Chronic pain has been estimated to affect approximately 24 to 54% of the Swedish population (Bergman et al., 2001; Gerdle et al., 2004), and developing effective interventions for chronic pain is considered a public health priority. Improving access to specialized pain clinics and developing specialists’ treatments are imperative (Thunberg & Hallberg, 2002). However, the first point of contact for patients experiencing pain is usually primary care. In addition, patients often return to primary care after eventual treatments at specialist clinics. Sometimes, patients return to see their specific provider in primary care, leaving the practitioner in a situation where they do not have much more treatment to offer. Other times, patients come back to primary care seeing a new general practitioner, which makes the situation challenging for both parties. All these facts make research on how general practitioners support patients experiencing chronic pain very important (Phelan et al., 2009; Upshur et al., 2010).

Thus, the aim of this study is to explore general practitioners’ coping strategies from a holistic perspective, meaning we explore not only aspects related to the individual provider but also organizational and temporal factors. The research question of the study is:

Research Question 1 (RQ1): How do general practitioners cope with the challenges they face when trying to provide effective and supportive interventions to pain patients within the organizational context of a health center?

Subsequently, we outline our theoretical perspective on pain and earlier research.

A Transdiagnostic Perspective on Pain in Research

Pain is frequently presented as a result of a disease or an injury and has numerous causes ranging from fibromyalgia to nerve damage. Although there are important incitements to study particular medical conditions separately, several...
commentators argue that long-term pain can, and should, be considered a condition in itself (Rief et al., 2012) with its own medical definition and taxonomy (Mills et al., 2019). Studies that utilize transdiagnostic approaches to pain show that some challenges and issues are shared among people experiencing pain with different underlying diagnoses, such as relationship issues (Osborn & Rodham, 2010), physical symptoms such as fatigue (Zautra et al., 2007), mental health problems (Burke et al., 2015), and long periods of sick listing (Bartys et al., 2017). In clinical practice, providing the patient with a correct diagnosis is usually one of the main challenges for health-care providers (see discussion by e.g., Treede et al., 2019). This study is informed by the perspective that many challenges in providing pain management are shared across diagnoses despite differences in causes, intensities, and durations, including ongoing or relapses, of pain.

**Previous Research on General Practitioners and Chronic Pain Management**

Several studies suggest that general practitioners face challenges in providing evidence-based and patient-centered chronic pain care. Some of these include dealing with the diverse perspectives that patients and health professionals hold regarding the causes of pain (Nielsen et al., 2013; Phelan et al., 2009) and the different expectations on appropriate interventions (Brown, 2004; Darlow, 2016; Lundberg & Melander, 2019; Matthias & Bair, 2010). Competing expectations of patients and providers give rise to situations where providers try to avoid conflicts with patients (Breen et al., 2007; Cushman et al., 2017; Egerton et al., 2017; Leppänen, 2008), for example, in negotiating treatment with opioids (Harle et al., 2015; Matthias et al., 2013, 2014, 2017). These concerns are further complicated by an inflexible health care system with insufficient resources (Breen et al., 2007; Upshur et al., 2010) not well designed to meet the needs of these patients (Carlin et al., 2018; Lincoln et al., 2013; Thunberg & Hallberg, 2002). The sum of these challenges creates an emotional burden on providers, and feelings of frustration, guilt, and dissatisfaction have been reported (Carlin et al., 2018; Lincoln et al., 2013; Matthias et al., 2010; O’Brien et al., 2011; Vegni et al., 2005). Such feelings may affect providers’ well-being and are important to address to prevent and decrease burnout among health professionals (Hall et al., 2016).

Although many challenges inherent in clinical practice are already documented in the research literature, relatively few studies have focused on how general practitioners deal with such issues related to pain management. Some researchers have highlighted the importance of effective communication, proper patient education and support of self-care, enabling trusting relationships, showing empathy in clinical practice, and fostering shared decision-making (Ahles et al., 2006; Lincoln et al., 2013; Matthias & Bair, 2010; Nowakowski et al., 2017; Upshur et al., 2010). Others have explored communication and negotiations in clinical practice with a focus on opioid treatment (Harle et al., 2015; Matthias et al., 2013, 2014, 2017). Some studies have highlighted the perspectives and feelings of providers (Breen et al., 2007; Leppänen, 2008; Vegni et al., 2005), whereas others show the importance of further training opportunities for professionals (Carlin et al., 2018). Finally, other commentators suggest that research should consider that general practitioners are part of an administrative system, which is limited in time and resources and frame how care can be delivered (Cooper et al., 2015) that, in turn, might affect physicians’ well-being (Wallace et al., 2009).

Although previous research highlight important aspects, these earlier studies have not addressed coping from a holistic perspective, including individual, organizational and temporal factors (which has been called for by e.g., Fu et al., 2018), which is the focus of our study. Subsequently, we introduce the theoretical perspectives framing this study and previous research on health professionals’ coping strategies.

**Coping Strategies Among Health Professionals: Theories and Earlier Research**

According to the foundational work on stress and coping by Lazarus and Folkman (1984, p. 19), “psychological stress is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being.” In their model, both the environment producing stress and the individuals’ appraisal and reaction to it are accounted for. To understand coping in clinical practice from a holistic perspective, we first need to understand what situations are appraised as challenging for general practitioners, and second, what cognitive and behavioral efforts professionals utilize to respond to these challenges.

In their early theories, Folkman and Lazarus (1980) suggested two different types of coping. One was termed problem-focused coping, and this concept captures responses where the individual tries to modify the environment to reduce stress or limit the exposure to the stress (Hasbrouck & Waddimba, 2017). Emotion-focused coping, on the contrary, refers to mental processes where the situation is reinterpreted or reappraised by the individual. This can involve using humor to approach the stressful situation differently or trying to avoid engagement by emotionally distancing oneself (Hasbrouck & Waddimba, 2017). General psychology research suggests that problem-focused coping, in particular, has positive correlations with health outcomes (Penley et al., 2002).

Many studies have addressed work-related stressors and health professionals’ coping and resilience (e.g., Chang...
et al., 2006; Lemaire & Wallace, 2010; Wallace & Lemaire, 2007; Weiner et al., 2001; Zwack & Schweitzer, 2013). These studies conclude that physicians utilize emotion-focused strategies, such as avoidance or approaching a challenge differently, and problem-focused strategies, such as limiting work hours and cultivating professionalism, to cope with challenges in their clinical practice (Hasbrouck & Waddimba, 2017; Lemaire & Wallace, 2010; Wallace & Lemaire, 2007; Weiner et al., 2001; Zwack & Schweitzer, 2013). However, although problem-solving coping seems to be more beneficial for long-term health outcomes, many physicians use some emotion-focused strategies, such as avoidance and distancing, which might become maladaptive in a longer perspective (Hasbrouck & Waddimba, 2017; Lemaire & Wallace, 2010). This points to the importance of differentiating strategies used in clinical practice at different stages of treatment and to analyze their functions at those specific times.

Some previous quantitative research on physicians’ coping strategies also has its limitations. Lemaire and Wallace (2010) argue, for example, that it might be problematic to solely rely on coping measures developed within general psychology. In addition to such measures, they suggest inductive approaches to coping, where physicians can freely describe how they handle challenges to better address strategies that might be occupationally and contextually specific. Some qualitative studies have been undertaken to explore coping inductively (e.g., Hasbrouck & Waddimba, 2017; Weiner et al., 2001), but no study has had a holistic focus on coping when it comes to general practitioners and pain management. However, commentators in the topic area have called for the development and evaluation of strategies that could promote effective pain management (Matthias & Bair, 2010).

Regarding sources of stress, several studies point to the strains caused by organizational factors (e.g., Hasbrouck & Waddimba, 2017; Wallace & Lemaire, 2007). In a study by Wallace and Lemaire (2007), almost half of the participants experienced stress because they were overwhelmed by their workload and many also reported temporal aspects such as time limitations as challenging. In another study exploring how psychiatrists manage uncertainty and risks when providing care (Hautamäki, 2018), participants also reported problems related to how care was structured temporally. In this study, Hautamäki (2018) illustrated a discrepancy between how the organization of care was supposed to be delivered following a linear time structure, while professionals and patients voiced a need to adjust to patients’ changing states of being, which suggests that care rather should be structured as cyclical. The temporal structure of the clinical consultation could thus, in itself, create tensions for professionals when they attend to the patients’ everyday needs.

In addition to organizational sources of stress, several studies show that patient interactions can be experienced as burdensome (e.g., Hasbrouck & Waddimba, 2017; Wallace & Lemaire, 2007). Wallace and Lemaire (2007) report, however, that patient interaction was understood by the participants as the most challenging but also the most rewarding aspect of their work. This raises two important points. First, that general practitioners have to utilize coping strategies in the direct interactions with their patients and, second, that finding effective coping strategies to deal with problematic patient interactions might be very important to promote the well-being of both parties in the clinical interaction.

In accordance with this theoretical understanding of coping, and drawing on the findings from previous studies on chronic pain reported earlier (Breen et al., 2007; Cooper et al., 2015; Lincoln et al., 2013; Upshur et al., 2010), a theoretical assumption of the current study is that practical, personal, and emotional challenges, as well as the coping strategies employed, need to be explored and understood in the context of the organizational and temporal dimensions of pain management framing the work of general practitioners. This study may inductively identify constructive strategies to be utilized in pain management that are both effective for the patient and rewarding to the provider.

Method
Recruitment and Participants
This study is part of a larger project investigating dilemmas in chronic pain management. In this particular study, we conducted 15 interviews with general practitioners, of which 6 participants were recruited after participation in a survey, 4 participants were recruited via advertisements in social media, and 5 via snowball sampling (where participants asked their colleagues to take part). The 15 participants all worked in health centers in several different parts of Sweden. Eight participants were based in three of the largest cities in Sweden, while the rest worked in smaller cities (3 participants) or more rural areas (4 participants). Nine women and six men participated; all were born between 1957 and 1986 ($M_{\text{age}} = 41$ years). Of the participants, nine had finished their specialist training as a general practitioner (experience after completed training was 0–29 years, $M_{\text{experience}} = 7.5$ years), and an additional six were in the final phase of their training.

Ethics
The study was approved by the regional research ethics committee in Gothenburg (No: 1120-16). All participants were given verbal information about the study before the interviews were conducted. They were promised anonymity and the right to withdraw from the study at any time. All participants gave written or oral consent.

Interviews
The first author conducted individual semi-structured telephone interviews with all participants but one. This participant responded to the questions by email. The interviewer
guided the participants through the information sheet and consent form before the interview. Participants were given an opportunity to ask further questions about the study. The interview guide prompted participants to talk about their experiences of caring for patients experiencing chronic pain. Questions included how often they meet people with chronic pain complaints, if they could describe a typical patient seeking help for chronic pain, what they think about their role as a general practitioner in relation to these patients, what they understand as important interventions to manage chronic pain, and the factors that might foster or impede the wellbeing of patients. Interviews lasted for 31 to 44 min ($M_{\text{time}} = 36$ min) and were audio-recorded. The recordings were transcribed verbatim and anonymized. In that process, participants were assigned codes (P1, P2, and so on).

**Data Analysis**

The interviews were initially coded and summarized inductively consistent with Steps 1 and 2 as outlined by Braun and Clarke (2006) in their description of thematic analysis. This was done with NVivo software (version 11 for Mac, by QSR International). These steps involved familiarization with the data (Step 1) and discussion of potential codes and coding of the data with agreed codes (Step 2). Data coded under headings “challenges experienced by the participant” and “coping strategies used by the participant” were further analyzed for this article. By exploring these codes, we tried to focus on all the different ways that the participants experienced challenges and the different coping strategies they employed, instead of just summarizing the most common challenges and coping strategies that were reported. In accordance with our aim to present a holistic perspective on coping, including individual as well as organizational and temporal factors, the inductive analysis moved to a theoretical thematic analysis (Braun & Clarke, 2006). During this process, a narrative methodology (Murray, 2008) was also used to interpret and structure how relevant challenges appeared in relation to temporal dimensions. Narrative analysis is typically used to address how people make sense of a series of events by ordering data within a time dimension with a beginning (e.g., meeting a patient for the first time), a middle (e.g., trying to provide treatment), and an end (e.g., ending the process of care with a patient) (Willig, 2013). The narrative analysis helped to clarify when participants utilized specific coping strategies and make sense of why they chose to act in a certain way with specific patients. This analysis led to the formulation of two timelines and the development of themes (Step 3) which were reviewed and written up in accordance with thematic analysis, Steps 4 to 6 (Braun & Clarke, 2006).

**Findings**

All participants described that providing evidence-based and patient-centered chronic pain care included different challenges and burdens. One participant said that meeting these patients “do not put a smile on my face” (P5) because helping them was often considered difficult. Although most participants thought that they had some effective interventions to offer, they did not always feel well prepared to meet and support these patients. However, the challenges that were described seemed to shift depending on two different temporal dimensions that can be narratively interpreted as placed on two timelines, one of which is called the process of care (see Figure 1). This timeline describes the process from the “initial consultation” with a new patient to the provider’s practice and “post-treatment” as the time in the treatment process when all treatments had been tried and the providers’ arsenal of medical interventions had been emptied. The other timeline is called the help-seeking process and refers to whether the consultation took place early, close to the onset of pain, or late when the patient has had pain for a longer time.

These two timelines may, but do not have to, start at the same time. Each specific phase on these two timelines seemed to present specific challenges in clinical practice that the participants had to cope with (see Table 1). These challenges were accentuated when the timelines did not start simultaneously (see Figure 1), described as a very common situation by the participants. These issues were further framed by organizational challenges, including time-limited consultations, problems with staffing, and long waiting lists.

Subsequently, we describe these challenges and how providers coped with them, structured by the timeline of the process of care. The other timeline, early or late in the help-seeking process, and organizational challenges are elaborated as part of the subthemes presented subsequently. We end with the emotional challenges described by participants.

**Initial Consultations**

**Establishing and sustaining a trusting relationship.** Several participants described the importance of establishing a trusting relationship during the initial consultation with a new patient to their practice: “It is of utmost importance to establish a good relationship in the beginning, that the patient trusts you. Because otherwise they will not listen to what you have to say” (P2). This was especially evident when the patient had seen several providers before coming to the current general practitioner: “Many patients have bad experiences from earlier consultations [. . .] They feel misunderstood” (P6). Participants coped with these situations by letting the patient tell their story (coping strategy 1). This was considered to be helpful for the patient to “to feel closure” (P6), especially if the patient had been offended by their previous provider encounters. These are examples of when the “beginning” of the two timelines does not appear simultaneously and the specific problems this may cause in consultations (see Figure 1).
However, organizational challenges, such as time-limited consultations, typically not longer than 20 to 30 min, affected the ability to build a trusting relationship, as time to listen and validate the patient’s experiences was restricted. One participant explained:

I would say that I need more time when the patient visits. But my schedule is so under pressure [...] so even when they show up as planned I bet I have had [other things] stealing time, making me stressed out (P14).

To cope with these organizational challenges, participants used strategies to find time (coping strategy 2). Although some just worked “after working hours” (P7), others planned their consultations with pain patients to be followed by administrative duties: “The patients that I know need more time—then I plan to see them at times just before my administrative duties, so I know that I have more time if I need it [...] I think it is important to make time” (P6). In this way, the general practitioners found ways of focusing on the patient without getting too stressed out during the individual meeting. However, these coping strategies do not change the organizational structure, which is the source of the problem. In other words, utilizing such coping can be interpreted as a temporary solution.

Even when the provider and patient were able to establish a working alliance, this relationship needed to be sustained. Several participants said that “continuity” (P1, P2, P3, P4, P5, P10, P11, and P13) was important for them to do their job properly by sustaining the relationship. However organizational demands as well as the patients’ rights to seek help elsewhere often led to a severing of the relationship:

It is really hard to see them several times, because we have really long waiting lists. You have to wait for two months to see someone [...] if the patient is unhappy with my assessment [or treatment], then they will just visit someone else [...] until they are satisfied (P5).

Although most participants said that they needed to see the patients regularly, this was hard because of organizational strains. Participants were aware that this was problematic for patients with chronic pain who have had to see many different providers. However, few said that they could do anything to change this fact.

Detecting patients at risk of developing chronic pain. Another challenge that participants said they were not well equipped for was to detect patients with acute pain at risk of developing chronic pain in order “to avoid the negative spiral they might end up in” (P8), which was considered crucial for a good prognosis. Some said that a thorough assessment was important and that using assessment tools (coping strategy 3) to identify patients at risk of developing chronic pain was helpful: “you need to detect these patients, when you understand that yes, this is not progressing as it should [...] and then you can use these assessment tools [...] I think it is called the Linton [activity screening] questionnaire” (P15).
However, organizational challenges not only made this harder but also contributed to the development of chronic pain because in primary care “it takes time for [follow-ups and] referrals and things. [. . .] at that time they might already have had their pain for months and there is a risk it might develop into something chronic” (P7). So although some individual providers had found strategies to cope with this challenge, many were frustrated by not having the organizational conditions to intervene more promptly in these cases. The concept that providers should screen all at-risk patients at an early stage is more complicated in practice because of how care is organized. Again, there was a gap between what participants thought would be most effective to do and what they could actually do in their clinical practice.

Seeing a patient with acute pain right after onset was, nevertheless, not described as the most challenging scenario. On the contrary, the patients who were described as most problematic were those who had experienced pain for a long time, who had seen many health professionals since the onset of their pain, and who did not have objective findings explaining their symptoms:

They might have had the pain for a very long time [. . .] and then you get patients that come to us and they might have been to another health centre before and they are unsatisfied because they haven’t received any help [. . .] and they end up in a vicious cycle [. . .] and I just think it is a bit too late to come at that stage. It is all about finding these patients a bit more early to be able to help them (P6).

This is an example when the two timelines do not start at the same time (see Figure 1) and the subsequent challenges that arise. The general practitioners described that these cases made initial consultations as well as assessments very difficult (see subsequently). Although many patients were described as having seen several health professionals before the current provider, some turned up in clinics without a diagnosis and without having received much help, meaning providers usually had to start from square one. In some cases, providers were also struggling to understand or know “what is what” (P1, P10, P11, P14, and P16), a challenge we turn to next.

### Assessments

**Knowing what is what.** Many participants described that knowing “what is what” (P1, P10, P11, P14, and P16) was challenging, since chronic pain very frequently co-occurs with mental health conditions and/or other psychosocially related problems. In addition, it is not always possible to provide the patient with a well-grounded diagnosis. Finding “the

| Challenges                                      | Coping strategies                                      |
|------------------------------------------------|--------------------------------------------------------|
| Initial consultations                          | 1. Letting the patient tell their story                 |
| Establishing and sustaining a trusting relation | 2. Finding time                                          |
| Detecting patients at risk of developing chronic pain | 3. Using assessment tools                              |
| Assessments                                    | 4. Excluding potential life-threatening conditions that could cause pain |
| Knowing what is what                           | 5. Adopting a biopsychosocial perspective               |
| Diverse expectations and perspectives          | 6. Providing information                                |
|                                              | 7. Letting patients seek help elsewhere                 |
|                                              | 8. Meeting the patient’s demands                        |
|                                              | 9. Using written agreements                            |
| Treatments                                     | 10. Resisting prescribing opioids                        |
| Negotiating treatments                         | 11. Pressuring the patient to make an effort             |
|                                              | 12. Finding compromises                                 |
| "Post-treatment"                               | 13. Using regulations to turn down demands              |
| Accepting and containing                       | 14. Using metaphors                                     |
| Emotional challenges                           | 15. Letting go of the "Mr Fix It-hat"                    |
|                                              | 16. Making sure that everything has been done           |
|                                              | 17. Being there for the patient                         |
| Continuous challenges                          | 18. Limiting the number of patients                     |
| Organizational challenges                      | 19. Being able to look after yourself                   |
|                                              | 20. Doing what you can                                  |

See e.g., coping strategies 2, 10 and 19.
Diverse expectations and perspectives. Although several providers said they tried to adopt a biopsychosocial model in their clinical practice, many patients seem to understand their pain from a biomedical model leading to a “collision”:

There is often a collision now. Because there are these dualistic, you know mind-body dynamics. And so the provider says: “Well, this is because you have mental pain” and then the patient responds “No, my body aches!” And this means you are not getting anywhere (P15).

Although the provider wanted to focus on the patient’s whole life situation and strategies of dealing with the pain, some patients were described as simply wanting to focus on finding underlying reasons and a cure. An interpretation of this finding is that many general practitioners have a biopsychosocial understanding of chronic pain and are able to consider biomedical as well as psychological and social factors, while some patients focus on biomedical aspects only. This means that providers might be able, in one single consultation, to move from the first to the last step in the timeline outlining the process of care (see Figure 1). In contrast, patients might need more time, validation, information, or other interventions to shift their perspective. To handle the potential discrepancies, providers are required to be aware of their own and their patients’ perspectives and use communication skills to motivate patients to shift their perspective as well as skills to describe the biopsychosocial model in a way that makes sense to patients.

Handling discrepancies between these perspectives was not something participants said that they were trained to do. Several participants described trying to provide information (coping strategy 6) to shift the patient’s perspective. However, some patients were described as not “taking” information on board (P7, P8, P10, and P12): “In the best of worlds you can see the patient a couple of times and then move on, but the experience is that these patients seek help somewhere else until they find someone who shares their perspective” (P3). Another way of coping with this challenge was, actually letting patients seek help elsewhere (coping strategy 7): “and they might see someone else. But then you have done what you can [. . .] in relation to these patients [. . .] your help will always be insufficient” (P15). Some said that this was their strategy despite the fact that they thought this would not help the patient come to terms with their condition. Again, there was a gap between what participants did and what they thought would help the patient.

Several participants described additional strategies to help the patient get “on board” (P7). Some said that they met the patient’s demands (coping strategy 8) because they thought that this might eventually change the patient’s perspective and understanding of their condition:

I deal with that by helping the patient to access all kinds of help the patient can think of [. . .] after a while they also understand
that if you have seen [several professionals] and no one can find anything—then no one will ever find anything (P10).

Others used written “agreements” (P7, coping strategy 9) that outlined the responsibilities of the patient and the provider and could include compromises. For example, before a patient’s demand was met, for example, having another X-ray, the patient needed to try an intervention suggested by the provider, for example, going back to work. Such negotiations of care are discussed next.

**Treatments**

**Negotiating treatments.** The biomedical perspective that some patients bring to the consultation implies that some patients expect treatments that can fix their pain, and that “getting rid of the pain is the only way to wellbeing” (P10). Participants said that some patients might demand certain interventions or sick listing and might become “angry” (P1), “disappointed” (P14) or “sad” (P12) when learning that the provider might disagree and not be able to meet their expectations. This situation was understood as difficult because it challenged the relationship:

I think the hard part is when […] I need to say no, to […] still be there. […] if patients are very angry […] when I say no to, for example, a certain medication or sick listing […]—then it is an art to stay […] to still be there and support the patient—when you, yourself, also might become emotionally affected (P1).

As mentioned by this participant, saying no to opioids or sick listing were two situations that could lead to conflicts with patients.

**Opioid treatments.** Most participants said that they did not provide patients with any opioid treatments because of the risk of addiction. Some patients are already on opioids and “you can’t help everyone” (P15). One important organizational factor recognized to help with this issue was having a general policy on prescribing opioids at the specific health center outlining the specific information that patients should be provided:

First of all, you need to inform the patient that it is only for a short period of time and that there is a plan […] well, for how long you are allowed to use these opioids and that you are not allowed to take more than prescribed and that the doctor will not prescribe any more tablets if you lose some of them (P14).

Such general policies illustrate how organizational factors not only create challenges for the practitioners but also provide support in dealing with them.

**Sick listing.** Sickness certifications were described by some participants as very problematic. One provider found the double role as “the treating doctor but also a social security officer” challenging, because: “you should focus on the salutogenic factors […] but now, it can almost develop into a situation where the patient isn’t interested in getting better” (P8), as getting better would threaten their welfare pensions.

Participants also described some patients demanding sickness certifications, which sometimes conflicted with the perspectives of the provider. When it is understood that patients “have given up hope and aren’t interested to get better” (P7), some participants tried to pressure the patient to make an effort (coping strategy 11). By using agreements (described earlier), some providers only agreed to further sick listings if patients did something in return. With a strong working alliance, such pressure was said to actually help patients to become more active. However, others explained that to sustain the relationship, they had to find a balance between emphasizing their perspectives, with the risk of the patient seeking help somewhere else, and giving in to some of the patient’s demands to sustain the relationship. This was described as finding a compromise (coping strategy 12) between the patient’s and the provider’s perspectives: “[U] sually there is a compromise. You know, I give in eventually. […] The patient doesn’t get exactly what the patient wants. And I don’t get what I want.” (P5).

Although some found regulations set by the authorities as problematic for patients, others used the regulations to turn down demands (coping strategy 13) that patients brought to the consultation. For example, participants turned down requests of sickness certification on the grounds that the Swedish Social Insurance Office would deny the request: “People know about this, that getting sick leave is hard nowadays […] and you can use that to stop the person from sliding into a passive state. And I think that is good.” (P9). In these situations, many participants tried to support their patients to return to work by having conversations with employers. Again, a way to try to intervene in the social context as part of a biopsychosocial perspective.

A final strategy to deal with expectations on sick listings was using metaphors (coping strategy 14):

Okay, you have been sick listed for two years and we are not getting anywhere here. If I had given you a pill for two years for high blood pressure and your blood pressure was still high, then it would have been very natural to change that medication, right? (P7).

By using metaphors such as referring to treatments for other conditions, this participant hoped that the patient would understand that trying a new strategy was reasonable to promote change.
**Post-Treatment**

Late in the help-seeking process (see Figure 1), many participants still felt they wanted to do something for their patients: “you still carry on and hope that you will be able to find something, find an angle to tackle [the problem], to turn things around” (P14). Developing “national guidelines” (P15) outlining follow-up plans, similar to those developed for other chronic conditions, was mentioned as assisting providers in feeling that they actually do something for these patients. However, guidelines addressing chronic pain in general, including when and how follow-ups should be done, are currently lacking in Sweden.

**Accepting and containing.** When physiotherapy, medical treatments, psychosocial support, and referrals to specialists all have been tried out, some patients were described as returning to primary care with little or no improvement. In these situations, participants said that they had to move on to a phase in which both the provider and the patient need to accept the situation. To accept the situation, many participants said they had to contain their own and their patients’ worries, anxieties, feelings of helplessness, and frustrations. Here, the role of the provider, therefore, becomes less about fixing and more about containing.

Moving on to accept that there is not much more to do was described as challenging: “you need to have a strategy to let go and move on. And not all of us are very good at that, I think” (P2). However, the key to acceptance was described as “letting go of the Mr Fix It-hat” (P10, coping strategy 15) because, as long as providers keep suggesting things to try, they reinforce the idea to the patient that there is a cure. Several participants also said that to move from fixing to acceptance, they needed to make sure that everything had been done (coping strategy 16). If someone else had done the assessments, they would not have been certain that everything had been done. Several participants recalled cases where other providers had done insufficient assessments, and they were able to provide interventions that effectively improved the patient’s pain, emphasizing the need for reassessment:

I met a patient [...] and he never had a proper assessment [...] and I did one and I found a cause [...] and he had surgery [...] and now he has no pain. So sometimes [...] I really need to check that a proper assessment has been done (P1).

This is another example of when the two timelines, process of care and the help-seeking process (see Figure 1), are not aligned, which raise specific challenges in practice.

In the “post-treatment” phase, providers also needed to help the patient accept their situation. This typically meant that consultations needed to change from how the provider could treat the pain as well as possible to how the patient could live with the pain as well possible. In some cases, participants could not identify what they had done, but some of their patients had now accepted their situation, meaning the provider “must be doing something right” (P12). As suggested earlier, being there for the patient (coping strategy 17), including “reiterating information” (P10 and P12), “listening to” (P2 and P10), and “validating” (P12) the feelings that the patient expressed, was considered important in supporting the patient’s move toward acceptance and learning to live well with their pain.

**Emotional Challenges**

In addition to the challenges described in relation to specific phases of the process of care and the help-seeking process (see Figure 1), working with pain patients was described as having an emotional effect on providers in every specific situation. It was described as “hard” (P1), “unrewarding” (P5), “tiresome” (P13), “frustrating” (P11), and “depressing” (P2). At times, feelings could be so strong that they had to focus on not taking it out on the patient: “sometimes it is almost like you are annoyed with the patient, even though I understand that no one wants to sit there, without work and with chronic pain” (P1). Many of the strategies described earlier were employed to handle the emotional challenges that participants experienced. As a result, some participants limited the number of patients (coping strategy 18) they cared for with these complaints:

Having about five of these patients [...] is about what I can handle at most. To be able to keep engaged and be there for them. I think it would be a lot harder if I had twice as many. That would have felt like an overload (P1).

Participants talked about this as a way to look after themselves and a prerequisite to being there for these patients. Some emphasized that being able to look after yourself (coping strategy 19) depends on how the clinic is “managed” (P2) and how they work is organized, for example, “in teams” (P10) or not. These statements suggest that emotional and organizational challenges are closely related. Within those limits, several participants also tried not to tire themselves out so as to have enough energy for all of their patients. For example, several participants talked about the importance of finding an approach that helped them deal with the existential dilemma of not being able to relieve all of their patients from their suffering. One approach was described as reminding yourself that “you are doing what you can” (P13, coping strategy 20) and that just has to be enough. To sum, coping with challenges inherent in chronic pain management is also about mobilizing the energy it takes to handle challenges on multiple levels and during different times in the process of care and the help-seeking process (see Figure 1).

**Discussion**

The aim of this study was to explore how general practitioners cope with the challenges they face when trying to provide interventions to pain patients from a holistic perspective,
including individual, organizational, and temporal factors. In accordance with earlier studies, the results show that participants experienced emotional (Lincoln et al., 2013; Matthias et al., 2010; O’Brien et al., 2011; Vegni et al., 2005) as well as organizational challenges (Breen et al., 2007; Hasbrouck & Waddimba, 2017; Lincoln et al., 2013; Upshur et al., 2010; Wallace & Lemaire, 2007). Issues related to establishing and sustaining a trusting relationship (Breen et al., 2007; Cushman et al., 2017; Egerton et al., 2017) as well as diverse expectations and perspectives on care and negotiations of treatments (Darlow, 2016; Matthias & Bair, 2010; Nielsen et al., 2013; Phelan et al., 2009) were also evident in this study. In addition, participants in this study did not feel well equipped to detect patients at risk of developing chronic pain or in knowing what is what, that is, what causes the problem and, thus, how to intervene (Slade et al., 2012). Some also said that they experienced challenges “post-treatment,” that is, knowing what to do when the arsenal of medical interventions had been emptied (De Rudder & Craig, 2016).

What is unique about our study is that the results specifically highlight how providers deal with these challenges with a focus on coping. We also address how these challenges and coping strategies need to be contextualized in an organizational setting (Cooper et al., 2015) and a temporal perspective (Hautamäki, 2018). The latter is especially important because different challenges and coping strategies were actualized at different times in the process of care, where the coinciding process of help-seeking could result in additional complications. To develop strategies that can be used to deliver chronic pain management, that is, both effective for the patient and rewarding to the provider, such factors need to be considered in practice as well as in future studies.

**Temporal and Organizational Factors Framing Challenges and Coping Strategies**

The results show that the challenges that providers experience, as well as how they cope with them, are related to the timing of their consultations with regard to the process of care as well as the timing of the help-seeking process (as shown in Figure 1). Temporal aspects are important to understand coping in a holistic perspective (Livneh & Martz, 2007); however, these aspects are often undertheorized in research. The timeline labeled the “process of care” covers participants’ descriptions of how challenges differed depending on whether it was the first consultation with a patient or if they had met the patient several times. This timeline is also compatible with a clinical model assuming that patients present symptoms and the provider assesses and diagnoses these symptoms and provides a treatment that could remove or ease these symptoms (for a critical discussion of this model see, e.g., Sturmberg & Cilliers, 2009). Using temporal models could, therefore, assist practitioners as well as researchers in identifying specific and separate challenges that appear in different parts of the complex process of clinical practice. Such models can help providers reflect on their work as well as identify more general needs of support, education, and resources that would assist them in providing supportive care to people with chronic pain.

The process of care was, however, further complicated by another timeline, namely, “the help-seeking process.” Each step outlined in the model of the process of care was more challenging if the patient—as is often the case—had experienced pain for a longer time and had seen several health professionals before the current provider. These situations meant that general practitioners had to work hard to build a trusting relationship, do assessments all over again, and encourage patients to stop their opioid treatment. All these processes were further complicated by organizational challenges. These arose because of how information is expected to flow in a medical consultation for the medical model to work; the patient provides the general practitioner with information for the provider to make a full assessment and proper diagnosis and thus to suggest and provide proper treatment for the problem to the patient. When information flows as expected, the provider is able to do their job within a 20- to 30-min time-limited consultation. However, participants in this study described that patients’ previous negative health care experience, the nature of chronic pain, diverse expectations, and perspectives as well as patients’ resistance to “taking information on board” was disruptive to this linear flow of information. Understanding processes of health care as linear can thus also be critiqued (see, e.g., Hautamäki, 2018; Sturmberg & Cilliers, 2009).

Although continuity, trusting relationships, and negotiations were seen as important to cope with these challenges, organizational barriers prevented providers from practicing optimally and rather led to a severing of the relationship. Although some practitioners saw this as positive, because noncompliant patients often sought help elsewhere, others stressed that this factor prevented them from providing effective care because there was a gap between what they could do and what they thought would be an ideal intervention.

In sum, in addition to the challenges that have been highlighted in previous studies, our results highlight how temporal dimensions combined with organizational aspects of medical practice seem to obstruct general practitioners from providing effective chronic pain care.

**Contextually andOccupationally Relevant Coping Strategies**

To further address the challenges that practitioners experience in their work with patients with chronic pain, we suggest that the coping strategies described in this study should be quantitatively developed and evaluated as interventions to support evidence-based and effective pain management, as
suggested by Matthias and Bair (2010). Drawing on previous research, the coping strategies that participants employed can be positioned within four domains.

The first set of coping strategies, including “using assessment tools to detect patients at risk of developing chronic pain,” “excluding potential life-threatening conditions that could cause pain,” “adopting a biopsychosocial perspective,” and “making sure that everything has been done” can be clustered as the domain relating to providers’ professionalism (Vegni et al., 2005; Zwack & Schweitzer, 2013), in the sense that they are trying to use medical knowledge to provide proper care.

The second domain is clustering around communication strategies (Matthias et al., 2010, 2014), for example, “providing information,” “letting the patient tell their story.” The strategies labeled “meeting the patient’s demands,” “resisting prescribing opioids,” “pressuring the patient to make an effort,” “finding compromises,” and “being there for the patient” could also be interpreted as related to communication if understood as an intrinsic part of a caring relationship (Matthias et al., 2014). Many also used materials or resources to try to enhance communication, such as “agreements,” “regulations,” and “metaphors.”

A third domain refers to coping with the organizational environment (Lemaire & Wallace, 2010; Lincoln et al., 2013; Zwack & Schweitzer, 2013). Several participants used such means to handle their organizational environment to “be able to look after themselves,” including “limiting the number of patients,” “finding time,” and “letting patients seek help elsewhere.” In coping theory, all of the strategies in these three domains seem to be employed to change or directly address the sources of stress, such as problematic direct interactions with patients as well as organizational factors. This could therefore be labeled problem-focused coping (Folkman & Lazarus, 1980).

A fourth domain included strategies labeled as “letting go of the Mr Fix It-hat” and “doing what you can” are understood as reappraisal and acceptance, which are two recognized emotional-focused coping strategies. Such kinds of coping have also been reported in other studies on physicians’ coping (Hasbrouck & Waddimba, 2017; Lemaire & Wallace, 2010; Zwack & Schweitzer, 2013).

**Future Research**

The four domains of contextually and occupationally specific coping strategies described earlier could be further developed and evaluated quantitatively as interventions to promote a more effective pain management and decrease burnout in overburdened primary care providers. A vast amount of research is focused on addressing challenges related to the professional domain, including developing screening tools (Mehling et al., 2015), assessments (Lichtner et al., 2014), and effective treatments (Oliveira et al., 2012; Veehof et al., 2016) as well as enhancing communication (Alperstein & Sharpe, 2016; Matthias et al., 2017). However, to facilitate constructive dialogue between general practitioners and pain patients, future studies must focus on developing strategies that address the organizational and emotional challenges that the participants in this study describe (Awa et al., 2010). These strategies must, in turn, be related to the temporal dimensions discussed earlier, as it is not only what happens in consultations that affect health care outcomes but also the timing of the consultation in relation to the process of care as well as the help-seeking process (see Figure 1).

In addition, our results suggest that future research with transdiagnostic approaches to pain should stay in close conversations with research on other complex medical phenomena such as medically unexplained symptoms (den Boer et al., 2019). Participants in this study talked about patients with pain as a complex, heterogeneous, and diverse group. Many said that the most challenging situations involved patients with chronic pain that could not be explained by medical findings or where a well-grounded diagnosis was hard to establish. To better address how to cope with these situations, such challenges could be explored across conditions.

**Limitations**

There are differences between countries in terms of how health services and primary care settings are organized as well as practices, for example, prescribing opioids. This means that the transferability of our results from Sweden to other countries may be limited. The situation in Sweden regarding opioids is very different compared to other countries, for example, the United States (Matthias et al., 2017). Another limitation of the study is that we explored the perspectives of providers and not patients in this study. In other words, we do not know whether the strategies that are described by the participants are employed in practice and whether they benefit people living with chronic pain.

This study is also based on a convenience sample of general practitioners of which several explicitly said that they enjoyed working with patients with chronic pain and that they had a specific interest in pain management. This means that their perspectives cannot be generalized to all primary care providers. However, our results highlight that even when such beneficial factors are in place, general practitioners face many challenges. If we are able to address these issues and provide support for the kind of professionals who took part in this study, such interventions would probably also serve primary care providers in general.

A focus to cover as many different kinds of strategies as possible does not tell us anything about how common or effective certain strategies are. However, by documenting as many different ways of coping as possible, further quantitative studies can research the frequency and extent of these different ways of dealing with challenges in clinical practice as well as their effectiveness.
Finally, while a transdiagnostic approach to pain might highlight concerns and issues that are shared across conditions, specific challenges can also be overlooked. This needs to be considered when results from this study are transferred.

Conclusion

We conclude that the coping strategies employed by general practitioners in their attempts to deliver high-quality services to patients living with chronic pain need to be understood in the context of temporal and organizational aspects of care. The coping strategies identified in this study need to be further quantitatively evaluated and developed in future research. An improvement in our general understanding of the challenges that providers experience and how they handle them, as well as when in the care process they need to do that, could be a helpful tool for the management of chronic pain to become more effective for the patient and more satisfying to the provider.

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Ethical Approval

The study was approved by the regional research ethics committee in Gothenburg (No: 1120-16).

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