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Implementing a Cognitive–Behavioral Pain Self-Management Program In Home Health Care Part 2: Feasibility and Acceptability Cohort Study

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Abstract

Purpose—The prevalence of pain in older adults receiving home health care is high, yet safety concerns for analgesic therapy point to a need for non-pharmacologic approaches to pain management in this population. The purpose of this study was to determine the feasibility and acceptability to physical therapists (PTs) and patients of a cognitive–behavioral pain self-management (CBPSM) program.

Methods—Thirty-one PTs volunteered to participate, completed two 4-hour training sessions, and recruited twenty-one patients with activity-limited pain who consented to participate in the study. PTs completed pre- and post-test assessments of CBPSM knowledge at the first training session, provided structured survey feedback after the second training session, and responded to a phone survey three months after training. Patients provided feedback during weekly phone interviews while receiving the CBPSM program. Treatment sessions were audiotaped during delivery of the self-management pain protocol. Audiotapes were evaluated by independent raters for program fidelity.

Results—Participating PTs were experienced in physical therapy (average 16.5 years) and in home health care (average 11.0 years). Analysis of pre- and post-test data showed that PTs' CBPSM knowledge increased from a pre-test mean of 60.9% to a post-test mean of 85.9%. Audiotape analysis indicated 77.7% therapist adherence to the protocol. At three-month follow-up, 24.0% of therapists continued to use the entire protocol with their patients presenting with activity-limiting pain. Patient data show high rates of patient recall of being taught protocol components, trying components at least once (ranging from 84.4 % to 100.0%), and daily use of protocol components (ranging from 47.3% to 68.4%). The percent of patients finding a technique helpful for pain management ranged from 71.4% to 81.2%.

A portion of this work was reported in a Late-Breaker poster entitled Translating Cognitive–Behavioral Pain Self Management Training Into Home Care Physical Therapy at the Gerontological Society of America 2010 Annual Conference.

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Conclusion—This study offers preliminary data on use of non-pharmacologic pain self-management strategies by PTs in home health setting. Positive feedback from PTs and patients suggests that the translated protocol is both feasible and acceptable.

Keywords

Pain Self-Management; Older Adults; Home Care; Physical Therapy

INTRODUCTION

Pain is a highly prevalent and disabling problem among older adults,¹⁻³ and is particularly problematic among those receiving home care.⁴ Cognitive and behavioral based techniques for pain management (e.g., relaxation exercises, use of distraction techniques, activity pacing and pleasant activity scheduling) improve patient functioning and quality of life⁵⁻⁷ and prior research has shown that programs emphasizing these and other pain self-management strategies can decrease pain and related disability among older adults with a variety of pain conditions.^{8,9} Despite the increasing evidence of the positive impact of this approach and the importance of the psychosocial aspects of pain, cognitive-behavioral strategies are infrequently implemented when managing pain in older adults.^{10,11}

Changing practice patterns to incorporate evidence-based programs is challenging for many health care providers and health educators.¹²⁻¹⁵ In particular, high work loads and time constraints limit ability to incorporate evidence-based interventions into practice.¹⁶⁻¹⁹ Other barriers to implementation of evidence-based programs include lack of access to literature,^{17,18} inadequate buy-in for the programs by front line workers or patients,¹² and lack of support from management for program implementation.¹³

To address the need for improved pain management in home care, we adapted a cognitive-behavioral pain self-management program for use in the home care physical therapy setting for patients with activity-limiting pain (see companion paper in this issue of the journal). Here, we report study results concerning the feasibility of integrating the adapted program into home care physical therapy practice and the program's acceptability among both patients and home care PTs. Recognizing the challenge of implementing this type of program in a decentralized health care system, we also sought to identify potential barriers prior to pursuing funding for a randomized clinical trial to determine program efficacy.

METHODS

This was a descriptive, non-experimental study incorporating two sources of data provided by: (1) physical therapists who were trained in and delivered the CBPSM program, and (2) patients who received the CBPSM intervention.

Setting

This study was conducted at the Visiting Nurse Service of New York (VNSNY), the largest nonprofit home care organization in the U.S. Study recruitment began in March of 2010 with data collection completed in July 2010. All study subjects were employees or patients of VNSNY during this time period. The study was approved by VNSNY's Institutional Review Board.

Participants

Physical Therapist Cohort—A total of 32 PTs were recruited via email announcement advertising the CBPSM training and research project. The announcement was sent to all 140

PTs working in two of the seven separate geographic regions served by VNSNY. We sought to enroll 30 PTs (10 per training group) due to training room availability and resource constraints. We purposefully avoided an overlap with the two regions where PTs were recruited to adapt the CBPSM protocol for use in home health care (see Part 1 paper). VNSNY serves a total of 7 regions. The two selected regions for this study are among the largest served (the largest region was included in Part 1), were operationally able to accommodate training sessions and include neighborhoods with predominantly English-speaking patients. (Only patients who speak English were eligible for enrollment in the pilot study -- see below.) PTs were enrolled on a first-come first-serve basis based on their response to the invitation to participate in the project. The groups were limited in size (10 to 11 PTs per group) to provide for an active learning environment and to ensure that all questions posed by program participants could be directly addressed. There were two groups of PTs in one region where 21 PTs were enrolled and one group in the second region where 11 PTs were enrolled. One PT withdrew at the end of the first training session for reasons unrelated to the study. The remaining PTs (N=31) completed a second training session and agreed to other study requirements described below (see Design section). The participating PTs received continuing education hours for attendance at the clinical portions of each training session.

Patient Cohort—Patient subjects (N=21) were recruited by the participating PTs after undergoing a physical therapy evaluation in their home leading to implementation of a home care program. Patients meeting the following criteria were eligible to participate in the study: (1) patient rated pain level of 3 or greater (on a 0-10 numeric rating scale) during the PT visit in which the patient was enrolled, (2) cognitively intact, (3) at least 6 more physical therapy sessions anticipated, and (4) English-speaking. We determined whether pain caused activity limitation by asking the patient to rate the extent to which pain interfered with general activity during the past week on a 0-10 numeric rating scale with 0 indicating no interference and 10 indicating that pain completely interfered with activity. This question was asked by research staff at the time of the first telephone interview with a rating of 3 or higher indicating that the patient's pain interfered with function. The screening for cognitive impairment was based on the federally-mandated, uniform home health patient assessment system (i.e., the Outcome and Assessment Information Set, or OASIS) cognitive functioning item. Patients with a value of 0 or 1 are alert, oriented and able to recall task directions and were eligible to participate in the study. Patients with a value of 2, 3, or 4 have an increasing need for assistance due to decreased orientation, alertness and ability to follow directions. These individuals were not eligible to participate in the study. The therapist evaluation was the basis for the number of anticipated therapy sessions remaining.

Patients' informed consent to participate in the study was obtained by their PT. Patients and therapists both consented to audio taping of the portions of treatment sessions related to pain management. Enrollment criteria also included consent of the patient to participate in a weekly phone survey. Patients were selected by participating PTs from their active caseload during the study enrollment period. Data on the number of patients approached and the number who refused were not collected. However, some therapists reported that they had difficulty recruiting patients for the study because their patients did not want to be audio taped or they did not want to be called weekly for interviews. While all participating PTs (N=31) implemented the CBPSM program with at least one patient with activity-limiting pain, a minority of PTs were unable to enroll patients into the study during the recruitment period. For this reason, the number of study patients (N=21) is less than the number of PTs implementing the CBPSM program (N=31).

Once patient consent was obtained, the PT initiated the CBPSM protocol and audio taped the portion of each visit devoted to pain management. For consenting patients, PT treatments

included the CBPSM and an individualized treatment program to address other physical therapy care and goals.

Design and Data Collection

The study design and data collection methods for this descriptive study are described separately for the two cohorts.

Physical Therapist Cohort—PTs attended a four-hour training session covering the rationale for CBPSM and the specific program to be implemented. A detailed description of the CBPSM protocol is presented in our companion paper in this issue of the journal.

Training was jointly delivered by two instructors, who were also project investigators, in a small group format of 10-12 PTs. One instructor was a PT with expertise in home care administration and quality assurance, the other was the PT who developed the original CBPSM program and also had prior experience in home care. At the end of the first training session, PTs were instructed to recruit appropriate patients (as defined above) from their caseload and implement the program. Illustrated pain self-management patient handouts covering all components of the CBPSM program were provided. The initial training session included detailed information about the protocol, provided an opportunity for demonstration and practice of the strategies during the session to ensure understanding, and included a review of the patient handouts. The PTs also were given digital recording devices to use when audio taping the portion of treatment sessions in which CBPSM content was delivered. Four weeks after the initial training, all 31 therapists met again in the same small groups to review the elements of the CBPSM program, view a video of a therapy session where CBPSM techniques were incorporated into a home physical therapy visit, and discuss the challenges and successes experienced enrolling study patients and implementing the program.

Instruments: Four methods were employed to obtain information about the impact of the intervention, including feasibility and acceptability of the CBPSM program from the home health PT perspective.

- **Knowledge of CBPSM.** In the first training session, a pre-test (7 items) and post-test (6 items) were administered to assess change in PT knowledge about CBPSM techniques. Pre-test items included open-answer questions such as “name 2 non-pharmacologic PT interventions for pain intervention” and “describe the connection between imagery and relaxation.” Post-test items included “describe (briefly) cognitive-behavioral approaches to patient care” and “write 2 examples of a verbal cue for imagery and relaxation training.” The pre- and post-tests were administered at the start and end of session 1 and were completed by all PT attendees.
- **Comfort in Program Delivery.** PTs completed a semi-structured written survey during the second group training session concerning: (a) their level of comfort in delivering each component of the program, rated on a 5-point scale; (b) barriers to program implementation (open ended question); and (c) the PT’s perception of whether each component of the program was helpful to their patients (yes/no), with an opportunity for open-ended comments about patients’ responses.
- **Treatment Fidelity.** The audio-taped recordings of treatment sessions were scored for PT adherence to the program protocol using a pre-developed checklist. Two raters independently listened to and scored 50% of the recordings using the checklist to indicate whether each portion of the content was covered by the therapist during the treatment session. The two raters achieved a 95.0% rate of agreement. A single rater then scored the remaining sessions.

- **Program Uptake.** Three months after the initial training course, 26 of the 31 PTs (83.8%) completed a telephone survey to determine the extent to which they continued to use the program with all patients on their caseload since initial training. Survey content areas included whether all or only selected elements of the CBPSM program were taught to the PT's patients with activity-limiting pain, whether some types of patients with activity-limiting pain were taught CBPSM techniques but not others, and the reasons why the entire protocol or protocol elements were not used with some patients.

Patient Cohort—Patients were contacted weekly by telephone to assess the acceptability of each CBPSM session. They were asked: (1) whether they recalled being instructed in the specific CBPSM techniques; (2) whether they had practiced the techniques learned in the past week; (3) if yes, how often they practiced the techniques; and (4) whether they found the techniques helpful in managing their pain. These data were collected by research assistants during weekly phone calls that started after the CBPSM protocol had been implemented by the PT.

Because two program components were taught in each session (see Table 4 in our companion paper), the survey questions were structured to ask about both program elements that should have been taught in a session. For example, if the patient was taught the third session in the past week, the patient was asked if he or she: (1) recalled being taught visual imagery and pleasant activity scheduling (yes or no); (2) If yes, were techniques understood (yes or no); and (3) were these components tried (yes or no). If the patient tried the techniques, the interviewer then asked: (4) how often were techniques tried in the past week; and (5) whether the techniques were perceived to be helpful for pain management. A final open-ended question asked about how the CBPSM program could be improved. The structured telephone interviews ended after completion of the CBPSM program as reported by the patient's PT. Patient data abstracted from participants' home care clinical records included basic demographic information, primary diagnosis and the number and type of comorbid conditions.

Statistical Methods: This was an uncontrolled pilot study that assessed the feasibility and acceptability to PTs and patients of a cognitive-behavioral pain self-management program. No hypotheses were specified and no statistical tests were conducted. Rather, simple statistics (means and proportions) are reported to describe our findings. In the case of the 5-point scale of therapists' comfort in delivering program components, we collapsed responses into two levels with a 4 or 5 indicating a relatively high level of comfort and ratings of 1, 2 or 3 a lower level of comfort. Responses to the open-ended question about barriers to program implementation were reviewed and grouped into mutually exclusive categories.

The scoring of the pre- and post-test of PT knowledge of CBPSM techniques conducted during the first group training session warrants comment. The pre- and post-test items were parallel but not exact in content. This approach was used to avoid rote responses due to the short time span between the completion of the pre- and post-tests. Items were structured with an open-ended response format to elicit evidence of content learned. Two study investigators (Bach and Beissner) independently scored each test. Each investigator's scoring results of correct and incorrect responses, weighted equally at one point each, then were compared and consensus obtained. Point values were converted to a 0 to 100% scale.

RESULTS

Physical Therapist Cohort Results

PT participants (N = 31) were staff therapists with an average of 16.5 years of clinical experience (range = 4-34 years). The average number of years of experience delivering care in the home care setting was 11.0 (range = 1-31). The self-reported race/ethnicity of PT participants was 44.8% Asian, 31.1% white (Non-Hispanic), 17.2% Black/African American, and 6.9% other. Slightly over half (54.8%) of the PTs were female.

Knowledge—The percentage of correct answers on the knowledge surveys increased from a pretest mean of 60.9% (SD=18.3%) to post-test mean of 85.9% (SD=17.8%).

Program Acceptability to PTs—One month after the initial training session, PT feedback concerning program acceptability was obtained. In general, PTs felt comfortable delivering CBPSM training to patients (Figure 1). The great majority reported a high level of comfort (i.e., a value of 4 or 5 on the 1-5 scale) teaching deep breathing (90.0%), followed by general relaxation (86.2%) and pain theory (79.3%). Fewer therapists, although still a majority, reported a high level of comfort delivering program content on pleasant activity scheduling (60.7%), sleep tips (59.3%) and imagery (57.1%).

In response to the question about barriers to program implementation, PT comments fell into two categories: study enrollment challenges (see patient eligibility criteria above) and problems with implementing the program itself. Study enrollment challenges included difficulty finding appropriate patients (mentioned by 8 PTs), and patient concerns with audiotaping (N=5), signing release forms (N=5) and the weekly phone calls from study staff (N=3). Program barriers included concerns with patient adherence and practice (N=6), patient distractedness during sessions (N=4), the time required to implement the program (N=3), specific problems with learning techniques (N=3), and unrealistic patient expectations (N=3).

Treatment Fidelity—Analysis of the audio tapes showed that therapist adherence to all components of the protocol was 77.7% (SD=24.6%). Adherence to the content in each of the six program sessions ranged from a low of 70.7% (SD=22.1%) for session 3 (Imagery and Pleasant Activity Scheduling) to a high of 90.3% (SD=13.3%) for session 5 (sleep tips and relapse prevention). Individual therapist adherence to the protocol varied considerably with one therapist adhering to an average of only 21.7% of content across the 6 sessions, while another therapist adhered to an average of 95.6% of content.

Program Uptake—Of the 31 PTs trained in the CBPSM protocol, 26 completed the 3-month follow-up telephone survey. The 5 PTs lost to follow-up did not return research staff phone calls after repeated attempts. Three months after initial training in the CBPSM program, the majority of PT participants continued to use one or more components of the program with their patients with activity-limiting pain. Instruction in deep breathing and relaxation exercises were used more frequently than the other CBPSM strategies (see Table 1). Seven of the 26 PT participants (24.0%) reported using the entire pain management protocol with all of their patients with activity-limiting pain.

The 19 PTs who did not use the entire program with all of their patients after the conclusion of the study were asked why the entire program was not used (see Table 2). The question: Why didn't you use the entire program with all of your patients? offered 6 response choices including "Other." The most frequent responses were that the patient would not understand the activity (68.4%), did not want to do the activity (57.9%), and other patient care needs

took priority (47.4%). Less frequent responses included that the therapist did not think the patient would benefit from the activity (31.6%), and the patient was discharged or hospitalized before the protocol could be completed (15.8%). The survey format allowed the therapist to indicate more than one reason if applicable.

Therapists overwhelmingly reported that patients benefited from program components, although one PT indicated that program effectiveness was limited in patients who present with significant levels of depression. Of the individual program components, progressive muscle relaxation was the one cited by the most therapists (n= 6) as being less helpful, noting that this technique was difficult for some patients to learn. Twenty-two of 25 therapists found deep breathing a helpful technique and added comments regarding frequent use of this program element in their respective care plans.

The PT phone survey provided feedback regarding the application of CBPSM to any patient on the home care caseload. Comments included the potential benefits of the program for patients younger than those enrolled in the study, that patient receptivity or openness to trying alternative approaches to pain management enhances the program, that some patients needed to practice program techniques more outside of PT sessions, and that the program contributes to a decrease in pain. Sample comments include:

- “I think it’s a good program. In home care it is difficult to apply because of the time constraints but it is doable; the packets are very helpful, it really works;” and
- “You can use at least one of these techniques on your patients. There isn’t any part that cannot be used at all.”

Some PT’s expressed concerns about the amount of time required to deliver CBPSM in addition to usual care and that it would add to visit length affecting patient tolerance and PT productivity. Some PTs also suggested that the program be delivered in a menu format in which a briefer program would be delivered with topics selected based on individual patient needs. PTs also commented that their patients with some degree of cognitive impairment were unable to practice the techniques between sessions due to the need for continual correction and reinforcement. Sample comments include:

- “Not good for patients with dementia, but good for other patients.
- Many patients only used the therapy when I was there.”
- “It did help the patients in age group less than 65 grasp it better. Older patients had a more difficult time in understanding what to do.”

The survey did not include any interactive process between interviewer and PT so further explanation or discussion to gain insight did not take place. While cognitively impaired patients were excluded from the study, the comments support the notion that not all home health patients may be able to benefit from the CBPSM program.

Patient Cohort Results

Twenty-one patients enrolled in the study. Their average age was 78 with more than one-quarter (28.5%) over age 85. Most patients were female (85.7%); 66.7% of the sample was non-Hispanic white and 28.6% non-Hispanic Black. Two-thirds of the patients lived alone and a substantial minority (38.0%) had orthopedic surgery aftercare as a reason for home health admission. The mean pain score at the time of enrollment was 5 (standard deviation of 1.8) on a 0-to-10 numerical rating scale with higher scores indicating greater pain.

At least 90.5% of patients recalled being taught about the CBPSM program techniques during each session except for sleep tips and relapse management which were recalled by

66.7% (Table 3). Virtually all patients who recalled learning relaxation and deep breathing reported trying these techniques at least once (95.0%), and 72.2% of those who reported using the techniques at least once said that they used them daily. Of the 90.5% of patients who recalled learning visual imagery and pleasant activity scheduling, 100.0% used the techniques at least once in the prior week and 47.4% reported using the techniques daily. While learning sleep tips and relapse prevention was recalled by fewer patients, all who recalled learning these techniques used them at least once and more than half (57.1%) used them daily. Learning progressive muscle relaxation and activity pacing was recalled by 90.4% of patients, and 84.2% of those who recalled learning the techniques used them at least once and 62.5% used the techniques daily.

Figure 2 shows the percentage of patients -- among those reporting that they tried the pair of CBPSM techniques at least once -- who reported that the techniques were helpful in managing their pain. Patient ratings of helpfulness were high across the techniques ranging from 71.4% for sleep tips and relapse prevention to 81.2% for progressive muscle relaxation and activity pacing.

DISCUSSION

Prior research has documented delivery of cognitive-behavioral pain management content by PTs in different clinical settings,²⁰⁻²² but to our knowledge this is the first study to incorporate this pain management approach in home care. PTs reported positive experiences learning about and using the CBPSM protocol and felt that patients benefit from its use, indicating that the adapted CBPSM program is acceptable to PTs working in the home care setting. Further evidence of the acceptability of this approach is the level of use of the program and program components after the study ended. Therapists were not instructed to continue to use the program, yet a substantial proportion of the PTs did so. The majority of these individuals chose to use only portions of the full CBPSM program, citing various concerns with the use of different components based on their patient population. The potential of a “menu” approach to program implementation where patients and PTs select certain CBPSM components (i.e., they develop individually tailored treatment) warrants further investigation.

In a nationwide survey of practicing PTs,¹⁰ 59% of respondents expressed concern about their ability to deliver interventions with cognitive-behavioral components, indicating a lack of knowledge and skill in the techniques. We found in this study that the majority of PTs reported a high level of comfort delivering the CBPSM program following two relatively brief training sessions. However, among the CBPSM techniques, fewer therapists reported a high level of comfort teaching content in areas such as imagery, sleep tips, and the importance of pleasant activity scheduling. Future work with this program will include additional training in these areas and additional resources to support therapists after training.

We found substantial adherence to the CBPSM protocol with adherence rates similar to those found in a clinical setting.²⁰ Interestingly, program adherence was highest for the content areas of sleep tips and relapse prevention, areas where PTs reported lower levels of comfort in delivery. We speculate that PTs used their notes and patient handouts to a greater extent when delivering instruction in these content areas. Additional training may enhance overall adherence to the protocol and could potentially improve program outcomes.

The training preferences of PTs identified in the literature include multiple in-person interactive and case-based learning sessions.²³ Salbach²⁰ notes that study therapists were most engaged in inter-active discussions and watching a patient care video demonstration. In our study, the sharing of practical experience and real world implementation discussions

were highly rated by the PTs completing training evaluations. Online and video resources were identified as a positive way to reinforce program elements for PTs and patients alike.

Training was needed on the individual program elements, even when some program components were felt to be elements of PT practice such as deep breathing. The training provided was not extensive in amount of time, indicating that the PTs did not need a significant amount of training to achieve fidelity when implementing the CBPSM program. PTs expressed strong, positive feedback about sharing and discussing the program with each other during the second training session which occurred 4 weeks into the study. During the study, the enrolled PTs could contact the instructors regarding any question but did not have a forum to share concerns such as team meetings or support from a supervisor. They felt, however, that earlier and additional opportunities to share their experiences would improve implementation of the CBPSM program in the home setting. Participating PTs also provided valuable suggestions regarding patient materials and identified enhancements such as improving examples of pleasant activities by focusing on wellness activities that were not sedentary.

Patient acceptability was evident in phone survey data. Patients recalled being taught the session elements and then trying them at high rates. Among those who tried techniques at least once, most tried them several times a week if not daily. Finally, over 70% of patients who recalled being taught about each pair of techniques said they were helpful in managing pain.

The CBPSM program examined in this pilot study was designed to be incorporated into regular PT practice and implemented without adding visits to the therapy care plan. The amount of CBPSM program usage after the study ended indicates feasibility in routine patient care. However, we did not gather data on the length of treatment sessions that incorporated the CBPSM content, nor were we able to determine whether inclusion of this content altered the number of treatment sessions required to meet patients' goals.

Limitations of our pilot study include a lack of data on the number of patients who met enrollment criteria, the number of patients approached by study PTs, and the number of patients who declined to enroll in the study. The sample of patients may be biased toward individuals predisposed to try alternative therapies given the requirement that patients had to consent to audio taping of the pain management component of therapy treatments as well as participate in a weekly survey while receiving the intervention.

CONCLUSION

In conclusion, this research demonstrates that implementing a CBPSM program for PTs treating patients with activity-limiting pain in the home care setting is feasible. The program was also found to be acceptable by the PTs, who felt comfortable delivering the program and found it to be helpful to their patients. Patients found the program to be helpful in their pain management, and reported using most of the strategies on a regular basis. Future research is needed to determine program efficacy in terms of pain intensity and pain-related disability.

Our intent was to establish the feasibility and acceptability of the program in the home health care setting, as demonstrated in this pilot study. We also gathered patient and clinician information about its impact on the patient's pain and functioning as well as suggestions for how the program could be improved. Program materials and training session feedback provide additional suggestions to improve the adoption and impact of the CBPSM program. In particular, the use of video and other online resources support may prove beneficial to PTs and patients alike.

Future research may also be directed toward tailoring the program to meet individual patient needs. The tailoring, or “menu format,” of program components requires a protocol for determining which elements are most advantageous for individual patients based on patient characteristics, PT assessment, and other components of the treatment plan. The impact of streamlining or reducing the elements of CBPSM program would need to be weighed against effectiveness and related practice and patient outcomes.

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Figure 1.
Percent of Therapists Reporting a High Level of Comfort in Delivering Program Content

Figure 2.
Percent of Patients Who Found Technique Helpful^a

Table 1

Three Month PT Follow-up Telephone Survey - Program Techniques PTs Said They Always Used with Their Patients Who Had Activity-Limiting Pain. (N=26)

Technique	Number	Percent
Pain Theory	14	53.8
Goal Setting	15	57.7
General Relaxation	21	80.8
Deep Breathing	24	92.3
Visual Imagery	18	69.2
Pleasant Activity Scheduling	18	69.2
Activity Pacing	18	69.2
Progressive Muscle Relaxation	16	61.5
Sleep Tips	12	46.2
Dealing with Pain Flare-ups	14	53.8

Table 2

Three Month PT Follow-up Telephone Survey - Reasons PTs Selected when Asked Why Entire Program Was Not Used with All Patients (N =19)

Reasons	Number	Percent
Patient discharged or hospitalized before protocol completed	3	15.8
Patient did not want to do the activity	11	57.9
Other patient needs took priority	9	47.4
Did not think patient would understand the activity	13	68.4
Did not think patient would benefit from the activity	6	31.6
Other	1	5.3

Notes. More than 1 reason can be reported.

Table 3
Percent of CBPSM Techniques Patients Recalled and Tried in Past Week (N=21)

Session ^a	Frequency with which CBPSM Technique Tried ^b				
	CBPSM Technique	Recalled	Among Those Who Recalled, Tried at Least Once	Every Day	Several Times but Not Every Day
1	Goal Setting and Pain Theory	90.4%	N/A ^c	N/A ^c	N/A ^c
2	Relaxation and Deep Breathing	95.2%	95.0%	72.2%	16.7%
3	Progressive Muscle Relaxation and Activity Pacing	90.4%	84.2%	62.5%	18.8%
4	Visual Imagery and Pleasant Activity Scheduling	90.4%	100.0%	47.4%	42.1%
5	Sleep Tips and Relapse Prevention	66.6%	100.0%	57.1%	28.6%
					14.3%

^aSession 6 of the program (Review/Reinforcement) was not rated.

^bAmong patients who said they tried the technique at least once, the frequency with which they reported using the technique in the past week. One participant who was unsure of the frequency with which they tried relaxation and deep breathing was excluded when calculating the frequency with which that technique was tried.

^cData on the frequency with which goal setting and pain theory were practiced was not collected from study participants.