THE LIVED EXPERIENCE OF CHRONIC PAIN IN NURSE EDUCATORS

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ABSTRACT

Pain is associated with a wide range of disease and injury, and is sometimes the disease itself. Millions suffer from chronic pain every year and the effects of pain lead to tremendous costs for healthcare, rehabilitation, and lost worker productivity, as well as the emotional, psychological, and financial burden it places on patients and their families. The nurse has a key role in effective pain management with the need for accurate assessment, prompt intervention, and evaluation of pain relief measures for positive patient outcomes. The purpose of the study was to explore the lived experience of chronic pain in nurse educators in order to determine a better understanding for discovery in nursing curriculum. An interpretive phenomenological approach was used to frame this research study. The study employed a purposive sample of two Associate Degree Nurse (ADN) educators and one Baccalaureate (BSN) educator having personally experienced chronic pain.

Semi-structured three-part interviews were conducted using an interview guide. The participants of the study offered a depiction of the lived experience and the researcher sought commonalities in meanings, situations, practices, and bodily experiences. Themes emerged, which aligned with and assisted in answering the research questions. Five essential themes from the study emerged: vulnerability, physician/provider trust, fear of disability, coping, and need for pedagogical discourse. Two subthemes: stoic and alien also emerged. Understanding the lived experience of nurse educators with chronic pain is important and valuable to healthcare. Nurse educators are responsible and challenged in their daily work with the need to teach about chronic pain in the best way possible assuring the best care possible. Implications for nursing curriculum
and practice relate to preparing nurse educators and students, addressing psychosocial issues, and incorporating how to do better chronic pain assessments and better manage chronic pain.
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The most beautiful people are those who have known defeat, known suffering, known struggle, known loss, and have found their way out of the depths. These persons have an appreciation, sensitivity, and an understanding of life that fills them with compassion, gentleness, and a deep loving concern. Beautiful people do not just happen.” God whispers to us in our pleasures, speaks to us in our conscious, but shouts to us in our pains: It is His megaphone to rouse a deaf world. (C. S. Lewis, 1940)

This work is dedicated to my dear husband Emile Jones and to my parents Jeffie and Gertrude Parker. Emile has encouraged me to reach for the stars and has been a driving force behind every endeavor of my graduate school efforts. He has made it possible for me to endure the long hours of study, research, and writing with his encouraging words and unconditional love. God has blessed me beyond measure and for that I am most grateful.

My mother is the inspiration behind my desire to explore and write about passionate topics. Her schoolteacher background and artistic ways carried over into my life more than she will ever know. I miss her tremendously. My father inspired in me the importance of knowing that Faith is the most valuable possession a person can have and to remember that service to others is an important part of life. I will never forget the occasions when he would have a new little calf born to his lot only to come home and tell me he had a new little Troy State born today. My parents made sure my basic education was affordable no matter their struggles, even if it meant selling a cow.

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wish to thank all of my friends who changed their schedules to meet my schedule during the last four years. Friends are like jewels, precious indeed! God has richly blessed me and it is my desire to use my blessings from this pedagogical experience to give back to others in some way that will shape and promote a better lived experience.

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CHAPTER I
INTRODUCTION

To grasp the issues involved in a greater understanding of chronic pain and what this understanding can offer to nursing pedagogy, it is essential to look into the lived experiences of nurse educators who have been personally affected by chronic pain. In listening carefully to the many accounts and stories of those with lived experiences, it is possible to direct more attention to those aspects which nursing has tended to overlook: namely the life phenomena. The phenomenology of every life occurrence that is described empirically and theoretically benefits the world because it allows for the study of the person in each unique situation, offers a way of studying the realms of health and illness, and allows for discovery in understanding the problems of subjectivity or objectivity. The phenomenology of life can be used to understand everyday practices, meanings, and knowledge embedded in skills, stress, and coping (Benner, 1985a).

Studies of life phenomena can contribute to the enlightenment of something central and forgotten in the world in which we live because research into the lived experience can be an example of how what is present and meaningful in the daily life of an illness or disease obtains a voice through the research. It opens up further conversation about what can be relevant research questions in the nursing of the future, of empirical, theoretical, and philosophical character. The phenomena of life need to be understood broadly, not only as an articulated philosophy of life, but also as something produced in clinical practice and in research as interpretations of life in the concrete lived experience (Benner, 2000).
A major reason individuals seek healthcare is the presence of pain. Pain is a complex, subjective experience that is difficult to evaluate with no objective measure existing, despite decades of research on the subject. A lack of knowledge concerning pain assessment and management is a consistent theme in the literature (Al-Shaer, Hill, & Anderson, 2011). The quality of pain care delivery in the United States continues to fall remarkably short of the potential for optimal care. Pain medicine remains fragmented and without a unified organizational pain model. These consequences of fragmented care threaten patient safety and well-being. Effective pain treatment requires the highest level of clinical reasoning, coordination of medical skills, and strategic use of resources using medical expertise (American Academy of Pain Medicine, 2011).

Research studies concerning pain management and nursing practice have focused mostly on cancer pain and staff nurses in general. Most studies highlight nurses’ lack of knowledge related to pain and analgesics, the persistence of misconceptions related to opioid use, fear of addiction, and the frequent underestimation of patients’ pain (Briggs, 2010; Clark, French, Bilodeau, & Capasso, 1996; Fontana, 2008). In a study by Fontana (2008), critical analysis of data revealed that decisions made by advanced practice nurses for patients with chronic pain are characterized by a conflict of interest in which the patients’ best interests are given a low priority. This conflict, which is socially and politically created and maintained, renders nurses unlikely to fulfill their ethical responsibility to patients. Nurses did not see prescribing decisions as ethical ones and, as a result, did not recognize the conflicts that were at work in their decision making. Factors that included the best interests of patients consisted of nurses wanting to make the right clinical decision from a desire to identify the etiology of the pain as well as the use of their personal experience and education related to pain management. Clinicians talked
extensively about their own best interests to reduce the burden of practice inherent in prescribing opioids. Their perceptions of controlled substance laws resulted in fear of Drug Enforcement Administration (DEA) scrutiny; as a result, they modified their practice to reduce this risk. The heavy influence by a desire to protect society from the illegal abuse and diversion of drugs resulted in conditional treatment and the creation of mechanisms of control to ensure compliance taking away from the patient’s welfare and pain relief.

Individuals experiencing chronic pain also deal with significant psychological, spiritual, and physiological side effects. Psychological issues of depression, anxiety, and anger can interfere with adequate pain assessment by nurses and result in loss of work, loss of independence, and interference with relationships and important life events (Duke, Yarbrough, & Northam, 2010).

Nurses play a vital role in the assessment and management of patients’ pain across the lifespan and in diverse clinical settings. Research has shown, however, that knowledge deficits, especially in the areas of pain assessment and titration of dosages, may contribute to the under-treatment of pain (McCaffery, Grimm, Pasero, Ferrell, & Unman, 2005). Historically, nurses have been at the forefront of initiatives to improve quality of life for patients experiencing pain; however, many nurses maintain myths and beliefs about pain, and they lack up-to-date knowledge on pain techniques affecting their ability to provide good pain management to patients and families (Linkewich, Sevean, Habjan, & Polling, et al., 2007). In examining the barriers to effective pain management and positive pain relief outcomes, obstacles spring up at the level of patient, the healthcare professional, and the healthcare system itself. A nurse may have preconceived notions about a topic and that belief will direct behavior, often in a way that is detrimental to patient care (Ashley, 2008). Education regarding pain assessment and pain
management needs to be a high priority because accurate knowledge and application of pain management principles are essential to clinical nursing practice as they directly and positively influence patient outcomes (Al-Shaer, Hill, and Anderson, 2011).

Pain is associated with a wide range of disease and injury and is sometimes the disease itself. Millions suffer from acute or chronic pain every year and the effects of pain lead to tremendous costs for healthcare, rehabilitation, and lost worker productivity, as well as the emotional and financial burden it places on patients and their families. Pain affects around 116 million people, more Americans than diabetes, heart disease, and cancer combined. The total annual incremental cost of healthcare due to pain ranges from $560 billion to $635 billion (in 2010 dollars) in the United States, which combines the costs related to disability days and lost wages and productivity (American Academy of Pain Medicine, 2011).

The nurse has a key role in effective pain management with the need for accurate assessment, prompt intervention, and evaluation of pain relief measures for positive patient outcomes (Plaisance & Logan, 2006). In the assessment of pain, the nurse depends partly on the message the patient can communicate to the nurse and partly on how the nurse perceives, interprets, and responds to the content of the pain message (Bergh & Sjostrom, 2007). These are the skills in nursing education that are some of the most important in chronic pain assessment, yet are lacking in the curriculum. A study by Goodrich (2005), to determine the knowledge and attitudes of nursing students and faculty about the science of pain management, looked at the content of pain management material as well as the extent to which it is integrated into the nursing curriculum. Students were found to have gained knowledge in certain areas of pain management but many gaps remained. The study revealed that pain management is not addressed consistently throughout the curriculum and, as a result, there is a need to develop pain
knowledge and skills into the plan of study. Another study by Kantar and Alexander (2011) was conducted to understand the influence of nursing curriculum on clinical judgment development in baccalaureate nursing students. Findings indicated that presenting subject matter in the classroom, with the focus on understanding a health problem, does not resemble the clinical situation in which nurse’s function. This study revealed a need to focus teaching on understanding a health problem based on the context in which nursing occurs and that the content must reflect that which nurses use in patient care. Qualitative studies in nursing chronic pain assessment and management are needed and necessary to provide information for curriculum design and content.

The importance of addressing pain in curriculum is not new. The International Association for the Study of Pain (IASP), a leading professional forum for science, practice, and education in the field of pain, appointed an ad hoc committee challenged with preparing an outline for pain curriculum in basic nursing education. The committee, consisting of registered nurses and doctorate prepared individuals outlined minimal competencies in order to assess and manage pain. Entry-level nursing education varies between countries. The IASP curriculum represents the optimal level of pain education for nursing within the scope of what is possible considering the existence of some resource-poor countries. The publication addresses chronic pain as a multi-dimensional and complex phenomenon, requiring effective assessment and management based on current knowledge. The multi-dimensional nature of pain requires the involvement of working toward the effective management of pain experienced by patients in a variety of settings (IASP, 2006).

Every practitioner is involved in serving as an advocate for the person experiencing pain and ensuring that the chronic pain care adheres to ethical principles and standards of quality. The
nurse has frequent contact with patients receiving care in the community, at home, or in in-patient or out-patient settings. This frequent contact places the nurse in a unique position because the nurse is usually the healthcare provider spending the most time with the patient, allowing for a more thorough assessment. In addition, the nurse is often the first person to assess pain or pain changes in a patient. The central role and responsibility in assessment and management of pain means that nurses are required to be knowledgeable about pain mechanisms, the epidemiology of pain, barriers to effective pain control, and the frequently encountered chronic pain syndromes (International Association for the Study of Pain, 2006).

Pain assessment involves a skillful process negating the assumption that all nurses have the same baseline knowledge about pain because nurses have varied experiences in education and pain management (Michaels, et. al, 2007). Recognizing that increased education fosters greater knowledge, nurse educators need to critically assess current curricula on pain assessment and management. The amount of time, the depth, the breadth, and the methods used to teach students about pain should be included in the assessment (Plaisance & Logan, 2006).

Several life phenomena (facts or situations being observed to exist or happen) have been described philosophically, but there is a lack of empirical nursing professional research. It is important to study life phenomena in nursing because often the most elementary phenomena of our existence are the ones we are least aware of in our daily life as we go about caring for our patients. In nursing, there is the risk that life phenomena become invisible to those whose task it is to help the ill person adjust to life situations. The phenomenology of life’s observances must therefore be understood broadly, not only as an articulated philosophy of life, but also as something produced in clinical practice and in research as interpretations of life in the concrete lived experience (Delmar, 2006). Studies about life phenomena can contribute something central
and forgotten in the world in which we live. Dysvik, Sommerseth, and Jacobensen (2011), in a study, pointed out the important aspects of living with chronic pain. By listening to patients’ narratives, chronic pain can be investigated, which might aid nurses in the quest to reduce pain and strengthen those areas that can lead to a meaningful life (Delmar, 2006). Chronic pain presents lifelong demands in coping with health changes and an unforeseen life course. There is often a profound change in peoples’ ideas about themselves and many people experience a sense of loss (Dysvik et al., 2011).

The reality of clinical practice in nursing is complex, multifaceted, confusing, and, in many ways, unpredictable. Pain for example, can be physical and spiritual. Pain can be physical as a bodily lesion or the nervous system’s reaction to an infection. Pain also generates the opening of feelings and moods, experiences of meaning or meaninglessness. It means that the nurse looks beyond the immediate needs and sees the unique in the situation and then acts accordingly. Experience-based knowledge is then possible to be transferred to the concrete and unique situation (Delmar, 2006).

Pain that is not visible to others, yet felt and experienced by the individual, is viewed as subjective pain. Further highlighting the subjectivity of pain, according to Keyte and Richardson (2011), barriers to successful pain management for nurses are not simply related to knowledge, but are linked to factors such as the complexity (pain originating from multiple organ sources), and subjectivity of pain (pain experienced by the individual but not obvious to others), lack of accountability (healthcare providers who do not understand pain management), organizational issues (promotion of pain relief as a legal right or training issues within the system), and culture (such as fear of addiction or being seen as weak). The numbers of people who must live with multiple chronic illnesses and chronic pain will increase as the population ages. Through our
personal stories, the intangible can become tangible, and the artfulness of good nursing practice can be rescued from the margins. Nursing as a practice is a socially organized body of knowledge with sets of skills and styles of relating to other practices and to science and technology. Socially organized in the world of nursing means learning or the actual practice of nursing is never achieved by isolated individuals. A socially embedded practice such as nursing holds more than its requisite science and technology. Caring in the practice of nursing is often described as artistic or intangible. It may be more accurate to say that the intangible and artistic caring is the core of nursing practice because it renders technical, curative procedures, helping patients and families weather illnesses and sustain or regain familiar lifeworlds. “Lifeworld” means the particular social and historical world of the person, complete with culture, community, and networks of sustenance (Benner, 2000, p. 101).

A search of the literature for peer reviewed articles using CINAHL, Pub Med, ProQuest, Nursing Academic Search Premier, Google Scholar, and Allied Health Source to gain a better understanding of the phenomenology of the personally lived chronic pain experience of nurse educators and its relatedness to how they might articulate the lived experience to nursing education resulted in few findings. Nurses must tell their personal stories so that the hidden bedrock of caring practices for a healthy and good society will become more apparent to all. This means that experiential learning in the practice of nursing leads to the development of better practice environments so that the apparent intangibility does not lead to its dismissal. Healing relationships should not be reduced to propositional statements, yet we know them when we experience them, and we recognize them when they are missing. This differs from medical practice involving the objective sciences of pathophysiology, biochemistry, and genomics, among others. Each of these disciplines passes over the patients’ lifeworlds and their lived
embodied experience in order to treat the physical, biochemical aspects of the disease or injury (Benner, 2000).

The subjectivity for this study may best be understood from the voices of nurse educators who have personally experienced chronic pain. The participants of this study offered a depiction of the lived experience and the interpreter sought commonalities in meanings, situations, practices, and bodily experiences. The interpreter used distance and perspective to understand the immediacy of the lived situation. The experience-distant perspective must take into account the person in the situation. Nurse educators need to be the holders of knowledge. By engaging with others in shared inquiries, we come to understand how this insightful information forms professional knowledge that shapes our lives and stories thereby illuminating our personal practical knowledge development (Benner, 1985). Understanding the lived experience of nurse educators with chronic pain is important and extremely valuable to healthcare. Nurse educators are responsible and challenged in their daily work with the need to teach about chronic pain in the best way possible to assure the best care possible.

**Researcher’s Positionality**

My previous experience from years ago as a young graduate nurse working in a small community emergency room plays an important role in the context of the study. Working toward a doctoral degree with a major in instructional leadership has changed how I view teaching and learning. I often misjudged and poorly assessed chronic migraine pain patients seen in the emergency room where I worked full time. The patients were viewed as drug seekers and their pain experiences were viewed as not genuine, based on what I had learned in nursing school. In fact, I was never taught the different variances of migraine pain. Years later, when I experienced
my first personal migraine headaches, which became chronic in duration, I began to gain insight into my personal lived experience. I found myself waking up each day and wondering if I could function normally with the pain. I wondered if I would be able to give that presentation scheduled for the day, interact with co-workers, and think clearly with the pain, and I wondered if the pain episodes would ever end. I was scared and for the first time in my life unsure of my future. No one in my family has migraines. I began to question, “why me”? I felt that few truly believed or understood my pain experience. I felt shortchanged in my undergraduate curriculum regarding the understanding of chronic pain, which, in turn, led me to shortchange the patients committed to my care. As I started to teach in undergraduate nursing programs, it became apparent to me that many ways of teaching about pain in nursing programs exist and that the quality of what I observed being taught was lacking. Although many organizations have given guidelines for pain assessment, the way in which these guidelines are articulated differs with each school. Most of the pain instruction taught is interspersed within the different nursing courses and for only a short and limited amount of time. This is disconcerting to me as nurse educator because I know that pain is one of the main reasons people seek healthcare. I believe it is essential for students to gain the best knowledge and skills possible because this essential knowledge impacts significantly on patient care.

My personal experience with chronic migraine pain changed my life. I now understand the fear, the frustration, and the lack of understanding by practitioners about chronic pain. I know what it is like to finally find a practitioner (by the way who was a physician who personally suffered from migraine headaches) who truly understands your dilemma, who is non-judgmental, and who will take the extra time to fully assess and treat you. I know the wonder of finding a
practitioner who will not just prescribe you a pill and be frustrated if the pill does not cure your condition.

Deficits in teaching about chronic pain in nursing curriculum exist globally as gleaned from the literature review. I am now challenged with trying to make sure the students entrusted to my service know about proper pain assessment and treatment. I tell my story when teaching students about chronic pain in hopes of making a difference in future nurses. I do not want this same mistake to be repeated by other practitioners. I want to know if there is a better way for nurse educators to present chronic pain curricula to nursing students, to improve nursing education, and to impact nursing curriculum. Competent and knowledgeable practitioners are the key to excellent patient outcomes. Improving nursing students’ knowledge by what we can learn from nurse educators who have personally experienced chronic pain seems important to explore. This is necessary in order to evaluate our methods of curriculum design and promote patient care. It is with this in mind that I began my journey to discover what can be learned about the lived experience of nurse educators who have personally experienced chronic pain with the attempt to gain understanding from their unique perspective.

Purpose of the Study

The purpose of this study is to explore the meanings and interpret as closely as possible the “lived experiences” of nurse educators who have personally experienced chronic pain, or cared for another individual with chronic pain, in an attempt to better understand how these educators articulate and shape how they teach about chronic pain. Understanding the “lived experiences” of nurse educators can assist in determining how the “lived experience” links and gives voice to the way they teach about chronic pain assessment and management and determine
if implications exist for reform in undergraduate nursing curriculum. For the purposes of this study, nursing faculty will be defined as any graduate prepared instructor of nursing with a master’s degree and/or higher, who has experienced chronic pain and who is employed by an Alabama Board of Nursing approved Registered Nurse program.

Research Questions

There was one broad research question for this baseline study and additional focused questions. In what ways does the “lived experience” with chronic pain shape how a nurse educator understands and engages with pain assessment? Additional focused questions I attempted to answer are as follows:

1. How do nurse educators who have “lived experience” with chronic pain theorize or understand chronic pain?

2. How can the “lived experience” relate to how pain is taught by these individuals?

3. What are the prescribed methods of teaching chronic pain assessment where nurse educators teach and how does it fit into the nursing curriculum?

Significance of the Study

Pain is a subjective experience in which nurses must refrain from basing their assessment, management, and interventions on personal beliefs and judgments. Sensitivity and empathy are critical components of nursing education. Accurate knowledge and application of pain management principles are essential to clinical nursing practice as they directly and positively impact patient outcomes (AL-Shaer, Hill, & Anderson, 2010). Nurses may have a preconceived notion about a topic and that belief will direct behavior, often in a way that is detrimental to
patient care (Ashley, 2008). Despite some progress in research on physiological processes involved in chronic pain, it is still among the least well understood phenomena in medicine and nursing. Chronic pain changes lives because it is a multifaceted problem consisting of both physical and psychological components, in many cases, such as anxiety and depression (Fisher et al., 2007b).

Several studies have investigated many aspects of chronic pain. These studies include: the “lived experiences” of chronic pain and occupation (Fisher et al., 2007), nursing students’ knowledge and attitudes regarding pain (Plaisance & Logan, 2006), women in chronic pain (Skuladottir & Halldorsdottir, 2008), and living a meaningful life with chronic pain from a nursing perspective (Dysvik et al., 2011). Despite these studies, a literature search failed to reveal any present research focusing on how the lived chronic pain experiences of nurse educators may contribute to greater understanding about chronic pain assessment and nursing care, the amount of time that is devoted to teaching chronic pain management in nursing curricula, and the methods of nursing student instruction about chronic pain.

Philosophical Perspective

Phenomenology was both the philosophical perspective as well as the methodology of this study. An understanding of what the “lived experience” of chronic pain is like for nurse educators contributes to the body of nursing knowledge. Exploration of the lived experience is best suited by a phenomenological approach such as Benner’s (1994) *Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness* and van Manen’s (1990) hermeneutical phenomenological reflection in *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. The nursing literature lacks studies that explore the qualitative
aspects of nurse educators’ experiences as they relate to chronic pain and how nurse educators with personal lived experience with chronic pain might articulate or shape pain assessment.

Phenomenology is descriptive in the sense of aiming to describe rather than explain why. A number of researchers and scholars distinguish between descriptive and hermeneutic or interpretive variants. Interpretive versions have emerged from the work of hermeneutic philosophers such as Heidegger (1962), Gadamer (1996), and Ricoeur (1970), who argue that people are embedded in the world of language and social relationships. Any understandings we gain, they say, are founded on our experience and depend on our perspective. These understandings necessarily involve interpretation. In hermeneutic phenomenology, meanings can never be fixed. They are always emergent, contextual, and historical. These meanings shape our understandings and must be taken into account. The central concern of phenomenological research is a return to embodied, experiential meaning, to seek fresh, complex, vivid descriptions of a “phenomenon” (a human experience in all its complexity) as it is concretely lived (Finlay, 2009).

Theoretical Frameworks

Patricia Benner

Nurses encounter daily the “lived experiences” of patients, nurses, and other health-care workers. Benner (1994) devoted much of her professional life studying nurses and their “lived experiences” to add to the body of nursing knowledge. Benner offered a different approach from the cognitive rationalist quantitative paradigm. It constitutes an interpretive movement away from epistemological linear, analytic, and quantitative methods toward a new direction of ontological, hermeneutic, holistic, and qualitative approaches. This approach is highlighted by
the capacity to uncover, articulate, and bring recognition to embedded qualitative aspects of practice that are not apparent from the quantitative perspective. Benner notes that this research methodology constitutes a situation-based interpretive approach of describing nursing practice that overcomes some reductionism problems. It begins to critique Cartesian epistemology and focuses on the study of human beings from within their life world and projects embodiment, and their skilled know-how embedded in practice situations such as coping with chronic illness and health promotion (Chan, Brykczynski, Malone, & Benner, 2010).

Benner explained that articulation research describes, illustrates, and gives language to “taken-for-granted areas of practical wisdom, skilled know-how, and notions of good practice” (Benner, Hooper-Kyriakidis, & Hooper, 1999, p. 5). Interpretive phenomenology as a philosophy and a qualitative research methodology has its origins in the work of several philosophers such as Heidegger (1927/1962), Kierkegarrad (1848/1962), Gadamer (1960/1995, Merlequ-Ponty (1945/1962), Dreyfus (1991), Benner (1984, 1994), and van Manen (1990). Benner explained how “much of our knowledge of the life world is not articulated. If someone were to ask us how we walk or ride a bicycle, we have trouble giving an answer. Such knowledge is often called unarticulated or tacit knowledge” (p. 17).

Phenomenology uses interpretation to uncover patterns, concerns, and meanings. Benner used three narrative strategies to assist in uncovering meanings of socially embedded knowledge: (a) paradigm cases (known as marker cases that stand out with a particular pattern of meaning), (b) thematic analysis (identification of common themes in interviews or observations), and (c) exemplars (smaller than paradigm cases but hold strong meaning as in a vignette or story of particular meaning). Understanding another person’s subjective experiences and feelings by study is important to know how nurse educators perceive their role in nursing education. Benner
(1994) believed that “the interpretive researcher creates a dialogue between practical concerns and lived experience through engaged reasoning and imaginative dwelling in the immediacy of the participants’ worlds” (p. 99). There is no stepwise formula to follow in conducting interpretive phenomenological study. However, Benner, Tanner, and Chesla (2009) provided a clear delineation of the Interpretive Phenomenological method. Certain research practices typical of this approach can be

- Participant observations and interviews for data collection.
- Interviews provide narrative access to the person’s particular experience, capture the temporal progression of situations, and elicit stories in everyday language.
- Identification of paradigm cases, exemplars and thematic analysis are three interrelated interpretive strategies used for analyzing the narrative and observation data.

Nursing theory using a phenomenological approach reflects the reality of nursing practice that is complex and situational. Small group interviews and first-person experience used in Interpretive Phenomenology differ from participant reports of opinions or generalizations about practice. Experience-near narratives are stories that require the storyteller to dwell in the story as experienced, including thoughts and concerns, providing accounts of actual events, including dialog, all with as much detail as possible. The interviewer listens carefully to the story without interrupting unless understanding breaks down and clarification is needed. The philosophical underpinning accounts for the person’s perceptions and meanings or at the very least, how the world presents itself to the storyteller in practice and is uncovered (Chan et al., 2010). Such knowledge generated from practice has great relevance for nurses. Patricia Benner is the author and past project director of a federally funded grant titled: Achieving Methods of Intra-
professional Consensus, Assessment and Evaluation Project (the AMICAE Project). The research attempted to discover and describe knowledge embedded in the practice of nursing. This research led to the publication of Benner’s first book in 1984, *From Novice to Expert*, and numerous articles. The AMICAE Project was “an interpretive, descriptive study that led to the use of Dreyfus’ five levels of competency to describe skill acquisition in clinical nursing practice” (Brykczynski, 2002, p. 169). The Dreyfus Model of Skill Acquisition (originally developed with pilots) considers the advancement in skilled performance, based upon experience, as well as education, clinical knowledge development, and career progression in nursing (Altmann, 2007). The model posits that individuals, while acquiring and developing skills, pass through five levels of proficiency: novice/beginner, advanced beginner, competent, proficient, and expert. The five different levels reflect changes in the three general aspects of skilled performance:

1. A move from a reliance on abstract principles to the use of past concrete experiences;
2. A change from viewing a situation as multiple fragments, to seeing a more holistic picture with a few relevant factors; and
3. A movement from detached observer to active performer.

A move from novice to expert is characterized by transition from explicit rule-governed behavior to intuitive, contextually determinate behavior. Progression from novice to expert is not guaranteed; not every nurse becomes an expert. “The Dreyfus model provides the concepts needed to differentiate between what can be taught by precept and what must be learned experientially from comparison of similar and dissimilar cases” (Benner 1984, p. 186).

Understanding the work of Dreyfus and Benner gives one a viable alternative to traditional ways of understanding practice, theory, and knowledge; not to devalue science.
Benner believed that skilled pattern recognition can be taught and will lead to advancement through stages. The teaching is facilitated by a holistic assessment of the situation and not by breaking the situation down into individual parts. Benner believed that nurses develop and accrue global sets of paradigms about patients. These paradigms develop expert intuition and sets not readily apparent to the outside observer. Expert nurses use empirics, ethics, and personal knowledge. Individuals interpret their own concerns, practices, and life experiences that are always situated. They are engagedmeaningfully within the context of the situation. Benner’s work uses a Heideggerian phenomenological interpretive approach of synthesis. The Heideggerian approach (Heidegger, 1962) is an interpretive approach where synthesis and conclusions are derived from interviews, experience, and/or observations. Experience leads to intuition, ethical/moral reasoning, and personal knowledge. Benner’s model uses practical reasoning, looks at what effects underlie reality, and proposes a guide to shape nursing practice. It provides a framework that supports lifelong learning for nurses thus it is applicable to nursing practice, research, and education (Altmann, 2007).

(Benner, 1982, p. 36) defined experience as “not the mere passage of time or longevity; it is the refinement of preconceived notions and theory by encountering many actual practical situations that add nuances or shades of differences to theory.” Interpretive research is a systematic approach to interpreting text. Interview material and observations are turned into text through transcription. The interpretation entails a systematic analysis of the whole text, an analysis of parts of text, and a comparison of the interpretations for conflicts and for understanding the whole in relation to the parts and vice versa. This shifting back and forth reveals new themes, new issues, and new questions that are generated in the process of understanding the text itself. The participants offer depictions of the lived experience and the
interpreter seeks commonalities in meanings, situations, practices, and bodily experiences. Interpreters use their distance and perspectives to understand the lived situation. The interpreter enters into a dialogue with the text. For example the interpreter must consider the experience-distant perspectives as possible points for interpretation: (1) the changing experience of the body; (2) changing social relationships as a result of illness; (3) changing demands and tasks of different stages in the disease process or illness trajectory; (4) predictable responses and effective coping strategies for treatment side effects and sequelae; and (5) the particular of what the illness interrupts, threatens, and means to the individual. These provide a starting point for the interpretation without setting limits on what can be discovered in the process. The Hermeneutic, or interpretive methodology described, is a holistic strategy because it seeks to study the person in the situation rather than isolating person variables and situation variables and then trying to put them back together (Benner, 1985).

Max van Manen

The hermeneutic phenomenological method and human science approach of van Manen (1990) offers much to nursing research, as does that of Patricia Benner (1985). His phenomenology is commonly used in conjunction with other contemporary influences like Benner to explore and interpret the lived experience (Dowling, 2007). Common to Patricia Benner, Max van Manen views phenomenology as a philosophy of being as well as practice. This perspective allows a view of experiential understanding by questioning lived experience through reflective writing. In this way, meaning can be understood and we can become practitioners of ever-fragile phenomenological wisdom (Munhall, 2007). Benner shares the view, as does van Manen (2007, p. 11), that phenomenology is a project of sober reflection on the lived
experience of human existence. It is sober in the sense that reflecting on experience must be thoughtful and as much as possible free from theoretical, prejudicial, and suppositional intoxications. A respect for the habitual, skilled body of the patient with a chronic illness causes the nurse to respect the patient’s knowledge and develop lines of clinical inquiry that go beyond mere mapping of symptoms onto pre-existing explanations. The patient’s learning about his or her own illness becomes a source of clinical discovery and inquiry. By being an embodied human in situations, being present in the situation, and performing skills, the nurse develops knowledge so that the nurse acts from a deep background understanding or sense of salience in most clinical situations (Benner, 2010, p. 134).

According to van Manen (1990), “‘methodology’ means the ‘pursuit’ of knowledge” (p. 28). The essence of this inquiry lies in the pursuit of knowledge to come to know the humanistic experience as presented by the lived experience of nurse educators and chronic pain. This method of inquiry supports the humanistic science that “aims at explicating the meaning of the human phenomena and at understanding the lived structures of meanings” (van Manen, 1990, p. 4). The interest of this study was in gaining a deeper understanding of the lived experience of nurse educators with chronic pain and “interpreting these meanings to a certain degree of depth and richness” (van Manen, 1990, p. 11). Max van Manen’s (1990) six research activities were used to identify, understand, and interpret the experience in question. These activities included:

- Turning to a phenomenon which seriously interests us and commits us to the world.
- Investigating experience as we live it rather than as we conceptualize it.
- Reflecting on the essential themes which characterize the phenomenon.
- Describing the phenomenon through the art of writing and rewriting.
- Maintaining a strong and oriented pedagogical relation to the phenomenon.
Balancing the research context by considering parts and whole. (p. 30)

Max van Manen (1990) recognized that the person cannot reflect on the lived experience at the time it is occurring; therefore, reflection is not immediate, but retrospective. A person lives in the moment and experiences specific emotions within the moment. The exact meaning derived from the moment’s experience does not become known until reflection occurs. Cultural influences, memories, age, gender, one’s upbringing, and the like influence the individual’s experience. These meanings are different to different individuals. Some commonalities exist, however, and the identification is useful to understanding the phenomena. In phenomenology, questions relate to the search for meaning and significance. The meaning is derived from the interpretations applied to observed descriptions. Phenomenological research is the study of “lived experience,” the study of essences, the explication of phenomena, and the describing of experiential meanings as they are found in living (van Manen). Phenomenologically inspired research aims at describing essence of experiential phenomena; for example, the essence of living with a chronic painful body. The essence of the lived experience, according to van Manen (1997), dwells in the tension between particularity and universality. Particularity refers to the subjectively experienced and concretely lived through meanings of being in the world, whereas universality is connected to essential structures within which our experienced world is enclosed. Rich descriptions of the lived experience of chronic pain must be understood in this context. This means multilayered descriptions able to capture the ambiguity and complexity of the phenomenon at hand, the immediate and subjectively experienced, as well as the deeper meanings (Raheim & Haland, 2006).
Max van Manen (2007) suggested that,

Not unlike the poet, the phenomenologist directs the gaze toward the regions where meaning originates, wells up, percolates through the porous membranes of past sedimentations, and then infuses us, permeates us, infects us, touches us, stirs us, and exercises a formative affect. (p. 12)

In other words, phenomenology is the study of the life world in which we live. It aims at gaining a deeper understanding of the nature or meaning of everyday experiences. It differs from almost every other science in that it attempts to gain insightful descriptions of the way we experience the world without abstracting it. Consciousness is the only access human beings have to the world. It is by being conscious that we are aware of the world in some aspect. From a phenomenological point of view, to do research is always to question the way we experience the world and to want to understand the world in which we live as human beings. To understand it is to profoundly be in the world in a certain way, the act of researching, questioning, and theorizing. In doing research we question the world’s very secrets and intimacies which make up the world. Phenomenology is interested in the significant world of the human being. Phenomenology, not unlike poetry, is a poetizing project that tries a primal telling wherein the aim is to involve the voice in the world (van Manen, 1990). We must discover what lies at the core of our being so that we better find meaning in an attempt to improve our world.
CHAPTER II

REVIEW OF THE LITERATURE

In reviewing the literature, this researcher conducted searches in CINAHL, Pub Med, ProQuest, Nursing Academic Search Premier, Google Scholar, and Allied Health Source for articles to gain a better understanding of the phenomenology of lived pain experiences and its relatedness to nursing curriculum. Search terms were pain, chronic pain and lived experience, chronic pain and curriculum, pain/chronic pain and teaching nurses, pain and self-knowing, pain/chronic pain and phenomenology, and pain and nursing education. The primary timeframe for this search was 2006-2011. Some classic articles outside of this timeframe were identified and included in the literature review. The thematic focus areas for this literature review included embodied or lived experience, chronic pain assessment, and curriculum and education of undergraduate nursing students regarding chronic pain. Each of these themes was explored further in the following literature review. As a result of this review, an identifiable gap was found related to the study of the lived experiences of nurse educators and any influencing factors congruent to the amount of information and time spent teaching nursing students about pain assessment.

Chronic Pain and the Embodied or Lived Experience: What Is It?

Pain is famously defined by McCaffery (1968) as “whatever the experiencing person says it is, existing whenever he says it does” (McCaffery & Pasero, 1999, p. 17).
Chronic pain is ubiquitous in life and an experience essential to being human. Chronic pain sufferers often complain of sleep disturbances, inactivity, and decreased socialization (Fischer et al., 2007). Despite substantial progress in the study of physiological processes involved in chronic pain, it continues to be among the least, well-understood phenomena in medicine (Raheim & Haland, 2006). Phenomenology operates in the space of the relationship of who we are and who we may become, between how we think or feel, and how we act. These relationships have pedagogical consequences for professional and everyday practical life. Phenomenological reflection can contribute to the formative dimensions of a phenomenology of practice. Studying the lived experience makes possible thoughtful advice and consultation. In some sense, it is the practice of living and the exploration of how it relates to our personal and professional lives (van Manen, 2007). Phenomenology of the lived experience offers the moments of seeing-meaning or “in seeing” into “the heart of things.” The phenomenologist gazes toward the regions where meaning originates (van Manen, 2007, p. 11).

Evolution of the Concept of Pain

The word “pain” comes from the Latin word peona, which means punishment. Even though the idea of pain as punishment has to a large extent disappeared, it is of interest to note how this early belief about the origin of pain reflected society’s perception of the ultimate nature of reality, a pattern seen repeated over time. History offers early understandings that pain was often attributed to the presence of evil spirits that inhabited the sufferer. During the time of Aristotle (384-322 BC), and in keeping with Greek emphasis on the mind, attribution for pain shifted from the external spiritual forces to the mind (The Ancient Library, 2005, p. 929). The medical reform movement of the late 19th century gave way to the notion of psychogenic pain
for pain that could not be objectively documented and therefore had no status in reality. This belief was consistent with the dominant conceptualizations held by the science of the day to be an objective undertaking characterized by empiricism, the belief that only that which could be experienced by the senses could qualify as reality. Any subjective expression of pain that could not be empirically verified was not real, except in the mind of the sufferer (Overgaard, 2010).

During the mid-1900s, the positivistic, empirical approach to science began to be challenged. Thomas Kuhn’s groundbreaking work in the philosophy of science explained how scientific understandings are always shaped by human values, understandings and choices (Kuhn, 1996).

A key shift in understandings of pain 40 years ago is credited to Melzack and Wall (1965) who proposed the Gate Control theory. This theory asserted the existence of mechanisms in the body for altering pain signals before they reach the brain. The belief about an integration and interplay of mind and body in pain experience replaced Descartes’ notion of a mind-body split. Thus was the view that the mind’s interpretation is paramount to all pain, and thus the mutual exclusivity or clear distinction between physical and psychogenic pain was no longer valid. Pain became a subjective notion where the physical aspects of pain were subordinated to the authority of the experience constructed by the patient. If pain could not be empirically verified, then it was considered psychogenic having social implications (Melzack, 1986).

What Makes Chronic Pain Problematic?

The ineffective management of pain leads to additional health issues. Pain that is not treated appropriately and promptly results in persistent pain that eventually causes irreversible changes in the nervous system. This cycle translates into progressive bio-psycho-social findings leading to further pain and disability. The functional human being becomes transformed into the
dysfunctional individual seen as a burden to family, to society, and to oneself. Considering that we live in a country where there is adequate medical science, adequate technical skills, and adequate resources, delayed pain care is paradoxical, leading us to the need for effective remediation (Lippe, Brock, David, Crossno, & Gitlow, 2010).

Pain has been shown to have a significant adverse effect on work and productivity. A major study published in the Journal of the American Medical Association found that 13% of the total workforce in the United States experienced a loss in productive time (a mean of 4.6 hours per week) during a 2-week time period due to a chronic pain condition. Headaches, back pain, and arthritis were the most common conditions. The loss in production time among active workers had an estimated cost of $61.2 billion every year. Over three-fourths of this lost production time occurred in the form of reduced performance while employees were at work (Dubois et al., 2009). A greater understanding of the lived experiences of nurse educators who have personally experienced chronic pain is needed, in order to maximize patient care and nurse understanding. The goal of studying the lived experience is to fully describe the lived experience stressing that only those that have experienced the phenomena can best communicate them to the outside world (Mapp, 2008). This philosophical method of inquiry lends to the exploration of what shapes how nurse educators who experience chronic pain, teach about pain, in an attempt to improve nursing curriculum from information learned from the lived experience.

Challenges in Chronic Pain Assessment

Pain assessment is one of the most complex issues in nursing, and deficiencies in pain assessment may explain the high prevalence of unrelieved pain. People often ascribe different quantitative meanings to words used to describe pain, further complicating assessment (Bergh &
Sjostrom, 2007). In the assessment of pain, nurses must realize that patients may refer to pain using different terms such as discomfort, hurt, ache, or pain all over meaning total pain, including physical and emotional dimensions. Assessment is dependent upon recognition of the barriers to pain assessment and pain relief. Patient barriers include the reluctance to report pain, concern that reporting pain will distract the practitioner from treating the underlying disease, fear that the pain means worsening disease, a desire to be viewed as a “good patient,” fear of addiction, concern over medication costs, and reluctance to take pain medications (Sherman, Matzo, Paice, McLaughlin, & Virani, 2004).

According to Hall-Lord and Larsson (2006), the assessment of chronic pain may be improved through self-reflection and awareness of attitudes in the assessment of pain. Nurses must continuously increase their awareness of personal biases when assessing and managing chronic pain. There is an element of moral agency (based on experienced-based moral perception in practical situations to a nurse’s response) involved in the treatment of chronic pain (Benner et al., 2009). Many hospital and hospice nurses have significant moral obligations to patients. The traditional approach of American healthcare ethics has evolved out of principles. The nurse often has to interface with the caregiver who must be trained about chronic pain care. Understanding the beliefs, values, and other influences that give rise to caring behavior becomes important to the nurse. The patient has a right to pain relief or the best death possible. Nurses often encounter caregivers who are reluctant to give pain medications because of fear. These fears include respiratory depression of the loved one or addiction (Kirk, 2007).

According to the The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (2011), it is estimated that in the United States more than 76 million people suffer from pain. Pain can be chronic or acute. The importance of understanding the difficult issues
found in pain assessment and management has been addressed by JCAHO and further justifies the importance of the nurse educator’s responsibility for teaching about chronic pain. On January 1, 2001, pain management standards went into effect for JCAHO accredited ambulatory care facilities, behavioral healthcare organizations, critical access hospitals, home care providers, hospitals, office-based practices, and long-term care providers. These pain standards require organizations to do the following:

- Recognize the right of patients to appropriate assessment and management of pain
- Screen patients for pain during the initial assessment and when clinically required during ongoing periodic reassessments
- Educate patients suffering from pain, and their families, about pain management

The pain management standards were developed in collaboration with the University of Wisconsin, Madison Medical School, and were part of a project funded by the Robert Wood Johnson Foundation. These pain management standards appear in the Provision of Care, Treatment and Service (PC) and the Rights and Responsibilities of the Individual (RI) chapters of The Joint Commission’s accreditation manuals (JCAHO, 2011).

Pain crosses cultural and social lines making assessment and pain management a high priority. Deficits in this area of practice may be attributed to inadequate knowledge (AL-Shaer et al., 2011). Patient perceptions may manifest in a reticence to report pain because of misconceptions about treatment and side effects. This reluctance to seek pain control may be exacerbated by the desire to “be good” and not wanting to “bother” the clinician (Duke et al., 2010). In a study by Yu and Petrini, (2007), as a vulnerable group, older people are more likely to have serious side effects of medication therapy. They often present with serious side effects of medication therapy. Many have multiple medical problems and are more susceptible to
inadequate pain assessment and management. Some people hold beliefs that older people are less sensitive to pain and hold beliefs that pain is normal and expected due to aging. Older people may be more reluctant to report painful symptoms than adults (Yu & Petrini, 2007).

How is Pain Measured?

Planning effective pain measurement and management is a crucial part of the nurses’ profession. To achieve this it is necessary to assess and measure what level of pain a patient may be having and to identify a potential course of action. Pain is multidimensional. Nurses’ assessments of patients’ pain may not be in accordance with what the patient is experiencing (Hall-Lord & Larsson, 2006).

The idea that pain is “whatever the patient says it is” has been a popular term since McCaffery (1972) first introduced the definition of pain to nursing. McCaffery’s definition was mostly a response to a belief that pain was being under-treated in healthcare. McCaffery suggested that this under-treatment was due to healthcare workers’ beliefs about how pain should manifest and fear of opioid addiction risks. She emphasized that pain, particularly chronic pain, will not always manifest through the classic signs of grimacing, restlessness, and vital sign changes. She believed that patients may distract themselves to mask the pain. There may be unfounded concerns over potential patient addiction to opioids and she emphasized the difference between physical and psychological addiction. McCaffery’s definition of pain was aimed at helping nurses to more fully embrace the patients’ subjective experiences to pain and treat that pain liberally to provide relief.

Pain assessment includes identifying the location of the pain, realizing that many patients have multiple pain sites or have referred pain. In 1981, Donna Wong, a pediatric nurse consultant
and Connie Morain Baker, a child life specialist, worked together in a burn center in Tulsa, Oklahoma. Wong and Baker believed that with the proper tools, young patients could participate in assessing their pain, leading to development of the Wong-Baker FACES scale (Wong-Baker FACES Foundation, 2009). The method is a visual analogue scale to identify the degree of pain the individual is having. Initially the numbers of 0-5 were used to quantify pain in children in order for staff to communicate effectively with the child, staff, and parents. This was updated using the numbers 0-10 to be more consistent with the numeric scale where 0 is no pain and 10 is the worst pain imaginable. The FACES scale may also be used to correlate the facial expression selected by the patient with the degree of pain he or she is experiencing (Figure 1). The FACES scale is used with children and those with cognitive impairment.

![Wong-Baker FACES pain rating scale](image)

**Figure 1.** Wong-Baker FACES pain rating scale.

According to Bozimowski (2010), assessing pain of any kind is traditionally grounded in outcomes management. This refers to the patient’s report after an intervention, usually using a visual acuity scale such as FACES described previously in this paper. An obvious problem in this approach is not only the subjective nature of the pain interpretation, but also with the variables associated with the use of the pain scale. Because it is common practice for nurses to
ask their patients to rate their pain on a scale of 0 to 10, it is more accurate to state that the practitioners use a pain numeric scale (PNS) more often than a true (VAS) visual assessment scale. The use of a scale such as the FACES has been generally accepted; however, it has been shown to be a poor indicator of clinically significant pain (pain that is outside of the range of normal) in primary care patients, in a study by Krebs, Carey, and Weinberger (2007). Krebs et al., using a pain numeric rating scale (NRS) with 275 adult clinic patients found only moderate accuracy for identifying patients with clinically significant pain. It is possible that this simple measure cannot be expected to identify all clinically important pain in primary care. Pain is a multidimensional experience and this dimensionality has important implications for its measurement. In settings where pain is chronic and complex, the simple pain NRS scale may fail to identify patients with pain-related suffering driven by functional limitations, illness, worry, or other factors (Krebs et al., 2007).

**Stigma and Delegitimation of Chronic Pain**

The noted anthropologist, Arthur Kleinman, defined delegitimation as “the experience of having one’s perceptions of an illness systematically disconfirmed” (Kleinman, 1992, p. 347). For an individual to be legitimately ill in the eyes of others, the individual often needs to have a credible explanation for his or her illness. There is a belief that real and legitimate diseases have organic causes (Chang, Toner, Fukudo, Guthrie, Locke, Norton, & Sperber, 2006). In chronic pain, it is not always possible to have a credible explanation, especially when there is a lack of evidence to demonstrate physical pathology (Newton, Southall, Raphael, Ashford, & LeMarchand, 2010, p. 4). Patients for whom the pain stimulus does not appear to match the pain experience are often labeled as malingers or as having mental health issues. The idea that “pain
is whatever the patient says it is” may have contributed to moving nursing away from psychogenic labeling towards credibility of the patient experience. The concept of chronic pain over a 30-year period (1970s-1990s) changed from the perceived role of psychological problem to that which might be seen as having a relationship to the consequence of chronic pain. The centrality of the psychogenic component remained, but patients were likely to be blamed for their pain. This change in emphasis on subjectivity of pain helped to overcome some of the psychological consequences of “invisible pain” (Pesut & McDonald, 2007).

Jordan, Eccleston, and Osborn (2007), using an interpretative phenomenological analysis approach, reported on distress and pressures of parenting children with chronic pain. The authors described the guilt of parents in desiring something wrong to be found with their child. The elation of parents obtaining a medical label for their child’s pain could be seen and understood in the face of feeling societal disbelief toward the reality of the pain. Holloway et al. (2007) gave detailed accounts of enacted stigma experienced by those with chronic back pain. Individual interviews with 17 participants in narrative format regarding pain, offered insight into loss experiences of being in various “systems” (i.e., healthcare and social security systems), and stigmatization was a main theme. Stigmas were socially wide ranging to include medical professionals, employers, the general public, and even spouses. One participant reported having her medication thrown at her by a nurse and was told she was “costing the NHS (National Health Services) far too much money” (Holloway et al., 2007, pp. 1, 459). Another participant reported being told his pain was due to lack of fitness. Another reported receiving letters through his door accusing him of falsely claiming benefits following the receipt of his mobility car. These experiences display enacted stigma in contrast to felt stigma where there is no outright disbelief expressed toward the individual (Newton et al., 2010).
In a study by McCaffery et al. (2005), nurses’ comments and suggestions were solicited in a survey developed to identify behaviors that may cause nurses to refer to a patient as drug seeking. The purpose was to identify what nurses think the term “drug seeking” means, to explore how nurses regard the use of the term “drug seeking” in healthcare, and to identify differences between general nurses, emergency nurses, and pain management nurses with regard to those items. Identified behaviors that would cause the majority of all three nurse groups to refer to a patient as a “drug seeker” were as follows: going to different emergency departments to get opioids, telling inconsistent stories about pain or medical history, or asking for a refill because the prescription was lost or stolen. All three groups of nurses agreed that when the term “drug seeking” was used, it was likely to mean the patient was addicted to opioids and that the patient was abusing pain medicine, or that the patient was manipulative. One-half or more of the nurses indicated they had used the term “drug seeking” in talking about patients, but less than 10% said they used it in charting. After taking the survey, one-half or more of the nurses in each group were less inclined to use the term. The use of stigmatizing terms in clinical practice exists (McCaffery et al., 2005). Healthcare professionals need to be aware of the tension patients face between being able to adequately describe their pain and to be understood so as not to risk the accusation of complaining about their pain. A more structured assessment of the patient’s pain might help to overcome this tension (Newton et al., 2010).

Culture and Chronic Pain

The United States of America is a racially and ethnically diverse country with non-Caucasian minority groups now comprising around one-third of the US population. By the year 2042, minorities are expected to become the majority. In 2050, the United States is projected to
be 54% minority, yielding a multi-ethnic, multiracial, and multilingual society (US Census Bureau, Origin, 2000-2050). Race is a complex, multifaceted term with different conceptualizations. Some investigators have defined race primarily by ancestry and combinations of physical characteristics. Others claim race is largely a social or sociopolitical construct that includes self-identity and culture (Fisher, Burnet, Huang, Chin, & Cagney, 2007).

A higher prevalence of risk factors for illness, such as lower socioeconomic status, poor health habits, and inadequate access to healthcare services, predisposes minority groups to suffer a higher burden of pain (Anderson, Green, & Payne, 2009). The literature on disparities in pain has suffered from inconsistent and discrepant uses of the terms “race” and “ethnicity” (Ezenwa, Ameringer, Ward, & Serlin, 2006). Because there are no universally accepted definitions of race and ethnicity, investigators must be careful in the definitions used. Barriers to optimal pain assessment and treatment for racial and ethnic minority patients include factors related to the healthcare provider and the healthcare system. Provider barriers often include the lack of knowledge and training related to pain treatment, inadequate assessment and treatment of pain, and beliefs and expectations regarding minority and culturally different patients. Limited access to care, lack of insurance, or underinsurance, and limited availability of resources add to the system barriers (Anderson, Green, & Payne, 2009). The significance of cultural influences on nurses’ pain assessment attitudes is important as it is culture that guides its members’ thinking, decision making, and actions. No culture is homogeneous and there are distinct groups of people who have different expectations and attitudes. Each culture has its own system of attitudes and behaviors which shape how they respond to their patients’ pain (Harper et al., 2007). Cultural differences become important in the assessment of chronic pain and in bringing significance to understanding possible underlying pain behaviors.
Jimenez, Gar Routte, Kundu, and Morales, (2011) searched 109 peer-reviewed journal articles focused on pain in the populations of American Indian (AI), Alaska Native (AN), and Aboriginal Canadian Peoples (ACP) focusing on pain, pain assessment and treatment, and healthcare utilization. A key finding was that the AI/ANs have higher prevalence of pain symptoms and painful conditions than the U.S. general populations. They also found evidence in the articles for problems in provider-patient interactions that affect clinical assessment of pain, as well as indications that AI/AN patients frequently use alternative modalities to manage pain. Further study is needed to focus on all types of pain and co-morbid conditions for understanding these problems. They concluded that studies about the “lived experience” of pain in these groups are needed because particular tribal populations can bring distinctive communication patterns to the medical encounter including specific metaphors, disease models, and word usage, further complicating chronic pain assessment.

Education and Nursing Pain Curriculum

Teaching nurses and other healthcare professionals regarding chronic pain and its management presents several challenges. Responsibility comes about through a nurse’s connectedness to the patient and family. Empirical qualitative research on the lived experience aligns itself well with the requirement of nurses’ empathetic commitment toward patients and their family members. It unfolds what it means to individuals and their family to have to go through the experience of ill health and/or treatments, and uncovers how these experiences are rooted in patients’ lives and existence. Listening to the lived experience of healthcare workers and healthcare teachers can help us to understand what it means to provide care in a specific
situation or under particular conditions (De Casterle, Verhaeghe, Kars, Coolbrandt, Stevens, Stubbe, & Grypdonck, 2011).

According to a study by Duke et al. (2010), although pain management has been targeted as a top priority, it continues to be inadequately addressed. This descriptive study done in Texas included 162 junior and senior baccalaureate nursing students and 16 faculty members and looked at determining the knowledge and attitudes toward pain to establish a foundation for a systematic and comprehensive integration of pain content in nursing curricula. Significant differences were found in the assessment of pain through case scenarios. The study indicated the need for re-evaluation of the way pain assessment and treatment is taught across the nursing curriculum. Despite the fact that pain content is covered in every semester of the program, understanding and retention were not evident in the study.

In a qualitative study by Briggs (2010), three questions were addressed to nursing students who were given treatment choices for patients in a case vignette. The vignette contained patients who were experiencing pain in which the student would determine the thought processes underlying their decisions. Data were collected from junior and senior nursing students to provide insight for nurse educators and to point to areas where curricula and instruction may be enhanced with the hope to reduce patient pain and improve comfort and satisfaction. The three questions asked were as follows: (1) To what extent do nursing students correctly rate patients’ verbal reports of pain intensity in two case vignettes? (2) To what extent do nursing students who correctly rate patient pain also correctly administer the recommended dosage of analgesic under the conditions provided in the vignette? and (3) What rationales do students identify for their ratings of pain intensity and medication administration in the vignettes? The analysis of the quantitative data revealed that more than half of the students in the sample tended to assess pain
accurately; however, rather than documenting verbal ratings provided by the patient, many were swayed by behavioral factors. It is misleading for educators to believe that students who accurately assess pain will also administer adequate amounts of analgesics. In this study, a theme emerged where students documented a middle ground or average by looking at the number between the patient’s self-report and the number they believed to be correct, based on the patient’s behavior. When 2 mg of medication was ineffective in controlling the patient’s pain at the previous administration, students were reluctant to increase the dosage. Although this study was based on a hypothetical patient situation, there is concern for the need for additional study (Briggs, 2010). New qualitative data are needed to further assess the influence of the knowledge and beliefs that many students hold about pain management in out-patient and in-patient healthcare settings.

A phenomenological study done by Izumi, (2006) demonstrates how listening to the voices of nurses in their own context can assist in further understanding ethical concerns about their connectedness to patients, as well as, bridge the gap between the abstract universal ethics of healthcare and practical and local ethics. Izumi studied the “lived experiences” of families being approached for organ donation, parents facing imminent death of their children, and patients being treated using stem cell transplantations. The project investigated how people experience their life when characterized by the presence of a specific condition such as a demanding health-related situation. Qualitative research into lived experience aligns itself to a phenomenological view of human existence. The researcher tries to uncover messages to benefit knowledge (De Casterle et al., 2011).
The Ineffectiveness of Current Nursing Pain Curriculum

Nurses have a key role in effective pain management. The nurse’s accurate assessment, prompt intervention, and evaluation of pain relief measures are necessary for positive patient outcomes, yet acute and chronic pain continues to be poorly managed in many settings despite the introduction of pain management standards by the JCAHO (Plaisance & Logan, 2006). The literature suggests that inadequate pain relief may also stem from nurses’ acknowledgment that a main source of pain management information was nursing school (Cason, Jones, Brock, Maese & Milligan, 1999; Clark, French, Bilodeau, & Capasso, 1996). Although many of the nurses in those studies rated their knowledge as adequate, their mean scores on knowledge and attitude surveys did not reflect current knowledge of pain management practices. Ineffective care of people experiencing chronic pain has been linked within the studies of the knowledge and attitudes of nurses (Fontana, 2008).

It is during the process of undergraduate education that students develop skills, knowledge, and attitudes that will accompany them into their professional practice. Attitudes are conveyed to students as they interact with one another, educators, and patients during their education. The findings in a cross-sectional study taking place between 2001 and 2005 with third-year students due to graduate nursing school between 2002 and 2005 reported a gap in the existing research exploring the misconceptions (inaccurate knowledge and inadequate attitudes) student nurses have of adults experiencing chronic nonmalignant pain. These findings indicate that, like qualified and practicing nurses, students hold misconceptions about adults with chronic pain, representing inaccurate knowledge and inappropriate attitudes that appear not to be addressed to a substantial degree during the course of undergraduate education. It appears that chronicity and disability need to be obvious in the curriculum, and those educational processes
that enable students to explore their own attitudes and engage in the perspectives of colleagues and patients should be encouraged. These findings are compelling because, even though the data were collected between 2001 and 2003, there is no evidence in the literature of substantial curriculum developments since that time (Shaw & Lee, 2010).

To test the hypothesis that educational deficits are in part responsible for the low priority given to pain management by nurses, a study conducted by Twycross (2000) was carried out to ascertain the pain content in the Common Foundation Program (CFP) and the four branches of pre-registration diploma nursing courses in England. Results indicated that while child and adult programs cover a broad number of topics, there is minimal pain content. These results suggest that there is superficial coverage of pain as a topic and there is a need to reevaluate the teaching of pain in preregistration nursing courses. The amount of time teaching pain is considered (on average less than 10 hours), making it apparent that the teaching of pain may not be in any depth. This superficial coverage of pain content makes it hardly surprising that nurses appear ill equipped to manage pain (Twycross, 2000).

Teaching about a subject (such as chronic pain) does not mean that the student has learned it. It is possible to engage in non-reflective learning such as memorization of facts, skills learning, and preconscious learning. This is, learning that does not involve reflection. Reflective learning involves contemplation, reflective skills learning, and experiential learning. For learning to take place, reflection is needed (Twycross, 2002).

Despite the importance of pain, there is a relative lack of pain management curricula in health professionals’ training and a lack of new studies reporting on pain curriculum. This is especially noted with respect to behavioral techniques as noted by Zalon (1995) who conducted a study to evaluate the nature of pain management training provided to nursing students in
associate and bachelor degree programs. Results indicated that a relatively small amount of nursing curriculum was devoted to such training. Programs in the study reported, on average, only 9.6 clock hours of instruction dedicated to pain, with a large portion dedicated to non-pharmacologic techniques. Of the 9.6 hours, an average of 2.9 hours was devoted to coverage of such techniques. Non-pharmacologic strategies receiving coverage were both behavioral and non-behavioral to include massage, application of heat or cold, relaxation, distraction, and imager recall of pleasant images techniques. Some programs reported the use of both theoretical and practical information on these techniques; however, the majority of program respondents reported these strategies were “just mentioned.” Unfortunately, the authors did not provide an estimate of total clock hours in nursing curricula reviewed. It appears, however, that the coverage of pain in nursing curricula is not proportionate to the incidence of pain or the impairment caused by the condition (Zalon, 1995).

Ferrell, McCaffery, and Rhiner (1992) conducted a content analysis of 50 of the most frequently used nursing textbooks and evaluated their coverage of pain-related material. Of the 45,683 pages reviewed, 249 of the pages included pain content. Results examining the coverage of the textbooks provided non-pharmacologic interventions with a total of 61 pages dedicated to behavioral and physical interventions. This number doubles the 31 pages dedicated to pharmacologic interventions. The authors noted that non-pharmacologic interventions were presented in a positive manner, but that the level of detail provided on these strategies was inadequate to prepare nursing students to use them effectively (MacLaren & Cohen, 2005).

In a more recent qualitative study using content analysis to describe pain management clinical judgment of senior nursing students (Samuels & Leveille (2010), students reported their experiences of patients who ranged from 6 to 86 years old, including two pediatric patients.
Forty-six of the patients were male. The 37 cases generated 178 clinical judgments from which four judgment themes emerged: intention to treat pain, making sense of assessment data, intervening for comfort, and communicating with others. The results of this study offer educators examples of pain management judgments that occur in practice. The findings highlight a need to present assessment and pharmacological knowledge in an integrated, contextual, and comprehensive manner well before the senior immersion experience. The need to help students delve further into patient assessments was identified, which suggested the use of role play or using paradoxes identified in practice to challenge student thinking. Studying the lived experience of nurse educators with personal chronic pain will help direct faculty in teaching and curriculum development in pain management practice realities.

Goodrich (2006) conducted a study to determine the baseline knowledge and attitudes of nursing students and faculty about the science of pain management, and to evaluate the content of pain management material and the extent to which it is integrated into curriculum. In this descriptive study, students were found to have gained knowledge in certain areas of pain management from the beginning of their nursing program until graduation, but many gaps remained. Faculty members who tested satisfactorily on the pain knowledge and attitude survey did not address pain management consistently throughout their nursing courses. Survey results revealed gaps in the understanding of the use of pain medications, pain experienced during sleep, and believing patients’ self-reports of pain. Other areas needing improvement included knowledge about the incidence of respiratory depression; equianalgesic conversions; use of placebos; ceiling effects of opioids; use of nausea medications; and the definitions of addiction, tolerance, and physical dependence. Faculty surveys identified strengths in the area of patient assessment and drug therapy. Areas needing improvement included knowledge about the ceiling
effects of drugs and differentiating addiction from tolerance and physical dependence. The open-ended questions addressed how the science of pain management was incorporated into individual class content. Out of 10 faculty members, 7 indicated they included pain information within the course content. Pain concepts were presented in lectures and reinforced in student presentation topics, discussion in the clinical setting, and case study review. Six faculty members indicated they tested students on pain material, and six described themselves as being current in their knowledge of pain and related issues. As a result, there is a need to develop comprehensive plans to integrate pain knowledge and skills into nursing study. Despite the growing professional awareness of pain science, the study found gaps in nursing knowledge and attitudes incorporating pain interventions into patients’ plans of care (Goodrich, 2006).

The American Medical Association (AMA), faced with the reality of the need to improve pain care, held its first Pain Medicine Summit in June of 2008. Resolution 321 (A-08), set into motion a process to bring together a diverse group of stakeholders (American Association of Medical Colleges, Accreditation Council for Continuing Medical Education, Accreditation Council for Graduate Medical Education, American Board of Internal Medicine Foundation, American Board of Medical Specialties, American Medical Association, American Osteopathic Association, American Osteopathic Board of Emergency Medicine, Association of American Medical Colleges, Association for Hospital Medical Education, Blue Cross/Blue Shield Association, Christiana Care, Council of Medical Specialty Societies, Crozer-Keystone Health System, Educational Commission for Foreign Medical Graduates, The Federation of State Medical Boards, Iowa Board of Medical Examiners, Michigan Board of Medicine, National Board of Medical Examiners, National Board of Osteopathic Medical Examiners, The Robert Wood Johnson Foundation, and Texas A&M Health Science Center) to discuss the future status
of pain care in America. This process included a broad-based coalition of physicians and organizations dedicated to improving pain care. The First National Pain Medicine Summit Final Report (Lippe et al., 2010, pp. 1447-1448) identified the five most pressing issues:

- Medical education in the field of Pain Medicine is inadequate and fragmented. It needs to be fortified in scope, content and duration.
- Credentialing and certification processes in Pain Medicine are variable, diverse, and deficient in many instances.
- Deficiencies in these areas lead to suboptimal and fragmented pain care having a negative impact on direct patient care and public health.
- Effective and prompt remediation is desirable and essential to achieving the goal of high quality pain care.
- Barriers inhibiting or retarding progress toward the common good.

Knowledge deficits and attitudinal barriers to pain management remain and challenge us to determine why these deficits exist. Nursing faculty need to critically review current curricula to determine the presence of the in-depth and up-to-date pain management instruction for evidence-based research and quality nursing standards of care. Educators should recognize the powerful influence of feelings and attitudes on pain management behaviors among nursing students (McCaffrey et al., 2005). Educators and healthcare providers need to understand the complexity of the pain management process. They must move beyond assessment and communication to implementation and evaluation of improvements in pain management (Michaels et al., 2007). Inconsistencies exist in the nursing process based on variables such as educational preparation, specialty area, and personal experience caring for others. It is important for faculty to assess students’ knowledge and attitudes about the treatment of pain. The nursing
curriculum and instruction should not only include pathology and the management of pain, but current research on common misconceptions held by nurses regarding pain control (Briggs, 2010). Preparing new graduates to manage pain and to be advocates for their patients experiencing chronic pain requires action so that these nurses can be mentors to others. The following quote from Benner and Wrubel (1989) clearly incorporates a view of the influence of habits, thoughts, practice, and illness that we have dogmatically rejected concerning the mind’s influence in the chronic pain or other illness experience:

We have much to learn from expert patients who have developed habitual skilled bodies in response to a chronic illness. A respect for the habitual, skilled body of the patient with a chronic illness causes the clinician to respect the patient’s knowledge and develop lines of clinical inquiry that go beyond a mere mapping of symptoms onto pre-existing explanations. The patient’s learning about his or her own illness becomes a source of clinical discovery and inquiry in its own right. (Benner and Wrubel, 1989, p. 74)

Patients with pain have the right to optimal pain management and should be able to expect that healthcare providers will adequately assess, inform, implement, and evaluate treatments for their pain. Given the psychological, spiritual, and physical costs of unrelieved pain, nurse educators have an ethical obligation to improve current practice through addressing curricular pain content, policy initiatives, and research (Duke, 2010). Phenomenological inspired research aims at describing essence of experiential phenomena, for instance the essence of living with a chronic painful body. The essence of lived experience, as described by van Manen (1997), dwells in the tension between particularity and universality. Rich descriptions of the lived experience of chronic pain must be understood in this context. This means descriptions that are able to capture the ambiguity and complexity of the chronic pain, the immediate and subjectively experienced phenomena, as well as the deeper meanings (Raheim & Haland, 2006). Meanings of the lived experience provide guidance for curricula that otherwise would be left unexplored. The investigation of one’s own pain experience lends to knowledge about the world and others with
similar experiences. From a phenomenological point of view, to do research is to always question the way we experience the world, to want to know the world in which we live as human beings. Then research becomes a caring act of wanting to know that which is essential to being. To care is to serve and to share our being with others (van Manen, 1990). The literature review reflects that no current research has been done related to how nurse educators articulate their personal “lived experience.” There is a need for phenomenological studies to give richer data to address better ways of teaching pain assessment to nursing students. The hermeneutical method of interpretation can be used for research with the aim to affect people’s perception of reality and help them to become aware of possibilities (i.e., alternative ways of being in the world). It is the interpretation integrated into the world that allows knowledge gained to be productive in human life and used to improve care (Lindseth & Norberg, 2004).

Phenomenology attempts to study the human experience as it is lived. It is not just a research method, but is also a philosophy and an approach. This study is needed to identify themes, patterns, essences, and insight within the personal “lived experience” of nurse educators that may contribute to education, nursing practice improvement, and the promotion of patient care.
CHAPTER III
RESEARCH DESIGN AND METHODOLOGY

Conceptual Framework

Qualitative Design

The purpose of this study was to interpret as closely as possible and explore the meanings of “lived experiences” of nurse educators who have personally experienced chronic pain, in an attempt to better understand how these educators articulate and shape how they teach about chronic pain. A qualitative approach was chosen for this study. This approach is chosen by researchers who are interested in understanding or seeking to change a social phenomenon. Creswell (2009) stated, “Qualitative research is a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem” (p. 4).

In qualitative research, questions and procedures change and evolve, data are collected from participants in the setting where the phenomena occurred; data are analyzed inductively using general details to broad themes. Meaning is derived from the data by the researcher (Creswell, 2009). In qualitative research, a phenomenological approach to inquiry is often used to explore the lived experience of individuals with a common phenomenon, focusing on what the participants have experienced as individuals and how meaning is ascribed (Creswell, 2007).

Phenomenology

Using a phenomenological approach frames research and allows the researcher a path for finding meaning in the lived experiences of individuals. Researchers using a phenomenological
approach explore phenomena for meaning and understanding gleaned from individuals who have lived it and are willing to describe through communication their experience (Mapp, 2008).

Lived experiences do not manifest themselves immediately, but are grasped by reflection on the past presence. Reflection does not occur while living through it; therefore, phenomenological reflection is retrospective (Van Manen, 1990). When exploring lived experience, one must look with reflection based on past experience to glean present meaning.

Methodology

The central guiding question is, “In what ways does the ‘lived experience’ with chronic pain shape how a nurse educator understands and engages with pain assessment?” Additional questions will focus on the following: (1) How do nurse educators who have “lived experience” with chronic pain theorize or understand chronic pain? (2) How can the “lived experience” relate to how pain is taught by these individuals? and (3) What are the prescribed methods of teaching chronic pain assessment where nurse educators teach and how does it fit into the nursing curriculum? These questions were explored with a qualitative design consisting of three-part interviews and field notes.

The specific methodology that guided the data collection, analysis, and report writing was interpretive using the phenomenological works of Benner (1994) and van Manen (1990). Exploration of the lived experience is best suited by a phenomenological approach and point of view because to do research is always to question the way we experience the world, to want to know the world in which we live as human beings (van Manen, 1990, p. 5). Through phenomenology, we discover new ways of describing and understanding what it means to be a human being, who is finite and always situated in a world with a history and concerns. In
exchange, nursing may draw on a mixture of natural and medical sciences that assist in understanding human beings in their physical and cultural diversity and in caring practices. A qualitative design is the most appropriate approach for answering the proposed questions because qualitative designs have been encouraged in areas of study where the voice of the group has been unexplored (Benner, 1994).

Recruitment and Selection

This qualitative study included purposeful interviews with three nurse educators who had personally experienced chronic pain or who had cared for someone with chronic pain. The participants met the inclusion-exclusion criteria as discussed in Chapter I. Additional criteria for participation was nursing faculty with a master’s degree in nursing and who may also have possessed a degree in nursing or a related field beyond the master’s degree, who taught full-time, and who lived in the United States. Only full-time nursing faculty were selected to participate in the study. Most phenomenological studies engage in a relatively small number of participants for a relatively long period of time (at least 2 to 3 hours), which is reflective of this study with the three interview process. The participants were the experiential experts on the phenomenon being studied (Rudestam & Newton, 2007). A sample size was projected at the beginning of this study as being not less than three, but could have been adjusted depending on the quality of the text, the amount of the intensity, and until saturation was reached. The researcher knew that saturation has been reached when each additional interviewee added little to nothing to what was learned (Benner, 1994). According to Polit and Beck (2008), there are no rules for sample size in qualitative research. Sample size is largely a function of the purpose of the inquiry, the quality of the informants, and the type of sampling strategy used. Qualitative study sample sizes should be
determined based on informational needs; hence a guiding principle in sampling is data saturation that is to the point at which no new information is obtained and redundancy is achieved.

Definitions

*Nurse faculty* are nurses licensed as a professional nurse with a minimum of a master’s degree in nursing and may possess a further graduate degree in nursing or a related field, and who are current instructors in schools of nursing either accredited by the National League for Nursing Accrediting Commission or the Commission on Collegiate Nursing Education. The participants used in this study had personally experienced chronic pain or had personally cared for someone with chronic pain.

*Graduate degree* refers to any master’s degree in nursing and a higher degree in nursing or a related field, which meets the requirements for a faculty position within an accredited school of nursing.

*Full-time faculty* refers to those faculty members in academic or clinical positions within an accredited school of nursing for either a 9- or 12-month contract as required by the institution.

*Chronic pain* refers to persistent pain where pain signals keep firing in the nervous system for weeks, months, even years. There may have been an initial mishap such as a sprained back, serious infection, or there may be an ongoing cause of pain such as arthritis, cancer, ear infection, or other problem. Some people may suffer chronic pain in the absences of any past injury or evidence of body damage. Common chronic pain complaints include headache, low back pain, cancer pain, arthritis pain, neurogenic pain (pain resulting from damage to the peripheral nerves or to the central nervous system itself), psychogenic pain (pain not due to past
A person may have two or more co-existing chronic pain conditions. Such conditions include chronic fatigue syndrome, endometriosis, fibromyalgia, inflammatory bowel disease, interstitial cystitis, temporomandibular joint dysfunction, and vulvodynia. It is not known if these disorders share a common cause (National Institute of Neurological Disorders and Stroke [NINDS], August 10, 2011). The International Association for the Study of Pain defines chronic pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. The precise definition of chronic pain is debatable; however, sources agree that chronic pain typically lasts 6 or more months and can be classified according to its origin (International Association for the Study of Pain, 2006).

*Lived experience* refers to the phenomena and essence of experience of living with a chronic painful body. The essence of lived experience as described by van Manen (2003) dwells in the tension between particularity and universality. This particularity refers to the subjectively experienced and concretely “lived through meanings” of being in the world, where as universality is connected to essential structures within which our experienced world is enclosed. Rich descriptions of the lived experience of chronic pain must then be understood in this context.

Sample Size, Setting, and Access

A purposive sampling was sought to ensure the “lived pain experience.” Purposive sampling involves selecting volunteer cases that will most benefit the study. In qualitative studies, sample size is determined based on informational needs and data saturation. Data saturation is sampling to the point that no new information is obtained from the participants. The guiding principle in selecting the sample is that all participants must have experienced the
phenomenon and must be able to articulate what it is like to have lived that experience. “The purposive sample method is one in which the researcher selects participants based on personal judgment about which ones will be most informative” (Polit & Beck, 2008, p. 763). Participants for this study were full-time educators of Baccalaureate degree or Associate degree nursing programs who taught about chronic pain to senior level student nurses and who had personally experienced chronic pain. These educators were recruited by sending a formal letter to the President of the Alabama League for Nursing. The Alabama League for Nursing is a professional organization that supports nursing educators and quality nursing education at all levels. The President distributed the request for participants by asking interested individuals to reply directly to the researcher via a confidential e-mail address, which was provided. Four individuals responded to the request for participants. One individual did not meet the inclusion criteria because she taught in a vocational school and not in a college or university setting.

Protection of Participants

Institutional Review Board approval was sought from, and approved by, The University of Alabama Institutional Review Board prior to beginning the study.

Data Collection

The methodology was based on the philosophical framework in which fundamental assumptions and characteristics of human science perspectives are made (van Manen, 1990). Within the methodology, techniques and procedures are applied in an approach that tries to avoid “constructing a predetermined set of fixed procedures, techniques, and concepts” (van Manen, 1990, p. 29). In phenomenology, the natural attitude is one in which there is a tendency to judge
and to have already made judgments about existing phenomena. We already know, we conclude, we state the facts, and we take for granted what is meant. To shift to the phenomenological attitude, the researcher must refrain from making judgments about the factual. This is accomplished through bracketing. “Bracketing is the act of suspending one’s various beliefs in the reality of the natural world in order to study the essential structures of the world” (van Manen, 1990, p. 175). “Putting aside personal experience becomes necessary, particularly when the researcher has personal experience and/or knowledge of a phenomenon” (Munhall, 2007, p. 219). The easiest way to do this is to narrate from lived experience. In narrating, we refrain from judging or concluding. We are not interested in stating facts, but in relating what we have experienced. We do not judge what is said as right or wrong, but rather participate in the story: “so this is what you have experienced or so that is what you thought.” The researcher brackets personal judgments about the factual and about what is the case in order to become open to our own experience. This openness helps in understanding the meaning, which is implicit to the experience (Lindseth, 2004). Data analysis was ongoing where data were analyzed throughout the process between each interview allowing for the analysis to impact subsequent interviews.

An interpretive and descriptive view of van Manen (1990) was used to try to grasp the essential meaning of the experience being studied. According to van Manen, thematic aspects of experience can be uncovered or isolated from participants’ descriptions of the experience by three methods: (1) the holistic approach (viewing the text as a whole and trying to capture its meanings), (2) the selective or highlighting approach (pulling out statements or phrases that seem essential to the experience under study), and (3) the detailed or line-by-line approach (analyzing every sentence for themes which were used in follow-up interviews for interpretation through meaning (van Manen, 2006).
Max van Manen (1990) listed six activities that occur in gathering phenomenological research: (a) focusing on the phenomenon of interest, (b) investigating experience as we live it rather than as we conceptualize it, (c) reflecting on the essential themes that characterize the phenomenon, (d) describing the phenomenon through the art of writing and rewriting, (e) maintaining a strong and oriented relation to the phenomenon, and (f) balancing the research context by considering parts and whole. Lived experience is something recognized in retrospect (van Manen, pp. 30-31).

According to Seidman (1991), the purpose of in-depth interviewing is not to get answers to questions, nor to test hypotheses, and not to “evaluate” as the term is normally used. At the root of interviewing is an interest in understanding the experience of other people and the meaning they make of that experience. Max van Manen’s six activities for phenomenological inquiry assisted the researcher in understanding the interview process described by Seidman (1991), because from a phenomenological point of view, to do research is always to question the way an individual experiences the world, and to want to know the world in which human beings live. Humans question the world’s very secrets and intimacies, which bring the world as a world into being for us and in us. Research is a caring act: we want to know that which is most essential to being. The procedure to capture this inquiry was a three-part interview process based on Seidman’s (1991) qualitative guide. The analytical work for this phenomenological study was field notes, transcription, and qualitative data analysis. Discoveries gleaned in interviews (meanings, the emerging themes, and the valid comments) were documented. The researcher looked at the discourses of life experiences in a social context. A scholarly approach was used with careful listening and hearing of the participants’ voices.
Procedure/Setting

Three-part, face-to-face interviews were conducted. Each interview was audio-recorded by the researcher in a mutually agreed upon location and later confidentially transcribed by the researcher for coding. Informed consent was obtained from all participants prior to the interviews. Information regarding the study’s follow-up procedures and participant rights were given to the participant in writing before the interview. The participants were given a chance to ask questions prior to the start of the interviews. The study participants were contacted by the researcher to schedule a time to meet for the initial private interview. Subsequent private interviews were scheduled at times and places in mutual agreement with the researcher and the participant. The researcher asked a series of questions divided into three parts consisting of three interviews. The first interview focused on the life history of the participant. The second interview concentrated on the details of the participant’s experience (s) with pain. The third interview asked participants to reflect on the meaning of their experience and to look at how factors in their lives interact to bring meaning. Ongoing data analysis occurred throughout the process of all three interviews allowing for impact on subsequent interviews. Responses of the participants in the study were kept only by the researcher in a password protected computer file and a locked file cabinet with key access only by the researcher.

Data Analysis

Data analysis was an ongoing process throughout the study. Research questions were used as a guide to review transcripts and relevant data were identified to create meaningful units. The Colaizzi data analysis method for qualitative data analysis was utilized to help ensure validity (Polit & Beck, 2008). The seven-step process was utilized to maintain uniformity.
Information was transcribed verbatim from audio recordings of interviews. The text was analyzed for recurring ideas in the statements, phrases, and/or themes that captured the nature and core of the experiences described and was ongoing throughout the interview process based upon the process described by van Manen (1990). Each interview transcript was read several times, in order to identify lines of inquiry or meaningful statements. “Strong instances of a particular pattern of meanings” (Benner, 1985, p. 9) were assessed in the data. Each theme was allocated a color-matched number during coding of information. This part of the procedure required considerable time, as coding is an interactive process (i.e., the researcher coded and recoded as the scheme developed). Once the coding was matched to the transcripts, an attempt was made to interpret their meaning in the context in which they appeared. The interviewer asked the participants to confirm the right interpretation of what they said, which added credibility to the validity and reliability of the results (Guba & Lincoln, 1983). Paradigm cases were analyzed to distinguish between what van Manen (1990) terms incidental and essential themes (pp. 106-107). Van Manen argued that only some meanings that are gleaned from a given phenomenon are unique to it. These are the essential themes in which the phenomenon would not exist if this theme was not present. “Phenomenological themes may be understood as the structures of experience. When a phenomenon is analyzed, there is an attempt to try to determine what the themes are, the experiential structures that make up experience” (van Manen, 1990, p. 79). “Because our everyday lived experience is so taken for granted as to go unnoticed, it is often through breakdown that the researcher achieves flashes of insight into the lived world” (Benner, 1994, p. 59).

The data generally flowed into categories. The researcher moved back and forth making notes through journaling for an audit trail, color-coding the text for common themes and
essences, and utilizing Nvivo 10™ software to assist in categorizing nodes found in the interview texts. The researcher began with excerpts of significant statements, which led back to the original transcripts and produced themes. After organizing categories, the researcher then searched for meaning among the categories in order to develop a meaningful interpretation of the data using the participants’ words. The researcher then determined if the themes were essential or incidental by looking at the data as a whole. Credibility, dependability, confirmability, and transferability, as identified by Colaizzi (as cited in Polit & Beck, 2008, p. 520), were utilized to ensure trustworthiness. This method includes the following:

- Reading all protocols to acquire a feeling for them
- Reviewing each protocol to extract significant statements
- Spelling out the meaning of each significant statement (i.e., formatting meanings)
- Organizing the formulated meanings into clusters of themes. (A) Refer these clusters back to the original protocols to validate them. (B) Note discrepancies among or between the various clusters, avoiding the temptation of ignoring data or themes that do not fit
- Integrating results into an exhaustive description of the phenomenon under study
- Formulating an exhaustive description of the phenomenon under study with an unequivocal statement of identification as possible
- Asking participants about the findings thus far, as a final validating step

Interpretation required abstraction from the themes containing the participants’ words to meanings so they could be looked at as a whole. The final abstraction yielded the true essence of the phenomenon of interest, lived experience. Through this process, the data were pushed to go beyond the words of the participants to a level of abstraction (van Manen, 1990). This level of
abstraction, presented in the form of essences and known as member-checking, is necessary in order to make the data meaningful to nursing and other disciplines.

Sample Demographics

Three out of four responding nurse educators met the inclusion criteria and were interviewed for the study. Two of the three nurse educators were nursing faculty with a Master’s degree in nursing working full time on two different campuses of an associate degree program (community college), and one of the nurse educators held a Master’s degree in nursing and a Ph.D. in Public Administration and was employed full time as an assistant professor in a bachelor’s degree university setting. All three nurse educators were female Caucasians over the 35-year-old age range. Faculty teaching years ranged from 16 to 18 years for the associate degree faculty and 12 years for the bachelor’s degree associate professor. Years of nursing practice ranged from 23 to 31 years as a registered nurse. Each nurse educator stated she worked 40-plus hours per week during the fall and spring semesters. All of the nurse educators were married. One educator had small children, one had grown children living out of the home with grandchildren, and one did not have any children. Subjects taught by the three participants included Fundamentals, Medical Surgical Nursing I and II, Leadership, Obstetrics, Pediatrics, and Community Health Nursing. The average number of students per class ranged from 40 to 60 each semester. The types of chronic pain represented among the group consisted of rheumatoid arthritis, psoriatic arthritis (severe psoriatic dermatitis complication of feet and hands), and chronic back pain with history of severe pelvic pain. Each study participant’s pain time of onset was 2-3 years from date of the initial interviews (see Table 1). The interviews were conducted during the months of May through July 2012 and were done at least one week apart for a total of
three interviews each in person and one follow-up interview with one participant who was hospitalized related to her chronic pain, shortly after the course of her last interview. Each interview lasted about an hour.

Table 1

Demographic Data for Participants

<table>
<thead>
<tr>
<th></th>
<th>Participant A</th>
<th>Participant B</th>
<th>Participant C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age range in years</td>
<td>&gt;35</td>
<td>&gt;35</td>
<td>&gt;35</td>
</tr>
<tr>
<td>Race</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Highest degree</td>
<td>MSN</td>
<td>MSN</td>
<td>PhD</td>
</tr>
<tr>
<td>Number of years in nursing</td>
<td>23</td>
<td>31</td>
<td>25</td>
</tr>
<tr>
<td>Nurse educator years of teaching</td>
<td>16</td>
<td>18 yrs. 8 mos.</td>
<td>12</td>
</tr>
<tr>
<td>Type of chronic pain</td>
<td>Rheumatoid arthritis</td>
<td>Psoriatic arthritis with severe dermatitis</td>
<td>Chronic back pain</td>
</tr>
<tr>
<td>Years of chronic pain</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Field notes and journals were used to connect the researcher’s observations to the researcher’s transcribed interviews and to continue the explorative process. The Colaizzi (Polit & Beck, 2008) method of interview material validation of data by the participant was used as a final step in the analytic method. Computerized copies of all data collected will be kept for 5 years, and a back-up copy will be kept on an external jump drive for 5 years. All data were collected on the personal lap top computer owned by the researcher and password protected. All equipment such as audio recorder and jump drive will be stored in a locked file cabinet for 5 years. Only the researcher will have access to the passwords used and the key. Pseudonyms were
used during the private audio recordings to protect the identity of the participants. A reference code was assigned to each participant to facilitate confidentiality. All codes and contact information were kept in a locked file in the researcher’s office. Only the researcher had access to stored information. Data analysis was ongoing throughout the study. An interpretive description of the lived experience was written and shared with the participants to verify the faithfulness of the descriptions and the interpretation of the experience as captured by the researcher. The participants were given a summary of the interviews and had the opportunity to clarify any misinterpretation of data.

Trustworthiness and Validity of the Study

Trustworthiness and validity were established through triangulation, confirmability, and transferability. *Triangulation* refers to the use of multiple methods, sources, or referents to draw conclusions about what constitutes the truth. In qualitative research, this might involve trying to understand the full complexity of a poorly understood phenomenon by using multiple means of data collection to converge the truth (e.g., having in-depth discussions with study participants, as well as watching their behaviors in natural settings). It might also involve triangulating the ideas of multiple researchers working together as a team (Polit & Beck, 2008). Findings were clarified with each subsequent interview and through member checks to allow clarification and modification of the transcript and to establish credibility. *Credibility* refers to the truthfulness of the data (Polit & Beck, 2008). Credibility was maintained by keeping a journal-audit trail reviewed by committee members during the process detailing insights, content, and observations. Participants were invited to review their transcripts within a week after they were transcribed to add, change, or clarify their stories. This ensured that the researcher was building trustworthiness.
into each phase of the research and not just focusing on the end. **Transferability** refers to the extent to which qualitative findings can be transferred to other settings or groups (Polit & Beck, 2008). Transferability was maintained in that the findings of the research had meaning for nurses and nurse educators. **Confirmability** is the process of minimizing bias during the research process and in the final product (Polit & Beck 2008).

A good description that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of the experience in a hitherto unseen way. (van Manen, 1990, p. 39)

Bias is a major concern in designing a research study due to the study’s ability to reveal the truth. **Bias** is an influence that produces a distortion or error in the study results. Biases can affect the quality of evidence in both qualitative and quantitative studies. It is the job of the researcher to prevent bias to the extent possible and to establish mechanisms to detect or measure it when it exists. Triangulation was used with multiple sources of information with points of view to counterbalance the biases or identify their existence.

**Member checking** is a process where feedback is provided to the research participants about emerging interpretations and to obtain the participants’ reactions for clarity. Member checking is an important technique for establishing credibility and is an important process to represent the realities of the participants’ statements of meaning (Polit & Beck, 2008). The researcher asked the participants at the beginning of each of the three interviews to reflect on what was talked about in the previous interview. The researcher provided written transcripts to each participant for input on meaning, feedback, and clarification.

Some limitations of the study were found in the possibility that participants could be inhibited by the presence of a tape recorder, and audio taping the interviews may have made them reluctant to share private thoughts and experiences. Including participants with a variety of
different types of chronic pain may have caused some variation in scope. Conducting a set of narrative interviews is a delicate task in which the interviewer should create a permissive climate of comfort. As interviewees can only understand and narrate their lived experience in relation to their pre-understanding and the interviewers can only understand the narrative in relation, there is a risk of misunderstanding. Skillful interviewers, in an attempt to reduce this risk, check their understanding of the narrative or elements of the narrative with the interviewees during the interview and use questions such as, “What do you mean” (Lindseth, 2004)?

Ethical Considerations (IRB)

There was minimal risk of psychological or physical harm to the participants in the study. Participants could withdraw from the study at any time without questions related to reasons for withdrawal. Confidentiality of interviews was assisted by using pseudonyms for the prevention of tracing. Each participant was assigned a reference code. All identifying information was kept locked in the researcher’s office under lock and key. Only the researcher had access to the lock and key access. Participants were notified that the researcher was the only person who could match the names and data to the information obtained in the study. Confidentiality procedures were given to the participants at the time of the interview and when the informed consent was signed. Every effort to ensure a nonjudgmental perspective was made. The researcher attempted to identify and document personal biases in the interview process and utilize triangulation methods. Any opposing views to those of the researcher were kept private with a non-judgmental attitude. The researcher’s voice remained even tone to avoid any audible cues and the researcher did not voice any personal beliefs, bias, or opinions that may have affected the integrity of the
interview process. A faculty mentor was consulted as needed during the study to assist in
avoiding potential research bias and to aid with any questions that arose during the study process.
CHAPTER IV

RESEARCH FINDINGS

This study used a phenomenological method to interpret as closely as possible the “lived experiences” of nurse educators who have personally experienced chronic pain. Using the broad and focused research question as a guide, the researcher carefully analyzed and reviewed the transcripts of three participants for emergent themes, totaling nine interviews. Initially, each interview transcript was read several times in order to identify lines of inquiry. Meaningful statements that described structures of experience emerged with some consistency describing the lived experience. These “Strong instances of a particular pattern of meanings” (Benner, 1985, p. 9) gave rise to what van Manen (2003) termed as incidental and essential themes. Five major themes emerged, paralleled, and assisted to answer the questions with two subthemes (see Table 2).

Table 2

Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vulnerability</td>
<td>desperate, embarrassed, ashamed, crying, inferiority, hopelessness, loss of joy, disbelief, <em>Subtheme: stoic</em></td>
</tr>
<tr>
<td>Physician/Provider Trust</td>
<td>poor assessment, drug seeker mentality, questioning, not listening</td>
</tr>
<tr>
<td>Fear of Disability</td>
<td>desire to be “normal,” need for independence, betrayed by body, dependent, loss of socialization, disappointing family, difficulties with activities of daily living, <em>Subtheme: alien</em></td>
</tr>
<tr>
<td>Coping</td>
<td>self-realization, adaptation, understanding, reflection, accommodation</td>
</tr>
<tr>
<td>Need for Pedagogical Discourse</td>
<td>lack of adequate teaching hours, poorly written texts, need for better chronic pain assessments, need for more psychosocial content</td>
</tr>
</tbody>
</table>
Chronic Pain Defined

The definition of chronic pain used in this study refers to persistent pain where pain signals keep firing in the nervous system for weeks, months, even years. Some people may suffer chronic pain due to a mishap such as a sprained back, serious infection, or there may be an ongoing cause of pain such as arthritis, cancer, or other problem. Some people may suffer chronic pain in the absence of any past injury or evidence of body damage. Common chronic pain complaints include headache, low back pain, neurogenic pain, psychogenic pain, endometriosis, and more (NINDS, 2011). Nurse educators provided a description of their understanding of chronic pain at the beginning of the second interview.

The participants defined chronic pain in a variety of ways: Pain that you have off and on like a headache, pain that is not relieved, pain that is there but is never completely gone, unresolved pain, or pain lasting longer than 6 months. Throughout the literature, chronic pain is represented by a variety of definitions and the participants’ representations were no different. During the analysis process, it also became apparent that there are similar viewpoints and understandings of how chronic pain is theorized among the group of participants. Each of the participants expressed that chronic pain is misunderstood by members of the healthcare system and by society in general.

Research Questions

There was one broad research question for this study. In what ways does the lived experience with chronic pain shape how a nurse educator understands and engages with pain assessment? Additional focused questions follow: (1) How do nurse educators who have the lived experience with chronic pain theorize or understand chronic pain? (2) How can the lived
experience relate to how pain is taught by these individuals and what are the prescribed methods of teaching assessment where nurse educators teach and how does it fit into the nursing curriculum?

In the initial interviews all three participants were asked to tell a little about where they grew up, their earliest memory of hearing about or experiencing chronic pain, and to give some examples of life encounters with chronic pain. Two of the participants grew up in a rural area and one participant grew up in the city.

The first participant remembered learning initially about chronic pain at the age of 12 from an aunt who had pancreatic cancer. The aunt refused chemotherapy after it made her quite sick. Participant A reflected on her lack of understanding about genetic tendencies at such a young age. The participant said,

I don’t know if I connected. I mean, I knew it was cancer. I knew she’d die, but I don’t think I thought about that being genetic. (Participant A Interview I, ADN instructor)

The second participant remembered an uncle when she was about five years old who was one of her favorite people to go visit. She speaks of her intrigue with his illness. She expected him to be deformed and scary. She discovers something quite different. She stated,

He had rheumatoid arthritis and was bedbound. He smoked a cigar and his hands were in a position where he could get his cigar in. He worked puzzles and had an aquarium by his bed. As a child, I was just intrigued by an adult doing puzzles and staying in the house all day long. Everyone came to his bedroom to visit him. I thought he would be scary, but he was not scary. Everybody loved him. (Participant B Interview I, ADN instructor)

The third participant remembers grandparents who had chronic pain related to degenerative arthritis and osteoarthritis. Her earliest memory is at about eight years of age when she watched them struggle with their activities of daily living. Her early experience of observing chronic pain made a lasting impression that gave way to the career she chose in life. Watching relatives struggle stirred her compassion. She stated,
I think that is what started making a lot of impressions on me that probably led to me wanting to be a nurse. Watching them struggle, I realized that because my mother was their only child, and not being in the same city that she was not going to be able to supply them with the resources that she would have liked for them to have. This was in the years before you had home health in a close proximity and all the support systems that could be put into place now. They were just in this tiny little town and just kind of struggling on their own. (Participant C, Interview I, BSN instructor)

During the first interviews, study participants were asked to describe if there is anything or things they believe shape how they view pain and to speak about any personal experiences that triggered anxiety or concern based on what they know about pain? One study participant talked about a patient she had cared for as a young nurse. She spoke about problems often encountered in the physician/provider trust relationship. Authenticity becomes an awareness of self by others that chronic pain may not exist in the absence of physical signs or the need for frequent pain medication. She said,

She had a spinal injury and she was in a wheelchair. She had morphine in the house, which in the home . . . you try to have locked up. She had a guy come in and steal . . . she’d filed a police report where she tried to go after him and then she went to the hospital . . . and they treated her like a drug seeker at the hospital . . . and so I had to go through all kinds of avenues trying to get her more medication. The pain clinic refused to give her that. I called the patient advocate for her but they would not let me talk . . . so I said, fine, the patient is here, you talk. So, that’s how . . . because she had such a hard time. I kind of got involved with her more than others. Just because they were like, well, you know, you’re just up here to get medication. Because that’s who you go to, the drug clinics, and they will only provide a certain amount for the month. They refused to give her anything. I couldn’t even talk the physician with the clinic into it. And so they said, well you know, you’re just taking it. “No, I didn’t take it all, I actually had somebody break in.” They did not believe her, but they gave her a shot and sent her home. Just a shot, they didn’t give her anything else. Just a drug seeker is how they treat them in the ER. They just don’t listen to them and the elderly on top of that. (Participant A, Interview I, ADN instructor)

A second participant voiced her thoughts about people who have chronic pain having a choice to make between what is considered adequate drug intake and what is considered too much. There seems to be a wisdom garnered and insight about the daily nuances of the disease and the lived knowledge about managing at arduous times. She said,
A choice to make... at a level they can tolerate. Some people become addicted, and then, they’re seeking more with more drug-seeking behaviors. Where others will cope in other ways and not let it affect them as far as addiction in their family as much. So I’ve seen the difference in treatment with acute versus chronic that are already addicted. I believe there is a level they have every day... that they have learned to cope with, but once they go above that level, they’ve used all their coping ability to deal with it already, and they’ve exhausted it. I believe short-term management is fine. But you can’t continue with short-term management. You’ve got to make it short-term and help them in different ways... maybe exercises, relaxation, but you can’t continue medication. They have used up everything they have and they need some help... because the pain is real. (Participant B, Interview I, ADN instructor)

A third participant talked about how her most recent episode with pain has shaped how she views pain and how she has approached the assessment of pain in patients she has cared for in the past. The nurse may not realize that the patient who is hurting may not feel like answering so many questions until relief is obtained.

I remember thinking, Oh, gosh, I know exactly how my poor patients feel now. And... I remember the frustration of being in such severe pain and having nurses questioning me to death. And, that was my thought... you know, because literally you’re lying there and you can’t even open your eyes and you’re thinking, Oh, don’t keep asking me this because I am not in any shape to answer these kind of questions right... even though in the back of your mind you know they are having to ask you these things. They are having to try to get you to describe things. And, the more and more you feel like you can relate completely to your patient’s frustration with feeling horrible and having us do these long detailed assessments on them, asking them these questions, over and over, and they’re just thinking please just give me some relief, because I think I’m going to die today. (Participant C, Interview I, BSN instructor)

One other note made by this same participant about how pain has shaped her view has to do with stoicism. The culture of her family upbringing was to endure, as all would eventually be well. There is reluctance to the disease nuances in order to prevent negative reactions by others. She said,

I tend to be sort of on the stoic side. Now I saw my grandmother had a lot of problems with chronic pain, in particular. Like I said, probably osteoarthritis related and a lot of surgeries. So, I’m sure she had a lot of scar tissue and adhesions. I always saw my mother being very stoic. She was never once a big one to complain you know? She was never sick with anything. She wouldn’t be down for the count for long. And so, I think I tend to have that same kind of attitude. Because always my thing is, I’m the one who’s saying,
“I’m going to be alright. I’m going to be alright.” You know, with the last episode with
the pain from the fibroid, I kept telling them over and over . . . even though their thing
was they wanted to take me to the ER, I said, “I am not going to the hospital, I am not
going to the hospital.” (Participant C, Interview I, BSN instructor)

Despite the stoicism of this participant she goes on to further comment about how her
understanding and view of chronic pain changed when she took on work as a Hospice (end of
life care) nurse. She stated,

As far as my views of pain as a nurse, I worked for a long time with cancer patients and
so, saw them in terrific pain. I think I have a lot more, probably liberal ideas on pain
medicine for my patients than a lot of nurses do. Because I remember the days I gave
cancer patients 18mg of MS-Contin. You know, with a big glass of water . . . that’s what
it took to deal with it. And I remember when people used to not want to float to our
cancer floor because their thing was, like, well, I can’t give the medication y’all give and
I am not going to do that. The doctor would prescribe MS-Contin way outside of the
ordinary dose a nurse normally would give. You saw people that you knew were in the
active dying process. I mean, you wanted them to be comfortable. These people would
build up such a tolerance to it over the years of dealing with this. (Participant C,
Interview I, BSN instructor)

Themes

In the interviews, each of the three participants responded to open-ended questions with
five essential themes emerging (see Table 1): vulnerability, physician/provider trust, fear of
disability, coping, and need for pedagogical discourse. The Subtheme stoic emerged related to
the theme vulnerability and the subtheme alien emerged related to fear of disability. The themes
and meanings to follow reflect the experience of the participants as they expressed it.

Vulnerability

Vulnerability is defined as an adjective meaning exposed to the possibility of being
attacked or harmed, either physically or emotionally, open to moral attack, criticism, or difficult
to defend (Oxford English Dictionary, 2013). In the thematic breakdown, each of the participants indicated feeling on multiple occasions either desperate, embarrassed, ashamed, inferior, hopeless, had cried on occasion, and displayed at times a loss of joy as well as disbelief. One of the participants illustrated this when she said,

It was honors night for the students and I had to wear a brace. I got home to get dressed and I could not get dressed. I could not zip my pants or anything. So I changed, put a dress on, and I put on the brace that just immobilizes so I could go because I had to speak at honors night. It bothered me because it was embarrassing to have to wear it. No big black brace is attractive. (Participant A, Interview II, ADN instructor)

Participant A further explained about her vulnerability when she spoke about the symptoms and embarrassing side effects related to dealing with the required treatment for her chronic pain. There is a fear that people in general, do not have a deep understanding of chronic pain and form their opinions, and often negative ones, based on what they see:

Chronic pain is always there. It may be relieved up to like a level two or a three, but it’s never completely gone. When I started with tendonitis, I could not do a lot because my joints would lock up and hurt. Now . . . my hands . . . when I wake up in the morning, I can’t use my hands a lot because they feel like clubs, and it hurts to bend them, my fingers. This one was trying to lock up the other day so I started my methotrexate this week. It has been about five days now but it will go down with the methotrexate. It aches and mine is a weakness associated with it also. You can’t do a lot with your hands because they hurt. I pay for a clinical day of twelve hours on the floor. I do clinical once a week. I had to stop taking it when I had my wisdom teeth taken out because it is an immunosuppressant. He [physician] gave me a new medication, and I can’t even think of the name of it. It was for nausea. Hopefully, it will keep my hair from coming out. It thinned. It’s really thin. It makes me feel old when you can’t do things you feel like an idiot and old woman. It was more of a self-esteem issue too. (Participant A, Interview II, ADN instructor)

Participant B described her vulnerability manifested in tears, shame, and inferiority by telling about an encounter she had during a time when her hands were cracking and bleeding from the psoriasis.

When I say things, I’m very calm with it. If I’m upset or anything, I don’t let them see the emotion behind it. So particularly on one visit to the physician, I had some psychological issues to discuss because it was beginning to affect me when I would hand money to
someone when I’m shopping. I have had them [store clerk] draw back when they see my hands and it had upset me. That had happened the day before. So when I went for my scheduled appointment I tried to tell her about it. It started out very well but then I lost my little composure in my front and I started crying. That was the first time I let her see my emotion. (Participant B, Interview I, ADN instructor)

She further spoke about her vulnerability and inferiority manifested in hiding her condition when dealing with students in the clinical setting. When asked if she shared her physical pain and difficulties with the students she said,

The doctor had said not to wash my hands as much and to try to keep some type of gloves on to see if they would not sting so badly. So, um . . . telling a nurse not to wash her hands is like, oh sure! (Laughter). I think because I had my gloves on the students were seeing me wash my hands and the students were doing most of the touching at that point. I had a higher level group of students and so they knew how to do more things. I would try intentionally, not to have them where they could see my hands so well because I did fear that they were not going to want me touching them because I had blood under my gloves. I would keep my hands back and try to keep them out of the field of vision. If I had to do anything, I tried to hold them back away. (Participant B, Interview II, ADN instructor)

Participant B went on to say she would start having what she termed “pity parties” or feelings of hopelessness when she would sit at home and not do things with her family. This would depress her because she did not want to be left out of the activity. The negative feelings include fear, anger, frustration, self-consciousness, and depression. Anxiety and anger can be part of the emotional response to chronic pain and especially during very painful days of the illness or disease. It is often a normal response to the limitations imposed by the disease or illness. She stated that “good health equals joy in life.”

I have learned this about myself . . . that I have to be more guarded about my feelings because I tend to get more sensitive. Because I am hurting, I take things more personally than they are meant to be. I’m tending to overreact to a situation that I may not have even paid attention to before. It’s not coming from outside, it’s coming from within me. That’s different because I’ve always trusted my feelings really well, and now I’m having to examine them. I think one of the things I have realized more this past week . . . and it may be because of thinking about it and answering questions, is that I don’t want to be a burden. I don’t want to be the person that somebody says something about thinking I am lazy because I am not doing anything. Maybe I should try to get up and go do it. It’s challenging me to examine my feelings. My daughter is getting married and came home
this weekend. At showers, I’m worried about, are people thinking that I am just lazy or not a good hostess? Do I need to tell them that I have a problem? Or do I need to just be quiet and smile and let this pass? This weekend we had a lot of people that didn’t know me. I wondered, do they think that this is a grandmother who just comes and thinks she’s privileged to not do anything? (Participant B, Interview III, ADN instructor)

Participant C was not expecting her disbelief behavior and feelings of hopelessness when she was caught off guard at a follow-up physician’s phone call. The physician asked her to come back next week and he would do some more invasive testing. Because she is a nurse, and knows the order of things, she thought about the kinds of tests that are usually completed prior to biopsies. This lived experience gives way to the notion that people in the medical profession have a fair understanding but, not an in-depth understanding of chronic pain. This insight leads to searching for the right provider until a satisfactory one is found. She said,

I wanted to sit down and look at the lab work from last week. I wanted to sit down and look at a biopsy report. I wanted to be able to read this on my own. And, um . . . and then, of course, you know I managed to get off the telephone with him and then just kind of sat there stunned. You know, sort of thinking, well, . . . what just happened? You know, basically at that point, life stopped. I started making telephone calls to everybody I knew that could give me some information on this. Could it be cancer? That’s the only reason I could think of why the doctor himself would call me at home to tell me this. (Participant C, Interview III, BSN instructor)

Participant C revealed an emerging therapeutic occurrence, also found in the interview with participant B and not expected by the researcher. Both participants voiced that these interviews were proving to be cathartic and helpful in allowing unvented reflection to appear. There is a tendency to see life in a different light, to take one day at a time, and to learn from the personal experience. There is almost a sense of “I have a knowledge that not everyone has unless they have been down this road or participated in the journey. She stated,

You are expected to deal with it. There’s this thing, I really think as a woman you’re expected to sort of just suck it up and take it because you don’t want to inconvenience everybody else. And kind of, if at all possible, down play it. I have found myself at least twenty times the last couple of weeks doing it with my family. You don’t want anybody to know what it was really like. You don’t want anybody to know. I have to say these
interviews have been very helpful because I don’t know that there is anybody that I’ve been able to let them really know just how scared I was this week when I saw the GYN physician and the pain hit. Because I was so scared and quite honestly, I’m so ashamed as a Christian that I was that afraid. I kept thinking to myself, this is not the way you’re supposed to be as a Christian, to be so scared. But I was so afraid. I remember putting my make-up on to go to the doctor and my hand shook so bad I thought I was going to have my eyebrows drawn on upon my scalp! It’s almost like you had too much knowledge as a nurse. Every crazy thing you’ve ever seen or heard about happening in a hospital was going through your mind. I am not going to say this to my parents. I don’t want to make a spectacle in front of my students. So what do I do? I get in an elevator and ride all the way down and trot all the way across campus to the nursing building. I was determined I was going to get there before I passed out. It’s so embarrassing when your boss has to help you across the hallway to the nursing care clinic. It makes you feel vulnerable. I’m not one of these. I don’t like feeling vulnerable. That’s one of my things. (Participant C, Interview II, BSN instructor)

Subtheme: Stoic. The subtheme stoic emerged meaning “a person who can endure pain or hardship without showing their feelings or complaining” (Oxford English Dictionary, 2013). For example, Participant A said, “And I guess it depends on your personality. I don’t want to be told I can’t do that, because I can do it.” There is a resilience that seems to be cultivated from the chronic pain experience. Although participants recognized their physical limits, they did not exaggerate them and instead showed zealous perseverance in using their remaining abilities.

Participant B said,

So, I’ve gotten very good at blocking . . . the back pain. And I would find that I would hurt in my jaws because I would clinch. . . . Maybe this is something that I’m expected to have to just tolerate. You know, maybe other people deal with this and don’t have to have pain medication. So maybe I’m just being a wuss, and I need to just toughen up.

Participant C said,

Um . . . I tend to be sort of on the stoic side. Probably a lot of it . . . now I saw my grandmother had a lot of problems with chronic pain, in particular. Like I said, um, probably osteoarthritis related and she had a lot of surgeries. So I’m sure she had a lot of scar tissue and adhesions. But I always saw my mother being very stoic. She was never once a big one to complain you know? I think I tended to have that same kind of attitude because my thing is I’m the one who’s saying “I am going to be alright.” I mean, usually, your primary care providers are not terribly concerned about something like back pain unless you just really act like you are dying with it. Their thing is going to, well, I can
refer you to this specialist. We can do an x-ray or something like that. So unless you know, essentially, you are just doubled over in pain, you are almost better off if you just don’t say anything.

Participant C also said,

Because that’s one of my biggest fears, what if I’m somewhere and I cannot get out and get any help. Cause it’s so stupid, but you don’t want to make a spectacle of yourself by, like, fainting in front of a crowd or something like that . . . I very seldom talk to my students about my personal pain.

**Physician/Provider Trust**

Physician/provider trust contributed significantly to the data from the interviews and is talked about 52 times in the transcripts. The majority of the contributing statements have to do with failure to listen or hear the individual’s needs, along with poor chronic pain assessment. Participant A told about her visits to the chiropractor, whom she felt attended to her muscle pain best compared to her physician. She has seen several physicians in an attempt to get pain relief. During Hurricane Katrina, a physician visited the town where Participant A lives to help with the storm victims who were living in shelters. Participant A volunteered and observed a particular physician assessing storm victims. She said,

Physicians, half the time, they don’t listen to you. They don’t believe . . . and that’s when I chose a doctor here who is really nice. If there is ever a problem, they just push you off. So I chose Dr. ___ because I knew she would listen. She listens to what you say. I know as my experience as a nurse that you can tell them stuff and they don’t listen. Chiropractors are better at listening and they will treat you. There are a lot of things they can do that are non-drug, a lot of massage or the heat. They have this new thing called spinal stretching. I had to chase a physician down. I did home health and they sent a guy home with no pain medicine after he had surgery. It’s the way hospitals run now. You have the internist and you have the guy outside. I chased one doctor. Called and he did not answer. He was a primary but the other physician didn’t order it. He would not answer my pages. I finally called the operator and asked where he was. He was doing rounds. I found him and asked him what was going on. He said he did not have my number. Well, that is not an excuse. He told me he would not write the prescription for anybody but for me he wrote the script for the patient . . . and then I took it to the pharmacy. So, you know my experiences with physicians, they don’t listen well. (Participant A, Interview I, ADN instructor)
Dissatisfaction with medical care included short visits, restricted medical model of care, and limited choices. Participants verbalized disappointment over the lack of progress or new knowledge about etiology and treatment. The participants changed providers frequently in order to gain satisfaction. There appeared to be a lack on the provider side of getting involved with the disease process. Participant B told about a situation she encountered with her family physician, who did not seem to be listening to her in the same way he was listening to her husband.

My husband had some sort of lesion on his chin, and it looked like a spider bite. He went to the same general practitioner and told him it “hurt like hell.” The first thing he did was to start writing a prescription for pain and he never asked for any. A day later, I go to that same physician and am hardly able to walk into the office. I have a bite also on my abdomen that looks just like the one he has on his chin. We believe the spider got into the bed and bit both of us. I hurt so badly. My pants or anything touching against it, my underclothes hurt the spot. Not once! Not once did he give me anything for pain! I thought, is this a man/woman thing? They have treated me for a long time and never had me asking for pain medication. I did not ask for anything. So maybe I’m just being a wuss and I need to just toughen up. I haven’t been back to that physician. I’m thinking of changing physicians. (Participant B Interview I, ADN instructor)

Participant B went on to talk about how difficult it was for her to get a definitive diagnosis. She could not get in to see a specialty dermatologist for 3 months. She called another physician group and scheduled an appointment. She kept as many as three appointments for assurance of a physician who would listen and get to the bottom of her problem. She was wrongly diagnosed three times before the final physician in a larger town gave her a definitive answer to her problem. There was a sense of relief that “there is this creature and that’s what I’ve been dealing with all of these times.”

Participant C spoke about having a lot of anger and lack of trust over the way her gynecologist treated her after presenting to his office with the primary problem of chronic pain. This conversation took place initially and was followed by an appointment to a different
physician with whom she developed a greater trust. She later found that she did indeed have the
diagnosis of ovarian cancer.

There was no offer of any kind of pain medication while a biopsy was being done. In
fact, the comment was made “that’s what I like about you nurses, you’re tough.” I felt
like once he found out I was a nurse, any kind of flow of information stopped. I had to be
the one to bring up the subject of the possibility of cancer with him. To the point that I
had to say, well, you know that when thus and such occurs your first thought is, you
know, do I have cancer? He immediately brushed it off and said, Oh well, I’m not really
thinking about that. But then we go directly into taking a biopsy! He really, really
brushed over and discounted the whole idea. Then, I get this call and he is reading the
biopsy results to me over the phone. Yet, he cannot give me any kind of details as to what
size. Is this in fact cancerous? Pre-cancerous? Anything? No. Huh-uh, just kind of
reading the results off to you. He just wanted me to come back for some more invasive
things. Well, as I was listening to him reading this off, my thought was, I know exactly
how all of my patients I’ve dealt with as a nurse have ever felt now because I literally
could feel myself start to get hot and sweat to start rolling down inside my clothes. My
first thought was . . . I really don’t even know what he’s saying, then it registers and you
think, Oh dear God, is this man telling me I have cancer? Everything in the world is
going through your mind from I should have gone sooner. I should have paid more
attention to what was going on. How stupid of me not to realize that this pain was
significant. I don’t have time to have surgery. Who is going to tend to my family while I
am off? Everything in the world goes through your head. (Participant C, Interview II,
BSN instructor)

Later she reflected on her physician visit, her pain assessment and her feelings of being
almost invisible,

Combined with this last phone call, I am going to change GYN’s because the more I got
to thinking after I got home, you know, he did not offer me so much as a Tylenol! He did
not explain to me he was doing a biopsy. I had to figure that out when I heard him tell the
nurse to get him an EBS kit. I’m thinking EBS kit, Oh! Holy Moly! He’s doing a biopsy
right now! About that time you know, you feel it. I thought well, so much for that big
explanation! And when he said oh, you nurses are so brave I thought . . . so you’ve had
one of these done? I didn’t appreciate that at all. (Participant C Interview II, BSN
instructor)

Participant C continued with more about poor assessment saying,

You know it is kind of like the fifth vital sign and whatever your patient says it is. This
really hit home with me. You know, trying to do all the classic things of trying to
describe it appropriately. What was so interesting is trying to do all the right things and
right ways you wish somebody would describe and he picked up on his one thing he
wanted to know . . . who referred me? I said, well the clinic at the college where I work
because there is where I presented with pain. So I’m going to describe my symptoms and he asks me what I do there. Oh well, I teach. And I thought, who cares? What difference does it make if I collect garbage there. So, that is how he found out I was a nurse. His main concern seemed after that that he might be giving too much information out to me. (Participant C, Interview II, BSN instructor)

Fear of Disability

All three participants universally experienced fear of disability at various times during the study interviews. Fear of disability is described as a desire to be “normal,” a need for independence, being betrayed by the body, being dependent, a loss of socialization, disappointing the family, and difficulties with the activities of daily living. Fear revolved around concerns related to adverse effects of medications, future outcome of the disease process over time, possible physical deformity and forced dependency, and inability to assume usual personal and professional responsibilities. A subtheme alien emerged as well, and is discussed in the following section.

Participant A described her first encounters with feeling disabled when she said,

Sometimes I couldn’t put my bra on. My husband had to help me. Then it would go away. After I had my last child . . . right before I had her, I got to where I had a knee, they said I pulled a tendon. They were not sure. I went ahead and got a cortisone injection because I was pretty far along. I couldn’t walk, couldn’t get off the commode, that kind of stuff. I couldn’t raise my arms . . . you heard it pop and then one day I couldn’t raise it. I thought, oh I pulled it but nothing that would lead you to it because it was on one side. And then it was my knees. I thought I pulled it going up and down the stairs in the auditorium. I didn’t know what I’d done. You know, it’s like you sit down on the commode, like I talk about in Fundamentals class. You don’t think about not being able to move and do simple things. I couldn’t get off the commode. You had to pull yourself up. I couldn’t squat; if I was on the floor wrapping presents, I’d have to roll to get up. Then I got the cortisone injection, I got a little bit better. (Participant A, Interview I ADN instructor)

She further explained,

And I had my baby. She was almost a year and I could not pick her up. It got further in that summer and she knew I couldn’t pick her up. She had to pull up because I get
tenosynovitis so easy. I had to put my hands under her shoulders and she’d turn on around and I’d pull her onto me . . . I can see patients one day a week and that’s all I need to see. And I am getting true feelings that I’m too old to get on the floor because with RA and my back, eight hours into it, I have to sit down a lot more. (Participant A, Interview I, ADN instructor)

The lived experience with chronic pain is like the extraordinary transformation of a caterpillar to a butterfly. There is no conscious decision to become a butterfly, but instead the metamorphosis occurs through the forces of nature. The participants seem to face the challenges of chronic pain on a daily basis and to develop resilience while coping with the grief of their negative feelings brought on by the diminishing physical abilities. In speaking about the future she said,

As far as the future or present, just the same thing, that I can continue to take the medicine. That I won’t be able to do anything, I mean that’s the fear. I won’t be able to move because it’s a different pain than acute pain. It just aches all the time. (Participant A, Interview I, ADN instructor)

Participant B talked about her fear of job loss when she said,

When I am coming up for something I know is going to be very important for me to be able to walk and use my hands, I start getting anxiety about, am I going to have a flare? If I’m clear enough I could do it now, is it going to make it till I can accomplish this? Or, am I going to have a flare and then I’m going to have to figure out how I can do this or what I can do about it. So it’s caused a lot of anxiety. Even when my hands will get to a point they feel, I’m thinking, oh please can you stay this way until I get this done? Or, you know as closer as it gets, I’m thinking, Oh no, is that going to pop open? So it causes me anxiety during clinical. I know that classroom and I’m okay and can manage in ways I have learned to manage. Parts of clinical I can manage. When my hands are really bad . . . I don’t know that I can do it. And . . . that’s scary, when you do this for your livelihood and because you love doing it. It’s not just something you do but you love to do it. (Participant B, Interview II, ADN instructor)

Difficulties in the activities of daily living are described as she talks about,

You know, sometimes I’ve caught myself just crying before I get up because I know how bad it’s going to hurt. Can I do my hair today? Can I put on my jewelry today? I can get a shower and that feels good, but can I blow dry my hair with a dryer and use a curling iron? Am I gonna be able to present myself the way I want to today? And then the next step is . . . okay, now it’s time to put your feet on the floor and that is very painful. My
feet hurt worse in the morning time. My pain level on most those days is about a seven out of ten. (Participant B, Interview II, ADN instructor)

There are accommodations to hide her condition related to her fear of disability. Adaptation to the accommodations needed become necessary. Developing new life skills such as alternative ways to succeed in a task, setting priorities, saying no, and using laughter to deal with difficulties become essential. There is also a need to deal with lost abilities and to reconcile.

So, when I was doing clinical, my hands started to crack and bleed inside the gloves. So I would have to put some kind of dressing that could withstand water so I could wash my hands and then I would put on gloves and keep gloves in my pocket. The way the rooms were arranged, I could step outside the curtain, wash my hands, try to get them to stop bleeding, and put a new set of gloves back on. I don’t want my students to miss out on something because of me. I want them to get that experience. (Participant B, Interview II, ADN instructor)

The desire to be normal and have independence in the simple things like dressing cause creativity on the part of the pain patient as explained when she said,

If a callus comes next, it’s going to split. And you know, to put my clothes on, I had to change the way I dress because I needed elastic. If I’m having a flare-up, I can’t zip or button. So I’m looking at pullovers or elastic or I’m actually putting off going to the bathroom if you have worn something that day you are going to have to deal with. It’s like, this is going to hurt but you’ve got to go to the bathroom. You can’t call somebody in the bathroom to zip your pants and button your buttons. (Participant B Interview II, ADN instructor)

Participant C spoke about how the pain prevents her activities of daily living and mobility:

I was thinking about it lately. It’s very frustrating when you realize changes you find you are making in your ADL’s to accommodate it. You find that after you have had one of these episodes you are trying to prevent yourself form going somewhere by yourself, in case you have an episode and you are stranded somewhere, and all of a sudden you can’t drive because you are just incapacitated. You find that you don’t go anywhere without your pain medicine. I mean, literally within arm’s reach. Just in case. And there is always that thing of like, what if, what if, just in case I’ve you know, I don’t want to be somewhere where there’s nobody to help me, there’s nobody, you know, that I can’t reach my pain medicine? And so that’s the most frustrating thing for me, is you find that
you are changing your activities of daily living to accommodate this. (Participant C Interview I, BSN instructor)

Participant C went on to explain her feelings of loss of control and concerns about disappointing others with any disability due to her illness. There is cognizance of the need for others. Despite the realization of the potential need for dependency, total dependency is resisted due to fear of disability and deformity that might lead to loss of stamina and fortitude or perhaps even their job.

It will be a real hardship on my job if I am to be out an extended period of time . . . um, you know, and there’s just a lot of things and people that depend on me. For various things; whether it’s your job or it’s your parents or your husband or . . . whatever it is. You know? And I’m . . . nobody is indispensable, like the house might rot down while I was out of commission. (Participant C, Interview II, BSN instructor)

She further explained,

I think one of the biggest issues with me and the whole chronic pain thing is, I don’t want it to ever be where it affects my job, where there’s some doubt with my boss of things like, well, I don’t know if she can do that . I don’t know if she can handle that. Maybe this is too much for her. Because, I try to pride myself on being that one kind of like, I mean, if they give me something I’ll take it I’m fine, I’m good with it, no problem, I can handle it. You don’t complain. You don’t act like this is too much and you don’t want to seem like you are overwhelmed whether you are or whether you aren’t. So that was a big thing. And I’ve actually thought about that, you know, a good bit that I don’t want it to be something like this where it affects my job. (Participant C, Interview III, BSN instructor)

Subtheme: “Alien.” Two of the three participants spoke about chronic pain and the feeling of a creature or alien living inside them. The other of the three participants did not describe her illness in the same way; however, she did refer to her hands as clubs, which is considered foreign to how one’s limbs should feel. Participant A commented, “Now my hands . . . . when I wake up in the morning, I can’t use my hands alot because they feel like clubs, and it hurts to bend them, my fingers” (Participant A, Interview II, ADN instructor)
Participant B stated, “I researched and found out that it was true. That there is this creature. And that’s what I have been dealing with all the times” (Participant B, Interview I, ADN instructor).

Participant C stated,

The helplessness, the feeling of, that initial feeling that your body has betrayed you, that thing, where that’s your first thought. It’s like it’s almost somebody else’s body. The thing of, what the heck is this that’s going on in here? And why is this so difficult to figure out. What kinds of things are you going to have to do to accommodate this? Because it’s almost like it’s this whole separate little compartment that lives inside of you and you are having to do all this stuff to kind of accommodate this thing that has taken up residence there. It’s sort of like having a little alien up in there. It’s sort of like you are having to rest more, change the way you eat, and there are all kinds of things. (Participant C, Interview III, BSN instructor)

At one point Participant C even gives the “alien” a name saying,

I actually named my fibroid, Phil the fibroid. There again, I guess that’s probably my way of coping with it. I’ve gotten used to Phil sitting over here, you know. And I’m kind of, Okay with it, you know? Now if Phil chooses to shrink up to a little peapod, we’re good with that. If he chooses to die, we’re not even going to give Phil a funeral. (Participant C, Interview III, BSN instructor)

Coping

The coping theme describes the many feelings of the nurse educators with chronic pain who are placed in a situation of incredible responsibility with performance expectations in the life and work settings. The theme coping describes the many thoughts and feelings taken on by the individual dealing with chronic pain and how they deal with the chronic pain. The theme encompasses self-realization of the disease/illness itself, the seeking of understanding of the disease/illness process, the facing of reality, adaptation, accommodation, and reflection about the lived experience.
Participant A describes the difference the medication methotrexate makes in her life when she says,

It has to get into your system so right now, it’s still where I was. When I move and I’m busy, I’m not really conscious of it. But in the morning when I’m getting ready, I am. Plus, it’s really numb. I don’t even know the word. It’s like they are clubs . . . my fingers are and they feel like you can’t manipulate your fingers. I have to go back on something. My doctor just told me it was a good vacation when I had to stop taking it for my wisdom teeth removal. (Participant A, Interview II, ADN instructor)

And she says, “I just want to stay the same way or better. But if I don’t, I’ll just accommodate for it however I have to . . . and continue to teach . . . the same things I’ve been doing with the pain and the ADL experiences (Participant A, Interview III, ADN instructor).

Participant B explained about coping, accommodation, and adaptation when she said,

When we go on family trips, I don’t want to be the one that causes the family not to get to do something or they feel bad because they had to leave me behind. So, many times, I will think, Okay, where are we going? Where could I sit and be a part of this but not have to walk as much? Because of the pain in my feet and my husband’s had to take on a different role. Which is strange because I see myself as the caregiver and the helper. The one that, you know, makes things work smoothly. And now he’s had to come around to thinking, Okay. I’m going to be out of town, what do I need to do for these days? Because he’s not coming back and he will see that I haven’t been able to do certain things or get things. One of the things that is funny is just drinks. To open the top of drinks. He will come back and I’ll still have all the drinks in the refrigerator and he knows how much I enjoy them. He is, “why did you not, you know they’re cold. I put them in there” and I’m . . . um, I couldn’t open them. That’s very frustrating. And you know to put my clothes on, I had to change the way I dressed because I needed elastic. Can’t zip or button. (Participant B, Interview II, ADN instructor)

She further explained about additional ways she uses coping mechanisms when she stated,

And if I am going to an Alabama ballgame, I know it’s going to hurt. I know once I get to my seat that I will feel some better, but I’m going to hurt. It’s something I can tolerate to be with my family because we are big tailgaters. You know, things like that. I have found ways to use Lidocaine. Putting it on my feet, I found it helped with my shoes. I have found that I can say, “I’d like to sit here a while. Ya’ll go on down and you know, I’ll catch up with you later. I have just found ways to not feel left out or not try to focus the attention on, “Oh, mother’s coming. I don’t want that to be, Mother’s coming down, now we can’t do certain things” . . . because I want them around and to not dread it. (Participant B, Interview II, ADN instructor)
Participant C discussed her faith as a basis for self-reflection and understanding saying,

I just, you know, literally talking about pray without ceasing, I did. Because I just thought-it was just panic at first, and I thought “this is terrible.” What kind of way is this for a Christian to act, you know? And of course, I’m praying that the Lord would actually heal everything completely. The thing is that he’ll give me direction to the right way to go with the treatment when they suggest things. (Participant C, Interview III, BSN instructor)

Participant C reflected that pain is not always a negative thing. The description is one of personal inner strength in adapting to changes and reconciling losses. The self becomes changed or transformed by the lived experience of chronic pain despite any negative physical changes that might occur.

It could very well be in my case that this got me to a doctor before anything more significant could happen, maybe before cancer started or something like that. So, in the case with something like that, pain can be a really good thing if it’s like a warning signal to you. In my case, I truly believe it is making me trust God more. It’s putting me in a position I have to trust Him. There’s nothing else I can do. And another good thing about that, if there’s nothing I can do, there’s nothing I have to do. So in a lot of ways, it is a freeing thing. It’s okay for at least a little while to fall apart. Now, you know, there’s a point where you have to get it all together or they’ll institutionalize you, you know? (Participant C, Interview III, BSN instructor)

Need For Pedagogical Discourse

Each of the three participants indicated that pedagogical discourse exists in nursing education as identified by meanings of lack of adequate teaching hours, poorly written textbooks, poor chronic pain assessments of patients, and the need for more psychosocial content in nursing curricula. Many of the examples given by the participants related to their personal dealings with chronic pain and their insight into what is missing in the curricula.

Participant A spoke about time to teach about pain when she said,

There’s not adequate time to teach about pain. In the fall, I talk a little bit about it and in the spring when I teach medical surgical class and G.I. symptoms. Over the course of
three semesters, I guess I teach about 2 weeks total. I want to say six hours altogether if you are talking about three semesters. It’s connected to everything else because everything has pain as a part of it. We are crammed full anyway. I just pull in a lot of pain scales and a lot of different ways that the student can identify pain. But pretty much, we use what we have in the textbook or the assessment sheet. I think because of what happened to me, I try to tie it into a lot more when we do talk about activities of daily living because I teach Fundamentals. We go . . . about the pain and how it affects everything. How you know, they don’t realize when you go to the restroom and you can’t get up. Do you hurt, you know, how does it affect you? What can you do with your ADL’s I don’t think, before I ever did that because it was just a segment in a book that you had to teach. So, I try to expound upon everything that kind of associates with me. Of course, like the GI stuff I teach, we talk about the pain and everything and what causes this. But I try to put it with what’s happened to me. So . . . they don’t understand it. They don’t think about it. I think home health probably did that too. Because I would be in the houses and I would see when they were home . . . things they would have to do for pain with ADL’s or how they walk. Does that make sense? (Participant A, Interview II, ADN instructor)

In the third interview, when asked what sense chronic pain makes to her, she said,

I hope to be doing what I am doing right now and not debilitated. That was my biggest problem I guess, worrying about the future because of what I have leading to debilitation if you don’t take the right medicine. So, I just want to stay the same way or better. But, if I don’t, I’ll just accommodate for it however I have to and continue to teach the same things I’ve been doing with the pain and how it affects patients with ADL’s and their experiences. I didn’t spend a lot of time on chronic pain, even though I had the community health background and I’ve done tons of home care. Just because I have experienced it, I know how to teach them now, the patients and the students. Now I know what they are going through, as opposed to when I didn’t beforehand. (Participant A, Interview III, ADN instructor)

When asked if there is anything she does different now in how she previously taught about pain she said,

Just that I make them do a good pain assessment . . . go in-depth with it, where before, you just kind of passed it off. The joke was that this county’s worse with more people on drugs because of the doctors. Initially I thought that there were going to be more people wanting drugs, more people wanting pain medicine and you have to do the assessment. I don’t think one gave credence to pain a lot unless it was surgical pain or cancer pain. That was the way I learned in school and it is just the whole mindset of people you work with here. I mean they didn’t teach you to think that people were drug seekers. It’s just pain was not a big thing you learned about. You did your assessment and you did ask about the pain, you learned your pain scale and I remember that picture (pain scale). You learned all that stuff, but they didn’t do an in-depth assessment back then. You learned about surgical pain, cancer and childbirth pain. But, it wasn’t what it is now where you
do a better pain assessment. You still see nurses not assess it as well as they know they should and know what questions to ask. That’s what I try to teach to students. In class and clinical . . . more in clinical I guess because we have patients right there. We talk about it in class because I have to grade their assessments. We put them on the computer and I make them go back and ask if they did not ask. I am trying to make them understand that the patient is a holistic entity, not just “that patient in that room.” When the student is done assessing, I assess the patients and see what they were weak in and see that nothing is left out. When you teach patients to take medicine, you have to teach them that it is important to control chronic pain. All the aspects of pain . . . that I didn’t do before because it didn’t happen to me. So I think, after the fact, just knowing you couldn’t go to the bathroom, you know . . . get off the commode . . . really sticks in my mind. You know, cause I did home health for so long and I did a housing assessment when you are in the house. I don’t think I realized how important it is than what I gave credence to . . . taking it for granted. We used to talk about fibromyalgia or RA. I was like, God, I don’t want fibromyalgia because you can’t treat it. Really, you know, we used to kind of make fun of it as to whether it was a true illness or not? I was like, Okay, I’m getting paid back for all those people I didn’t believe, I guess when they were really hurting and you couldn’t find anything wrong with them. So it makes you think, pain is the holistic part for the patient, you know. Pain controls everything . . . you can’t learn if you are in pain. I hope that I teach the students how to do a better pain assessment and to realize that part of their role is to do that and not treat it like it’s not their role.

(Participant A, Interview III, ADN instructor)

When I asked Participant B how she teaches about pain and how often, she replied,

I teach pain in Fundamentals in the fall and spring. In the summers, we don’t really have a pain module but if we are covering arthritis or any of those issues, then I bring the pain element into it and about how they have to cope with the pain and what medications. As far as that, I bring that in but fall and spring have the larger pain modules that we do. I spend a total of about 45 minutes on pain in general. When we do clinical, of course, with care plans, then we address the client’s needs and often times it will be pain or discomfort when they start trying to do their care plans. I do find myself staying longer on chronic pain to try to get an understanding for the students to develop that understanding of their clients and even their family that they may be experiencing. I think it is more getting them to get the concept in their mind that chronic pain is real. It’s not everyone out there drug-seeking and trying to get attention or loving the sick role. (Participant B, Interview II, ADN instructor)

Participant B also spoke about barriers that exist to teaching,

I think that there are barriers because, I’ve seen students go into clinical and hear other nurses at report talking about how much medication or pain medication that patient has taken. I know myself, that when I had my first baby, I would not ask for any pain medication in the postpartum area because I knew how they talked about someone that took medication. “She had every dose she can have and she’ll ask you for it before it’s due.” So, yeah, I think that’s been an issue. You know, the students get that when they go
to report. They get a prejudice or a bias opinion about someone they’ve never seen because we nurses talk about it in report. (Participant B, Interview II, ADN instructor)

With the elderly and need for general compassion she commented,

If they are in the hospital setting, I see more. With the elderly, when we take them into the nursing home, I don’t see them looking at the clients and going, “Oh they’re not having pain.” But in the hospitals, they will say you know, “They’ve already had their pain medicine” and then let it go. To me that is totally inappropriate. You know they are saying their pain scale is this and you’ve looked for the signs I have told you because we have learned that pain is subjective and what the patient says it is. Once they have looked and they have already had their pain medication, they dismiss it and think, you know well, they can’t be hurting that bad! I think what’s missing is realizing that there is more than just medications we can do to help pain. I think we want a quick fix and that the way nursing are learning to think. They have pain so let’s put a pill in their mouth and then we are through. I think compassion and caring is missing and that is hard to teach someone. What is also missing in my view is that people are going into nursing for a job and financial security and don’t really have the characteristics that we see in people who come because they want to help. I try to bring it home and make it personal with them. If we are talking about arthritis, because that’s one of the ones we talk about a lot, I’ll ask about sharing with their families, if they’ve had someone with chronic pain issues or arthritis or anything that comes in. What did they see? What did they do? How did they make them feel? I always say, you know, if this were your family member, if this were your mother, or if this were your child experiencing it what would you want done for them. You know would you want someone there that was caring and considerate, checking on them and letting them know somebody is there? (Participant B, Interview III, ADN instructor)

Participant B talked about poorly written textbooks and the need for more psychosocial content in textbooks. There are deficits in the understanding of chronic pain as a disease/illness. Understanding the nature of chronic pain and how chronic pain manifests itself in individuals will give insight into better nursing care.

I take more time talking about how to deal with chronic pain and how to understand what the person is going through, rather than just talk about chronic pain and what we can do. You know the textbook issues with it. I go more into the psychosocial rather than just the physiological and treatment modalities. I tend to stay more in the psychological. I teach those, but spend more time in the psychological and psychosocial. You really don’t find that in the textbook a whole lot. Maybe it’s a couple of sentences so I add more to it. (Participant B, Interview III, ADN instructor)
Participant C spoke about the amount of time she spends teaching and the psychosocial issues that need to be taught about pain. There is insufficient time to cover chronic pain in-depth with only about an hour devoted to chronic pain in lecture/classroom activities.

I teach about pain as part of health assessment. You know, what does it mean? What does it mean to your patient? Essentially, it’s whatever your patient says it is. It is integrated into the curriculum and not a separate topic. I spend maybe about an hour on pain. The one thing I have picked up here lately is all the mental health issues that go along with that. You know? How . . . like I said, just how frustrating, how exhausting it is and the fear of what if it comes back? What am I going to do if it hits during graduation or somewhere that I literally cannot jump up and run out? (Participant C Interview II, BSN instructor)

Participant C was asked if her chronic pain has changed her as a teacher and she replied,

Oh, absolutely because I want to bring in something about pain and I think you would call it the pain experience because it is not just a, can you rate it on a 1 to 10-scale kind of thing which they had me do. It is an overall complete experience of like, how does your life change with this? Not only is it truly, you know what the patient tells you it is….but you need to ask more so you need to focus on things other than just well, is it sharp? Is it stabbing? It is more than the rate it from 1 to 10 kind of thing. You need to ask questions about how is your life changing as a result of this pain. What kind of things are you having to stop doing or start doing? What are you having to do to accommodate this? It is almost like it is a whole separate little compartment that lives inside of you and you are having to do all this stuff to accommodate this thing that has suddenly taken up residence there. You are having to change, rest more, change what you eat and all kinds of things. (Participant C, Interview III, BSN instructor)

Summary

In this chapter, the researcher introduced the sample findings from the thematic breakdown of the data obtained while exploring the nurse educators’ lived experience with chronic pain. The research questions and designated nodes or themes were aligned and used as a guide to make sense and describe the findings represented by the study participants. The researcher shared experiences from the participants’ perspective to include emotional responses and findings of impact related to the lived experience of chronic pain in nurse educators.
Through the process of intuiting, the data were pushed to go beyond the words of the participants to a level of abstraction (van Manen, 1990). This level of abstraction, presented in the form of essences, is necessary to make the data meaningful to nursing and other disciplines. Each theme was reviewed for understanding of the impact of the shared experiences. The emergent themes of vulnerability, physician/provider trust, fear of disability, coping and need for pedagogical discourse, as well as, the two subthemes, stoic and alien, were examined in relationship to the research questions.

The stories of the nurse educators who have personally experienced chronic pain interviewed for this study demonstrate an inconsistency in the number of hours chronic pain is taught in the curricula as well as the need for better textbook materials dealing with chronic pain assessment and psychosocial issues dealing with chronic pain. The nurse educators in this study were relatively new to personally experiencing chronic pain. None of the nurse educators had more than 2 or 3 years of the lived experience with chronic pain. Through the findings, the researcher was able to better understand the meaning behind the lived experiences of nurse educators with chronic pain and how these lived experiences impact the way chronic pain is taught. Chapter 5 discusses theoretical, practice, research, and educational implications resulting from this research.
CHAPTER V
DISCUSSION, LIMITATIONS, AND RECOMMENDATIONS

The literature reviewed indicates a knowledge deficit in understanding chronic pain by healthcare providers and in nursing education. According to the research participants, a lack of understanding about chronic pain continues to be a concern in both patient care and in nursing education. These areas of concern have led the researcher to understand the significance of this research to further the literature and the implications for nursing education and healthcare practice.

At first, the researcher reviewed the literature and compared the data from the study with the data from the literature review. The researcher continued the exploration by looking at the data from an interpretive phenomenological standpoint, attempting to view what was there, what was not there, and to determine what insight could be gained from the phenomenological perspective. Finally, the researcher began the tedious process of interpretation of findings using the research questions, emergent themes, and essences gleaned from the participants to understand. The interpretation and analysis of the findings were also understood from the researcher’s personal history and experience as a nurse educator impacted by the knowledge of chronic pain. The researcher attempted to look for the story under the story to determine meaning behind the experience from the participants. The thematic representations of the participants and the research questions were used to guide and interpret data. This understanding is important because, as previously stated in the literature, we have much to learn from expert patients who have developed habitual skilled bodies in response to chronic illness and the patient’s learning
about his or her own illness becomes a source of clinical discovery and inquiry in its own right (Benner & Wrubel, 1989, p. 74).

The purpose of this study was to interpret as closely as possible and explore the meanings of lived experiences of nurse educators who have personally experienced chronic pain, in an attempt to better understand how these educators articulate and shape how they teach about chronic pain. This chapter discusses theoretical implications relevant to the results of the study; conclusions based on the findings; limitations of the study; and recommendations for practice, education, and research. Lived experience research from a phenomenological point of view, is to question the way the world is experienced and to want to know the world in which we live as human beings (van Manen, 1990). Van Manen indicated that, “there is one word that most aptly characterizes phenomenology itself . . . thoughtfulness . . . in the words, or perhaps better, in spite of words, we find “memories” that paradoxically we never thought or felt before” (pp. 12-13).

From the analysis of the study participants’ responses there emerged five major themes: vulnerability (mentioned 67 times), coping (mentioned 64 times), physician/provider trust (mentioned 52 times), fear of disability (mentioned 47 times), and need for pedagogical discourse (mentioned 34 times). Two subthemes also emerged: stoic (mentioned 17 times) and “alien” (mentioned in some form by each participant). The analysis process involved an immersion in the data consisting of multiple readings of the transcript interviews, the selection of significant statements the participants voiced in describing their lived experience, and color coded grouping of nodes, statements, and essences to define meanings and themes. Nvivo™ software was utilized to assist in the node groupings. Defined themes and meanings were adjusted continuously until the final meanings and themes emerged that were descriptive of the
participants’ lived experience with chronic pain. The researcher explored the lived experiences of each participant from a phenomenological viewpoint in an attempt to identify the meaning behind the experiences and interpret for understanding. It is important to recognize that meaning for an individual is how we individualize nursing care. Meaning should be at the core of our nursing care and is what we do and plan with others. Understanding that individuals are unique organisms in interaction with their environment, makes understanding the life world important to nursing care (Munhall, 2007).

Discussion

The following section reviews the research questions. It is important to note that the perspectives of the participants of this research are their truth as interpreted by the researcher along with the analysis and interpretation of the findings. The key elements of the major themes of this study are aligned with the research questions. The analysis is the lived experience as perceived by the researcher looking in with knowledge and experience with chronic pain, while attempting to understand the meaning behind the experience from the participants. The thematic representations of the participants, along with the research questions, guided the interpretation of the data. Van Manen indicated that, “When a person shares with us a certain experience, then there will always be something there for us to gather” (van Manen, 1990, p. 92).

In phenomenology, “The human being is seen and studied as a ‘person’ in the full sense of that word, a person who is a flesh and blood sense maker” (van Manen, 1990, p. 14). For the researcher, using van Manen’s approach to phenomenology does not stand before practice in order to inform it, but rather theory enlightens practice. He says, “Practice or life always comes first, and theory comes later with reflection” (van Manen, 1990, p. 15).
The interview process used in this study involved three separate interviews lasting approximately one hour, and separated by at least a week or more. The importance of the interview technique used by the researcher cannot be underestimated. Every attempt was made to honor the participant in the ways listed above during the interview process, in order to have rich and quality data. According to Benner,

Interviews are a familiar form of exchange in contemporary life. Several factors contribute to the success of the disclosive interview process. These include the attitude, or philosophical positioning of the interviewer, the interpersonal comfort of the researcher, maintaining a stance of curiosity and openness to unanticipated answers from the participant, and listening with a sensibility for the need to probe further in a specific direction. The researcher must have an appreciation that the interviews comprise access to disclosive spaces, as opposed to opportunities to interrogate participants, lending the researcher to a position of better understanding. (Chan et al., 2010, p. 18)

Broad Research Question

In what ways does the “lived experience” with chronic pain shape how a nurse educator understands and engages with pain assessment?

Participants linked their personal descriptions of the phenomenon of living with chronic pain in their conversations and synthesized with one another in the explanatory accounts of their lived reality. The participants gave definitions of chronic pain using descriptive words of the phenomenon representing their understanding of chronic pain. The descriptive definitions included the phrases “pain that does not go away,” “pain that stops your activities of daily living,” “unresolved pain that keeps coming back,” “pain lasting longer than six months,” “pain that stops you in your tracks daily,” and “pain you can’t truly describe to anyone.” The participants’ definitions line up with the chronic pain definition of the IASP (2006), which defines chronic pain as characterized by continuous pain that persists for at least three months and is unresponsive to available medical treatments. They are also in keeping with the famous
definition by McCaffery (1968) as “whatever the experiencing person says it is, existing whenever he says it does” (McCaffery & Pasero, 1999, p. 17). The theoretical understanding of these participants and how this understanding shapes their engagement of teaching about chronic pain is further discussed with each theme identified from the study.

Vulnerability

Each participant described significant vulnerable experiences encountered by healthcare professionals, some outsiders, and family members related to vulnerability such as feeling desperate, feeling embarrassed, feeling ashamed, crying, feelings of inferiority, hopelessness, loss of joy, and disbelief in their own illness. The subjective experience of being weakened mentally and emotionally regarding one’s own level of individual and psychological wellbeing can lead to a kind of vulnerability or demoralization. In an article introducing an evolving theory on women’s “sense of control” by Skuladottir and Halldorsdottir (2008), women who are demoralized because of their pain and disempowering encounters with health professionals and others can manage to regain a sense of control and be remoralized. Yeung, Arewasikporn, and Zautra (2012) presented a two-factor model to classify vulnerability and resilience which differentiate stable and modifiable indicators that influence adaptation to chronic pain. The framework underscores the importance of incorporating social resilience into the development of interventions that aim to promote adaptive and prevent maladaptive functioning in chronic pain patients. The ability to attune to others’ emotions, to build social bonds, to improve communication, and to have mutual understanding and trust may promote resilient functioning.

Several common features such as vulnerability, coping, and fear of disability were found in other phenomenological studies of the lived experience. In a study by (Yeung et al., 2012),
two factors, vulnerability and resilience, were shown to influence adaptation to chronic pain. The ability to expand resilient capacities, such as staying attuned to others’ emotions, building of social bonds, and improving communication and trust appeared to encourage or promote resilient functioning. In a study by Kindermans, Roelofs, Goossens, and Huijnen (2011), findings suggest the existence of several activity patterns related to disability and depressive symptomatology in patients with chronic pain. Activity patterns such as avoidance behavior and persistence behavior play an important role in disability outcomes. Patients who exhibit resilient behaviors tend to have better pain adaptation.

Through the words and phrases of the participants, it is evident that their understanding and sense of vulnerability is present as it relates to the chronic pain experience. Participants spoke about the fear of what they know as nurses concerning chronic pain and disease processes. Each one of the participants spoke about the adjustments that are required when dealing with the chronic condition of pain. Despite a lack of validation at times by others, resilience and the willingness to be open to vulnerability is clearly evident as they cultivate wisdom, fortitude, and insight into living with chronic pain. These rich descriptions capture the ambiguity and complexity of the chronic pain as discussed in the early literature (Raheim & Harland, 2006). These meanings give guidance for curricula that otherwise would be left unexplored. The investigation of pain experience lends to knowledge about the world of others with similar experiences.

Each of the participants in this study identified ways they incorporate social resilience to avoid some of the vulnerability they feel. Some of these ways included having a stoic attitude and handling things with prayer, trying to figure out ways to manage the pain such as, topical medication, the importance in staying positive, adapting to travel by making excuses such as “I’ll
sit here with the baby,” and adapting to the activities of daily living such as wearing elastic pants because of the inability to zip or button. The information identified in this study mirrors that by Lindseth and Norberg (2004) who said it is the interpretation integrated into the world which allows knowledge gained to be productive in human life and used to improve care.

**Subtheme: Stoic.** The individuals in this study worried about the vulnerability of everyday life. Lundman and Jansson, (2007) confirmed this in a study about the meaning of living with a long-term disease. The study showed that the main cause of worry in long-term disease was not the disease, but rather its consequences in everyday life. Study findings found that participants talked little about the disease while their narratives were permeated with expressions of worry about daily life, the people close to them, and the future. The hopelessness came from feelings of uncertainty about the future. The study showed a great need for fellowship and belonging to alleviate feelings of hopelessness and isolation. The results revealed a high priority given to values such as working, taking care of oneself, and independence. This is in keeping with the subtheme *stoic.* Each of the participants voiced the importance of doing what they love to do, which is to teach and give their best to the students they instruct. Like many individuals, having this stoic attitude helps with personal security that the chronic pain threatens.

Each of the study participants spoke about the importance of moving on with their chronic pain. This included the need to look for alternative ways to function, learning to deal with it, and not being a quitter. Challenges in pain assessment need to be acknowledged by healthcare professionals, as well as the need for empowerment in order to promote self-protection of the individual. There needs to be a true dialogue where individuals can tell their story in order for meaning to be found. Until these stories are heard, clinics will remain tense.
places and individuals will remain unheard. Pain is a subjective experience in which healthcare professionals must refrain from basing their assessment, management, and interventions on personal beliefs and judgments. Sensitivity and empathy are critical components of understanding and learning about chronic pain (Al-Shaer et al., 2010).

There is a tradition within nursing that sees stoicism as a virtue. Nurses are ready to put up with any hardship in order to ensure the wellbeing of patients (Scott, 2001). The nurse educators in this study spoke about the need to “learn to deal with it” or “suck it up (pain) and go on,” “I have gotten good at hiding it,” and “I have accepted the need to accommodate the pain.” Personality features such as optimism are potential resilience resources. Optimism has been associated with lower ratings of pain. This underscores the importance of incorporating social resilience into the development of interventions to promote adaptive behaviors contributing to stoic type behaviors (Yeung et al., 2012).

**Physician/Provider Trust**

The accuracy of pain assessments has received considerable empirical attention. Across a wide range of conditions and settings, nurses often underestimate pain compared to patient self-report. Many reasons likely exist for these discrepancies, including provider bias and lack of insight into the decision-making processes. In a study by Hirsh, Jensen, and Robinson (2010), biases related to patient sex, race, and age appeared to be prominent in practitioner decision making about pain assessment and treatment. The providers in their study appeared to have minimal awareness of bias as indicated by the lack of correspondence between statistical and self-report data. Nurses can learn from these studies by becoming aware of the need for better insight into patient chronic pain assessment and management.
Despite the lack of validation by others, resilience is evident as individuals grow in wisdom, fortitude, and insight into living with chronic pain. The study participants indicated that healthcare providers do not always seem to have an in-depth understanding of chronic pain. The participants’ spoke of the need for the nurse to enter into the life-world of the patient through dialogue with an exploration of the lived experience. Empathetic listening to the chronic pain patient’s concerns, including spirituality, is essential in promoting encouragement and resilience. Initial literature findings also indicate that provider-patient interactions affect clinical assessment of pain. Jimenez et al. (2011) identified that there is a need for distinctive communication patterns in patient encounters such as disease models, word usage, and metaphors, to avoid complicating chronic pain assessment. Pediaditaki, Antigoni, and Dimitrios (2010) found that healthcare professionals’ personal experiences of pain helped them gain insight into the complex issue of pain. It would be unethical and irrational for healthcare professionals to seek pain in order to improve their pain management skills; yet they can gain knowledge from those who have experienced pain and thereby improve their understanding of everyday clinical pain management and assessment.

All three participants in this study spoke about physician/provider trust issues of concern. One of the participants said she was treated differently for pain when compared to her husband. Both of them had visited the same physician only a few days apart for what appeared to be a spider bite. Her husband was given pain medication and she was not, even though her bite was around her waist where her clothes touched the area and her husband’s bite was on his chin. Another participant spoke about changing physicians several times because she did not feel she was being listened to concerning her condition. This participant had witnessed a treating physician being kind to other patients who were being seen in her town after hurricane Katrina.
This witness to the kindness shown by the provider caused her to change over in order to receive the trust that she was going to get the care she deserved. A third participant felt her condition was not taken seriously and being brushed aside as minor. This participant changed providers only to be hospitalized a few days later when she was found to have ovarian cancer. Listening and trust issues are found in the literature frequently. In a study by Cocksedge and May (2005), data emphasized the importance of spotting cues during patient interactions. Factors influencing judgments in assessment of patients included pressure of work, the healthcare provider’s mood or feelings about the patient, and the context of the interaction. Methods of limiting, blocking, or resisting listening, included reassuring, changing the subject, interrupting, or making a plan, reducing sympathy, and using body language. Pain has consequences on patient wellbeing, functional status, as well as health related quality of life. Chronic pain is detrimental as it affects physical and psychological wellbeing in both adults and children. There is increasing recognition that pain as a distinct symptom, is often poorly addressed in the setting of chronic illness, even with terminal disease. The reasons for poor pain control and assessment may be multiple, including inadequate control of disease, poor attention to a treatment plan, and barriers on the part of the patient or physician (Fitzcharles, Dacosta, Ware, & Shir, 2009).

All three of the study participants spoke about physician disbelief related to the need to prescribe pain medications and the emotional distress related to not being heard by the physician. The invisibility of pain is possibly the central problem that chronic pain patients face and it is an aspect that affects the identity of the individual. Newton et al. (2010) explored the phenomenon that chronic pain patients and their experience of being believed is often alluded to in the literature. Key results from their study of a narrative review of the impact of disbelief in chronic
pain noted three main themes: stigma, emotional distress, and isolation. There is strong evidence to suggest that the experience of being disbelieved by the healthcare provider is stigmatizing.

In the initial literature review, a study by Shaw and Lee (2010) found that student nurses demonstrated misconceptions about adults with chronic pain to a considerable degree. The specific knowledge deficits were apparent with between 59% and 79.6% believing that psychological impairment, stress, and depression have some causative role in the experience of chronic non-malignant pain. Further deficits in knowledge were apparent with between 38.2% and 54.8% who demonstrated inaccurate understandings about the treatment of pain. This was specifically the existence of tolerance among patients with chronic nonmalignant pain and the risk of addiction to opioids. Slightly more than (34.5%) of the participants indicated they believed chronic pain patients were likely to be manipulative, and almost one-half (47.9%) of the respondents indicated they believed that patients with chronic pain may exaggerate their pain to gain compensation. The misconceptions represented inaccurate knowledge and inappropriate attitudes that were not addressed, to a substantial degree, during the course of undergraduate education.

 Fear of Disability

All three participants spoke about their fear of disability. All three participants said that the inability to perform the activities of daily living (ADL’s) was a major concern. They expressed the need for independence. Fear of loss of the ability to function socially and fear of disappointing the family were anxiety provoking factors. All three participants talked about the inability to function due to pain and implications for job loss. Fear of relapse during periods of remission was another concern. They spoke about the elevation of fear when a sudden onset or
exacerbation with their chronic pain occurs such as not being able to open a can or bottle top,
dress one’s self, walk in shoes due to friction, or being caught without pain medication. The
participants suffer in silence regarding their inabilities and hold to secrecy for the most part. A
study by Kindermans et al. (2011) provided support for the existence of several important
activity patterns in participants with chronic pain. Results showed that pain avoidance, activity
avoidance, excessive persistence, and pacing were all related to higher levels of disability.
Increased understanding of the lived experience and activity patterns might help to improve
tailored care for patients with chronic pain.

Early literature published in the *Journal of the American Medical Association* addresses
that pain has been shown to have a significant effect on work and productivity, as much as 13%
of the total workforce (Dubois et al., 2009). Pain-related fear leads to avoidance behaviors such
that individuals defer activities they perceive as threatening (Perry & Francis, 2011). Evidence
supporting the effects of significant symptom experience of people living with disability,
especially for symptoms of pain and fatigue, was explored, in a study by Patterson, Doucett,
Lindgren, and Chrischilles (2012). Symptom experience is found to partially mediate the effects
of disability on self-reported general health status and physical functioning. This suggests that
symptoms serve as an important link to health outcomes in persons with disability. Further
understanding of symptom experience may identify useful approaches to improving quality of
life, associated costs, and the processes associated with being disabled.

The participants in this study experienced difficulty with symptom relief with the most
difficult periods at the beginning of their diagnostic process. One participant could not get three
out of four physicians to prescribe something for her pain. She suffers from severe psoriatic
psoriasis with bleeding and cracking lesions of the hands and feet. Her job requires that she
instruct students to draw up medication in a syringe using tactile hand movements and to wash her hands frequently. The participant found ways to do her job. She carried gloves and band-aids in her lab coat pocket in order to cover her painful and bleeding fingers. This attempt to compensate for the results of her disease process offered her hope to continue to do her job duties. The healthcare provider had not given her options, so she developed her own methods for coping. Finding ways to compensate and improve symptoms offers hope to situations leading to fear of disability. Open communication and provider trust are necessary to deter the feelings of permanent disability or loss in cases where individuals suffer emotionally out of fear.

Subtheme: “Alien” (feeling as though something foreign has become housed in the body or that something has taken up residence). The chronic pain discussion of the three participants took on a personification role. According to Schattner and Shahar (2011), chronic pain may be internalized and integrated into the person’s object-relations, thereby influencing the sufferer’s depression. Participant A stated that her arms and hands feel like “clubs.” Participant B referred to her pain as an “organism” or “creature.” Participant C said,

It’s like a separate compartment with an “alien” living inside you. It is almost like it’s somebody else’s body. The thing is, what the heck is this that’s going on in here? And, why is this so difficult to figure out? It is the helplessness, the feeling that your body has betrayed you.

As we consider how we might communicate human experiences of pain, one of the most salient characteristics of our species is our embodiedness. Human beings are creatures of flesh. Primarily our experiences and how we make sense of what we experience is dependent upon the kinds of bodies we have and on the ways in which we interact with the environment we inhabit (Vakoch, 2011). Reflecting on the words of the participants leads to the belief that the terms “alien” and “creature” are the internal human reasoning of the participants speaking out to say, “I
Coping

The meaning of coping expressed by the participants seems to be linked to self-realization, adaptation, understanding, reflection and accommodation. Coping manifested with the participants in many ways, such as adaptation to the activities of daily living, understanding not to let pain get out of control, toleration of pain at times, understanding the importance of a positive attitude, finding ways to deal with the pain, acknowledging the pain, acceptance of the pain, and understanding that pain is a warning signal. Retaining a sense of control in chronic pain challenges the learning to live with pain and the ability to cope with the unpredictability and incurability of the pain. There is a challenge to find meaning in the suffering, create personal space, be self-protective, and keep a positive self-image and self-esteem while trying to live a “normal life” (Skuldottir & Halldorsdottir, 2008).

The statements made by the participants match a study by Park and Sonty, (2010) who examined the role of positive versus negative emotion in the relationship between control and coping efficacy and pain-related interference in social activity in a sample of chronic pain patients. After controlling for level of education, income, and average pain intensity, positive emotion, but not negative emotion, was found to partially mediate the relationship between control and coping efficacy and pain-related interference in social activities. This suggests that...
positive emotions may play an important part in predicting the relationship between control and coping efficacy and social functioning in chronic pain patients.

Each of the participants in this study had a tremendous desire to continue to work and not become disabled. Each indicated that they saw themselves in the future teaching nursing. They represent examples of adapting to a new form of existence, living with chronic pain. Holding on to participation on important arenas seems to be an essential part of successful coping strategies and a caring attitude toward one’s body (Raheim & Haland, 2006).

In a study by Fisher, Emerson, Firpo, Ptak, Wonn, and Bartolacci (2007), chronic pain was found to elicit innovative adaptive responses to coping by making interesting temporal, lifestyle, and cognitive adaptations. Frequently used temporal changes included allocating more time to undertake a task or shortening the time devoted to a task. The participants in this study frequently attempted to alter schedules to lessen the pain debilitation time. One of the participants would still go on family vacations, but stated that she wanted to sit with the grandchild for a while in order to compensate for her tiredness and pain. She felt this made her condition seem less noticeable. She would ask her husband to pre-open the soft drink caps before he left town so she could easily access them while he was gone. Her arthritic condition prevents her from being able to open soft drink cans and bottle caps. Another participant talked about coping by praying on a daily basis. She stated that her pain has actually caused her to trust her faith more.

Need for Pedagogical Discourse

In this study, nurse educators shared stories about their lived experiences with chronic pain and described how they teach about pain in the classroom and clinical setting. One
educator recalled a time earlier in her career when she first learned about a chronic pain condition called fibromyalgia. She stated, “I didn’t think as much about pain before. Now I realize the importance. I’m getting paid back for all those people I didn’t believe” (Participant I, Interview III). She talked about how the utilization of additional pain assessment techniques, and pain scales are now a part of her lesson plans. She also goes behind the student in clinical to do an assessment on the student’s assigned patient in order to grade the student on how well the pain assessment was completed. She emphasized the importance of not letting chronic pain or any type pain get out of control. A frequent quote she used was, “It’s not just that patient in that room” (Participant A, Interview III). Shaw and Lee (2010), studying misconceptions about chronic pain held by student nurses across 3 years of undergraduate education, found that student nurses hold misconceptions about adults with chronic pain. The study demonstrated inaccurate understandings in relation to the treatment of pain, specifically the existence of tolerance among patients with chronic nonmalignant pain and the risk of addiction to opioids. This represents inaccurate knowledge and inappropriate attitudes not addressed, to a substantial degree, during the course of undergraduate education. Chronicity and disability need to be obvious in the curriculum.

Another participant spoke about her desire to be thorough when teaching about pain assessment and management. She teaches students to understand that a pain patient may be more sensitive, frustrated, feel inadequate, or even be angry. She frames these additions to her lectures based on her own actions and experience with chronic pain. She feels it is important to teach reassurance on behalf of the patient and to incorporate that the patient is not a burden. Validation of the pain is essential. Speaking about the family role in pain is important for the students to understand. She uses discussion frequently in her classroom and integrates more psychosocial.
She is quick to point out that there is a deficit in the psychosocial issues in nursing curricula. She believes that the psychosocial aspect is only touched on in the textbooks, leaving the necessity to teach this up to the nursing instructor. In a nursing curriculum study by Kantar and Alexander (2012), subordination of judgment skills was revealed with preceptors responses helping to identify deficiencies in the skills. The multiple-case study was designed to better understand the influence of nursing curriculum on clinical judgment development in baccalaureate nursing students and the capacity to provide safe nursing practice in healthcare settings. Healthcare providers are responsible for assessing and treating pain based on a patient’s verbal and nonverbal communication. Inconsistencies exist in the nursing process, based largely on such variables as a nurse’s educational preparation, specialty area, and personal experience caring for others. These various factors may influence nurses’ responses to and beliefs about pain (Briggs, 2010; AL-Shaer et al., 2011).

One of the participants stated, “I feel like I know every patient I have ever had now.” She went on to say that teaching the pain scales is not enough. Additional teaching focus needs to be on things describing pain such as, “Is it sharp, is it stabbing, etc.?” We need more of “What have you had to stop or start doing?” “Do you have to accommodate this?” “Are you resting more?” (Participant III, Interview III). She believed pain is a warning signal and tried to bring these areas into her lecture and classroom experiences. The results of a study by Dysvik et al. (2011) shed light on important aspects of living with chronic pain. By listening to a patient narrative the total situation can be investigated, which might aid nurses in the quest to reduce pain and strengthen those areas that can lead to a meaningful life. The extent to which living a meaningful life is possible depends on many factors, including a person’s belief system and attitudes, early life
experiences, illness, personal resources, the meaning of pain, and extent to which nurses understand the overall situation.

Narrow Research Sub-question 1

How do nurse educators who have “lived experience” with chronic pain theorize or understand chronic pain?

The nurse educators interviewed in this study shared their personal knowledge about living with chronic pain. Personal knowledge is a powerful reminder that the life being lived is the life of the recipient of nursing care. Nurse educators who have personally experienced chronic pain are in the position to justify their actions and support an individual’s agency when it comes to better understanding how pain is theorized. Personal knowledge is the theorized knowledge of the individual as a self with a personal biography who occupies a certain social space and acts according to his or her own desires and intentions for reasons that make sense to him or her (Dyck, 2002). This knowledge links to the patient as a person. Because this knowledge is linked to nursing work, insight is given to practicing nurses enabling them to think more theoretically about their work and to articulate it in the world.

Patricia Benner (1984) was the guiding theorist for this research study. Benner postulated that studying the person in the situation is required in nursing practice because nurses coach patients through their illness, injury, or birthing, or when facing death. An objectified, detached view of practice covers over the patient and nurse as well as the relational caring practices that allow the nurse to coach, accompany, bear witness, and empower patients and families. The nurse educators in this study allowed for insight into the connection between the body with chronic pain and its connection in biomedical discourse related to the lived experience.
Discussions based on in-depth interviews about their daily lives, emphasize the powerful influence of dominant social norms in the medical world and the social world. From these conversations, nurse educators need to theorize carefully about how the medical environment plays a major role in producing or magnifying unnecessary vulnerability, lack of provider trust, fear of disability, need for coping strategies, and the need for pedagogical changes. How these educators engaged with the environment and their provider encounters mediated through both their diagnosis and with their activities of daily living. In many instances, through the lack of embodying insight on the part of providers and others, their care went lacking and their chronic pain assessment and management suffered. Benner explained that articulation research describes, illustrates, and gives language to “taken-for-granted areas of practical wisdom, skilled know-how, and notions of good practice” (Benner, Hooper, Kyriakidis & Hooper, 1999, p. 5).

The participants of this study indicated that persons with pain have the right to optimal pain management and should be able to expect that healthcare providers will adequately assess, inform, and implement good pain care. Frustration was expressed by all of the participants and was related to chronic pain treatment and the disease, itself. Specific issues included appointment response times, not receiving pain medications, ineffective results from physician visits, incorrect diagnoses, and believing they actually had a chronic pain diagnosis.

Feelings of self-consciousness were conveyed by all three participants with respect to physical body changes, attempts to hide their illness, and fear of being viewed as a drug seeker, or lazy. Resultant of being physically ill or undiagnosed, all of the participants experienced sadness. Comments such as, “I knew I was going to have to learn to live with it,” and “I need to learn to adapt to the pain,” reflected the emotional intensity felt by the individuals.
The participants spoke about what they perceived to be the needed role of a healthcare provider or nurse who is caring for the patient with chronic pain. They expressed the desire for the healthcare provider or nurse to encourage the patient to talk about their pain, demonstrate compassion, listen as though they are truly interested in their problem, and offer possible choices in treatment plans. The participants expressed a lack of involvement by healthcare providers during the assessment phase of their chronic pain. The participants remarked, “There is a lack of personalization to the experience,” “It’s an uncaring attitude of the provider,” and “There is a lack of communication.” The nurses in this study theorized chronic pain by seeing the lived experience of chronic pain as complex and life changing. Living with chronic pain means understanding days of depression, anger, frustration, fear, and self-consciousness. It is, at times, an emotional “rollercoaster.” There is need to retain a sense of control and not give up in spite of the pain. The inability to maintain a sense of control of self and pain and to avoid demoralization is a common chronic pain issue. Chronic pain patients are challenged to find meaning in their suffering, to create personal space, and to be self-protective while keeping a positive self-image to live a “normal” life. Health professionals are viewed as potentially powerful people in the lives of chronic pain patients. Empowerment and disempowerment from health professionals greatly influence whether the chronic pain is or is not demoralized (Skuladottir & Halldorsdottir, 2008).

The nurses in this study spoke about the importance of successful adaptation to chronic pain. Resilience plays an important role in adaptation to chronic pain and can be heard in the voices of the women interviewed. It is vital to acknowledge that an individual can be resilient in some ways and not in others. For example, one can learn from a challenging experience without fully recovering from it. Important purposes in life may be lost while, at the same time, new
plans and goals are shaped by the learning and growth that has resulted from successful adaptation. Success in one area may often facilitate resilience in the other two (Yeung et al., 2012). The nurse educators in this study spoke about the importance of support systems to help with their chronic pain issues. Comments like, “I don’t know what I would do if I did not have my husband to help me dress some mornings, especially when I am having a flare-up,” “I have a fear of being “needy” to others,” “I debate to tell, or not to tell about my chronic pain in social situations,” and “Sometimes I feel my family doesn’t understand” are examples of the importance for resilient responses to stressful events like living with chronic pain. Life difficulties and struggles help to fuel an individual to develop resilience while learning to cope with grief, negative feelings, anger, fear, and depression. The ability to cultivate an inner strength to adapt to changes is necessary to find meaning and rise above personal suffering. There is evidence from a study by Park and Sonty (2010) that maintaining a satisfactory quality of life while living with a chronic pain condition could depend on mediators that result in decreasing the effects of stress (thus leading to a proved quality of life) or an increase of its effects (thus leading to a deterioration in the quality of life). A positive emotion appears to protect against increases in negative emotion during times of increased pain or stress, facilitating coping. The protective function of positive emotions is only beginning to be understood. The evidence thus far indicates a need to consider such resources as important clinical tools, strategies, and avenues for future research.
Narrow Research Sub-question 2

How can the “lived experience” relate to how pain is taught by these individuals? What are the prescribed methods of teaching chronic pain assessment and how does it fit into the nursing curriculum?

The diagnosis of acute pain and interventions are often simple, but this is not usually the case with chronic pain, as the processes of investigation, diagnosis, and management are often complex and lengthy. The American Association of Colleges of Nursing (AACN) is the national voice for baccalaureate and graduate nursing education. AACN’s educational, research, federal advocacy, data collection, publications, and special programs work to establish quality standards for nursing education; assist deans and directors to implement those standards; influence the nursing profession to improve healthcare; and promote public support for professional nursing education, research, and practice curriculum. Using a national consensus-based process, AACN has led the development of a series of Essentials documents that outline competency expectations for graduates of Baccalaureate, Master’s, and Doctor of Nursing Practice (DNP) programs. Using these documents, schools of nursing are able to ensure they adhere to the highest standards for their educational programs and meet accreditation guidelines. AACN also has published quality indicators for research-focused doctoral programs, a White Paper on the Clinical Nurse Leader, and guidelines defining the essential clinical resources for nursing education, research, and faculty practice (AACN, 2008). The Essentials documents regarding baccalaureate nursing education do not specifically address pain assessment, but are broad to include the ability to identify, assess, and evaluate patient care. Essential II: Basic Organizational and Systems Leadership for Quality Care and Patient Safety and Essential IX: Baccalaureate Generalist Nursing Practice addresses the following regarding nursing curriculum:
Baccalaureate nursing graduates are distinguished by their abilities to identify, assess, and evaluate practice in care delivery models that are based in contemporary nursing science and are feasible within current cultural, economic, organizational, and political perspectives. (Essential II p. 13)

The graduate will understand and respect the variations of care, the increased complexity, and the increased use of healthcare resources inherent in caring for patients who are vulnerable due to age, the very young and very old, as well as disabilities and chronic disease. (Essential IX, p. 30)

The National League for Nursing Accrediting Commission (NLNAC) supports the interests of nursing education, nursing practice, and the public by the functions of accreditation. Accreditation is voluntary, and is a self-regulatory process by which non-governmental associations recognize educational institutions or programs that are found to meet or exceed standards and criteria for educational quality. Accreditation assists in improving the institutions or programs as related to resources invested, processes followed, and results achieved. The NLNAC monitors certificate, diploma, and degree nursing programs and is tied closely to state examination and licensing rules and to the oversight of preparation for work in the profession. The mission of the nursing education unit reflects the core values and is congruent with its missions/goals. The organization has the administrative capacity resulting in effective delivery of the nursing program and achievement of identified program outcomes (NLNAC, 2013).

The NLNAC Standards do not specifically address pain assessment; however, they are broad to include the ability to identify, assess, and evaluate patient care. Curriculum guidelines for Baccalaureate nursing programs related to pain assessment in general and nursing care are found in Standard 4.4 and 4.10:

The curriculum supports the achievement of the identified student learning outcomes and program outcomes of the nursing education unit consistent with safe practice in contemporary healthcare environments. “The curriculum includes general education courses that enhance professional nursing knowledge and practice.” (NLNAC Standards and Criteria Baccalaureate 2013, Standard 4.4)
Students participate in clinical experiences that are evidence-based and reflect contemporary practice and nationally established patient health and safety goals. (NLNAC Standards and Criteria Baccalaureate, 2013, Standard 4.10)

Curriculum for Associate Degree nursing programs related to pain assessment in general and nursing care are found in Standard 4.4 and 4.10:

The curriculum includes general education courses that enhance professional nursing knowledge and practice.” (NLNAC Standards and Criteria Associate, 2013, Standard 4.4)

Students participate in clinical experiences that are evidence-based and reflect contemporary practice and nationally established patient health and safety goals. (NLNAC Standards and Criteria Associate, 2013, Standard 4.10)

Accreditation is important to nursing curriculum for strengthening educational quality, fostering educational equity, access, opportunity, mobility, and preparation for employment (NLNAC, 2013). Although, chronic pain is not specifically addressed in the accreditation curriculum guidelines for NLNAC or AACN, curriculum that includes educational courses to enhance professional nursing knowledge and practice, as well as, evidence-based clinical practice are core to the criteria needed to meet the program outcomes.

Each of the participants stated that they do teach about pain differently since experiencing chronic pain personally. The impact on their understanding has allowed them to reflect on how they want to be treated regarding their pain and what they need to add to their teaching plans. It is important to help the student to know that not every patient is a drug seeker and that most are simply trying to find an answer or find someone who will listen. Bias during clinical reporting time at change of shift is a problem. Nurses have been witnessed making judgmental remarks about patients seeking pain medications or patients appearing to hyper-inflate their pain symptoms. The importance of teaching students about these types of judgments in the clinical setting is important in order to help them avoid negative mentoring.
The participants acknowledged that it is important to make the material personal in their lectures about chronic pain. When assessing pain it is important to ask things like, “What can you not do with the pain, and what can you do with the pain?” “Do you rest more and are you eating?” Assessment is more than just a pain scale. Each participant stressed the importance of caring and compassion. It is debatable in their opinion about whether you can teach caring and compassion, but it is important to look for ways to assess that the student is caring and compassionate. It is also important to add the psychosocial aspects of pain assessment and pain management to curriculum content. These findings are consistent with a study by Shaw, and Lee (2010) where qualified practicing nurses and students were found to hold misconceptions about adults with chronic non-malignant pain. This represented inaccurate knowledge and inappropriate attitudes that are not addressed, to a substantial degree, during the course of undergraduate nursing education. Chronicity and disability need to be in the curriculum. Through listening to chronic pain patient narratives, situations can be investigated which aid the nurse in the quest to reduce pain and strengthen those areas that can lead to a meaningful life (Dysvik et al., 2011). Students need guidance to develop evidence-based practice rather than continue with what we have taught in the past (McCaffrey, Zerwekh, & Keller, 2005; Shaw & Lee, 2010).

Participants indicated that their lived experience with chronic pain has affected how they teach about pain in diverse ways. Since their personal experience with chronic pain, each participant said they take more lecture time in class on the topic of chronic pain and on the topic of pain in general. Pain is integrated into the curriculum at all three of the schools represented in this study. Each of the participants expressed the need for more time to teach the subject of pain because they spend only about an hour each time it is taught. Each participant indicated that pain is covered over the course of three or more semesters ranging from Fundamentals class to
scattered in the Gastrointestinal, Hematology, and Cardiac modules. There is some variance as to which modules are covering pain; however, the periods and subject matter appear to be similar. Scheduling does not allow for longer than the allotted time. This is because of the amount of material nurse educators are expected to cover prior to routine exams in preparation for students to be ready for the National Council Licensure Exam (NCLEX) upon graduation.

Understanding the prescribed methods of teaching nurses about chronic pain assessment is important for the future care of patients. Goodrich (2006) studied students’ and faculty members’ knowledge and attitudes regarding pain management. The majority of the faculty in her study perceived themselves as competent in pain management, and believed their current practice to be maintained through reading professional journals and attending continuing education programs. Faculty appeared to have basic knowledge to build pain management skills into curriculum, yet integration of pain content is inconsistent.

Each of the three participants indicated that pedagogical discourse exists in nursing education as identified by lack of adequate teaching hours, poorly written textbooks, poor chronic pain assessments of patients, and the need for more psychosocial content in nursing curricula. Many of the examples given by the participants related to their personal dealings with chronic pain and their insight into what is missing in the curricula.

Chronic pain is a complex, dynamic disorder, impacting the individual in a multitude of ways. The purpose of this study was to better understand the ways in which the “lived experience” with chronic pain shapes how a nurse educator understands and engages in pain assessment. Through this study, the researcher also looked at how pain is theorized by the lived experience, how pain is taught, and the prescribed methods of teaching as well as how does chronic pain fit into the curriculum. Through a living relationship with oneself, others, and the
world, human beings assign meaning to experiences. In this living relationship, things such as self and others matter. Letting things matter is part of being human and is one of life’s challenges (Benner, 2001). When experiencing an illness or something like chronic pain, the habitual living in a homelike world is disrupted. During the illness or pain, the I becomes forced to confront the fact that this I is in the world as a lived body. So, if understanding life, meaning, and concerns fails, this renders into experiences of being de-situated (learning ways outside the real world experience; Benner & Wrubel, 1989). Through the lived experience, we are led to think about the need to teach in a different way.

The participants talked about the importance of teaching students to collect accurate and complete information when doing a pain history. It is necessary to teach the importance of observing, recording the location of pain, the duration, the frequency, the degree of pain, and the characteristics that will help in making the correct choice of effective management of pain. The importance of observation in pain assessment is made clear in the Joint Commission of Accreditation of Healthcare Organizations, which defined pain assessment as part of the vital signs measurement (JCAHO, 2011). Findings in a study by Pediaditaki et al. (2010) suggested that healthcare providers become more sensitive to patient pain after their own experience of pain. Statements such as, “I now think I know every pain patient I have ever had better,” “Now I know fibromyalgia is real,” and “I didn’t think much about pain before my situation” confirm that pain can be the teacher who will help us to see the human being in a different light with concern, interest, and compassion for care.

The educators in this study pointed out that taking time to assess, looking the patient in the eye, having a caring tone in the voice, showing interest, being cognizant of body language, and being thorough in patient encounters are all things that should be included in teaching
student nurses about chronic pain assessment and management. The educators also pointed out that it is important that the teacher assess the student’s ability to carry out an assessment that includes these important components. The educator cannot properly assess the student for learning unless the educator can verify in some way that the student has reached the objectives for good pain assessment and management. The teaching objectives are assessed by these nurse educators through observing the patient assessment encounters by the students, going over a student’s computerized pain assessment to check for completeness with feedback to the student on the day of clinical, and telling personal stories about the life lived with chronic pain. The participants also use classroom activities such as vignettes that stress the psychosocial aspects of chronic pain, classroom discussion about factors related to the activities of daily living, and the role of stress on chronic pain. The lived experience of chronic pain has provided the nurse educators in this study with valuable insight about how to approach teaching chronic pain in the classroom. The knowledge provided by their life experience of chronic pain serves as an important heuristic tool that can help healthcare professionals decipher what they see and hear, and, to make well-informed decisions about what is most likely most appropriate or the best approach to helping the chronic pain patient. This knowledge can contribute considerably to the adequacy of ethical decisions attuned to a specific situation and to nursing curriculum change (deCasterle et al., 2011).

The educator’s dilemma is how to include an ever-growing body of essential knowledge in the curriculum that is already full and in a manner that is pedagogically sound. Both the associate degree and baccalaureate nurse educators in this study said chronic pain is taught using an integrated model of curricula where pain is discussed throughout the semesters and included in several different modules of study. For example, pain is included in the fundamental, medical
surgical, and obstetrical nursing modules. The extent, to which pain is covered, depends upon several types of curriculum. These are the “operational curriculum” (includes knowledge, skills and attitudes emphasized by faculty in the classroom and clinical setting), the “illegitimate curriculum” (that which is actively taught by the teacher and how its importance is communicated to the student such as caring, compassion, and power), the hidden curriculum (consists of values and beliefs taught through verbal and nonverbal communication by the faculty who may not be aware of their expressions, priorities and interactions with students), and the “null curriculum” (the curriculum that is not being taught such as content or skills the faculty think are not critical to the design; Billings & Halstead, 2009). Each of the participants estimated that pain in general (includes, acute and chronic pain) is covered in about 10 hours or less total in the ADN and BSN nursing curricula. This is interesting, because the length of ADN and BSN programs differ in semester hours of preparation for graduation. To test the hypothesis that educational deficits are in part responsible for the low priority given to pain management by nurses, a study was conducted to ascertain the pain content in the Common Foundation Program in four branches of nursing courses in England. Results indicate that while child and adult programs cover a wide breadth of topics, pain is covered in 10 hours or less. These results indicate superficial coverage of the pain topic. When the amount of time spent teaching, pain is considered (on average less than 10 hours), it becomes apparent that the teaching may not be in any depth (Pediaditaki et al., 2010; Twycross, 2000, 2002). Further study is needed regarding the number of hours spent teaching about chronic pain in schools of nursing. Curriculum development is led by, and reflective of, the mission and philosophy of the institution and guided by the community and stakeholders.
Preparing new graduates to assess and manage pain and to be advocates for their patients with pain requires action so that these graduates can be mentors to others. Modeling this mentoring relationship puts emphasis on the importance of nurse faculty being adequately prepared to teach pain management across the curricula (Duke et al., 2010). Healthcare professionals have to keep in mind that chronicity of pain represents constant aggravation for the pain patient. Nurse educators and healthcare providers can help patients navigate through the difficulties of dealing with the persistent and invisible nature of chronic pain by understanding, validating, and teaching students about the lived experience of chronic pain. Treatment must take into account the context of each individual, emphasizing support, empowerment, and acknowledgement of the individuals’ own resources (Skuladottir & Halldorsdottir, 2008).

Implications for Nursing

As evidenced by the thematic review from this study, there are implications for better instruction, nurse educator training, and nursing curriculum change regarding how chronic pain is taught. Nurse educators and teachers are eternal learners. Almost every day we learn something new about ourselves, about our students, and about our teaching. The unyielding commitment to help students reach their full potential leads us to question how we teach. Teaching is an embedded part of the teacher’s identity. It is important to explore new ways to teach familiar and unfamiliar content. Sharing personal stories with students can be a powerful way to connect the student to the subject matter. Educators are works in progress, continuously evolving, seeking, and transforming. Nurse educators must consider how experiences influence the selection of content and pedagogy in the classroom (Cone, 2007).
In a study by Pediaditaki et al. (2010), designed to gain insight into the way the personal experience of pain affects the attitude of healthcare professionals toward pain management, participants recognized the insufficient knowledge of staff regarding pain management. They assessed that the personal experience of pain is a chance for self-criticism. They also noticed that after a personal experience of pain, there is an increased sensitivity to the problem of pain with more awareness of the patient’s needs. Furthermore, they proposed educational interventions to focus on a holistic approach and to improve communication skills. Pain is experienced by all people through time and has no boundaries. Schools of nursing and other healthcare educational establishments should enrich their curriculum with pain education, using those who have had personal experience of pain to illustrate the importance of empathetic pain management. It would be advantageous to invite ex-patients who had substantial experiences of pain to illustrate where gaps in the system need improving.

Nurse educators in this study were asked about their thoughts, feelings, and knowledge related to chronic pain. Through this study, the researcher added to the body of knowledge about the “lived experience” of chronic pain and implications for how pain is taught in nursing schools. The research on the “lived experience” of nurse educators with chronic pain filled a gap in the literature regarding how pain is assessed and taught by individuals who have actually had chronic pain. This research is important for nursing education, because in order for the problem of poor chronic pain assessment and better nursing instruction, it must first be realized, studied, and brought forward for change. The resultant information is significant because it comes from first-person accounts of nurse educators who have personally had chronic pain. These nurse educators have insight that is evidenced by life itself giving meaning and understanding for education.
The researcher concluded that nurse educators believe chronic pain is under-assessed, misunderstood, and poorly addressed by medical practitioners and nursing students. This presents a negative impact in patient care. The findings from this study support the need to challenge educational epistemologies that suggest there is a consistently corresponding relationship between pain scales, objective pain assessment, and preconceived judgments regarding chronic pain assessment and management. Deconstructing this way of thinking is important by using interpretive pedagogies, which change our preconceived notions. Subject matter presented in the classroom needs to focus on understanding the problem, which may not resemble the clinical situation in which nurses function. Instruction should be based on context and experience. Nurse educators who use only content-based instruction tend to underpin the gap between theory and practice (Kantar & Alexander, 2012).

Preparing new graduates to manage pain and to be advocates for their patients experiencing pain requires action through mentoring so that these graduates can be mentors to others. Modeling this mentoring relationship means emphasizing the importance of nursing faculty being adequately prepared to teach pain management across the curricula. Persons with pain have the right to optimal pain management and expect healthcare providers to adequately assess, inform, implement, and evaluate treatments for pain. Given the psychologic, spiritual, and physical costs of unrelieved pain, nurse educators have an ethical obligation to improve current practice through addressing curricular pain content, policy initiatives, and research (Duke et al., 2010).

According to the American Association of Colleges of Nursing (2008), learning opportunities for baccalaureate and associate degree nurses, including direct clinical experiences, must be sufficient in breadth and depth to ensure the nurse graduate attains practice-focused
outcomes and integrates the delineated knowledge and skills into the graduate’s professional nursing practice. The knowledge provided by qualitative studies can serve as an important heuristic tool to help nurse educators and healthcare professionals to decipher what they see and hear, and to make well-informed decisions about the most appropriate approach to nursing care. This knowledge can contribute considerably to ethical decisions regarding chronic pain assessment and management (Casterle et al., 2011).

This study shows that the personal experience of chronic pain can enable nurse educators a better way to comprehend the complexity of chronic pain leading to improved holistic approaches to improvement in pain assessment and management. There is a need to ensure that nurses have the knowledge and skills to assess and manage pain effectively. Regular updates about chronic pain and changes in practice are necessary for nurse educators to use in teaching students. Teaching strategies that support adult learning and various other learning styles need to be incorporated in the classroom and clinical experiences of student nurses. There is a need for further research related to classroom teaching methods, learning retention, and transference to the clinical setting.

Limitations of the Study

The study participants were all Caucasian females from a middle-class perspective. Studying a broader range of ethnicities would be helpful and it would be helpful to include male participants in the sample. The study represented two participants from a rural background and only one from a metropolitan orientation. It is noted that all three participants had been diagnosed with chronic pain for less than three years during the interview timeframe. It would be
interesting to know if the number of years each participant has suffered with the chronic pain would alter the results such as their willingness to talk about their pain more in front of students.

Recommendations for Future Research

The discovery challenge of the lived experience of nurse educators with chronic pain answered many questions, just as it fostered additional questions. Further research is needed that will focus on gender differences in chronic pain assessment and the lived experience. Additional studies regarding provider gender in the assessment of pain might be helpful in eliminating gender bias on the part of the provider and the participant. Two of the three participants were close in age range while one participant was slightly younger. Additional studies to see if age differences might skew the data would be beneficial. Research should be conducted on ways to implement the findings of the lived experience of nurse educators with chronic pain into the nursing curricula. The study’s findings may assist with the development of other studies on the structure of nursing curriculum. This could assist in curricula that teach better chronic pain assessment and management, establishment of a curriculum framework, and the creation of strategies or tools for the classroom. The research revealed a deeper understanding; however, limitations were present and questions remain for further study.
REFERENCES


Briggs, C. L. (2010). What were they thinking? Nursing students’ thought processes underlying pain management decisions. Nursing Education Perspectives, 31(2), 84-88.


APPENDIX: A

IRB APPROVAL
April 6, 2012

Moniaree Jones, MSN
Instructional Leadership for Nurse Educators
Capstone College of Nursing/College of Education
The University of Alabama

Re: IRB # 12-OR-121-ME “The Lived Experience of Chronic Pain in Nurse Educators”

Dear Ms. Jones:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your application will expire on April 5, 2013. If your research will continue beyond this date, complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, complete the Modification of an Approved Protocol Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, complete the appropriate portions of the IRB Study Closure Form.

Please use reproductions of the IRB approved informed consent form to obtain consent from your participants.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,

[Name]

Carrie T. Myles, MSN, CCM
Director of Research Compliance Officer
Office for Research Compliance
The University of Alabama
UNIVERSITY OF ALABAMA

INSTITUTIONAL REVIEW BOARD FOR THE PROTECTION OF HUMAN SUBJECTS
REQUEST FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS

I. Identifying Information

Principal Investigator: Moniarcos Jones, MSN
Second Investigator: Douglas McKnight, Ph.D.

Third Investigator: 

Department: College of Nursing
Instructional Leadership

College: Nursing and Education
University: Univ. Alabama

Address: 1093 Stonykirk Road,
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205-348-1449

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E-mail: moniarcosj@gmail.com or djajones@bama.ua.edu

dmcknight@bama.edu

Title of Research Project: The Lived Experience of Chronic Pain in Nurse Educators

Date Submitted: 2-29-2012
Funding Source: N/A

Type of Proposal: ☑ New  ☐ Revision  ☐ Renewal  ☐ Completed  ☐ Exempt

Please attach a renewal application

Please enter the original IRB # at the top of the page

UA faculty or staff member signature: [Blackened]

II. NOTIFICATION OF IRB ACTION (to be completed by IRB):

Type of Review: ☑ Full Board  ☐ Expedited

IRB Action:  ☑ Approved Pending Revisions  Date:  ☑ Approved this proposal complies with University and federal regulations for the protection of human subjects. Approval is effective until the following date: 4/5/12

Items approved: ☑ Research protocol (dated 12/11/11)
Informed consent
Recruitment materials
Other

Approval signature

Date 4/6/2012
UNIVERSITY OF ALABAMA INSTITUTIONAL REVIEW BOARD

Informed Consent for a Medical or Health-Related Research Study

Study Title: The Lived Experience of Chronic Pain in Nurse Educators

Investigator(s) Principle Investigator:
Rosa (Moniaree) Jones RN, MSN, Doctoral Student
The University of Alabama College of Nursing and College of Education
(Instructional Leadership).

Co-Principal Investigator:
Douglas McKnight Ph. D.
Associate Professor Curriculum Theory
Educational Leadership, Policy and Technology Studies
The University of Alabama College of Education

Funding Source: None

You are being asked to take part in a research study. This study is called "The
Lived Experience of Chronic Pain in Nurse Educators". This study is being done
by Moniaree Jones, RN, MSN. She is a doctoral student in the College of
Nursing at the University of Alabama.

Ms. Jones is being supervised by Dr. Douglas McKnight, who is a professor at
the University of Alabama in the College of Education.

What are the Possible Benefits for Me or Others?

There is no cost for you to be in this study. No compensation will be given for
taking part. You are not likely to have any direct benefit from being in this
research study. Taking part in this study may help improve undergraduate
nursing curriculum about how pain is taught.

You may request a copy of the results of the study by showing your interest at
the end of this form. If you have questions about any part of this study, please tell
the researcher before signing the form. You may also contact the supervising
faculty if you have questions about being in this study. The researcher has
provided contact information at the bottom of this form.

Two copies of this consent form are provided. Please sign both, showing you
have read, understand, and agree to take part in the study. Return one to the

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 4-6-12
EXPIRATION DATE: 4-5-13
researcher and keep the other for your files. The Institutional Review Board of The University of Alabama has access to all signed consent forms.

What is this study about?

This study will look at how nursing faculty who have personally experienced chronic pain, or who have cared for an individual with chronic pain, teach about pain. This study will try to understand how nurse educators share and define how they teach undergraduate nursing students about chronic pain.

You will be asked about your thoughts, feelings and personal dealings with chronic pain. You will be asked to tell any personal stories you have in teaching about chronic pain. The three part interviews will be audio recorded with detailed notes made so the researcher can remember what you said. You will be audio recorded only with your permission. You have the right to review and change the recordings by removing any material you do not want. You may also ask us to turn off the recorder at any point in the conversation.

If you do not wish to be audio recorded you will not be able to take part in the study. After the interview, the recording will be put into printed word. A written copy will be given to you for review. You may delete anything you do not want in the recordings.

Why have I been asked to take part in this study?

This study is about undergraduate nursing instructors (nurse educators) who have chronic (long lasting) pain. This is part of Moniaree Jones’ doctoral dissertation. You are being asked to take part in this study because:

- you told us of your interest in this study as seen in an announcement sent out through the Alabama League of Nursing
- you are an undergraduate nursing instructor
- you have personally had chronic pain or personally cared for someone with chronic pain
- you possibly teach undergraduate nursing students about pain.

How many people will be in this study?

The investigator hopes to interview three nurse educators who have had chronic pain for three separate visits.
What will I be asked to do in this study?

Please read this form carefully. Ask any questions you may have before agreeing to take part in the study. If you meet the study requirements and you agree to take part in the study, you will be asked to participate in three interviews. Moniaree Jones, RN, MSN, will interview you. Interviews will be done at a mutually agreeable location and time. Each interview will last about sixty minutes or less, depending on the length of the answers you might give. The all three interviews will take place over a period of three to twelve weeks. This will be based on your availability and the researcher. You will be asked at the beginning of each interview if you wish to continue to be in the study. This study hopes to gain useful information about how pain is taught to undergraduate nursing students.

How much time will I spend being in this study?

Each of the three interviews will last about an hour. The length of the interview will depend on how much information about your life with pain you choose to share.

Will being in this study cost me anything?

The only cost to you from this study is your time.

Will I be paid for being in this study?

There is no pay for taking part in this study.

Can the researcher take me out of this study?

The researcher may take you out of this study if she/he believes the study is upsetting you or, if you do not meet the study requirements.

What are the Risks of being in this study?

Taking part in this study does not involve any physical or emotional harm to you beyond that of everyday life. The main risk to you is that you may find the talk about your pain to be sad or stressful. You can control this by not being in the study, by refusing to answer a question, or by not telling us things you find to be sad or stressful. We can also give you the names of counselors to see if you seem to be upset or depressed. Seeing the counselor would be at your own cost:

- You may gain a greater personal awareness of teaching about pain because of your being in this research.

- You may get tired during the interview. You can rest at any time.
• You may feel emotional or upset when answering some of the questions. Tell the interviewer at any time if you wish to take a break or stop the interview.
• You may be uncomfortable with some of the questions and topics. If you are uncomfortable, you do not have to answer the question or you may skip to the next question.

What are the benefits (good things) that may happen to me if I am in this study?

There are no benefits to you unless you find it pleasant or helpful to share about your life with chronic pain or sharing information about caring for someone with chronic pain.

How will my confidentiality/privacy be protected?

Your answers will be kept private however, your willingness to take part in this research study may result in a loss of privacy. You are free to decide where your interviews will take place so we can talk without being overheard. Unless necessary by law, only the study investigator, co-investigator, representatives of the University of Alabama Office for Research Compliance, and representatives from the International Review Board (IRB) have the authority to review your study records. They are required to maintain privacy regarding your personal information.

The only place your name appears in this study is on the informed consent. A name/number list is not used. There is no way to link a consent form to an interview.

Your name will not be used on the audio recording. No one will know who you are on the recording. The informed consent forms and other personal information will be kept separate from the information collected. Moniaree Parker Jones will keep all materials in a personal file cabinet under lock and key. Audio recordings will be listened to only by Moniaree Jones and/or Douglas McKnight, Ph.D., the Dissertation Chair, and possibly a research assistant. The research assistant will sign the attached Professional Assistance Confidentiality Agreement. The assistant could be a certified transcriptionist trained to record information from private audio recordings. Any records that would identify you as taking part in this study, such as informed consent forms, will be destroyed by Moniaree Jones in about two years after the study is completed.

You will be asked to provide a different name for any statements that might be used in a final research report with your permission. The results of this research
will be published in Moniaree Jones’ dissertation and possibly in additional journals or books.

What are the alternatives/choices to being in this study? Do I have other choices?

The only choice is not to participate.

What are my rights as a participant in this study?

Taking part in this study is voluntary—it is your free choice. You can refuse to be in the study. If you start the study, you can stop at any time. There will be no effects on your care or your relations with the University of Alabama. If you choose to be in this study, you have the right to be treated with respect. This includes respect for your decision whether or not you wish to continue or stop being in the study. Choosing not to be in this study or to stop being in this study will not result in any punishment to you or loss of gain. Your part in the study may be stopped by the investigator without your consent if the researcher, faculty advisor, or Institutional Review Board stops the study.

The University Of Alabama Institutional Review Board (IRB) is the committee that protects the rights of people in research studies. The IRB may review study records from time to time to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

Who do I call if I have questions or problems?

If you have questions, problems, or complaints about the study right now, please ask them. If you have questions later on, please contact the researcher Moniaree Parker Jones at 205-663-4621 (home) or 205-901-6237 (cell). In the event that you have concerns regarding your emotional discomfort as a result of your part in the study and feel stressed, the investigator can give you a one-time free screening referral to a licensed professional counselor. You may also be given a list of counseling services if needed. Please know that the researcher is not responsible for the payment of any counseling visits should you need them. You will need to use your private insurance for any further counseling services. If you have questions or complaints about your rights for taking part in this research study, call the Research Compliance Officer of the University of Alabama, Ms. Tanta Myles at 205-348-8481.

You may also ask questions, make a suggestion, or file complaints and concerns through the IRB Outreach Website at http://osp.ua.edu/site/PRCOWelcome.html. After you take part in the study, you are encouraged to complete the survey for research participants that is online there, or you may ask Dr. Johann for a copy of it. You may also email us at participantoutreach@bama.ua.edu. You may ask the investigator for a copy of it. Mail it back to the University of Alabama Office.
for Research Compliance, Box 870127, 358 Rose Administration Building, Tuscaloosa, AL 35487-0127.

I have read this consent form. I have had a chance to ask questions. I understand what I will be asked to do. I freely agree to take part in it. I will receive a copy of this consent form to keep.

________________________________________
Signature of Research Participant       Date

________________________________________
Signature of Investigator               Date

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 4-6-18
EXPIRATION DATE: 4-5-18
APPENDIX B

CONSENT FOR AUDIO RECORDING
Consent for Audio Recording

I understand that I will be audio recorded during the three interviews as a part of this study.

Initial one of the following to indicate your choice:

_____ (initial) I agree to be audio recorded

_____ (initial) I do not agree to be audio recorded

Subject’s Name (printed) and Signature

Date

Name (printed) and Signature of Person Obtaining Consent

Date
APPENDIX C

PROFESSIONAL ASSISTANCE CONFIDENTIALITY AGREEMENT
I understand that I will be transcribing to an electronic and or paper format, private/confidential audio recordings that are part of a dissertation research study at the University of Alabama being conducted by a doctoral student researcher, Moniaree Jones. The title of this study is: The Lived Experience of Chronic Pain in Nurse Educators. I agree to keep all information private and to protect the rights and welfare of all records I transcribe as stated above.

Initial one of the following to indicate your choice:

_____ (initial) I agree to the above stated agreement

_____ (initial) I do not agree to the above stated agreement

_______________________________________________   ____________
Research Assistant/Transcriber Name (printed)      Date

_______________________________________________   ____________
Research Assistant/Transcriber (signature)      Date
APPENDIX D

LETTER REQUESTING PERMISSION TO CONDUCT STUDY
Reitha Cabaniss, MSN, RN, CNE  
President  
Alabama League for Nursing  
3209 Hudson Street  
Jasper, AL 35503  

Dear President Cabaniss:

My name is Moniaree Jones and I am a doctoral student working on my dissertation in the College of Nursing and the College of Education (Instructional Leadership) at The University of Alabama. My study will look at how nursing faculty who have personally experienced chronic pain, or who have personally cared for an individual with chronic pain, teach about pain. This purpose of the study is to understand how these nurse educators share and define how they teach undergraduate nursing students about chronic pain.

As President of the Alabama League for Nursing, I seek your assistant in sample recruitment for this important study. The sample of nurses will need to be full-time nursing faculty of Baccalaureate or Associate degree programs with a minimum of a master’s degree in nursing. The nurses may possess a further graduate degree in nursing or a related field, and need to be current instructors in schools of nursing either accredited by the National League for Nursing Accrediting Commission or the Commission on Collegiate Nursing Education. The participants accepted into this study will have personally experienced chronic pain or have personally cared for someone with chronic pain.

Chronic pain refers to persistent pain lasting six or more months. The pain may be caused by an initial mishap such as a sprained back, serious infection, or there may be an on-going cause of pain such as arthritis, cancer, ear infection, or other problem. Common chronic pain complaints include migraine headaches, low back pain, arthritis pain, neurogenic pain, and psychogenic pain.

Your help in distributing the study criteria to the Alabama League for Nursing members is greatly appreciated. Please see the attached Study Recruitment Script, which may be used in your e-mail distribution to members. Interested members should contact me directly at my secured e-mail address of moniareej@gmail.com or they may contact me at 205-663-4621 or 205-901-6237. All information received including the names of individuals and their schools will remain confidential.

Thank you in advance for your assistance in this study with hopes to foster insight into how nurse educators teach about chronic pain.

Sincerely,

Moniaree Jones RN, MSN, COHN-S, CCM  
Doctoral Student (Instructional Leadership)  
The University of Alabama at Tuscaloosa
APPENDIX E

ALABAMA LEAGUE OF NURSING E-MAIL RECRUITMENT SCRIPT
My name is Moniaree Jones and I am a doctoral student at The University of Alabama in the College of Nursing and College of Education (Instruction and Leadership) program. The purpose of my study is to explore the lived experiences of nurse educators who have personally lived with chronic pain or cared for someone with chronic pain. I want to gain a better understanding of how these educators share about their pain, and to understand how their lived experience may shape how they teach about chronic pain. Understanding the lived experience of nurse educators can assist in determining if there are changes in how nursing faculty teach pain assessment, and determine if implications exist for reform in undergraduate nursing curriculum.

I am seeking interested nurse educators to agree to be in my study. Nurse Educators who may wish to participate in this study will be full-time nursing faculty of Baccalaureate or Associate degree programs with a minimum of a master’s degree in nursing. The nurses may possess a further graduate degree in nursing or a related field, and need to be current instructors in schools of nursing either accredited by the National League for Nursing Accrediting Commission or the Commission on Collegiate Nursing Education. The participants accepted into this study will have personally experienced chronic pain or have personally cared for someone with chronic pain. Each educator will be privately interviewed three times and each interview may last about sixty minutes at a location mutually convenient to the educator and the researcher.

Chronic pain refers to persistent pain lasting six or more months. The chronic pain may be a result of an initial mishap such as a sprained back, serious infection, or there may be an ongoing cause of pain such as arthritis, cancer, ear infection, or other problem. Common chronic pain complaints include migraine headaches, low back pain, arthritis pain, neurogenic pain, and psychogenic pain.

Your consideration to participate in this study is important and appreciated. Interested nurse educators should contact me directly at my secured e-mail address of moniareej@gmail.com or they may contact me at Home-205-663-4621 or Cell-205-901-6237. All information received, including the names of individuals and their schools will remain private.

Thank you in advance for your assistance in this study with hopes to foster insight into how nurse educators teach about chronic pain. Should you need any additional information, please feel free to contact me at the address and numbers listed above with your questions.
APPENDIX: F

INTERVIEW PROTOCOL SCRIPT
My name is Moniaree Jones and I am a doctoral student in the College of Nursing and the College of Education (Instructional Leadership) at the University of Alabama. The purpose of my study is to explore the lived experiences of nursing faculty (nurse educators) who have personally experienced chronic pain and to better understand how these educators share about their pain and to understand how the experience of living with chronic pain may shape how they teach about chronic pain. Understanding the lived experiences of nurse educators can assist in determining if there are changes in how nursing faculty teach pain assessment and determine if implications exist for reform in undergraduate nursing curriculum.

I understand that you are willing to participate in this study and you understand that there is no penalty for choosing not to participate or for withdrawing from the study. Is this correct?

You may ask me any questions at any time during this study. I wish to speak to you about your personal experiences dealing with chronic pain and about learn how you teach about pain to nursing students. The study consists of three interviews about one hour or less each depending on how you answer the questions. I will be audio taping the interviews because I wish to capture your experiences in the best way possible. I may take a few notes during our time together. I invite you to share any information that will give insight into your lived experience.

The information you share with me will be confidential and a pseudonym (type of identifying code to replace your identifiable name) will be used to help maintain confidentiality and connect you to the information you share with me. You do not have to discuss anything you do not choose to and you may end the interview at any time.

Do you have any questions about what I have just explained?

Are you willing to participate in this interview?

We will now begin the interview questions.

Part One (First Interview)

1. I would like you to tell me a little about where you grew up.
2. What is your earliest memory of hearing about or experiencing chronic pain?
3. Could you give me some examples of any life encounters with acute or chronic pain that you have experienced and your thoughts about those experiences?
4. Is there anything or things that you believe shape how you view pain, and if so, can you describe those to me?
5. What have been your personal experiences in the healthcare system regarding pain issues? Are there things that trigger anxiety or concern based on what you know about pain?

Part Two (Second Interview)

- Last time we spoke, we talked about where you grew up and your experiences of learning about pain. We also talked about your personal experiences with the healthcare system regarding pain and things that trigger anxiety or concern based on your pain. Is there anything that you would like to add that you did not talk about last time?

2. How do you define pain? What is the difference between pain and chronic pain? When does pain stop being chronic pain? What are your symptoms like, and how do you manage to get through the day or week? What is it like to live with your symptoms day after day? How has your chronic pain changed over time or has it?

3. Tell me when your personal symptoms began? What was that like then and what is it like now. Do they differ in any way and if so how?

4. How do you think our culture deals with pain?

5. How has living with your symptoms affected your life? Has your experience of chronic pain affected the way you feel about yourself?

6. Do you teach about pain? If so, when and how often? Do you believe barriers exist in teaching about accurate pain assessment? If so, describe these barriers.

7. Tell me about a time when you had a student who cared for a patient who they thought might be faking pain or a time you felt a patient was improperly assessed for pain.
Part Three (Third Interview)

- Last time we spoke, we talked about your personal symptoms with chronic pain, what they are like and how you manage your pain. We also talked about how you teach about pain. Is there anything that you would like to add that you did not talk about last time?

1. Given what you have said about your life before chronic pain, and given what you have said about your lived experience with chronic pain now, how do you understand the chronic pain in your life? What sense does it make to you? In other words, given the fact that you experience chronic pain in your life, where do you see yourself in the future?

2. Is there anything you would like to add to our conversations about chronic pain?

I am thankful for your time in helping me with this important study. I will gladly share the findings of the study with you once the study is complete.
APPENDIX G

APPROVAL LETTER FROM PRESIDENT REITHA CABANISS,
ALABAMA LEAGUE FOR NURSING
March 29, 2012

Dear Ms. Jones,

I am writing this letter as confirmation of our previous conversation regarding your doctoral dissertation. As I stated over the phone, I agree to send out the email to current ALN members giving them an opportunity to volunteer as a participant in your study, *The Lived Experience of Nurse Educators with Chronic Pain*. My understanding is that once the ALN member contacts you at a secure email that you will provide detailed information outlining how they would participate. I understand that you will determine if the ALN member meets the criteria for your study.

I recognize the value of nursing research. I look forward to assisting you in the pursuit of higher education.

Warm regards,

Reatha Cabaniss, ALN President 2011-2013
APPENDIX H

PERMISSION TO USE WONG-BAKER FACES PAIN RATING SCALE
Hello Moniaree,

Congratulations on your pending doctorate. I am attaching a jpeg file. It might be better in your paper than the pdf download.

Good luck!

Best Wishes,

Connie

Connie M. Baker, MS
President and Executive Director
Wong-Baker FACES Foundation
www.WongBakerFACES.org
(405) 633-2230

On 5/16/11 2:49 PM, "moniareej@gmail.com" <moniareej@gmail.com> wrote:

Name
Moniaree Jones
Phone
205-663-1621
Email
moniareej@gmail.com
Website
http://
What is your planned use for the Wong-Baker FACES Pain Rating Scale?
I am a doctoral student in nursing education at The University of Alabama at Tuscaloosa and I would like to put a copy of this scale in my dissertation as an example of one pain rating scale. Thank you for your help!
Moniaree Jones MSN, RN, CDHP-E, CCM
Which items are you planning to use?

- FACES Scale in English

Copyright Agreement

- I agree to the Terms and Conditions of the Copyright.

Best Wishes,

Connie M. Baker, MS
President and Executive Director
Wong-Baker FACES Foundation