Advancing the Assessment and Management of Chronic Non-Oncological Pain: Qualitative Research with Albanian Primary Healthcare Providers

Fatjona Kamberi[1], Glodiana Sinanaj[1], Jerina Jaho[1], Vjollca Ndreu[2], Ilirjana Zekja[2], Enkeleda Sinaj [2]

[1] Scientific Research Centre for Public Health, Faculty of Health, University of Vlore "Ismail Qemali", Vlore, Albania
fatjona.kamberi@univlora.edu.al, glodiana.sinanaj@univlora.edu.al, jerinacelaj13@gmail.com
[2]Faculty of Technical Medical Sciences, University of Medicine Tirana, Albania
vndreu@hotmail.com, ilirjana.zekja@umed.edu.al, enkeleda.sinaj@umed.edu.al

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Abstract

This qualitative descriptive study explored the experiences, perceptions, and practices of primary healthcare providers—nurses and family doctors—in assessing and managing chronic non-oncological pain in Albania. Using purposive sampling, eight professionals (four nurses and four family doctors) from primary care centers in Vlore and Tirana participated in semi-structured interviews between January and February 2025. Data were analyzed thematically using Braun and Clarke's six-step approach. Nine key themes emerged: assessment strategies, pain history and analysis, communication, management approaches, non-pharmacological methods, collaboration, education, barriers, and solutions. Nurses relied largely on patient-reported symptoms and observational cues, while family doctors employed diagnostic tools and considered psychosocial factors. Both groups emphasized interdisciplinary collaboration, patient education, and individualized care planning. Challenges included limited resources, patient non-compliance, and systemic barriers. Despite their differing roles, both nurses and doctors underscored the need for validated assessment tools and a holistic, team-based model to enhance patient outcomes. These findings support the DJO KRON project's objectives, which aim to improve chronic non-oncological pain care through education, innovation, and primary healthcare system reform. The study highlights the importance of integrated care models, ongoing professional development, and the adoption of multidisciplinary strategies to better address the complex needs of patients living with chronic pain.

Key-words: chronic non-oncological pain, primary healthcare, pain assessment and management, DJO KRON project, Albania.

Introduction

Chronic non-oncological pain (CNOP) is a prevalent and often debilitating condition that significantly impairs quality of life and places a substantial burden on healthcare systems worldwide. Defined as pain persisting for more than three months and not associated with malignancy, CNOP affects approximately 20% of the global population [1, 2]. Additionally, chronic non-oncological pain and high-impact chronic pain are more prevalent in women, increase with age, vary by race and ethnicity, and are more common in less urbanized areas [3]. Common conditions such as osteoarthritis, fibromyalgia, chronic low back pain, and neuropathic pain syndromes are among the primary contributors to CNOP [4]. Despite its high prevalence, CNOP is frequently underdiagnosed and undertreated in primary healthcare settings, where time constraints, inadequate training, and limited access to multidisciplinary resources hinder effective management [5, 6]. Primary healthcare practitioners (PHCPs) serve as the first point of contact for many individuals experiencing chronic pain, placing them in a critical position to assess and manage CNOP effectively. However, the complexity of chronic pain—

encompassing biological, psychological, and social dimensions—requires a comprehensive biopsychosocial approach to both assessment and intervention [7]. Pharmacological approaches, especially opioids, are commonly used in primary care settings to manage chronic non-oncological pain [8]. However, their long-term effectiveness is limited, and they are associated with risks such as dependency and adverse side effects [9]. A recent study highlighted the complex nature of chronic pain management, showing that psychological, social, and economic factors significantly contribute to chronic non-oncological pain. This reinforces the need for standardized guidelines and protocols, particularly in primary care settings [10]. Furthermore, advances in pain pathophysiology are transforming pharmacological pain management by enabling the identification of pain sources and mechanisms. In this regard, multimodal therapy targets specific mechanisms through the appropriate use of drugs, including non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroids, sodium channel inhibitors, opioids, antidepressants, and other agents [11]. In Albania, there is a lack of scientific evidence regarding the assessment and management of non-oncological chronic pain in clinical settings, both in hospitals and primary care. A study conducted in Albanian hospitals in 2018 showed that pain is the most common symptom that brings people to the hospital, but the use of validated questionnaires to assess pain in clinical settings is lacking [12]. Additionally, a recent study of Albania's healthcare system suggests that there is a lack of standardized protocols for assessing and managing pain. The study also highlights the need for continuous scientific research and development to address the challenges identified while offering solutions based on the proven practices of developed countries in pain management [13]. The limited scientific evidence available on pain management in Albania, as suggested by the literature review, primarily focuses on the pain management of cancer patients rather than on non-oncological chronic pain [14]. Global evidence highlights that the high prevalence and associated characteristics of chronic pain emphasize the need for comprehensive, multicomponent care pathways, grounded in a biopsychosocial model and interdisciplinary approaches for effective management [15]. This underscores the necessity for better assessment tools, clinical guidelines, and multidisciplinary strategies to improve the management of chronic non-oncological pain (CNOP) in primary care. Therefore, the aim of this study is to explore and understand healthcare providers' experiences, perceptions, and practices in assessing and managing CNOP in primary healthcare settings in Albania.

Materials and Methods

Study Design

This study employed a qualitative descriptive design using semi-structured interviews to explore the experiences, perceptions, and practices of healthcare providers—both nurses and family doctors—in the assessment and management of non-oncological chronic pain in primary healthcare settings. A thematic analysis approach was used to analyze the data and identify patterns relevant to clinical practice and healthcare system challenges.

Participants and Sampling

Participants were healthcare professionals—both nurses and family doctors—involved in the management of chronic non-oncological pain. A purposive sampling strategy was used to select participants based on the following criteria: a) Direct involvement in managing patients with non-oncological chronic pain, b) A minimum of one year of clinical experience in primary healthcare settings, and c) Willingness to participate in an in-depth interview. A total of eight participants—four nurses and four family doctors—were interviewed until data saturation was reached, indicating that no new themes emerged. The healthcare providers were from primary healthcare settings in the cities of Vlore and Tirana. These settings were purposively chosen, as the study is part of the research project DJO KRON – Improving the Assessment and Management of Chronic Non-Oncological Pain in Primary Health Care Services, which was selected as a winner in the call for projects under the National Research and Development Program for the period 2024–2025 by NASRI, Albania. The implementation of the DJO KRON project included primary healthcare centers located in the cities of Vlore and Tirana.

Data Collection

Data were collected through semi-structured, in-person interviews conducted between January and February 2025, each lasting between 30 and 60 minutes. An interview guide was developed based on a review of the literature and expert input and included tailored questions for nurses and family doctors. The guiding questions for nurses focused on the following topics: 1) Methods and tools for assessing chronic non-oncological pain; 2) Challenges in the management of chronic non-oncological pain; and 3) Barriers to effective pain management in clinical practice.

The guiding questions for family doctors addressed the following topics: 1) Methods and tools for assessing chronic non-oncological pain; 2) Management and treatment strategies for chronic non-oncological pain (both pharmacological and non-pharmacological); 3) Interdisciplinary collaboration; 4) Systemic barriers and challenges; and 5) Views on emerging technologies and innovations.

All interviews were audio-recorded (with participants' consent), transcribed verbatim, and anonymized to protect participant identities.

Data Analysis

The transcribed interviews were analyzed using thematic analysis, following Braun and Clarke's six-step process [16]:

1. Familiarization with the data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Coding was conducted manually, and themes were refined through iterative comparison across transcripts. To ensure credibility and consistency, two independent researchers reviewed the themes. To ensure credibility, dependability, transferability, and confirmability, triangulation was applied by involving multiple researchers in the data analysis process. Member checking was conducted by providing participants with summaries of the findings for validation and feedback. Additionally, a detailed audit trail documenting coding decisions and theme development was maintained to enhance transparency and accountability.

Ethical Considerations

The study received approval from the Ethics Counci at the University of Medicine, Tirana, Albania. All participants gave their informed consent before engaging in the research. To ensure privacy and confidentiality, participants were assigned unique codes, and the data was secure stored codes, and the data was secure stored.

Results

A total of 4 primary care nurses and 4 family doctors were approached and agreed to participate in the study, with 2 nurses and 2 doctors from each of the cities of Vlore and Tirana.

The average age of the nurse participants was 46 years (SD = 5.5), and all were female (N = 4; 100%). They had an average of 19.5 years of clinical experience (range: 14–25 years). The average age of the family doctor participants was 39.5 years (SD = 3.2), and, like the nurses, all were female (N = 4; 100%). Their average length of clinical practice was 12 years (range: 10–14 years). The healthcare providers indicated that they primarily serve older adults and individuals from low socio-economic backgrounds, typically treating 1 to 3 patients daily with chronic non-oncological pain.

The interviews lasted between 30 and 60 minutes and were conducted at healthcare centers in Vlore and Tirana. The healthcare providers were given the opportunity to review the list of guided questions before the interviews, which were sent via email.

The analysis revealed nine key themes related to chronic non-oncological pain for both nurses and family doctors, which included: identification & assessment, pain history & analysis, communication & engagement, pain management strategies, non-pharmacological methods, collaboration, education, barriers, and solutions & recommendations. A summary of the thematic findings is presented in
Table 1.

Table 1. Thematic Findings of Primary Healthcare Providers Interviewed, n=8 (4 Nurses and 4 Family Doctors)

Theme	Family Doctor's Perspective on Chronic Non-Oncological Pain	Primary Healthcare Nursing Perspective on Chronic Non-Oncological Pain
Identification & Assessment	Use of chronic pain criteria, diagnostic tools, psychosocial factors (e.g., depression), and impact on daily life. Reluctance to report pain is a key challenge.	Based on patient self-report, posture, discomfort, vital signs, and limited assessment tools. Challenges include dishonesty and poor cooperation.
Pain History & Analysis	Detailed anamnesis including lifestyle, job, education, and socioeconomic status.	Focus on history (onset, location, and family background), intensity, frequency, physical/emotional/social dimensions.
Communication & Engagement	Relies on patient communication and regular follow-ups.	Use of simple, clear questions; probing daily habits to encourage honest reporting; education and empathy to manage non-adherence.
Pain Management Strategies	Combines pharmacological (NSAIDs, antidepressants) and non-pharmacological (physiotherapy, psychotherapy) treatments. Opioids used rarely.	Goal-setting, monitoring effectiveness, pharmacological treatments prescribed by doctors; nurses track outcomes and side effects.
Non-Pharmacological Methods	Preferred methods: physical therapy and psychotherapy. Less reliance on alternative medicine.	Lifestyle education, physical therapy, psychiatric referral, symptom tracking via patient feedback.
Collaboration	Shifting from limited to more multidisciplinary collaboration; referrals to specialists based on triage and history.	Work with doctors, specialists, psychologists, and physiotherapists for coordinated care.
Education	Tailored to patient's literacy and background. Includes diet, lifestyle, and treatment understanding. Monitored through follow-ups.	Patient and family education, home visits, use of printed materials, and emotional support.
Barriers	Major challenges include non-compliance, system-level limitations (reimbursement, access), financial hardship, and unrealistic patient expectations.	Systemic (lack of cooperation, tools), structural (undervalued nurse roles), and socioeconomic (poverty, labor, nutrition).
Solutions & Recommendations	Call for better-qualified staff, increased tech integration, use of non-invasive treatments, and addressing post-COVID-related chronic pain.	More training and resources, stronger nurse-patient relationships, improved documentation of roles, and better system-level support.

Discussion

Chronic non-oncological pain management in primary healthcare settings is a complex issue that requires a comprehensive, multidisciplinary approach. The thematic analysis of pain assessment and management practices by both nurses and family doctors in primary healthcare settings in Albania highlights key similarities and differences in their roles, strategies, challenges, and recommendations for enhancing patient care. More detailed insights into the themes identified in Table 1 and their alignment with existing literature are outlined below:

Identification and Assessment

As evidenced in our study, both nurses and family doctors emphasize the importance of patient self-reporting and clinical observations in identifying chronic non-oncological pain. Nurses rely heavily on cues such as patient posture, visible discomfort, and vital signs to assess pain, while also acknowledging the challenges posed by limited patient cooperation. These findings contrast with a systematic review on pain management by nurses, which found that the majority of nurses employed standardized pain assessment tools with patients, regardless of their ability to self-report. Current guidelines recommend that pain assessment and management by nurses be conducted as routinely as the monitoring of vital signs [17]. In our study, family doctors underscore the use of chronic pain criteria, diagnostic tools, and the consideration of psychosocial factors—such as depression—in pain assessment. They also highlight the challenge of patient reluctance to report pain, which can complicate diagnosis. These results are consistent with findings from other studies, which indicate that family doctors frequently take into account psychosocial factors like depression and anxiety, both of which can exacerbate the perception of pain [18]. However, physicians typically utilize a broader range of diagnostic tools, including questionnaires, physical examinations, and psychological evaluations, to complement the patient's medical history. Despite these efforts, both groups of primary healthcare providers in our study face significant barriers due to the inherently subjective nature of pain, as patients often underreport symptoms or provide inconsistent responses—a challenge also well-documented in the literature [19].

Pain History and Analysis

In taking pain history, nurses primarily focus on patient-reported information such as the onset, location, and duration of pain, while also observing physical indicators like skin color and vital signs. This approach aligns with their role in maintaining continuous patient engagement through routine assessments [20]. In contrast, family doctors tend to gather a more comprehensive history, taking into account the patient's socioeconomic status, lifestyle factors, and comorbid conditions. The inclusion of psychosocial dimensions—such as social isolation and stress—is integral to both nursing and medical assessments, as these factors are frequently associated with increased pain intensity [21].

Communication and Engagement

Both nurses and family doctors interviewed in our study recognize the importance of effective communication with patients to accurately assess pain levels and support treatment adherence. The significance of communication is also well-supported in the literature. One study suggests that nurses are particularly focused on using simple, clear language to encourage honest reporting, emphasizing empathy and persistence in addressing patient reluctance or non-adherence [22]. In contrast, doctors tend to rely more on clinical interviews, drawing on patient history and, in some cases, incorporating psychological counseling to explore the underlying causes of non-adherence [23]. Both healthcare providers agree on the value of patient education as a strategy to reduce non-compliance. However, their approaches differ: nurses often prioritize emotional support and the involvement of family members, while doctors tend to focus on promoting lifestyle changes and enhancing patient understanding of treatment plans. In this context, our findings align with previous research highlighting the role and effectiveness of cognitive behavioral therapy as a widely used therapeutic approach in managing various health issues, including chronic pain [24].

Pain Management Strategies (Non-Pharmacological Methods, Collaboration and Education)

When it comes to pain management, nurses and family doctors often work collaboratively, as evidenced by our study. Family doctors are primarily responsible for prescribing pharmacological treatments—such as NSAIDs, anti-inflammatory drugs, and analgesics. Nurses, in turn, play a key role in monitoring treatment effectiveness and managing side effects through regular follow-up visits. While doctors may prescribe stronger medications, including opioids in rare cases, they generally favor a multidisciplinary approach that incorporates non-pharmacological interventions such as psychotherapy and physiotherapy. Nurse participants in the study also emphasized the importance of patient education and lifestyle modifications as complementary strategies to pharmacological treatment. Non-pharmacological interventions for individuals with chronic non-oncological pain have been shown to be effective in reducing pain, as supported by the literature [25]. Furthermore, other studies highlight the value of a complementary approach, reinforcing the interdisciplinary nature of pain management, in which both healthcare providers contribute uniquely to the overall care plan [26].

Barriers

As the findings of our study suggest, both nurses and family doctors face a variety of barriers in managing chronic non-oncological pain. System-level challenges—such as the lack of validated assessment and diagnostic tools, limited interdisciplinary cooperation, and

insufficient resources—are commonly reported by both groups of primary healthcare providers. Socioeconomic factors, including financial hardship and housing instability, also hinder patients' ability to adhere to pain management plans, as noted in previous research [27]. In our study, nurses emphasized structural barriers, such as the undervaluation of their role in pain management. In contrast, family doctors highlighted systemic limitations, including restricted access to care and issues with medication reimbursement.

Other studies have also highlighted similar obstacles, such as patient-related issues, a lack of professional knowledge, and organizational limitations, which hinder the delivery of both pharmacological and non-pharmacological treatments [28]. Furthermore, unrealistic patient expectations and poor adherence to treatment remain ongoing challenges for both professions, which must often be addressed through patient education and continuous follow-up, as recommended by the literature [29].

Solutions and Recommendations

Both nurses and family doctors in the study suggest strengthening interdisciplinary collaboration as a critical solution to improving pain management. Nurses recommend more training and resources to enhance their role in chronic non-oncological pain care, including better documentation and formal recognition of their contributions. Family doctors advocate for better-qualified staff, especially coordinators and general practitioners, to improve multidisciplinary collaboration. Since medical treatments often cannot fully alleviate pain, it is important to adopt comprehensive management strategies for chronic pain, which include psychological interventions. Psychotherapy for chronic pain primarily aims to enhance physical, emotional, social, and occupational functioning, rather than solely focusing on eliminating pain [30]. Additionally, both groups support the integration of technological advancements, such as electrode therapy and telemedicine, to enhance the effectiveness of chronic pain management. In this regard, the future perspective on pain management is under development, incorporating new technologies and advancements as stated [31]. Furthermore, both nurses and family doctors emphasize the role of patient education as a key factor in improving treatment adherence and self-management. Nurses specifically highlight the need for emotional support and family involvement in education, while family doctors focus more on lifestyle modifications and disease awareness. Both healthcare provider groups recognize the importance of psychological support in addressing mental health issues like anxiety and depression, which are often associated with chronic pain. These findings are consistent and contribute to the growing evidence supporting the use of interdisciplinary approaches, acceptance and commitment therapy, and patient education for chronic pain, particularly regarding the clinical effectiveness of shorter treatment durations [32].

Conclusion

The key findings from the perspectives of family doctors and primary healthcare nurses on chronic non-oncological pain in Albania highlight several important themes. Family doctors use specific criteria and diagnostic tools, taking psychosocial factors into account, although patient reluctance to report pain remains a challenge. Nurses, in contrast, rely on patient self-reports, vital signs, and posture but face issues such as dishonesty and poor cooperation. Family doctors collect detailed lifestyle and socioeconomic data and emphasize follow-ups, while nurses focus on pain history, its impact, and prioritize empathy. In terms of pain management, doctors employ a mix of treatments, using opioids sparingly, whereas nurses concentrate on goal-setting and tracking treatment effectiveness. Both emphasize the need to collaborate with specialists, work in teams, tailor patient education, and navigate challenges such as non-compliance and healthcare system limitations. Both healthcare providers agree on the importance of education, multidisciplinary collaboration, and patient-centered care, although their methods and perspectives reflect their distinct roles within the healthcare system. They stress the value of a holistic, coordinated approach to chronic non-oncological pain management, along with the use of validated assessment tools in clinical practice. In conclusion, it is emphasized that the future of chronic non-oncological pain management may benefit from a stronger interdisciplinary approach, continuous education, and technological innovations aimed at improving patient care and outcomes.

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