



Staff perspectives regarding the implementation of a yoga intervention with chronic pain self-management in a clinical setting



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ABSTRACT

Chronic pain affects millions of Americans and can be addressed through multiple modalities, interventions, and strategies. Yoga and self-management have been proven effective in treating chronic pain, but little research has been conducted on the feasibility and implementation barriers related to these alternative intervention forms. In our qualitative study, we examined staff perceptions regarding the feasibility of implementing yoga along with established self-management at a pain management clinic in Colorado. We utilized the Implementation Drivers of *Competency*, *Organizational*, and *Leadership*, and our added *Hypothetical Driver* to explore barriers and facilitators related to project implementation. Our findings suggest that positive staff and patient attitudes were crucial for successful implementation. We also identified physical space, transportation, and supportive leadership as necessary components of project implementation. Further research is needed to examine barriers such as funding to ensure intervention sustainability and the need for adequate staffing.

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1. Introduction

Approximately 126 million U.S. adults experience some level of pain, of these nearly 50 million suffer from chronic or severe pain [1]. Chronic pain is pain that persists beyond normal healing time; pain duration between 3 and 6 months is used to distinguish chronic pain [2]. Females, individuals with low-income (\$25,000 and below), and less education (high school and below), and individuals who are divorced are at higher risk of experiencing chronic pain [3].

Chronic pain impairs function, cognitive and physical ability, and mobility and negatively impacts quality of life, disrupts sleep, and increases the likelihood of experiencing depression and anxiety [4,5]. Relationships and interpersonal lives are also affected by chronic pain as evidenced by increased social isolation, family

stress, caregiver burden, spousal depression/anxiety, negative relationships, lower relationship quality and satisfaction, embarrassment, and fear of stigmatization [4,6].

Self-management, the ability to manage the symptoms, treatment, physical and psychological consequences, and lifestyle changes inherent to living with a chronic condition [7], is important for the proper management of chronic pain [8]. Yoga is another method demonstrated effective in improving outcomes in people with chronic pain [9]. The form of yoga most commonly utilized in treatment of chronic pain is Hatha yoga—noted for its gentle practices, traditional postures, and focus on breathing techniques [10,11]. Iyengar style of Hatha incorporates the use of props and is therefore well suited for individuals with pain or disabilities [12]. As an intervention, yoga has been shown to support reduction in functional disability and pain intensity, as well as lowered depression levels for participants [12].

Little is known about the feasibility of implementing a yoga and self-management intervention together in a clinical setting. Much of the current research focuses on individuals' with chronic pain perceptions of participating in self-management interventions. The purpose of our qualitative evaluation was to investigate project staff's perspectives regarding the implementation of yoga programming into ongoing self-management at a pain management

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clinic. Specifically, the purpose of our study was to assess the strengths of implementing yoga; the barriers to implementation; and how the yoga intervention can be modified to improve implementation with established self-management programming. As a part of our evaluation, we, as a separate part of the research team acting as external reviewers, explored the yoga project staff's perceptions of project implementation.

2. Material and methods

Although self-management and yoga improve health outcomes for people with chronic pain, the interventions have not yet been combined to maximize benefits. Therefore, part of the research team conducted a pilot study by adding yoga to a previously established self-management program at a pain management clinic, while we as a separate part of the research team looked at the feasibility of implementation from the staff perspective. The yoga intervention consisted of an eight-week class, which met for 1 h twice a week; the yoga itself was modified specifically for individuals with chronic pain and utilized certified occupational therapists as yoga instructors. Several rounds of the eight-week program were offered at differing skill levels allowing individuals to progress from beginner to moderate to advanced moderate if they chose. The yoga pilot was completed in June 2016.

2.1. Study design and setting

This descriptive, qualitative case study [13] was conducted at a pain management clinic in Colorado. The pain management clinic's mission is to help patients function better in daily life. This clinic is embedded in a larger general medical clinic. They do however have their own separate physical space and a dedicated entrance with their own phone line that enhances consumer friendliness. This study has Institutional Review Board approval.

2.2. Sample

Our study used a purposeful sample which included all project staff associated with the yoga intervention as a part of ongoing self-management at the pain management clinic. Our sample consisted of 13 project staff. The project staff represent varied disciplines including doctors, nurses, clinicians, yoga instructors, and occupational therapy research assistants. Project staff were recruited verbally via phone and/or email to arrange a time to conduct interviews. Due to the small sample size, all participants are referred to as "project staff" in order to maintain confidentiality.

2.3. Interview protocols

Our focus was project staff's responses, opinions, and attitudes regarding implementation of the yoga intervention with established self-management at the pain management clinic. We utilized semi-structured interviews consisting of open-ended questions [13]. These questions emphasized project staff's perceptions of yoga and the integration of this intervention into the pain management clinic, feasibility of future implementation, generalizability, observed benefits, and perceived barriers.

2.4. Data collection

We conducted seven individual interviews and one focus group at the pain management clinic. The semi-structured format allowed researchers to ask follow up questions in order to clarify information provided by project staff. The individual interviews and focus group were completed in January and February 2016 and were

facilitated by four of the researchers (E.W., R.R.F., R.B., and G.C.). Each individual interview and focus group was digitally audio recorded, with an average length of 30 min, and then transcribed verbatim for use in analysis.

2.5. Data analysis

2.5.1. Coding procedure

We conducted our analysis using a theoretical coding structure [14] based on *Implementation Drivers: Assessing Best Practices* [15]. In their review of the relevant implementation science literature, Fixsen et al. [15] found that *Implementation Drivers* can be both barriers and facilitators in the implementation of evidence-based programs. *Implementation Drivers* include: *Competency, Organizational, and Leadership Drivers* [15] and we defined them as *Competency*, attitudes and beliefs of staff and patients that affect the delivery of services; *Organizational*, structural elements of the intervention or organization that impact the delivery of services; and *Leadership*, the level of support for the intervention by leadership and the ability to address financial concerns that impact sustainability.

We used these *Implementation Drivers* as a lens to guide our data analysis. We created an additional category, *Hypothetical Barrier*, to gather project staff's perceptions of potential barriers for continued project implementation at the pain management clinic or in other clinical settings. In addition to the theoretically driven codes, each unit of measurement was also given an open code [30], combining in vivo and researcher words to capture relevant ideas or themes [14]. Fig. 1 illustrates our data analysis process.

2.5.2. First cycle coding

Several pages of transcript were coded adhering to the theoretical coding structure and open coding procedure [16]. Our open codes specifically reflected how the thought related to the associated theoretically driven code. For example, the thought "so the separate space is, in my opinion, crucial" was coded as an *Organizational Facilitator* and the open code "pain clinic is separate from bigger clinic" summarized the idea. These coded portions were then compared and the research team came to an agreement on the codebook. Next, each of the eight transcripts were coded independently by two researchers, who did not conduct the original interview for the transcripts they coded; this was done to increase credibility. We selected four of the transcripts for review, discussion, and clarification of any discrepancies in order to come to an agreement on the codebook to move forward into focused coding [14].

2.5.3. Second cycle coding

We utilized focused coding [14] in our second cycle coding process. The purpose of the focused coding was to establish broad categories for the open codes within each of the theoretically driven code groups. Each researcher (E.W., R.R.F., R.B., and G.C.) reviewed a single theoretically driven code group (*Competency, Organizational, Leadership, and Hypothetical*) and all the first cycle open codes within that group were evaluated to determine which would be collapsed into categories. Once this was completed the research team met to review and come to an agreement on the categories. For example, within the theoretically driven code of *Organizational Facilitator*, the open code of "pain clinic is separate from bigger clinic" was then categorized with similar thoughts as *structure of the clinic*.

2.5.4. Thematic analysis

We employed headings and subheadings [14] as the format to reflect our thematic analysis. Our headings were derived from our

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