated the themes through a questionnaire-based survey that was completed by 1219 people living with chronic pain. They found participants strongly agreed that the themes [1) my pain gives rise to negative emotions, 2) changes to my life and to myself, 3) adapting to my new normal, 4) effects of my pain management strategies, 5) hiding and showing my pain, 6) medically explaining my pain, 7) relationships with those around me, and 8) working while in pain] developed through the synthesis reflected their pain experience.

In response to the presented evidence, it can be argued that by design, CBT for chronic pain, which is often structured and standard in nature, potentially fails to consider the impact of personal meanings and how these meanings could implicate how an individual might engage with CBT treatment. As aptly put by Themelis and Tang (2023), "the limited success of current clinical interventions highlights the need to better understand the lived experiences of individuals" (p.4). van Rysewyk et al. (2023) goes on further to assert that the lived experience is often a "blind spot in pain management" (p.592). Despite some successes in psychological therapies, challenges persist. The field still grapples with the challenge to maximise and improve clinical outcomes for chronic pain patients. The need for research focused on bringing forth innovative psychological interventions catered to chronic pain together with research that leads to improvements to current psychological interventions is evident (Themelis & Tang, 2023).

Noteworthy advancements in the form of hybrid treatment protocols are starting to emerge. Hybrid treatment protocols not only include CBT interventions directly targeting chronic pain factors but also the complex and personal psychological factors accompanying the experience of chronic pain. An excellent example of a hybrid treatment is that of Tang et al. (2012) in which pain related psychological factors and sleep difficulties (insomnia) were targeted simultaneously as part of a single episode of CBT treatment for chronic pain. It is common knowledge that sleep is necessary for daily functioning and wellness. It is also not surprising that being in persistent pain can significantly impact one's ability to sleep, which in turn not only exacerbate the pain experience but also lead to other difficulties such as depression and chronic fatigue (Nutt et al., 2008). Tang et al. (2012) found significantly higher improvements in fatigue and mood and the rate to which pain affected daily life in the hybrid treatment group when compared to a control group. This result lends support to the shift towards hybrid treatment manuals that address psychological factors exacerbating chronic pain as well as the personal and complex psychological factors making up the chronic pain experience. These findings also serve as an encouragement for further research exploration into CBT for chronic pain that does not shy away from dismantling the status quo as the field journeys towards better understanding what works and how clinical outcomes from CBT treatment could be improved for chronic pain patients.

A dismantling might look like a dedicated examination of individual CBT interventions often adopted in the treatment of chronic pain. One might propose such an inquiry to be investigated through quantitative methods. However, it can be argued that owing to the multi-faceted nature of the chronic pain experience and the lived experience of chronic pain being a common blind spot in chronic pain treatment (van Rysewyk et al., 2023) there are deeper insights into the effectiveness or ineffectiveness of specific CBT interventions necessary in the journey to improve clinical outcomes that ought to be gleaned through patient experience focused inquiries.

Justification for a qualitative inquiry

The current study seeks to adopt an inductive qualitative approach to facilitate the exploration of how CBT interventions for chronic pain are experienced by participants. Placing the participant centrally and amplifying their voice is advantageous as it potentially culminates in access to the insider's view, gaining deeper insights to an individual's experience and perspective (Conrad & Conrad, 1987). With the lived experience being the "blind spot" plaguing pain management (van Rysewyk et al., 2023, p. 592), qualitative studies in which knowledge is built from "the ground up rather than handed down entirely from a theory or from the perspectives of the inquirer" (Creswell, 2013, p. 22) facilitate the capturing the richness and complexity of the experience potentially bring in focus the blind spots alluded to by van Rysewyk et al. (2023).

The researcher asserts that a qualitative focus to the current study provides an opportunity for her to adopt a genuinely curious stance that will enable her to understand how CBT interventions were experienced and the personal value led clinical outcomes ascribed to CBT interventions by participants with chronic primary pain. With the distinct classifications of chronic pain into chronic primary pain and chronic secondary pain clusters being a relatively new update (World Health Organisation, 2019/2021), very few studies have adopted this distinction clearly in their study reporting. The researcher views the current study as the beginning of an explorative journey, focusing solely on chronic primary pain. The beginning stages of this journey lend themselves well to adopting a qualitative approach as this approach facilitates the capturing of knowledge grounded in participants' own experiences. This knowledge could potentially become the foundation on which hypotheses for future quantitative studies are generated.

Chapter Summary

The current chapter sought to introduce the reader to the current landscape of CBT psychological therapy for chronic pain. Theoretical foundations of CBT and how these are applied to how chronic pain is understood from a CBT perspective were presented. Key research demonstrating the efficacy of CBT for chronic pain was discussed and appraised. The chapter concluded with a presentation of the challenges plaguing the field and a brief discussion on the need for patient focused inquiries in responding to these challenges.

The next chapter is a presentation of the review of literature. The goal is that of investigating what knowledge from the lived experiences of patients already exists within the field of CBT for chronic pain as well as identifying gaps within the already existing research.

Chapter 3 Literature Review

Chapter Introduction

This chapter is dedicated to orienting the reader to the currently available qualitative data on patient experiences of CBT for chronic pain. A thematic analysis of identified qualitative studies exploring patient experiences of CBT for chronic pain that was conducted will be discussed and findings reported. Particular attention will be paid to what the synthesis of the included studies informs pertaining to how CBT for chronic pain is experienced by patients as well as reporting on the gaps identified within the already existing qualitative literature.

Review Aims and Objectives

The review seeks to explore the patient focused qualitative data on CBT for chronic pain that already exists within the field.

The objectives are threefold, namely, 1) to identify published research on the subjective experiences of receiving CBT for chronic pain and provide a critical evaluation of the identified research, 2) to synthesise the findings, 3) to identify research gaps within the available data.

Methodology

Although traditionally systematic reviews have been focused on quantitative data, newer methods allowing for qualitative data to be synthesised through qualitative systematic reviews without compromising the scientific rigour of systematic reviews have now been developed. This review adopted Thomas and Harden (2008) qualitative systematic review method, thematic analysis. This approach was favoured for this review as its foundations are within health promotion, making it more aligned to the matter under investigation as the aim of the review is that of investigating healthcare related experiences.

Study Inclusion and Exclusion Criteria

The review inclusion criteria centred on chronic pain patient experiences of CBT. Studies in which third wave CBT approaches such as Acceptance and Commitment therapy (ACT) and compassion focused therapy (CFT) were the primary core offer were excluded to ensure the review is centred primarily on CBT. The decision to exclude third wave CBT approaches was made to ensure that studies included within the review were comparable.

Definition of CBT Adopted

Due to the broad application of the CBT treatment label as highlighted by Lim et al. (2018), it is critical for studies to be explicit on what their adoption of the label 'CBT' is referring to. This review adopts the definition of CBT as an amalgamation of behavioural and cognitive therapy principles as represented within the British Association of Behavioural and Cognitive Psychotherapists (BABCP) minimum training standards (BABCP, 2012). Box 3.1 below sets out the full criteria used in the selection of published literature included within the review.

Box 3.1

Inclusion and Exclusion Criteria

Inclusion Criteria

1. Qualitative or Mixed Method research with a primary aim of exploring subjective individual experiences of adults who had received CBT based treatment for chronic pain.
2. Studies where there is clarity that individuals had attended at least three sessions of CBT based treatments in a group or one to one therapy setting.
3. Treatment description to match the theoretical framework of Cognitive Behavioural Therapy
4. Research published in English in peer reviewed academic journals
5. Studies including adults aged 18-75 years old diagnosed with chronic pain by a physician.
6. Clearly identifiable aims with appropriate research design

Exclusion Criteria

1. Studies where the treatment does not align with core CBT principles or is primarily ACT or CFT based.
2. Studies where chronic pain was alongside other primary conditions such as cancer and other terminal conditions.

Databases

Searches for relevant studies were conducted on multiple electronic health-based databases namely, PsycINFO, PubMed, MEDLINE, CINAHL and the Psychology and Behavioral Sciences Collection. The search strategy as highlighted in table 3.1 below was adopted across all databases.

Table 3.1

Database Search Strategy

Search Criteria	Search Terms	Search options
Problem	“Chronic pain*” OR “Persistent pain*” OR “Long term pain*” OR “Chronic primary pain*”	Boolean /Phrase Title OR Abstract
Intervention	“CBT*” OR “cognitive behavioural therapy *” OR “Cognitive behavioural therapy *” OR “Cognitive behavioural interventions”	Title OR Abstract
Outcome	“Patient View*” OR “Patient experience*” OR “Patient opinion*” OR “Patient attitude*” OR “Patient perception*” OR “qualitative”	Title OR Abstract

Search Results and Limitations

Initial searches were conducted between January and April 2020. The second search was conducted in July 2023 and final searches were carried out in May 2024. The identified studies were also reviewed with supervisors to ensure thoroughness in the retrieval of studies. The searches across the named databases led to a total yield of fifty-one studies.

Table 3.2 below presents the final search outcome across all the relevant databases.

Table 3.2

Database Search Results

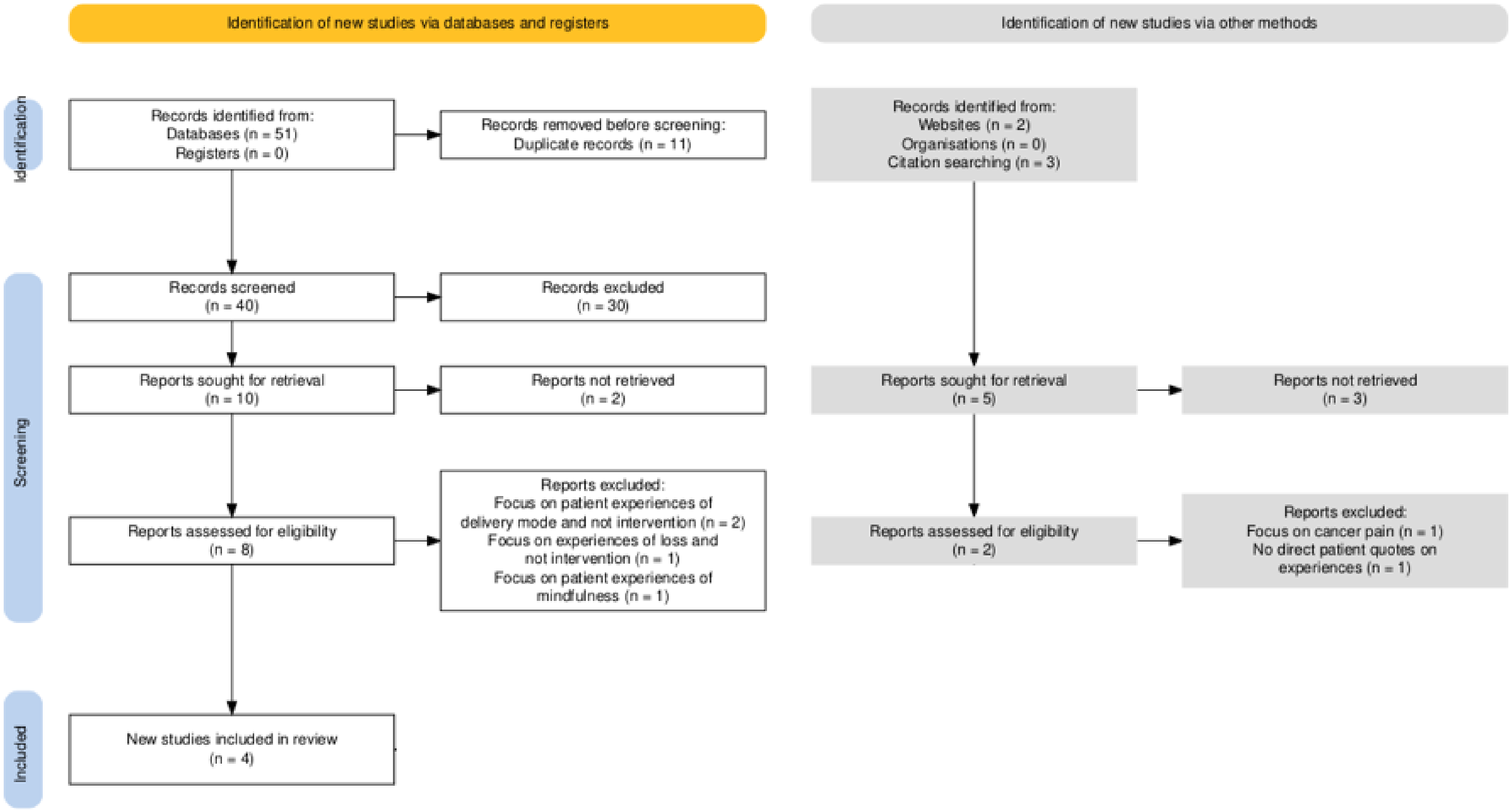
Database	**Search Results**
CINHAL	9
MEDLINE	16
PsycINFO	10
PubMed	15
Psychology and Behavioral Sciences Collection	1
Limitations English Language, Date: 1995-2024, Peer reviewed, Adults (18+)	
Total Papers from Databases 51	

Preferred Reporting Items for Systematic Reviews

PRISMA (Preferred Reporting Items for Systematic Reviews) guidelines were used, as such a PRISMA flow chart was completed as presented in Figure 3.1.

Figure 3.1

Paper Selection Process- Prisma Flow Chart



PRISMA Flow Chart, Haddaway et al. (2022)

Overview of Included studies

The following summaries provide an overview of the studies included within the review.

Study One

Egan et al. (2017) investigated patients' long-term perceptions of a Cognitive Behavioural Therapy pain management programme. Patients who had undergone a four-week CBT pain management programme over a span of 7 years were recruited for participation and grouped into clusters depending on when they engaged in their treatment. A focus group study design was employed in their exploration of how the CBT programme itself was viewed and experienced. Particular attention was paid to the exploration of the strategies patients learnt during the four-week programme and which of the strategies they continued to use post treatment. The study was conducted in Dublin, Ireland. A total of sixteen participants comprising of 12 female and 4 male participants with a mean age of 54.9 were included in the study.

Study Two

Bee et al. (2016)'s qualitative investigation on patient perspectives of the management of chronic widespread pain in UK primary care was nested within a larger randomised control trial. The qualitative arm of the investigation sought to better understand what influenced treatment acceptability from the perspective of patients. Patients had received either CBT, prescribed exercise or a combination of both CBT and prescribed exercise. The qualitative findings were presented for each of the groups enabling this study findings to inform this review on CBT for chronic pain. The study was conducted in Aberdeen, Scotland. A total of forty-four participants comprising of 34 female and 10 male participants with a mean age of 58 were included in the study.

Study Three

Through written reports six months post treatment, Furnes et al. (2014) sought to investigate patients' experiences of an eight-week CBT based chronic pain management programme. The study aim was centred on the exploration of how therapeutic elements such as the role of writing, a core component of CBT, was experienced. The study was conducted in Norway. Thirty-four participants with a mean age of 49 were included in the studies, the authors did not provide gender-based demographics.

Study Four

Cattanach et al. (2021) investigated patient experiences of three psychological interventions for chronic pain namely, mindfulness meditation, cognitive therapy, and mindfulness-based cognitive therapy. Participants were recruited from a randomised control trial comparing the three interventions. The study captured the experiences of participants in groups based on the intervention they received thus making this study suitable for inclusion within the review as the findings for cognitive therapy could be gleaned separately from the other interventions. One of the study’s aims was that of examining firsthand accounts of how participants experienced treatment techniques based on their group and what they deemed most useful, making this study a useful addition to the review. 19 female participants with a mean age of 47 were included within the study.

Quality Assessment of Studies

One of the recommendations from the Cochrane Qualitative and Implementation methods group guidance is for systematic reviewers to conduct quality checks on studies, to ensure conclusions drawn were birthed from robust evidence (Noyes et al., 2018). In assessing the methodological limitations, judgements can be made on how individual study findings could potentially implicate the synthesised findings. Assessing the quality of qualitative studies is not without its challenges, the multifaceted nature of qualitative studies lends itself to nuances in judgement based on the researcher if the quality check lacks a foundational standard checklist. As such, The Critical Appraisal Skills Programme (CASP UK, 2023) qualitative checklist was used in critically appraising studies included within the review. The CASP was favoured due to its wide acceptability and usage within health-related syntheses of qualitative data (Long et al., 2020). Table 3.3 below provides a presentation of the CASP checklist outcome for all included studies.

All studies were found to have clearly identifiable aims with appropriate research designs fitted to the aims and the methodological quality acceptable for inclusion.

Table 3.3

CASP appraisal of qualitative studies

Study ID (Author/ Year)	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?
Egan et al. (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Findings are considered in relation to relevant research-based literature
Bee at al. (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Findings are considered in relation to relevant current practice.
(Furnes et al., 2014)	Yes	Yes	Yes	Yes	Yes	Yes	Can’t Tell	Yes	Yes	Discusses Transferability of the findings to similar clinical situations
Cattanach et al. (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Findings are considered in relation to clinical practice and the authors make suggestions for Improvements to rehabilitation programs

Methods

Data Extraction

Data extraction from qualitative studies is not without its challenges. An important question at the core of data extraction from qualitative studies being what constitutes data. To ensure trustworthiness and rigour of method, this review followed the data extraction method set out by Campbell et al. (2003) which involves extracting what they coined “key concepts” (p. 674). Following on from this, for the purposes of transparency, box 3.2 highlights what the current review identified as key concepts for data extraction from the studies included within this review.

Box 3.2

Data extracted from included studies

- All text labelled as Results.
- Direct quotations from participants presented within the study findings.
- Key findings in the form of the themes identified within the study and their descriptions as presented within the study findings.
- Key conclusions drawn / Key Summaries as presented within the concluding chapter of the study.

Data analysis

Data analysis followed the three staged thematic synthesis approach as posited by Thomas and Harden (2008). The three stages are presented in Box 3.3 below.

Box 3.3

Thomas and Harden's (2008) Thematic Synthesis Stages

1. Line by Line Text Coding
2. Developing descriptive Themes
3. Generating analytical Themes

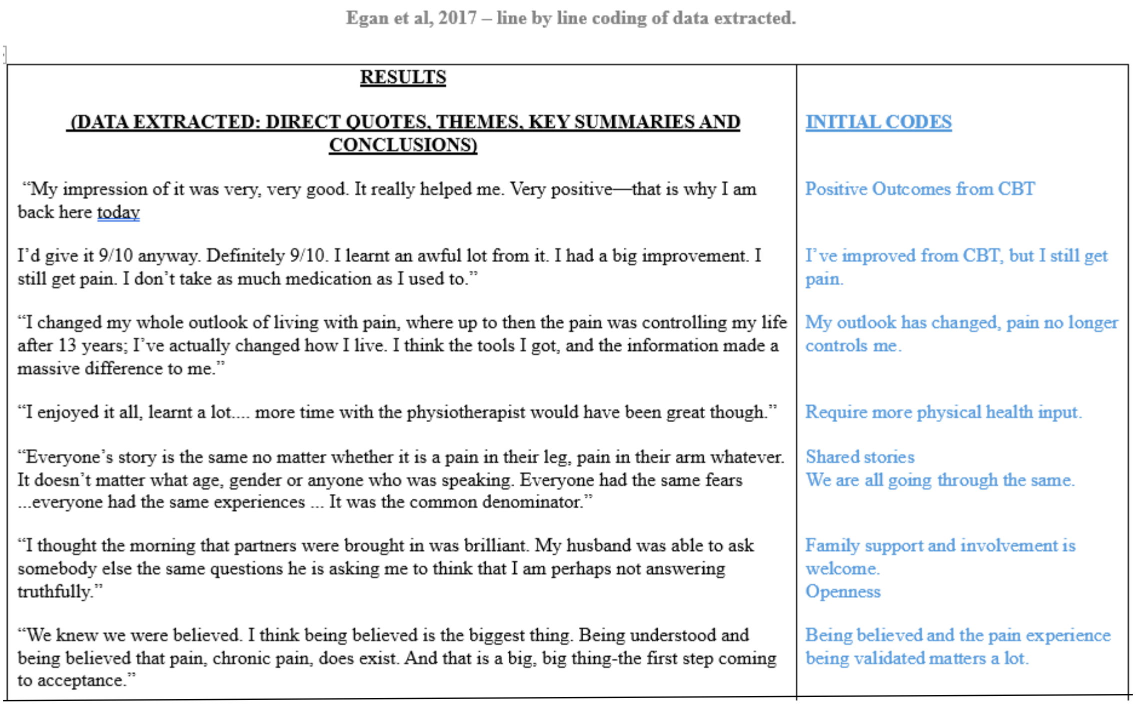
Line by line Text Coding

Data extracted from each individual study was added to separate Microsoft Word documents. Within each document, a table with two columns, one for housing extracted data and another for codes was created. All extracted data was entered verbatim to ensure data stayed the same as within the original study.

As the text was being read line by line, 'codes' which were unit descriptions of what was being read (Thomas & Harden, 2008) were generated and added in the second column in a different colour font as presented in figure 3.2 below.

Figure 3.2

Line by Line Text Coding Process (Example extract from analysis)



Egan et al, 2017 – line by line coding of data extracted.

RESULTS (DATA EXTRACTED: DIRECT QUOTES, THEMES, KEY SUMMARIES AND CONCLUSIONS)	INITIAL CODES
"My impression of it was very, very good. It really helped me. Very positive—that is why I am back here today	Positive Outcomes from CBT
I'd give it 9/10 anyway. Definitely 9/10. I learnt an awful lot from it. I had a big improvement. I still get pain. I don't take as much medication as I used to."	I've improved from CBT, but I still get pain.
"I changed my whole outlook of living with pain, where up to then the pain was controlling my life after 13 years; I've actually changed how I live. I think the tools I got, and the information made a massive difference to me."	My outlook has changed, pain no longer controls me.
"I enjoyed it all, learnt a lot.... more time with the physiotherapist would have been great though."	Require more physical health input.
"Everyone's story is the same no matter whether it is a pain in their leg, pain in their arm whatever. It doesn't matter what age, gender or anyone who was speaking. Everyone had the same fears ...everyone had the same experiences ... It was the common denominator."	Shared stories We are all going through the same.
"I thought the morning that partners were brought in was brilliant. My husband was able to ask somebody else the same questions he is asking me to think that I am perhaps not answering truthfully."	Family support and involvement is welcome. Openness
"We knew we were believed. I think being believed is the biggest thing. Being understood and being believed that pain, chronic pain, does exist. And that is a big, big thing-the first step coming to acceptance."	Being believed and the pain experience being validated matters a lot.

The end result was five separate documents with each study data coded individually. The second part of the line-by-line coding involved organising and cleaning the codes, ensuring code names are consistent within each transcript as well as across all transcripts.

Developing Descriptive Themes

In developing a thematic framework, the researcher firstly related back to the review question, aim and objectives. The research question pertains to the experiences of CBT and its interventions and tools by patients. The first step in developing descriptive themes involved extracting codes across all studies into one document, identifying related codes (themes) within the codes and grouping the codes based on the theme identified.

The three descriptive themes identified from the codes were: 1) therapeutic gains, 2) the experience of CBT and its interventions, 3) challenges. Within each descriptive theme sub-themes were identified as presented in Table 3.4 below. The codes were organised under the theme they fell under, also noting the number of times each code appeared within the data set.

Table 3.4

Descriptive Themes and Sub Themes

Therapeutic Gains	**The experience of CBT and its Interventions**	**Challenges**
Healthier mindset. (6) Better coping with situations (7) Regained confidence (5) I've regained control. (4) Pain no longer limits me. (7) No more guilt (3)	**Perception of interventions** Pacing, a new way of life. (4) Changing the pain thoughts is key and leads to other benefits. (4)	It is hard work to try to release positive thoughts. (2) Learning CBT was a struggle. (4) Cbt requires a lot of time to practice. (4)
	Perception of Procedural elements Writing down improves focus. (4) Homework is important. (2) Collaboration is key. (4)	
	New Knowledge and Skills I now have the right tools (4) Knowledge on Boom – bust cycles gained. (4) Now I know what to do with my pain. (3)	

Findings

Three key themes pertaining to patient experiences of cognitive behavioural therapy for chronic pain were identified across the included original studies. The following section will provide the findings within each theme.

The CBT Techniques

The theme *'The CBT techniques'* accounts for the specific CBT techniques / interventions represented within the data set and participants' experiences of them. Pacing, which is a key component in the CBT treatment for chronic pain (Nielson et al., 2013) was represented within the data set. Egan et al. (2017) shared excerpts from participants' experiences that gave insight into their experiences with pacing post-treatment. One participant was quoted to have shared how pacing had become a permanent way of life,

"Pacing, definitely pacing… pacing in everything, exercising, whatever I am doing at home, work, rest play- it's all paced" (Egan et al., 2017, p.223).

It is evident through this excerpt that pacing had become a daily life skill frequently engaged in.

Furnes et al. (2014) provided excerpts of participants stating how through their therapists they *"got so much advice that increased physical activities and improved my situation*" (p.1088). It is plausible to assume that the increased physical activities could be referring to pacing but caution must be exercised in finalising this assumption as increased physical activity is also part of other interventions such as physical exercise, graded exposure and behavioural activation which although similar to pacing, has subtle but very key differences to pacing.

Cattanach et al. (2021)'s study provided a spotlight on the cognitive restructuring method of thought challenging. A clear presentation of the various aspects of this intervention (i.e., knowledge of automatic thoughts and core beliefs, weighing evidence and generating alternative more helpful thoughts) experienced by participants was provided and corroborated by excerpts from participants accounts. For example, alongside the presentation of 'generating restructured thoughts' was the following participant account:

"it's been really good to be able to use that to break down my thought patterns and work on recognising that I don't need to be in control all the time…" (Cattanach et al., 2021: p.324).

Cattanach et al. (2021) went a step further in highlighting specific benefits (i.e., improved emotional regulation and increased behavioural repertoire) participants ascribed to thought challenging.

Bee et al. (2016) presented patient reported benefits from techniques such as relaxation, which though not CBT specific, are regular accompaniments of CBT therapy. For example, one of the participant excerpts reported in Bee et al. (2016) highlighted the effectiveness and importance of relaxation techniques in the management of chronic pain, *"you manage your pain better. You know what to do now if it starts to reach the top"* (p.16).

It is evident from the findings from Bee et al. (2016) that their course of CBT therapy led to better pain management and provided knowledge and tools to prevent the escalation of early warning signs.

The Benefits of CBT

The theme '*The Benefits of CBT'* accounts for participants reported positive gains from CBT for chronic pain. A key finding across all four studies was that CBT for chronic pain enhanced their quality of life. Quality of life encompasses multiple facets, including physical factors such as sleep, psychological factors like mood and emotional wellbeing as well as social and environmental factors (World Health Organisation, 1995). This array of factors marking quality of life is represented in the reported participants' experiences. In the study by Furnes et al. (2014), there are accounts of participants reporting physical aspects of wellbeing such as sleep to have improved post therapy, while Egan et al. (2017) report accounts of participants sharing changes to their outlook, and this having improved their quality of life.

"I have changed my whole outlook of living with pain where up to then pain was controlling my life after 13 years, I've actually changed how I live" (Egan et al., 2017: p.223).

From this excerpt as well as the follow-on discussion, it appears in Egan et al's (2017) CBT pain management programmes were credited to have led to individuals feeling more in control of their life. Prior to engaging in the support, it is safe to assume that for individuals, chronic pain had started to be more dominating in how they engaged with their life, consequently affecting their quality of life and perceived sense of control. Thus, it can be inferred from the data that CBT was credited with improving quality of life and one's sense of control and autonomy.

In Cattanach et al. (2021) study, cognitive therapy appears to be credited with participants feeling more in control of their internal world and this was supported by participant excerpts such as one from a participant who stated that despite challenges, she had acquired a better outlook that was credited with helping manage daily life better.

Bee et al. (2014) shared the experiences of participants expressing elevated levels of satisfaction with treatment. This led to some finding their voice, which they reported to have consequently enabled them to make decisions that worked for them instead of masking their thoughts and feelings in fear of being judged by others.

The Costs of CBT

In-between session homework tasks are a key feature of CBT treatment (Tang & Kreindler, 2017). Kazantzis et al. (2010, p. 120) provided a definition of in-between session homework in CBT as “specific, structured, therapeutic activities that are routinely discussed in session, to be completed between sessions”. Furnes et al. (2014) reported positive patient experiences of self-management tasks, drawing the conclusion that being actively involved through self-management tasks led to new insights. This conclusion is supported by patient accounts highlighted within the study. One participant account was reported:

“the writing was awareness raising. It brought up several thoughts and resulted in new perspectives” (p.1089*).*

Similarly, Egan et al., (2017) reported participants gaining a new way of life as they made long term changes to daily life through engagement with the practical elements of CBT. Their conclusions are corroborated by patient accounts:

“Whatever I am doing at home and at work rest and play its all paced, I have had to change my lifestyle” (p. 223).

It is evident from the accounts of participants in both Furnes et al., (2014) and Egan et al., (2017) that the engagement with the in-between session homework tasks in CBT was a key factor which may have contributed to participants’ positive experiences. However, this was certainly at a cost. In their study Cattanach et al., (2021) reported how some participants did not necessarily find the in-between sessions homework tasks in themselves challenging or difficult to engage with but highlighted the motivational cost of engaging with the tasks outside of sessions. As one participant reported:

*"I didn't find it difficult; I am just fundamentally lazy so getting over that laziness of actually doing it" (*p.324).

Another costly factor raised in Cattanach et al., (2021)'s study is that of time. Time constraints can lead to an individual struggling to be consistent with or worse abandoning the in-between session homework task element of CBT entirely. Despite the reported benefits experienced from the practical elements of CBT in their study, Furnes et al., (2014) also shared experiences of a participant who reported how *"it is hard work to try and release positive thoughts, but I am working on this all the time"* (p.1087).

Through the presented data from original studies, the finding of this review pertaining to the costly nature of engaging in CBT is corroborated. Engaging in practical elements of CBT can be costly at various levels for individuals with chronic pain. The practical elements of CBT are not just implemented within the session and left there, rather their effectiveness is determined by how much they are taken out of the therapy room and embedded into one's life. This can feel like a great cost for some individuals for reasons such as a lack of time, motivation or understanding. The review highlights how CBT is experienced as requiring a personal cost at multiple levels by chronic pain patients. As aptly advised to all prospective CBT patients for chronic pain by a participant in Bee et al., (2016)'s study,

"*I would tell them to keep a very open mind and to physically throw themselves into it because I think a lot depends on what you put into to yourself as well"* (p.8).

These sentiments represent that there is a cost to CBT positive outcomes for chronic pain patients.

Discussion

The current review sought to explore patient focused qualitative data on CBT for chronic pain that already exists within the field. The objectives were threefold, 1) to identify published research on the subjective experiences of receiving CBT for chronic pain and provide a critical evaluation of the identified research, 2) to provide a synthesis of the findings 3) to identify research gaps within the available data.

The current review highlights the sparsity of qualitative studies focusing on patient experiences of CBT treatment for chronic pain. A number of studies that are dedicated to the exploration of patient experiences are focused on patients' perspectives and experiences of the mode of delivery; for example, patient experiences of group-based CBT or web-based CBT (Moore et al., 2016; Terpstra et al., 2022). Other qualitative studies have dedicated themselves to the exploration of specific emotions accompanying the chronic pain experience, emotions such as grief (Haraldseid et al., 2014) and whether CBT is useful in addressing them. Although these are useful research inquiries, it is critical to invest in research dedicated to the exploration of how CBT treatment itself is experienced. Meta-analyses such as the largest Cochrane review on psychological interventions for chronic pain carried out by Williams et al. (2020) were useful in demonstrating the efficacy of cognitive behavioural therapy for chronic pain. Their review showed CBT to be efficacious in addressing pain related disability and mood when compared to treatment as usual post treatment (Williams et al., 2020). It is important to note that reviews such as these solely include randomised control trial studies (RCTs). RCTs were prescribed as the "gold standard of evidence" through the work of medical scholars such as Archie Cochrane (1972/1989) (Morse, 2006, p. 402). However, within human sciences research such as psychotherapy and counselling, trial conditions are hardly ever replicable in real clinical practice. As Kravitz et al. (2004, p. 664) puts it, " RCTs mean score does very little to inform individual care". In her keynote, “The politics of evidence”, Morse (2006) argues that human discipline research deals with crucial and complex matters that cannot always be quantitively researched. Due to the complexity accompanying the experience of chronic pain, the researcher argues that qualitative studies from the viewpoint of patients can provide a unique perspective in better understanding what about CBT works, why it works and for whom it works, as such, the sparsity of patient focused qualitative studies highlighted within this review presents a missed opportunity in advancing the field.

The second objective of the current review was to provide a synthesis of the qualitative patient focused data emanating from the included studies.

Three overarching themes were developed from the thematic analysis. The first, ‘*The CBT techniques*’ captured the reported participants’ experiences of CBT specific techniques / interventions within the included studies. The overall patient perception of CBT treatment that can be gleaned from the studies included within this review is that CBT is useful. This finding corroborates the findings from Beehler et al. (2021) who reported high levels of satisfaction and usefulness from participants on their self-report survey following engagement with brief CBT for chronic pain. This is encouraging, however what is missing is an in-depth exploration of what about the CBT treatment itself was useful. The current review identified that only two papers (Cattanach et al., 2021; Egan et al., 2017) directly discussed participants’ perceptions of specific CBT interventions, namely pacing and thought challenging. Moreover, none of the included studies provided an account as to why the specific CBT factors making up the course of participants’ treatment were experienced in the way participants experienced them. This is a missed opportunity as such knowledge can be useful in improving clinical outcomes (Ehde et al., 2014; Lim et al., 2018).

The second theme, '*The Benefits of CBT,'* highlighted the positive effects attributed to CBT for chronic pain by the participants of the studies included within this review. CBT was reported to have led to improved quality of life, which appeared to be the most significant gain encompassing multiple facets such as physical health (Egan et al., 2017), emotional regulation (Cattanach et al., 2020) improved self-esteem (Furnes et al., 2014) and improved confidence (Bee at al., 2016). These findings lend support to a number of available studies evidencing CBT as improving quality of life for chronic pain patients such as the study by Hajihasani et al. (2019).

However, it is important to note participants did find CBT costly, as highlighted by the third theme, '*The cost of CBT.'* The theme highlighted how the practical elements of CBT in the form of 'homework' were experienced as requiring energy and time investments that were not always possible to make. The current review lends support to studies such as that of Tang and Kreindler (2017) that allude to adherence with in-between session tasks being a challenge for many patients with chronic pain.

Strengths and Limitations

A key strength of this review is that it focused on reviewing and synthesising qualitative research that is often overlooked within the field. Qualitative research can add another dimension to knowledge and understanding in ways quantitative research does not always achieve (Peters, 2010). As aforementioned, Morse's writing highlights an important point for consideration for researchers within human sciences, a consideration disciplines such as psychotherapy are "addressing confusing and chaotic problems that are too difficult to tackle quantitatively… but are important problems"(Morse, 2006, p. 403). This statement aptly matches the sentiments of the researcher in relation to chronic pain research. The experience of chronic pain can be complex, involving a myriad of emotional and cognitive facets that can be difficult to untangle or make sense of for both the individual experiencing chronic pain and those around them (Kela et al., 2021). As such, the current review which sought to investigate the existing patient focused qualitative studies on chronic pain and provide a synthesis of these studies is a crucial step.

The current review utilised the Critical Appraisal Skills Programme qualitative checklist in appraising the studies included within the review (CASP, 2023). The six questions checklist for critical thinking (Aveyard et al., 2015) were also used in the continued assessment of the studies further demonstrating trustworthy and rigour of the current review. The included studies were critically evaluated and found to have clearly identifiable aims with appropriate research designs fitted to the aims and the methodological quality acceptable for inclusion. A limitation of the included studies is in the lack of depth in the analysis to include what about CBT and the interventions reported was useful and why it was experienced as useful by participants. The failure to address the 'what and why' is a missed opportunity to glean from patients insights that could lead to patient led clinical practice improvements. Another key limitation in the included studies is the lack of distinction between the experiences of participants with chronic primary pain and those with chronic secondary pain conditions. Emerging research as well as patient accounts support the assertion that the psychological experience of chronic primary pain and chronic secondary pain differs (Barke et al., 2022), which potentially also hints at experiences and perceptions to CBT treatment differing based on the type of chronic pain condition. Thus, research that is explicit on the chronic pain conditions represented within the participant sample is necessary.

A methodological strength of this review also lies in the methods adopted. The current review utilised an already established and published method, Thomas and Harden's thematic analytical method (Thomas & Harden, 2008). There are many benefits to be gained through thematic synthesis done with safeguards to ensure the analytical process is as uncompromised as possible. The review was explicit on what constituted data as presented in box 3.2 and the step by step following of Thomas and Harden (2008)'s method enabled for transparency. The process of describing rather than interpreting information was also beneficial as it kept extracted data as close to the original as possible. Analytical themes were generated following an iterative process of reading and re-reading individualised scripts and checking codes. Therefore, this review put in place transparent and rigorous analytic processes to ensure trustworthiness and rigour of method.

The current review has limitations that must be considered. The search terms adopted failed to account for spelling variations. For example, 'behaviour' was utilised in the search strategy intervention component without considering the US spelling 'behavior'. Furthermore, the outcome component utilised the term 'patient', failing to broaden the search by including other terms such as service user and client that are often utilised synonymously with patient in psychotherapy research. The term qualitative in the search could have been specified further **to** include terms such as process evaluation and lived experience. The researcher acknowledges that while the terms utilised were suitable, the search strategy may have failed to encompass diversity and variation in search terms resulting in some papers being overlooked. As the researcher continues to gain experience in designing and conducting research, this limitation could be addressed through future reviews that adopt a more comprehensive search strategy.

Implications for research and practice

The findings from the current review raise important points for consideration. Firstly, the review highlights the limited qualitative studies available dedicated to the exploration of patient experiences of CBT treatment for chronic pain. The UK Guardian newspaper published an article that reported an increase in the number of adults suffering from chronic pain silently (Davies, 2016). There is a need for research dedicated to bettering understanding not only the experience of chronic pain but treatment approaches.

The second crucial point emerging from this synthesis is the need for depth in exploration that focuses not only on how useful participants found CBT but attends to what about CBT was found useful and why from the perspectives of patients. This insider knowledge can be useful in further advancing the field of CBT for chronic pain. What works and for whom it works is still a hotly debated area within the field of CBT for chronic pain with a corpus of randomised control trials being conducted to test out and work this out. However, ignoring qualitative explorations of the same questions is a missed opportunity given the complexities accompanying the lived experience of chronic pain.

Thesis Focus

Currently, despite the changes in NICE Guidance (NICE, 2021) and diagnostic manuals such as the ICD-11 reclassifying chronic pain into two distinct classes of chronic primary and secondary pain, clinical approaches to chronic pain remain the same regardless of classification. There is need for research to acknowledge these differences. Although chronic primary and secondary pain can co-exist, this thesis will specifically focus on the exploration of the experiences of adults with chronic primary pain conditions as stipulated within the International Classification of Diseases -11 (World Health Organisation, 2019/2021).

As previously stated in chapter 2, the term 'CBT' can be used as an umbrella under which an array of interventions such as cognitive behavioural therapy, cognitive therapy, behavioural therapy, acceptance and commitment therapy and compassion focused therapy are housed (David et al., 2018). It is therefore paramount to be specific on what contributes CBT in any given research. This thesis adopts the term CBT to refer to an amalgamation of behavioural and cognitive therapy principles and interventions as stipulated within the British Association of Behavioural and Cognitive Psychotherapists (BABCP) minimum training standards (BABCP, 2012).

This thesis will investigate how individuals with chronic primary pain conditions experienced the cognitive behavioural interventions for chronic pain that made up their CBT treatment. The benefits and challenges attributed to each CBT intervention represented within the data will be explored and considerations on how this could inform both the research and clinical spheres will be investigated with the goal of not only adding knowledge to the research field of CBT for chronic primary pain but also improving clinical outcomes for patients.

Chapter Summary

This chapter presented the findings of a qualitative systematic review on the patient experiences of cognitive behavioural therapy for chronic pain. This review sought to explore the qualitative data that already exists within the field, synthesising this data as well as identifying gaps within the existing qualitative data. The chapter concluded with a presentation of the research gap the current study seeks to respond to. The current study will investigate how CBT interventions are experienced by adults with chronic primary pain. Chapter 4 will now present the methodology adopted for this investigation.

Chapter 4 Methodology

Chapter Introduction

This chapter's first objective is that of providing the reader with a clear justification for the adoption of an Interpretative Phenomenological Approach (IPA) to the current investigation. Secondly, the epistemological theoretical foundations of IPA will be discussed, with particular attention and focus paid to phenomenology, hermeneutics and idiography. This chapter concludes with a critical discussion of IPA, its limitations, and other considerations.

Defining IPA

Interpretative phenomenological analysis (IPA) is the study of people's lived experiences with the primary aim of understanding and providing interpretations of how people make sense of their experiences through the meanings they apply to experience. Simply put, it is the study of a specific people's specific experience of a specific phenomenon (Smith et al., 2022).

Justification for IPA Methodology

The primary objective of the current study is to undertake an in-depth exploration of how individuals with chronic primary pain (CPP) conditions experience Cognitive Behavioural Therapy (CBT) interventions. Interpretative Phenomenological Analysis (IPA) was adopted for the current study primarily because of IPA's focus on understanding and making sense of how people make sense of their lived experiences (Smith et al., 2022). Within IPA, the driving motivation centres around uncovering what about an experience makes it significant for the person experiencing the experience and what meanings they made of this experience and from this experience (Nizza et al., 2021). In further expanding on what constitutes an experience, Smith et al. (2022) emphasised experience in IPA to not merely be experiencing from an English language point of view, rather a significant often life changing experience as described by Dilthey and Rickman (1976) whereby an individual's level of awareness has been heightened in response to undergoing major life events and transition. It is this awareness that marks the emergence of 'an experience' and it is this experience and the meanings that follow from the personal reflections of the individual who has undergone the experience that IPA is interested in exploring. This view of an experience is very much suited to the current study in which chronic primary pain (CPP) is spotlighted.

It is undeniable that living with CPP for which there often is no clear medical rationale for its existence is a major life changing event whose impact permeates all areas of an individual's life (Raffaeli & Arnaudo, 2017). Prior to living with CPP, an individual may not have had a conscious awareness of the inner workings and feelings of their body or how certain therapeutic interventions or activities can quickly or slowly alter these inner workings, however persistent pain increases awareness (Dydyk & Conermann, 2024). As such, it can be argued that both the experience of living with CPP and engaging in CBT for CPP are major life experiences in line with Dilthey and Rickman (1976) descriptions of what constitutes an experience and Smith et al's (2022) sentiments of the experiences IPA explores.

With the experience of chronic primary pain being unique, the researcher asserts that there is a need for each individual participant's experience to be explored and examined in its own right prior to any group patterns being explored. IPA is committed to the careful and detailed exploration of each singular case. It is this commitment to understanding the 'particular' from an individual's personal experience that stamps IPA's idiographic nature (Smith et al., 2022). As such, IPA's idiographic nature makes it best suited to the current study.

IPA is an interpretative endeavour; knowledge is not gained by a mere collection of factual descriptive accounts of events and experiences, rather an active engagement with the personal accounts given through the process of intersubjective meaning making (Smith et al., 2022). Smith et al. (2022) posits that IPA's interpretative endeavour is informed by hermeneutics. The two layered interpretation process in IPA creates a double hermeneutic cycle that occurs as the researcher makes sense of how the individual is making sense of their experience (Larkin & Thompson, 2011). IPA's interpretative endeavour was best suited to the current study as the researcher sought to engage interpretatively with data, "reading between the lines" to identify unique meanings within the detail (Nizza et al., 2021, p. 45).

With its origins in healthcare research, a significant proportion of studies in psychology focused on the exploration of illness adopt an IPA methodology, with IPA being termed the methodology of choice in healthcare research (Biggerstaff & Thompson, 2008). Furthermore, Smith and Osborn (2015) recommending IPA as a useful methodology for research investigating the lived experience of pain is encouraging and lends support to IPA being suited for the current study. Overall, IPA was deemed best suited for the current study to enable a careful and detailed exploration of participants' experiences of chronic primary pain and engaging with CBT interventions for chronic primary pain.

Ontological Stance

The ontological stance adopted by IPA is closely related to Heideggerian minimal hermeneutic realism (Dreyfus, 1990). Larkin et al. (2006, p. 107) put forward a poignant quote explaining minimal hermeneutic realism, stating that “what is real is not dependent on us, but the exact meaning and nature of reality is”. This quote captures the essence of minimal hermeneutic realism, on one end, an acceptance of the presence of a very real world independent of whether individuals are aware of its existence or not while on the other, the meaning making that takes place as individuals encounter it, engage with it and contextually make sense of it (Larkin et al., 2006). As individuals encounter things and begin to ask questions, they become aware of how they are experiencing their encounter with the thing and begin the to make sense of their experience. This demonstrates Heidegger’s realism as interpretative in nature (Ginev, 2016). As asserted by Nizza et al. (2021), the IPA researcher’s aim must be that of understanding the participant’s reality, getting as close as possible to the participant’s experience. From this position, the researcher undertakes the rewarding but challenging task of making sense of how a participant is making sense of their world (Smith & Osborn, 2015). As the researcher presents questions about a particular experience, the researcher brings the experience to the participant’s awareness. As the participant becomes aware of it, the engagement process ensues as the participant begins to contextually make sense of the subject matter. The researcher recognises the inter-subjectivity between her experience as a researcher interpreting participants’ experiences and the experiences of participants as agents making sense of their experiences as the researcher asks them of their experiences. It is this connectedness and mutuality (Meyer, 2022) that shaped the nature of the reality pertaining to the current study.

Epistemology of IPA

Simply put, epistemology highlights what is considered as knowledge, how it is created and how the said knowledge is best acquired (Moon & Blackman, 2014). The current study adopts the position of knowledge to be the subjective meanings participants will apply to their experience of CBT interventions. The current study asserts that this knowledge is created through the dynamic interplay between the participants and the CBT interventions for CPP that made up their CBT treatment. IPA was selected as the method best fitting this stance. The following section will focus on the discussion of IPA's epistemological position.

Phenomenology

IPA's roots are deeply embedded in phenomenology as IPA is interested in the clarification of phenomena (Smith et al., 2022). Phenomenology is defined as the study of structures of consciousness as experienced from the first-person point of view" (Smith et al., 2022, p. 11). In studying any given phenomena, phenomenology is concerned with questions pertaining to how individuals experience things, how the said things appear in their experience and what sense or meanings individuals make from their experiences (Nizza et al., 2021). Phenomenology has been described in literature as both a discipline and a movement in history (Smith, 2008). The in-depth conversations pertaining to this is beyond the remit of this thesis however the key phenomenological philosophers whose work influenced the current IPA methodology employed within this thesis will be presented and their contributions highlighted.

Husserl

Although Husserl (1913/82) was a philosopher and not a psychologist, his work is very influential in psychology and social sciences, as it was Husserl who developed and firstly introduced a phenomenological method to the study of human experience and its core features (Smith et al., 2022). Husserl posited that for a deeper understanding of human experience to be gained, it was important to adopt a phenomenological attitude; an attitude he described as being characterised by the adoption of intentional consciousness to the essence of an experience (Husserl, 1931). In adopting a phenomenological method, a researcher is committing to the suspension of their own personal beliefs, world view and assumptions and be concerned with fully immersing themselves in the experience of the subject of investigation this to gain the “universal essence” of a given phenomenon (Larkin & Thompson, 2011, p.100). Husserl coined the term bracketing to describe this posture of a phenomenological method. Bracketing is surrounded by controversy, first, because it can straddle two camps (interpretivist or positivist) depending on theoretical position, and secondly its feasibility has been challenged (LeVasseur, 2003). Some of the debates around bracketing concern the plausibility of truly engaging with data without drawing on personal beliefs, assumptions, and experiences even if a researcher engages in bracketing. Some have argued it is not only possible, but very beneficial as through bracketing, data contamination is mitigated (Tufford & Newman, 2010). On the other hand, others have questioned the necessity of bracketing altogether due to IPA’s interpretative processes as one engages with the data (Biggerstaff & Thompson, 2008). Despite these theoretical debates, Husserl’s earlier work has been influential in setting the foundations of IPA, as it is known today in particular IPA’s commitment to truly engage in the subjective lived experience of the subject experiencing the phenomenon under study.

Heidegger

Heidegger (1927/62) advocated for an interpretative phenomenology; critiquing Husserl's phenomenology as too descriptive (Dreyfus & Wrathall, 2005). In his 1962 publication titled, '*Being and Time*', Heidegger introduced the concept of '*Dasein',* referring to being one with the world; his concern was focusing on what it means to be a being in the world and how individual beings engage with their world, their understanding and interpretations of it (Stapleton, 2009). To Heidegger, interpretation was necessary for phenomena to be fully uncovered (Horrigan-Kelly et al., 2016), with the process of interpretation ever evolving and focused on *Dasein's* past, present and future. Heidegger's philosophy can be credited for paving the way in the development of hermeneutical philosophy. Although Heidegger did not provide a clear or distinct methodological process for phenomenological research, his amplification of interpretative phenomenology paved the way to a variety of phenomenological research methods focused on uncovering the human experience including IPA (Dreyfus & Wrathall, 2005). Interpretation has a central role within IPA. As per Heideggerian principles, an IPA researcher's goal is to provide as much opportunity as is possible for the object or subject of investigation to be seen, heard and show itself without interference of any preconceived assumptions of ideas from the researcher. However, there is an appreciation that complete decontamination is not possible. Nevertheless, this must not prevent a researcher from trying and being transparent of any assumptions that may get in their way and their attempts to account for these assumptions (Larkin & Thompson, 2011).

Merleau-Ponty

Like Hurssel and Heidegger, Merleau-Ponty's writings point to a commitment to understanding "our being- in- the -world" (Smith et al., 2022, p. 18). According to Merleu-Ponty, the body or being is the vehicle through which humans interact with their world

(Finlay, 2011). As succinctly put by Merleu-Ponty asserts that “the body shapes the fundamental character of our knowing of the world” (Smith et al., 2022, p. 19). This stance puts significant importance to the physical body and its engagement with the world. The primacy placed on the body and its communication with the world is of particular interest given the current study’s participants being individuals whose physical bodies experience chronic persistent pain.

Hermeneutics

The process of engaging in interpretation is central to IPA (Smith et al., 2022). Thus, hermeneutics, which is the theory of interpretation (Letsas, 2007) is an important influence in IPA. The task of fully firming up a definition of hermeneutics is a challenging one, as its influences involve a wide range of different traditions and scholars. However, the key thinkers on hermeneutics whose views informed IPA’s epistemological stance include Schleiermacher, Dilthey, Heidegger, Gadamer and Ricoeur (Smith et al., 2022). Hermeneutics can be traced back to theology in the quest to interpret biblical texts. Hermeneutics has gone through major shifts, most notably the shift from the interpretation of “authorial intent”, a position that puts the author of a text in a central position whereby any interpretation of the text must reflect and not deviate from the original intentions and meaning of the author (Farrell, 2021) to the linguistic turn through the work of Schleiermacher, Dilthey, Heidegger (Eatough & Smith, 2017). Schleiermacher (1998) viewed interpretation as an art in which a range of skills are utilised, with interpretation situated between the grammatical (the objective meaning of the given text) and psychological (the subjectiveness of the one writing speaking on the given text). This view of interpretation allows the one engaging with a text to offer meaning to a participant’s text.

For Heidegger (1962), life is a process of constant interpretation utilising already existing "fore- concepts"(Smith et al., 2012, p. 24). Such fore structures include individual preconceptions; however, Heidegger stressed the importance of prioritising the "new object" instead of these preconceptions in interpreting (Smith et al., 2012, p. 27). The second major shift was towards dialectical hermeneutics with notable contributions from Gadamer (Eatough & Smith, 2017). Gadamer's (1960/1990) writings pick up from where Heidegger left off, further reinforcing the importance of keeping one's own inner intellectual and experiential ideas in check.

Simply put, Gadamer's interpretation encourages the researcher to be aware of what they bring to the participants' text and intentionally let the "new stimulus speak in its own voice" without hindrance from preconception (Smith et al., 2012, p. 26).

For IPA researchers, there is an acceptance that biases in the form of fore structures as posited by Heidegger are indeed inevitable. From the selection of a topic of study, a researcher would naturally gravitate towards research that has meaning for them or some level of interest. However, this does not make the task of interpreting phenomena a fruitless task, rather; as posited by Gadamer (1989), the goal is to be consciously aware of internal distractions through processes such as journaling one's own thoughts as they engage with the text and commit to creating room for the new stimulus to speak in its own voice and be heard.

Idiography

Idiography is the third key influence on IPA (Smith, 2022). An idiographic approach is focused on the particular. The goal is not that of providing generalisations as in nomothetic approaches, but that of unearthing and understanding experience subjectively (Jeanes, 2019).

Within IPA, the focused particulars are 1) the depth and breadth of detail of information gained, which in turn paves way to a detailed analysis, and 2) a particular “experiential” phenomenon which refers to the specificity of the situation or event being experienced by a particular group of people under investigation (Smith et al., 2022). All generalisations made from IPA studies must always be rooted in the particular, as IPA advocates for the detailed examination of an individual primarily in their own right. In IPA, the logical route to broader “universal laws” starts with an idiographic foundation (Eatough & Smith, 2017, p.7). As such, every case is afforded its own detailed examination in relation to the phenomenon under investigation prior to engaging in any cross-case analysis and making overarching generalisations (Larkin & Thompson, 2011). Only after each individual case has been afforded its own detailed examination can shared themes across cases be produced whilst still allowing for distinctive variations to be seen and heard (Smith et al., 2022).

Criticisms of IPA

IPA has both a long and brief history. The long history has been evidenced by its phenomenological and hermeneutical philosophical foundations spanning across centuries as presented earlier within this chapter. As a methodology, IPA’s inception was in the 1990s through the work of Jonathan Smith (Smith et al, 2012). Despite this newcomer status as a methodology, IPA has fast become a staple within the qualitative research methodology camp across many social science disciplines (Tuffour, 2017). IPA appeals as it is both qualitative and structured, as well as not requiring large sample sizes for meaningful findings to be gained. However, IPA is not without criticisms. Willig and Billin (2011) argued that the role of language was not fully accounted for within IPA. This is integral as language is the vehicle with which participants transport the meanings they assign to their experiences. This raises questions as to what happens when a participant does not have adequate communication skills, for example due to learning difficulties or cultural differences, to share their experience in a manner that gives ample voice to their experience. Does this then exclude their participation? Are the words being utilised by the participant meaning the same thing for them as it is for the researcher? This has led IPA to being criticised for potentially being elitist (Tuffour, 2017). Another key criticism of IPA is around the clarity of what is being captured. The goal is to capture experiences and or meanings; yet it can be argued that opinions rather than meanings can be mistakenly captured from the interviews and opinions reported by an inexperienced researcher rather than a thorough analytical interpretation. Interpretation of the ‘particular’ is at the heart of IPA and as such, it is therefore important to take active steps to mitigate these criticisms as IPA conducted skilfully and has the potential to bring forth rich detail that will add to already existing bodies of knowledge especially within health-related studies (Tuffour, 2017). Not only has IPA gained prominence in health-related studies, but the developers of IPA advocate for IPA as a useful methodology on the lived experience of pain (Smith & Osborn, 2015). This is encouraging and further lends support to the appropriateness of IPA methodology for the current study.

Chapter Summary

This chapter sought to orient the reader to the chosen methodology for the current study. A brief description of the study design and its epistemological positioning was presented. IPA’s theoretical foundations were discussed, paying attention to how they relate to the current study. This chapter concluded with critical appraisal of IPA and a justification for the usage of IPA for the current study. The following chapter will discuss the methods employed within the current study.

Chapter 5 Method

Introduction

This chapter will provide the reader with an account of the research methods utilised within the current study. The recruitment of participants including the inclusion/exclusion criteria and sampling methods will be presented. Secondly, the interview approach to data collection employed in line with an Interpretative Phenomenological Approach (IPA) as highlighted in the previous chapter will be discussed, paying attention to the development of the interview schedule adopted for the current study. Thirdly, this chapter will present a discussion on the interview process and considerations taken. Fourthly, the data analytical process will be outlined. Lastly, reflexivity, trustworthiness and rigour of method will also be discussed.

Inclusion and Exclusion Criteria

Guided by the current study aims, objectives and research questions, the inclusion and exclusion criteria were defined. The current study's inclusion and exclusion criteria presented in box 5.1 below were developed to ensure the homogeneity of the participant sample to be recruited for participation. In IPA, a homogenous sample facilitates the meaningful exploration of a specific phenomenon occurring in a specific context; in this case, the lived experience of CBT interventions for chronic primary pain (Smith et al., 2022).

Box 5.1

Study Inclusion and Exclusion Criteria

Inclusion Criteria

1. Adults aged 18+
2. Living with a chronic pain condition fitting the ICD-11 classification for chronic primary
3. Chronic pain not attributed to another primary health condition (e.g. musculoskeletal pain or fibromyalgia)
4. Having engaged with CBT specifically to address chronic pain
5. CBT treatment received matching the theoretical framework of CBT
6. CBT treatment can be in a group or individual setting delivered face to face or remotely online
7. Attended at least four sessions of CBT treatment

Exclusion Criteria

1. Chronic pain conditions that are in fitting with the Chronic Secondary Pain classification within the ICD-11 including Arthritis
2. Having received CBT primarily to address mental health conditions such as depression and anxiety
3. Having received treatment that is more in fitting with third-wave CBT interventions such as Acceptance and Commitment Therapy (ACT) and Mindfulness as the core treatment components
4. Not having received CBT

It was imperative to ensure the chronic pain conditions participants recruited for the current study were experiencing, did meet the International Classification for Diseases eleventh edition (ICD-11) classification of CPP (World Health Organisation, 2019/2021). Chronic primary pain is defined as pain lasting for longer than three months causing significant physical, emotional distress and disability that cannot be accounted for by another primary condition (WHO, 2019/2021). Chronic pain conditions fitting the chronic primary pain classification include fibromyalgia, complex regional pain syndrome, chronic migraine, irritable bowel syndrome and non-specific low-back pain (Barke et al., 2022).

Moreover, due to the broad application of the CBT treatment label as highlighted by Lim et al. (2018), the inclusion and exclusion criteria also set out what the current study regarded as CBT treatment. The label of CBT can be applied as an umbrella term representing an array of approaches including but not limited to Cognitive Therapy, Behavioural Therapy, Acceptance and Commitment Therapy and Schema Therapy (David et al., 2018). However, the most common definition of CBT is an amalgamation of behavioural and cognitive therapy principles as represented within the British Association of Behavioural and Cognitive Psychotherapists (BABCP) minimum training standards (BABCP, 2012). The current study inclusion and exclusion criteria adopts the latter as a definition for CBT treatment.

Due to the aim of the current study being that of investigating how CBT interventions were experienced, it was necessary for participants to have had at least attended four sessions of CBT. This decision was taken to reflect the structure of most CBT treatment; the first two sessions would likely involve assessment and psychoeducation prior to specific CBT interventions being introduced. As such, it was necessary to ensure participants did have experience of specific CBT interventions beyond assessment and introduction to CBT.

Sampling

The current study utilised a purposive sampling method. Purposive sampling involves the selection of individuals for participation intentionally, led by a specific purpose and or objective (Palinkas et al., 2015). One of the key goals of purposive sampling is that of identifying and selecting individuals who possess personal attributes, experiences or knowledge on the phenomenon under investigation (Creswell & Plano Clark, 2011).Owing to the current study aims and objectives, it was imperative for participants taking part within the study to have had personal lived experiences of chronic primary pain and having engaged in

Cognitive Behavioural Therapy. As such, purposive sampling was the chosen non-randomised approach to sampling that facilitated the recruitment of a small homogenous sample in fitting with the inclusion criteria set out in Box 5.1 purposely selected to give an in-depth understanding of the subject matter (Malterud et al., 2016).

Sample Size

The goal sample size discussed and agreed in supervision in line with IPA recommendations was between seven and ten participants. Although a seven participant sample is small, the sample size in IPA studies is small as the focus is on gaining an in-depth understanding of how and why something matters to a person or group of persons through detailed explorations of lived experiences (Smith et al., 2022). As such, through in-depth qualitative interviewing, this sample size is sufficient for the detailed and in-depth exploration of participant accounts of their experiences of CBT interventions making up their course of CBT treatment.

Recruitment

Following the successful ethics application as presented in appendix 1, an advert seeking participants fitting the research inclusion criteria was developed.

The researcher approached chronic pain support groups via email introducing the study and seeking permission for the advert to be posted on their social media groups (Appendix 2b).

After being approved, adverts for participation were posted on chronic pain support group social media sites. This advert can be found in appendix 2a. The advert was posted alongside email contact details for further information and or registering interest in participation. All respondents were replied to, with the researcher further clarifying whether the respondent matched the inclusion criteria. All respondents matching the inclusion criteria were sent a consent form (Appendix 4) and a participant information sheet as presented in Appendix 5 which provided detailed information about the purpose of the study and the practicalities of participation. Respondents wishing to take part were asked to complete and return the informed consent form.

Participant Recruitment Overview

At least eight social media-based peer support groups for chronic pain were contacted with information about the study, yielding a total of fifteen people expressing interest in participation across all eight support groups. Of the fifteen, twelve people responded to the initial contact email. Four of the respondents did not meet the inclusion criteria as their chronic pain was secondary to other illnesses. Of the remaining eight respondents, one did not respond to further communication. The final sample was made up of seven participants unknown to the researcher who were all checked against the inclusion and exclusion criteria set out and presented in box 5.1.

Data Collection Method

Qualitative interviews were selected as the most suitable data collection method to allow for the collection of in-depth and rich data about subjective experiences relevant to the study matter. At the heart of IPA is the goal of examining how people make sense of their experiences (Smith et al., 2022). As such, qualitative interviews provide a perfect platform on which individuals can share their thoughts, feelings and behaviours and reflections in their own words. It is therefore paramount the researcher refrains from a highly structured interview in favour of a less structured interview to allow for free expression. Semi-structured interviews were therefore selected as the most appropriate qualitative interview structure. Semi-structured interview methods are characterised by an in-depth dialogue between a researcher and participant stirred by a set of questions/probes within an interview schedule which acts as a flexible guide to keep the dialogue focused on the subject matter without interrupting the flow of the dialogue (DeJonckheere & Vaughn, 2019) which Smith and colleagues referred to as “a conversation with purpose” (Smith et al., 2022, p. 57). Owing to the nature of the inquiry being personal (i.e., personal lived experiences of chronic pain), semi-structured interviews were deemed suitable to allow participants room to express as they felt comfortable but also for the researcher to be able to gently probe them were appropriate to do so.

Developing the semi structured Interview Schedule

Using the research aims, key areas of exploration were initially mapped out to include individual CBT treatment interventions, focusing on their introduction and how they were experienced during and after therapy as well as how pain was experienced and the perceived impact of individual CBT treatment interventions making up a participant’s course of therapy. From this, short, open questions designed to facilitate in depth conversations were drawn up. Through supervision as well as literature reviewing, the questions and probes were refined. The funnel technique was utilised to structure the order of the questions within the interview schedule, starting with broad general questions designed to build rapport and gently building towards more detailed and specific questions about interventions (Ward, 2014).

The final interview schedule as presented in Table 5.1 below was made up of four sections. The questions in section A were centred on the exploration of participants’ current health status. The questions around how the participant may be feeling, their subjective pain levels, their pain diagnosis and how they make sense of it made up section a with the goal of firstly establishing rapport as well as clarifying that the participant's chronic pain condition did fit the chronic primary pain cluster as per the ICD-11 classification. Section B questions provided an opportunity for the researcher to identify the service in which CBT was accessed by the participants and the style of delivery (group or one to one). Section C began the in-depth exploration of the CBT treatment itself by asking participants to provide a brief overview of their treatment followed by the identification of all CBT interventions/techniques that made up their CBT treatment. The subsequent questions facilitated an in-depth further exploration of each singular CBT intervention making up the participant's CBT treatment. Section D questions centred on giving participants an opportunity to share their experiences of their CBT treatment as a whole. The interview schedule concluded with an opportunity for participants to share any other comments.

Table 5.1

Interview Schedule

Section A Current Situation and Health Status

(Researcher prompt for section: focus on building rapport)

1. How are you? How are you feeling today?
2. What is your understanding of why you experience persistent chronic pain?
3. Do you currently have a diagnosis of your chronic pain? If yes, what is it ***(researcher prompt: if no re-check to make sure their description still fits with ICD-11 for cpp conditions)***
4. What has been your journey with pain up until you ended up receiving CBT?
5. How did you feel about CBT being suggested at that point?

Section B Access to CBT and brief Treatment Overview

6. How did you access Treatment - pain clinic/ talking therapies?

7.What was the delivery style (one to one/ group CBT?)

8.Can you describe what your CBT sessions were like (structure)

Section C
Identification and exploration of Individual CBT Interventions

9. So, if we could get more specific, what CBT tools/ techniques/ interventions did your CBT therapist teach you? **(researcher prompt: use the language the individual understands, either tools, intervention or technique)**

9b: Could we list them individually so we can discuss how you found each of them? **Researcher prompt: Clarify which interventions by making sure their description of the intervention matches the label they are using and the label you have applied (e.g. thought challenging, problem solving, behavioural activation)**

10: What was your experience of X

11: What about X did you find helpful? Not so helpful and why?

12: Did you grasp X? How long did it take you to grasp X, why?

13: If you could share how X improved your life, what would you say X has helped change?

14: Is there anything else that contributed to your experience of X?

Researcher prompt: repeat questions 2-6 for each intervention that they listed

Section D Their CBT Treatment in general

15: Do you think CBT has helped with CPP, if so, in what ways?

Any other comments

"Now that we have completed the interview, are you still happy to give consent for your participation, and for your answers to be included in the study data, or is there anything you said that you would like removed?"

The Interviews

With the COVID pandemic of 2020, all interviews were conducted on Microsoft Teams. Participants were provided with a joining link prior to the interview and advised on how to access Microsoft Teams via the provided link. The interviews were scheduled for an hour and lasted between 35 and 50 minutes. Participants were interviewed between August and November 2022. All participants were asked to re-consent to participation prior to the commencement of the interview. The interview schedule presented in table 5.1 was used.

Data Transcription

In line with ethics approval, raw data was stored onto an encrypted file on the University OneDrive. The first draft of the written transcript was generated through voice recognition software available on Microsoft windows. This draft was carefully read and any errors against the audios corrected. Due to the novice researcher status, transcription was full verbatim ensuring all information provided was left in the script to provide as detailed as possible transcripts, what Bucholtz (2000) referred to as “denaturalised transcription” (Bucholtz, 2000, p. 1441). The final transcripts were designed in line with Smith et al.’s (2022) recommendations, leaving wide margins on both the left and right sides to allow for any initial comments and emerging themes.

Data Analysis Process

There is no prescribed single method of data analysis for IPA presented in literature, however Smith et al. (2022) posit that the key driving principles must be a) analytic attention directed at a commitment to understanding the participant’s viewpoints and b) the personal meanings made by the participant about their experiences. The focus moves from the particular to the shared as each transcript is individually analysed in its own right prior to any shared connections across scripts being made. Similarly, analysis may begin as descriptive as it transitions to interpretative in nature. Smith et al. (2022) suggested key stages to data analysis which were followed in the analysis of the research data collected within this study, as described below.

Reading and re-reading of transcripts

This stage involves immersing oneself in the written data through the process of reading and re-reading the written scripts.

In relation to the current study, the first draft of the transcript was checked for accuracy against the audio as the researcher listened to the audio with the transcript and made any corrections that were required. Through reading the transcript whilst listening to the audio, hearing the participant's own voice alongside the written text enabled the researcher to slow down, resist the urge to quickly deduct information and reach conclusions but keep the participant as the key focal point.

Initial Noting

Smith et al. (2022) suggest this stage to be characterised by paying attention to everything that appears to stand out within the transcript, identifying objects of concern for the participant, the use of language in their descriptions as well as conceptual comments made by participants in relation to the topic under investigation.

In relation to the current study, as the transcripts were being read, the researcher would underline anything that stood out including places, items, descriptors and interventions and any other contextual factors that appeared to have been emphasised by the participant. The goal was to identify any object of concern for the participant following which descriptive comments were made on the transcript in line with Smith et al.'s (2022) recommendation for the initial noting stage. The language employed by the participant was also noted as well as conceptual comments such as the meanings the participant applied to phenomena (Nizza et al., 2021). Further exploration with the data focused on seeking to understand what it was about the highlighted data stood out. It was this deeper exploration that marked the beginning of the interpretative engagement process with the data.

IPA Terminology changes affecting subsequent steps

It is acknowledged that there has been a change in terminology used within IPA literature following the revision of IPA's seminal text (Smith et al., 2022). The researcher followed the advice that for established projects, originating before the new publication, "you can use either the old terminology or change to the new" (Smith et al., 2022, p.76). The researcher found the new terms to be better aligned with the goal of each stage of the analytical process and made the decision to adopt the new terminology within the data analysis and reporting of findings. These terms will now be used to describe the remaining data analysis stages.

Developing Experiential Statements

This initial stage of analysis is concerned with the summation of experiences within short text lengths. As the researcher engages in short bursts of data and summarising what this data means for the participant, experiential statements are developed (Starr & Smith, 2023). As highlighted by Starr and Smith (2023, p. 110), this stage heavily relies on engagement with the initial notes while at the same time "holding in mind" the whole transcript and this is the stage at which hermeneutic circle of interpretation begins to be seen in action.

In relation to the current study, as the researcher engaged with the notes and comments, new understanding was gained consequently leading to the development of experiential statements. These experiential statements were discussed in supervision as well as with peers. This was followed by further reading of the initial notes and the whole transcripts repeatedly continuing examining the parts and the whole and how they interacted. This brought forth clarity and depth. This iterative process led to further observations and more in-depth analysis.

Personal Experiential Themes (PETs)

This stage involved an exploration of the cluster of themes within the experiential statements for each individual case. In examining connections across experiential statements, all experiential statements were initially typed up in the order in which they were developed. Following on from this, the function method of looking for connections based on the function of the experiential statement as suggested by Smith et al. (2022) was deemed most suitable and in line with the research aims and objectives. At this stage, the researcher also re-listened to the interview audios, ensuring the themes reflected experiences shared by participants.

Group Experiential Themes (GETs)

Group experiential themes are characterised by the development of themes across all cases (Starr & Smith, 2023). Upon completion of individual case analyses for all transcripts, the researcher drew upon personal experiential themes (PETs) developed from individual case analyses as she begun moving from the particular to the shared through cross case analysis. Each PET, together with statements and supporting quotes underneath them were collated and examined. Themes and quotes were examined for commonalities and differences, with the researcher moving themes around and grouping them based on shared higher order characteristics in alignment with the CBT intervention they were based on.

From this, the researcher was able to develop preliminary higher order themes for consideration as group experiential themes (GETs). The researcher further examined these initial higher order themes and the material underneath them across CBT interventions and identified commonalities and differences across CBT interventions. The researcher further grouped data, clustering CBT intervention level themes that shared commonalities into the same group and those that were different remained as stand-alone groups. This led to the development of three GETs namely, regained autonomy, a changed pain mindset and the pain in pacing. The remaining clusters of non-CBT intervention specific data and the material underneath them were also further examined and led to the development of two additional GETs namely, indirect interventions and CBT did not cure my pain. The GETs were reflected upon and discussed in supervision. The researcher revisited the PETs and participant quotes underneath each preliminary GET to ensure the preliminary GETs were aligned to participants' narratives on which they were developed. It was imperative to ensure that the essence of participants' stories was not lost during the cross case analytical process. The researcher revisited the full original transcripts and notes. Following on from these checks, the researcher confirmed the GETs that captured the heart of the participants' reported experiences of each CBT intervention represented within the data set as well as the non-CBT specific experiences that were reported to have impacted their CBT intervention experience. Please see Appendix 9 evidencing the steps towards developing the GETs. A full presentation of these GETs is discussed in full within the following chapter.

Ethical Considerations

The current study was approved by the University of Derby College of Health and Social Care Ethics Committee in March 2022 (ETH2122-2663) as presented in Appendix 1. It was imperative to ensure that the study design considered all ethical considerations. With the researcher being an accredited CBT Psychotherapist, the standards of conduct, performance, and ethics of her accrediting body; the British Association of Behavioural and Cognitive Psychotherapists (BABCP) were adhered to throughout. Within the BABCP standards of conduct, informed consent and confidentiality are core standards to be adhered to at all times. Ensuring that prospective participants have given their consent prior to participation is an important legal and ethical stance (Blease et al., 2016). It is imperative to ensure that consent given is informed and meaningful (Kadam, 2017). Meaningful informed consent is hallmarked by the disclosure of full and valid information pertaining to the issue / study to be consented to, the individual to whom the information being disclosed being competent to understand it and comprehend and evaluate the consequences of taking part and then freely choose to take part (Kadam, 2017). As such, all prospective participants were provided with a detailed participant information sheet as presented in Appendix 5 informing them of the study and what taking part involved. Participants were provided with contact details and were able to email the researcher and her supervisors directly if they had further questions prior to giving their consent for participation. The use of opt-in slips that were mandatory to return back to the researcher were used to ensure consent was explicit. Consent was formalised once the individual completed the informed consent form and returned it via email to the researcher. Participants were asked to confirm their consent prior to the beginning of their interviews as well as at the end of the interview. Engaging in continuous consent was critical in ensuring participants did not feel trapped in their original decision to participate, they were able to freely withdraw if they wished to do so (Klykken, 2022).

In line with the university guidelines, the UK Data Protection Act 2018 was considered at all times. Due to the sensitivity of the subject matter (receiving therapy and having a long-term health concern), adhering to standards of confidentiality was critical. It was important to consider and manage all facets of confidentiality, providing measures to protect the confidentiality of would-be participants. The personal data of prospective participants was handled in line with the general data protection regulation (GDPR) principles. Only necessary personal information was collected, encrypted, and stored onto the secure university drives. All participants were asked to assign a pseudonym that was used in their interview and beyond. Transcription was completed in a private place and any identifiable information removed, for example names of children or place of work. Transcripts from the interviews were stored in a separate file to the audio files.

Researcher Positionality

Ethical considerations in relation to the researcher's positionality as a CBT therapist investigating experiences of CBT was also considered. It is plausible to assume that some participants may have felt intimidated to share experiences they may have deemed 'negative' about CBT with a CBT Therapist. The researcher made considerable efforts to build rapport at the beginning of each interview in which she explicitly stated that her role within the study was that of a researcher and not a representative of CBT itself or CBT therapists. The researcher shared that she was genuinely curious to hear from the participants about their experience. This honest disclosure not only built rapport but demonstrated approachability, which Adu-Ampong and Adams (2020) posit to be integral in the process of gaining insider status. Approachability paves way to participants being able to share all facets of their experiences without fear of researcher judgement (Hordge-Freeman, 2018). The researcher was also mindful of her existing knowledge and experience of CBT for chronic pain and the necessity of suspending this knowledge in order for her to fully immerse herself in the experience of participants. The following section discusses in detail the researcher's personal stance on bracketing and how bracketing was utilised.

Reflexivity and Personal Stance on Bracketing

The researcher's personal stance on bracketing aligned with Dörfler and Stierand's (2021) position of bracketing not being about absolute objectivity, rather the acceptance and acknowledgement of the existing subjectivity that exists around a subject matter under inquiry whilst remaining committed to placing the subject matter centre stage. Within Husserl's (1931/2012) philosophy, bracketing was not viewed as "a matter of excluding all prejudices that cloud the pure objectivity of research", rather bracketing was viewed as the process by which one became aware of the ways in which their preconceptions interacted with others and the world around them (Husserl, 1931). In facilitating the process of bracketing, the researcher utilised a reflexive journal.

At the beginning of the data analytical process, the researcher spent time reflecting on her own already existing knowledge of CBT interventions for chronic pain and recording these as an initial statement within her reflexive journal (Stutey et al., 2020). These reflections were frequently re-read throughout the data analytical process. The reflection points included the protocol driven nature of the researcher's CBT training. Protocol driven CBT follows a structured approach in which specific interventions, with clear steps and processes are utilised in the treatment of specific mental health difficulties (Roth & Pilling, 2007). Consequentially, the researcher had pre-existing knowledge on which CBT interventions made up some chronic pain CBT protocols and manuals and the existing evidence base in support of these interventions for chronic pain. Taking stock of this prior knowledge followed by the journalling of initial statements of this knowledge served as an anchor and a check point, helping the researcher remain rooted and grounded in the commitment to see and hear the participants while resisting the temptation to assume certain facts about participants' experiences based on prior knowledge about CBT interventions. This process also facilitated the adoption of a genuinely open and curious stance to data analysis as well as engagement in a “meditative thinking” as stipulated by (Heidegger et al., 1966). According to Heidegger (1959/1966), whilst calculative thinking was encompassed by logic, planning and calculative ways of engaging with knowledge, meditative thinking involved sitting with, listening, openness as one attends to the meanings applied to things by people (Stutey et al., 2020). Instead of looking out for the CBT the researcher knew, she resigned her therapist ‘hat’ to the background with its knowledge and ideas and through meditative thinking she was able to bring to the forefront her researcher ‘hat’, opening herself to the experiences of participants.

Following on from the reflexive exercise, the researcher listened to the first interview without taking notes. The researcher’s goal was that of immersing herself in the experience of the participants with no set agenda. The researcher found this process to be an important step in bracketing. This process allowed the researcher to practice active passivity as coined by Dahlberg (2022) in describing the stance in which the researcher intentionally lets go of pre-emptying an outcome and watchfully wait, ready to take in what is coming in rather than going ahead of the data.

After listening to the first interview, the researcher used her reflexive diary to record her response to the question ‘what did I hear?’. This was an important exercise that allowed the researcher to interrogate her own understanding. Following from this step, the researcher begun the process of reading and re-reading the first interview written transcript. As the researcher begun to pay attention to things that stood out within the transcripts, she begun taking diligent notes that she checked against her ‘What did I hear’ entries from her reflexive journal. This enabled the researcher to interrogate what she heard versus what she highlighted as standing out.

As the researcher began developing themes, she listened to her the original recordings and re-read the initial statements within her reflexive journal that encompassed her prior-CBT interventions knowledge. This was an important step as the initial statements served as a reminder, alerting the researcher to her preconceptions and helping her stay committed to seeing the experiences of participants as much as possible. There was some anxiety in this process as the researcher being a novice did not want to 'ruin' the analysis. The journal was also used as a tool that facilitated the processing of these emotions. As put forward by Vagle, the journal can be a place in which the researcher can "wonder, question, think, contradict oneself, agree with oneself, vent, scream, laugh, and celebrate" (Vagle, 2010, p. 403). Box 5.2 below is an example of one of the logs from the reflexivity journal.

Box 5.2

Reflexivity Log

Date: 1/10/2022

What happened: *Begun the process of engaging with the data and developing experiential statements*

My Feelings: *Hopeful*

My reflections: *I am making some interesting observations, the feelings attached to what people have lost through CPP are standing out to me a lot. This is good but after discussing in supervision I can see now that upon reflection I need to re-focus on the participants and their shared feelings as they engage with CBT. They are sharing with me about their experiences of cbt interventions and not losses from chronic pain, the study is not on the experience of chronic pain although I am empathic to it, it's about how CBT interventions are experienced.*

Action plan: Re- listen to transcripts, underline all CBT interventions discussed, review and re-generate experiential statements and take them to supervision.

Adopting a qualitative approach to the current study carried with it a key and necessary responsibility of ensuring that though the researcher is well meaning and desired to capture the experiences of participants, the researcher also had subjective perspectives that would interact with the qualitative research process (Olmos-Vega et al., 2023). The danger of not being aware of this intertwined relationship can be costly to the validity and reliability of the study findings. Through the ongoing process of self-disclosure, the researcher was able to create room to see and hear what may be happening for the individual as they seek to understand and make sense of a subject matter (Dahlberg, 2006).

Larkin et al. (2006) asserts that what constitutes a successful IPA study is not the unearthing the pure experience of a participant, rather a demonstration that the researcher has undertaken IPA sensitively and responsibly. The researcher remained open and actively engaged as she continued with the data analytical process, avoiding the urge to rush through the process and on to the next prospect or case as cautioned by Heidegger et al. (1966). The steps that have been discussed in this section were repeated as the researcher engaged in a case-by-case analysis before moving to across case analysis.

Supervision served as an important resource for audit trailing (Merriam, 1998).Through supervision the researcher’s data analytical processes and decision making was open to evaluation, further providing opportunities for reflexivity for the researcher.

The researcher credits the ongoing process of bracketing to keeping her open to understanding the phenomenon in a new way even when that new way contradicted previously held knowledge on CBT interventions for chronic pain.

Trustworthiness

The researcher also utilised Lincoln and Guba’s (1985) framework to ensure trustworthiness of method. According to Lincoln and Guba (1985), just as there are constructs in quantitative work to assess trustworthiness that are suited to quantitative research methods, qualitative research can also have constructs unique to qualitative research that can be used in assessing trustworthiness. Lincoln and Guba’s (1985) constructs are a) credibility, transferability, dependability, and confirmability. In relation to trustworthiness, credibility is seen as the most important construct. The current study design demonstrates elevated levels of credibility as evidenced by how the researcher adopted reflexive journalling as an ongoing measure for self-analysis and correction. Supervision was used every month as well as when needed. Moreover, peer scrutiny was welcomed throughout as the researcher shared of her research at all stages with fellow peer researchers as well as CBT therapist colleagues. Although participants were recruited through purposive sampling, the sample was not generated from one pain social media group. The methodology of IPA adopted for the current study is an established methodology not only for researching lived experiences, but IPA was shown specifically to be an ideal methodology in exploring the pain experience (Smith & Osborn, 2015). The researcher ensured that the CBT intervention label the participants applied fitted the description of the intervention itself and what the researcher thought they meant due to the similarity in interventions such as pacing, graded exposure and activity scheduling also known as behavioural activation in CBT clinical practice.

Rigour of Method

Smith (2011) provided a useful guide in evaluating the quality of IPA studies. To Smith (2011) the hallmarks of a good IPA study include clear understanding and discussion of the theoretical principles of phenomenology, hermeneutics and idiography that form the foundations of IPA. The current study has met this criterion as chapter four was primarily dedicated to a presentation and critical discussion of IPA's epistemological stance and justifications for IPA's use within the current study. Smith (2011) also includes studies providing detailed and clear descriptions of methods, of which the current chapter has endeavoured to do. The next chapter seeks to provide experiential evidence of how the researcher engaged with the data in line with the other hallmarks of good IPA such as the in-depth analysis of each individual case, seeking not only convergence but recognising each individual case's nuances and where divergence may be. Smith (2011) also includes the inclusion of extracts that are a good balance from each participant across the themes presented, it is hoped this would be evidenced in the next chapter in which findings will be presented.

As a methodology, IPA has been demonstrated across literature to be suitable for inquiries that are health related and in particular inquiries seeking to investigate lived experience. What is important to note being that the experience need to not be merely an experience in the English language sense, but an experience that has the potential to shape a person (Smith et al., 2022). Chronic primary pain and the process of engaging in treatments to alleviate the distress chronic primary pain cause is indeed a significant experience for which IPA is best suited.

Chapter Summary

The current chapter sought to provide the reader with a transparent presentation of the methods adopted for the current study from recruitment to data analysis in line with IPA methodology. The recruitment process and the data collection method of semi-structured interviews were introduced and discussed. Ethical as well as practical considerations were discussed, with the chapter concluding with a critical discussion of trustworthiness and rigour of method. The following chapter is a presentation of the findings from the analysis of data described within this current chapter.

Chapter 6 Findings

Chapter Introduction

This chapter will firstly present a brief introduction to the participants who took part in the current study. Secondly, this chapter will present an account of findings from the data analytical process, examining participants' experiences of each cognitive behavioural therapy (CBT) intervention that made up their CBT treatment for chronic primary pain (CPP). Themes will be corroborated with direct participants' quotes that will be italicised and referenced following the format of pseudonym, transcript page number followed by the line number.

Final Participant Sample

To preserve confidentiality, pseudonyms are used throughout this chapter and the same pseudonyms will be adopted in all subsequent chapters.

John, who identified himself as a White British male in his early thirties, reported experiencing pain which eventually started to affect his mobility. John was subsequently referred to an orthopaedic surgeon for investigations into the persistent pain leading to a diagnosis of chronic lower back pain for which he was referred to a CBT pain management programme. John reported not being in employment at the time of the interview.

Mary identified as White British female and was in her early forties. She reported her earliest memory of experiencing acute pain which eventually became chronic to have started over 8 years ago after the loss of her father. After two years of investigations initiated by a general practitioner (GP) with a specialist interest in pain, Mary was eventually diagnosed with fibromyalgia (chronic widespread pain). Mary was referred to a pain clinic and completed group-based CBT before being referred for one to one CBT through an Improving Access to Psychological Therapies service (IAPT).

Jane identified as a White British female aged forty-three living with her fiancée and three children. Jane was formally diagnosed with fibromyalgia by a specialist rheumatologist in May 2021 after fifteen years of experiencing persistent widespread pain. Jane engaged in a 12-week pain management programme through the rheumatology clinic and subsequently received CBT via a self-referral to Talking Therapies service. Jane reported having been a nursery nurse assistant prior to giving her work up due to ill health. She was unemployed at the time of the interview.

Matt identified as a Black British male in his mid-thirties with chronic persistent pain and chronic fatigue. After multiple visits to his GP, Matt was referred for CBT for pain management which has both group-based and one to one therapy sessions. Matt lived with his partner and was in employment at the time of the interview.

Amy identified as a 38-year-old White British female who was made redundant due to ill health and was self-employed working from home at the time of the interview. Amy described her diagnosis as chronic pain syndrome which she has suffered from for fifteen years. Amy received one to one CBT through a private pain specialist psychologist as well as group-based CBT through an NHS pain service.

Suzie identified as a White British female in her late twenties with a diagnosis of fibromyalgia as well as experiencing what she described as chronic nerve and bone pain. Suzie reported having received one to one CBT twice from two different therapists. Suzie reported living with her mother and embarking on master’s level studies at the time of the interview.

Paul identified as a Black British African male in his early thirties with chronic persistent pain after suffering a knee injury. Paul reported experiencing widespread chronic pain since this injury although there is no medical explanation for this pain. Paul received group-based CBT through an NHS pain programme and was a student at the time of the interview.

CBT Interventions identified within the Data

To orient the reader to the current study findings, the CBT interventions identified within the data set will be outlined and a brief description of each intervention presented.

Behavioural Activation, also known as activity scheduling, is primarily a depression intervention in which individuals who may have withdrawn from activities of daily living in response to low mood are encouraged to structurally re-introduce activities that give a sense of mastery, enjoyment and closeness to others (Riebe et al., 2012). The steps of behavioural activation in CBT are 1) developing a baseline diary of current activity, 2) the identification of routine, pleasurable and important activities that are not being done, 3) making a hierarchy list of the activities in point two ordered from the least difficult to the most difficult 4) the planning of where and when a few selected activities will be re-introduced within the week 4) carrying out the activity and recording levels of mastery and pleasure from the activity.

Graded Exposure, often prescribed in the psychological treatment of phobias is characterised by the structured exposing of patients to feared stimuli in a graded manner (Vlaeyen et al., 2001). The steps to graded exposure involve: 1) development of a feared situations hierarchy, 2) the exposure to the hierarchy steps starting with the least feared situation until the individual habituates to the situation as their anxiety level reduces, and 3) moving on to the next step of the hierarchy. Graded exposure is unique to behavioural activation and pacing in that graded exposure targets external and internal feared situations including sensations cognitions with the goal of helping the individual face their anxieties and reach a zone of learning such that the perceived fearful situation is not to be feared or that they can cope with it.

Problem Solving as a CBT intervention is characterised firstly by the clear identification of a problem or concern at hand followed by an objective exploration of potential solutions or actions that can be taken in response to the identified problem. The identified potential solutions are critically evaluated, paying attention to the costs and benefits of each potential solution or action. The individual is then empowered to decide on their course of action based on the cost-benefit analysis of the available potential actions (Nezu & Nezu, 2001).

Thought challenging is a cognitive restructuring intervention that involves the identification of negative and or unhelpful thoughts which are then evaluated for accuracy in relation to factual evidence. The end result is an alternative thought that is adaptive and helpful (Greenberger & Padesky, 2016).

Pacing is a core concept in the management of chronic pain and is a staple in CBT for CPP (Antcliff et al., 2021). The logical reasoning behind pacing is by modifying the nature, frequency, and duration of activities an individual can avoid pain flare ups commonly caused by boom-and-bust cycles in which an individual overdoes things on a pain free day causing extreme pain on the following day. The steps in pacing commonly involve: 1) Identification of a baseline through a weekly activity diary, 2) identification of patterns of overdoing (boom) and the subsequent crashes (bust), and 3) scheduling activities throughout a period of time to ration energy by scheduling activities with clear time quotas (Antcliff et al., 2021).

Group Experiential Themes

Following on from the analytical process discussed within the previous chapter and presented in Appendix 9, five group experiential themes were developed. These GETs, along with their sub-themes are presented within this chapter with the aim of attending to the research questions, providing answers to the research questions in a manner that seeks not to take away but rather interpret participants' experience in line with the principles of IPA methodology. Extracts of raw data from the participants' accounts during the interviews will be presented in an italicised font. The page and line number from the participant's transcripts will also be presented in evidence.

Table 6.1

Summary of the Group Experiential Themes (GETs) and Sub-Themes

Group Experiential Theme	Sub- Themes	CBT interventions associated with each Sub-theme
6.1 Regained Autonomy	6.1.1. Not everything is now out of reach	Behavioural Activation
	6.1.2. Pain does not mean damage	Graded Exposure
	6.1.3. I can cope	Problem Solving
6.2 A changed Pain Mindset		Thought Challenging
6.3 The Pain in Pacing	6.3.1. Logical reasoning vs. emotional reasoning 6.3.2. Stolen freedom 6.3.3. What if I am now ok again?	Pacing
6.4 Indirect Interventions	6.4.1. My therapist played a part	All Interventions
	6.4.2. Loved ones go through it with us	
6.5 CBT did not cure my pain		All Interventions

Table 6.1 is a presentation of the Group Experiential Themes, ‘GETs’ (Nizza et al., 2021), their sub-themes and the CBT interventions related to each GET and its sub-themes.

Regained Autonomy

The first Group Experiential Theme, ‘Regained autonomy’ describes how participants experienced problem solving, behavioural activation and graded exposure as CBT interventions for chronic primary pain. These CBT interventions were positively experienced by participants as giving back power of choice, improving self-perception, and increasing their sense of agency. Although these interventions do not come as a package, the reported experiences were similar and thus it was beneficial to report these findings within the same GET.

This GET is organised into three sub themes, the first, ‘*Not everything is now out of reach’* represents participants’ regained confidence in engaging with tasks and hobbies that reflected their personal values, a confidence that participants’ accounts attributed to behavioural activation. The second sub-theme, *‘Pain does not mean damage’* represents the shift from perceiving pain during activity as signalling the occurrence of further damage to recognising some pain as a part of their growth through structured graded exposure-based interventions. The third sub-theme, ‘*I can cope’* represents an improved self-perception as an agent able to cope with the challenges accompanying living with CPP as these challenges arose.

Not everything is now out of reach

John, Matt and Jane, the three participants whose CBT sessions included behavioural activation reported experiencing behavioural activation as empowering, improving behavioural repertoire and reducing perceived pain-related disability.

Prior to sharing his experiences of CBT interventions, John described how through chronic pain life as he knew it previously had changed and how his *“inability*” (John, P.7, L.97 to do things, including previously enjoyed exercises made him feel "*incapacitated or disabled"* (John, P.7, L.97). This is significant to note as the picture John painted through his use of language is very powerful. John's use of the words "*incapacitation or disabled*" (John, P.7, L.97 evoked a picture characterised by permanent substantial impairment negatively impacting daily life. At a crucial time in which John reported that he felt "*incapacitated and disabled"* (John, P.7, L.97), engaging in behavioural activation was reported to have positively challenged these feelings for John. The challenge appeared to have facilitated the birthing of a fresh realisation, what John described as a "*sense that I'm actually still able to do a lot of things"* (John, P.7. L.99). The use of the word "*actually*" by John in the afore-presented quote is telling. It was as if John suddenly awoke to the realisation or a light bulb moment that he was still capable. Hope was found in what may have initially been perceived by John to be a hopeless situation marked by pain-related disability with substantial and long-term negative effects on the ability to engage in activities of daily living, let alone hobbies and employment. John had gained back power to recoup some of his losses in life domains.

Behavioural activation's focus on adding back meaningful value-laden activities into an individual's life was credited as improving understanding and better self-management:

"I think my day out before going into my day, I create a matrix with all the things and prioritise them and then add them... this has allowed me to understand my activities more and manage well" (Matt, P.5, L.75-76).

Behavioural activation was experienced as bringing forth knowledge on the doing of activities. It wasn't just about doing activities, it was about understanding the doing of activities and making an informed choice on which activities to do and when based on this knowledge. Matt's account corroborates John's experience of behavioural activation as empowering and choice giving:

"I am able to make optimal use of my time and my resources and my energy… I have a way of scheduling different type of activities so that I'm doing them, I'm able to prepare" (John, P.7, L.101-104).

Matt's account emphasises the autonomy gained through having the ability to choose how practical and internal resources were to be utilised. Matt felt in control of his choices and more equipped on how to make the most favourable choice through behavioural activation.

Jane's account pointed to behavioural activation as leading to a reduction in mental load.

"… I was sort of like doing it carefully, slowly planning in things…. I found it helpful when I finally grasped it, my mind was less full." (Jane, P.4, L.46-51).

Behavioural activation improved the ability to streamline and become efficient in energy utilisation. Through behavioural activation, John, Matt and Jane reported to have found they were still in control of their resources and could learn to manage their day to day more efficiently without giving up everything that mattered to them. Behavioural activation created opportunities to better understand the relationship between pain and doing and how this impacted self. Through behavioural activation John, Matt and Jane found ways to cope and create reasonable adaptations that have enabled them to be part of what they loved, staying true to their core values, leading to a reduction in pain related disability which consequently improved pain intensity and mood. Across all three participants' accounts, behavioural activation appears to have been experienced as hope giving, empowering, confidence rebuilding and restoring power of choice.

Pain does not mean damage

Three out of seven participants reported graded exposure to have been part of their CBT treatment package. The accounts across these three participants suggest a significant shift began the moment they realised experiencing pain during an activity did not mean damage. It is from the point of this learning that these participants described experiences that can be likened to a regaining of their autonomy:

"One thing they did say to me was things are going to hurt ... but when its hurting you're not doing any more damage to yourself. So, I kept that massively at the back of my head and just thought let's try and see... that's been such a positive help" (Jane, P.3, L.89-92).

"I learned early on that the pain doesn't mean damage and that was a really important thing" (Suzie, P.13, L.272).

From the accounts of both Jane and Suzie, the knowledge that the presence of pain wasn't indicative of harm occurring had a significant positive effect. This knowledge was credited as leading to an openness to experiencing without which avoidance would have continued to dominate with negative consequences. Paul's account prior to CBT exemplified this relationship between pain related fear and avoidance:

"I couldn't just do anything that's moderately stressful so as to not agitate my knee" (Paul, P.6, L.89).

Avoidance can be costly to quality of life as evident in Paul's later reflections. The cost of pain avoidance due to fear of causing harm increased feelings of hopelessness and powerlessness as highlighted in this follow-on statement by Paul, "*it just takes over my whole life*" (Paul, P.6.L.91).

The experiences of Suzie, Jane and Paul pointed to graded exposure as the CBT intervention that led them to acquiring knowledge and awareness that pain was not a sign of more trouble ahead, rather that there were worthwhile gains waiting beyond the pain if they were willing to venture out into unfamiliar territory:

"Yes, we graded many things, and I think one of them was swimming, and it was literally getting to the swimming pool. Not actually going swimming, then building up to changing and just sitting on the edge and things…before I got diagnosed, I was swimming pretty good because I've always been a swimmer and things. I had a physiotherapist that took me swimming. My mum would drive me and literally have to literally chuck me back in the car because I was knackered. So, yeah, we're so learning how to work up to things, which I still do now. It's a second nature thing…" (Suzie, P.10, L.215-220).

The CBT intervention graded exposure matched the description Suzie gave of her new approach to swimming. Graded exposure enabled Suzie to build up confidence in tackling the energy consuming steps between leaving her home and eventually being in the pool swimming. These grades enabled a sense of achievement to come not only from the result of getting back into swimming, but every step of the ladder as well.

Suzie's account highlighted the cementing of knowledge that as she builds her way up the ladder indeed there may be pain, however beyond the pain on the other side there are significant and worthwhile gains to be had. Graded exposure was experienced as a safe vehicle for the exploration of new possibilities as participants learnt to live alongside persistent pain without fear.

The experiences of participants show confidence being regained as they engaged with graded exposure:

"She *gradually helped me build my confidence to get back in the field and play some football with my peers without having to worry about my knee, but it is a very gradual process… gradually I was able to get over the phobia of climbing"* (Paul, P.6, L.105-107).

Similarly to behavioural activation, graded exposure was experienced as giving back to the participants what they had lost (both perceived and actual losses) as they reclaimed their lives from CPP. Graded Exposure appeared to work best for losses due to pain avoidance in response to fears of the experiencing intense pain and or causing further damage. Through a gradual journey of exploration and experiential learning graded exposure led to improved confidence and increased behavioural repertoire for the participants

I Can Cope

Participants whose CBT treatment included the CBT intervention problem solving, pointed to problem solving as equipping them with skills that cultivated an improved sense of personal agency and control. This is well encapsulated through Suzie and Amy's accounts:

"It's just like well I am in this situation. What can I do about it what can't I do about it... what's the problem? Is it a major issue? ... how can I get rid or deal with it? If it's a major issue, how can I cope with it?... so, it just makes me go no its ok it's not in my control but what can I do to have some control of myself ...It's giving the permissions and things…" (Suzie, P.5, L.101-105).

"It's like let's see what the problem is... It literally draws your focus to that. So, you can just deal with that one element, and then it takes you through it like, okay, what is it? How is it making me feel? Can I change it if I can, what can I do? If I can't, then what? Can I deal with it? So, it's literally taking it stage by stage, and then at the end you're going, okay, right. And

then you can sort of I can now forget about it, or I deal with it, and then it doesn't influence anything else that's happening around me" (Amy, P.7, L.121-126).

Suzie's account highlighted multiple faces of how problem solving was experienced by participants and the significance of this. Firstly, Suzie's account highlighted in action the steps she took in problem solving, which are: the acknowledgement of the challenging situation, clarification of the problem and a reflection on whether the problem is actual or perceived followed by an exploration of available solutions to actual problems. Suzie goes on to share how this process leads her to a realisation of things that are within her control and those that are not. The question-and-answer style adopted by Suzie captures Suzie's journey towards clarity and personal agency. Similarly, Amy's account highlighted the use of questioning that terminates at the same destination. The destination that can best be described as coming face to face with the fact the situational obstacle in front of them might not shift. The questions provided a roadmap towards the tolerance and acceptance of uncertainty and reduced situational control. It was from this new position of tolerance of the external uncertainty and lack of situational control that both Suzie and Amy's focus shifted from their external worlds to their internal worlds. This is **encapsulated** in the latter part of Suzie's account as she ceases engagement with the question-answer-style in favour of a clarity statement. The previously described journeying has been replaced with arrival as Suzie accepts that "*its ok it's not in my control"* (Suzie, P.5, L.104). Arrival at this new position where a potential lack of external control is acknowledged and accepted opened both Suzie and Amy to secondary questioning as they reflected on what they could do to gain control of themselves. This secondary questioning is personal, no longer is the focus the situation, but the person themselves. Instead of seeking to control and manage the situation, focus shifted to how they can best manage themselves. Suzie's account evidenced problem solving extending beyond the management of practical obstacles to the management of self. Suzie's personal confidence growing can almost be felt from the statement, *"It's giving the permissions and things…"* (Suzie, P.5, L.105). This statement conjured up an image of Suzie gaining back control, back in the driving seat of her life and mentally undefeated by chronic primary pain. *"Control and Permission"* (Suzie, P.5, L.105) are descriptors that stand out, as they affirm the position of an individual asserting that their life is theirs and they are the ones that give permission to the pain and not vice versa. In a similar manner, Amy ended her account by sharing how reflecting on what she could or couldn't change externally and shifting her focus of attention internally led to her gaining control over external circumstances:

"then it doesn't influence anything else that's happening around me" (Amy, P.7, L.121-126).

Suzie and Amy's accounts appear to place importance on the gear shifting from seeking external control to gaining internal control. Their accounts suggest that engaging in problem solving can be re-positioning from external locus of control to internal locus of control.

Mary's account adds another powerful observation to problem solving as a vehicle to acceptance:

"The pain is always there. It's just how you approach it. I think it's the way you approach the pain because there are different ways to approach the pain. So, I think it's very useful, actually, at the beginning in terms of managing approaching the pain and then coping with that, coping with the pain" (Mary, P.5. L.123-125).

There was an understanding across participants whose treatment included problem solving that problem solving did not eventually lead to the absence of pain, rather, problem solving presented an opportunity to evaluate all positions, after which they could embark on a journey towards acceptance. Through problem solving, these participants felt empowered to face every possible outcome even if that outcome was, they were in pain and could not go further. It appeared the self-questioning and answering process marking the beginning of problem solving was a powerful tool that facilitated the processing of what could and could not be salvaged when faced with situational obstacles. A common theme across the participants who engaged in problem solving was the emotional grounding and comfort that came from a knowing that they had considered and done all they externally could through the questioning and answer stage of problem solving. This grounding led to them looking inward, locating their calm in the storm internally. Instead of mental defeat, a positive personal belief in their ability to cope even in the face of challenges and setbacks was observed across participants' accounts.

Summary of GET 'Regained Autonomy'

The participants' experiences of the CBT interventions behavioural activation, graded exposure and problem solving for CPP represented within the GET 'regained autonomy' can be interpreted as rebuilding. Participants experienced these CBT interventions as providing the building blocks that enabled them to firstly assess the aftermath damage following CPP, a process leading to an identification of what of the old them still stood and then secondly the interventions providing tools for rebuilding confidence, personal belief, and autonomy. Where damage was beyond repair, participants learnt that they could cope. The focus on firstly recouping what is not lost provided a critical foundation which paved the way for a new build, even if this new build looked different from what was. The appeal of these interventions was their ability to shift one's focus from the limitations of pain to one's capacity, consequently improving one's sense of control and combating negative self-critical thoughts and mental defeat. Through a focus on the exploration of how much one can safely do versus what one must not do, participants' locus sense of control improved and perceived pain-related disability decreased. Participants shifted focus from feeling of agency to a judgement of agency. Rather than ruminating on the pain and its limitations, narrowing one's life, these interventions encouraged reflection focusing on the individual's capabilities and developing coping which in turn improved emotional wellbeing, perceptions of self and behavioural repertoire.

A Changed Pain Mindset

Five out of seven participants reported the CBT intervention of thought challenging being part of their CBT treatment. Overall, across most of these participants' experiences thought challenging was experienced as facilitating the development of a new mindset towards themselves, pain and suffering:

"Obviously my mindset about pain has changed obviously, because at the first point I thought this pain was like, if this pain doesn't go, how would I be able to live my life? (Paul, P.7, L.133-134).

Paul's account perfectly captured the potential fear and trepidation felt at the prospect of pain becoming a permanent feature by all five participants. This emotional burden was shared across all participants. There was a perceived threat to life as it was previously known, enjoyed and lived. The perceived threat manifested itself both cognitively and emotionally, with the unpleasant thoughts and worries potentially producing feelings of fear, despair and hopelessness.

John's account pointed to the presence of frustration at not only being in pain but having to engage in thought challenging:

"I am in pain, of course I am in pain how can I challenge that, it's a true thought" (John, P.9, L115).

The frustration is fuelled by the implied notion that through engagement with thought challenging the threat for pain was perceived and not actual.

"...because even though they say it's like psychological pain, they often say it's psychological pain, but I feel it physically. I feel physical pain, even though physically there is nothing wrong with me. Well, that's what they say. There is nothing wrong with me physically" (John, P.10, L.141-143).

In further delving into John's account, the mind body struggle in relation to pain becomes even more evident. John's relationship with pain was through the body. He felt it, it was a real physical bodily experience. Consequentially, any suggestion that the threat is psychological in nature was experienced by John as dismissive of his physical experience. John's experience highlighted the challenges of disputing the content of cognitions in the absence of an awareness and acceptance of the dynamic interplay between the mind and body in relation to chronic primary pain.

"I am in pain, of course I am in pain how can I challenge that, it's a true thought" (John, P.9, L115).

The sense from John's account is that of someone digging their heels in that their experience was simply that. When they think about their pain, they are merely stating a fact that they were experiencing physical pain and there was nothing about that to be cognitively restructured through thought challenging. Contrastingly, the other four participants' experience of thought challenging was that thought challenging ushers in another way making sense of their chronic pain:

my thoughts just changed, I started having thoughts like everyone has one or two problems that like to deal with, but I shouldn't kind of let it take precedence over other things. So, the pain I don't really think very much about pain these days. I don't feel it like the way I used to *do it back in day, obviously. So really, I think my way of thinking about being in pain has changed. I just try not to think negatively"* (Paul, P.7, L.133-138).

The cognitive change experienced appeared to have been metacognitive in nature. As evidenced through Paul's account, there was a shift from deliberating and fearing the prospect of pain being permanent to a metacognitive focus on pain and suffering being part of everyone's life. This shift paved way for cognitive openness that facilitated the generation of a changed mindset with a wider perspective about life and suffering that could be adaptive to many situations by these four participants.

The process was not without costs for participants as reflected across participants through the following extracts:

"Sometimes it was a struggle when I was in a really painful time or a really low time to do it, like to motivate myself... It took a lot of practice to be able to do that and it took a longer process. I might have been in pain for an hour before thinking right I need to challenge these thoughts and get out of this pain" (Mary, P.4, L.119-121).

Mary's account spotlighted the mind-body struggle in relation to thought challenging yet again. Unlike in John's case where the mind-body struggle was observed in the beginning stages of thought challenging as John grappled with making room for the cognitive element of his pain experience, Mary's account showed a different facet of the mind-body struggle during times of intense chronic pain. Mary was not grappling with making room for the cognitive element of pain, she had passed that stage and made sufficient room yet now she faced yet another mind-body struggle, working through her cognitions when physically feeling burdened by intense pain. This highlighted how thought challenging requires physical as well as emotional resources that are at times in short supply during episodes of heighted chronic pain. Until the resources have been garnered, thought challenging is more than likely suspended, albeit its usefulness.

Similarly, Suzie shared how there is an energy cost to the process of thought challenging, stating that:

"*I don't like writing it down. I think it was a waste of energy for me to physically think"* (Suzie, P.9, L.192).

Suzie's account brings to light an interesting observation. Thought challenging which is meant to bring forth psychological and emotional gains is experienced as requiring physical energy withdrawals. There is a mental balancing of the books that ensued as Suzie worked out whether the physical energy required for thought challenging was worth the psychological benefits. From Suzie's account, the mental balance sheet must balance, and some aspects of thought challenging such as the writing of a diary were experienced as physically withdrawing more than the psychological benefits it generated.

Lastly, participants' experiences also shed light on the disconnect between mastering the skill of thought challenging and believing the new thoughts generated through thought challenging. This is exemplified in Amy's account:

"I threw myself into it (thought challenging) I was doing homework like every day, so the actual process didn't take me very long, but it did take long to believe it" (Amy, P.7, L.115).

Amy's account can be interpreted as the doing of thought challenging does not guarantee belief in the new thoughts. The fact Amy went to great lengths to share how much effort she put in the process of thought challenging and then ending her experience clearly stating that she didn't believe the thoughts straight away is noteworthy. It was almost as if her efforts reached a crescendo, only to be followed by an anticlimax. It is plausible to assume Amy felt deflated after giving her all into the process of thought challenging and yet not attaining the emotional gains that come not only with a change in thoughts on paper but a belief in the credibility of the new thoughts.

Summary of GET ‘A Changed Pain Mindset’

Participant’s experiences painted thought challenging as useful in bringing about a new adaptive lens through which an individual with CPP can engage with their world. However, participants’ accounts highlighted thought challenging to be physically and emotionally taxing for various reasons. Moreover, even after making the practical investment the returns were not immediately guaranteed.

The Pain in Pacing

The second GET, ‘*The pain in pacing’* represented participants’ practical and emotional experiences of the CBT intervention pacing. Pacing was experienced as “*difficult, hard, frustrating and a struggle*” by participants (Jane, P.9, L.250-357, Paul, P.7. L136; Suzie, P.12. L.25-257). The process of unpacking what this looked like and also what it meant led to the development of this GET, which was organised into three sub-themes namely, 1. *‘logical reasoning vs emotional reasoning*’, which spoke of the felt disconnect between logically understanding the concept and benefits of pacing and the emotional experience accompanying engaging with pacing. The second sub-theme, ‘*stolen freedom’* captured the frustrations participants reported feeling due to the time contingent nature of pacing while the third sub-theme, *‘what if I am now ok again*’ represented how pacing can be in direct conflict with the desire to cling to any shred of hope the pain they have been experiencing has gone and they are back to their old self. These sub-themes will now be presented evidenced by participants' accounts.

Logical reasoning vs Emotional reasoning

Participants reported having an intellectual understanding of pacing from their experiences of treatment as highlighted through Jane's account below:

"The *concept I totally get it and know exactly what I need to be doing"* (Jane, P.8, L.234).

However, the commentary that ensued led to the realisation that this logical and intellectual knowing did not automatically bring about a positive emotional state towards pacing.

"*but then if I've had a great night sleep and feel fine, I then struggle and think I might as well try to do everything*" (Jane, P.8, L.240).

As Jane continued to share her experience of pacing, it is evident that although Jane logically understood the rationale for pacing, there is an emotional struggle that ensues in response to pacing on a pain free or pain less day. Jane's experience was not unique as Suzie, Mary and Amy shared similar experiences of pacing to Jane:

"*Doing pacing as well which I think is one of the hardest things to do is pacing because your brain goes, I feel like I could do a marathon today..."* (Suzie, P.11, L.232-233).

"so*, I do pacing but I get frustrated with pacing I can see how it should work… but I just want to colour…."* (Mary P.7, L.164&167).

"… Very often, because I'm a very active person, it's very difficult for me not to be active, and it's very difficult to stop and go down" (Amy, P.8, L131).

In examining the emotive language used by these participants, it is evident that pacing as a CBT intervention for CPP is not just a practical experience for them, but also an emotional experience characterised by an array of emotions. Suzie used the metaphor of a marathon that captured pacing in both logical and emotional thinking frames. On days Suzie would wake up with higher levels of energy that she perceived as enabling higher levels of activity, her natural and logical desire was to follow this energy and utilise it to achieve the things she may have wished to achieve. However, pacing was experienced as the unwelcome bridle that controlled how much activity could be done even in the absence of pain. The most challenging part in accepting the bridle based on Suzie's account was the struggle for personal freedom of choice to do as much or as little as she wished, especially during pain less moments. Across cases, participants displayed a logical understanding of pacing and its potential benefits. Mary's account exemplifies the logical versus emotional reasoning associated with pacing as she acknowledged having attained the knowledge that enabled her to rationally "*see how pacing should work*" (Mary P.7, L.164). This **rational** knowledge appeared to be co-existing with an emotional experience marked by frustration and defiance. Mary ""*Just wanted to colour"* (Mary P.7, L.167). The defiance in this statement can almost be felt. She didn't want to think about and abide by rules or the time contingency part of pacing and the restrictions this may place on how much she can enjoy her hobby. She wanted to engage in her hobby for herself without a care or concern, yet, to fully embrace the benefits of pacing, she had to choose to engage in her hobby in a time contingent manner, stopping when the time lapses even if she did not feel the need to stop due to pain. This can potentially be interpreted as their rational brain knowing the benefits of pacing, yet the emotional brain posing a different agenda focused on preserving personal freedom of choice. Mary's experience is shared across participants as exemplified in Amy's account:

"… Very often, because I'm a very active person, it's very difficult for me not to be active, and it's very difficult to stop and go down" (Amy, P.8, L131).

Amy firstly introduced herself as *"a very active person"* (Amy, P.8, L131). This introduction was necessary and served to inform the researcher how Amy personally identified herself. Amy's personal identity involved being a doer. It is plausible to interpret that Amy's sense of self and worth were rooted in this personal identity. Pacing and any suggestions of slowing down or engaging in doing in a different manner to how Amy would have previously done would have been experienced as a loss of self. Consequentially, despite logically knowing the benefits of pacing, there was an emotional struggle to retain the previously held sense of self.

Suzie shared a very poignant experience of what happened a few years back when she went for a long walk:

*"I went on a walk, and I went way too far… I was like yeah; I should turn around now. But then I said no you used to do this when you were little, you can do it now…I had to send for my brother to come fetch me" (*Suzie, P.12. L.25-257*).*

The emotional charge in this experience was undeniable. This example given by Suzie highlighted the difficult experience of coming face to face with the losses that CPP brings and how these losses can affect personal identity. Pacing was met with some resistance and brought about feelings of frustration despite its well-known benefits as it appears to be seen as a reminder that despite having a good day, life as it was once known and lived has changed. This can be a painful and traumatic experience. There appears to be a compelling case of what 'I know versus what I feel' in how the CBT intervention of pacing was experienced by participants.

Another striking observation is how there appeared to be an emotional consequence whether an individual followed the principles of the CBT intervention of pacing or chose to go against the pacing principles. This is clearly evidenced in Jane’s summation of her experience of pacing:

“*I think the idea of it, it makes so much sense. Perfect, perfect sense. It's just actually putting it into practice. When you're feeling like you feel okay, it's really hard to stop and think, well, maybe I'm not actually going to be okay if I try and even... I mean, for me, I'd just be standing trying to make a meal or doing everything just from scratch, doing too much around the house or something. It then just just absolutely knocks me out. Then you beat yourself up for doing it and for not. So it just you end up in a vicious circle”* (Jane, P.11, L.301-306).

Jane was sharing that when she feels ok and ends up not pacing, she ends up overdoing, which causes her to become exhausted and in more pain after. However, despite knowing this, when she is feeling ok, she finds it difficult to stop and think of this potential outcome. Jane is alerting to yet another round of negative emotional reactions that can come from not engaging in pacing such as guilt, further highlighting the strong emotional reasoning charge of pacing that is not usually accounted for when considering or introducing pacing as a CBT intervention for chronic primary and persistent pain. This emotional reasoning seems disconnected to the logical reasoning behind why pacing is beneficial for participants.

Stolen Freedom

Participants appeared to perceive their freedom of choice as limited by CPP to a greater degree when engaging in pacing as a CBT intervention compared to when they are not pacing. There was a powerful sense of wanting to just live life without much thought into how much one does, a sense that lingered as participants gave their account. In its truest sense, pacing as an intervention involves the individual engaging in a specific activity for a specific amount of time and so in many cases an individual ends up having to take a break from an activity before they physically felt the need to. This time contingent versus pain contingent nature of pacing appeared to be a great contributor to the sense of stolen freedom participants experienced as highlighted in Mary's experience:

"Yeah, it just frustrates me because of course with the pacing you stop before the pain kicks in to stop kicking in later…" (Mary, P.7, L.174).

Participants found it quite challenging to appreciate in the moment future benefits as evidenced by Mary's account. Mary's account brought to light the challenge of immediate versus long term gratification with pacing. In the moment, participants had to choose to stop before their body was in pain. The promise of future gains did not appear to deter from the immediate feelings of frustration and loss of freedom stemming from the perceived restrictions placed through pacing. Mary continues:

*"and I don't want these timers, I don't want to have all these timers and I just want it for me" (*Mary, P.7, L.173).

The fact that Mary repeated the same sentiment "*I don't want these timers" (*Mary, P.7, L.173) *twice* in a row speaks volumes. Mary's frustration could be sensed from this repetition. The statement, "*I want it just for me*" *(*Mary, P.7, L.173) is also striking. This was something that was hers that now she feels she cannot have just for her, as if ownership of her hobby has exchanged hands from her control to that of pain as she engaged with pacing. These two statements understood together paint a picture of an individual frustrated because of a sense of injustice and unfairness that she now must use timers on activities that she enjoys, activities that were her hobbies and now how she does them and the duration she does them is being taken out of her control: in essence creating a sense of loss of freedom to pain through pacing. This is similar to Paul's experience:

"It does take away that freedom of the fact that I'm having a good day and I just want to go out and enjoy it…" (Paul, P.7. L136).

Whether the loss of freedom is actual or perceived is debatable and is dependent on what is being regarded as freedom. Suzie shared an interesting experience that helped shed light into the meaning of freedom attributed to by participants across cases.

"I was with a group of people, and they were going out to town. And I said Well I will come and have a Chinese and go home while you stay out and go clubbing. So that's the kind of I've already pre-empted you have to do a lot of pre-empting" (Suzie, P.12, L.268-271).

The freedom lost is more than just a loss of control over an activity (what is done and how long it is done for) but also a loss of the freedom to live life without being in a mindset of constant mental balancing and calculating, as Suzie put is "*pre-empting*" (Suzie, P.12, L. 271). The evidence suggests that participants had to not only physically make changes to their doing if they were to engage in pacing and benefit from it, but also their mindset had to change to accommodate the frequent balancing act of weighing how much can be done without over or underdoing in the allotted time. There are grounds to suggest from the accounts of participants that this constant mental processing is not only frustrating, but also mentally taxing and or exhausting. The process led to a sense that personal freedoms were being threatened or taken from them by pain through pacing.

What if I am now ok again?

In moments where there was a reported absence of pain, participants' accounts suggest the presence of a belief or hope that chronic pain had gone, and they were back to their old self prior to suffering with chronic pain.

Engaging with pacing as a CBT intervention was experienced by participants as a reminder that they still had a chronic disease, and that disease (CPP) was ever present and must be considered when planning and engaging with activities. This is in direct contradiction with the hope that a day of no pain may be the day the disease, which no one knows why it was present had mysteriously gone just as it had mysteriously come. Participants' sense making suggest pacing as an intervention was experienced as challenging and difficult as it appears as though engaging in pacing meant accepting that chronic pain was there to stay. This is perfectly exemplified by Jane and Amy's accounts below:

"I think if I am having a better day I feel, I mean I don't think I've fully accepted it yet. I do just think they've got it wrong, and it's been something it's just gone now. I'm alright I feel fine. It's not going to make a difference if I try and do whatever I don't need to pace and then obviously it does hit me massively if I do everything" (Jane, P.9, L.250-357).

*"I think you just want to prove to yourself that you can do it you are not sick and it's something you can control… and then sometimes I think is it in my head" (*Amy, P.9, L.156).

Jane and Amy's accounts paint a picture of someone trying their hardest to cling to the hope that a pain free day could be a sign of chronic pain finally going away inexplicably; just as it came. From this, it is evident that the experience of pacing regularly collided with the hope of being ok again. A pain free day thus becomes bittersweet with pacing, the sweetness of hope of being ok mixed with the bitter pill of having to still take or adhere to treatment for chronic pain in the form of pacing. It appears as though to consistently engage in pacing, one has to have reached a level of acceptance that the pain is chronic, long term and potentially a permanent companion in their life journey.

From the experiences of participants, pacing reduced their freedoms. The emphasis on stopping before the pain kicks in and the time quotas in pacing were experienced as restrictive by participants. The term pacing conjures up images of slowing down or a reduction of something. Participants' experience points to an internal resistance that ensued as they fought to keep hope alive that life as they knew it prior to pain will be their reality again someday.

Summary of GET 'The Pain in Pacing'

The second GET 'The Pain in Pacing' interprets how participants experienced the CBT intervention of pacing. Through participants' accounts, it became evident that pacing was experienced through logical and emotional lenses by participants. The logical lens showed how pacing was seen as sensible whilst simultaneously the emotional lens showed acing to be difficult, challenging and at times a threat to hope, which can be argued to be wishful thinking that on a good day the pain may just have mysteriously gone since its presence isn't medically not always explainable. Embracing pacing was experienced as accepting the permanency of pain. Pacing was experienced by participants as a threat to their old self identity, in response to this threat participants clung even more tighter to the hope that they will one day be like they were before chronic pain. In conclusion, pacing was experienced as logically sensible but also a very emotionally challenging CBT intervention to adhere to.

Indirect Interventions

The fourth group experiential theme (GET) *'Indirect Interventions,'* discusses factors participants reported to have contributed to how they experienced CBT interventions. This GET is organised into two sub-themes: 1) My therapist played a part and 2) Loved ones go through with us.

My therapist played a part

Suzie's account in particular sheds light on the critical role the therapeutic style of the therapist can play in influencing how CBT interventions are experienced. Having had two rounds of CBT, Suzie opted to discuss her experiences of the same intervention with different therapists as two separate accounts without being prompted. Suzie's account of the differences in her experience of thought challenging based on therapist style were illuminating:

"I didn't really click with her, but I think it's because she didn't think I understood CBT straight away. Like the first time I did it and I got it and it's like she didn't believe me that I got it…she wanted me to fill out different tables. I think she came across as teachery. Like I am above you…Like she was boasting I am a therapist, and you have to do it this way because I know everything …" (Suzie, P.4, L.78-85).

Suzie reported not feeling a connection between her and her first therapist. Suzie's use of the term "teachery" (Suzie, P.4, L.81) in describing her therapist's style is very telling. The picture painted by Suzie appeared to suggest that critical thinking and questioning were unwelcome in this set up, the therapist held all knowledge and power within the therapy space. The experience pointed to a relationship devoid of warmth and collaboration.

Suzie went on to point to the overly structured diaries and how she perceived the therapist's expectation to be that Suzie had to fill the diaries as prescribed by the therapist. This points to two key interpretations: 1) rigidity in therapist approach being experienced as a lack of person-centred care and concern by Suzie and 2) a lack of trust between Suzie and the therapist. The latter is evidenced by Suzie's earlier assertions:

"...Like the first time I did it and I got it and it's like she didn't believe me that I got it..."

There was something about the therapist's reported reaction by Suzie after having completed her first diary that led Suzie to believe that her therapist did not trust her word. This could have potentially led Suzie to holding back her own thoughts and feelings and just do as she was told. The therapist's style and approach as described by Suzie was experienced by Suzie as communicating to Suzie that there was no room for her individuality in the therapy space, she was there as a recipient of the support that was on offer in the way it was offered. Suzie's experience can also be interpreted as demonstrating a lack of effort or skill on the part of the therapist in developing a shared understanding of the problem and how CBT interventions being delivered to tackle the problem are being experienced. The implication that can be interpreted from Suzie's account is that Suzie did not feel heard, valued or understood by this therapist.

Contrastingly, Suzie described experiencing her other therapist in a completely different light.

"I have had a new therapist, and she is 100% different because she also has long term health issues. So, she gets it, I don't have to explain the situation and what my body is doing every session, she just gets it. The table had simple headings, and I think it gave one example, and I went ok this makes sense. The first lot of CBT was good learning but it was the person, that therapist that dropped it off." (Suzie, P.7, L.141-146).

As evidenced in Suzie's account, both therapists utilised diaries in the form of tables, yet this was experienced differently by Suzie. Suzie experienced her second therapist as someone who "*just gets it*" (Suzie, P.7, L.142). The use of the word "*just*" could be interpreted as highlighting effortlessness in the process to developing a shared understanding of Suzie's difficulties between Suzie and this therapist. How much the therapist having a long-term health condition herself may have contributed to this cannot be fully teased apart, however what is evident from Suzie's account is this therapist's collaborative and person-led style enhanced Suzie's CBT intervention experience. From Suzie's description of the tables as "*simple*" (Suzie, P.7, L.143), it is plausible to interpret this to mean her therapist ensured material was mentally and practically accessible to Suzie. Moreover, the latter part of Suzie's account showed that in providing one example and letting Suzie have a go with the diaries, the therapist demonstrated trust and power sharing within the therapy space. The therapist may have started with the power of knowledge yet during course of the session, the **reins** of control were passed on to Suzie as she gained understanding of the intervention. Suzie's final statement solidified the interpretation that therapist style did indeed play a significant role in how she experienced CBT interventions.

It is important to note that this was not unique to Suzie. Mary also shared of her therapist's style and its implications. Like Suzie, Mary engaged in thought challenging as one of the CBT interventions with her therapist and this was her account:

"She wasn't like although she'd say at the beginning this is the plan for the session if something had cropped up it was fine to go off task onto something else, she was good in doing that. So, it was really helpful like to bounce off ideas and being able to talk about things because although I have family and we are close it gets to a point you don't want to keep telling them about pain and so it was really helpful to be able to talk to somebody about what is happening, what you were thinking and get a different perspective on it". (Mary, P.8, L. 206-207).

Although there was structure to the session which the therapist would set at the beginning of the session as per Mary's account, the account suggests Mary felt the session followed her needs, if something different to the agenda "*cropped up*" (Mary, P.8, L. 206) it would be addressed in that session. This reflexive approach in which the therapist assesses what is going on for the individual and react to it in the moment, in this case in the session rather than putting that off and sticking to the agenda appeared to be a powerful indirect intervention.

The power of this reflexive and idiosyncratic approach can also be seen in the account of Amy as she described the therapeutic style of the psychologist she worked with:

"He adjusted to my case; each session I would learn something suitable for me…." (Amy, P.7, L. 126).

This account highlighted that Amy felt seen and heard through the reflexive idiosyncratic approach employed by her therapist. Moreover, this reflexive approach appeared to have fostered trust and improved motivation without which the direct CBT interventions will be useless as seen in John's account:

"… it takes a lot for me to put what I have been taught in practice… I didn't put a lot of what we were learning in practice. Therapy should be personal because we are dealing… everyone suffers at a different level with different things at different times. Especially after the doctor has given you a diagnosis, a general session is not going to be as effective as personal one designed for you and what you are going through." (John, P.7, L.54).

It is evident from John's account that he did not fully engage with CBT interventions and the homework practices accompanying the interventions. The reasoning for this can be deciphered from John's subsequent comments. John did not feel that his personal difficulties and individual needs were accommodated. John did not experience parts of his therapy as idiosyncratic nor reflexive as evidenced by his use of the term "*general sessions*" (John, P.7, L.54) to describe some sessions making up his therapy. To John, there were critical moments in his journey with chronic pain that he felt warranted a person-centred approach to treatment planning and execution. John pointed to the early stages in diagnosis being a critical time marked by unique psychological, emotional and physical challenges that cannot be made sense of through a generic pre-formulated therapy treatment plan delivered by therapist whose style is rigid.

Not only does the therapeutic environment need to be a safe space for exploration, the experiences of participants across cases point to the therapist themselves being a human safe space for vulnerability:

"…although I have family and we are close it gets to a point you don't want to keep telling them about pain and so it was really helpful to be able to talk to somebody about what is happening, what you were thinking…". (Mary, P.8, L.207).

From the accounts of participants, the role of the therapist's style and approach can be interpreted as active rather than passive. The therapist was experienced as an active agent whose own doing independent of the CBT interventions implicated how CBT interventions were experienced by participants.

Loved ones go through it with it us

Like therapist style, familial relationships contributed to participants' experiences of CBT interventions. Family involvement was not related to a direct question in the interview schedule, however three of the participants shared how those close to them encouraged them to engage in therapy, stay in therapy and adhere to therapy interventions in between sessions. The experiences reported within this theme reflect the shared experiences across these three participants' experiences:

"My fiancé has been there she's been helpful trying to pass encouragement, she is the one who encouraged me to seek therapy as she is a nurse." (Paul, P.1, L.10).

Here it is evident Paul is crediting his partner with motivating him to seek therapeutic support. Motivation without which Paul may have never got to experience therapy.

"The idea of therapy came from my partner who noticed my low mood… there was a lot of resistance but after some events my internal reflection showed me, I did need it…" (Matt, P.2. L.23-25).

Similarly, Matt credited his partner for suggesting therapy in response to them observing the emotional impact of chronic pain on him. Although Matt initially resisted the idea of seeking therapy, he reported how conversations with his partner led to personal reflections that eventually led him to seeking therapy. Matt alluding to his resistance as "*a lot*" (Matt, P.2. L.23-25) suggested the presence of potential emotional obstacles to therapy seeking. It is plausible to interpret this as evidence of a potential fear of the unknown for Matt. Coupled by events Matt faced, his partner became the instigator and a safe place for him to uncover his perceptions of what going to therapy may have meant for him and overcome his initial apprehension.

Overall, the pattern across the three cases (Paul, Matt and Suzie) in which loved ones were brought up in discussion loved ones were being experienced as the gentle encouragers credited for the eventual decision to access therapy by these participants. Their role during therapy can further be interpreted as that of reminding and supporting with the adherence of in between therapy tasks:

"I live with my mum…mum has to come to me and say do you think you should come in?" (Suzie, P.3, L.55).

Here Suzie was giving insight into how her mother prompted her to reconsider whether she (Suzie) had been engaged in activity for far too long. Left to her own efforts Suzie may have continued to immerse herself in her activities even if that may have triggered a boom-and-bust cycle. It is not clear whether Suzie would have alerted her mother beforehand to keep watch of time, however it was still plausible to interpret from this that Suzie's mother wasn't just reminding Suzie of time, Suzie's mother was going through the journey with Suzie. Across the cases in which loved ones were brought up in discussion, the role of family members went beyond that of reminding participants of their out of session tasks and helping in the development of new coping tools. Loved ones were shown to have shared and experienced the participants' experiences too. Loved ones were active companions, providing both practical and emotional support at the beginning, mid and end of the therapeutic journeys these participants were on. The experiences participants can be interpreted as showing family support to be an integral part of adherence with CBT interventions.

Summary of GET 'Indirect Interventions'

This GET presented an important consideration, the role non-intervention factors in the experience of CBT interventions. Although not directly asked about their therapist or family support, some participants referred to their therapist's style and approach and or family in making and or breaking their experience of CBT interventions. To fully interpret the participants' experiences, these factors needed to be made sense of and their role in the experience of CBT interventions accounted for.

CBT did not cure my pain

The fifth group experiential theme (GET) accounts for participants' perception of CBT as a treatment for chronic primary pain. When asked for any additional comments about their experiences, six out of seven participants highlighted a similar perception to the term treatment being applied to CBT.

"I think the approach taken into whatever like CBT – it's not going to cure your pain; it might help you cope with it and cope with what's going on around it… it shouldn't be linked with pain treatment because it doesn't take the pain away and it hints that it can kind of hint that your pain is not real. I don't think it should be linked with pain, personally. That's also a lot of people have said to me, it's like, oh, this will help with your pain. Yeah. But pain actually is a physical feeling completely different to a mental you get, like, anxiety, then you get the secondary physical symptoms, pain is physical" (Suzie, P.15, L.334-339).

"…but a lot of people say it's just in your head. The pain is in your head. It's not in your head because you do have something wrong with your body. It just doesn't show in the test because it's neurological pain. I don't think it could be improved with CBT. I think it helps to understand the problem, to help to kind of manage and not to panic, not to have anxiety over it. But definitely this is not the treatment" (Mary, P.7, L.137-139).

"But I can feel the pain. It's a nerve pain, it's a physical pain. CBT or psychological treatments, they only help you to sort of manage. But they will not make the pain better. They will not make the pain go away" (Amy, P.4, L.62).

"…because even though they say it's like psychological pain, they often say it's psychological pain, but I feel it physically. I feel physical pain, even though physically there is nothing wrong with me. Well, that's what they say. There is nothing wrong with me physically" (John, P.10, L.141-143).

A common theme cutting across the experiences of participants was the incongruence between how participants made sense of their pain and the psychological nature of CBT. Despite having engaged with CBT, the participants appeared to have held on to a primarily biomedical understanding of pain. The influence of the biomedical frame through which participants viewed their chronic pain was visible. The prospect of CBT as a treatment for chronic pain was met with resistance and frustration:

"*… it shouldn't be linked with pain treatment because it doesn't take the pain away…*" (Suzie, P.15, L.339).

"...But definitely this is not the treatment." (Mary, P.7, L. 139).

"...They will not make the pain go away" (Amy, P.4, L.62).

It is almost as if CBT being referred to as treatment was experienced as discounting the realness of their pain and suffering. To these participants, the term 'treatment' should be reserved for that which can extinguish the physical pain being experienced. Asserting CBT as a treatment was experienced as dismissive of their experiences. The story ceases to be theirs and it becomes that of professionals as alluded to through John's account:

"...Well, that's what they say. There is nothing wrong with me physically..." (John, P.10, L. 143).

There was a resignation that can be felt through John's account. It was as if pushing back and asserting his own story became too tiresome and he resigned himself to the professionals' interpretation of his pain experience.

Across the cases it is evident that participants needed to be seen and heard, and their pain experience understood and validated:

"...it's not going to cure your pain; it might help you cope with it and cope with what's going on around it..." (Suzie, P.15, L.333-334).

"I don't think it could be improved with CBT. I think it helps to understand the problem, to help to kind of manage and not to panic, not to have anxiety over it…" (Mary, P.7, L.137-138).

"…they only help you to sort of manage. But they will not make the pain better…" (Amy, P.4, L.62).

The participants were not discounting the benefits they gained through engaging with CBT and the utilisation of CBT interventions, they were discounting the positioning of CBT as treatment in their journey with chronic pain. To participants, CBT led to better management and coping with chronic pain. Therefore, what made sense to them based on their experiences was CBT in a supportive role in their pain journey and story. Referring to CBT as treatment was experienced as giving CBT the main character role in the pain story production and not the supportive role that felt more closer to their experience of CBT.

Chapter Summary

This chapter presented and discussed five Group Experiential Themes (GETs) developed from the researcher's interaction with participants' data, firstly on a case-by-case basis and then across cases in keeping with IPA methodology. Raw extracts from participants' accounts were presented in evidence of the interpretations made as the researcher dealt with the task of making sense of the lived experiences of CBT interventions for chronic pain by participants with CPP. The researcher addressed the answering of the research question informing this study, the question of how individual CBT interventions making up CBT treatment for chronic pain are experienced by individuals with CPP. The GET, '*Regained Autonomy'* introduced a group of CBT interventions that were positively experienced by participants. Regained autonomy was developed to encapsulate the experiences of new-found hope, improved internal sense of control as well as the widening of participants' worlds through interventions that focused on helping participants refocus on what they were still capable of achieving whilst simultaneously equipping them with tools to aid in their coping with challenges presented by CPP.

The GET, '*a changed pain mindset'* provided interpretation of the benefits reported by participants to have been acquired through thought challenging. This GET also shed light on the challenges to believing alternative more adaptive thoughts faced by participants whose CBT sessions included thought challenging.

The GET, '*the pain in pacing'* was developed to interpret participants' experiences of the emotional and practical challenges participants faced as they sought to adopt pacing measures that were time contingent to create a position that would enable them to manage their pain. Although fully on board with the concept of pacing, participants found it a challenge as it exposed emotional battles they may not have had otherwise addressed including some amount of denial of the chronicity and potential permanency of chronic pain in their lives.

The common thread tying all CBT interventions together was the significance of the doing making up CBT interventions and the meaning participants assigned to the doing. The doing is concerned with the procedures that are to be followed for an individual to benefit from an intervention. Participants' experiences of CBT interventions highlighted an interplay between the meanings assigned to the doing required for the intervention and their personal fight to preserve self-identity. Their experience of each intervention wasn't solely focused on whether the intervention led to pain reduction or reduced pain related disability. Participants' level of engagement with the CBT interventions was attached to whether the doing procedures making up the intervention helped them recoup more of their old self, adding back activities they may have previously thought were lost due to chronic primary pain. Interventions with procedures that involved reducing activity for longer term gain were less favoured and experienced as further assaulting their sense of self that would have already been affected by chronic primary pain.

In addition to direct CBT interventions, the experiences of participants uncovered therapist related factors as well as family related factors that impacted both positively and negatively on the CBT intervention experience. The GET*, Indirect interventions* discussed participants' experiences of factors that participants perceived to be influential in how they experienced and engaged with CBT interventions.

The last GET, *'CBT did not cure my pain'* provided an interesting take on the positioning of CBT as a treatment for chronic primary pain from the vantage point of participants and the implications this positioning carried for the participants.

In summary, these findings are enlightening and there is much to glean from them from both research and clinical spheres. The experiences of all participants within the current study spotlighted the implication of the meanings participants attached to the practical elements involved with the CBT interventions making up their CBT package. The next chapter will apply critical lenses on these findings with the goal of critically discussing and evaluating key findings within the context of broader literature, current clinical practice, and guidance.

Chapter 7 Discussion

Chapter Introduction

The current study sought to understand how CBT interventions for chronic pain are experienced by people living with chronic primary pain. The focus of this chapter is to present a thorough discussion of key findings developed from the present study and how these findings contribute to the current body of knowledge within the field of CBT for chronic primary pain (CPP). These findings will be critically discussed on the backdrop of already existing literature and current clinical practice and policy. The study's strengths and limitations will be evaluated, paying particular attention to methodological issues arising in relation to the execution of the current study. An outline of considerations for future research will be presented followed by a conclusion to this thesis.

A discussion of key findings

The key finding unifying the experiences of all participants across all the CBT interventions represented within the data set was the significance of the meaning participants attached to the practical elements (procedures) accompanying each CBT intervention and what following through with these practical elements meant to them. Participants' experiences highlighted the internal struggle between their old self and the new unwanted self they perceived chronic primary pain to be trying to forcefully assert in the place of their wanted old self. Consequentially, CBT interventions experienced as allies in this battle for self were interventions whose doing was experienced as adding or reclaiming back elements of their old self and life as they knew it prior to CPP. Interventions with procedures where the doing was perceived as taking, subtracting or negotiating with chronic pain were met with emotional and practical resistance. This may have been particularly important to the participants within the current study owing to their life stage. Throughout the course of life, individuals are often acquiring new roles, moving roles or losing roles (Thoits, 2012). The typical expectation within the early to middle adulthood stages is for an individual to be either acquiring new roles or transitioning into other roles in domains such as employment, parenting and relationships (DeLiema & Bengtson, 2017). Participants were all within the twenty to early forties age bracket and were focused on building their lives with their futures in mind. Three of the participants lived with their partners, two participants had children, one participant reported being on a master's programme and one shared being a teaching assistant although she had had to resign due to CPP. The life stage participants were in could help in making sense of why the 'doing' posed by CBT interventions and its meaning mattered to them.

According to the role theory, it is through the roles individuals occupy and the dynamic interactions with others while within roles that lead to the development of a sense of self (George & Ferraro, 2016). Hogg et al. (2017) went on further to assert that roles provide a guide for behaviour in situations that may be unknown. Given their life stage, participants were all occupying roles that carried with them expectations of conduct. For example, as a mother, Jane would have had set expectations on the behaviours associated with being a good mother. Pre-chronic primary pain, Jane may have had to work hard to meet the expectations without pain related barriers. Consequentially, as stated by DeLiema and Bengtson (2017), the role of being a mother as well as other roles Jane may have occupied would have brought meaning and purpose to her life. Post-chronic primary pain, Jane was no longer the only one deciding which behaviours to engage in as part of her role as a mother, she had to make room for chronic primary pain. Toye et al's (2013, 2017) syntheses of qualitative research on the lived experiences of chronic pain identified a conflict between chronic pain and an individual's self they referred to as the "adversarial struggle" (Toye et al., 2013, p. 30). This struggle is hallmarked by the desperate attempts made by individuals with chronic pain to hold on to their pre-chronic pain sense of body, self-identity, sense of body, roles and relationships (Toye et al., 2013). The experiences of all participants within the current study corroborate this struggle between pain and self. The experiences of participants highlighted that a CBT intervention with practical elements perceived as requiring subtractions to how they engaged in their roles day to day was experienced as threatening to their view of self as well as their hope of getting back to their pre-chronic pain selves. Contrastingly, CBT interventions with practical elements focused on adding to what they may have already been doing were more welcome, consequently restoring some aspects of self they had deemed lost.

To facilitate a logical and thorough critical discussion of these findings, each CBT intervention represented within the data set will be presented and discussed singularly in line with relevant literature, policy and clinical guidelines.

Behavioural Activation

Behavioural activation, also referred to as activity scheduling is primarily a behavioural intervention for depression (Walsh et al., 2022). The principles of behavioural activation are rooted in operant conditioning, which posits that behaviour is controlled by its consequences, thus behaviour can be shaped by the reward or punishment following the behaviour (Skinner, 1963). The therapeutic goal in behavioural activation is that of increasing behaviours that allow for an individual to experience both planned and naturally occurring positive reinforcers. These positive reinforcers can be external or internal, with internal psychological reinforcers including a sense of accomplishment, closeness to others, enjoyment and relaxation (Cuijpers et al., 2007). Behavioural activation was experienced by participants as improving sense of agency as defined by Moore (2016) to refer to the degree to which an individual feels themselves to be in control of their actions and the consequences of their actions. Participants who engaged with behavioural activation gave accounts of how them being in control of the selection of value-based activities they would engage in, forward planning these activities and engaging in these activities with mastery and pleasure in mind increased their sense of control and choice which in turn led to greater levels of internal satisfaction. John, Matt and Jane's accounts highlighted continued engagement with behavioural activation was not solely due to the number of activities they were able to complete, but also due to the internal rewards they experienced. The internal rewards created a platform on which negative self-beliefs about perceived losses of self could be tested through action. Smith and Osborn (2007, p. 517) poignantly described the experience of living with persistent pain as "an assault on the self". This assault is characterised by the engagement in negative self-appraisals as a response to an individual's inability to engage with life as previously done prior to living with pain. These negative appraisals consequently impact the individual's personal identity and their perceptions of autonomy. The experiences of participants who engaged in behavioural activation suggest behavioural activation to be useful in potentially loosening negative self-appraisals, indirectly challenging these appraisals as the individual's behavioural repertoire improves through engagement with behavioural activation.

Through the experiences of participants who engaged with behavioural activation, the current study findings add a greater understanding of how behavioural activation can be potentially an empowering CBT intervention in the treatment of CPP. At present, behavioural activation is very seldom routinely adopted as an intervention for chronic pain in clinical practice in the absence of depression (Walsh et al., 2022). This presents a missed opportunity as the current study findings show the internal rewards stemming from behavioural activation's focus on mastery and pleasure from activities to be powerful, hope giving and a step towards the regeneration of positive self-appraisals. A scoping review conducted by Walsh et al. (2022) identified evidence of behavioural activation potentially having a positive effect not only on mood, but on pain itself. Although the limited number of papers included within the review warrants caution in forming firm conclusions, the evidence in favour of behavioural activation for chronic pain is promising.

Graded Exposure

Like behavioural activation, graded exposure was positively experienced by all participants who had engaged with it as part of their CBT package. Participants attributed therapeutic gains including a reduction in pain related fear and improved confidence to their engagement with graded exposure (Paul, P.6, L.105-107; Suzie, P.10, L.215-220). As participants begun approaching situations and activities they had previously avoided, they found better ways of coping practically as well as a newfound understanding that the presence of pain did not correlate to internal damage occurring. Lethem et al (1983) centrally placed the perception of fear at the heart of chronic pain. Through the Fear-Avoidance Model, Lethem et al. (1983) postulated that it was individuals who avoided experiencing pain and engaging in activities perceived as causing pain that were more likely to develop a pain perception that was not in proportion to the actual situation. This exaggerated pain perception was found to be responsible for high levels of pain related catastrophising consequently leading to higher pain related disability (Zale & Ditre, 2015). The experiences of some participants exemplified the Fear-Avoidance Model in action. For example, Paul stopped playing football as he became fearful that playing football was exacerbating the pain in his knee and legs. Instead of engaging in activity, Paul would rest his knee, choosing to sit on the bench while his teammates played. Through graded exposure, Paul started attending practice sessions, gradually building up to partaking in light warm up exercises with his team which reduced his fear of causing harm to his knee. Paul's experience together with those of other participants who also engaged with graded exposure pointed to graded exposure as facilitating a reduction in pain related fear, which ultimately led to confronting rather than avoiding behaviours. This finding lends support to already existing literature advocating for graded exposure in the psychological treatment of chronic pain (Lethem et al., 1983; Riecke et al ., 2020; Vlaeyen et al., 2001). Through graded exposure, participants not only reported coming to terms with the fact that engaging in activities previously avoided would lead to pain, but that this painful experience was tolerable. Through the experiences of participants, the current study findings point to graded exposure as potentially making room for pain and equipping the individual to live a full life alongside their pain. The participants' experiences demonstrated how as the individual safely and gradually confronts their feared activities, factual and adaptive appraisals of what they can and can't safely do are developed, which not only leads to a reduction in pain-related catastrophising and disability but also internal self-confidence and improvements to quality of life.

Problem Solving

The experiences of participants who engaged with problem solving as part of their CBT package highlighted problem solving as enabling adaptive responses to practical challenges accompanying living with CPP as well as positively enhancing personal beliefs of coping (Suzie, P.5, L.101-105; Amy, P.7, L.121-126). The adaptive responses to practical challenges were birthed through the question-and-answer process making up problem solving. As participants followed a line of self-questioning that started with problem identification followed by the generation of potential solutions and the evaluation of potential solutions for suitability they gained better clarity on the problem in front of them. Instead of avoidance without analysis, problem solving provided participants with an avenue to explore an assess the threat. The second level of questioning in problem solving shifted the focus from the situation to individual coping. It is through this second step of self-questioning participants' accounts reflected a shift in focus from the situation to self-management. Stress and coping models such as the Transactional Model put forward by Lazarus and Folkman (1984) assert the importance of personal appraisals of stress and coping. Within this model, primary appraisals encompass an individual's beliefs about the threat within the situation while secondary appraisals are concerned with beliefs about their ability to cope with the potential threat identified. According to the Transactional Model, when faced with stressful situations, individuals are faced with the choice to either change the situation, which the Transactional Model regards as problem focused coping or modifying their response to the stressor which is referred to as emotion focused coping (Lazarus & Folkman, 1984). The experiences of participants who engaged with problem solving show problem solving as encompassing both elements of responding to stressors as postulated within the Transactional Model. As participants shifted their focus towards emotion focused coping through problem solving, internal locus of control increased. This is an important finding as research shows that people with high internal locus of control are less likely to suffer from major depressive disorders (Abramson et al., 1989; Khumalo & Plattner, 2019).

Participants' experiences also pointed to problem solving as facilitating acceptance. The process of evaluating what could be realistically done to improve a stressful situation prior to considering how to cope with the situation without changing it, appeared to have prepared participants to journey towards acceptance. Research shows the term acceptance is often rejected by individuals living with CPP, as it is associated with giving up hope of the pain completely going away (Lachapelle et al., 2008). Through problem solving, participants appeared to have subtly begun accepting chronic primary pain as a companion and not a foe. Participants' experience pointed to a fine balance between acceptance and change that must be navigated with skill and caution. Linehan (2015) through his work on dialectics argued that the “tension between two opposing emotions or ideas must be used constructively” (p.31). Participants’ experiences point to an engagement with practical acceptance through problem solving. There was an understanding across participants whose treatment included problem solving that problem solving did not eventually lead to the absence of pain, rather, problem solving led to an emotional grounding and comfort that came from a knowing that they had considered and done all they externally could. The result was not giving up or mental defeat, rather it was what McKay et al. (2019) referred to as practical acceptance characterised by balancing the change of behaviour causing suffering with the acceptance of self in its current state.

Summary of behavioural activation, graded exposure and problem solving

The reported regaining of autonomy by participants is the unifying factor linking participants’ experiences of behavioural activation, graded exposure and problem solving. These three interventions facilitated the rebuilding of self. These interventions provided processes and tools that paved way for the participants to safely evaluate how much they could still do instead of a focus on what they shouldn’t do. According to the Self-Determination Theory, one of the key innate needs for humans is the need to feel competent in managing the environment and dealing with life’s situations (Deci & Ryan, 2000). Through graded exposure, behavioural activation and problem-solving, participants’ own accounts reflected growing competency in managing the challenges presented by chronic primary pain whilst also engaged in the rebuilding of a meaningful life. The Self-Determination Theory also points to the need for autonomy as a key innate need (Ryan & Deci, 2000). The experiences of participants support the assertion that the appeal of these interventions was in their ability to shift focus of attention from the limitations of pain to focusing on the individual’s capabilities and developing coping, consequently improving one’s sense of control. An improved sense of control not only leads to improved motivation but also improvements to personal wellbeing, confidence and overall mental health (Hong et al., 2021). The Self-Determination Theory points to the third innate human need to be the need for relatedness, a need characterise by feeling connected to others and feeling part of them (Deci & Ryan, 2000). As participants became more confrontational rather than avoidant of activities and situations they perceived as threatening, their social lives improved which in turn improved wellbeing. For example, as Paul gradually got back into football, he became part of his teammates again. As Suzie begun better managing her energy resources, she was able to go out socially with her friends. This pattern was observed across all participants. Through behavioural activation, graded exposure and problem solving, the experiences of participants point to the connection with others being fostered as confidence and willingness to confront and make room for pain rather than avoid pain grew.

Thought Challenging

Thought challenging, which is one of the original cognitive restructuring interventions stemming from Beck's work on cognitive therapy for depression was represented within the data set (Beck, 1970). Traditionally, thought challenging as postulated by cognitive theorists focuses on the modification of thought content (Beck, 1970). There are indeed merits in examining the content of unhelpful and negative thoughts followed by a rebuttal of these thoughts with factual evidence, however some participants like John shared their frustrations with content focused thought challenging as they did not perceive the contents of their thoughts on pain and being in pain to be false and warranting restructuring. Paul's account of thought challenging highlighted that beyond challenging the contents of pain related thoughts, it was the pain mindset that must be uncovered and challenged instead. Grünenwald et al. (2023) asserted that most treatments for chronic pain were limited due to their focus on the development of coping behaviours whilst bypassing the individual’s stress mindset. Grünenwald et al. (2023) defined the stress mindset as “an individual’s belief about whether stress is perceived as benefiting performance, productivity, health and growth” (p.155). A positive stress mindset is when an individual’s attitude towards stress is adaptive. The experiences of participants like Paul lend support to Grünenwald et al. (2023) as it was through addressing the pain mindset rather than the content of thoughts that positive gains were reported to have been made from thought challenging. Thought challenging that led to metacognitive level changes led to adaptive and helpful thinking processes which could be transported to other situations as highlighted in the experiences of participants. Positively reframing the pain experience as a whole rather than in parts (thoughts experienced in each situation) led to a changed pain mindset that facilitated positive and active coping.

The experiences of thought challenging by participants within the current study encourage an evaluation of current clinical practice in relation to the focus and level of thought challenging for chronic primary pain. Callesen et al. (2020) compared the clinical efficacy of cognitive behavioural therapy and metacognitive therapy which focuses on targeting thinking processes. The results on the beck depression inventory (BDI-II) showed metacognitive therapy to be superior to traditional cognitive behavioural therapy for depression at both post treatment and follow-up 6 months later (Callesen et al., 2020). What was more promising was the evidence of the gains being maintained longer term. Although Callesen and colleagues focused primarily on depression, their findings and conclusions are useful to the current discussion. The experiences of participants from the current study suggest that focusing on metacognitive thinking processes carries the potential to yield better clinical outcomes for chronic primary pain patients. The experiences of participants represented within the current study on thought challenging are indeed interesting, however further research exploration is warranted, more so as research solely focusing on thought challenging for CPP within the field is limited.

Pacing

Pacing is a common staple in the treatment for chronic pain, not only within CBT therapy but also physiotherapy and occupational therapy (Antcliff et al., 2021; Torrance et al., 2011). All participants within the current study had experienced pacing, which is often introduced as a way of helping avoid cycles of overdoing and underdoing commonly observed in individuals with chronic pain (Gill & Brown, 2009). The current study's participant's experiences of pacing were in contrast with the experiences of participants represented within the systematic review of qualitative research presented in chapter 3. In their study, Egan et al. (2007) shared excerpts from participants who regarded pacing as a new permanent way of life that they had adopted with positive outcomes, *"*pacing, definitely pacing… pacing in everything, exercising, whatever I am doing at home, work, rest play- it's all paced" (Egan et al., 2017, p.223). Contrastingly, all participants in the current study struggled with pacing and reported experiencing the practical steps of pacing as restrictive and robbing them of their freedom of choice. This variation can be explained through an examination of the research in support of pacing for chronic primary pain. Jamieson-Lega et al. (2013) reported a lack of demonstrable evidence in support of pacing for CPP. Attali et al. (2023) postulated that the inconsistencies in the research on pacing outcomes could be due to the multiple variations of pacing strategies, with some focused on conserving energy resources while other are focused on activity restriction. Attali et al. (2023) asserted that it was important to acknowledge that although some papers report pacing to be associated with negative emotions, when measured accurately various pacing strategies yielded different results, therefore, pacing strategies were not all corelated with negative emotions equally. Although it is impossible to confirm, it is still plausible to consider that variations in pacing strategies may potentially explain why participants in Egan et al's (2007) study reported different experiences and emotional reactions to pacing in comparison to participants in the current study. However, it is important to not lose sight of the fact that despite the prolific use of pacing, the evidence lending support to pacing as an intervention capable of improving functioning and wellbeing for individuals with chronic pain is not only limited but is also inconsistent (Attali et al., 2023; Jamieson-Lega et al., 2013). These findings highlight that there is still room to further understand pacing and make improvements to better the outcomes of patients.

The participants in the current study painted a picture of pacing that is two sided, with one side showing the concept of pacing as acceptable and efficacious in alleviating psychological distresses and disabilities associated with CPP whilst the other side painted the act of engaging with pacing as emotionally charged and accompanied by a myriad of challenging and often painful emotions. As participants engaged with the practical steps of pacing, their experiences pointed to the beginning of an internal struggle in which self, personal choice and autonomy were the trophies for the winner of the struggle. To prove that she wasn't sick, Amy like many of the other participants reported a strong urge to engage in activities as they previously would have on pain-free days. Despite understanding and appreciating the potential long-term benefits of pacing, engaging in pacing would have served as a reminder that despite being pain-free, there was an illness they needed to always factor in. Consequently, this led to an internal conflict marked with an off and on-again relationship with pacing. The embracing of pacing was perceived as an acceptance of CPP as permanent, a position that was in direct conflict with the hope of one day being back to the old self. Unlike chronic secondary pain conditions in which an individual's pain is attributed to a primary disease, chronic primary pain conditions cannot be adequately medically explained or attributed to another primary disease such as cancer (Redding et al., 2024). It is plausible to assume that this lack of medical clarity played a part in shaping participants' experiences of pacing.

In addition to the emotional challenges presented by pacing, participants' experiences also pointed to the goals of pacing conflicting with individual goals and values. Mary emphatically stated how her desire was to engage in her hobby without additional secondary considerations. Her personal goal was to enjoy her hobby by engaging with her hobby how she wanted and for as long as she wanted. However, the goal of pacing would have been to help her manage how she engaged in this and for how long to prevent the boom-and-bust cycle. This goal conflict was not unique to Mary but was shared across participants. It was not always possible to attend to both goals at the same time, a situation that would create a goal conflict which is characterised by a power struggle (Austin & Vancouver, 1996). As succinctly put by Crombez et al. (2012), patients with pain often not only want to avoid the pain, but they also want to pursue other valued activities". (p.477).

An important observation from the experiences of participants within the current study was that the greater challenge was not always in the act of pacing itself but what engaging in pacing meant for them. The foundations of pacing lie within pure behaviourist theories which do not directly attend to cognitive processes (Staats et al., 2004). The experiences of participants within the current study suggest the behavioural procedure of pacing could potentially be too simplistic in attending to the emotional and cognitive complexities accompanying the experience of CPP. Curtis and Pirie (2018) concluded that equipping individuals with chronic pain with simple tools designed to bring awareness of the grief and loss processes taking place behind the logical scene will lead to a better understanding of their condition, have their feelings validated and leave them equipped with the knowledge to articulate their thoughts which in turn would improve their management of pain.

An Overview of CBT interventions

The experiences of CBT interventions reported by participants are illuminating. Participants' experiences centrally placed doing as a key factor in determining CBT interventions were experienced. For interventions participants regarded as additive such as behavioural activation and problem solving, not only was their engagement higher but participants reported these interventions assisting them in rediscovering parts of self they had thought chronic primary pain had completely shattered. The concept of self is critical in chronic pain as research has consistently highlighted that living with chronic pain evokes an internal conflict marked by a struggle to preserve their pre-chronic pain sense of self (Morley, 2010; Smith & Osborn, 2007; Yu & McCracken, 2025). As reflected through the experiences of participants, part of their armour in this struggle with chronic pain was the internal defiance that often led to them engaging in activities as they would have pre-chronic pain to prove that they were still them. However, most participants reported experiencing negative physical and emotional consequences as a result. What started as a quest towards proving that they were not ill ended with them feeling more ill and plagued by negative self-perceptions and images as highlighted through John's account. This "assault on the self" as poignantly referred to by Smith and Osborn (2007, p. 517) led to feelings of hopelessness and helplessness that if left unaddressed could pave way for mental defeat with each repeated pain episode. Mental defeat is a psychological concept that has been useful in providing insights on symptom severity, emotional distress and impairment across mental health conditions such as post-traumatic stress disorder (Ehlers et al., 1998) and depression (Taylor et al., 2011).

The concept of mental defeat in chronic pain was spotlighted through the work of Tang et al. (2007). Using the validated pain self-perception scale administered to 304 participants, their results showed individuals with chronic pain to display higher levels of mental defeat when compared to all control groups. Interestingly, chronic pain patients seeking treatment were reported as showing elevated signs of mental defeat when compared to individuals who had reported comparable chronic pain severity but were not seeking treatment (Tang et al. 2007, 2010). The experiences of participants within the current study lends support to these findings. Participants were selected for participation because they had sought treatment. Their reported experiences showed evidence of some level of mental defeat as some participants described themselves as *"incapacitated, disabled, weak"* (John, P.7, L.97). It is plausible from the experiences of participants within the current study to postulate that at the point of making decisions to seek treatment, participants were grappling with elevated levels of mental defeat. Tang et al. (2010) described mental defeat as "a psychological state characterised by the perceived loss of autonomy, agency and human integrity in the face of persistent and uncontrollable events" (Tang et al., 2010, p. 549). Tang et al. (2007, 2010) asserted that it was crucial to not lose sight of the fact that mental defeat goes beyond helplessness, it encompasses the deeper and more complex psychological impact of chronic pain on how individuals view themselves, their self-identity and how this impacts their interactions with the world around them. Participants' experiences of CBT interventions centred around the doing of the practical elements accompanying CBT interventions and whether the doing facilitated the regaining of self-governance, autonomy and agency. Participants favouring interventions with practical elements they perceived as facilitating self-governance, autonomy and agency lends support to the assertion that mental defeat may be a key cognitive marker in making sense of the uptake of and/or rejection of CBT interventions (Collard et al., 2023). The experiences of pacing reported by participants within the current study demonstrate the necessity for cognitively targeting mental defeat, an addition without which pacing risks being experienced as a further assault on self. The reported experiences of behavioural activation and problem solving painted a different picture to pacing in relation to mental defeat. Through the examination current limitations and problems, participants reported being able to move from trying to control or change the situation to looking inward and focusing on how they could manage themselves and cope in the given situation. The cognitive flexibility displayed by participants as they became more familiar with utilising the tools within this group of interventions warrant consideration of whether CBT interventions made up of practical elements perceived as additive could improve mental defeat.

Contributing Factors

The experiences of participants within the current study pointed to therapist factors and support from loved ones as having noteworthy influences on how they experienced and engaged with CBT interventions.

Influential pioneers of CBT including Beck (1970) argued that interpersonal factors, though important, had very little influence on outcomes independent of structured CBT interventions (Easterbrook & Meehan, 2017). However, it is now commonly agreed within the field of psychotherapy that the client-therapist relationship is a crucial factor potentially affecting outcomes (Teyber, 2006). The experiences of participants within the current study lend support to family support and therapist factors playing a more critical role than alluded to in the early writings of Beck (1970). The account of Suzie, who over the course of a few years had received CBT treatment twice, with the treatment being delivered by different therapists, provided interesting insights into the role of therapists in clinical outcomes. The findings lend support to studies such as that of Dattilio and Hanna (2012) that point to collaboration as a key and necessary ingredient for positive outcomes in CBT. The current study's finding proposes that alongside better understanding how individual CBT interventions are experienced, therapists' skills and approaches must not be left behind. There are clinical and training implications to this finding such as the need for continued professional development that puts a spotlight and emphasis on the importance of person-centred care in the effective management of chronic pain. Given that despite being efficacious, CBT outcomes for chronic pain have repeatedly demonstrated limited impact, with small to very small benefits reported long term on pain, disability and distress (Williams et al., 2020), the need for psychological therapies that place individual needs at the centre of their care and therapists that are skilled in delivering person centred care for chronic pain has never been more apparent. Suzie's experience of her first CBT episode of care pointed to a pairing with a therapist who may have been very skilled in delivering CBT protocols for chronic pain but lacking in the ability to consider Suzie's idiosyncratic needs and adapt their CBT tools in response to Suzie's needs. John aired his frustrations with the "*general*" (John, P.7, L.54) nature of his CBT sessions. John shared his desire for therapeutic support that was tailored to his own experience as well as the stage in his journey with chronic pain. It is evident from the experiences of most participants that like Suzie and John, although they found most of their overall CBT treatment useful, a more person-centred approach was a key missing ingredient.

The World Health Organisation (WHO, 2015) define person centred care as "an approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that respond to their needs and preferences in humane and holistic ways" (p.5). In their narrative review, Themelis and Tang (2023) made a strong case for the necessity of patient centred care that considers not only generic pan management but attends to the individual needs of the patient. Similarly, Linton et al. (2024) also advocate for individualised patient centred care for chronic pain, positing that it is the clinician that can attend to individual emotional, psychological idiosyncrasies as well as their social contextual space that will enable patients to make sense of their pain. In a recent publication, Scholten and Glombiewski (2025) posited that the lack of a consideration of individual differences in the treatment of chronic pain could account for limited successes with psychological therapies such as CBT. According to Scholten and Glombiewski (2025, p. 4) personalisation at the individual level in chronic pain paves way for the "multiple, complex, interacting and self-sustaining factors" at the core of the development and maintenance of chronic pain to be therapeutically attended to. Although most CBT Therapists would assert that they do individualise treatment as any kind of therapeutic intervention requires some form of individualisation to be effective, Lutz et al. (2022) argued that those efforts though positive steps in the right direction, are often inconsistent and plagued by biases. As aptly put by McCrae et al. (2015, p. 4) therapeutically working with chronic and often complex long term health conditions such as chronic pain is not business as usual, there are complexities accompanying major life changes that require more "sophisticated" and idiosyncratic formulations, skills that therapists relying on standardised treatment manuals do not possess.

Hutting et al. (2022) provided a framework to support clinicians in putting person centred principles in practice when working with individuals with musculoskeletal pain. The framework comprises of three phases which are, 1) identification and goal setting, 2) coaching and self-management and 3) evaluation phase (page). The identification and goal setting phase is characterised by the building of a shared understanding of the presenting problem as the clinician collects information about the individual's situation, challenges, needs and priorities. Hutting et al. (2022) assert that this stage must include elicitation of the individual's understanding of their chronic pain, their cognitions and attitudes towards treatment and acceptance. The result from this must be the setting of goals that are centred around the person and their needs. In their comparison of different aspects of person-centred care, Burton et al. (2017) found the most valued aspects of person-centred care to be attention to the individual's personal situation and a commitment to focusing on person led values and goals (Burton et al., 2017). The experiences of participants pointed to an unspoken incongruence between their indirect goals and their perception of the goals of some CBT interventions (for example Mary's desire to colour as she would pre chronic pain as a way of reconnecting with the self-pre-chronic pain in conflict with her perceived immediate goal of pacing being that of slowing her down). A personalised approach to therapy led by frameworks such as that presented by Hutting et al. (2022) may have led to the exposure of this goal conflict consequently helping the therapist better understand the root of Mary's reservations with pacing and together formulate an action plan that worked best for Mary. The coaching and self-management phase is focused on equipping the person with skills and tools for self-management. The last phase, the evaluation phase is a reflective phase in which the individual can reflect on gains and set future goals. The person-centred framework as put forward by Hutting et al. (2022) emphasises the need for clinicians and individuals seeking support to "meet as equals" and for the clinician to validate the experiences of individuals. The therapeutic encounter must remain dynamic and responsive to the needs of the person. The accounts of participants from the current study point to the need for clinicians that are reflexive, responding to information and adapting to the idiosyncratic emotional, cognitive and or behavioural needs of the person in situ and not in the next session (Rolfe, 1997).

In addition to frameworks such as that of Hutting et al. (2002), hybrid treatment protocols incorporating the complex and personal psychological factors accompanying the experience of chronic pain can also be useful in allowing for personalisation in treatment as evidenced by Tang et al. (2012). The need for recentring person-centred care in the management of chronic pain as postulated by Themelis and Tang (2023) has never been more crucial and urgent.

The role of loved ones was also identified within the current study's findings to be an important contributing factor to how participants experienced CBT and the interventions making up their treatment. The support of loved ones was experienced as instrumental in the facilitation of in-between session homework tasks that are a core component of CBT treatment. The accountability theory highlights how by virtue of one perceiving they have to give justification of their actions to another, one's sense of accountability for the manner in which they execute action and the decisions taken increases (Vance et al., 2013).

From the experiences of participants, loved ones played a pivotal in the positive engagement with in-between session tasks. In-between session homework tasks facilitate the solidification of therapeutic gains (LeBeau et al., 2013). Research goes further to cite the failure to complete homework tasks as a significant contributor to negative therapy outcomes (Helbig-Lang & Fehm, 2004). Adherence with in-between session tasks is a common challenge for many patients (Tang & Kreindler, 2017). Therefore, having loved ones act as co-therapists, gently reminding the individual with CPP to engage with homework and utilise CBT coping skills in their own environment appears to be an important consideration based on the experiences of participants within the current study.

The meaning of treatment

The discussion has so far focused on participants' experiences of CBT interventions making up their CBT treatment as well as factors participants reported to have contributed to participants' experiences of CBT interventions. However, a common concluding remark was a rejection of the assertion that CBT was a treatment for chronic pain. Although participants acknowledged the usefulness of CBT, they strongly disagreed with CBT being a treatment and labelled as such.

The Misdirected Problem-Solving Model put forward by Eccleston and Crombez (2007) could potentially provide useful insights in making sense of why participants may have struggled to view CBT as a treatment. The Misdirected Problem-Solving Model of chronic pain asserts that even when biomedical solutions have failed to extinguish pain, a common response to persisting pain is a continued quest for a biomedical solution to pain. Despite the fruitlessness of each biomedical solution, Eccleston and Crombez (2007) stated that the individual with chronic pain struggles to come out of this perseverance loop. According to this model, when an individual with chronic pain is within the perseverance loop, they are often unable to reframe the problem from a non-biomedical frame, as such they continue persevering for a solution that does not materialise. Although participants in the current study did engage with non-biomedical approach to chronic pain, it is plausible to assume that most of the participants struggled with the concept of CBT as a treatment because of still being in the perseverance loop as postulated by Eccleston and Crombez (2007).

From their syntheses of qualitative studies on chronic pain, Toye et al. (2013) stipulated that people who were able to move forward were those who were willing to take the difficult decision of letting their old self go to make room for the reconstruction of a new self that was acceptable to them. This could only be possible when individuals accepted that the pain they were experiencing did not have a medical cure and was going to be a permanent companion on their life journey. While an individual is within the perseverance loop as postulated by Eccleston and Crombez (2007), their ability to move forward towards acceptance is potentially limited even if they did engage with CBT.

Another important consideration in the discussion of participants' perceptions of CBT as a treatment is the use of language in psychological therapies. The accounts of participants highlight the importance of language utilised by professionals and how the use of treatment in describing CBT can be interpreted as dismissive of their full pain experience. Labelling CBT as a psychological treatment for chronic primary pain, moreover with the CBT being delivered outside of a multidisciplinary context could be seen as validating that the pain being experienced was in their heads and therefore requiring a purely psychological intervention. Participants did not deny the usefulness of CBT, however for participants, CBT was experienced facilitating the management of chronic pain and not as a cure as implied by the term treatment. With chronic pain being much more effectively understood from a biopsychosocial model (Gatchel et al., 2007), labelling CBT delivered in a silo may unintentionally invalidate the full pain experience of individuals with chronic pain as highlighted in the accounts of participants within the current study. Carlson (2014) proposed an alternative approach to chronic pain that accounted for biological, psychological and social facets making up the chronic pain experience. Through an amalgamation of dialectical behavioural therapy, acceptance and commitment therapy behavioural activation and motivational interviewing processes Carlson (2014) developed the Teach Apply Generalise (TAG) model to chronic pain. The TAG model is made up of treatment components designed to specifically attend to biological basis of pain, life span and social roles, the meaning of pain as well as grief and loss. Carlson (2014) recommends treatment components and the order in which they are delivered to be chosen based on the needs and goals of the individual client. It is plausible to assume that an approach that acknowledges all facets (biological, social and psychological) of chronic pain may be better suited in understanding, validating and responding to the experiences of individuals with chronic primary pain.

Research Strengths, Limitations and Recommendations for Future Research

The remainder of this chapter provides a discussion of the current study's strengths, limitations and builds upon the suggestions for future research already made within the discussion.

Research Strengths

The focus of Inquiry

The current study sought to specifically investigate the experiences of individuals whose chronic pain fit the chronic primary pain cluster to make sense of how CBT interventions were experienced when chronic pain is not fully attributable to another primary medical and was the primary disease itself (Treede et al., 2019). Thus, the findings of the current study are unique to chronic primary pain.

At its core, chronic primary pain is a personal and subjective experience, and it can be argued that qualitative inquiries investigating the lived experiences of participants are best placed to provide insider knowledge and experience that yields a greater return in advancing understanding and improving clinical outcomes (Osborn & Rodham, 2010). The current study amplified the voices of participants within a field that is mostly dominated by randomised control trials and from the vantage point of professionals and researchers.

A widespread problem in the evaluation of CBT for CPP studies within the field is the application of CBT as a general label for a variety of interventions, making it difficult to assess what is working and how (Lim et al., 2018). Thus, the current study strength also lies in the researcher's attempt to dismantle the 'CBT whole' in order to make better sense of the

‘CBT parts.’ Participants’ experiences of the individual CBT interventions making up their course of treatment were explored, and participants’ experiences made sense of in the context of the part (CBT intervention) and not the whole (course of CBT treatment).

Methodological Strengths

Nizza et al. (2021) postulate the hallmarks of an excellent IPA study to include 1) the construction of a compelling and unfolding narrative, 2) the development of a vigorous experiential and/or existential account, 3) close analytical reading of participants' words and 4) attendance to convergence and divergence (p. 3). These hallmarks provided a benchmark for the researcher of the current study. Extracts from the dataset were thoughtfully and carefully selected with the aim of capturing the heart of individual accounts. The language used was also examined, exploring why that language was used and the meaning for the individual employing the said language.

The analysis kept at the centre the iterative process of IPA as individual scripts were read and re-read as well as original voice data recordings were listened to alongside the written scripts to ensure the meanings being inferred from the written scripts reflect the participants’ experience as tone and silences add to the meaning of words employed.

In keeping with IPA’s idiographic nature, the goal was never that of generalisation, each participants’ account was afforded its own detailed exploration as highlighted in appendix three. The end result has been a powerful and insightful narrative completing the double hermeneutic circle as the story told is the story of the accounts of participants as the researcher interprets the interpretations of the participants their accounts. The researcher’s aim from the offset was to conduct an IPA study that was thoughtful to not lose sight of the experiences of participants but also provide an interpretation that is meaningful through the lens of the researcher. In addition to the aforementioned, the researcher has been transparent with the methods used and kept IPA's theoretical principles of phenomenology, hermeneutics and idiography at the core.

Reflexivity

Owing to its roots in phenomenology, hermeneutics and idiography, IPA can be fascinating and insightful but also challenging (Larkin & Thompson, 2011). As outlined in chapter one, the motivations for this research stemmed from a desire to gain an in depth understanding of how cognitive behavioural therapy was being experienced by a specific cohort of chronic pain clients who had either dropped out or reported very little gains from attending our therapy group. IPA quickly became the methodology of choice as it concerns itself with the exploration of lived experiences (Smith et al., 2022). The possibilities of gaining deeper understanding and new insights that could potentially improve outcomes for chronic pain patients was exciting.

However, upon embarking on this research journey, I soon realised the importance of ensuring my passion and goal, though positive did not get in the way of how I approached the inquiry. This was a challenging and deflating realisation. Further reading around IPA led to an understanding that a successful undertake of IPA did not mean a suspension of personal values, beliefs and in my case passion, rather an acknowledgement of their presence as part of my own "fore-structures" and committing to a process of ongoing reflection of their interaction with the IPA process and bracketing them (Smith et al., 2022).

Reflective journalling as presented in Box 5.3 in Chapter 5 was adopted as part of the ongoing reflection process. The process of keeping this reflexive journal enabled for thoughts and feelings to not be hidden but explored in the context of supervision. Having supervisors who are not fellow CBT Therapists was beneficial in harnessing this passion and keeping the researcher focused on exploring the data with as pure a lens as possible whilst not discounting the personal passion.

However, during the data analysis stage it became clear that my initial attempts at analysing data were too descriptive due to fear of taking away from the experiences of participants. IPA is an interpretative endeavour (Smith, 2011) with Larkin et al. (2019, p. 375) emphasising the importance of quotes " not being left to speak", but rather analysed and meaningfully interpreted. Reading papers that adopted an IPA methodology was beneficial in the process of improving confidence. Wagstaff et al. (2014)'s paper which investigated researchers' experiences of using IPA was instrumental in normalising fears and challenges that accompany the process of engaging in IPA.

Overall, the current study reflects research in keeping with IPA's commitment to the exploration of lived experiences and making sense of how the individuals whose lived experience it is make sense of their experience (Smith et al., 2022).

Research Limitations

Sampling Limitations

The current study adopted a purposive sampling approach (Palinkas et al., 2015) to recruit participants. Although purposive sampling facilitated the selection of a small homogenous sample that matched the inclusion and exclusion criteria set out in Chapter 5 box 5.1, it is important to consider the drawbacks. Owing to the non-randomised nature of purposive sampling, the final sample over-represented the early adult to middle adulthood life stage. All participants were aged between 20 and 47, leaving older adults under-represented in the final sample. Theories of adult development show significant differences in physical, social and cognitive changes across the different life stages (Newton, 1994). The over-representation of one life stage may have led to a partial understanding of how CBT interventions are experienced by people living with chronic primary pain. According to Andrade (2021), these drawbacks can be mitigated as long as there is transparency on who the population making up the sample are so that findings can be understood as relevant only to that specific population. In mitigating this limitation, the researcher was transparent in reporting the ages, reported gender and ethnicity of the participants making up the current study's sample. While discussing the key finding of the impact of doing in CBT, the researcher provided a discussion of this finding on the backdrop of the participants' life stage.

Study Design

The inclusion criteria for participation included participants who had received CBT therapy irrespective of the source or style of delivery. As such, some participants had their CBT delivered through group-based CBT while a small minority had their CBT delivered in a one-to-one setting. Although the mode of therapy delivery should not impinge on how specific CBT interventions are shared and taught to participants, the role of delivery cannot be ignored. It is possible the setting may have contributed to how CBT interventions may have been experienced, for example participants in Egan et al. (2017) and Furnes et al. (2014) studies included in chapter 3 described the group experience to have facilitated their understanding and uptake of CBT interventions and motivated adherence to out of session tasks. As such, one of the current study's methodological limitations lies in the lack of separation of CBT experience based on the delivery mode. The current study recommends future studies to consider the implications of delivery mode in how CBT interventions are experienced.

In seeking to better understand the parts (interventions) making up the whole (course of CBT for CPP), during interviews participants were asked to describe what they remembered of their treatment. Some participants were not able to recall the specific names to interventions but were able to provide descriptions of their experience. It is from this description the interviewing researcher would then adopt a question such as "was it thought challenging?" To which the participant would either reply yes or no and then further expand on their experience. Although the researcher being a CBT Therapist with extensive experience including supervision and lecturing in CBT, it is important to consider the limitation this poses. Future research could include a step in which all interventions are listed, and descriptors provided prior to the interview so that participants have chosen themselves what the most fitting label for the intervention they are feeding back on is.

Number of Participants

Although the sample size was appropriate for the nature of this IPA inquiry, it is worth noting that a limitation of small sample sizes is that they lead to critiques about the validity of the findings. However, it is worth noting that though the size of the sample may be small, the in depth rich data provided by each single case leads to a large amount of data and if the data is relevant to the phenomenon under investigation the researcher ends up with copious amounts of data albeit from a relatively small sample and thus sample size cannot automatically discount qualitative study findings (Vasileiou et al., 2018). Through utilising the Lincoln and Guba (1985) Framework to ensure trustworthiness of method as well as Smith's guide in evaluating the quality of IPA studies (Smith, 2011), the researcher made reasonable efforts to ensure the findings have an acceptable level of trustworthiness.

‘Novice’ IPA status

Making ‘meaning’ from the perceived ‘meanings’ of individuals sharing their experience is quite a complicated task. Interpretative analysis of qualitative data can be challenging for the seasoned and experienced researcher as highlighted by Pringle et al. (2011) and even more for a researcher in their early stages. The researcher modestly acknowledges her position to be that of a ‘beginner’ or ‘an advanced beginner’ at best in relation to phenomenological analysis. It is important for this limitation to be considered in making sense of the current study findings and its conclusions. However, through five years of supportive supervision and learning milestones which included conducting a small-scale pilot project to gain familiarity with research in general and also interpretative phenomenological analysis prior to embarking on the current study, the researcher believes the current study to be sufficiently credible and rigorous.

Recommendations for Future Research

Cognitive Behaviour Therapy has largely enjoyed a dominant position within psychological therapies owing to its scientific basis (David et al., 2018). In describing the processes undertaken in the development of CBT treatments for anxiety disorders Clark (2004) posited that an attention to phenomenology was integral in the exploration and identification of therapy targets, more so in the early stages. The results from phenomenological studies pave way to the generation of problem theories and development of treatment models. Clark (2004) asserted that the subsequent steps would involve experimental studies designed to test the efficacy of theories and models. In a similar fashion to Clark (2004), the researcher proposes that the current study is the beginning of a long and fruitful research journey marked by seeking to further understand the lived experiences of individuals with chronic pain and their CBT treatment, identification of patterns which will form the backdrop for the development of hypotheses and empirically testing these hypotheses through quantitative experimental designs.

Owing to the qualitative focus of the current study, the findings reflect only the experiences of the participants within the current study. The researcher proposes that the first step towards building upon the current research could potentially be the validation of the experiences of CBT interventions shared by participants within the current study through a survey study involving a large number of participants. A survey questionnaire reflecting the current study themes can be developed and a Likert scale utilised to facilitate the gathering of quantitative data for analysis. The proposed method is advantageous as it would widen the reach from a few participants to potentially hundreds of participants representative of a wider range of demographics. However, the researcher acknowledges that such an undertaking would be best placed within a research team and not undertaken as a sole researcher.

The experiences of participants within the current study opened novel and interesting research avenues. Participants' experiences of behavioural activation, graded exposure and problem solving appeared to lend support to the amenable nature of mental defeat as postulated by Tang et al. (2007, 2010). Further research testing potential positive associations between these interventions and mental defeat are promising lines of future research inquiries. The Pain Self Perception Scale (Tang et al., 2007) can be utilised to reliably measure pre-intervention levels of mental defeat. Participants can be assigned into single CBT intervention treatment groups as well as treatment as usual groups. Mental defeat can be measured again post therapy and comparisons across the groups made. Not only is there a significant correlation between mental defeat and pain interference sleep disturbance, anxiety, low mood pain related disability (Tang et al., 2010), associations between mental defeat and suicidality in individuals with chronic pain have also been identified with mental defeat being found to be a predictor of increased suicidal risk (Themelis et al., 2025). Hazeldine-Baker et al. (2018) found mental defeat to have the strongest influence on self-efficacy in individuals with chronic pain even when compared with pain related catastrophising, hopelessness and anxiety. Therefore, further research focused on investigating if CBT interventions experienced by participants within the current study as facilitating the regaining of self and improving autonomy could in fact lower levels of mental defeat in chronic primary pain patients could prove beneficial a mental defeat in chronic pain has been found to be amenable to change through the extensive work of Tang and colleagues over the last 17 years.

In addition, future research focusing on the exploration of whether thought challenging with a focus on metacognitions potentially yields better outcomes in CPP and a more targeted and thorough comparison of behavioural activation and pacing are useful research avenues illuminated through the current study.

In considering that the participants within the current study had engaged with CBT and had attended at least four CBT sessions, phenomenological studies exploring the lived experiences of CBT by individuals who may not have engaged with CBT post assessment is valuable and will bring forth deeper understanding of how CBT and its interventions are experienced.

The current study findings also spark interesting clinical discussions on whether interventions are experienced differently based on whether chronic pain is primary or secondary to another disease. The separation of chronic primary pain and chronic secondary pain is a very recent development in the field of chronic pain (Treede et al., 2019). To date, only a limited number of studies have adopted these distinct clusters in their reporting of chronic pain studies. Future research must attend to potential experiential differences to psychological treatment that may exist between chronic primary pain and chronic secondary pain patients.

Explorations into these differences and how they impact treatment are a useful and necessary step in research.

The rejection of CBT as a treatment and the need for person-centred approaches to chronic pain as highlighted through the experiences also brings in question whether CBT is a suitable psychological intervention for chronic primary pain. There is need for future research that also steps out of the comfort zone of CBT into the realms of exploring and developing alternative treatments for chronic primary pain that are tailored to the individual needs of people living with chronic primary pain.

Overall, the current study findings on the experiences of CBT interventions by patients with CPP are promising and contribute to the field's agenda of investing in chronic pain research efforts that seek to investigate what works, how it works and for whom it works (Vlaeyen & Morley, 2005).

Future directions for training and clinical practice

Roth and Pilling (2016) set out core CBT competencies for working with people with chronic pain that identified maladaptive cognitions and behaviours such as primary and secondary threat appraisals to be targeted through psychological therapies such as CBT. The experiences of participants within the current study can be mapped onto these areas, lending support to Roth and Pilling (2016). Roth and Pilling (2016) suggest that practitioners must have knowledge of chronic pain models on which to formulate the experiences of participants. Throughout the research process, the researcher continued bracketing to minimise her fore knowledge of CBT from bleeding into the experiences of participants. After completion of the writing up of the current study, the detailed re-reading of this thesis sparked reflections on training and clinical practices that had made up the researcher's CBT journey. The researcher's reflections led to the development of clinical and training proposals that have been presented in Appendix 12. Although these proposals are interesting and provide insightful adaptations, the researcher acknowledges that given the nature of IPA methodology, these proposals are merely that, proposals. These proposals are still in their very infant stage; however, they are useful considerations for the future. Presently they are requiring additional evidential scaffolding prior to being included as part of the formal recommendations emanating from the current study or implemented as part of training or clinical practice.

Dissemination

The researcher aims to continue furthering research on chronic pain and how psychological therapies could be improved and or developed to effectively meet the needs of individuals living with chronic pain. Careful considerations on how future research efforts could be disseminated to clinicians, researchers, patients as well as other stakeholders were made and a proposed dissemination strategy drawn up on the backdrop of the framework for Enhancing the Value of Research for Dissemination and Implementation by Neta et al. (2015). The dissemination strategy that also includes the publication of academic papers from the current study findings is presented in Appendix 13.

Chapter summary

The current chapter presented a critical discussion of the findings emanating from participants' experiences of various CBT interventions offered during their engagement with CBT as a psychological therapy treatment for chronic primary pain. Particular attention was paid to presenting a coherent and thorough discussion of the singular CBT interventions participants discussed in their interviews in line with existing theory, research and clinical practice whilst highlighting the significant new contributions the current study has made to the field of CBT for CPP. The discussion highlighted the positive therapeutic gains, and the CBT interventions participants attributed the gains to, providing an invaluable thread to follow for future research. The study strengths and limitations were presented to ensure sober interpretation of the current study findings as well as inspire further research within the field of cognitive behavioural therapy for chronic pain. The next chapter is a conclusion to this thesis.

Chapter 8 Conclusion

Chapter Introduction

This chapter provides a conclusion to the thesis.

This thesis sought to investigate the lived experiences of receiving CBT interventions for chronic pain by individuals whose chronic pain conditions are classed within the chronic primary pain cluster (Treede et al., 2019). An Interpretative Phenomenological Analytical (IPA) approach facilitated the acquisition of in depth, qualitative rich subjective experiential accounts from which meaningful knowledge was gained and novel contributions made.

The experiences of participants uncovered a significant role played by how participants experienced and perceived the procedural elements central to CBT interventions. As the grappling between chronic pain and the old self ensued, participants' experiences highlighted the internal struggle between their old self and the new unwanted self they perceived chronic primary pain to be trying to forcefully assert in the place of their wanted old self. Consequentially, CBT interventions with practical elements experienced as additive or focused on reclaiming back elements of their old selves were perceived as allies in this battle whilst those with practical elements experienced as subtracting or negotiating with chronic pain were met with emotional and practical resistance. This finding makes a significant contribution to the field of chronic primary pain as it exposes potential incongruences existing between how patients experience the practical elements making up CBT interventions and the meanings they attach to the doing associated with these elements versus the theoretical and evidential reasonings behind the practical elements of CBT interventions. The variations in how participants experienced and perceived the practical elements of CBT interventions also casts a light not only on the psychological complexities accompanying chronic pain but also the individual differences in how people make sense of chronic pain, CBT and their sense of self. Journeying with chronic primary pain as a life companion is a unique psychological experience. Consequentially, the predefined treatment categories birthed out of group averages that make up treatment matching processes often overlook personal meanings as highlighted through the current study's participants' experiences and back up by findings such as that of Scholten and Glombiewski (2025). The experiences of participants lend support to the necessity of individualised person-centred approaches to chronic pain even within a structured therapy such as CBT.

Chapter Summary

The researcher acknowledges the long road ahead before the findings of the current study could be fully disseminated and become impactful beyond the doctoral thesis stage. However, it is still plausible to conclude that this thesis has made some contributions to ongoing conversations both within research and clinical spheres in relation to how to further improve clinical approaches to chronic pain. This is an important endeavour given how chronic pain affects 2 billion adults worldwide (Zimmer et al., 2022). There are ample avenues for continued research stemming from this thesis that the researcher hopes to continue exploring on her journey post this thesis.

References

Abramson, L. Y., Metalsky, G. I., & Alloy, L. B. (1989). *Hopelessness depression: A theory-based subtype of depression* [doi:10.1037/0033-295X.96.2.358].

Adu-Ampong, E. A., & Adams, E. A. (2020). “But You Are Also Ghanaian, You Should Know”: Negotiating the Insider–Outsider Research Positionality in the Fieldwork Encounter. *Qualitative Inquiry*, *26*(6), 583-592. https://doi.org/10.1177/1077800419846532

Andrade, C. (2021). The Inconvenient Truth About Convenience and Purposive Samples. *Indian Journal of Psychological Medicine*, *43*(1), 86-88. https://doi.org/10.1177/0253717620977000

Antcliff, D., Keenan, A. M., Keeley, P., Woby, S., & McGowan, L. (2021). Testing a newly developed activity pacing framework for chronic pain/fatigue: a feasibility study. *BMJ Open*, *11*(12), e045398. https://doi.org/10.1136/bmjopen-2020-045398

Attali, D., Leguay, F., Milcent, L., & Baeza-Velasco, C. (2023). Association Between Activity Pacing and Negative Emotions in Patients With Chronic Pain: A Systematic Review. *Clin J Pain*, *39*(8), 426-435. https://doi.org/10.1097/ajp.0000000000001128

Austin, J. T., & Vancouver, J. B. (1996). Goal constructs in psychology: Structure, process, and content. *Psychological Bulletin*, *120*(3), 338-375. https://doi.org/10.1037/0033-2909.120.3.338

Aveyard, H., Sharp, P., & Woolliams, M. (2015). *A beginner's guide to critical thinking and writing in health and social care*. McGraw-Hill Education (UK).

BABCP. (2012). Minimum Training Standards For the Practice of Cognitive Behavioural Therapy. [online] Available:

http://www.babcp.com/files/Accreditation/General/Minimum-TrainingStandards-V7-0215.pdf [accessed 10.04.24]

Barke, A., Korwisi, B., Jakob, R., Konstanjsek, N., Rief, W., & Treede, R.-D. (2022). Classification of chronic pain for the International Classification of Diseases (ICD-11): results of the 2017 international World Health Organization field testing. *PAIN*, *163*(2), e310-e318. https://doi.org/10.1097/j.pain.0000000000002287

Beck, A. T. (1970). Cognitive therapy: Nature and relation to behavior therapy. *Behavior Therapy*, *1*(2), 184-200. https://doi.org/10.1016/S0005-7894(70)80030-2

Bee, P., McBeth, J., MacFarlane, G. J., & Lovell, K. (2016). Managing chronic widespread pain in primary care: a qualitative study of patient perspectives and implications for treatment delivery. *BMC Musculoskeletal Disorders*, *17*(1), 354. https://doi.org/10.1186/s12891-016-1194-5

Beehler, G. P., Loughran, T. A., King, P. R., Dollar, K. M., Murphy, J. L., Kearney, L. K., & Goldstein, W. R. (2021). Patients' perspectives of brief cognitive behavioral therapy for chronic pain: Treatment satisfaction, perceived utility, and global assessment of change. *Fam Syst Health*, *39*(2), 351-357. https://doi.org/10.1037/fsh0000606

Biggerstaff, D., & Thompson, A. (2008). Interpretative Phenomenological Analysis (IPA): A Qualitative Methodology of Choice in Healthcare Research. *Qual Res Psychol*, *5*. https://doi.org/10.1080/14780880802314304

Blackwell, S. E., & Heidenreich, T. (2021). Cognitive Behavior Therapy at the Crossroads. *International Journal of Cognitive Therapy*, *14*(1), 1-22. https://doi.org/10.1007/s41811-021-00104-y

Blease, C. R., Lilienfeld, S. O., & Kelley, J. M. (2016). Evidence-Based Practice and Psychological Treatments: The Imperatives of Informed Consent [Opinion]. *Frontiers in Psychology*, *7*. https://doi.org/10.3389/fpsyg.2016.01170

Brosschot, J. F., & Verkuil, B. (2013). Worry. In M. D. Gellman & J. R. Turner (Eds.), *Encyclopedia of Behavioral Medicine* (pp. 2071-2072). Springer New York. https://doi.org/10.1007/978-1-4419-1005-9_855

Bucholtz, M. (2000). The Politics of Transcription. *Journal of Pragmatics*, *32*, 1439-1465. https://doi.org/10.1016/S0378-2166(99)00094-6

Burton, C. D., Entwistle, V. A., Elliott, A. M., Krucien, N., Porteous, T., & Ryan, M. (2017). The value of different aspects of person-centred care: a series of discrete choice experiments in people with long-term conditions. *BMJ Open*, *7*(4), e015689. https://doi.org/10.1136/bmjopen-2016-015689

Callesen, P., Reeves, D., Heal, C., & Wells, A. (2020). Metacognitive Therapy versus Cognitive Behaviour Therapy in Adults with Major Depression: A Parallel Single-Blind Randomised Trial. *Scientific Reports*, *10*(1), 7878. https://doi.org/10.1038/s41598-020-64577-1

Campbell, R., Pound, P., Pope, C., Britten, N., Pill, R., Morgan, M., & Donovan, J. (2003). Evaluating meta-ethnography: a synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Soc Sci Med*, *56*(4), 671-684. https://doi.org/10.1016/s0277-9536(02)00064-3

Carlson, M. (2014). *CBT for Chronic Pain and Psychological Well-Being: A Skills Training Manual Integrating DBT, ACT, Behavioral Activation and Motivational Interviewing*. Wiley. https://books.google.co.uk/books?id=ADxjAwAAQBAJ

Cattanach, B. K., Thorn, B. E., Ehde, D. M., Jensen, M. P., & Day, M. A. (2021). A qualitative comparison of mindfulness meditation, cognitive therapy, and mindfulness-based cognitive therapy for chronic low back pain. *Rehabil Psychol*, *66*(3), 317-334. https://doi.org/10.1037/rep0000344

Clark, D. M. (2004). Developing new treatments: on the interplay between theories, experimental science and clinical innovation. *Behav Res Ther*, *42*(9), 1089-1104. https://doi.org/10.1016/j.brat.2004.05.002

Collard, V. E. J., Gillett, J. L., Themelis, K., & Tang, N. K. Y. (2023). An exploratory investigation into the effects of mental defeat on pain threshold, pain rating, pain anticipation, and mood. *Current Psychology*, *42*(3), 1738-1749. https://doi.org/10.1007/s12144-021-01548-3

Conrad, P. A., & Conrad, P. (1987). The experience of illness: Recent and new directions.

Creswell, J., & Plano Clark, V. (2011). *Designing and conducting mixed methods research* (2nd Edition ed.). SAGE Publications. https://books.google.co.uk/books/about/Designing_and_Conducting_Mixed_Methods_R.html?id=6tYNo0UpEqkC&redir_esc=y

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications. London.

Crombez, G., Eccleston, C., Van Damme, S., Vlaeyen, J. W., & Karoly, P. (2012). Fear-avoidance model of chronic pain: the next generation. *Clin J Pain*, *28*(6), 475-483. https://doi.org/10.1097/AJP.0b013e3182385392

Cuijpers, P., van Straten, A., & Warmerdam, L. (2007). Behavioral activation treatments of depression: a meta-analysis. *Clin Psychol Rev*, *27*(3), 318-326. https://doi.org/10.1016/j.cpr.2006.11.001

Curtis, S. A., & Pirie, K. I. (2018). Chronic pain, loss and the future - Development and evaluation of an innovative, interactive pain education tool. *Br J Pain*, *12*(3), 136-144. https://doi.org/10.1177/2049463717728809

Dahlberg, H. (2022). Balancing at the Beginning of Words—Revisiting the Idea of Open Awareness in Qualitative Research. *Qualitative Inquiry*, *28*(10), 1019-1026. https://doi.org/10.1177/10778004221099564

Dahlberg, K. (2006). The essence of essences–the search for meaning structures in phenomenological analysis of lifeworld phenomena. *International journal of qualitative studies on health and well-being*, *1*(1), 11-19.

Dattilio, F. M., & Hanna, M. A. (2012). Collaboration in cognitive-behavioral therapy. *J Clin Psychol*, *68*(2), 146-158. https://doi.org/10.1002/jclp.21831

David, D., Cristea, I., & Hofmann, S. G. (2018). Why Cognitive Behavioral Therapy Is the Current Gold Standard of Psychotherapy. *Front Psychiatry*, *9*, 4. https://doi.org/10.3389/fpsyt.2018.00004

Davies, N. (2016). 'Silent epidemic' of chronic pain affects nearly 28 million in UK, study suggests. *The Guardian*, 16 March 2016.

De Vlieger, P., Crombez, G., & Eccleston, C. (2006). Worrying about chronic pain. An examination of worry and problem solving in adults who identify as chronic pain sufferers. *PAIN*, *120*(1), 138-144. https://doi.org/https://doi.org/10.1016/j.pain.2005.10.022

Deci, E. L., & Ryan, R. M. (2000). The "what" and "why" of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry*, *11*(4), 227-268. https://doi.org/10.1207/S15327965PLI1104_01

DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: a balance of relationship and rigour. *Fam Med Community Health*, *7*(2), e000057. https://doi.org/10.1136/fmch-2018-000057

DeLiema, M., & Bengtson, V. L. (2017). Activity Theory, Disengagement Theory, and Successful Aging. In N. A. Pachana (Ed.), *Encyclopedia of Geropsychology* (pp. 15-20). Springer Singapore. https://doi.org/10.1007/978-981-287-082-7_102

Dilthey, W., & Rickman, H. P. (1976). *W. Dilthey, selected writings*. Cambridge University Press.

Dörfler, V., & Stierand, M. (2021). Bracketing: a phenomenological theory applied through transpersonal reflexivity. *Journal of Organizational Change Management*, *34*(4), 778-793. https://doi.org/10.1108/JOCM-12-2019-0393

Dreyfus, H., & Wrathall, M. (2005). A Companion to Heidegger. In (pp. 560). https://doi.org/10.1002/9780470996492

Dreyfus, H. L. (1990). *Being-in-the-World: A Commentary on Heidegger's Being in Time, Division I* (Vol. 102). Bradford.

Dydyk, A. M., & Conermann, T. (2024). Chronic Pain. In *StatPearls*. StatPearls Publishing Copyright © 2024, StatPearls Publishing LLC.

Easterbrook, C., & Meehan, T. (2017). The Therapeutic Relationship and Cognitive Behavioural Therapy: A Case Study of an Adolescent Girl With Depression. *The European Journal of Counselling Psychology*, *6*, 1-24. https://doi.org/10.5964/ejcop.v6i1.85

Eccleston, C., & Crombez, G. (2007). Worry and chronic pain: A misdirected problem solving model. *PAIN*, *132*(3), 233-236. https://doi.org/https://doi.org/10.1016/j.pain.2007.09.014

Eccleston, C., Williams, A. C., & Morley, S. (2009). Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database Syst Rev*(2), Cd007407. https://doi.org/10.1002/14651858.CD007407.pub2

Egan, A., Lennon, O., Power, C. K., & Fullen, B. M. (2017). "I've Actually Changed How I Live"-Patients' Long-Term Perceptions of a Cognitive Behavioral Pain Management Program. *Pain Med*, *18*(2), 220-227. https://doi.org/10.1093/pm/pnw148

Ehde, D. M., Dillworth, T. M., & Turner, J. A. (2014). Cognitive-behavioral therapy for individuals with chronic pain: efficacy, innovations, and directions for research. *American Psychologist*, *69*(2), 153.

Ehlers, A., Clark, D. M., Dunmore, E., Jaycox, L., Meadows, E., & Foa, E. B. (1998). Predicting Response to Exposure Treatment in PTSD: The Role of Mental Defeat and Alienation. *Journal of Traumatic Stress*, *11*(3), 457-471. https://doi.org/10.1023/A:1024448511504

Farrell, J. (2021). What is Authorial Intention? *Philosophy and Literature*, *45*(1), 55-70.

Fayaz, A., Croft, P., Langford, R. M., Donaldson, L. J., & Jones, G. T. (2016). Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies. *BMJ Open*, *6*(6), e010364. https://doi.org/10.1136/bmjopen-2015-010364

Finlay, L. (2011). Phenomenology for Therapists: Researching the Lived World. *Phenomenology for Therapists: Researching the Lived World*. https://doi.org/10.1002/9781119975144

Furnes, B., & Dysvik, E. (2010). Dealing with grief related to loss by death and chronic pain: an integrated theoretical framework. Part 1. *Patient Prefer Adherence*, *4*, 135-140. https://doi.org/10.2147/ppa.s10580

Furnes, B., Natvig, G. K., & Dysvik, E. (2014). Therapeutic elements in a self-management approach: experiences from group participation among people suffering from chronic pain. *Patient Prefer Adherence*, *8*, 1085-1092. https://doi.org/10.2147/ppa.S68046

Gadamer, H.-G. (1989). *Truth and method*. Second revised edition / translation revised by Joel Weinsheimer and Donald G. Marshall. New York : Continuum, 1989. https://search.library.wisc.edu/catalog/999594260402121

Gatchel, R. J., Peng, Y. B., Peters, M. L., Fuchs, P. N., & Turk, D. C. (2007). The biopsychosocial approach to chronic pain: scientific advances and future directions. *Psychol Bull*, *133*(4), 581-624. https://doi.org/10.1037/0033-2909.133.4.581

Gelso, C. J. (2009). The real relationship in a postmodern world: Theoretical and empirical explorations. *Psychotherapy Research*, *19*(3), 253-264. https://doi.org/10.1080/10503300802389242

George, L. K., & Ferraro, K. F. (2016). Chapter 1 - Aging and the Social Sciences: Progress and Prospects. In L. K. George & K. F. Ferraro (Eds.), *Handbook of Aging and the Social Sciences (Eighth Edition)* (pp. 3-22). Academic Press. https://doi.org/https://doi.org/10.1016/B978-0-12-417235-7.00001-9

Gill, J. R., & Brown, C. A. (2009). A structured review of the evidence for pacing as a chronic pain intervention. *Eur J Pain*, *13*(2), 214-216. https://doi.org/10.1016/j.ejpain.2008.03.011

Ginev, D. (2016). Interpretive Internalism and Hermeneutic Realism. *Journal of Indian Council of Philosophical Research*, *33*. https://doi.org/10.1007/s40961-016-0043-0

Greenberger, D., & Padesky, C. A. (2016). *Mind over mood: Change how you feel by changing the way you think, 2nd ed*. Guilford Press.

Grünenwald, I., Kaluza, A. J., Schultze, M., & van Dick, R. (2023). Stress Mindset and Social Identification in Chronic Pain Patients and Their Relationship to Coping, Well-Being & Depression. *J Clin Psychol Med Settings*, *30*(1), 153-168. https://doi.org/10.1007/s10880-022-09883-8

Haddaway, N. R., Page, M. J., Pritchard, C. C., & McGuinness, L. A. (2022). PRISMA2020: An R package and Shiny app for producing PRISMA 2020-compliant flow diagrams, with interactivity for optimised digital transparency and Open Synthesis. *Campbell Systematic Reviews*, *18*(2), e1230. https://doi.org/https://doi.org/10.1002/cl2.1230

Hajihasani, A., Rouhani, M., Salavati, M., Hedayati, R., & Kahlaee, A. H. (2019). The Influence of Cognitive Behavioral Therapy on Pain, Quality of Life, and Depression in Patients Receiving Physical Therapy for Chronic Low Back Pain: A Systematic Review. *Pm r*, *11*(2), 167-176. https://doi.org/10.1016/j.pmrj.2018.09.029

Haraldseid, C., Dysvik, E., & Furnes, B. (2014). The experience of loss in patients suffering from chronic pain attending a pain management group based on cognitive-behavioral therapy. *Pain Manag Nurs*, *15*(1), 12-21. https://doi.org/10.1016/j.pmn.2012.04.004

Hazeldine-Baker, C. E., Salkovskis, P. M., Osborn, M., & Gauntlett-Gilbert, J. (2018). Understanding the link between feelings of mental defeat, self-efficacy and the experience of chronic pain. *Br J Pain*, *12*(2), 87-94. https://doi.org/10.1177/2049463718759131

Heidegger, M., Anderson, J. M., & Freund, E. H. (1966). Discourse on thinking. *Philosophy and Rhetoric*, *1*(1).

Helbig-Lang, S., & Fehm, L. (2004). Problems with homework in CBT: Rare exception or rather frequent? *Behavioural and Cognitive Psychotherapy*, *32*, 291-301. https://doi.org/10.1017/S1352465804001365

Hogg, M., Abrams, D., & Brewer, M. (2017). Social identity: The role of self in group processes and intergroup relations. *Group Processes & Intergroup Relations*, *20*, 136843021769090. https://doi.org/10.1177/1368430217690909

Hong, J. H., Lachman, M. E., Charles, S. T., Chen, Y., Wilson, C. L., Nakamura, J. S., VanderWeele, T. J., & Kim, E. S. (2021). The positive influence of sense of control on physical, behavioral, and psychosocial health in older adults: An outcome-wide approach. *Prev Med*, *149*, 106612. https://doi.org/10.1016/j.ypmed.2021.106612

Hordge-Freeman, E. (2018). “Bringing Your Whole Self to Research”:The Power of the Researcher's Body, Emotions, and Identities in Ethnography. *International Journal of Qualitative Methods*, *17*(1), 1609406918808862. https://doi.org/10.1177/1609406918808862

Horrigan-Kelly, M., Millar, M., & Dowling, M. (2016). Understanding the Key Tenets of Heidegger’s Philosophy for Interpretive Phenomenological Research. *International Journal of Qualitative Methods*, *15*(1), 1609406916680634. https://doi.org/10.1177/1609406916680634

Husserl, E. (1931). *Ideas: general introduction to pure phenomenology. [Trans. by W. R. B. Gibson.]*. Macmillan.

Hutting, N., Caneiro, J. P., Ong'wen, O. M., Miciak, M., & Roberts, L. (2022). Person-centered care for musculoskeletal pain: Putting principles into practice. *Musculoskelet Sci Pract*, *62*, 102663. https://doi.org/10.1016/j.msksp.2022.102663

Jamieson-Lega, K., Berry, R., & Brown, C. A. (2013). Pacing: a concept analysis of the chronic pain intervention. *Pain Res Manag*, *18*(4), 207-213. https://doi.org/10.1155/2013/686179

Jeanes, E. (2019). idiographic approach. In: Oxford University Press.

Kadam, R. A. (2017). Informed consent process: A step further towards making it meaningful! *Perspect Clin Res*, *8*(3), 107-112. https://doi.org/10.4103/picr.PICR_147_16

Kazantzis, N., Arntz, A. R., Borkovec, T., Holmes, E. A., & Wade, T. (2010). Unresolved Issues Regarding Homework Assignments in Cognitive and Behavioural Therapies:

An Expert Panel Discussion at AACBT. *Behaviour Change*, *27*(3), 119-129. https://doi.org/10.1375/bech.27.3.119

Kela, I., Kakarala, C. L., Hassan, M., Belavadi, R., Gudigopuram, S. V. R., Raguthu, C. C., Gajjela, H., & Sange, I. (2021). Chronic Pain: A Complex Condition With a Multi-Tangential Approach. *Cureus*, *13*(11), e19850. https://doi.org/10.7759/cureus.19850

Khumalo, T., & Plattner, I. E. (2019). The relationship between locus of control and depression: A cross-sectional survey with university students in Botswana. *S Afr J Psychiatr*, *25*, 1221. https://doi.org/10.4102/sajpsychiatry.v25i0.1221

Klykken, F. H. (2022). Implementing continuous consent in qualitative research. *Qualitative research*, *22*(5), 795-810. https://doi.org/10.1177/14687941211014366

Knoerl, R., Lavoie Smith, E. M., & Weisberg, J. (2016). Chronic Pain and Cognitive Behavioral Therapy: An Integrative Review. *West J Nurs Res*, *38*(5), 596-628. https://doi.org/10.1177/0193945915615869

Kravitz, R. L., Duan, N., & Braslow, J. (2004). Evidence-based medicine, heterogeneity of treatment effects, and the trouble with averages. *Milbank Q*, *82*(4), 661-687. https://doi.org/10.1111/j.0887-378X.2004.00327.x

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med*, *16*(9), 606-613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Lachapelle, D. L., Lavoie, S., & Boudreau, A. (2008). The meaning and process of pain acceptance. Perceptions of women living with arthritis and fibromyalgia. *Pain Res Manag*, *13*(3), 201-210. https://doi.org/10.1155/2008/258542

Larkin, M., Shaw, R., & Flowers, P. (2019). Multiperspectival designs and processes in interpretative phenomenological analysis research. *Qualitative Research in Psychology*, *16*(2), 182-198. https://doi.org/10.1080/14780887.2018.1540655

Larkin, M., & Thompson, A. R. (2011). Interpretative Phenomenological Analysis in Mental Health and Psychotherapy Research. In *Qualitative Research Methods in Mental Health and Psychotherapy* (pp. 99-116). https://doi.org/https://doi.org/10.1002/9781119973249.ch8

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, *3*(2), 102-120. https://doi.org/10.1191/1478088706qp062oa

Lazarus, R. S., & Folkman, S. (1984). *Stress, Appraisal, and Coping*. Springer Publishing Company. https://books.google.co.in/books?id=i-ySQQuUpr8C

LeBeau, R. T., Davies, C. D., Culver, N. C., & Craske, M. G. (2013). Homework Compliance Counts in Cognitive-Behavioral Therapy. *Cognitive Behaviour Therapy*, *42*(3), 171-179. https://doi.org/10.1080/16506073.2013.763286

Leeuw, M., Goossens, M. E., Linton, S. J., Crombez, G., Boersma, K., & Vlaeyen, J. W. (2007). The fear-avoidance model of musculoskeletal pain: current state of scientific evidence. *J Behav Med*, *30*(1), 77-94. https://doi.org/10.1007/s10865-006-9085-0

Lethem, J., Slade, P. D., Troup, J. D. G., & Bentley, G. (1983). Outline of a fear-avoidance model of exaggerated pain perception—I. *Behaviour Research and Therapy*, *21*(4), 401-408. https://doi.org/https://doi.org/10.1016/0005-7967(83)90009-8

Letsas, G. (2007). *A Theory of Interpretation of the European Convention on Human Rights*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199203437.001.0001

LeVasseur, J. (2003). The Problem of Bracketing in Phenomenology. *Qualitative health research*, *13*, 408-420. https://doi.org/10.1177/1049732302250337

Lim, J. A., Choi, S. H., Lee, W. J., Jang, J. H., Moon, J. Y., Kim, Y. C., & Kang, D. H. (2018). Cognitive-behavioral therapy for patients with chronic pain: Implications of gender differences in empathy. *Medicine (Baltimore)*, *97*(23), e10867. https://doi.org/10.1097/md.0000000000010867

Linehan, M. M. (2015). *DBT® skills training manual, 2nd ed*. The Guilford Press.

Linton, S. J., O'Sullivan, P. B., Zetterberg, H. E., & Vlaeyen, J. W. S. (2024). The "future" pain clinician: Competencies needed to provide psychologically informed care. *Scandinavian Journal of Pain*, *24*(1). https://doi.org/doi:10.1515/sjpain-2024-0017

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31-42. https://doi.org/10.1177/2632084320947559

Lutz, W., Schwartz, B., & Delgadillo, J. (2022). Measurement-based and data-informed psychological therapy. *Annual Review of Clinical Psychology*, *18*(1), 71-98.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qual Health Res*, *26*(13), 1753-1760. https://doi.org/10.1177/1049732315617444

McCracken, L. M., Sato, A., & Taylor, G. J. (2013). A Trial of a Brief Group-Based Form of Acceptance and Commitment Therapy (ACT) for Chronic Pain in General Practice: Pilot Outcome and Process Results. *The Journal of Pain*, *14*(11), 1398-1406. https://doi.org/https://doi.org/10.1016/j.jpain.2013.06.011

McCrae, N., Correa, A., Chan, T., Jones, S., & de Lusignan, S. (2015). Long-term conditions and medically-unexplained symptoms: feasibility of cognitive behavioural interventions within the improving access to Psychological Therapies Programme. *J Ment Health*, *24*(6), 379-384. https://doi.org/10.3109/09638237.2015.1022254

McKay, M., Wood, J. C., & Brantley, J. (2019). *The Dialectical Behavior Therapy Skills Workbook: Practical DBT Exercises for Learning Mindfulness, Interpersonal*

Effectiveness, Emotion Regulation, and Distress Tolerance. New Harbinger Publications. https://books.google.co.uk/books?id=CjqvDwAAQBAJ

Melzack, R. (2001). Pain and the neuromatrix in the brain. *J Dent Educ*, *65*(12), 1378-1382.

Melzack, R. (2005). Evolution of the neuromatrix theory of pain. The Prithvi Raj Lecture: presented at the third World Congress of World Institute of Pain, Barcelona 2004. *Pain Pract*, *5*(2), 85-94. https://doi.org/10.1111/j.1533-2500.2005.05203.x

Melzack, R., & Wall, P. D. (1965). Pain mechanisms: a new theory. *Science*, *150*(3699), 971-979. https://doi.org/10.1126/science.150.3699.971

Melzack, R., & Wall, P. D. (1996). Pain mechanisms: A new theory: A gate control system modulates sensory input from the skin before it evokes pain perception and response. *Pain Forum*, *5*(1), 3-11. https://doi.org/https://doi.org/10.1016/S1082-3174(96)80062-6

Merriam, S. B. (1998). *Qualitative Research and Case Study Applications in Education. Revised and Expanded from" Case Study Research in Education."*. ERIC.

Meyer, G. (2022). Ontology and Closeness in Human–Nature Relationships: Beyond Dualisms, Materialism and Posthumanism , by Neil H. Kessler. *Journal of Posthuman Studies*, *6*, 94-99. https://doi.org/10.5325/jpoststud.6.1.0094

Moon, K., & Blackman, D. (2014). A Guide to Understanding Social Science Research for Natural Scientists. *Conservation biology : the journal of the Society for Conservation Biology*. https://doi.org/10.1111/cobi.12326

Moore, J. W. (2016). What Is the Sense of Agency and Why Does it Matter? *Front Psychol*, *7*, 1272. https://doi.org/10.3389/fpsyg.2016.01272

Moore, S., Guarino, H., Rosenblum, A., & Marsch, L. (2016). Patients experiences with web-based CBT for the treatment of chronic pain: using qualitative research to deepen understanding of intervention effects. *The Journal of Pain*, *17*(4), S107. https://doi.org/10.1016/j.jpain.2016.01.339

Morley, S. (2010). The Self in Pain. *Rev Pain*, *4*(1), 24-27. https://doi.org/10.1177/204946371000400106

Morley, S. (2011). Efficacy and effectiveness of cognitive behaviour therapy for chronic pain: Progress and some challenges. *PAIN*, *152*(3, Supplement), S99-S106. https://doi.org/https://doi.org/10.1016/j.pain.2010.10.042

Morse, J. M. (2006). The Politics of Evidence. *Qualitative health research*, *16*(3), 395-404. https://doi.org/10.1177/1049732305285482

Mundt, J. C., Marks, I. M., Shear, M. K., & Greist, J. H. (2002). The Work and Social Adjustment Scale: a simple measure of impairment in functioning. *Br J Psychiatry*, *180*, 461-464. https://doi.org/10.1192/bjp.180.5.461

Neta, G., Glasgow, R. E., Carpenter, C. R., Grimshaw, J. M., Rabin, B. A., Fernandez, M. E., & Brownson, R. C. (2015). A Framework for Enhancing the Value of Research for Dissemination and Implementation. *Am J Public Health*, *105*(1), 49-57. https://doi.org/10.2105/ajph.2014.302206

Newton, P. M. (1994). Daniel levinson and his theory of adult development: A reminiscence and some clarifications. *Journal of Adult Development*, *1*(3), 135-147. https://doi.org/10.1007/BF02260089

Nezu, A. M., & Nezu, C. M. (2001). Problem solving therapy. *Journal of Psychotherapy Integration*, *11*, 187-205.

Nicholas, M. K. (2022). The biopsychosocial model of pain 40 years on: time for a reappraisal? *PAIN*, *163*(Suppl 1), S3-s14. https://doi.org/10.1097/j.pain.0000000000002654

Nielson, W. R., Jensen, M. P., Karsdorp, P. A., & Vlaeyen, J. W. (2013). Activity pacing in chronic pain: concepts, evidence, and future directions. *Clin J Pain*, *29*(5), 461-468. https://doi.org/10.1097/AJP.0b013e3182608561

Nizza, I. E., Farr, J., & Smith, J. A. (2021). Achieving excellence in interpretative phenomenological analysis (IPA): Four markers of high quality. *Qualitative Research in Psychology*, *18*(3), 369-386. https://doi.org/10.1080/14780887.2020.1854404

Noyes, J., Booth, A., Flemming, K., Garside, R., Harden, A., Lewin, S., Pantoja, T., Hannes, K., Cargo, M., & Thomas, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series-paper 3: methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. *J Clin Epidemiol*, *97*, 49-58. https://doi.org/10.1016/j.jclinepi.2017.06.020

Organisation, W. H. (1995). The World Health Organization Quality of Life assessment (WHOQOL): position paper from the World Health Organization. *Soc Sci Med*, *41*(10), 1403-1409. https://doi.org/10.1016/0277-9536(95)00112-k

Osborn, M., & Rodham, K. (2010). Insights into Pain: A Review of Qualitative Research. *Rev Pain*, *4*(1), 2-7. https://doi.org/10.1177/204946371000400102

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. *Adm Policy Ment Health*, *42*(5), 533-544. https://doi.org/10.1007/s10488-013-0528-y

Peters, S. (2010). Qualitative Research Methods in Mental Health. *Evidence Based Mental Health*, *13*(2), 35-40. https://doi.org/10.1136/ebmh.13.2.35

Pringle, J., Hendry, C., & McLafferty, E. (2011). Phenomenological approaches: challenges and choices. *Nurse Res*, *18*(2), 7-18. https://doi.org/10.7748/nr2011.01.18.2.7.c8280

Raffaeli, W., & Arnaudo, E. (2017). Pain as a disease: an overview. *J Pain Res*, *10*, 2003-2008. https://doi.org/10.2147/jpr.S138864

Redding, A., Kalesnikava, V. A., Bergmans, R., Redding, S., Dent, K., & Mezuk, B. (2024). Medically unexplained pain and suicidal ideation among US adults. *Journal of Affective Disorders*, *351*, 425-429. https://doi.org/https://doi.org/10.1016/j.jad.2024.01.192

Riebe, G., Fan, M. Y., Unützer, J., & Vannoy, S. (2012). Activity scheduling as a core component of effective care management for late-life depression. *Int J Geriatr Psychiatry*, *27*(12), 1298-1304. https://doi.org/10.1002/gps.3784

Riecke, J., Rief, W., Vlaeyen, J. W. S., & Glombiewski, J. A. (2020). Generalizability of harm and pain expectations after exposure in chronic low back pain patients. *European Journal of Pain*, *24*(8), 1495-1504. https://doi.org/https://doi.org/10.1002/ejp.1604

Rolfe, G. (1997). Beyond expertise: theory, practice and the reflexive practitioner. *Journal of Clinical Nursing*, *6*(2), 93-97. https://doi.org/https://doi.org/10.1111/j.1365-2702.1997.tb00290.x

Roth, A., & Pilling, S. (2007). The Competences Required to Deliver Effective Cognitive and Behavioural Therapy for People with Depression and with Anxiety Disorders.

Roth A, & Pilling, S. (2016). A Competence Framework for Psychological Interventions with People with Persistent Physical Health Conditions. London: UCL.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *Am Psychol*, *55*(1), 68-78. https://doi.org/10.1037//0003-066x.55.1.68

Schleiermacher, F. (1998). *Hermeneutics and criticism and other writings*. Cambridge University Press.

Scholten, S., & Glombiewski, J. A. (2025). Enhancing psychological assessment and treatment of chronic pain: A research agenda for personalized and process-based approaches. *Current Opinion in Psychology*, *62*, 101958. https://doi.org/https://doi.org/10.1016/j.copsyc.2024.101958

Skinner, B. F. (1963). Behaviorism at fifty. *Science*, *140*(Whole No. 3570), 951-958. https://doi.org/10.1126/science.140.3570.951

Smith, D. W. (2008). Phenomenology. In L. Nagel (Ed.), *Stanford Encyclopedia of Philosophy*. Macmillan.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5*(1), 9-27. https://doi.org/10.1080/17437199.2010.510659

Smith, J. A., Flowers, P., & Larkin, M. (2012). *Interpretative Phenomenological Analysis: Theory, Method and Research*. SAGE Publications.

Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative Phenomenological Analysis: Theory, Method and Research*. SAGE.

Smith, J. A., & Osborn, M. (2007). Pain as an assault on the self: An interpretative phenomenological analysis of the psychological impact of chronic benign low back pain. *Psychology & Health*, *22*(5), 517-534. https://doi.org/10.1080/14768320600941756

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *Br J Pain*, *9*(1), 41-42. https://doi.org/10.1177/2049463714541642

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch Intern Med*, *166*(10), 1092-1097. https://doi.org/10.1001/archinte.166.10.1092

Staats, P. S., Hekmat, H., & Staats, A. W. (2004). The psychological behaviorism theory of pain and the placebo: its principles and results of research application. *Adv Psychosom Med*, *25*, 28-40. https://doi.org/10.1159/000079056

Stapleton, T. (2009). Dasein as being-in-the-world. In B. W. Davis (Ed.), *Martin Heidegger: Key Concepts* (pp. 44-56). Acumen Publishing. https://doi.org/DOI: 10.1017/UPO9781844654475.004

Starr, R. A., & Smith, J. A. (2023). Making sense of an artwork: An interpretative phenomenological analysis of participants' accounts of viewing a well-known painting. *Qualitative Psychology*, *10*(1), 107-120. https://doi.org/10.1037/qup0000231

Stutey, D., Givens, J., & Henderson, A. (2020). The Practice of Bridling: Maintaining Openness in Phenomenological Research. *The Journal of Humanistic Counseling*, *59*, 144-156. https://doi.org/10.1002/johc.12135

Taguchi, K., Numata, N., Takanashi, R., Takemura, R., Yoshida, T., Kutsuzawa, K., Yoshimura, K., & Shimizu, E. (2021). Integrated cognitive behavioral therapy for chronic pain: An open-labeled prospective single-arm trial. *Medicine (Baltimore)*, *100*(6), e23859. https://doi.org/10.1097/md.0000000000023859

Tang, N. K., Salkovskis, P. M., & Hanna, M. (2007). Mental defeat in chronic pain: initial exploration of the concept. *Clin J Pain*, *23*(3), 222-232. https://doi.org/10.1097/AJP.0b013e31802ec8c6

Tang, N. K. Y., Goodchild, C. E., Hester, J., & Salkovskis, P. M. (2010). Mental defeat is linked to interference, distress and disability in chronic pain. *PAIN*, *149*(3), 547-554. https://doi.org/10.1016/j.pain.2010.03.028

Tang, N. K. Y., Goodchild, C. E., & Salkovskis, P. M. (2012). Hybrid cognitive-behaviour therapy for individuals with insomnia and chronic pain: A pilot randomised controlled trial. *Behaviour Research and Therapy*, *50*(12), 814-821. https://doi.org/https://doi.org/10.1016/j.brat.2012.08.006

Tang, W., & Kreindler, D. (2017). Supporting Homework Compliance in Cognitive Behavioural Therapy: Essential Features of Mobile Apps. *JMIR Ment Health*, *4*(2), e20. https://doi.org/10.2196/mental.5283

Taylor, P. J., Gooding, P., Wood, A. M., & Tarrier, N. (2011). The role of defeat and entrapment in depression, anxiety, and suicide. *Psychol Bull*, *137*(3), 391-420. https://doi.org/10.1037/a0022935

Terpstra, J. A., van der Vaart, R., van Beugen, S., van Eersel, R. A., Gkika, I., Erdős, D., Schmidt, J., Radstake, C., Kloppenburg, M., van Middendorp, H., & Evers, A. W. M. (2022). Guided internet-based cognitive-behavioral therapy for patients with chronic pain: A meta-analytic review. *Internet Interventions*, *30*, 100587. https://doi.org/https://doi.org/10.1016/j.invent.2022.100587

Teyber, E. (2006). *Interpersonal Process in Therapy: An Integrative Model*. Thomson Brooks/Cole. https://books.google.co.uk/books?id=t-BGAAAAMAAJ

Themelis, K., Gillett, J. L., Karadag, P., Cheatle, M. D., Ilgen, M. A., Balasubramanian, S., Singh, S. P., & Tang, N. K. Y. (2025). Mental Defeat Predicts Increased Suicide Risk in Chronic Pain: A 12-Month Prospective Study. *European Journal of Pain*, *29*(2), e4779. https://doi.org/https://doi.org/10.1002/ejp.4779

Themelis, K., & Tang, N. K. Y. (2023). The Management of Chronic Pain: Re-Centring Person-Centred Care. *J Clin Med*, *12*(22). https://doi.org/10.3390/jcm12226957

Thoits, P. A. (2012). Role-identity salience, purpose and meaning in life, and well-being among volunteers. *Social Psychology Quarterly*, *75*(4), 360-384. https://doi.org/10.1177/0190272512459662

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*(1), 45. https://doi.org/10.1186/1471-2288-8-45

Thorn, B. E. (2017). *Cognitive therapy for chronic pain: a step-by-step guide*. Guilford Publications.

Torrance, N., Smith, B. H., Elliott, A. M., Campbell, S. E., Chambers, W. A., Hannaford, P. C., & Johnston, M. (2011). Potential Pain Management Programmes in primary care. A UK-wide questionnaire and Delphi survey of experts. *Fam Pract*, *28*(1), 41-48. https://doi.org/10.1093/fampra/cmq081

Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., Andrews, J., & Barker, K. (2013). Patients' experiences of chronic non-malignant musculoskeletal pain: a qualitative systematic review. *Br J Gen Pract*, *63*(617), e829-841. https://doi.org/10.3399/bjgp13X675412

Toye, F., Seers, K., Hannink, E., & Barker, K. (2017). A mega-ethnography of eleven qualitative evidence syntheses exploring the experience of living with chronic non-malignant pain. *BMC Med Res Methodol*, *17*(1), 116. https://doi.org/10.1186/s12874-017-0392-7

Trachsel, L. A., Munakomi, S., & Cascella, M. (2025). Pain Theory. In *StatPearls*. StatPearls Publishing Copyright © 2025, StatPearls Publishing LLC.

Treede, R. D., Rief, W., Barke, A., Aziz, Q., Bennett, M. I., Benoliel, R., Cohen, M., Evers, S., Finnerup, N. B., First, M. B., Giamberardino, M. A., Kaasa, S., Korwisi, B., Kosek, E., Lavand'homme, P., Nicholas, M., Perrot, S., Scholz, J., Schug, S., . . . Wang, S. J. (2019). Chronic pain as a symptom or a disease: the IASP Classification of Chronic Pain for the International Classification of Diseases (ICD-11). *PAIN*, *160*(1), 19-27. https://doi.org/10.1097/j.pain.0000000000001384

Tufford, L., & Newman, P. (2010). Bracketing in Qualitative Research. *Qualitative Social Work*, *11*, 80-96. https://doi.org/10.1177/1473325010368316

Tuffour, I. (2017). A Critical Overview of Interpretative Phenomenological Analysis: A Contemporary Qualitative Research Approach. *Journal of Healthcare Communications*, *02*. https://doi.org/10.4172/2472-1654.100093

Vagle, M. D. (2010). Re-framing Schön's call for a phenomenology of practice: a post-intentional approach. *Reflective Practice*, *11*(3), 393-407. https://doi.org/10.1080/14623943.2010.487375

van Rysewyk, S., Blomkvist, R., Chuter, A., Crighton, R., Hodson, F., Roomes, D., Smith, B. H., & Toye, F. (2023). Understanding the lived experience of chronic pain: A systematic review and synthesis of qualitative evidence syntheses. *Br J Pain*, *17*(6), 592-605. https://doi.org/10.1177/20494637231196426

Vance, A., Lowry, P., & Eggett, D. (2013). Using Accountability to Reduce Access Policy Violations in Information Systems. *Journal of Management Information Systems*, *29*, 263–289. https://doi.org/10.2753/MIS0742-1222290410

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Med Res Methodol*, *18*(1), 148. https://doi.org/10.1186/s12874-018-0594-7

Vlaeyen, J. W., de Jong, J., Geilen, M., Heuts, P. H., & van Breukelen, G. (2001). Graded exposure in vivo in the treatment of pain-related fear: a replicated single-case experimental design in four patients with chronic low back pain. *Behav Res Ther*, *39*(2), 151-166. https://doi.org/10.1016/s0005-7967(99)00174-6

Vlaeyen, J. W., & Morley, S. (2005). Cognitive-behavioral treatments for chronic pain: what works for whom? *Clin J Pain*, *21*(1), 1-8. https://doi.org/10.1097/00002508-200501000-00001

Vlaeyen, J. W. S., & Morley, S. (2005). Cognitive-Behavioral Treatments for Chronic Pain: What Works for Whom? *The Clinical Journal of Pain*, *21*(1). https://journals.lww.com/clinicalpain/fulltext/2005/01000/cognitive_behavioral_treatments_for_chronic_pain_.1.aspx

Wagstaff, C., Jeong, H., Nolan, M., Wilson, T., Tweedlie, J., Phillips, E., Senu, H., & Holland, F. (2014). The Accordion and the Deep Bowl of Spaghetti: Eight Researchers' Experiences of Using IPA as a Methodology. *Qualitative Report*, *19*, 1-15. https://doi.org/10.46743/2160-3715/2014.1216

Wallace, L. S., Wexler, R. K., McDougle, L., Miser, W. F., & Haddox, J. D. (2014). Voices that may not otherwise be heard: a qualitative exploration into the perspectives of primary care patients living with chronic pain. *J Pain Res*, *7*, 291-299. https://doi.org/10.2147/jpr.S62317

Walsh, S., Moseley, G. L., Gray, R. J., Gillam, M., Gunn, K. M., Barker, T., Tran, K., Eshetie, T., & Jones, M. (2022). Use of behavioural activation to manage pain: a systematic scoping review. *BMJ Open*, *12*(6), e056404. https://doi.org/10.1136/bmjopen-2021-056404

Ward, J. (2014). Questioning skills. *Engagement and Therapeutic Communication in Mental Health Nursing*, 65.

Waugh, O. C., Byrne, D. G., & Nicholas, M. K. (2014). Internalized Stigma in People Living With Chronic Pain. *The Journal of Pain*, *15*(5), 550.e551-550.e510. https://doi.org/https://doi.org/10.1016/j.jpain.2014.02.001

Williams, A. C., Eccleston, C., & Morley, S. (2012). Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database Syst Rev*, *11*(11), Cd007407. https://doi.org/10.1002/14651858.CD007407.pub3

Williams, A. C. d. C., Fisher, E., Hearn, L., & Eccleston, C. (2020). Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database of Systematic Reviews*(8). https://doi.org/10.1002/14651858.CD007407.pub4

Willig, C., & Billin, A. (2011). Existentialist-Informed Hermeneutic Phenomenology. Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners. (pp. 117-130). Wiley-Blackwell. ISBN 9780470663738.

Wislocki, K., Tran, M. L., Petti, E., Hernandez-Ramos, R., Cenkner, D., Bridgwater, M., Naderi, G., Walker, L., & Zalta, A. K. (2023). The Past, Present, and Future of Psychotherapy Manuals: Protocol for a Scoping Review. *JMIR Res Protoc*, *12*, e47708. https://doi.org/10.2196/47708

World Health Organization (2015). WHO global strategy on integrated people-centred health services. Geneva: World Health Organization.

Yu, L., & McCracken, L. M. (2025). The self in pain. *Curr Opin Psychol*, *62*, 101972. https://doi.org/10.1016/j.copsyc.2024.101972

Zale, E. L., & Ditre, J. W. (2015). Pain-Related Fear, Disability, and the Fear-Avoidance Model of Chronic Pain. *Curr Opin Psychol*, *5*, 24-30. https://doi.org/10.1016/j.copsyc.2015.03.014

Zimmer, Z., Fraser, K., Grol-Prokopczyk, H., & Zajacova, A. (2022). A global study of pain prevalence across 52 countries: examining the role of country-level contextual factors. *PAIN*, *163*(9), 1740-1750. https://doi.org/10.1097/j.pain.0000000000002557