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Research paper

AN EXPLORATION OF ATTITUDES TOWARDS PSYCHOLOGICAL INTERVENTIONS FOR PAIN MANAGEMENT AMONGST MALTESE CHRONIC PAIN SUFFERERS

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Abstract. Chronic pain is a living reality for many individuals. Research reveals that individuals are often reluctant to seek psychological help. Chronic pain research and attitudes towards psychological treatment among a Maltese chronic pain population is solely lacking. This study sought to explore attitudes towards psychological interventions for the management of chronic pain amongst persons with chronic pain. A grounded theory methodology was adopted. Interviews were conducted with 21 participants. Five superordinate categories comprising 12 sub-categories were generated. An attitude model reflecting inter-relationships between categories was developed. The theory entitled '*Readiness to Try What Ever it Takes*' reveals that a number of facilitating factors contribute to the formation of positive attitudes to psychological help-seeking. Although the study did not reveal polarized views in relation to gender, impeding factors comprising negative affect, lacking resources and stigma hinder help-seeking behaviour. Most participants were unfamiliar with psychological services for pain management. Findings also indicate that individuals who perceive a link between psychological factors and pain are not necessarily more inclined to access psychological help, mostly because help-seeking behaviour is influenced by an array of psychosocial factors which are difficult to quantify. Service uptake can be enhanced by adopting a bio-psychosocial framework incorporating cultural factors and a multi-disciplinary approach to treatment involving not just health care professionals, but also significant others who influence the chronic pain sufferers' decision-making, including family members and the clergy.

Keywords: Grounded theory, chronic pain, qualitative method, psychological interventions, pain management, attitudes

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1 INTRODUCTION

Chronic pain is defined as pain persisting for more than 3 months (International Association for the Study of Pain, 2003). Enduring pain becomes problematic when it impairs the quality of life of the sufferer and when no pain relief is available (Vlaeyen, Crombez & Goubert, 2009). Biological factors play a crucial role in the aetiology of pain. Nonetheless, although physical damage to body tissues or organs will cause pain, the pain reported by individuals does not always reflect the extent of physical injury. The bio-psychosocial approach (Engel, 1980) sheds light on the complexity of chronic pain, affirming the interdependence of biological, psychological and social factors as playing an important role in health and illness. Conclusively, physical factors alone cannot fully explain the pain sensations experienced by the individual.

Pain can seriously affect the quality of life of the sufferer and interfere with the ability to carry out day-to-day tasks. It can result in social withdrawal, loss of interest in hobbies, job loss, family conflicts, inability to perform normal and taken-for-granted family roles and taking care of oneself (Fine, 2011). Enduring pain often threatens to 'unmake' the individual's world, shake taken-for-granted identities, disturb life balance and narrow the horizon of time (Good, 1992, cited in Crossley, 2000). The accepted gold standard treatment for the management of chronic pain in most health settings relies on a multi-disciplinary approach to treatment. This involves feedback from diverse health care professionals working closely with the patient to ensure a holistic treatment plan (Institute of Medicine, 2011). Psychological interventions incorporated alongside medical treatments play a crucial role in helping patients adjust to pain and changing roles, cope with feelings of distress, sadness or depression and help foster adherence to medication. The most commonly used psychological interventions include behavioural treatments and activation, Cognitive Behaviour Therapy (CBT), biofeedback, relaxation and distraction (Morley, 2008; Sarafino & Smith, 2014).

In health care, help-seeking behaviour is the act of using health care services or the communication of a problem to selected health sources (Rickwood, Deane, Wilson, &

Ciarrochi, 2005). Social and cultural factors play a significant role in the expression of pain, whether the individual decides to seek help and pain management efforts. Malta is no exception to other western countries, with its heavy reliance on pharmacological models and physical rehabilitation. The field of psychological help in Malta is still in its infancy (Abela & Sammut Scerri, 2010; Xerri, cited in Samele, Frew and Urquia, 2013). Although the collaboration between different healthcare professionals in Malta is increasing, only a small number of doctors have access to a designated psychologist or trainee psychologist. This makes service access for patients difficult.

Although psychological interventions play a crucial role in fostering adaptation (Vlaeyen et al, 2009), some individuals fail to resort to psychological therapies. Reasons for this include skepticism about their effectiveness and unsupportive health care professionals (Tan, Alvarez & Jensen, 2006). Another barrier to service access is lack of availability, the Maltese islands being a case in point. Due to Malta's small size, specialization and expansion of services is not always possible. Conclusively, pain management services in Malta revolve mainly around pharmacological treatment, transcutaneous electrical nerve stimulation and acupuncture, with very limited psychological input. Currently, there are few (three) psychologists working at the local general state hospital who work mostly in the perinatal setting with young children, in the oncology sector, in the genetics department, the diabetes clinic and renal unit. There is no psychologist specialized in pain management at the Pain Clinic. Unavailability of multi-disciplinary services in may reinforce the notion that psychological factors do not play a role in the pain experience.

Allport (cited in Fishbein, 1967, p. 257) defines an attitude as *'a learned predisposition to respond to an object or a class of objects in a consistently favourable or unfavourable way'*. Attitudes have an enduring impact on pain behaviour (Rollman, cited in Kazarian & Evans, 1998) and play a significant role in accessing psychological services (Cornally & McCarthy, 2011). Although behaviours are often hard to predict, individuals are often inclined to behave in ways consistent with their attitudes. Thus, it can be concluded that individuals who hold negative attitudes towards help-seeking will be less inclined to access the service.

Help-seeking behaviour for psychological problems amongst European countries is reportedly low, with factors such as lack of awareness and costs of service access being potential barriers (Evans-Lacko, Brohan & Mojtabai, 2012). It is currently unclear whether the former is the case across diverse health conditions, including amongst persons with chronic pain sufferers. Given that attitudes have an enduring impact on behaviour (Ajzen & Fishbein, 1980) they play a significant role in facilitating or inhibiting access to psychological services. Although behaviours are often hard to predict, individuals are often inclined to behave in ways consistent with their attitudes. Unfortunately, negative attitudes towards help-seeking may have wide ranging repercussions including job dissatisfaction and suicidal ideation (Vogel, Wester & Larson, 2007). Research to date has failed to shed light on attitudes individuals have towards psychological interventions with specific reference to pain management. Given the broad implications of chronic pain, the aim of this study was to explore prevalent attitudes towards psychological help-seeking and the perceptions chronic pain patients have towards accessing psychological services with the aim of identifying ways of improving service uptake. The research question guiding the study was: *What attitudes do Maltese chronic pain sufferers hold towards psychological services for pain management?*

2 METHODS

This research aimed to shed light on an area that has not been thoroughly investigated and which may be difficult to access using traditional research methods. Diverse theories have attempted to shed light on the complexity of chronic pain. For instance, both the Gate Control Theory (Melzack & Wall, 1965) and the bio-psychosocial model (Engel, 1977) have challenged the notion that pain entails a simple mechanical response to stimuli, leading to increased recognition that pain entails an intricate relation between physical and psychological factors. Although this led to the development of more sophisticated pain assessment scales such as the Pain Discomfort Scale (Jensen, Karoli, & Harris, 1991) or the Pain Anxiety Symptoms Scale (McCracken, Zayfert, & Gross, 1992), these tools are a simplistic representation of the human subjective experience (Crossley, 2000). Achieving such an understanding requires different methods and theoretical orientations that incorporate experiential and cultural elements of pain and illness (Crossley, 2000).

The Maltese culture is a rich one, comprising beliefs and practices resulting from the process of adaptation of different societies that came in contact with the Maltese islands through history. Malta's historic processes have resulted in a culture comprising an ethnic admixture that defines Maltese identity (Gouder, 2010). The implications of demographic and cultural differences have not been taken into account mostly because input from a Maltese population is lacking. To the extent that these differences influence attitudes and pain coping amongst the Maltese in diverse ways, they are worth exploring, particularly when attempting to create a meaningful portrait of the Maltese experience. This is important when devising interventions that are culturally sensitive since it will ensure the target needs of the population under concern are being taken into account.

Most research about attitudes employs quantitative methodologies to score and code people's replies, thereby falling short of providing an in-depth understanding of the complex bio-psychosocial phenomena behind people's behaviours and perceptions (Eiser & van der Plight, 2015; Waller & Gilbody, 2009). The present study sought to understand the meaning behind human behaviour in an area which may be difficult to access using traditional research methods. Existing theories that are often applied to conceptualize strategies in relation to attitude research, such as the Theory of Reasoned Action (Ajzen & Fishbein, 1980), fail to provide an in-depth exploration of meaningful constructs that play a role in pain perception and the uptake of psychological services. Gender, culture, the severity of the problem and the socioeconomic circumstances of the individual influence pain perception (Hechler, Chalkiadis, Hasan, Kosfelder, Meyerhoff et al., 2009; Houser & Zamponi, 2011). Subsequently, a qualitative methodology was used.

Semi-structured interviews were used to provide a rich account of participants' experiences and create new theories in areas where knowledge is lacking or sparse (Charmaz, 2014). Stereotypical norms and expectations influence differences in pain expression and behaviour (Keogh & Denford, 2009). Moreover, although pain is subjective, individuals of similar cultural backgrounds tend to display similar pain responses (Houser & Zamponi, 2011). Traditional attitude research often relies on methods that take responses out of context and ignore the ways meanings are constructed in ordinary talk (Potter & Wetherell, cited in Langdridge et al, 2007). Keeping in mind the questions being addressed by this study, attitudes are formed within a social context and are the result of social processes. The investigation of attitudes towards seeking psychological help incorporates the social and interpretative element. Moreover, different researchers may come up with their own interpretations of participants' experiences. For reasons outlined above, it was felt that Charmaz's constructivist approach to grounded theory particularly suited for the aim of this study.

2.1 Participants

11 males and 10 females were recruited. The average age was 52 years. All participants were Maltese. Inclusion criteria for participation comprised being over 18 years, having suffered from a pain condition lasting more than 3 months, being of Maltese nationality and currently receiving services from the local pain clinic. Participant details can be found in the Appendix 1 at the end of the study.

2.2 Interview guide

Demographics and information related to the presenting problem were collected prior to the interview. Following a pilot interview, an interview guide using open-ended neutral questions was finalized. Sample interview questions included:

- What kinds of treatments you have sought so far to cope with pain and to what extent have they been helpful?
- Have you ever sought psychological help and what is your attitude towards psychological services?
- In your opinion, what is the role of psychological factors in the experience of pain?

2.3 Procedure and recruitment

Purposeful criterion sampling was used to recruit participants. Participants had to be suffering from pain for more than 3 months to meet the criteria for chronic pain. Posters with brief information on the research and contact details of the researcher were placed in pain clinics at the local hospital. Since there are only two pain clinics on the island, it was assumed that this method would yield individuals from different strata of society and result in a heterogeneous sample. Nonetheless, this method did not result in a large enough sample. Conclusively, patients attending the pain clinic were approached and invited to participate in the study. Having initially ascertained they met all the inclusion criteria, this process resulted in the recruitment of 21 participants.

An outline of the aims of the study was provided to potential participants. The stipulated wait time for deciding whether to participate in the study was two weeks. Nevertheless, this was not necessary since all patients who were approached agreed to participate and indicated they were willing to be interviewed during their current visit to the pain clinic. None of the participants dropped out of the study. Interviews were conducted over a four-month period whilst participants were waiting to be seen by the pain management consultant. This process helped eliminate some barriers to data collection such as transport problems, failure to turn up for scheduled interview appointments, loss of interest in participating in the study, problems with finding a time and place to conduct interviews that is convenient for both parties and elimination of researcher travel costs. All interviews were conducted by the researcher and audio-recorded. Participants did not receive any remuneration for participating in the study.

2.4 Ethical considerations

Ethical approval was obtained from the necessary institutions in London and Malta. Confidentiality was ensured. In order to safeguard both the participants and researcher, interviews were carried out throughout the day when the Crisis Team at a local hospital as still operating. Contact details of the psychology department at the same hospital were also provided for additional support.

2.5 The process of data collection and theory building

A number of open-ended neutral questions were formulated. Interview questions were based on findings from successive narratives to build a theory grounded in data. Themes raised by participants were followed up in subsequent interviews with new participants, thereby allowing data collection and interpretation to proceed iteratively in line with a grounded theory approach (Oktay, 2012). This allowed emergent themes to be explored in more detail in successive interviews.

Theoretical sampling was used to expand the categories developed during the process of data collection. This was done by seeking out interviews with a wide range of participants who might be expected to give different accounts from those already collected and through more focused questioning around the concepts as they emerged. Variation facilitates in-depth exploration of dimensions and relations as well as theoretical sampling and constant comparative analysis (Oktay, 2012). Memos were used as part of the analytic process of the development of categories and their inter-relationships.

In keeping with the principles of theoretical sampling, constant comparative analysis was used whereby data were collected over a four-month period. This iterative process allows theory building to evolve (Oktay, 2012). Data were transcribed and analysed after each interview. Additional data was gathered at different points to ensure further development and concept verification. No predetermined sample size was identified since this can interfere with the process of theory building by resulting in the omission of potentially rich and important information (Oktay, 2012) In line with a grounded theory methodology, as suggested by Urquhart (2013), data collection continued until theoretical saturation was reached, namely until no new data nor codes were occurring in the data. This was also due to the fact that the research question was quite focused and specific.

In line with recommendations for increasing trustworthiness of responses in qualitative research (Brink, 1993) it was ensured that participants had a clear understanding of the nature of the study. Credibility was ensured via prolonged engagement with participants and reviewing written records and confirming these with participants for completeness, meaning and accuracy of data as suggested by Morrow (2005). Credibility was also ensured via the use of the participants' words in the emergent theory in line with the grounded theory approach (Morrow, 2005).

2.6 Procedures for data analysis

Interview data was translated from Maltese to English, transcribed verbatim and typed up with wide margins for note-taking during the coding process. Memos were used throughout to enhance theoretical sensitivity and ensure that the interview was fresh in the researcher's mind. Memos allowed the researcher to record initial impressions on the data. The stages for data analysis are illustrated below.

Open coding: Interviews were re-read several times to allow for increased familiarity with data. No coding scheme was set up prior to the process of data collection to avoid forcing data into pre-existing categories (Oktay, 2012). Emerging key words, thoughts and associations were noted. Line-by-line initial coding with gerunds was used as a heuristic device to bring the researcher closer to the data, allow interaction and further fragmentation (Oktay, 2012). Categories and sub-categories were recorded and coded into smaller chunks according to their meaning and relevance to the study.

Focused Coding: This process entailed using the most significant and frequent earlier identified codes to sift through and analyse large amounts of data. Information was verified alongside the original transcripts to ensure categories were an accurate reflection of participants' replies and to facilitate higher level analysis. Data was reassembled by drawing attention to relationships and shared meanings. Memos and categories were hand-written on individual cards and scattered on a large table. This process facilitated the process of linking concepts in a meaningful manner.

Selective Coding: Core categories were generated from the data. This was done without having a predetermined hypothesis. Whenever a particular incident was noted, this was compared with other incidents for similarities and differences. Making comparisons is a useful in reducing bias since previously formed concepts were challenged with emergent data (Corbin & Strauss, 1990). This process allowed for the integrating and identification of core categories to form an over-arching theory. Constant comparative method was used where data coding was performed until a strong theoretical understanding emerged (Charmaz, 2014).

2.7 The translation process

Since interviews were done in Maltese, the data had to be translated to English. Since the author had a good command of the English language, the translation process was not very difficult. Nevertheless, it was not a straightforward process and the author was faced many dilemmas when trying to find the most appropriate words for particular expressions, phrases and thoughts. Translation involves the transfer of meaning from one language to another, not a simple word for word replacement. It does not merely entail a consideration of separate sentences but a complete understanding of the overall text, often comprised of a whole paragraph, in order to convey the intended meaning. A key challenge involved translating idiomatic expressions and words which did not have any equivalent in the English language. For instance, there is no proper English word for the Maltese word *beżżul* which is a term used when the person feels victimized and that events that are happening are beyond them. Translation is a decision-making process whereby the researcher ponders the kind of words and phrases to use that would in turn provide the closest equivalent meaning, what Birbili (2000) refers to as *conceptual equivalence*. This process can have two repercussions. One is the introduction of *pseudo-information* or information that was not originally there, and another is the loss of important information (Ervin & Bower, 1952).

A way of increasing research trustworthiness in translation involves developing culturally competent knowledge (Meleis, 1996) or a good understanding of language variations adopted by the target population. Apart from a good knowledge of the language, one needs to be familiar with the culture of the participants (Vulliamy, cited inVulliamy, Lewin & Stephens, 1990). The fact that the researcher grew up and lived in Malta facilitated this process. Sometimes, participants switched from Maltese to English and vice versa. In other situations, participants used only English whilst in others, Maltese was used throughout. Since the author consider herself to be bilingual, she had no problem switching between the two languages. When participants spoke in English, words were transcribed verbatim, alongside any grammatical or syntax errors participants may have used. This process helped to ensure that at least, during these instances, the transcript was a transparent reflection of participants' replies.

2.8 Reflexivity

Reflexivity is an ongoing evaluative process in data collection and analysis. It requires a reflection on personal perspectives and biases that may influence knowledge construction.

The phenomenon of chronic pain is not novel to a health psychologist. As a result, it is difficult to totally distance oneself from what one already knows about the subject matter. Nonetheless, as Dey (1999, pg 251) rightly points out, '*prior conceptions need not become preconceptions*'. Efforts were made to reduce the contamination of emergent data. A reflective diary was kept during the process of data collection. The researcher tried to remain open to what was happening in the interview by listening to participants' narratives and concerns. As a health psychology researcher, the author recalled feeling frustrated upon finding out about the lack of psychological input in local pain clinics. Thus, to the question '*What is the role of psychological factors in the experience of pain?*', caution was exercised in relation to the paradox she could have shared with participants, particularly those who did not share similar views. The author tried to maintain a neutral stance without impinging personal views both during data collection and analysis. A conscious effort was also made to avoid providing health-related advice as this could have contaminated the data by making participants alter their account to conform to the researcher's expectations rather than being true to their own experiences and feelings. It posed the risk of promoting oneself as a superior source of health knowledge and expertise, thereby creating a power imbalance between participants and the researcher.

It is worth pointing out that in Malta, having a Master degree in psychology and a number of hours of practice entitles the person to apply for a warrant and hold the legal title of *psychologist*. Although no reference to this was made in the participant information sheet, participants were aware I was a doctorate student specializing in health psychology. This could have influenced their replies and their readiness to disclose. Such instances were food for thought and served to reveal two important findings. Although I tried to retain a neutral stance, having someone to talk to about their pain was a cathartic and therapeutic experience for some participants. Moreover, during certain instances, participants disclosed very sensitive information including having been the victim of sexual abuse and having experienced the death of a child. The researcher used empathy during such disclosures and validated the participant's experiences but nonetheless tried to redirect them to the topic at hand. These participants were advised to access psychological help.

Precautions were taken to reduce direction of content. Initial questions were broad and general, with occasional prompts and minimum interference from behalf of the researcher. The researcher reflected back on participants' narratives in order to check for understanding, gain further insight and clarify meanings.

3 RESULTS

The section below provides an in-depth description of emergent core categories.

3.1 Positive expectancies/attitudes

This category encompasses three sub-categories contributing to the formation of positive attitudes namely: i) previous encounters ii) openness to experience and iii) the interview as a cathartic experience.

i) Previous encounters: Five participants had accessed some form of psychological help at some point. This has resulted in the formation development of positive attitudes towards psychological help-seeking. Thus, *previous encounters* play a crucial role in the formation of positive attitudes and to an increased tendency to seek help in the future, should the need arise. This was evident in Nick's (pseudonyms used throughout) comments: *'He (the psychologist) taught me how to cope with certain situations...not to be carried away by thoughts of the past...he helped me...yes why not (seek future help)?' (P2, L137-138)*

For Phil, seeing a psychologist was an opportunity of validating and acknowledging his pain: *'Yes...very positive... very positive...I can speak to someone who can understand...just to express myself to someone.' (P7, L109-110)*

ii) Openness to experience: This sub-category comprises participants who are willing to embrace alternative forms of treatments. Paul described himself as an '*open person*', ready to find out what psychological services have to offer. He believes psychologists '*are there to help...not as an obstacle*'. Jes was experiencing frequent panic attacks. Although he had never seen a psychologist, he endorsed a positive attitude towards accessing the service: '*Overall, I am in favour of these services...yes I mean, why not? If they can be beneficial, I agree.' (P4, L72-73)*

iii) The interview as a cathartic experience

All participants who were initially approached agreed to take part in the study and none of them refused. Positive attitudes were seemingly being formed during the interviewing process itself as participants were given the opportunity to talk about their pain in a non-judgmental and '*supportive*' environment. Some participants perceived the interview as beneficial as evident in Doris' comments: *'I felt this (interview) was more useful than the appointment with the doctor!' (p13, L219-220)* The same was true for Mary Ann who commented: '*I feel you are helping me...this helps...even talking about it...I feel better*'. *(P15, L202-203)*

On a similar note, Nick's attitude towards self-disclosure was a positive one. He believed talking is an opportunity for self-growth: *'When I talk to people....it is a learning opportunity... talking always helps...this has helped me...'* and *'maybe not in this very instant...maybe in a month's time I might remember something you said and it might ring a bell...talking helps'. (P2, L144-147)*

Thus, the interview was a cathartic experience, helping to increase participants' willingness to engage in similar 'sessions' in the future because they had the opportunity to talk about their pain and to have a sympathetic ear willing to listen to their concerns.

3.2 Negative beliefs/attitudes

This category comprises negative attitudes towards help-seeking and comprises two sub-categories i) weakness and reaffirming control ii) equating pain solely with the physical body.

i) Weakness and reaffirming control: Some participants equated accessing psychological help with *weakness.* The term '*weakness'* may be associated with different forms of frailty, ranging from a feeble physical body to weakness of character. For some, seeking psychological help meant giving in to the debilitating effects of pain and allowing pain to take over. One way of coping involved trying to achieve a sense of mastery and control, even though this may sometimes come at a cost.

Age is contextualized by social norms and expectations. 33-year-old Leo equated psychological help with physical weakness, old age and a lack of physical fitness: *'I am talking from the perspective of a 33-year-old...my friend...he cannot practice any of the exercises I used myself.... he is a bit fat...it is harder for him...my perspective is to fight pain...but he is over 60...if I were in his situation I would probably see a psychologist.'(P3, L200-204)*

Leo also equated help-seeking with a different form of weakness, lack of determination: *'Some people are weak and lack determination, they might need help.' (P3, L123)* The same was true for Tony who commented: *'I think it would be beneficial... for the elderly...because they are lonely.... even the disabled might benefit from a psychologist...or those people who have mental health problems...or those with a low IQ...or for those who cannot take care of themselves' (P6, L252-255).*

ii) Equating pain solely with the physical body: Another factor contributing to negative attitudes stemmed from the belief that pain is purely physical, arising from injury or wear and tear of the physical body as evident in Mabel's comments: *'I don't think that psychological factors play a role in pain...because the pain is coming from my back. It is very physical.' (P21, L134-135).* On a similar note Joe commented: *'If there is a marathon, I still take part...I do not stop because my mind is telling me I am unable to run, I stop because the pain is in my back.' (P5, L271-272)*

Although participants perceived no link between pain and psychological factors, pain had a significant impact on their mood and psychological well-being as evident in Sharon's comments: *'I have been feeling quite irritable lately...the pain has changed me.' (P20, L52-54)*

3.3 Impeding factors

This category comprises five sub-categories that interfere with psychological help-seeking, namely: i) stigma ii) lack of familiarity iii) lack of resources iv) negative affect v) individual characteristics.

i) Stigma: Although some participants endorsed a positive attitude towards seeking psychological help, the fear of being labelled and of not finding back-up from significant others seemed to be a major obstacle. For instance, Joe said: *'In this country...if you tell people you have been to a psychologist you immediately get that label...it is like schizophrenia.... you are doomed...they say you are crazy' (P5, L246-248).*

On a similar note, Ivan disappointedly pointed out that he did not always find backing: *'I believe that psychological services are important. Unfortunately, if I tell colleagues...they end up making a joke out of it.' (P1, L241-243).* It seems that in Malta, people still rely a lot on medication and psychological services are often a last resort. Psychological help could also come at a price, the fear of being ridiculed.

ii) Lacking familiarity: Another obstacle to help-seeking is the lack of service familiarity and having never accessed the service. For instance, Charles said he had no clue what a psychologist is. Lacking familiarity was also true for Doris who asked: *'Is that a shrink?' (P13, L193).* Similar comments were raised by other participants.

iii) Lack of resources: This sub-category comprised the lack of financial or material resources that interfere with service uptake. For instance, Ivan had to terminate the service for financial reasons: *'I would have continued but...it was expensive and I had to stop'. (P1, L189)* The same was true for Sharon: *'When you are in pain, you try everything. However, money is a problem. It puts a limit on what you can and cannot do' (P20, L245-246).*

iv) Negative affect: This sub-category comprised the predominance of a low mood, alongside elements of passivity, often characteristic of depression. Affect played a role in attitude formation and the likelihood of seeking help as evident in Phil's reply: *'It depends on my mood...today I might feel like it...tomorrow I might not...I feel that...I don't know... what is the use of being in this world?'. (P7, L144-145)* Similar comments were raised by Rita: *'What can I say? I really don't know. I am always in pain.... crying. ...I feel useless. Sometimes I just stare blankly at the wall, I just don't want to do anything' (P18, L 156–158).*

v) Individual characteristics: This encompassed individual characteristics that may interfere with service uptake including the person's understanding of the utility of psychological services, their level of intellectual ability and education. For instance, Rose pointed out: *'The individual needs to be educated to the level where they realize that psychological help can be equally beneficial.' (P14, L415-416)* Another factor encapsulating individual traits and characteristics is introversion as evident in Paul's comments: *'I don't like to talk to others about my personal problems' (P8, L176-177).*

Age seemed to be another individual characteristic that influences help-seeking. Despite believing that psychological help can be valuable, Rita felt she was too old to tackle certain traumatic issues that are haunting her up to this day. She wondered whether her physical pain was a manifestation of emotional pain: *'Seeing a psychologist would not really make a difference...what's done is done. You cannot undo the past now...If I were younger, it might help, but now it is too late' (P18, L245-246).*

3.4 Factors facilitating access

The majority of participants were willing to avail themselves of the service when barriers outlined earlier were overcome. Two emergent subcategories were identified i) facilitating factors ii) referent others.

i) Facilitating factors: A number of facilitating factors can help increase service uptake, including the psychologist's ability to build a therapeutic relation with the client and to validate the client's experience, as evident in Laura's comments: *'Not all psychologists are the same. Some are ok, some are easy to talk to.... I want someone to listen to me and support me, not simply take notes all the time. A psychologist needs to be human' (P12, L356-358).*

Having specialized training in pain management is another desirable attribute the psychologist must have as reflected in Carmen's comments: *'You need to know that the person is a professional...someone who is trained to do the job and knows what they are doing' (P19, L 301–303).*

ii) Referent others: The final sub-category influencing the formation of attitudes comprised *referent others* or the inclination to rely on word of mouth in deciding whether to give psychological interventions a try. More often than not, referent others include individuals who are in pain and have tried similar services and found them beneficial. For instance, Ivan commented: *'Listening to what others have to say and what they have tried and what they found useful is good (P1, L99).*

This sub-category also incorporates trusted sources such as doctors. Since doctors never referred any of the participants to a psychologist, the need for psychological input was not perceived. As Mary pointed out, '*had I thought a psychologist could help, the doctor would have referred me to one by now*'.

3.5 Dissatisfaction with pharmacological therapy

Some participants expressed dissatisfaction with pharmacological treatment, particularly when these failed to alleviate pain. The latter is an incentive to try out psychological interventions. This is evident in Joe's comments: *'I am willing to try whatever it takes as long as I find some form of pain relief' (P5, L 264).* Interestingly, the absence of the pharmacological element in psychologically oriented therapies seemed particularly attractive to participants and was echoed by most participants. Conclusively, this was deemed to be the most important factors that would facilitate service access, hence the name of the theory.

The inability to find relief from pain can sometimes lead to a decreased tendency to access psychological services. Thus, pain was both a barrier and an incentive. It served as an incentive when nothing else seemed to work. It was a barrier when it interfered with the person's ability to engage in everyday activities. The latter is intricately linked to the sub-category '*Negative affect'* highlighted earlier.

4 AN ATTITUDE THEORY

The model illustrates how the aforementioned categories and sub-categories link together to explain attitude formation. Based on Charmaz's (2014) coding process, the theory '*Readiness to Try What Ever It Takes'* illustrates the complex interplay of psycho-social factors involved in shaping prevalent attitudes and perceptions towards psychological services as illustrated in Figure 1.

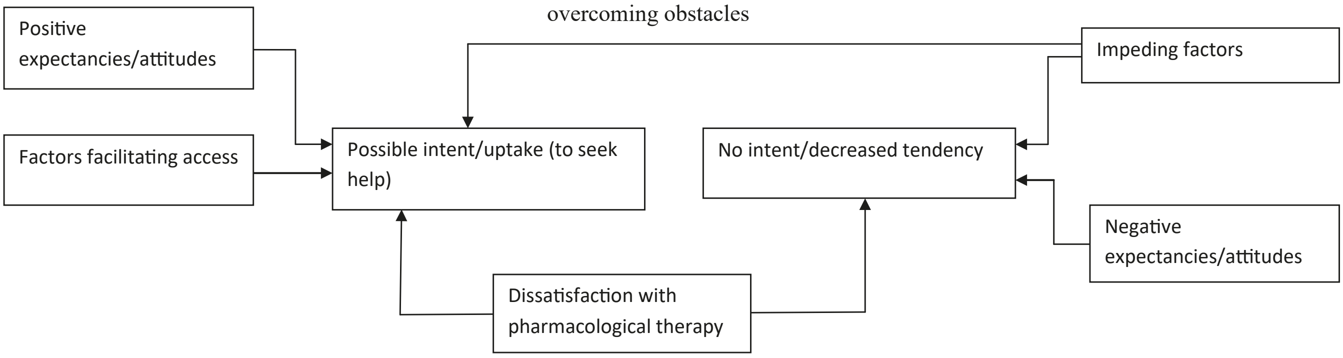

Figure 1: Readiness to try whatever it takes
A complex interplay of psycho-social factors that play a role in shaping prevalent attitudes and perceptions towards psychological services

5 DISCUSSION

Participants in the study seem to hold similar attitudes towards accessing psychological help, with no particularly polarized views with respect to gender. Demographic factors seem to play a role in help-seeking, with younger participants and those with higher level of education endorsing more accepting attitudes.

In line with previous research (Mechanic, 1975), an intra-psychic factor influencing the formation of positive attitudes is the individual's *openness to experience*. Some individuals were willing to embrace alternative forms of treatment, with the belief that doing so will be beneficial in some way. Some participants derived different benefits from the interview including a distraction from pain, a learning opportunity, a way of releasing pent up frustration and a situation that encouraged them to reflect on their current situation and about potential benefits of therapy. The interview seemed to play a role in the formation of positive attitudes. The process of engaging in active and supportive listening not only fosters self-disclosure but may have a healing and curative purpose for interviewees (Rossetto, 2014). The '*therapeutic*' effect of the interview could have been particularly pronounced amongst participants lacking support. The researcher fulfilled the role of an '*empty*' absorber of emotional turmoil.

Referent others seem to play a crucial role in attitude formation. Social forces seem to influence a person's perception of events and may in turn compel individuals to behave in certain ways. These forces are particularly evident in a small community such as Malta. Possibly, referent others could help bridge the behaviour-intention gap. Social networks can foster the flow of health-related information (Deri, 2005). According to Deri (2005), individuals who perceive that a particular health service is beneficial are more likely to influence significant others and encourage them to do the same. Health service utilization is also more likely amongst persons living within close geographical distances and those sharing common traits such as language and cultural backgrounds. Given Malta's small size, such findings come as no surprise.

The majority of participants were willing to avail themselves of the services, particularly when nothing seemed to alleviate pain. This is also reflected in the main title of the emergent theory which reveals that accessing psychological help was perceived as the last resort, if at all, something to be considered when all other attempts have been unsuccessful.

Subjective norms regarding the appropriateness and acceptability of particular behaviours play a crucial role in help-seeking (Ajzen & Fishbein, 1980). This was particularly striking amongst male participants, as evident in the type of discourse used to express constructed categories of psychological help-seeking including the fear of being '*doomed*' or labelled '*schizophrenic*'. Fear of stigma may be particularly prevalent in a small country such as Malta, where the possibility of keeping service access hidden from friends or acquaintances may be difficult. Participants' choice of words also serves to illustrate how meaning-making and interpretations are formed in a social context and the role they play in shaping prevalent attitudes and behaviours within a given culture. Lack of awareness regarding the utility of psychological help may be a primary contributor to the creation of stigma since help-seeking may be associated with psychiatric problems.

Lack of resources was identified an external barrier to service access as identified in previous research (Wuthrick & Frei 2015). Lack of equity between individuals coming from different strata of society contributes to discrepancies in life expectancies and health inequalities between populations (Vogel et al, 2007). Conclusively, individuals of low socio-economic status often do not have sufficient financial resources to pay for good-quality health care and a higher risk of suffering from enduring pain.

Unlike previous literature reporting a positive correlation between levels of distress and psychological service-seeking (Cramer, 2000), *negative affect* or a predominance of low mood resulted in decreased attitudinal tendency to seek help. This was true for participants reporting frequent feelings of unhappiness and help-seeking behaviour. Health care professionals may need to screen chronic pain sufferers prior to '*prescribing*' psychological interventions in order to identify those needing additional help, if therapy is to be of benefit.

Although younger participants seemed more endorsing of help-seeking behaviour, results reflect those of previous studies whereby discomfort revealing personal and intimate information seem to be major barriers to service uptake (Ajzen & Fishbein, 1980). Educating individuals about the benefits of self-disclosure, the anticipated feelings of relief after talking to trusted professionals and the assurance of confidentiality could facilitate the uptake of therapeutic services (Ajzen & Fishbein, 1980; Jenkins, cited in Tribe & Morrissey, 2015).

Health care professionals often play a crucial role in shaping normative beliefs and attitudes. Educating health-care professionals about the role of psychological factors in the experience of pain and the benefit of psychological therapies is important in promoting the service and reducing potential stigma. In line with a previous study (Waller & Gilbody, 2009), most interviewees were unfamiliar with psychological services and equated the service with psychiatric help. Psychological input is a fairly recent introduction in Malta, albeit with very limited availability. It seems that the psychological needs of chronic pain patients remain relatively unaddressed, with the medical model being the dominant approach to treatment. The lack of human resources and lack of specialized training in the delivery of chronic pain interventions are other barriers to treatments.

Persons with chronic pain often resort to the traditional bio-medical model when accounting for their pain. A clear comprehension of chronic pain sufferers' attitudes towards help-seeking behaviour requires an understanding of the social context in which these are embedded. The long-standing perception that accessing help entails some form of personal weakness seems to hold to this day. Findings corroborate previous literature showing that a major barrier to seeking help was the belief that one should be able to handle one's problems without resorting to expert help (Topkaya, 2015).

5.1 Implications for clinical practice

A way of enhancing service uptake may entail conducting an initial psychological interview with potential clients. Apart from having a diagnostic function, this could act as a cathartic experience and as an incentive to take up future therapy sessions. A high sense of self-efficacy may reduce the behaviour-intention gap. Persons with chronic pain may benefit from interventions aimed to boost their self-efficacy skills to overcome feelings of self-doubt via the use of motivational interviewing.

Fostering the utility of psychological help amongst health care professionals can be one way of encouraging service uptake. The use of cognitive behavioural strategies, normalization of feelings created by stigma and the establishment of support groups may be helpful in reducing internalized stigma. Efforts to disseminate the why, what, where, when and how to access psychological services amongst the general public by psychology professionals is also important.

Working in collaboration with other health care professionals such as psychiatrists may be necessary, particularly for patients suffering from depression. Since individuals with an external locus of control are less inclined to adopt active coping strategies, assessing the locus of control may be necessary to identify the most appropriate may forward. Possibly, these individuals may benefit from more directive and prescriptive approaches to engage in the desired behaviour. Incorporating mindfulness meditation practices may be another way of overcoming potential resistance to the uptake of psychological services and to fostering a positive and accepting attitude.

5.2 Future research

Future research aimed at exploring attitudes and perceptions of medical personnel can facilitate the access of psychological services. It can also identify factors that would encourage health care professionals to refer clients to psychological therapies.

Pain often has a rippling effect on family members who often experience feelings of alienation, powerlessness and stress due to changing family roles and lifestyle adjustments (Kannerstein & Whitman, 2007). One way of enhancing pain management practices may entail the incorporation of systemic approaches. The emergent theory could be revised and expanded upon, with data from a longitudinal perspective following coping mechanisms over time. This could compare attitudes of younger and older participants in order to assist researchers to further develop emerging categories.

5.3 Strengths and limitations

A number of strengths have been identified. Participants were balanced in terms of gender, making comparability of experiences possible. The use of grounded theory allowed the emergence of a new theory in a relatively unaddressed area with an unexplored population. The sample used renders generalization more possible, thereby shedding light on possibly shared attitudes. A number of limitations warrant acknowledgment. Pain duration varied. Possibly, the experience of participants suffering from pain for a number of years was different to those enduring a more recent onset. Some pain conditions were still undiagnosed; this may have exacerbated the level of distress experienced by some participants. The majority of participants had a secondary level of education and were over 45 years of age. Conclusively, results were more representative of this particular segment of the Maltese society. A limitation of the study was that it was not completely possible to follow the sampling procedure advocated by the grounded theory approach because the study had to be completed within a given time frame. Apart from that, the pain experienced by participants made data collection difficult.

6 CONCLUSION

This study reveals that demographic factors and level of education play an important role in psychological help-seeking. Individuals who perceive a link between psychological factors and pain are not necessarily more inclined to access psychological help, mostly due to the fact that help-seeking behaviour is influenced by a complex array of psychosocial factors. These include but are not limited to barriers to service access, the age of the individual, their level of education and understanding of the utility of psychological services, negative affect, the individual's openness to experience and the way significant others perceive psychological help, all of which may be difficult to quantify. Given the fact that pain alleviation and management remain a challenge, most persons with chronic pain are ready to try. whatever it takes to be free of pain. Thus, increasing service uptake requires addressing these factors.

7 DECLARATIONS

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APPENDIX 1

Table 1: Participant details

Participant pseudonym	Presenting problem and duration	Employment status & level of education	Age
Ivan	Degenerative disc disease, 3 years	Secondary level of education, property consultant	45 years
2 Nick	Back pain following fall, Familiar Mediterranean Fever, 37 years	Secondary level of education, computer technician	43 years
3 Leopold	Back pain, 2 years	Secondary level of education, carpenter	33 years
4 Jes	Sciatic nerve inflammation, 2 years	Secondary level of education, office work	47 years
5 Joe	Lower back pain following injury, 7 years	Secondary level of education, property consultant	33 years
6 Tony	Neurofibr-omatosis of the spine, syringomyelia, in a wheelchair, 10 years	Secondary level of education, cleaner	54 years
7 Phil	Unexplained chronic headache and Trigeminal myalgia, tinnitus, +10 years	Secondary level of education, boarded out	55 years
8 Paul	Unexplained pain in right abdomen, 2 years following operation	Secondary level of education, manual job	47 years
9 Carmel	Arthritis 15 years	Primary level of education, pensioner	75 years
10 Charles	Complex regional pain syndrome, 12 years	Secondary level of education, boarded out	46 years
11 Brian	Rheumatoid arthritis, pain in the hip	Secondary level of education, retired	64 years
12 Laura	Fibromyalgia	Secondary level of education, boarded out	34 years
13 Doris	Back and neck pain following car accident, 11 years	Secondary level of education	55 years
14 Rose	Fibromyalgia, 18 years	Tertiary level of education, social worker	54 years
15 Mary Ann	Fibromyalgia, Lumbar Spondolythesis, 8 years	Diploma in nursing, boarded out	58 years
16 Mary Doris	Scoliosis, back and hip pain	Tertiary level of education, physiotherapist,	59 years
17 Mary	Degenerative disc disease, scoliosis, back pain, +2 years	Diploma in nursing, boarded out	61 years
18 Rita	Myelopathy of the spine, also given fibromyalgia diagnosis, carpal tunnel	Secondary level of education, housewife	60 years
19 Carmen	Fibromyalgia	Secondary level of education, housewife	68 years
20 Sharon	Back pain due to slipped disk, 10 years	Secondary level of education, housewife	37 years
21 Mabel	Rheumatoid arthritis, back pain following operation gone wrong, 2 years	Secondary level of education, housewife	74 years

**denotes interviews that had to be stopped short since client was in pain*