# Evaluating the feasibility of delivering a pain management programme for adults living with sickle cell disease

Rebecca McLoughlin, Red Cell Pain Management & Psychology Service, St George’s University Hospitals NHS Foundation Trust, London, UK

Jenna Love, Cancer Psychological Support (CaPS) Team, St George’s University Hospitals NHS Foundation Trust, London, UK

Jared G Smith, (1) Population Health Research Institute, St George’s University of London, London, UK; (2) Clinical Research Unit, South West London & St George’s Mental Health Trust, Springfield University Hospital, London, UK

Whitney Scott, Health Psychology Section, (1) Institute of Psychiatry, Psychology and Neuroscience, King’s College London, London, UK (2) INPUT Pain management Unit, Guy’s and St Thomas’ NHS Foundation Trust, London, UK

Tim Noblet, Physiotherapy Department, St George’s University Hospitals NHS Foundation Trust, London, UK

**Correspondence:** Rebecca McLoughlin, Red Cell Pain Management and Psychology Service, Phoenix Centre, Perimeter Road, St George’s Hospital, Tooting, London, SW17 0QT Email: rebecca.mcloughlin@nhs.net.

**Author contributions:** JS and JL conceptualised and designed the study. JL and RM participated in data collection. JS, RM, WS and TN analysed the data. RM and JS drafted the manuscript. All authors critically revised the manuscript and approved the final version for publication.

**Funding:** This report presents independent research partly funded by the South West London Academic, Health and Social Care System; Application for Small Grants Fund. The views expressed are those of the authors and not necessarily those of the UK National Health Service or the South West London Academic, Health and Social Care System.

RM is an ICA Pre-Doctoral Clinical Academic Fellow supported by Health Education England and the National Institute for Health and Care Research (NIHR301902). The views expressed in this publication are those of the author(s) and not necessarily those of the NIHR, HEE, NHS or the UK Department of Health and Social Care.

WS is partly funded through the National Institute for Health Research (NIHR) Biomedical Science Research Centre at the South London and Maudsley NHS Foundation Trust and King’s College London. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care.

**ORCID:** Rebecca McLoughlin https://orcid.org/0000-0002-2910-1601

Jared G Smith https://orcid.org/0000-0001-6138-136X

Whitney Scott https://orcid.org/0000-0002-2529-9083

Tim Noblet https://orcid.org/0000-0002-7032-9966

**Data sharing**: The data that support the findings of this study are available from the corresponding author, upon reasonable request, to researchers who provide a methodologically sound proposal. Proposals should be directed to the corresponding author; to gain access, data requestors will need to sign a data access agreement.

**Conflicts of interest**: None of the authors have any conflicts of interests to disclose.

**Acknowledgements:** The authors thank all the people living with sickle cell who participated in this study, Dr Anna Mathieson for support in collecting healthcare utilisation data, Dr Penelope Cream & Dr Elizabeth Rhodes for support in the conceptualisation of this study.

## **Abstract**

**Background**

Pain is the prominent feature of sickle cell disease (SCD) and negatively affects quality of life. Delivery of pain management programmes (PMPs) has been suggested in clinical guidelines for pain management in SCD; however, further evidence of the feasibility and effectiveness of PMPs in this population is needed. This study explored the feasibility of delivering a sickle cell pain management programme (SCPMP) for adults within a haemoglobinopathies service.

**Methods**

A single arm, repeated-measures observational design was used to determine feasibility of delivering the SCPMP at one study site.Primary feasibility outcomes were recruitment, completion of treatment and outcome measures, satisfaction, credibility and acceptability to participants. Secondary feasibility outcomes were treatment outcomes and processes, frequency of vaso-occlusive crisis (VOC) and healthcare utilisation.

**Results**

Four of five feasibility criteria were met. Annual recruitment of eight participants to a SCPMP was not achieved. Twenty-nine people began a SCPMP during the study period. Twenty-five (86.2%) participants attended ≥ 5/8 sessions and 21 (84%) programme completers provided all end of programme questionnaires. Mean scores of > 7 on ten-point scales were seen across satisfaction and credibility questions. At least moderate (Hedge’s g > 0.5) effect sizes were seen in pre-post SCPMP measures of pain interference, anxiety, depression, self-efficacy, pain-related worry and acceptance. A small (Hedge’s g 0.4) effect size was seen in HRQoL. Following SCPMP attendance, mean frequency of self-reported VOC and hospital admissions reduced.

**Conclusions**

This study suggests that, given an adequate source of referrals, a SCPMP is feasible to deliver and appears acceptable and credible to participants. Exploration of influences on recruitment, such as barriers to group interventions, would be illuminating, prior to investigating feasibility of an adequately powered randomised-controlled trial.

## **Introduction**

### **Sickle Cell Disease**

Sickle cell Disease (SCD) is a debilitating, inherited blood disorder, the prominent feature of which is intense, fluctuating pain.1 The term SCD describes a group of related disorders, characterised by the formation of ‘sickle’ or crescent shaped red blood cells on deoxygenation.2 Sickled red blood cells lack flexibility, leading to haemolysis (reduced red cell life span) and haematological complications including vaso-occlusive crisis (VOC). VOCs are often unpredictable events associated with severe acute pain and potential for multisystem complications including stroke, retinal infarction, and acute chest syndrome.3 Through the lifespan individuals with SCD face additional chronic complications, including organ dysfunction, which contribute to substantial morbidity, impaired health related quality of life and increased risk of premature mortality.3, 4

The experience of pain associated with SCD is the rule rather than the exception5 and is the most common reason for hospitalisation.2, 6 In addition to acute pain associated with VOC, persistent pain (also referred to as chronic or nociplastic pain) is a recognised feature of SCD.7 The International association for the study of pain (IASP) defines chronic pain as pain that lasts or recurs for longer than three months.8 Persistent pain in SCD has been described as pain that is present most days for at least six months in a single or multiple locations and may, or may not, be associated with contributing disease processes such as avascular necrosis.6, 7, 9 In addition, Dampier and colleagues’9 diagnostic criteria for chronic pain in SCD requires report of pain sensitivity on palpation or with movement, decreased range of movement, or weakness in the region of reported pain. Individuals with SCD may present with any combination of; acute pain, chronic SCD pain without contributory disease complication (alternatively described as primary persistent pain), chronic SCD Pain with contributory SCD complications (secondary persistent pain) or mixed chronic SCD pain.8, 9 Consequences of persistent pain in SCD include biopsychosocial impacts commonly experienced by individuals with primary persistent pain, including sleep disturbance, fatigue, activity restrictions and reduced health related quality of life.9 Self-report data from adults with SCD shows high (27.6%) prevalence of significant depression and associations between depression, anxiety and daily pain (self-reported as ‘not crisis pain’) and poorer physical and mental health.10

In the UK, approximately 15,000 people who are predominantly of African and Caribbean descent live with SCD.11 Therefore, individuals living with SCD also face the burden of health inequalities known to disproportionally impact Black, Asian and minoritised ethnic groups12, 13 and are impacted by negative attitudes towards their condition which are often underpinned by racism.14, 15 Evidence from the UK and USA demonstrates that negative and racist attitudes towards individuals with SCD can; impact adherence to guidelines for medication delivery,16 underpin scepticism about severity of SCD related pain15 and perpetuate perceptions that people living with SCD are ‘drug seeking’ and ‘difficult’, resulting in inadequate treatment and additional suffering.15, 17 As a consequence, people living with SCD have described avoiding hospital due to lack of trust and difficult past experiences, placing additional burden on the individual.15

Historically, opioid analgesics have been the mainstay for managing acute and persistent pain in SCD.**4, 18** Opioid-based pain management addresses only the sensory/physical dimensions of pain and poses challenges including stigma,4 opioid related risks, adverse effects, potential loss of efficacy over time and risk of opioid-induced hyperalgesia.6, 7 The need for integration of non-pharmacological interventions has been identified to better address affective, behavioural, cognitive, cultural and social dimensions of pain.4, 18-21

### **Pain Management Programmes**

Pain Management Programmes (PMPs) have been described as the intervention of choice for people with persistent pain which adversely affects quality of life and significantly impacts physical, psychological and social function.22 PMPs consist of a package of interventions delivered by a multidisciplinary team, typically within a group setting. The aim of PMPs is to increase functioning through the development of cognitive and behavioural self-management skills, rather than to directly reduce pain.22-24 The largest body of research relates to PMPs utilising a traditional Cognitive-Behavioural Therapy (CBT) framework.25 ‘Third wave’ cognitive-behavioural approaches including Acceptance and Commitment Therapy (ACT) and mindfulness based approaches are now also incorporated into many contemporary PMPs.26, 27 Systematic review and meta-analyses of CBT interventions for persistent pain, including PMPs, demonstrated small to medium effect size improvements on disability, mood and pain-related worry25 thus supporting their routine implementation in clinical services. Additionally, group delivery of PMPs has social benefits and provides the opportunity to share experiences with others in similar circumstances, normalise pain experiences and address behavioural change and rehearsal in a natural social setting.22, 28-30

Despite the broad use of CBT within other pain populations, there remains limited evidence for CBT, including PMPs, for adults living with SCD. A single RCT evaluating group CBT for adults with SCD reported favourable differences in self-reported measures of coping and self-efficacy, immediately following the intervention.31-33 A subsequent systematic review of psychological therapies for SCD34 concluded that CBT may be useful for people with SCD but stated that efficacy/effectiveness remain unclear due to poor quality evidence. A feasibility study involving 22 young people with SCD (aged 16-24 years) showed improvement in self-efficacy following group delivery of the Stanford chronic disease self-management programme.35 RCTs involving children and young people with SCD have investigated single session CBT training with smart-phone based home practice36 and a family based CBT intervention37, both with change in acute pain experience as primary aims.

Based on the low certainty of evidence from SCD and extrapolation of evidence from low back pain and fibromyalgia literature, clinical guidelines *suggest* that cognitive and behavioural strategies are delivered as part of a comprehensive SCD pain management plan.19, 20 Interdisciplinary PMPs are identified as a potential method of delivery.19 However, there is currently no evidence regarding the clinical application of these guidelines.

## **Aims and Objectives**

### **Aim**

To evaluate the feasibility of delivering an outpatient, group PMP to adults living with Sickle Cell Disease (SCPMP) and present preliminary outcomes.

### **Objectives**

To evaluate the feasibility of delivering a SCPMP through:

1. Primary feasibility outcomes

a) analysis of rates of recruitment, and completion of treatment and outcome measures

b) assessment of credibility, satisfaction and acceptability of the intervention to participants

1. Secondary feasibility outcomes

a) preliminary outcome estimates on treatment outcomes and process measures

b) preliminary data reporting healthcare utilisation and frequency of self-reported VOC

## **Methods**

### **Design**

A single arm, repeated-measures observational design was used. Treatment and data collection took place as part of routine clinical practice.

The study was reported in line with CONSORT guidelines for pilot and feasibility trials.38 Where necessary, adaptations were made to reflect the aim of determining feasibility of delivering an intervention (rather than feasibility of trial design).39 Ethical (REC Reference 14/NE/1069) and institutional approvals were obtained at the host site prior to the study.

### **Study setting**

The SCPMP was delivered within an interdisciplinary pain management servicestaffed by a clinical psychologist (0.6 whole time equivalent) and specialist physiotherapist (0.4 whole time equivalent) both with more than ten years’ experience in delivering interdisciplinary PMP’s in specialist pain services and additional expertise in clinical haematology. The pain management service was situated within amultidisciplinary red cell and haemoglobin disorders unit which provides care for approximately 500 adults living with SCD, thalassemia and rare anaemias.

### **Participants**

Participants were a consecutive sample of adults with SCD and persistent pain (pain lasting greater than 3 months8). Referrals were predominantly from the units’ Consultant Haematologists. However, patients known to the service could self-refer for assessment and referrals into the interdisciplinary pain management service were accepted from Haematologists from other NHS Trusts. Potential participants were assessed by the programme facilitators to determine suitability for the SCPMP using inclusion and exclusion criteria presented in Table 1.

Insert Table 1 around here

Prior to attending the SCPMP, some participants completed individual pain management physiotherapy or psychology sessions due to clinical need judged at assessment. Haematological management of SCD continued throughout the SCPMP. Participants were allocated to programmes according to time of referral and ability to attend the course dates. Groups were not allocated based on demographic or other features. All participants provided written informed consent for their data to be used in this research prior to starting a SCPMP.

### **Sample size**

We aimed to recruit 30 participants to the study, estimating recruitment of 7-8 participants from each of the first four programmes. Groups of 8-10 participants were considered optimal.22 However, it was agreed that groups would run with a minimum of three participants, as ability to recruit to a SCPMP was unknown. Programme dates were not pre-determined.

A sample of 30 participants sits within the recommended range of 24 and 50 participants in feasibility studies to enable estimates of the standard deviation for use in sample size calculations for full-scale trials.40, 41

### **Intervention**

The SCPMP ran as an eight session, outpatient group programme providing 36 hours contact time.22 Additional group follow-up sessions, each lasting two hours, were provided at one, six and twelve months after the programme. (Please note: collection of data at twelve-month follow-up was not included in the original ethical approval and, therefore, was completed as part of routine clinical practice, but is not included in this study).

The SCPMP content aligned with guidelines for PMP’s,22 was grounded in CBT principles and integrated third wave CBT approaches, including values-based goal setting and mindfulness practice.42 Adaptations to standard PMP content were made to reflect the nature of SCD with significant examples including; i) acknowledgement within ‘impact of pain’ discussions of the life-long, hereditary nature of SCD, impact of pain and treatment burden throughout the lifespan, and impact of negative and racist attitudes towards individuals living with SCD, ii) integration of acute pain mechanisms related to VOC within pain education discussions and iii) discussion of strategies for managing pain attributed to both VOC and ‘flare-up’ of persistent pain. Adaptations were agreed following discussion with a patient representative and pain management and haematology clinicians. Core themes introduced within the SCPMP are shown in Table 2. Session format (described in more detail in supplementary Table 1) remained consistent during the period of data collection.

Insert Table 2 around here

## **Primary Feasibility Outcomes**

### **Recruitment and treatment and questionnaire completion**

During the study period, the following data were collected to enable calculation of robust estimates of recruitment and treatment and questionnaire completion:

Number of individuals:

1. referred for interdisciplinary pain management assessment
2. considered appropriate for SCPMP
3. enrolled on SCPMP
4. who completed SCPMP, one-month and six-month follow-ups
5. who completed outcome measures at each timepoint

### Credibility, satisfaction and acceptability

Credibility, satisfaction and acceptability of the SCPMP to participants was assessed on completion of the programme and at six-month follow-up. Questions were devised for this study with reference to the treatment credibility scale43 and standardized measures proposed for back pain research.44

Participants completed additional open-ended questions identifying the most useful aspects of the intervention, changes they would suggest to improve the SCPMP, and behavioural changes resulting from SCPMP attendance.

Patients Global impression of change (PGIC)

At six-month follow-up, participants completed a modified version of the Patient’s Global Impression of Change (PGIC).45 Participants provided a single rating of ‘perceived change (if any) in activity limitations, symptoms, emotions and overall quality of life’ on a seven-point rating scale with options ranging from ‘no change (or condition has got worse)’ to ‘a great deal better and a considerable improvement that has made all the difference.’

## **Secondary Feasibility Outcomes**

### **Treatment outcomes**

Participants completed standardised self-report measures at four timepoints; at the start and end of the SCPMP, and one-month and six-month follow-ups. Outcome variables, selected to align with IMMPACT recommendations,46 were pain intensity and interference (Brief Pain Inventory; BPI)47, Anxiety and Depression (Hospital Anxiety and Depression Scale; HADS)48, and health related quality of life (EQ5D5L).49

### **Treatment processes**

Self-report measures were also used to capture information about clinically relevant treatment processes; pain self-efficacy (Pain Self-Efficacy Questionnaire; PSEQ)50 and pain-associated worry (Pain Catastrophising Scale; PCS)51 for CBT and acceptance (Chronic Pain Acceptance Questionnaire-8; CPAQ-8)52 for ACT. Mean baseline scores and internal consistency values of secondary outcome measures can be found in supplementary Table 2. All questionnaires, other than the CPAQ, showed acceptable or good internal consistency.

### **Self-reported frequency of VOC and healthcare utilisation**

The frequency of painful VOC was self-reported by participants for the six-months prior to starting the SCPMP and the six-months between programme completion and the six-month follow-up. Electronic health records were used to calculate frequency of admissions and length of stay for the twelve-months prior to, and the twelve-months post, SCPMP attendance. Where participants were referred from another hospital trust, data was requested from that trust.

### **Feasibility criteria**

A priori criteria determining feasibility of delivering the SCPMP were not specified as the service was newly commissioned at the start of the study period. Feasibility criteria were formalised during and following the data collection period as the specific service context was better understood.

Feasibility of delivering the SCPMP (in the context of the study site) was judged against the following criteria: 1) Ability to recruit a minimum of eight participants to a minimum of one programme per year, 2) Attendance at a minimum of 5/8 sessions, which was considered the minimum required attendance to be exposed to the PMP core themes, by ≥ 80% of participants, 3) Completion of end of programme questionnaires by ≥ 80% of programme completers, indicating feasibility of collecting robust outcome data , 4) Mean treatment credibility and satisfaction scores of greater > 5 on ten-point numerical rating scales (representing the midpoint of the scale or higher) 5) Observed within-group differences from pre-to-post SCPMP of at least moderate magnitude (Hedge’s g ≥ 0.5), consistent with potentially clinically important changes, seen on at least some treatment outcomes and process measures (excluding pain intensity, as pain reduction is not an aim of PMPs).22

Collection and analysis of frequency of VOC, hospital utilisation and length of stay data was included because evidence of change in these domains was considered relevant to people living with SCD and service providers. However, change in these domains was not considered essential for the delivery of the SCPMP to be feasible, therefore, they were not included within feasibility criteria.

## **Data Analysis**

### **Primary outcomes**

Pre-intervention characteristics and baseline measures, referral, treatment and questionnaire completion rates, treatment credibility and satisfaction, and PGIC scores were described using means (SDs) or frequencies (percentages) according to the nature of the data. Comparisons of patient satisfaction levels between post-PMP and 6-month follow-up were administered using paired sample *t*-tests.

### **Secondary outcomes**

Differences on pre-PMP/post-PMP outcome measures between SCPMP completers and non-completers and between those with and without follow-up data were assessed descriptively (with means/SDs) and formally compared using one-way analysis of variance (ANOVA) when the number of participants were sufficient. To evaluate whether treatment outcomes changed after attending the SCPMP, an intention-to-treat (ITT) analysis was conducted using linear mixed models (LMMs), which yield more accurate estimates of effect for repeated measures studies with missing data.53 For each outcome, time (pre-PMP, post-PMP, one-month follow-up and six-month follow-up) was included as a categorical variable with a random intercept and specified autoregressive/identity covariance structure (selected according to model fit indices). Parameter estimates were obtained using the restricted maximum likelihood method (REML), with post-hoc pre-to-post-PMP and pre-PMP-to-six-month follow-up treatment effect sizes (Hedges *g*) calculated using estimated marginal means (EMMs) accounting for covariance across repeated assessments. Effect sizes were classified as small (Hedge’s g >0.2) medium (>0.5) or large (>0.8).54 In addition, pairwise comparisons (paired sample *t*-tests for pre-to-post-PMP and pre-PMP-to-six-month follow-up) including only those patients who completed treatment were carried out and Hedges *g* calculated.

Comparisons concerning patient-reported painful crises and record-based healthcare utilisation in pre-PMP and follow-up periods were computed using paired sample *t*-tests or mid-*p* McNemar tests.55 LMMs and corresponding Hedges *g* were estimated using transformed values where continuous (outcome) variables did not approximate a Gaussian distribution according to skewness and kurtosis estimates, with acceptable range being between -1 and +1 and -1.5 and + 1.5, respectively.56 Bias corrected and accelerated (Bca) bootstrapping using 2000 replications57 was employed in all other analyses. To control for potential Type I errors as a result of multiple outcome testing, the false discovery rate (FDR) approach was applied to within-group comparisons across standardised measures, with control set to 5%.58

## **Results**

### **Demographics**

Participants comprised mostly females with a wide variety of ages and multiple sickle cell genotypes (Table 3). Almost all participants were taking opioid medication to help manage their pain and the majority were receiving SC disease-modifying treatment, such as blood exchanges or transfusions. All but five patients had suffered from painful VOC in the last six- months; more than half had experienced four or more crises in that period.

Insert Table 3 around here

### **Feasibility**

Table 4 shows the feasibility of delivering the SCPMP against criteria relevant to the study setting.

Insert Table 4 about here

### **Recruitment, attendance and program completion**

In total, 196 individuals were referred to the service during the study period, of which 123 people were (based on referral) appropriate for interdisciplinary pain management input and opted in for an assessment (Figure 1). Following assessment, 49 (39.8%) people were invited to attend the SCPMP and of those people, 29 (59.1%) started a SCPMP.

Insert Figure 1 around here

Between February 2016 – June 2020, there were six SCPMP groups totalling 29 participants (Figure 2). Illness resulted in cancellation of one session, therefore, one SCPMP ran over seven sessions, not eight. Recruitment was put on hold in March 2020 when individuals with SCD began shielding due to the COVID-19 pandemic. Participants in the final SCPMP group attended a remote six-month follow-up and submitted questionnaire responses electronically.

Insert Figure 2 around here

Across the six SCPMPs, 25 (86.2%) participants attended five or more of the eight SCPMP sessions. Of the four (13.8%) participants who did not complete the SCPMP, two dropped out after the first session and two dropped out after the third session. Of the 25 people who completed the SCPMP, the average participant attended 83.7% (range=62.5-100%) of intervention sessions (for those in the 7-session group (*n*=3), mean (*M*)=5.67 (81.0%), SD=1.16, range=5-7; for those in the 8-session groups (*n*=22), *M*=6.73 (84.1%), SD=1.20, range=5-8).

Twenty-three (92.0%) of the 25 SCPMP completers provided responses to primary feasibility questions at the end of the programme and 21 (84.0%) SCPMP completers, also provided secondary outcome questionnaires. Two participants completed treatment but did not complete measures at any point after treatment concluded. All other treatment completers completed measures at least on one occasion after the PMP. There was little to suggest that those who did not complete treatment and/or outcome measures were distinguishable from those who did. Scores on pre-PMP measures were highly comparable between those with any outcome data (i.e., those completing measures at some point after PMP participation; *n*=23) and those without (i.e., dropped out or did not complete measures; *n*=6), except for EQ-5D VAS (*M*(SD)=53.05 (18.87) vs. 67.80 (15.66), respectively) which suggested better perceived current health in those without outcome data, although the small *n* in this group precluded formal comparisons. Similarly, there were no significant differences on any pre-PMP or post-PMP (controlling for pre-PMP) measure between those with and without outcome data at six-month follow-up (for all comparisons, *p*>0.053), suggesting missing outcome data was unlikely to be related to baseline pain-related and psychological function or the degree of change over the course of the PMP.

### **Acceptability, satisfaction and credibility of the intervention**

In general, participants provided positive views with regards to acceptability, satisfaction and credibility of the intervention (Figure 3). All 23 SCPMP completers who rated the intervention’s usefulness, the extent to which it met expectations of better pain management, and satisfaction in helping manage their pain, gave ratings of ≥ 5 on a ten point (0-9) numerical rating scale (where 0=‘not at all’/ ‘not at all ok’ and 9=‘very much so’/‘totally ok’). Mean scores for each question were >7. These levels were comparable on the corresponding measures at six-month follow up (for each comparison, *p*>0.341). Participants were not quite as satisfied with their present symptoms post-PMP (M(SD)=5.00 (2.22), although there was a (non-significant) increase at six-month follow-up (M(SD)=6.33 (2.69); *p*=0.087).

 Insert Figure 3 around here

The content analysis of open-ended treatment experience questions is shown in Supplementary Tables 3 and 4. On completion of the SCPMP, all respondents (n=23) identified various aspects of the intervention as useful with most responses including multiple useful elements. The most helpful aspects of the SCPMP were identified as increased understanding of pain and pain experiences (n=10, 43.5%), group aspects (n=4, 17.4.0%) and coping strategies/practical tips (n=4, 17.4%). Eleven (47.8%) participants stated that they would not change any aspect of the programme. The remaining participants made varied suggestions about changes they would make to the SCPMP, including hospital staff attending SCPMP sessions which was suggested by three (13%) participants. Nineteen (82.6%) participants identified at least one thing they were doing differently since attending the SCPMP, with pacing activity (n=5, 21.7%) and mindfulness practice (n=4, 17.4%) mentioned most frequently (Supplementary Table 3).

At six-month follow-up, 15 participants provided a broad range of responses to two open-ended questions (Supplementary Table 4). In response to the question ‘What has the programme led you to think about, or do, differently?’, four dominant responses were described; Pacing activity (n=6, 40.0%), exercise (n=5, 33.3%) and communication and altered perspectives (regarding pain) (both, n=4, 26.6%).

### **Participants’ perception of global change**

Fifteen participants completed the modified PGIC scale at six-month follow-up. Eight participants (53.3%) noted they felt better with a definite improvement that had made a real difference (one of these ‘a great deal better’), while another two (13.3%) indicated that they were moderately better with a slight but noticeable change. Three participants (20.0%) responded that they were somewhat better, but that the change had made no real difference or a little better with no noticeable change, while another two participants (13.3%) suggested there was no change or hardly any change at all.

### **Treatment outcome and process measures**

Table 5 shows the Estimated Marginal Means (EMMs) and main effects for treatment in linear mixed models on treatment outcome and process measures across pre- and post-PMP assessments and at one-month and six-month follow-ups. Participants significantly benefitted from the intervention across pain interference, anxiety and depression (treatment outcomes), as well as pain-related worry, acceptance and self-efficacy (treatment process) domains; differences across assessment periods were significant after controlling for multiple comparisons. There was less improvement in HRQoL and no change in pain severity, although HRQoL did show a medium (0.4) effect size improvement. Estimates of effect sizes for pre-to-post-PMP and pre-PMP-to-six-month follow-up indicated large improvements (>0.8) in pain-interference, anxiety, depression and pain self-efficacy and moderate (>0.5) benefits in pain-related worry and chronic pain acceptance. These effects were mostly maintained at 6-month follow-up, although the magnitude of (significant) treatment gains with respect to pain interference and depression was less pronounced. This pattern of findings was largely unchanged when considering the treatment completer sample (Supplementary Table 5).

Insert Table 5 around here

### **Reported painful crises**

Nine (64.3%) of the 14 participants who provided six-month follow-up data for self-reported frequency of VOC, reported a decrease in the number of painful crises experienced in the six-months post-SCPMP compared with that in the six-months prior to SCPMP attendance (three reported no change in frequency and two experienced increases). Excluding one outlier (who reported a decrease from 101 pre-PMP to 75 six-months post-PMP), the mean (SD) number of painful crises reported by patients in the periods before and after PMP participation numerically decreased from 4.62 (3.95) to 3.15 (2.67), but the difference was not significant (*p*=0.171). Pain severity of experienced VOC was comparable between pre- (M(SD)=8.65 (1.06)) and post-PMP periods (M(SD)=8.45 (1.34); *p*=0.502) as was the proportion of individuals with crises lasting 7 days or more (60% versus 50%; *p*=0.625).

### **Healthcare utilisation**

#### Hospital admission data were available for 21 SCPMP completers. In the twelve-month period prior to SCPMP participation, the mean number (SD) of admissions was 2.00 (2.93). Admissions decreased significantly in the twelve-months post-PMP (M(SD)=0.81 (1.36); mean difference (95% CI)=1.19 (0.45,2.00); p=0.009). While nine (42.9%) of the participants had multiple admissions in the year prior to PMP attendance, only four (19.0%) did so in the year following completion. The three patients with high numbers (i.e.,> 5) of (annual) admissions pre-PMP all reduced admissions post-PMP by more than 40% (9-to-3, 9-to-5, and 7-to-3). Days in hospital (following admission; available for 20 participants) decreased from 10.65 (15.21) per patient in the 12-months prior to PMP attendance to 6.00 (11.27) in the period following PMP completion (mean difference (95% CI)=4.65 (1.50,8.32); p=0.038).

## **Discussion**

This study aimed to explore the feasibility of delivering a group PMP for adults living with SCD. Feasibility was demonstrated on four of five criteria: 1) Completion of five or more SCPMP sessions by >80% of participants 2) completion of post SCPMP outcome measures by > 80% of programme completers, 3) Mean acceptability, satisfaction and credibility scores >5 on 10-point scales and 4) Moderate to large within group differences from pre-to-post SCPMP across treatment outcome and process measures, except for HRQoL where effect size was small (0.4). However, during the study period, it was not possible to recruit a minimum of eight participants to a minimum of one SCPMP per year, therefore, this criterion was not met. These data show promise for the feasibility of delivering the SCPMP and provide guidance for how to further improve future delivery.

### **Primary feasibility aims**

Following interdisciplinary assessment more than half (59.1%) of individuals assessed were offered 1:1 input, rather than the group PMP. It is not possible to identify when this decision was based on patient preference versus clinical judgement as reasons for 1:1 input were not collected. Potential influences on difficulties recruiting to the SCPMP could include the novel nature of this intervention within haematology services and lack of SCD specific evidence demonstrating effectiveness. Concerns about participating in a group may also have been a barrier to recruitment. Stigma associated with seeing a mental health provider or specialist has been reported within sickle cell literature21 and could represent a barrier to attending a group intervention. Committing to a PMP in addition to existing medical appointments may have been an additional barrier for potential participants, as could predictions of difficulty attending due to frequency of VOC’s and/or hospital admissions. Exploration of the impact of negative and racist attitudes towards individuals living with SCD could include examining the effect on engagement with services such as PMPs and would be a valuable area of future research. The factors impacting recruitment to the SCPMP cannot be elucidated from the data collected in this study. Therefore, future research exploring specific barriers and facilitators to group interventions in SCD would enhance understanding and strategies to address recruitment challenges. It also seems likely, based on these findings, that individual and group pathways that utilise cognitive-behavioural pain management approaches are needed to meet a diversity of patient need within this population.

Based on the ratios presented in this study, an average of 46 potential participants would need to be assessed to recruit 11 people per year to a SCPMP, which would bring attendance into optimum range when allowing for drop-out. Although a small number of external referrals were received, recruitment in this study came predominantly from one haematology service with an average referral rate of 31 potential SCPMP participants per year. Developing pathways to promote recruitment across regional haemoglobinopathies co-ordinating centres may represent a more feasible and efficient model, enabling programmes to run at optimum capacity. Issues relating to accessibility would, however, need to be considered. The SCPMP was modified for remote delivery during the COVID-19 pandemic (data is not included in this study) and remote delivery of PMPs has been explored in chronic pain populations.59, 60 Exploration of remote PMP delivery is warranted in SCD as this may increase accessibility and recruitment over larger geographical areas, although potential barriers presented by remote delivery for some participants, such as limited access to technology, would need to be considered.59

The feasibility targets of ≥80% of participants attending 5 or more sessions, and ≥80% of SCPMP completers submitting end of programme questionnaires, were achieved. The rate of attrition from the SCPMP was 13.8%. This compares favourably with rates of attrition across interdisciplinary PMP’s which have been reported as ranging from 5%-46%.61 Although this cannot be evidenced with the data collected, stringent assessment of suitability for a group PMP, and access to 1:1 input where indicated, may have contributed to the relatively low attrition rates. Of programme completers, average attendance was 83.7% (range 62.5% - 100%). Attendance at routine outpatient appointments is frequently cited as a challenge for adults with SCD, with published rates of attendance ranging from 47% to 77%.62 SCPMP participants rated the programme as a credible intervention that met expectations, felt useful and was associated with high levels of satisfaction, which may have contributed to the relatively high attendance rates and supports the potential value of this intervention. Thus, despite challenges with recruitment, the current study suggests that once recruited, participants engaged with the treatment as intended and found it acceptable.

### **Secondary Feasibility Aims**

Patient reported outcomes presented in this study must be interpreted with acknowledgement that this was not a controlled study, and the sample size was small. However, the preliminary data presented suggests that attendance at a SCPMP may positively impact pain interference, anxiety and depression, pain-related worry, self-efficacy, and pain acceptance, with improvements maintained at six months. The preliminary data presented also suggests that attendance at SCPMP may positively impact self-reported frequency of VOC, frequency of hospital admissions and length of stay. This is promising preliminary evidence which needs to be replicated in a larger sample, at other treatment centres and, optimally, using an RCT.

This study can inform future clinical practice and research to enhance inclusion of racialised and minority groups in pain research and treatment. This study describes delivery of the SCPMP in the context of a newly commissioned interdisciplinary pain management service. Delivery of the SCPMP continued during the study period with relatively small group sizes. This is significant because continued delivery of the SCPMP enabled the clinical team to develop relationships within the local SC community and increase trust. Letzen and colleagues**63** highlight that the mistreatment of racialised individuals in science and healthcare settings undermines trustworthiness, therefore, trust must be earned through actions. Over time, SCPMP participants shared experiences of the programme in video reflections, at awareness events and during informal conversations which, anecdotally, contributed to increased credibility of the SCPMP locally. Whilst recognising that more can be done and committing to ongoing improvement, we acknowledge that strategies to enhance inclusion of minoritized individuals, specifically actions to build trust and increase community awareness, were integral to the delivery of the SCPMP during the study period. Inclusion of minoritised individuals within pain services and pain research may be enhanced through commitment to several key actions, as proposed by Hood et al **64**. These include but are not limited to, building trust; developing early, enduring and mutually beneficial collaborations with advocates and stakeholders from minoritised groups; reflecting on implicit bias; and, taking action to foster cultural humility within clinical and research teams64**.**

## **Limitations**

There are several limitations of this study beyond the small sample size and uncontrolled design. The repeated measures design may have resulted in measurement fatigue and the extensive battery of questionnaires may have represented a burden to participants. Outcome measures utilised in this study were selected to align with IMMPACT recommendations46 to facilitate comparison across pain management literature but did not include collection of specific data relating to adverse events. Use of the treatment credibility scale43 in its entirety would allow greater comparison with other feasibility studies. The measures selected did not include a sickle cell specific measure, such as the sickle cell self-efficacy scale (SCSES)65 which should be considered in future studies to allow comparision across sickle cell literature. The appropriateness of the CPAQ for people with SCD should be ascertained before use in future studies, due to low cronbach’s alpha for this scale in this study. Baseline data included self-report of medication use (classifed in broad groups, e.g. opioids). However, we did not collect these data at end of programme or follow-up. Collection of pre and post SCPMP opioid use could provide insight into the potential for a SCPMP to assist individuals in reducing opioid use, which can pose significant challenges for individuals living with SCD7. Collection of quantiative and qualitative data, enabling exploration of meaning and impact of medication changes for the individual, would be useful for future research. As this study was uncontrolled, observed improvements may be due to non-specific factors such as natural changes over time or therapeutic relationships. However, the magnitude of observed effects across treatment outcome and process measures would appear unlikely in the absence of some type of treatment effect.

## **Conclusion**

Findings from this study, including a small cohort of 29 participants, suggest that, with an adequate source of referrals, delivery of a SCPMP is likely feasible, the intervention is acceptable to participants and may positively impact pain related treatment and process outcomes and hospital utilisation. Given the paucity of evidence related to interdisciplinary PMPs for adults with SCD and the lack of inclusion of racialised and minoritised groups in pain research66, this study provides valuable, real-life insights that can inform clinical practice and future research design. Evidence from this study suggests that exploration of potential barriers and facilitators of group work, and remote delivery of a SCPMP, both of which could facilitate recruitment, could be valuable areas of future research in SCD.

## **References**

1. Hollins M, Stonerock GL, Kisaalita NR, et al. Detecting the emergence of chronic pain in sickle cell disease. *J Pain Symptom Manage* 2012; 43: 1082-1093. 20120511. DOI: 10.1016/j.jpainsymman.2011.06.020.

2. Du S, Lin C and Tao YX. Updated mechanisms underlying sickle cell disease-associated pain. *Neurosci Lett* 2019; 712: 134471. 20190907. DOI: 10.1016/j.neulet.2019.134471.

3. Kato GJ, Piel FB, Reid CD, et al. Sickle cell disease. *Nat Rev Dis Primers* 2018; 4: 18010. 20180315. DOI: 10.1038/nrdp.2018.10.

4. Sinha CB, Bakshi N, Ross D, et al. Management of Chronic Pain in Adults Living With Sickle Cell Disease in the Era of the Opioid Epidemic. *JAMA Network Open* 2019; 2: e194410. DOI: 10.1001/jamanetworkopen.2019.4410.

5. Smith WR, Penberthy LT, Bovbjerg VE, et al. Daily assessment of pain in adults with sickle cell disease. *Ann Intern Med* 2008; 148: 94-101. DOI: 10.7326/0003-4819-148-2-200801150-00004.

6. Ballas SK and Darbari DS. Review/overview of pain in sickle cell disease. *Complementary Therapies in Medicine* 2020; 49: 102327. DOI: 10.1016/j.ctim.2020.102327.

7. Osunkwo I, O'Connor HF and Saah E. Optimizing the management of chronic pain in sickle cell disease. *Hematology Am Soc Hematol Educ Program* 2020; 2020: 562-569. DOI: 10.1182/hematology.2020000143.

8. Nicholas M, Vlaeyen JWS, Rief W, et al. The IASP classification of chronic pain for ICD-11: chronic primary pain. *Pain* 2019; 160: 28-37. DOI: 10.1097/j.pain.0000000000001390.

9. Dampier C, Palermo TM, Darbari DS, et al. AAPT Diagnostic Criteria for Chronic Sickle Cell Disease Pain. *J Pain* 2017; 18: 490-498. 20170105. DOI: 10.1016/j.jpain.2016.12.016.

10. Levenson JL, McClish DK, Dahman BA, et al. Depression and anxiety in adults with sickle cell disease: the PiSCES project. *Psychosom Med* 2008; 70: 192-196. 20071224. DOI: 10.1097/PSY.0b013e31815ff5c5.

**11. Sickle Cell Society. About Sickle Cell** [**http://www.sicklecellsociety.org/about-sickle-cell/**](http://www.sicklecellsociety.org/about-sickle-cell/) **(accessed 29 October 2023).**

12. Kapadia D, Zhang, J., Salway, S., Nazroo, J., Booth, A., Villarroel-Williams, N., Becares, L., Esmail, A.,. *Ethic inequalities in healthcare: A rapid evidence review*. February 2022. NHS Race and Health Observatory

13. Marmot M. Social determinants of health inequalities. *Lancet* 2005; 365: 1099-1104. DOI: 10.1016/S0140-6736(05)71146-6.

14. Mahase E. Sickle cell disease: inquiry finds serious care failings and racism towards patients. British Medical Journal Publishing Group, 2021.

15. Thalassemia APPGoSCa. *No one's listening: an inquiry into the avoidable deaths and failures of care for sickle cell patients in secondary care*. 15 Nov 2021. London, UK: Sickle Cell Society

16. Glassberg JA, Tanabe P, Chow A, et al. Emergency Provider Analgesic Practices and Attitudes Toward Patients With Sickle Cell Disease. *Annals of Emergency Medicine* 2013; 62: 293-302.e210. DOI: 10.1016/j.annemergmed.2013.02.004.

17. Power-Hays A and McGann PT. When Actions Speak Louder Than Words — Racism and Sickle Cell Disease. *New England Journal of Medicine* 2020; 383: 1902-1903. DOI: 10.1056/nejmp2022125.

18. Williams H and Tanabe P. Sickle Cell Disease: A Review of Nonpharmacological Approaches for Pain. *J Pain Symptom Manage* 2016; 51: 163-177. 20151117. DOI: 10.1016/j.jpainsymman.2015.10.017.

**19. Sickle Cell Society. *Standards for the clincial care of Adults with Sickle Cell Disease in the UK, 2nd Edition*. 2018. United Kingdom: Sickle Cell Society.**

20. Brandow AM, Carroll CP, Creary S, et al. American Society of Hematology 2020 guidelines for sickle cell disease: management of acute and chronic pain. *Blood Adv* 2020; 4: 2656-2701. DOI: 10.1182/bloodadvances.2020001851.

21. Badawy SM, Abebe KZ, Reichman CA, et al. Comparing the Effectiveness of Education Versus Digital Cognitive Behavioral Therapy for Adults With Sickle Cell Disease: Protocol for the Cognitive Behavioral Therapy and Real-time Pain Management Intervention for Sickle Cell via Mobile Applications (CaRISMA) Study. *JMIR Res Protoc* 2021; 10: e29014. 20210514. DOI: 10.2196/29014.

22. Society BP. *Guidelines for pain management programmes for adults*. 2013. London, UK: British Pain Society

23. Buscemi V, Chicken J, Mahy T, et al. An updated audit of the patient selection process for pain management programmes in a speciality care service before and during the COVID-19 pandemic. *British journal of pain* 2022: 204946372211472. DOI: 10.1177/20494637221147200

info:doi/10.1177/20494637221147200.

24. Kamper SJ, Apeldoorn AT, Chiarotto A, et al. Multidisciplinary biopsychosocial rehabilitation for chronic low back pain. *Cochrane Database Syst Rev* 2014: CD000963. 20140902. DOI: 10.1002/14651858.CD000963.pub3.

25. Williams ACC, Fisher E, Hearn L, et al. Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database Syst Rev* 2020; 8: CD007407. 20200812. DOI: 10.1002/14651858.CD007407.pub4.

26. McCracken LM, Yu L and Vowles KE. New generation psychological treatments in chronic pain. *BMJ* 2022: e057212. DOI: 10.1136/bmj-2021-057212.

27. McCracken LM and Vowles KE. Acceptance and commitment therapy and mindfulness for chronic pain: model, process, and progress. *Am Psychol* 2014; 69: 178-187. DOI: 10.1037/a0035623.

28. Thorn BE and Kuhajda MC. Group cognitive therapy for chronic pain. *J Clin Psychol* 2006; 62: 1355-1366. DOI: 10.1002/jclp.20315.

29. Newton-John TR and Geddes J. The non-specific effects of group-based cognitive--behavioural treatment of chronic pain. *Chronic Illn* 2008; 4: 199-208. DOI: 10.1177/1742395308091868.

30. Wilson D, Mackintosh S, Nicholas MK, et al. Are group identity and sense of belonging relevant for group pain management programmes? An exploratory pilot study. *British Journal of Pain* 2022. DOI: 10.1177/20494637221098941.

31. Thomas VN, Wilson-Barnett J and Goodhart F. The role of cognitive-behavioural therapy in the management of pain in patients with sickle cell disease. *J Adv Nurs* 1998; 27: 1002-1009. DOI: 10.1046/j.1365-2648.1998.00584.x.

32. Thomas VJ, Dixon, A. L., Milligan, P. Cognitive-behaviour therapy for the management of sickle cell disease pain: An evaluation of a community-based intervention. *British Journal of Health Psychology* 1999; 4: 209-229.

33. Thomas V. Cognitive behavioural therapy in pain management for sickle cell disease. *Int J Palliat Nurs* 2000; 6: 434-442. DOI: 10.12968/ijpn.2000.6.9.9055.

34. Anie KA and Green J. Psychological therapies for sickle cell disease and pain. *Cochrane Database Syst Rev* 2015: CD001916. 20150508. DOI: 10.1002/14651858.CD001916.pub3.

35. Crosby LE, Joffe NE, Peugh J, et al. Pilot of the Chronic Disease Self-Management Program for Adolescents and Young Adults With Sickle Cell Disease. *Journal of Adolescent Health* 2017; 60: 120-123. DOI: 10.1016/j.jadohealth.2016.08.022.

36. Schatz J, Schlenz AM, McClellan CB, et al. Changes in Coping, Pain, and Activity After Cognitive-Behavioral Training. *The Clinical Journal of Pain* 2015; 31: 536-547. DOI: 10.1097/ajp.0000000000000183.

37. Barakat LP, Schwartz LA, Salamon KS, et al. A family-based randomized controlled trial of pain intervention for adolescents with sickle cell disease. *J Pediatr Hematol Oncol* 2010; 32: 540-547. DOI: 10.1097/MPH.0b013e3181e793f9.

38. Eldridge SM, Chan CL, Campbell MJ, et al. CONSORT 2010 statement: extension to randomised pilot and feasibility trials. *BMJ* 2016; 355: i5239. 20161024. DOI: 10.1136/bmj.i5239.

39. Lancaster GA and Thabane L. Guidelines for reporting non-randomised pilot and feasibility studies. *Pilot Feasibility Stud* 2019; 5: 114. 20191006. DOI: 10.1186/s40814-019-0499-1.

40. Julious S. Sample size of 12 per group rule of thumb for pilot study. *Pharmaceutical Statistics* 2005; 4: 287-291. DOI: <https://doi.org/10.1046/j.152-1497.2001.016009606.x>.

41. Sim J and Lewis M. The size of a pilot study for a clinical trial should be calculated in relation to considerations of precision and efficiency. *J Clin Epidemiol* 2012; 65: 301-308. 20111209. DOI: 10.1016/j.jclinepi.2011.07.011.

42. Wilkinson P and Whiteman R. Pain management programmes. *BJA Education* 2017; 17: 10-15.

43. Devilly GJ and Borkovec TD. Psychometric properties of the credibility/expectancy questionnaire. *J Behav Ther Exp Psychiatry* 2000; 31: 73-86. DOI: 10.1016/s0005-7916(00)00012-4.

44. Deyo RA, Battie M, Beurskens AJ, et al. Outcome measures for low back pain research. A proposal for standardized use. *Spine (Phila Pa 1976)* 1998; 23: 2003-2013. DOI: 10.1097/00007632-199809150-00018.

45. Hurst H and Bolton J. Assessing the clinical significance of change scores recorded on subjective outcome measures. *J Manipulative Physiol Ther* 2004; 27: 26-35. DOI: 10.1016/j.jmpt.2003.11.003.

46. Dworkin RH, Turk DC, Farrar JT, et al. Core outcome measures for chronic pain clinical trials: IMMPACT recommendations. *Pain* 2005; 113: 9-19. DOI: 10.1016/j.pain.2004.09.012.

47. Cleeland CS and Ryan KM. Pain assessment: global use of the Brief Pain Inventory. *Ann Acad Med Singap* 1994; 23: 129-138.

48. Zigmond AS and Snaith RP. The hospital anxiety and depression scale. *Acta Psychiatr Scand* 1983; 67: 361-370. DOI: 10.1111/j.1600-0447.1983.tb09716.x.

49. Herdman M, Gudex C, Lloyd A, et al. Development and preliminary testing of the new five-level version of EQ-5D (EQ-5D-5L). *Qual Life Res* 2011; 20: 1727-1736. 20110409. DOI: 10.1007/s11136-011-9903-x.

50. Nicholas MK. The pain self-efficacy questionnaire: Taking pain into account. *Eur J Pain* 2007; 11: 153-163. 20060130. DOI: 10.1016/j.ejpain.2005.12.008.

51. Sullivan MJ, Bishop SR and Pivik J. The pain catastrophizing scale: development and validation. *Psychological assessment* 1995; 7: 524.

52. Fish RA, McGuire B, Hogan M, et al. Validation of the chronic pain acceptance questionnaire (CPAQ) in an Internet sample and development and preliminary validation of the CPAQ-8. *Pain* 2010; 149: 435-443. 20100225. DOI: 10.1016/j.pain.2009.12.016.

53. West BT, Welch KB and Galecki AT. *Linear mixed models: a practical guide using statistical software*. Chapman and Hall/CRC, 2006.

54. Cohen J. *Statistical power analysis for the behavioural sciences* 2nd edition ed. New York: Routledge, 1988.

55. Fagerland MW, Lydersen S and Laake P. The McNemar test for binary matched-pairs data: mid-p and asymptotic are better than exact conditional. *BMC medical research methodology* 2013; 13: 1-8.

56. Hair Jr J, Anderson R, Tatham R, et al. Multivariate data analysis 5th ed Prentice Hall Upper Saddle River. NJ, 1998.

57. Efron B and Tibshirani RJ. An introduction to the bootstrap. *Monographs on statistics and applied probability* 1993; 57.

58. Benjamini Y and Hochberg Y. Controlling the false discovery rate: a practical and powerful approach to multiple testing. *Journal of the Royal statistical society: series B (Methodological)* 1995; 57: 289-300.

59. Williams D, Booth G, Cohen H, et al. Rapid design and implementation of a virtual pain management programme due to COVID-19: a quality improvement initiative. *Br J Pain* 2022; 16: 191-202. 20210903. DOI: 10.1177/20494637211039252.

60. Eccleston C, Blyth FM, Dear BF, et al. Managing patients with chronic pain during the COVID-19 outbreak: considerations for the rapid introduction of remotely supported (eHealth) pain management services. *Pain* 2020; 161: 889-893. DOI: 10.1097/j.pain.0000000000001885.

61. Oosterhaven J, Wittink H, Mollema J, et al. Predictors of dropout in interdisciplinary chronic pain management programmes: A systematic review. *J Rehabil Med* 2019; 51: 2-10. DOI: 10.2340/16501977-2502.

62. Cronin RM, Hankins JS, Byrd J, et al. Modifying factors of the health belief model associated with missed clinic appointments among individuals with sickle cell disease. *Hematology* 2018; 23: 683-691. 20180329. DOI: 10.1080/10245332.2018.1457200.

63. Letzen JE, Mathur VA, Janevic MR, et al. Confronting Racism in All Forms of Pain Research: Reframing Study Designs. *J Pain* 2022; 23: 893-912. 20220226. DOI: 10.1016/j.jpain.2022.01.010.

64. Hood AM, Booker SQ, Morais CA, et al. Confronting Racism in All Forms of Pain Research: A Shared Commitment for Engagement, Diversity, and Dissemination. *J Pain* 2022; 23: 913-928. 20220226. DOI: 10.1016/j.jpain.2022.01.008.

65. Edwards R, Telfair, J., Cecil, H., Lenoci, J. Reliability and validity of a self-efficacy instrument specific to sickle cell disease. *Behaviour Research and Therapy* 2000; 38: 951-963.

66. Janevic MR, Mathur VA, Booker SQ, et al. Making Pain Research More Inclusive: Why and How. *J Pain* 2022; 23: 707-728. 20211020. DOI: 10.1016/j.jpain.2021.10.004.