



# REPORT

**On a survey of health journalists about sources of information,  
attitudes and beliefs about chronic pain and opioid addiction**

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## Health journalists survey report

### Premises

In 2011, the Institute of Medicine report, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, highlighted the burden of chronic pain in the United States. Per this report, over 100 million Americans live with chronic pain, more than those affected by heart disease, diabetes, and cancer combined, with an annual national economic cost estimated between \$560 billion and \$635 billion (IOM 2011, Steglitz, Buscemi et al. 2012). Yet, the social issue of chronic pain has been routinely minimized by the medical establishment, politicians, media and society.

The current International Classification of Diseases does not include a code for chronic pain as a distinct diagnosis (Mills, Torrance et al. 2016). Contrary to popular belief that chronic pain is mostly present at an advanced age, chronic pain has a significant impact on the quality of life of people of all ages (Hunfeld, Van Der Wouden et al. 1997, Hunfeld, Perquin et al. 2001). Chronic pain has been classified as a public health problem and should be a public health priority (Gallagher 1998).

Because of its multiple etiologies, chronic pain is poorly understood, both from clinical and research perspectives. Although a multitude of research papers have been published on the etiology and treatment of chronic pain, much remains to be done. The International Association for the Study of Pain (IASP) defines chronic pain as “pain which has persisted beyond normal tissue healing time,” which has been arbitrarily placed at 12 weeks (I.A.S.P. 2015). Pain is a subjective and personal experience, its intensity and expression varies with each individual, and it is almost impossible to objectively quantify and compare (Shelley and Comerci 2016). A patient’s report of pain intensity has been the staple of measurement for centuries; some symptoms are an expression of a somatic cause, some are not.

A study conducted in the mid-1980s, aimed at proposing a coding system for primary headache syndromes and pain of psychological origin, identified multiple causes and expressions of chronic pain (Merskey 1986). Multiple attempts have been made to develop clinical scales that look at pain from a comprehensive approach, supplementing self-reporting with level of disability, temporal characteristics, affective distress, etc. (Von Korff, Ormel et al. 1992, Smith, Penny et al. 1997, Farrar, Young et al. 2001, Dworkin, Turk et al. 2005). Although these various scales focus on measuring the expression of pain for clinical purposes, , which varies from mild but continuous discomfort to excruciating pain, depression, even suicidal tendencies (Davison and Jhangri 2005, Toth, Lander et al. 2009), chronic pain has significant impact on a person’s life that cannot be easily quantified. Chronic pain is a complex biopsychosocial phenomenon which does not solely affect the patient; job performance and family life, as well as social and community integration suffer because of chronic pain (Turk, Okifuji et al. 1995, Palermo 2000, Kemler and Furnée 2002, van den Berg-Emons, Schasfoort et al. 2007, Wu and Graham 2016).

Treating chronic pain is challenging. A comprehensive approach combining pharmaceutical therapy with psychological approaches, physiotherapy, self-management, and complementary and alternative medicines in the form of comprehensive Pain Management Programs (PMP) seem to show promise (Turner-Stokes, Erkeller-Yuksel et al. 2003, Warsi, Wang et al. 2004, Westman, Linton et al. 2008). Nevertheless, in the United States, access to these programs is limited because of finances, geography and/or availability. Some chronic pain patients have resigned themselves to suffering in silence, as the

bio-medical model has failed them and they have little hope of reprieve – at least 18% of those suffering with chronic pain have lost hope and are not seeking any treatment (Sternbach 1986, Hart 2003).

Cultural and societal attitudes influence not only how we treat chronic pain but, more importantly, how those suffering with chronic pain are perceived and regarded by society. National, comprehensive programs addressing pain have only been developed in the early years of the 21<sup>st</sup> century in both the United States and the European Union (Carr 2001, Niv and Devor 2007).

While significant progress has been made in the past century in treating pain, a dissociation exists between cultural norms and behaviors and societal acceptance of those living with chronic pain (Keefe, Abernethy et al. 2005, Morley 2011). Administrative, political and economic interests have frequently derailed the path towards comprehensive and adequate treatment of chronic pain. In the United States, analgesics are often compared with street drugs, and both professional and lay phobia against opioids is increasing (Compton and Volkow 2006, Paulozzi and Ryan 2006, Barry, Kennedy - Hendricks et al. 2016). Studies have found that physicians, especially those in primary care, have inadequate training in the prescribing and management of opioids and pain in general (Mortimer and Bartlett 1997, Rusch 2016).

Abuses by unqualified medical practitioners (Harrison 2015) and sensationalist mass media reports focused almost exclusively on prescription substance abuse, transition between opioid use and heroin addiction, and deaths associated with abuse of prescription opioids (including those of celebrities) have helped fuel a social movement against opioids (Rayne 2015, Mandak 2016, Rhodan 2016). These social phenomena translate into a general misunderstanding of chronic pain, stigmatization of those living with the disease, and decreased social, cultural and even medical tolerance (Werner and Malterud 2003, Jackson 2005, Shah and Diwan 2010). In 2015, under pressure from policy makers and advocates against drug use, the Centers for Disease Control and Prevention (CDC) released the first draft of proposed Guidelines for Opioid Prescribing (CDC 2015). While a welcome addition, especially for physicians untrained in the use of opioids, the prescribing guidelines could inadvertently make the burden of chronic pain greater for millions of Americans. Cindy Steinberg, the director of policy and advocacy for the patient advocacy group U.S. Pain Foundation, , said that “I am concerned that if these guidelines go forward as they are now written, they will lead to further restrictions on access to opioids for people with unremitting pain who truly need them and take them responsibly.” (Foreman 2016) After requesting public feedback and with little revision, the 12 recommendations became official CDC policy in 2016 (Dowell, Haegerich et al. 2016).

Media plays an important role in modeling public opinion about a multitude of issues, from political candidates to recreational use of psychotropic substances (Shoemaker, Vos et al. 2009, Heinderyckx and Vos 2016). Although the wide adoption of the Internet and social media has impacted the gatekeeping role of the journalist, media outlets still have a significant influence on what salient issues become part of the public agenda (Aruguete 2017, Kirby-Petruccio 2017).

There is little research into how media creates their frames when reporting about chronic pain or on media depictions of people living with chronic pain. There is evidence that there is a dissociation between traditional media’s (newspapers and magazines) depiction of chronic pain patients and how these individuals communicate about themselves in blogs and social media, with traditional media contributing to the “stigmatization and otherization” of those living with chronic pain (Donovan 2011). Research on how chronic pain patients use social media to share their experiences found that social

media sites such as Flickr and Tumblr help model patients' narratives as well as how those living with chronic pain communicate and share information (Gonzalez-Polledo and Tarr 2016). A study conducted at Antioch University in Seattle on online-reader-comments on a series of pain-care policy articles found that there is a relationship between social interpretation of the motivations for seeking care/treatment and the positive or negative perceptions of pain patients (Nickerson 2016).

To our knowledge, the present study is the first ever attempt to directly explore attitudes and beliefs of health journalists about chronic pain.

## Research

The survey instrument was developed by Dr. Mugur Geana and Dr. Scott Reinardy with input from PAINS. The instrument is based in part on previous research on attitudes and beliefs about people living with chronic pain, previous research on attitudes and beliefs of reporters and journalists, and an overview of current academic literature on reporting about chronic pain and opioid addiction.

The survey was administered online using the KU School of Journalism Survey Monkey account. The link to the survey was distributed to contact lists via email. The contact lists for the recipients of the survey had three provenances: 1) names and email addresses provided by PAINS, 2) names and email addresses provided by KU's public relations office, and 3) names and emails retrieved from newspaper, blog and broadcast stories published over the last five years on chronic pain, opioid addiction and current public health topics, through a Lexis-Nexis search. A graduate student performed an online search for the name of each of the authors to locate their email address in order to be included in the dataset. From those three sources, a total of 1096 names were validated and used for distribution of the survey.

The survey was administered in two instances, one in October-December of 2016 and one in February of 2017 (Figure 1). The first administration in November was done on a dataset of names only from sources 1 and 2 – 565 names total. After the initial administration, we proceeded with the Lexis-Nexis search and increased the dataset by another 531 names and email addresses. The second administration included both datasets, with the specific instruction for those that had done the survey in November not to complete the survey again.

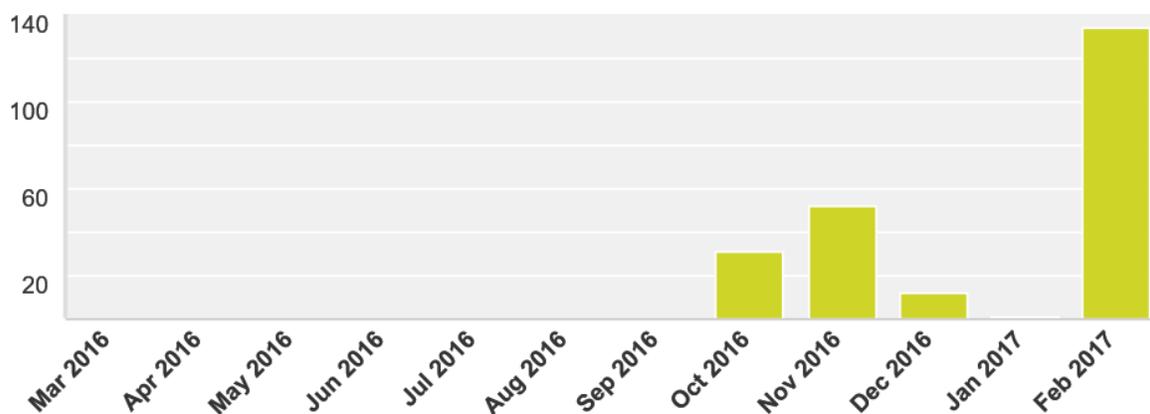


Figure 1. Timeline of collection of responses to the survey

The survey was anonymous; no personal data was collected. An analysis of IP addresses revealed only 9 instances (22 surveys total) in which participants shared the same IP address. A review of the correspondent surveys revealed that those were IP addresses for large area service providers or specific organizations; significant differences in the answers to the survey confirmed that different people provided the answers.

The geographic distribution of survey participants, based on the IP address used at the time of taking the survey, covers the entire United States (Figure 2).

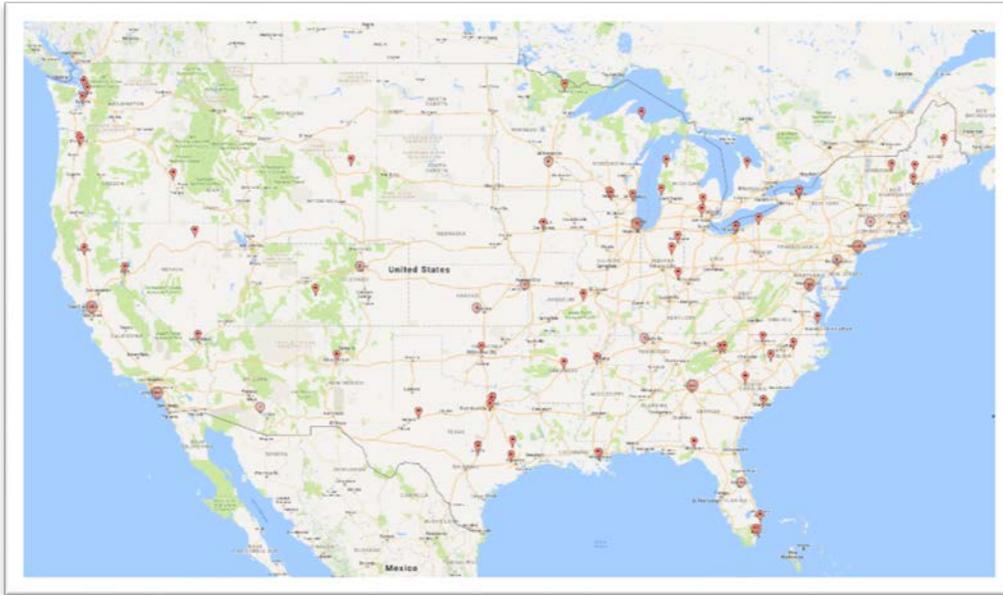


Figure 2. Geographic distribution of survey participants

The link to the online survey was distributed via emails sent by Dr. Scott Reinardy. The response was overall positive. The final 1,096 recipients represent the total number of emails that we kept for the current analysis. A significant number of emails (especially from source 1 mentioned above) were invalid emails or deceased persons. A few participants contacted Dr. Reinardy by phone enquiring about the purpose of the survey, some offering suggestions or inquiring about the funding source for the project.

Of the very few emails received from the recipients of our recruitment email, some addressed perceived concerns about some of the survey questions, qualifications for participating, technical issues or concerns about funding sources. There was interest on obtaining the results of the study. The most relevant emails are listed below:

*"I filled it out. I think opioid abuse and addiction is a huge problem in this country. The world for that matter. I host a radio show and many of my guests have spoken about it. Hope this helps with your study!"*

*"I didn't participate because I didn't really understand the purpose of the survey. Of course "medical experts" are any reporter's "primary source" for healthcare stories, but how a medical expert is defined should be part of the question (i.e. anyone or anything*

*can call itself a medical expert, regardless of whether he or she has an iota of true expertise? Dr. Oz? A medical student in first year? Someone who had an encounter with the healthcare system? A health insurance company rep? A physician scientist who has been published in a peer reviewed journal which carried the article on the topic being written about?). Since I primarily write about health policy, I don't often interview patients because they may or may not see the issues in terms of health policy. And when you ask about "spokespeople," I'm not sure what you mean. PR people? Doctors who head hospital departments? I use agencies at all layers of government, but they may or may not be my primary sources, depending on the story. I very rarely write about chronic pain."*

*"I recently completed a series of articles on chronic pain and have also written extensively about opioid abuse in Massachusetts. Does that disqualify me from your survey? Also, I am moderating a panel discussion on chronic pain at the annual conference of the Association of Health Care Journalists in April. Do you think you'll have results from your survey by then? If so, it might be interesting to mention them as we kick off the discussion. Would you be willing to share them with me?"*

*"I did not finish the survey because there was a point, later in the survey, where the participant had to prioritize among a list of things he/she used. I did not use any of them. But the survey would not let me finish without answering that question."*

*"Thank you for contacting me. You mention that to your knowledge, no pharmaceutical funds are being used to sponsor this research. But you don't mention that at least two of your funders receive funding from pharmaceutical companies. Curious whether you are aware of the ties."*

## Results

The participants received three reminders to complete the survey in each of the data collection periods (October-December 2016 and February 2017).

230 participants started the survey. Of these, 193 provided complete responses and 37 were partially completed surveys.

Due to the vetting process employed by the researchers when establishing the population for the study (i.e. confirmed email addresses), we considered the list as being accurate and current and all those in the dataset eligible to participate; thus all those from we did not receive a response are treated as non-respondents. We considered partially completed surveys all those surveys (37) that either 1) did not reach the last question of the survey or 2) completed the survey but did not provide an answer to all the questions in the survey.

We estimate that technical issues, failure to respond to demographic questions or topic-related issues were the major reasons for non-completion. Nevertheless, the structure of the survey instrument allows for analysis of even partially-completed results, so we decided to keep all the data for analysis.

Response rate calculated according to AAPOR (American Association for Public Opinion Research) formula was 17.3%, with a maximum cooperation rate of 98.7% (AAPOR Response Rate Calculator V4.0 – May 2016). Nevertheless, our approach uses a self-selected, non-probability sampling, so response rates should be interpreted accordingly.

The survey was constructed in five sections:

- A. Sources of story ideas
- B. Media organization
- C. Chronic pain and opioid abuse
- D. Experience with chronic pain
- E. Demographic data

**Descriptive statistics**

Primary sources for health stories (aggregated data Agree/Strongly agree - percentages)

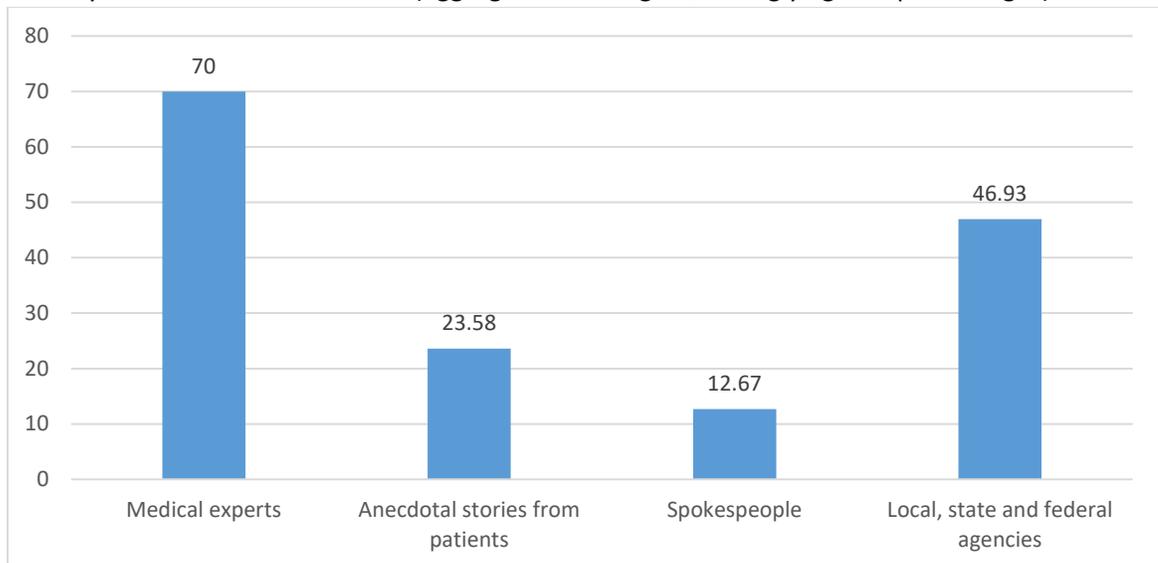


Figure 3 - Sources when producing stories about chronic pain

Arthritis Reputable Topic Rheumatologists Health  
 Professionals Knowledge Medical  
 Reports Advocacy Story Peer-reviewed  
 Literature Doctors Advocates Chronic

# Pain Researchers Patients Start Science Psychiatrists Chiropractors Pain Management Journal Articles Retired Social Opioids Subject Issue Typically

Medical sources rank first as the source for chronic pain articles. Some comments illustrating these are:

*“Doctors and **medical** centers that both research and treat chronic pain are primary sources.”*

*“Pain management specialists, academic **medical** centers, patients, peer-reviewed journals, and **medical** societies”*

*“Physicians who are chronic pain management experts, **medical** schools, and associations like the American Chronic Pain Association, studies by reputable **medical** groups or higher education institutions, etc.”*

Those reporters that have experience writing stories about chronic pain almost always defer to a medical source as their primary outlet to get information about chronic pain. While patients are sometimes mentioned as a source, it is almost never a primary source:

*“I always talk to a doctor (or researcher) who specializes in treating **chronic pain**. I also look at information provided by government websites and medical databases (like Up-to-Date) or journals. I will sometimes talk to people who are experiencing **chronic pain**, but mainly for the personal angle.”*

*“When we are reporting specific studies, we’ll often interview one of the study authors. For other stories, we’ll interview experts on **chronic pain**, including pharmacists, as well as complementary medicine experts”*

*“NIH (incl. National Center for Complementary and Integrative Health), CDC, professional societies (e.g., American **Chronic Pain** Association), published peer-reviewed research (via PubMed, PsycNet, Science Daily, Eurekalert)”*

Even reporters who never wrote stories about chronic pain would approach medical professionals as their first choice for information:

*“I have not written any stories about **chronic pain**, but I would probably start with a doctor or other medical professional.”*

*“I don’t think I’ve ever written on **chronic pain**. I mostly cover policy. But when I do medical stories, I try to rely heavily on researchers and clinicians, using anecdotes to illustrate.”*

*“Doctors, medical associations, nonprofit groups, advocacy groups and other groups attached to **chronic pain**. I rarely use patients unless offered by a group.”*

When asked about additional sources for health stories, the answers show a variety of options, with patients ranking among the first choices:

Patients	14.55%	24
Researchers	13.33%	22
Sources	9.70%	16
Government	6.67%	11
Nonprofit	6.06%	10
Chronic Pain	4.85%	8
Professional	4.85%	8
NIH	4.24%	7
News	4.24%	7
Peer-reviewed Journals	2.42%	4
Legislators	2.42%	4
Book Authors	1.82%	3
Alternative Medicine	1.82%	3
Literature	1.82%	3
People Experiencing	1.21%	2

When asked to think about their previous answers and select those sources that are most relevant to them when developing health stories, expert sources are predominant, but patients' stories may be used for their anecdotal value or to "humanize" the story. A similar answer was provided when asked about the process they go through to develop health stories:

*"Inspiration for stories may come from anecdotes, press releases, research reports, etc... but after a potential story idea arises, I go straight to recent research or data provided by government agencies to determine whether the potential story is actually based in fact or reflects a trend. For this purpose, I go to pubmed.gov, Google scholar, and HHS or state agencies. I might quote a medical expert, advocate or organization spokesperson in a piece, but I would never take their word as evidence of a fact."*

*"You need the medical experts. But if you want stories to have max impact you also need real patients."*

*"A good story needs a mix of experts (researchers, clinicians), people who are affected (patients), data (from local/state/fed agencies or research), and sometimes policy implications."*

*"It really depends on the focus of the piece and the intended audience. State and federal organizations are important when reporting statistics. Medical experts are important when discussing industry trends or providing insight into studies. The patient experience is highly overlooked, but is invaluable to helping to humanize the disease state when reporting. Unfortunately, not every publication wants the patient perspective, and it is not routinely included in reporting for actual medical professionals."*

*"I go to my usual sources for advice, I also access research by universities and NPOs online. Then I'll contact my usual sources and learn who the current experts are, ask them to help me gain access to patients. Then I'll compare all my sources to see where the areas of agreement are, learn what the current issues are and start interviewing people."*

When asked about the influence that local, state and federal agencies have on their development of health story ideas, participants emphasized the higher value of federal agencies as sources of reliable statistics and reports. Not so much for local or state agencies.

*“Federal agencies are an important source of reliable statistics and background information; I don't report for local outlets, so I rarely turn to local or state agencies”*

*“A lot. Their data often helps us figure out whether there's a trend. And if there's something of concern to patients, like MRSA and our state isn't tracking it (which ours does not) - then that is a story, too. So sometimes what the agencies are NOT doing is what helps us develop stories.”*

*“Federal agencies have the most influence on health story ideas. CMS and HHS are two that stand out.”*

Since medical practitioners were listed as an important source of health information, we asked if their media organization works in collaboration with a hospital or medical clinic in developing health content. Of the 207 participants that answered this question, only 25.06% were certain about the existence of such relationship. 57% of participants stated that no collaboration exists, while 17.39% were not sure. Some of this work was described as:

*“I'm not sure if the current station manager does this, but the previous one had a "health minute" that was sponsored by a local hospital and included interviews with various doctors from those hospitals to answer those questions.”*

*“We offer clients sponsored content and also publish contributed pieces from healthcare professionals.”*

*“We have many bloggers who write about health issues. They above-mentioned organizations will pitch ideas to us and we will cover their events.”*

*“Cape Cod Healthcare (parent company of two local hospitals) now pay to offer sponsored content in our paper. I am not involved in any way in that partnership.”*

Collaboration with non-profit or civic/professional organizations in developing health content was like the work with hospitals and medical clinics. Some of the study participants work for publications owned by non-profit organizations.

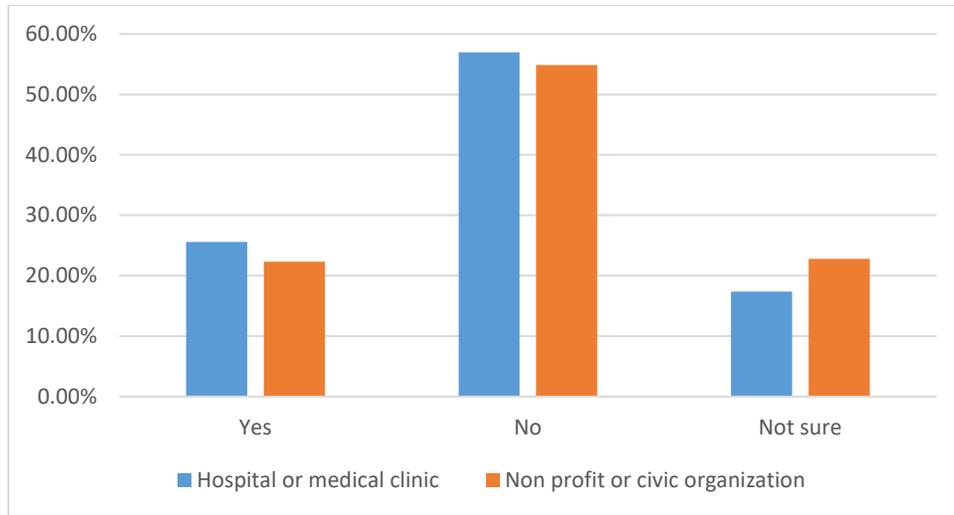


Figure 4 – Collaboration with other organizations

It is also worth noting that many of the respondents are freelancers, not working for a specific media organization.

An unexpected 63% of respondents (N=200) believe that chronic pain is a MAJOR CAUSE of opioid substance abuse. Only 8.5% disagree. 90% of respondents do have an opinion about this topic.

80.59% of respondents (N=201) believe that chronic pain is a major public health problem in the United States, while 90.55% consider opioid substance abuse a serious public health problem in our country. Opioid substance abuse seems to be perceived as a more serious public health problem than chronic pain.

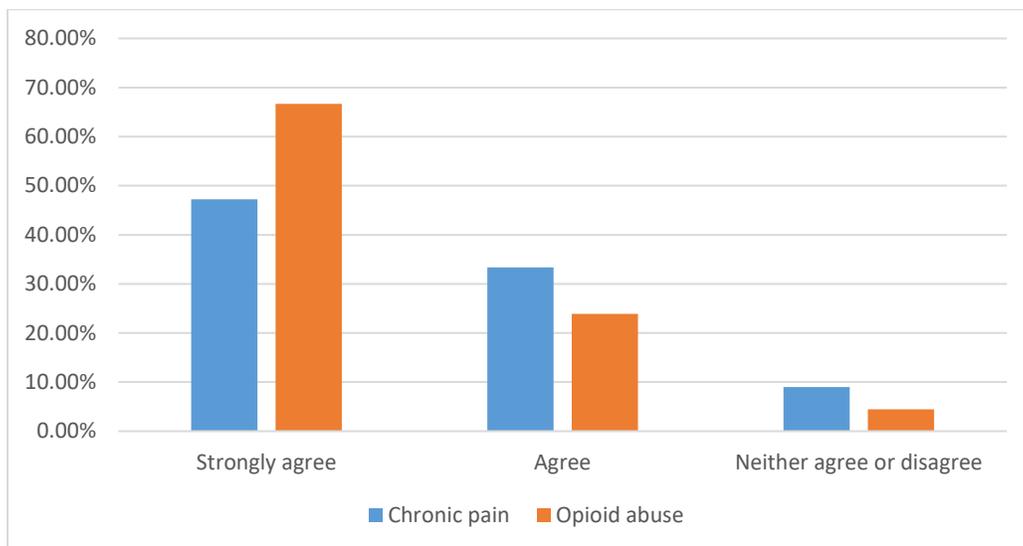


Figure 5 – Chronic pain vs. opioid abuse as a major public health problem.

Most health reporters and editors participating in our survey (69.35%) think that there is a DIRECT RELATIONSHIP between chronic pain and opioid substance abuse (N=199). Only 3.01% disagree.

Nevertheless, when asked if they believe that chronic pain sufferers experience more opioid overdoses than other users of opioids, almost half of them stated that they don't know (48.26%) and opinions were split between those in agreement with the above statement and those disagreeing with it (14.43% agreement vs. 12.93% disagreement).

Beliefs that the current opioid epidemic is due in part to people with chronic pain failing to manage their medications are also split among our participants: 20.71% disagree, while 27.28% agree (N=198). A similar percentage state that they don't know (22.22%), while 29.8% don't have an opinion.

There is stronger agreement among our participants (N=200) that overprescribing of opioids by doctors for chronic pain is the primary cause of the opioid epidemic (36.5% agreement vs. 18% disagreement). While those without a set opinion are at levels somewhat similar to levels found on our previous question (33%), the percentage of those that declared that they don't know is almost half that in the previous question: 12.5%.

Over 50 percent (51.5%) of our participants (N=200) don't know if most deaths from opioid addiction are people who do not suffer from chronic pain. 20.5% believe that that is the case and only 4% disagree.

27.18% of the health reporters and editors who participated in our survey (N=195) have experienced chronic pain (defined as pain that occurs on at least half the days for six months or more), and 15.9% of them are current chronic pain sufferers. 58.46% of them state that they have knowledge of a family member or an acquaintance that has suffered from chronic pain.

When asked if their personal experiences with chronic pain have influenced their coverage of the issue, the answers were diverse. A significant number of reporters and editors deny that they have been influenced. Nevertheless, some state that it has either increased their awareness about chronic pain or provided a new level of understanding of the struggles and challenges that those suffering with chronic pain are facing.

*"My fiancé' suffers from chronic pain, so I am more aware of the issues that sufferers go through"*

*"I don't feel it's really influenced my coverage. I see my experience as an outlier because I used supplements and exercise to control my pain - and these treatments are not part of established medical discussion."*

*"It's given me perspective on why people seek relief even when they know that opioids can be addictive."*

*"Provided me with deeper insights and perspective as to what's really important when dealing with chronic pain."*

*"I believe I have more empathy for chronic pain sufferers than the average person who hasn't walked in those shoes."*

Of the 53 journalists who stated that they have personally experienced chronic pain, 41 of them have written stories about chronic pain or have covered the topic. Of these, 30 (73.17%) stated that their experience influenced their coverage of the topic. Many said they have more understanding of the issue and more empathy for those suffering chronic pain. Others state that their experience has not influenced their reporting on this topic.

(See comments below):

- *My aunt has fibromyalgia. I take stories of hidden pain very seriously.*
- *I try to remain as impartial as possible. My mother experienced chronic pain right before hospice. Was prescribed fentanyl patch for a back injury, which left her catatonic until I took her off of it. She managed her pain from then on with Tylenol and heating pads. I don't cover chronic pain or opioid addiction, so I can't really say that it has altered my coverage any. I would say that my experience with seeing the effects of fentanyl first hand would make me more sympathetic to the user/addict should I ever cover these topics.*
- *Sympathetic to the need for treatment for those in chronic pain*
- *Only that I can understand the desire to be pain-free and try any drug to achieve it.*
- *I understand pain, and I understand what it is to have health professionals be dismissive of pain.*
- *I am interested in writing about pain management and new treatments.*
- *Made me skeptical of the wisdom or training of doctors who over prescribe.*
- *As former head psychologist of pain center, I know doctors fall into 2 categories: 1 tell patient to take as needed thus patients skip doses then double up experiencing high and withdrawal symptoms similar to drug seeking addicts; 2 those that gradually increase pain meds, have patient take them every so many hours as prescribed and gradually take them off the meds when the problem is solved (these patients never experience euphoria or withdrawal, have a tolerance to the meds thus they only take the edge off and are less likely to seek drugs afterwards).*
- *My father has struggled with chronic pain, and opioid addiction, throughout the last 10 years or so. Knowing someone who's living through this issue, it's certainly brought it close to my heart. As far as coverage, not sure it's had much of an influence though.*
- *I do not medicate for my pain so it has had minimal relationship to my reporting on pain medication use/abuse*
- *I am empathetic to sufferers, but do not use opioids myself. Try to offer hope. I do not believe narcotic medications should be illegal, but better managed.*
- *I certainly have empathy for sufferers.*
- *I've learned to tolerate the chronic pain of my wrist. I will not ask my doctor to prescribe anything related to opioids or related medications. I believe journalists should write more about these issues since so many people turn to heroin abuse, related to the opioids.*
- *I believe that there is such a thing as chronic pain with no understanding of why it occurs, despite absence of obvious disease, condition or defect.*
- *Better understanding of the condition and treatment options; increased search for knowledge from credible sources.*
- *raising awareness of it as a broader health issue*
- *It's given me perspective on why people seek relief even when they know that opioids can be addictive.*

- *My experience with alternative approaches to chronic pain no doubt influences my opinions, which are balanced by my witnessing of others' experiences with conventional opioid use for pain.*
- *Wider perspective.*
- *I know how complicated it can be to find the source of the pain -- having to do various screenings, testing different medications and weighing their side effects and going to physical therapy. I also know it can become costly and that by the end of it, you may not have any answers about the source. I think that has given me more insight into what people go through and to know what questions to ask.*
- *Yes, my personal experience has increased my awareness and compassion for pain sufferers.*
- *I lived with ovarian cancer for four years and no insurance. My oncologist gave me codeine and Tylenol to deal with the pain. Once I finally got insurance, I got a hysterectomy, and the cancer was still Stage 0. That was the end of the codeine, because I was no longer in physical pain.*

There was ample variety between the responses to our question about when was the last time they worked on a health story. Answers varied from “right now” to “3-4 years ago.” Most of the journalists participating in our survey are actively involved in writing health stories (N=177).

About 50% of the journalists have written stories about chronic pain issues (N-196)

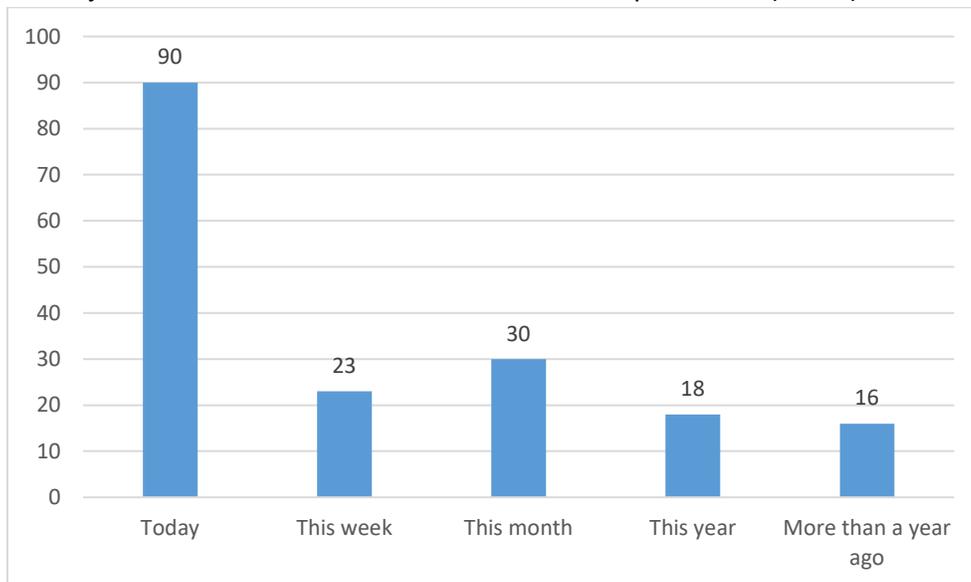


Figure 6 – Last time respondents wrote a health story

When asked what was the premise of the story or stories they’ve wrote, chronic pain (29.82%) and opioid (23.68%) came out as the dominant concepts:

Drugs in Development Coverage Pain Relief Lifestyle  
 Research Efforts Medical Remedies

# Manage Massage Opioid Heroin Chronic Pain Radio Stories Causes Treatment Journal Low-back Pain Angles Options Report Premise Effects

Most of the stories about chronic pain included opioid or prescription medication addiction.

*“Chronic pain has played into several stories I’ve written about the heroin problem as the anecdotal reason why my sources began abusing opioid pain medications and then heroin.”*

*“Drug options and alternative therapies for people suffering from chronic pain.”*

*“One was a story about an organization that helps people deal with chronic pain. Another was about legislation involving opioids.”*

There were also several stories about alternative treatments to chronic pain.

*“Drug options and alternative therapies for people suffering from chronic pain”*

*“I’ve written about the topic many times, often about alternatives to opioids for chronic pain, as well as new research into the issue.”*

*“Stories on natural ways to alleviate chronic pain and stories on how pain meds can start an opioid addiction.”*

Other stories focused on opioids.

*“An entire series about opioid prescribing practices and physician efforts to tackle the opioid epidemic.”*

*“While I haven’t written a story solely about chronic pain, I do write about the opioid epidemic frequently. Those stories sometimes mention chronic pain and/or opioid painkillers”*

*“Hospitals in our readership area are using new surgical protocols with alternative methods to treat pain that don’t involve the use of opioids. The hospitals are doing this as part of an effort to stem opioid addiction”*

More than 50% of participating journalists have written stories about opioid addiction (90 out of 172 respondents to our question). Topics address the relationship between prescription drugs and opioid abuse, stories about opioid abuse incidence or deaths due to overdoses.

*“Several young people have died here after overdoses and addictions. Family members spoke out. Police and local officials have combated the problem, working with community organizations for prevention and intervention. Police are now armed with Narcan here. I've also written about our state's Good Samaritan Law, covered convictions regarding heroin, pills and liquid fentanyl.”*

*“People asking for more treatment beds; addicts creating documentary film about addiction experience.”*

*“I'm working on a project about the local system of care for women who use opioids during pregnancy.”*

*“How a prescription for OxyContin for a high school football injury led a young man to pill addiction. He went on to buy the pills on the street. And, then when he couldn't get the pills, he was offered heroin to “hold him over.” He went on to have a heroin issue and then get clean.”*

To further explore the relationships within our dataset, the eight questions concerning the perspective of the relationship of chronic pain and opioid use was developed into one **ChronicPain** variable (Alpha = .78).

#### Results from testing the **ChronicPain** variable against other variables:

1. Job description influence on perception of chronic pain and opioid use (ANOVA)

Result: *No significant differences* between the groups' perspectives of chronic pain and opioid use.

2. Work experience groups (in years): 1-5; 6-10; 11-15; 16-20; 21-25; 26-30; 31 over (ANOVA)

Result: *No significant differences* between the groups' perspectives of chronic pain and opioid use.

3. Media outlet (ANOVA)

Result: *No significant differences* between the groups' perspectives of chronic pain and opioid use.

4. Those who have worked on chronic pain stories and those who have not (T-test)

Result: *No significant differences* between the groups' perspectives of chronic pain and opioid use.

5. Those who have suffered chronic pain and those who have not (T-test)

Result: **Significant difference** between the groups' perspectives of chronic pain and opioid use.

**Those who have experienced chronic pain are significantly less likely to associate chronic pain with opioid use/abuse.**

6. Those who have a family member or know someone suffering chronic pain and those who do not (T-test)

Result: *No significant difference* between the groups' perspectives of chronic pain and opioid use.

To look at the polarization of opinions on chronic pain and opioid addiction, we converted the Likert-type scale used previously by recoding the answer options as follows:

Strongly disagree	-2
Disagree	-1
Neutral	0
Agree	1
Strongly agree	2
Don't know	0
No opinion	0

Each question was analyzed and some were inversely coded to accurately reflect positive or negative attitudes. All the answers for neutral, don't know and no opinion were coded as 0 (zero) as they do not reflect a set attitude (either negative or positive). An aggregated score **AttitudePolarization** was computed by adding the values for the score variables.

The distribution of attitudes within the sample (N=196) is presented in figure 7.

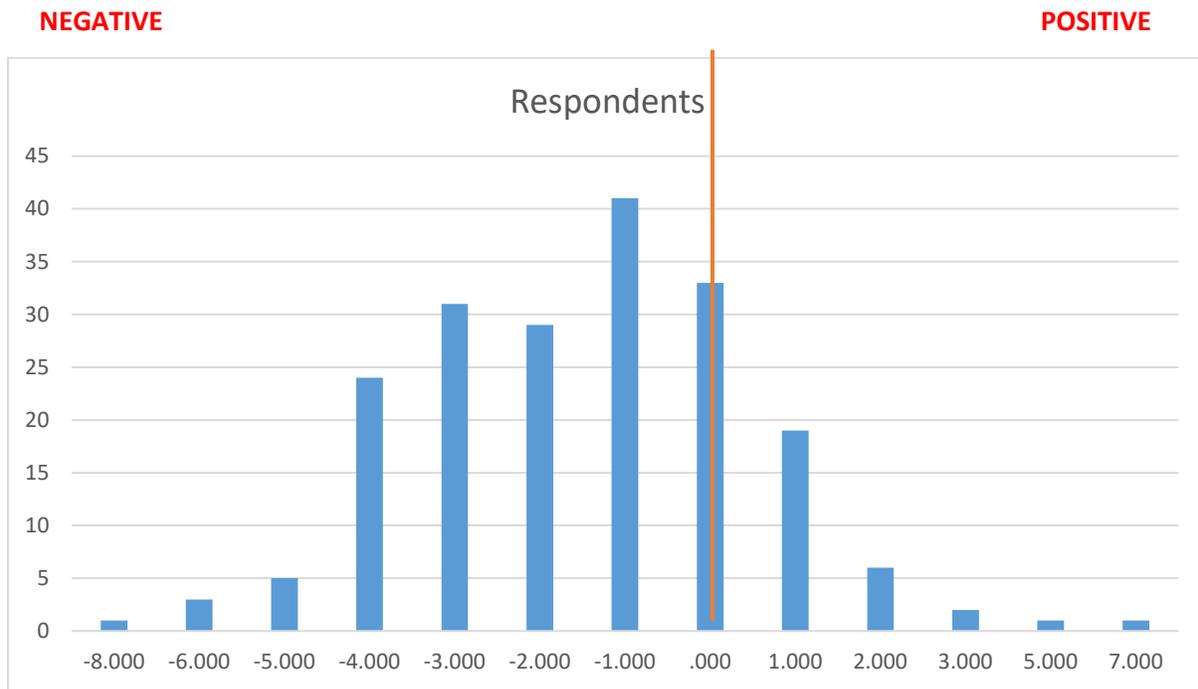


Figure 7 – Polarization of attitudes within the sample

There is an evident skewness towards the negative attitudes of journalists concerning chronic pain and opioid addiction.

**Results from testing the *AttitudePolarization* variable against other variables:**

1. Gender influence on attitudes about chronic pain and opioid use (ANOVA)  
Result: *No significant differences* between the groups' polarization of attitudes.
2. Job description influence on attitudes about chronic pain and opioid use (ANOVA)

Result: *No significant differences* between the groups' polarization of attitudes.

3. Those who have suffered chronic pain and those who have not (ANOVA)

Result: *No significant differences* between the groups' polarization of attitudes.

4. Those who have worked on a story about chronic pain and those who have not (ANOVA)

Result: *No significant differences* between the groups' polarization of attitudes.

Although there is a polarization of attitudes, none of the tested demographic variables seem to influence the observed polarization.

Although there are more respondents expressing negative attitudes compared to those expressing positive attitudes, the lack of extreme polarization may favorize an intervention aimed at addressing knowledge, beliefs and concerns of health journalists regarding chronic pain, opioid addiction and the relationships between these two public health challenges.

### Demographics

Journalists participating in our survey had an average of about 19 years of professional experience (N=136) and have worked an average of nine years for the same media company (N=116). All media channels have been represented, from newspapers to broadcast to online media.

74.47% of participants identified themselves as females and 25.53% as males (N=188). Mean age for the sample was 48.2 years. Although gender-based stereotyping and assignment of news beats is unprofessional, historically there are many more women covering beats like health or social life than men. This, as well as higher predisposition of women to answer calls for research participation may explain the gender structure of our sample.

Freelancers (42.71%), reporters (27.6%) and editors (16.67%) were the most significant jobs held by our respondents (N=192). 92.05% were Whites, 3.41% African-American and 2.84% identified themselves as Hispanic (N=176).

## Conclusions and Recommendations

To our knowledge this is the most comprehensive survey of health journalists that has ever been conducted in the United States on the topic of reporting about the relationship between chronic pain and opioid addiction.

The results of this survey paint a disconcerting image of the attitudes, beliefs and opinions of American journalists when it comes to chronic pain. There is a significant lack of knowledge and awareness about chronic pain, there are serious misconceptions about the relationships between chronic pain and opioid addiction, attitudes within the group are polarized, and often the voices of those living with chronic pain come secondary to those of experts or healthcare providers.

A significant number of our respondents suffer from chronic pain. For a substantial percentage of these journalists, their personal experience has influenced the way they report or cover chronic pain. It also significantly influenced their attitudes about the association between chronic pain and opioid abuse.

Nevertheless, none of the other demographic variables generated statistically significant differences in the composite *ChronicPain* score.

As found on our previous research, there is an intrinsic perceived relationship between chronic pain and opioid addiction that cannot be ignored and justifies why these two topics should be addressed together.

There is great need for education of journalists about chronic pain, opioid addiction and the need to give a voice to those suffering from both diseases. Our survey has shown that journalists trust and believe health professionals and researchers. Efforts should be made to facilitate this communication and provide not only exposure to moderate voices from both sides of the aisle, but also to establish and maintain a repository of peer-reviewed information about chronic pain and the opioid epidemic, facilitate access of journalists to knowledgeable sources. Complete transparency should be maintained on funding sources for this activity and a mechanism of feedback should be put in place to allow for the journalists to voice their concerns, ask questions and provide comments that could be used to improve how you talk and educate this profession (and the public) about chronic pain.

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