Psychological therapies (Internet-delivered) for the management of chronic pain in adults (Review)

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[Intervention Review]

Psychological therapies (Internet-delivered) for the management of chronic pain in adults

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ABSTRACT

Background

Chronic pain (i.e. pain lasting longer than three months) is common. Psychological therapies (e.g. cognitive behavioural therapy) can help people to cope with pain, depression and disability that can occur with such pain. Treatments currently are delivered via hospital out-patient consultation (face-to-face) or more recently through the Internet. This review looks at the evidence for psychological therapies delivered via the Internet for adults with chronic pain.

Objectives

Our objective was to evaluate whether Internet-delivered psychological therapies improve pain symptoms, reduce disability, and improve depression and anxiety for adults with chronic pain. Secondary outcomes included satisfaction with treatment/treatment acceptability and quality of life.

Search methods

We searched CENTRAL (Cochrane Library), MEDLINE, EMBASE and PsycINFO from inception to November 2013 for randomised controlled trials (RCTs) investigating psychological therapies delivered via the Internet to adults with a chronic pain condition. Potential RCTs were also identified from reference lists of included studies and relevant review articles. In addition, RCTs were also searched for in trial registries.

Selection criteria

Peer-reviewed RCTs were identified and read in full for inclusion. We included studies if they used the Internet to deliver the primary therapy, contained sufficient psychotherapeutic content, and promoted self-management of chronic pain. Studies were excluded if the number of participants in any arm of the trial was less than 20 at the point of extraction.

Data collection and analysis

Fifteen studies met the inclusion criteria and data were extracted. Risk of bias assessments were conducted for all included studies. We categorised studies by condition (headache or non-headache conditions). Four primary outcomes; pain symptoms, disability, depression, and anxiety, and two secondary outcomes; satisfaction/acceptability and quality of life were extracted for each study immediately post-treatment and at follow-up (defined as 3 to 12 months post-treatment).
Main results

Fifteen studies (N= 2012) were included in analyses. We assessed the risk of bias for included studies as low overall. We identified nine high 'risk of bias' assessments, 22 unclear, and 59 low 'risk of bias' assessments. Most judgements of a high risk of bias were due to inadequate reporting. Analyses revealed seven effects. Participants with headache conditions receiving psychological therapies delivered via the Internet had reduced pain (number needed to treat to benefit = 2.72, risk ratio 7.28, 95% confidence interval (CI) 2.67 to 19.84, p < 0.01) and a moderate effect was found for disability post-treatment (standardised mean difference (SMD) − 0.65, 95% CI − 0.91 to − 0.39, p < 0.01). However, only two studies could be entered into each analysis; hence, findings should be interpreted with caution. There was no clear evidence that psychological therapies improved depression or anxiety post-treatment (SMD −0.26, 95% CI −0.87 to 0.36, p > 0.05; SMD −0.48, 95% CI −1.22 to 0.27, p > 0.05), respectively. In participants with non-headache conditions, psychological therapies improved pain post-treatment (p < 0.01) with a small effect size (SMD −0.37, 95% CI −0.59 to −0.15), disability post-treatment (p < 0.01) with a moderate effect size (SMD −0.50, 95% CI −0.79 to −0.20), and disability at follow-up (p < 0.05) with a small effect size (SMD −0.15, 95% CI −0.28 to −0.01). However, the follow-up analysis included only two studies and should be interpreted with caution. A small effect was found for depression and anxiety post-treatment (SMD −0.19, 95% CI −0.35 to −0.04, p < 0.05; SMD −0.28, 95% CI −0.49 to −0.06, p < 0.01), respectively. No clear evidence of benefit was found for other follow-up analyses. Analyses of adverse effects were not possible.

No data were presented on satisfaction/acceptability. Only one study could be included in an analysis of the effect of psychological therapies on quality of life in participants with headache conditions; hence, no analysis could be undertaken. Three studies presented quality of life data for participants with non-headache conditions; however, no clear evidence of benefit was found (SMD −0.27, 95% CI −0.54 to 0.01, p > 0.05).

Authors’ conclusions

There is insufficient evidence to make conclusions regarding the efficacy of psychological therapies delivered via the Internet in participants with headache conditions. Psychological therapies reduced pain and disability post-treatment; however, no clear evidence of benefit was found for depression and anxiety. For participants with non-headache conditions, psychological therapies delivered via the Internet reduced pain, disability, depression, and anxiety post-treatment. The positive effects on disability were maintained at follow-up. These effects are promising, but considerable uncertainty remains around the estimates of effect. These results come from a small number of trials, with mostly wait-list controls, no reports of adverse events, and non-clinical recruitment methods. Due to the novel method of delivery, the satisfaction and acceptability of these therapies should be explored in this population. These results are similar to those of reviews of traditional face-to-face therapies for chronic pain.

Plain language summary

Psychological therapies delivered via the Internet for adults with longstanding distressing pain and disability

Chronic pain (i.e. pain lasting longer than three months) is common. Psychological therapies (e.g. cognitive behavioural therapy) can help people to cope with pain, depression and disability that can occur with such pain. Treatments currently are delivered via hospital out-patient consultation (face-to-face) or more recently through the Internet. This review looks at the evidence for psychological therapies delivered via the Internet for adults with chronic pain.

Four databases were searched up to November 2013. We found 15 trials that met our inclusion criteria. Four trials included individuals with headache pain, 10 trials included individuals with non-headache pain, and one trial included individuals with both headache and non-headache pain. We looked at data about pain, disability, depression, and anxiety immediately after the end of treatment and between 3 to 12 months follow-up. We also looked at how satisfied people were with the treatments, and its effects on their quality of life.

We found that for people with headache pain, pain symptoms and disability scores improved immediately following the end of treatment. However, only two trials could be entered into each of these analyses and so findings should be treated with caution. For people with non-headache pain, pain, disability, depression, and anxiety improved immediately after the end of treatment. Disability was also improved at follow-up. Only one study recorded quality of life scores in individuals with headache pain, so we were unable to analyse the results. Three studies presented quality of life scores for individuals with non-headache pain immediately following treatment. We did not find that quality of life improved after receiving the therapy. No data could be analysed on treatment satisfaction/acceptability.
We conclude that these findings are promising for psychological treatments delivered via the Internet for the management of chronic pain in adults, but more trials are needed to determine the efficacy of such therapies.

**BACKGROUND**

**Description of the condition**

Chronic pain is prevalent in both adult and child populations (Breivik 2006; King 2011; Standford 2008), impacting on physical, psychological, and social functioning. Given that chronic pain is a long-term health condition, sustainable solutions to problems of pain, disability, depression, and anxiety are needed. Individuals experiencing chronic pain should be able to access self-management therapies away from expert healthcare centres, and be enabled to sustain self-management over the long-term. There is an opportunity for Internet-delivered therapies to provide methods that support this self-management.

**Description of the intervention**

Inconsistent terminology, including telemedicine, telehealth, ehealth, and Internet-delivered therapy, are commonly used interchangeably. Here, we use the term ‘Internet-delivered therapies’ to encompass technology that uses the worldwide web and facilitates the multifaceted, often psychotherapeutic, approach to modern chronic pain management (Gatchel 2007; Williams 2012). Internet-delivered therapies are only one part of a larger telehealth family of interventions that can assist communication between practitioner and patient, and improve self-management. The potential benefits of telehealth interventions include increased access to healthcare resources, not limited by geographic location or personnel availability, and reduced costs (Jennett 2003). Although remote consultation between the healthcare professional (HCP) and patient may contribute to these benefits, this review is limited to the use of Internet-delivered psychological therapies that use technology as a medium for facilitating traditional therapy delivery. For example, an Internet-based pain management intervention (e.g. Berman 2009) would meet this criterion, whereas an intervention providing traditional therapy by telephone (e.g. Sandgren 2000) would not. Previous research suggests that Internet-delivered treatment in the absence of, or with minimal, HCP involvement may be an effective intervention for chronic pain (Bender 2011; Palermo 2009). Such interventions frequently focus on the reduction of pain intensity and emotional distress, and the encouragement of adaptive behaviour change and skills acquisition. This focus is congruent with policy directives in many countries that advocate self-management and patient empowerment in the treatment of long-term health conditions, such as chronic pain (Bodenheimer 2002; Fu 2003; Jordan 2007; Lewis 2004). The evaluation of the efficacy of standalone Internet-delivered therapy is integral to substantiating whether these types of interventions can facilitate the successful evolution of health care away from the traditional and unsustainable acute model of care. In short, this review assesses whether pain management therapies can be successfully delivered in the home using the Internet as a mode of delivery.

**How the intervention might work**

The use of Internet-delivered therapies for pain-related health care takes a variety of forms, from assessment and education to structured intervention programmes (Keogh 2010). The mechanisms through which Internet-delivered therapies operate vary depending on technology, content, and health condition. The standalone (or minimally facilitated) therapies included in this review are likely to be based on adaptations of established methods of psychological pain management. However, one cannot assume that the impact and function of treatment will be equivalent. The introduction of technology and the reduction, or absence, of human interaction in treatment delivery has the potential to significantly influence the experience of the intervention and, ultimately, the outcome. A function of this review will be to establish, where possible, relations between features of technology, therapy content, and treatment outcome.

**Why it is important to do this review**

This review is designed to complement the review on psychological interventions for chronic pain in adults that excluded psychological or behaviour change therapies delivered over the Internet (Williams 2012). Relevant reviews of similar Internet-based therapies in non-pain conditions include those that focus on a specific targeted behaviour such as smoking cessation (Civljak 2013), or sexual health promotion (Bailey 2010), or those with a focus on a range of relevant behaviours within a lifestyle, such as self-management of type 2 diabetes mellitus (Pal 2013). These reviews have found some evidence for treatment effectiveness but are inconsistent on the economic benefits of telehealth (Black 2011), and there
is a lack of analysable data when comparing telehealth interventions with traditional treatment approaches (Bailey 2010; Currell 2000). Furthermore, the quality of telehealth interventions and existing reviews (Martin 2008; Tuntland 2009; Whitten 2007) has been questioned (Black 2011). Evidence supporting the utility of Internet-delivered therapies for chronic pain appears more consistent. For example, Internet-delivered cognitive behavioural therapy (CBT) for chronic pain has produced clinically significant improvements in pain intensity in both adult and child populations (Bender 2011; Palermo 2009; Velleman 2010). At present, there is no systematic evaluation of the broader potential applications of psychological therapies delivered via the Internet. Furthermore, the moderating impact of demographic characteristics, including age, technology employed, and health condition, on treatment outcomes within Internet-delivered therapies has yet to be explored within chronic pain (Hardiker 2011; McLean 2010; McLean 2011).

**OBJECTIVES**

Our objective was to evaluate whether Internet-delivered psychological therapies improve pain symptoms, reduce disability, and improve depression and anxiety in adults with chronic pain. Secondary outcomes included satisfaction with treatment/treatment acceptability and quality of life.

**METHODS**

**Criteria for considering studies for this review**

**Types of studies**

We included randomised controlled trial (RCT) comparisons of Internet-delivered therapy for chronic pain compared to an active control, treatment-as-usual, or waiting-list control in this review. Studies had to include 20 or more participants with each condition at each extracted time-point (post-treatment and follow-up). We considered only peer-reviewed publications for inclusion in this review. We included trials if the primary aim was to deliver and evaluate a self-management psychological therapy in adults with chronic non-cancer pain.

**Types of participants**

Adults (aged 18 years or older) who reported non-cancer chronic pain. Studies included participants with headache or migraine (headache conditions) and pain in any body site (e.g. back pain, abdominal pain, musculoskeletal pain, fibromyalgia) (non-headache conditions). Chronic pain was defined as the experience of pain for three months or longer. Mixed-aged samples were included when adult and child data could be separated. We included studies in this review if the sample of participants was predominantly made up of those with chronic pain conditions.

**Types of interventions**

Included studies used an Internet-delivered psychological therapy that was required to be interactive with the user (e.g. respond dynamically based on data input by the user). Technology capable of delivering a psychological treatment programme via the Internet in the absence of, or with limited adjunctive HCP involvement was included. Adjunctive HCP involvement was categorised as involvement that supported a technology-based therapy, but that was not the primary source of treatment. The treatment therapy needed to be designed to promote pain management, by reducing pain experience, disability, and psychological distress, or adaptive behaviour change, or both. Therapies had to be based on an extant psychological model or framework, therefore including credible psychological content. Included studies needed to contain at least one arm using a psychological therapy and at least one comparator arm. Studies categorised as broader telehealth therapies, where technology was used to facilitate traditional communication and treatment between HCP and the individual with chronic pain, but did not deliver the primary psychological therapy itself and did not use the Internet to deliver the therapy (e.g. non-automated email, video conferencing) were excluded. However, these components were permitted to be additional parts to a Internet-delivered psychological therapy.

**Types of outcome measures**

**Primary outcomes**

The primary outcomes were pain, physical disability, depression, and anxiety. For pain outcomes, we extracted data on pain severity where possible. For studies that did not report a pain severity score, we extracted the most relevant outcome (e.g. average pain score). Pain specific measures were preferentially extracted to general measures (e.g. pain-related anxiety rather than a general anxiety measure). Adverse event data were also searched for.

**Secondary outcomes**

Secondary outcomes were quality of life, and treatment acceptability/satisfaction.
Search methods for identification of studies

Electronic searches
The following databases for RCTs of Internet-delivered interventions for adults with chronic pain were searched (see Appendix 1 for search strategies):
- Cochrane Central Register of Controlled Trials (CENTRAL) on The Cochrane Library, Issue 10 of 12 (2013);
- MEDLINE (OVID), 1950 to 8/11/13;
- EMBASE (OVID) 1980 to 2013 week 45;
- PsycINFO (OVID) 1806 to Nov week 1, 2013.

Searching other resources
We also conducted a search of the reference lists of included papers and relevant review articles to source any studies that did not appear in the electronic searches. We also searched trial registries for trials.

Data collection and analysis

Selection of studies
Only peer-reviewed studies were eligible for inclusion. Review authors (EF, LC, GBD) reviewed the titles and abstracts of studies identified by the searches to assess eligibility based on the outlined criteria. Full text of studies initially meeting the criteria, or not categorically failing to meet the criteria for final selection, were assessed. Discrepancies between review authors were resolved by discussion; in the event that resolution could not be reached, a third review author (CE) arbitrated. We selected studies for inclusion using the following criteria:
1. must be an RCT published in a peer-reviewed journal;
2. n => 20 in each arm at extracted time point;
3. therapy must be primarily psychological in at least one arm of the trial;
4. study must have the primary aim of promoting self-management in adults with non-cancer chronic pain;
5. study must use an Internet-delivered therapy as the primary mode of delivery.

Data extraction and management
Two review authors (EF, LC) independently extracted data from all included studies. Discrepancies between review authors were resolved by discussion; in the event that resolution could not be reached, a third review author (CE) arbitrated. Quantitative data were entered into Review Manager 5.2 (RevMan 2011). For outcome variables measured on continuous scales the standardised mean differences (SMDs) were calculated from extracted means and standard deviations (SD) collected post-intervention and at follow-up. For dichotomous outcomes, we calculated relative risk ratios (RR) with 95% confidence intervals (CI) using a random-effects model. The number needed to treat to benefit (NNTB) was also calculated:
NNTB = 1/absolute risk reduction (ARR), where ARR = the experimental event rate - the control event rate.
Where the necessary data were not reported, study authors were contacted. In addition to outcome data, participant demographic data were extracted and reported from the included studies.

Assessment of risk of bias in included studies
Two review authors assessed risk of bias using the Cochrane method (Higgins 2011), focusing on the evaluation of sequence generation, allocation concealment, blinding (outcome assessors), incomplete data, selective outcome reporting, and assessing other biases. Blinding of participants and personnel was not included in this review, as this category is redundant when reviewing psychological treatments (i.e. it is not possible to blind personnel to delivery of therapy). We categorised the risk of bias for each study as ‘low’, ‘unclear’, or ‘high’. Discrepancies between authors were resolved by discussion; in the event that resolution could not be reached, a third review author arbitrated.

Measures of treatment effect
Chronic pain conditions were split into headache and non-headache conditions. Control groups were combined for this review due to the small number of included studies. Each of the four primary outcomes and the two secondary outcomes were extracted and analysed post-treatment and at follow-up. If more than two measures were presented for one outcome, we extracted the most reliable and frequently used measure in the field. Self-report data were preferentially extracted. Post-treatment refers to the time-point first measured after treatment completion. The accepted timeframe for the collection of follow-up data was 3 to 12 months post-intervention. Data outside of this time frame were excluded. In the event of multiple follow-ups within the timeframe we used the latest data collection point. When a trial included more than two arms, we combined the results from the two most similar arms. If it was not appropriate to combine two arms together, (e.g. testing two different psychological therapies versus a control) the control group was split (Higgins 2011). Meta-analyses are presented only when two or more studies could be included for a given outcome. We conducted no sensitivity analyses because of the small number of studies.

Assessment of heterogeneity
We assessed heterogeneity by calculating the Chi² and I² statistics for all outcome variables. We considered values for the I² statistic above 50% to indicate high levels of heterogeneity, values between...
25% and 50% to indicate medium heterogeneity, and those below 25% to indicate low heterogeneity.

**RESULTS**

**Description of studies**

See: Characteristics of included studies and Characteristics of excluded studies.

**Results of the search**

The database search of CENTRAL, MEDLINE, EMBASE, and PsycINFO generated a total of 9390 papers (see Figure 1). Fifteen studies met the full inclusion criteria.
Figure 1. Study flow diagram.

9890 records identified through database searching
Five additional records identified through other sources

6508 records after duplicates removed

6508 records screened
6444 records excluded

- 49 full-text articles excluded
- 14 studies did not have chronic non-cancer pain
- 12 studies did not deliver therapy via internet as primary mode of delivery
- Nine studies did not evaluate a self-management psychological intervention
- Six were not randomised
- Three studies had a n < 20 at post-treatment
- Three studies used online peer discussion groups
- Two studies used non-inferiority designs

64 full-text articles assessed for eligibility

20 studies included in qualitative synthesis

15 studies included in quantitative synthesis (meta-analysis)
Included studies

We categorised the 15 studies on the basis of chronic pain condition: headache conditions (Bromberg 2011; Devineni 2005; Hedborg 2011; Ruehlman 2012; Strom 2000) and non-headache conditions (Berman 2009; Buhrman 2004; Buhrman 2011; Buhrman 2013; Carpenter 2012; Chiauzzi 2010; Dear 2013; Lorig 2008; Ruehlman 2012; Williams 2010). Ruehlman 2012 considered mixed pain conditions, including headache and back pain and is therefore included in both analyses (headache and non-headache conditions). Of the five studies included within the headache conditions category, three studies included individuals with migraines (Bromberg 2011; Hedborg 2011; Ruehlman 2012), one included individuals with chronic headache (Devineni 2005), and one included individuals with recurrent headache (Strom 2000). In the non-headache conditions category, five studies included individuals with chronic back pain (Buhrman 2004; Buhrman 2011; Carpenter 2012; Chiauzzi 2010; Ruehlman 2012), two included individuals with rheumatoid arthritis, osteoarthritis, or fibromyalgia (Lorig 2008; Williams 2010) and four included individuals with mixed pain conditions (i.e. not headache; Berman 2009; Buhrman 2013; Buhrman 2013a; Dear 2013).

The total number of participants providing data at the end of treatment was 2012 (mean = 134 participants per study, SD = 151, median = 78, interquartile range (IQR) 56 to 144). The total number of participants entering treatment was 2435 (mean = 162 participants per study, SD = 204.68, median = 86, IQR = 62 to 189). Therefore the completion rate for all studies was 82.6%, with the proportion of completers ranging across studies from 75% to 100%. The attrition rate was 17.4% (range 0 to 25%). The mean age of participants entering the studies was 47 years (SD = 7.59 years, range = 37 to 66 years, median = 44.93 years, IQR = 42.50 to 50.46 years). Mean duration of pain was reported in only eight studies (mean = 11.69 years, SD = 5.53 years, range = 9 to 23 years, median = 9.75 years, IQR = 7.46 to 14.50 years). A total of 1989 women were enrolled in the trials compared with 504 men. The average proportion of women per trial was 80%. All studies specified the source of the participants, who were recruited mainly using Internet-based promotion channels (e.g. Internet bulletin boards, established websites, and discussion groups). Fourteen studies used two comparator arms and one had three comparator arms (Hedborg 2011). Of the 14 studies that compared two arms, eight studies used waiting-list controls, three used treatment-as-usual controls, and three used an active control in which participants received educative text-based material or participated in an online discussion forum. The three comparator-armed study used an active control in comparison to two treatments. The first treatment group received a multimodal behaviour treatment and a CD of muscular relaxation. The second treatment group received a hand massage in addition to the Internet-based programme and muscular relaxation CD. The control group received only the CD of muscular relaxation (Hedborg 2011). Studies could not be analysed according to control type due to the small number of included trials. Fourteen studies evaluated an Internet-delivered psychological therapy of a CBT orientation. One study used an acceptance commitment-based therapy (Buhrman 2013a). The mean duration of therapy was 11 weeks (range 3 to 46 weeks). The primary mode of therapy delivery for all studies was via computer. Two studies offered adjunctive structured telephone support (Buhrman 2004; Buhrman 2011). Two studies used the same pain management therapy, termed painACTION (Bromberg 2011; Chiauzzi 2010). A further four studies were all from the same research group (Buhrman 2004; Buhrman 2011; Buhrman 2013; Buhrman 2013a). Data were available for extraction from all 15 included studies.

We present a summary of the characteristics of therapy and treatment content in Characteristics of included studies.

Excluded studies

Forty-nine studies did not meet the inclusion criteria for this study. Fourteen studies did not have chronic non-cancer pain as their primary pain condition (Anderson 2006; Chambers 2006; Cleeland 2011; Everitt 2010; Everitt 2013; Johns 2011; Kroenke 2010; Lorig 2006; Miller 2010; Oerlemans 2011; Premi 1993; Steel 2011; Taieb-Maimon 2012; Weingart 2008). Twelve studies did not use the Internet as their primary mode of treatment delivery (Allen 2008; Childs 2011; Greco 2004; Jennings 2008; Kjeken 2011; Kosterink 2010; Kristjansdottir 2011; Kristjansdottir 2013; Larsman 2010; Naylor 2008; Naylor 2010; Vonk Noordgraaf 2012). Nine studies did not evaluate a self-management psychological intervention (Bieber 2006; Bruce 2005; Fransen 2011; Hochlehnert 2006; Huffstutter 2007; Keulers 2007; Machedo 2012; Sandso 2010; Sciamanna 2006). Six studies were not randomised control trials (Borckardt 2004; de Bruijn-Kofman 1997; Jacobs 2013; Leboeuf-Yde 2012; Leveille 2007; Spunt 1996). Three studies were excluded because the number of participants in any study arm was less than 20 (Anderson 2002; Brattberg 2006; Brattberg 2007). A further three studies were excluded because the intervention had insufficient psychotherapeutic content; these studies were evaluations of online peer discussion groups (Krein 2010; Leveille 2009; Lorig 2002). Finally, two studies used non-inferiority designs (Kleiboer 2009; Russell 2011). The initial identification of these studies using the search strategy outlined supports the criticism that a diversity of terminology is used to describe pain and therapies. We acknowledge that these
judgements were often difficult to make and led to extensive discussions between review authors.

**Risk of bias in included studies**

‘Risk of bias’ summaries are shown in Figure 2 and Figure 3. Six ‘risk of bias’ categories were used: random sequence generation (selection bias), allocation concealment (selection bias), blinding of outcome assessment (detection bias), incomplete outcome data (attrition bias), selective reporting (reporting bias), and ‘free from other bias’. Eight studies described a convincing method of randomisation and were judged to have a low risk of bias; a further six did not provide an adequate description and were judged to be unclear. One study did not describe randomisation and was judged to have a high risk of bias for random sequence generation. Five studies described a convincing method of allocation and had low risk of allocation bias; a further eight studies did not provide an adequate description and we judged them to be unclear. We rated two studies as high risk of allocation bias because group assignment was not concealed from the research assistants. Thirteen studies took assessments online and were therefore judged to have low risk of bias for blinding of outcome assessment. Two studies did not provide an adequate description of outcome assessment and were unclear. No studies were rated as high risk of outcome bias. Seven studies adequately reported attrition and found no significant differences between completers and non-completers; these were judged to have a low risk of bias. Six were rated as unclear risk, mainly due to the non-reporting of differences between completers and non-completers. Two studies had high risk of bias for incomplete data due to statistical differences between completers and non-completers and a data management error that resulted in one outcome measure being unavailable for analysis. Eleven studies reported all outcomes and had a low risk of bias for selective reporting bias. A further four studies were rated to have high risk of selective reporting bias because data could not be extracted. No other sources of bias were found for the 15 studies included in the review. It is noteworthy that almost all outcomes were self-reported assessments, and so there were limited opportunities for influencing participants’ scores. Consequently, most of our judgements of high risk of bias were because of inadequate reporting.

**Figure 2. ‘Risk of bias’ graph: review authors’ judgements about each risk of bias item presented as percentages across all included studies.**
Figure 3. 'Risk of bias' summary: review authors' judgements about each risk of bias item for each included study.
Effects of interventions

Data were analysed by two categories; headache conditions and non-headache conditions. For both categories, outcomes were analysed post-treatment and at follow-up. Note, no data could be presented for the secondary outcome 'treatment acceptability/satisfaction' due to the lack of studies reporting this outcome quantitatively.

**Treatment versus control for headache conditions post-treatment**

Two studies with 131 participants were entered into an analysis of the effect of treatment on pain. The overall effect was beneficial for psychological therapies ($z = 3.88, p < 0.01$, RR $7.28$, 95% CI 2.67 to 19.84, $I^2 = 0$%; NNTB = 2.72). Two studies with 241 participants were entered into an analysis of the effects of treatment on disability. The overall effect of psychological therapies was beneficial ($z = 4.89, p < 0.01$), with a moderate effect size ($SMD = −0.65$, 95% CI $−0.91$ to $−0.39$, $I^2 = 0$%) (Analysis 1.2). Four studies with 617 participants were entered into an analysis of the effects of treatment on depression; there was no clear evidence of benefit for psychological therapies ($z = 0.82, p > 0.05$, SMD $−0.26$, 95% CI $−0.87$ to $0.36$, $I^2 = 92$%) (Analysis 1.3). Three studies with 546 participants were entered into an analysis of the effects of treatment on anxiety. Analyses showed there was no clear evidence of benefit for psychological therapies ($z = 1.26, p > 0.05$, SMD $−0.48$, 95% CI $−1.22$ to $0.27$, $I^2 = 94$%) (Analysis 1.4). Only one study could be entered into an analysis of the effect of psychological therapies on quality of life; hence, no conclusions can be drawn. Only one study reported adverse outcomes (Devineni 2005): the study reported that 11.6% of treatment completers reported worsening of headache symptoms; the distribution between treatment and control groups was not reported.

**Treatment versus control for headache conditions at follow-up**

No data were available for the analysis of the effects of treatment on pain at follow-up. Only one study could be included for the analysis of the effects of treatment on disability at follow-up; hence, no conclusions can be drawn. Two studies with 425 participants were entered into an analysis of the effects of treatment on pain at follow-up and there was no clear evidence of benefit ($z = 0.94, p > 0.05$, SMD $−1.03$, 95% CI $−3.18$ to $1.12$, $I^2 = 99$%) (Analysis 2.1). Two studies with 425 participants were entered into an analysis of the effects of treatment on anxiety at follow-up; there was no clear evidence of benefit ($z = 1.42, p > 0.05$, SMD $−0.46$, 95% CI $−1.09$ to $0.18$, $I^2 = 88$%) (Analysis 2.2). Quality of life outcomes were not assessed by any study for headache conditions at follow-up.

**Treatment versus control for non-headache conditions post-treatment**

Eleven studies with 1785 participants were entered into an analysis of the effects of treatment on pain. The overall effect of treatment was beneficial for psychological therapies ($z = 3.32, p < 0.01$), with a small effect size ($SMD = −0.37$, 95% CI $−0.59$ to $−0.15$, $I^2 = 77$%) (Analysis 3.1; Figure 4). Five studies with 1149 participants were entered into an analysis of the effects of treatment on disability. The overall effect was beneficial for psychological therapies ($z = 3.26, p < 0.01$), with a moderate effect size ($SMD = −0.50$, 95% CI $−0.79$ to $−0.20$, $I^2 = 79$%) (Analysis 3.2; Figure 5). Nine studies with 1013 participants were entered into an analysis of the effects of treatment on depression. The overall effect was beneficial for psychological therapies with a small effect size ($z = 2.41, p < 0.05$, SMD $−0.19$, 95% CI $−0.35$ to $−0.04$, $I^2 = 29$%) (Analysis 3.3). Ten studies with 1144 participants were entered into an analysis of the effects of treatment on anxiety. The overall effect for psychological therapies was beneficial, with a small effect size ($z = 2.54, p < 0.05$, SMD $−0.28$, 95% CI $−0.49$ to $−0.06$, $I^2 = 66$%) (Analysis 3.4). Three studies with 202 participants were entered into an analysis of the effects of treatment on quality of life. The overall effect did not show a benefit for psychological therapies ($z = 1.88, p > 0.05$, SMD $−0.27$, 95% CI $−0.54$ to $0.01$, $I^2 = 0$%) (Analysis 3.5).
Treatment versus control for non-headache conditions at follow-up
Four studies with 1202 participants were entered into an analysis of the effects of treatment on pain at follow-up and the overall effect was not beneficial for psychological therapies ($z = 1.34$, $p > 0.05$, SMD $= -0.48$, 95% CI $= -1.18$ to $0.22$, $I^2 = 96%$) (Analysis 4.1). Two studies with 850 participants were entered into an analysis of the effects of treatment on disability at follow-up and the overall effect for psychological therapies was beneficial ($z = 2.17$, $p < 0.05$), with a small effect size (SMD $= -0.15$, 95% CI $= -0.28$ to $-0.01$, $I^2 = 20%$) (Analysis 4.2). Three studies with 551 participants were entered into an analysis of the effects of treatment on depression at follow-up and the overall effect did not show benefit for psychological therapies ($z = 0.80$, $p > 0.05$, SMD $= -0.53$, 95% CI $= -1.84$ to $0.78$, $I^2 = 98%$) (Analysis 4.3). Three studies with 551 participants were entered into an analysis of the effects of treatment on anxiety at follow-up. The overall effect was not beneficial for psychological therapies ($z = 0.89$, $p > 0.05$, SMD $= -0.39$, 95% CI $= -1.25$ to $0.47$, $I^2 = 95%$) (Analysis 4.4). Quality of life outcomes were not assessed by any study for non-headache conditions at follow-up.

**DISCUSSION**

**Summary of main results**
We investigated the efficacy of psychological therapies for chronic pain management delivered via the Internet, in comparison with active, treatment-as-usual, or waiting-list controls. Fifteen studies met the inclusion criteria for the review and data were available for extraction from all studies. Studies were categorised as headache or non-headache conditions. Eight analyses were conducted for each condition including four primary outcomes of pain, disability, depression, and anxiety. These were assessed at two time points: immediately post-treatment and at follow-up. There were also two secondary outcomes (quality of life and acceptability/satisfaction),...
which are discussed separately. For headache conditions, pain and disability improved immediately post-treatment. However, these findings should be treated with caution as only two studies could be included in each of the analyses. For non-headache conditions, pain, disability, depression, and anxiety improved immediately post-treatment, and disability also improved at follow-up. However, similar to headache findings, only two studies could be entered into the disability analyses at follow-up, and so this finding should also be interpreted cautiously.

Only one study reported adverse events: 11.6% of the completing participants with headache conditions reported a worsening of headache symptoms (Devineni 2005).

The overall attrition from studies was 17.4% on average (range 0 to 25). Reasons for attrition included health problems and illness, difficulty using a computer or being physically uncomfortable using a computer, and personal problems. For those who stayed in the study, overall compliance rates with treatment requirements (e.g. number of sessions completed) are not known. The planned analyses of secondary outcomes (quality of life and acceptability/satisfaction) were limited because data were sparse. Only one study could be included in the analysis on quality of life in the headache condition so no analysis could be undertaken. No effect was found for the three studies that reported quality of life data immediately post-treatment in the non-headache condition. Internet-delivered psychological therapies are a novel method of treatment delivery, and acceptability and participant satisfaction are important yet neglected variables.

Internet-delivered psychological therapies had an impact on pain, disability, depression, and anxiety for non-headache conditions immediately post-treatment. Findings for the effect on all outcomes for headache conditions are minimal to limited. It should be acknowledged that the small effect sizes and lack of effect for depression and anxiety may be due to the lack of sensitivity to change: the baseline levels of depression and anxiety were low for the participants included in this review. This observation raises the question of the appropriateness of mental health interventions for individuals with chronic pain. In future studies/updates we might require a revised inclusion criterion requiring participants to be sufficiently depressed, anxious, and/or disabled.

In contrast to immediate post-treatment evaluations, few studies included follow-up assessments. Our conclusions regarding the effects of psychological therapies delivered via the Internet on longer-term symptom improvements, particularly with regards to pain, are therefore limited. There was no cut-off for pain severity in the inclusion criteria for this review and participants tended to have moderate pain ratings. It is acknowledged that different findings may have been obtained if studies had included participants with severe pain.

There are some limitations associated with the current set of primary studies included. A high level of heterogeneity was reported for some outcomes, which may have introduced an overestimation of effect. This could be attributed to the following reasons: first, most studies recruit people from the general population who self-select and volunteer to participate. The inclusion of such populations may limit the applicability of findings to clinical populations, and may introduce floor effects on some measures. Second, we combined studies with different comparison arms of treatments as there are not yet sufficient data within the same comparison group. Third, different measures were combined within the same outcome domain. Studies with a standard placebo control are needed. It is also not possible to state whether treatment is more effective than completing an active control (Williams 2012). Some have suggested that individuals in wait-list control groups do not take action to diminish pain-related problems during their waiting period because participants are expectant of future professional support (Cuijpers 2008). In future updates, when data allow, we will seek to compare treatments within their class of comparison treatment (e.g. placebo, treatment-as-usual). Internet-delivered treatment offers the possibility of matching treatment intensity to need, and to shape content to need, but we do not have data from this review that enable us to make any evidence-based comments on these possibilities. Finally, no analysis of adverse effects was possible, and no analysis of treatment expectations, satisfaction, or compliance was possible.

**Overall completeness and applicability of evidence**

Studies in this review were dominated by cognitive behavioural and behavioural treatments. The content of therapies reviewed was fairly homogeneous, with most including cognitive skill building components (e.g. problem solving skills training) as well as applied components (e.g. relaxation training). As found in the review by Williams 2012, which investigated face-to-face psychological therapies in adults with chronic pain (excluding headache), there was an apparent disjunction between the stated aims of treatment, actual treatment content and outcomes measured. Most studies did not include a comprehensive justification of treatment rationale and it was not always clear how the outcomes assessed linked to the intended aims of treatment.

We excluded a number of studies because of the absence of content that could be considered psychological. There are many ways in which the Internet and technology could be used to further the overall goal of independent management of pain. A broader consideration of developments in telehealth and chronic pain would capture work in sensing and assessment, mobile health monitoring, virtual reality including immersive environments, games for pain, and education, to name a few (Keogh 2010). Clearer information is required regarding whether therapies are designed to augment, replace, or improve on face-to-face psychological therapy, and in what way the proposed mechanism of improving self-management is psychological.

**Agreements and disagreements with other**
**studies or reviews**

The findings are consistent with other systematic reviews in this field. Similar effects for have been found for pain outcomes (Bender 2011; Cuijpers 2008; Macea 2010) and activity limitation (Bender 2011). Similar to the findings in this review for non-headache conditions, systematic reviews have found reductions in depression and anxiety scores after CBT was delivered via the Internet (Griffiths 2010; Spek 2007). The types of therapies that met the inclusion criteria varied across reviews. In addition to CBT interventions, Bender 2011 assessed peer-support programmes (e.g. social networking programmes) and clinical visit supports, although they found insufficient evidence for Internet-based clinical support interventions. Cuijpers 2008 considered interventions that consisted of online contact between therapist/moderator and participant, where the Internet facilitated contact, rather than acting as the primary intervention itself. This review, unlike the other three, excluded child studies. This review can be directly compared to Williams 2012, from which it was partly born. The average age and gender ratio in both reviews were very similar (mean = 48 years, SD = 9 years, women = 71% in Williams 2012, compared with mean = 47 years, SD = 8 years, women = 80% in the current review). Participants were recruited via different methods. Williams 2012 found that most participants were recruited via healthcare settings (e.g. pain rehabilitation clinics, rheumatology clinics, and the community). However, this review found that most participants volunteered after seeing an advert on an Internet forum. The findings of this review also were similar to the face-to-face therapies reviewed by Williams 2012. First, Williams 2012 found that pain, disability, mood (depression), and catastrophising in adults with chronic pain (excluding headache) improved immediately post-treatment. Similarly, this review revealed positive effects for pain, disability, depression, and anxiety post-treatment for individuals with non-headache conditions. However, the results differed at follow-up. Williams 2012 found an effect on mood to be maintained at follow-up. No such effect was found in this review. However, this review found disability to be maintained at follow-up, although the analysis included only two studies and so should be interpreted with caution. There are fewer studies included in this review (N = 15) compared to Williams 2012 (N = 35) and the overall number of participants was also fewer (N = 2012) compared to Williams 2012 (N = 4788).

**AUTHORS’ CONCLUSIONS**

**Implications for practice**

Internet-delivered cognitive behavioural therapy (CBT) for the management of chronic pain in adults may be effective for the short-term management of pain, disability, depression, and anxiety in individuals with chronic non-headache pain conditions, but there is currently limited evidence for their effectiveness for headache pain and disability, and no evidence for their effectiveness on depression and anxiety in individuals with chronic headache conditions. On average, participants entering trials of Internet-delivered treatment are mildly disabled and distressed. No conclusions can be made for treatments other than CBT. We do not know if these treatments are associated with adverse events and we do not know how satisfied participants are with these treatments.

**Implications for research**

Delivering cognitive and behaviour change therapies via the Internet without an expert health professional managing real-time delivery is possible. However, the exact content of therapy, the characteristics of the treatment method, and the methods by which individuals are selected for such therapy are not known. In essence we do not know what can work for whom and in what context. This research is at a very early stage of development and the studies reviewed here can usefully be considered immature. Two areas of research are needed.

First, the most effective method of face-to-face treatment identified in Williams 2012 should be adapted for delivery via the Internet using the most effective method of evaluation: the placebo-controlled RCT. Future RCTs should have the following critical features:

1. Be properly powered to detect meaningful changes in the primary outcomes measured (approximate n = 300);
2. Use a placebo therapy as the primary comparator;
3. Make attempts to blind both participants and investigators to treatment selection;
4. Measure adverse effects, participant satisfaction, adherence to treatment, and reasons for attrition;
5. Enrol only participants with moderate-to-severe pain, disability, or distress;
6. Select domains and outcome measurement tools commensurate with IMPACT guidance (Dworkin 2005).

Second, further pre-evaluation studies are needed to examine critical aspects of Internet delivery of therapeutic communication, such as, but not limited to the following.

1. Can therapeutic alliance be achieved with non-human objects/systems, and is it necessary to deliver behaviour change?
2. Can novel aspects of Internet systems be used therapeutically (e.g. immersion technology, multi-agent connections, remote sensing)?
3. Can Internet treatments augment traditional real-time human interaction and can limited human interaction (e.g. skills...
practice review or telephone support) augment Internet-delivered therapies?

Research is needed in both fundamental aspects of Internet communication: persuasion and therapy. However, whilst this research develops, we believe there is a case for efficacy studies on the current most promising treatments for adults with chronic pain.

ACKNOWLEDGEMENTS

We would like to thank Joanne Abbott for designing and running the search for this review.

REFERENCES

References to studies included in this review

Berman 2009 [published data only]

Bromberg 2011 [published data only]

Buhrman 2004 [published data only]

Buhrman 2011 [published data only]

Buhrman 2013 [published data only]

Buhrman 2013a [published data only]

Carpenter 2012 [published data only]

Chiauzzi 2010 [published data only]

Dear 2013 [published data only]

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Strom 2000 [published data only]
Strom L, Pettersson R, Andersson G. A controlled trial of self-help treatment of recurrent headache conducted via the...
References to studies excluded from this review

Allen 2008 [published data only]

Anderson 2006 [published data only]

Andersson 2002 [published data only]

Bieber 2006 [published data only]

Borckardt 2004 [published data only]

Brattberg 2006 [published data only]

Brattberg 2007 [published data only]

Bruce 2005 [published data only]

Chambers 2006 [published data only]

Childs 2011 [published data only]

Cleeland 2011 [published data only]

de Bruijn-Kofman 1997 [published data only]

Everitt 2010 [published data only]

Everitt 2013 [published data only]

Fraenkel 2007 [published data only]

Greco 2004 [published data only]

Hochlehnert 2006 [published data only]

Huffstutter 2007 [published data only]

Jacobs 2013 [published data only]

**Jennings 2008** [published data only]


**Johns 2011** [published data only]


**Keulers 2007** [published data only]


**Kjeken 2011** [published data only]


**Kleiboer 2009** [published data only]


**Kosterink 2010** [published data only]


**Krein 2010** [published data only]


**Kristjansdottir 2011** [published data only]


**Kristjansdottir 2013** [published data only]


**Kroenke 2010** [published data only]


**Larsman 2010** [published data only]


**Leboeuf-Yde 2012** [published data only]


**Leveille 2007** [published data only]


**Leveille 2009** [published data only]


**Lorig 2002** [published data only]


**Lorig 2006** [published data only]


**Macedo 2012** [published data only]


**Miller 2010** [published data only]


**Naylor 2008** [published data only]

Naylor MR, Keefe FJ, Brigadi B, Naud S, Helzer JE. Therapeutic Interactive Voice Response for chronic pain

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Oerlemans 2011 [published data only]

Premi 1993 [published data only]

Russell 2011 [published data only]

Sandso 2010 [published data only]

Sciamanna 2006 [published data only]

Spunt 1996 [published data only]

Steel 2011 [published data only]

Taieb-Maimon 2012 [published data only]

Vonk Noordegraaf 2012 [published data only]

Weingart 2008 [published data only]

Additional references

Bailey 2010

Bender 2011

Black 2011

Bodenheimer 2002

Breivik 2006

Civljak 2013

Cuijpers 2008

Currell 2000

Dworkin 2005

Fu 2003
Psychological therapies (Internet-delivered) for the management of chronic pain in adults (Review)

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Hardiker 2011


Gatchel 2007


Griffiths 2010


Higgins 2011


Jennett 2003


Jordan 2007


Keogh 2010


King 2011


Lewis 2004


Macea 2010


Martin 2008


McLean 2010


McLean 2011


Pal 2013


Palermo 2009


RevMan 2011


Sandgren 2000


Spek 2007


Standford 2008


Tuntland 2009


Velleman 2010


Whitten 2007

Williams 2012
* Indicates the major publication for the study
### Characteristics of included studies  
**[ordered by study ID]**

**Berman 2009**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Methods</strong></td>
<td>RCT; 2 arms; assessed pre-treatment and post-treatment (at 6 weeks)</td>
</tr>
</tbody>
</table>
| **Participants** | End of treatment n = 78  
Start of treatment n = 89  
Sex = 68 F, 10 M  
Mean age = 65.8 years (SD not given)  
Source = community-based settings (e.g. community centres)  
Diagnosis = most common causes of pain cited by participants were: arthritis, spinal stenosis or degenerative disc problems, previous injuries or surgery, and sciatica. Full descriptions not given  
Mean years of pain = not given |
| **Interventions** | "Online mind-body self care intervention" - "Cognitive-behavioural model with problem solving approach.... The self-care modules included a selection on mind-body exercises in each of the following areas: (1) abdominal breathing, (2) relaxation, (3) writing about positive experiences, (4) writing about difficult experiences, (5) creative visual expression, and (6) positive thinking" |
| **Outcomes** | Primary pain outcome: Brief Pain Inventory-Short Form (BPI)  
Primary disability outcome: none  
Primary depression outcome: Centre for Epidemiological Studies Short Depression Scale (CES-D)  
Primary anxiety outcome: State-Trait Anxiety Inventory (STAI Y-6)  
1. Pain Self-efficacy Questionnaire  
2. Awareness of response to pain, using a computed total score for the five relevant items on the Pain Awareness Questionnaire (PAQ)  
3. Confidence with pain management (two items on PAQ)  
4. Satisfaction survey  
5. Self care (one question in the satisfaction survey) |

**Notes**

**Risk of bias**

<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate sequence generation</td>
<td>Low risk</td>
<td>Participants were randomly assigned to either the intervention or comparison group via a simple coin toss</td>
</tr>
<tr>
<td>Allocation concealment</td>
<td>High risk</td>
<td>Group assignment was not concealed, participants assigned to the intervention group received orientation to the website by research assistants</td>
</tr>
</tbody>
</table>
**Berman 2009**  
*(Continued)*

<table>
<thead>
<tr>
<th>Blinding</th>
<th>Low risk</th>
<th>Assessments taken online</th>
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<tbody>
<tr>
<td>All outcomes</td>
<td></td>
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</tr>
<tr>
<td>Incomplete outcome data</td>
<td>Low risk</td>
<td>Fewer than 10% missing data with the exception of CES-D, for which instructions were followed. Attrition was adequately explained and missing data appeared to have been imputed using appropriate methods</td>
</tr>
<tr>
<td>All outcomes</td>
<td></td>
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<tr>
<td>Free of selective reporting</td>
<td>Low risk</td>
<td>Published report includes data for all expected outcomes</td>
</tr>
<tr>
<td>Free of other bias</td>
<td>Low risk</td>
<td>Study appears to be free of other sources of bias</td>
</tr>
</tbody>
</table>

**Bromberg 2011**

**Methods**

RCT; 2 arms; assessed pretreatment, post-treatment (at 4 weeks) and at follow-up (at 3 and 6 months)

**Participants**

End of treatment n =144  
Start of treatment n = 189  
Sex = 165 F, 20 M  
Mean age = 42.62 (SD 11.5) years  
Source = recruited through several methods: (1) website postings, (2) electronic newsletter announcements, (3) 22 neurology practices that distributed informational flyers to people with chronic pain and (4) postings to social networking/community sites  
Diagnosis = migraine  
Mean years of pain = not given

**Interventions**

"painACTION, Internet based self-management tool" - "The intervention incorporates cognitive behavior therapy and self-management principles to teach people with migraine "how to" apply practical self-management skills, techniques, and strategies to motivate and support participant engagement in active pain self-management behaviours. Tasks included completing self-assessments, taking lessons using interactive tools and using a pain tracker"

**Outcomes**

Primary pain outcome: none  
Primary disability outcome: Migraine Disability Assessment Questionnaire  
Primary depression outcome: Depression Anxiety Stress Scale (DASS-21)  
Primary anxiety outcome: DASS-21  
1. Daily Headache Record  
2. Chronic Pain Coping Inventory-42 (CPCI-42)  
3. Headache Management Self-Efficacy Scale  
4. Pain Catastrophizing Scale (PCS)  
5. Headache-Specific Locus of Control  
6. Patient Global Impression of Change (PGIC)
### Notes

#### Risk of bias

<table>
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<tr>
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<tbody>
<tr>
<td>Adequate sequence generation</td>
<td>Low risk</td>
<td>Random number table used for group assignment</td>
</tr>
<tr>
<td>Allocation concealment</td>
<td>Unclear risk</td>
<td>Study staff created a randomisation table that contained 8 blocks. It is not clear whether study staff were blinded</td>
</tr>
<tr>
<td>Blinding</td>
<td>Low risk</td>
<td>Assessments taken online</td>
</tr>
<tr>
<td>Incomplete outcome data addressed All outcomes</td>
<td>High risk</td>
<td>The study was originally powered for two primary outcomes; however, because of a data management error one outcome measure was not available for analysis. Attrition was fully described; however, there were statistical differences between completers and non-completers</td>
</tr>
<tr>
<td>Free of selective reporting</td>
<td>High risk</td>
<td>One expected outcome (Daily Headache Record) was not available due to a data management error, therefore all expected outcomes are not included</td>
</tr>
<tr>
<td>Free of other bias</td>
<td>Low risk</td>
<td>Study appears to be free of other sources of bias</td>
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</table>

#### Buhrman 2004

**Methods**

RCT; 2 arms; assessed pretreatment, post-treatment (at 6 weeks) and at follow-up (at 3 months)

**Participants**

End of treatment n = 51  
Start of treatment n = 51  
Sex = 21 F, 35 M  
Mean age = 44.6 (SD 10.4) years  
Source = newspaper articles in national and regional papers as well as through a webpage for health  
Diagnosis = chronic back pain  
Mean years of pain = 10.1 (SD 9.2) years
### Interventions

"Internet based pain management programme with telephone support" - "Treatment model delivered was derived primarily from a cognitive-behavioural model of chronic pain... and included psychological components (e.g. dealing with unhelpful thoughts and beliefs, changing focus) as well as stretching and physical exercises.... Telephone contact was with a therapist once a week to review homework, answer questions and maintain motivation"

### Outcomes

Primary pain outcome: Multidimensional Pain Inventory (MPI)
Primary disability outcome: none
Primary depression outcome: Hospital Anxiety and Depression Scale (HADS)
Primary anxiety outcome: HADS
1. Coping Strategies Questionnaire
2. Pain and Impairment Relationship Scale (PAIRS)
3. Pain Diary
4. Treatment credibility - 5 items on an adapted 10-point scale
5. Satisfaction with treatment format

### Notes

**Risk of bias**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Adequate sequence generation</td>
<td>Low risk</td>
<td>Subjects were randomised using dice, where even numbers meant treatment and odd numbers meant control condition</td>
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<tr>
<td>Allocation concealment</td>
<td>Unclear risk</td>
<td>Insufficient information regarding allocation concealment</td>
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<tr>
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<tr>
<td>All outcomes</td>
<td>Low risk</td>
<td>Report n = 5 dropped out, reason for attrition is not documented. Differences between completers and non-completers reported</td>
</tr>
<tr>
<td>Incomplete outcome data addressed</td>
<td>Low risk</td>
<td>Published report includes data for all expected outcomes</td>
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<tr>
<td>All outcomes</td>
<td></td>
<td>Study appears to be free of other sources of bias</td>
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<tr>
<td>Free of selective reporting</td>
<td>Low risk</td>
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<td>Free of other bias</td>
<td>Low risk</td>
<td></td>
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</tbody>
</table>
## Methods

RCT; 2 arms; assessed pretreatment, post-treatment (at 12 weeks)

### Participants

End of treatment n = 50  
Start of treatment n = 54  
Sex = 37 F, 17 M  
Mean age = 43.2 (SD 9.8) years  
Source = newspaper articles in national and regional papers, as well as recruitment through a webpage  
Diagnosis = chronic back pain  
Mean years of pain = 12.1 (SD 8.5) years

### Interventions

"Guided Internet-based cognitive behavioural treatment" - "Self help management programme administered via the Internet... based on CBT. The participants were instructed to test and practice different coping strategies e.g. relaxation, cognitive skills, stress management as well as physical exercise techniques... The text was divided into 8 modules. Participants were prompted to submit weekly reports on treatment progress. Treatment group had one structured telephone conversation with a therapist and access to a computer technician via email."

### Outcomes

- **Primary pain outcome**: MPI  
- **Primary disability outcome**: none  
- **Primary depression outcome**: HADS  
- **Primary anxiety outcome**: HADS  
- 1. Coping Strategies Questionnaire  
- 2. PAIRS  
- 3. Quality of life inventory

## Notes

**Risk of bias**

<table>
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<tbody>
<tr>
<td>Adequate sequence generation</td>
<td>Unclear risk</td>
<td>Randomisation was made by an independent person through a webpage with a randomisation program. Method used unclear</td>
</tr>
<tr>
<td>Allocation concealment</td>
<td>Low risk</td>
<td>Randomisation was made by an independent person through a webpage with a randomisation program. Third-party involvement therefore meets the criteria for concealment</td>
</tr>
<tr>
<td>Blinding</td>
<td></td>
<td>Assessments taken online</td>
</tr>
<tr>
<td>All outcomes</td>
<td>Low risk</td>
<td>&quot;Data were analysed using the intention-to-treat principle with all available data regardless of completion of the actual treat-</td>
</tr>
</tbody>
</table>
Participants lost to follow-up were first not replaced using last observation carried forward, as this assumes stability from pre-treatment. Given the few dropouts, the authors regarded this as a defensible procedure instead of modelling the lost observations (n = 5) using bootstrap methodology or mixed models approaches. All analyses were repeated with the 5 missing cases replaced by their baseline data. This did not affect the outcome.

<table>
<thead>
<tr>
<th>Free of selective reporting</th>
<th>Low risk</th>
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<tr>
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</tr>
</tbody>
</table>

**Buhrman 2013**

- **Methods**: RCT; 2 arms; assessed pretreatment, post-treatment, and at 6 months

- **Participants**
  - End of treatment n = 56
  - Start of treatment n = 72
  - Sex = 52 F, 20 M
  - Mean age = 40.1 (SD 8.94) years
  - Source = former attendants at a pain centre
  - Diagnosis = back, neck, shoulder, and generalised pain
  - Mean years of pain = 6.2 (SD 2.07) years

- **Interventions**: Eight treatment modules of the Internet programme, CBT-based. Included relaxation, physical exercise plan, balance when planning activities, cognitive restructuring, mindfulness, stress management, sleep hygiene. Control group participated in an online discussion forum with weekly discussion topics presented.

- **Outcomes**
  - Primary pain outcome: MPI
  - Primary disability outcome: none
  - Primary depression outcome: HADS
  - Primary anxiety outcome: HADS
  - 1. Coping Strategies Questionnaire
  - 2. PAIRS
  - 3. Quality of life inventory
  - 4. Chronic Pain Acceptance Questionnaire

- **Notes**

- **Risk of bias**
<table>
<thead>
<tr>
<th>Bias</th>
<th>Authors’ judgement</th>
<th>Support for judgement</th>
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**Buhrman 2013a**

**Methods**
RCT; 2 arms; assessed pretreatment, post-treatment, and at 6 months

**Participants**
End of treatment n = 61
Start of treatment n = 76
Sex = 45 F, 31 M
Mean age = 49.1 (SD 10.34) years
Source = attendants at a pain centre
Diagnosis = back, neck, shoulder, hips/legs/feet, and generalised pain
Mean years of pain = 15.3 (SD 11.65) years

**Interventions**
Seven treatment sections ACT-based. MP3 files could be played on MP3 player or computer. Treatment involved learning and practising mindfulness exercises
Control group participated in an online discussion forum with weekly discussion topics presented

**Outcomes**
Primary pain outcome: MPI
Primary disability outcome: none
Primary depression outcome: HADS
Primary anxiety outcome: HADS
1. Coping Strategies Questionnaire
2. PAIRS
3. Quality of life inventory
4. Chronic Pain Acceptance Questionnaire
### Buhrman 2013a (Continued)

**Notes**

**Risk of bias**

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**Carpenter 2012**

**Methods**

RCT; 2 arms; assessed pretreatment, post-treatment (at 3 weeks) and at follow-up (at 6 weeks)

**Participants**

End of treatment n = 131  
Start of treatment n = 141  
Sex = 117 F, 24 M  
Mean age = 42.5 (SD 10.3) years  
Source = Internet bulletin boards and advertisements in mainstream and alternative newspapers  
Diagnosis = chronic lower back pain  
Mean years of pain = 8.6 (SD 7.8) years

**Interventions**

“Online self-help intervention (Wellness Workbook)” - online interactive CBT intervention. It uses a mind/body treatment rational, including content on: pain education, CBT techniques (including cognitive restructuring), stress management, relaxation, mindfulness and values-based behavioural activation
Carpenter 2012  
(Continued)

Outcomes

Primary pain outcome: Pain Assessment Questionnaire (pain rating of average pain)
Primary disability outcome: Roland-Morris Disability
Primary depression outcome: none
Primary anxiety outcome: PCS
1. Survey of Pain Attitudes
2. Arthritis Self Efficacy Scale
3. The Fear Avoidance Beliefs Questionnaire (FABQ)
4. The Negative Mood Regulation Scale
5. Demographics and Pain Assessment Questionnaire

Notes

Risk of bias

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Chiauzzi 2010

Methods

RCT; 2 arms; assessed pretreatment, post-treatment (at 4 weeks) and at follow-up (at 3 and 6 months)

Participants

End of treatment n = 186
Start of treatment n = 209
Sex = 134 F, 64 M
Mean age = 46.14 (SD 11.99) years
### Chiauzzi 2010 (Continued)

| Source | “online dissemination through professional and patient contacts, and staff recruiting at a pain centre”
Diagnosis = chronic back pain
Mean years of pain = not given |
| Interventions | “painACTION, Internet based self-management tool” - painACTION-Back Pain is a website based on CBT and self-management principles. The intervention includes components on: 1) collaborative decision making with health professionals; 2) CBT to improve self-efficacy, manage thoughts and mood, set clinical goals, work on problem-solving life situations, and prevent pain relapses; (3) motivational enhancement through tailored feedback; and (4) wellness activities to enhance good sleep, nutrition, stress management, and exercise practices |
| Outcomes | Primary pain outcome: BPI
Primary disability outcome: Oswestry Disability Questionnaire
Primary depression outcome: DASS-21
Primary anxiety outcome: DASS-21
1. PGIC
2. CPCI-42
3. PCS
4. Pain Self-Efficacy Questionnaire
5. FABQ |
| Notes | |

### Risk of bias

| Bias | Authors’ judgement | Support for judgement |
| Adequate sequence generation | Unclear risk | Participants were randomised using an adaptive or “stratified” randomisation that ensures group equivalence on preselected variables that may relate to outcome across conditions. Gender, race/ethnicity, and age bracket (18 to 40, 41 to 60, 60 years and over) were included in the randomisation algorithm. No method described |
| Allocation concealment | Unclear risk | Insufficient information regarding allocation concealment |
| Blinding | Unclear risk | No description given |
| Incomplete outcome data addressed | Unclear risk | Attrition reported. Differences between completers and non-completers not reported |
### Chiauzzi 2010 (Continued)

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| Risk of bias |
|--------------|-------------------|

### Dear 2013

**Methods**

RCT; 2 arms; assessed pretreatment, post-treatment and at 3 months

**Participants**

- **End of treatment** n = 62
- **Start of treatment** n = 60
- **Sex** = 27 F, 4 M
- **Mean age** = 47 (SD 13) years
- **Source** = advertisements about the trial were placed in newsletters and on websites operated by non-governmental institutions that offer information and services to people with chronic pain, including beyondblue, Chronic Pain Australia, Australian Pain Management Association, and Arthritis Australia
- **Diagnosis** = mixed body pain sites
- **Mean years of pain** = 7.36 (SD 8.10) years

**Interventions**

- "The Pain Course" based on principles of CBT. Modules include sleep hygiene, problem-solving, assertiveness, managing attention, and core beliefs. 8 weeks in length. Wait-list control

**Outcomes**

- **Primary pain outcome**: Wisconsin Brief Pain Questionnaire
- **Primary disability outcome**: Roland-Morris Disability Questionnaire
- **Primary depression outcome**: Patient Health Questionnaire 9-Item
- **Primary anxiety outcome**: Generalized Anxiety Disorder 7-Item
  1. Pain Self-efficacy questionnaire
  2. TAMPA Scale of Kinesiophobia
  3. Pain Responses Self-Statements

**Notes**
Dear 2013  *(Continued)*

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**Devineni 2005**

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<th>RCT; 2 arms; assessed pretreatment, post-treatment (at 4 weeks) and at follow-up (at 2 months)</th>
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</thead>
</table>
| Participants | End of treatment n = 86  
Start of treatment n = 86  
Sex = 108 F; 31 M  
Mean age = 42.3 (SD 11.9) years  
Source = common Internet-based promotion channels  
Diagnosis = chronic headache  
Mean years of pain = not given |
| Interventions | "Internet-delivered behavioural regimen” - Behavioural regimen composed of: progressive muscle relaxation, limited biofeedback with autogenic training and stress management |
| Outcomes | Primary pain outcome: Headache Symptom Questionnaire  
Primary disability outcome: Headache Disability Inventory (HDI)  
Primary depression outcome: CES-D  
Primary anxiety outcome: STAI |

**Notes**

**Risk of bias**

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Psychological therapies (Internet-delivered) for the management of chronic pain in adults (Review)  
Copyright © 2014 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.
### Hedborg 2011

**Methods**

RCT; 3 arms; pretreatment, 8 months (experimental and control), 11 months (experimental only)

**Participants**

End of treatment n = 76  
Start of treatment n = 83  
Sex = 58 F, 25 M  
Mean age = 47.73 (SD not given) years  
Source = participants were recruited after being approached during a previous descriptive study on migraine  
Diagnosis = migraine  
Mean years of pain = 23.2 years (SD not given)

**Interventions**

"Internet-based multimodal behavior treatment (MBT) with hand massage" - "The MBT program was intended to increase participants’ awareness of essential factors in everyday life that might have an impact on their migraine. This training program consisted of the following topics: stress physiology, physical activity, diet, thought patterns, handling of emotions, and attitudes (toward oneself and others)"

**Outcomes**

Primary pain outcome: none  
Primary disability outcome: none  
Primary depression outcome: Montgomery-Asberg Depression Rating Scale  
Primary anxiety outcome: none  
1) PQS23 - An instrument developed at the Department of Environmental Stress Disorders (CEOS), Uppsala University  
2) Assessment of opinions about MBT and hand massage interventions

**Notes**

Outcome measures at 8 months are used as there are no post-treatment measures for the control group

**Risk of bias**

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Devineni 2005  (Continued)
### Adequate sequence generation

**Low risk**

“A sequence of random numbers was generated in Statistical Package for the Social Sciences 18.0 (SPSS) software, stratified by gender in order to obtain an equal distribution of women and men in the groups. Based on magnitude, these numbers were arranged into three equal-sized groups, which translated into the three study groups. The number sequence thus translated into a unique sequence of group affiliation which corresponded to the chronological order of inclusion”

### Allocation concealment

**Low risk**

The randomisation procedure was performed by an independent researcher, thus the process was blinded to the investigators

### Blinding

**All outcomes**

**Low risk**

Assessments taken online

### Incomplete outcome data addressed

**All outcomes**

**Low risk**

Attrition fully reported, no statistical differences between completers and non-completers

### Free of selective reporting

**Low risk**

Reported all data for expected outcomes

### Free of other bias

**Low risk**

Study appears to be free of other sources of bias

### Lorig 2008

**Methods**

RCT; 2 arms; assessed pretreatment, post-treatment (at 6 months) and at follow-up (at 12 months)

**Participants**

End of treatment n = 641  
Start of treatment n = 855  
Sex = 781 F; 74 M  
Mean age = 52.35 (SD 11.55) years  
Source = established websites, online newsletters and discussion groups  
Diagnosis = rheumatoid arthritis, osteoarthritis or fibromyalgia  
Mean years of pain = not given

**Interventions**

"Internet-based Arthritis Self-Management Program (ASMP)" - "ASMP consists of password protected, interactive, Web-based instruction (The Learning Center); Web-based bulletin board discussion (The Discussion Center); tools that the participants can use individually, such as exercise logs, medication diaries, and tailored exercise programmes. The Learning Center content includes design of individualized exercise programmes; use of cognitive symptom management such as relaxation, visualization, distraction, and..."
self-talk; methods for managing negative emotions such as anger, fear, and depression; an overview of medications; aspects of physician-patient communication; healthy eating; fatigue management; action planning; feedback; and methods for solving arthritis related problems

Outcomes

Primary pain outcome: Health indicator - Pain (0-10)
Primary disability outcome: Health indicator - Disability (0-3)
Primary depression outcome: none
Primary anxiety outcome: none

1. Six health-related quality of life indicators (Health distress, Self reported global health, Disability, Activity limitation, Fatigue, Pain)
2. Four health-related behaviours (stretching and strengthening exercises, aerobic exercise, use of cognitive symptom techniques and use of techniques to improve communication with healthcare providers)
3. Five utilisation measures (self-reported outpatient visits to physicians, emergency room visits, nights in the hospital, chiropractic visits and physical therapy visits)
4. Arthritis Self-Efficacy Scale

Notes

Intervention duration was 6 weeks, post-treatment outcome measures assessed at 6 months

Risk of bias

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**Ruehlman 2012**

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<tr>
<th>Methods</th>
<th>RCT; 2 arms; assessed pretreatment, post-treatment (at 7 weeks) and at follow-up (at 14 weeks)</th>
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</table>
| Participants | End of treatment n = 241  
Start of treatment n = 305  
Sex = 195 F, 110 M  
Mean age = not given  
Source = established websites, e-mails to website members and newsletters  
Diagnosis = "The most common diagnoses were migraine headaches (65.5%) and back injury (60.5%). Tension headaches, fibromyalgia, osteoarthritis, face or jaw pain, and premenstrual pain were somewhat less common, with 20-40% of the participants reporting these"  
Mean years of pain = Not given; however, 89.5% of participants reported having pain for more than 2 years |
| Interventions | "The Chronic Pain Management Program (CPMP)" - "CPMP leverages technical capabilities with program content and functionality derived from cognitive behavior therapy, interpersonal, and self-management approaches to address the adaptive burdens of chronic pain in adults. A custom learning plan is created for each user after the online completion of the Profile of Chronic Pain (PCP). The PCP includes online activities (e.g. interactive exercises) and off-line activities (e.g. lifestyle activities such as exercise)" |
| Outcomes | Primary pain outcome: Profile of Chronic Pain (PCP): Screen  
Primary disability outcome: none  
Primary depression outcome: CES-D  
Primary anxiety outcome: DASS-21  
1. Test of pain knowledge that assessed the role of thought, emotion, social responses to pain and behaviour to the pain experience  
2. PCP: Extended Assessment  
3. Functional limitations in 10 areas of daily living (social life, sex, sleep, recreation, chores, work, self-care, parenting, routine physical activities and exercise) |
| Notes | |

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### Ruchlman 2012 (Continued)

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### Strom 2000

**Methods**  
RCT; 2 arms; assessed pretreatment and post-treatment (at 6 weeks)

**Participants**  
End of treatment n = 45  
Start of treatment n = 45  
Sex = 69 F, 33 M  
Mean age = 36.7 years (SD not given)  
Source = participants were recruited by means of newspaper articles in national and regional papers and notes in Internet magazines  
Diagnosis = recurrent headache  
Mean years of pain = not given

**Interventions**  
"Self help treatment, applied relaxation and problem solving" - "The relaxation program was largely derived from the method of applied relaxation... and autogenic training.... The instructions were adjusted to suit the self help format. Participants were presented with different methods aimed to be useful in the identification of problems, coping with problems in general, and coping with headache-related problems..."  

**Outcomes**  
| Primary pain outcome: Headache Index |  |
| Primary disability outcome: HDI |  |
| Primary depression outcome: BDI |  |
| Primary anxiety outcome: none |  |
| 1. Number of headache days per week |  |
| 2. Peak intensity of headache |  |
| 3. Multidimensional Locus of Pain Control Questionnaire (MLPC) |  |

**Risk of bias**

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**Psychological therapies (Internet-delivered) for the management of chronic pain in adults (Review)**  
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<td>Some questionnaires taken online, other questionnaires filled out on paper. No description given if outcome assessors were blinded</td>
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### Williams 2010

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<th>Methods</th>
<th>RCT; 2 arms; assessed pretreatment and post-treatment (at 6 months)</th>
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</thead>
</table>
| Participants                 | End of treatment n = 106  
Start of treatment n = 118  
Sex = 112 F, 6 M  
Mean age = 50.46 (SD 11.45) years  
Source = conducted at the Avera Research Institute; participants were referred to the study by their primary or specialist care physician, who received recruitment materials through their local provider network  
Diagnosis = fibromyalgia  
Mean years of pain = 9.4 (SD 6.46) years |
| Interventions                | "Internet based exercise and behavioural self-management" - "The website entitled "Living Well with Fibromyalgia (FM) contained 13 modules segregated into three broad segments: (a) educational lectures providing background knowledge about FM as a disease state, (b) education, behavioral, and cognitive skills designed to help with symptom management, and (c) behavioral and cognitive skills designed to facilitate adaptive lifestyle changes for managing FM. Each of the 13 modules featured a video lecture on the topic by a clinician experienced in applying the selected topic with respect to FM, written summaries of the video lecture for reading or downloading, homework and self-monitoring forms for applying the behavioral strategies described in the video lecture;
and supplemental educational materials unique to each topic (e.g., audio relaxation exercises and readings) 

<table>
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<td>Primary disability outcome: The Short Form-36 Physical Functioning Scale</td>
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<tr>
<td>Primary depression outcome: CES-D</td>
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<td>Primary anxiety outcome: Stait-Trait Personality Inventory</td>
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<tr>
<td>1. Multidimensional Fatigue Inventory</td>
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<td>2. PGIC</td>
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<td>3. Mini-International Neuropsychiatric Interview</td>
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<td>4. Client Satisfaction Questionnaire</td>
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| Notes                                         |                  |

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**ACT** = Acceptance Commitment Therapy  
**BDI** = Beck Depression Inventory  
**BPI** = Brief Pain Inventory-Short Form  
**CBT** = Cognitive Behavioural Therapy  
**CES-D** = Centre for Epidemiological Studies Short Depression Scale
CPCI = Chronic Pain Coping Inventory  
DASS = Depression Anxiety Stress Scale  
F = Female  
FABQ = Fear Avoidance Beliefs Questionnaire  
HADS = Hospital Anxiety and Depression Scale  
HDI = Headache Disability Inventory  
M = Male  
MPI = Multidimensional Pain Inventory  
PAIRS = Pain and Impairment Relationship Scale  
PCS = Pain Catastrophizing Scale  
PGIC = Patient Global Impression of Change  
RCT = Randomized controlled trial  
SD = Standard deviation  
STAI = State-Trait Anxiety Inventory

### Characteristics of excluded studies [ordered by study ID]

<table>
<thead>
<tr>
<th>Study</th>
<th>Reason for exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allen 2008</td>
<td>Does not use the Internet as primary mode of delivering treatment</td>
</tr>
<tr>
<td>Anderson 2006</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>Andersson 2002</td>
<td>Inadequate n: number of participants in any study arm was less than 20</td>
</tr>
<tr>
<td>Bieber 2006</td>
<td>Does not evaluate a self-management psychological intervention</td>
</tr>
<tr>
<td>Borckardt 2004</td>
<td>Not a randomised control trial</td>
</tr>
<tr>
<td>Brattberg 2006</td>
<td>Inadequate n: number of participants in any study arm was less than 20</td>
</tr>
<tr>
<td>Brattberg 2007</td>
<td>Inadequate n: number of participants in any study arm was less than 20</td>
</tr>
<tr>
<td>Bruce 2005</td>
<td>Does not evaluate a self-management psychological intervention</td>
</tr>
<tr>
<td>Chambers 2006</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>Childs 2011</td>
<td>Does not use the Internet as primary mode of delivering treatment</td>
</tr>
<tr>
<td>Cleeland 2011</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>de Bruijn-Kofman 1997</td>
<td>Not a randomised control trial</td>
</tr>
<tr>
<td>Everitt 2010</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>Everitt 2013</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>Author</td>
<td>Issue</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Fraenkel 2007</td>
<td>Does not evaluate a self-management psychological intervention</td>
</tr>
<tr>
<td>Greco 2004</td>
<td>Does not use the Internet as primary mode of delivering treatment</td>
</tr>
<tr>
<td>Hochlehner 2006</td>
<td>Does not evaluate a self-management psychological intervention</td>
</tr>
<tr>
<td>Huffstutter 2007</td>
<td>Does not evaluate a self-management psychological intervention</td>
</tr>
<tr>
<td>Jacobs 2013</td>
<td>Not a randomised control trial</td>
</tr>
<tr>
<td>Jennings 2008</td>
<td>Does not use the Internet as primary mode of delivering treatment</td>
</tr>
<tr>
<td>Johns 2011</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>Keulers 2007</td>
<td>Does not evaluate a self-management psychological intervention</td>
</tr>
<tr>
<td>Kjeken 2011</td>
<td>Does not use the Internet as primary mode of delivering treatment</td>
</tr>
<tr>
<td>Kleiboer 2009</td>
<td>Used a non-inferiority hypothesis</td>
</tr>
<tr>
<td>Kosterink 2010</td>
<td>Does not use the Internet as primary mode of delivering treatment</td>
</tr>
<tr>
<td>Krein 2010</td>
<td>Intervention has insufficient psychotherapeutic content</td>
</tr>
<tr>
<td>Kristjansdottir 2011</td>
<td>Does not use the Internet as primary mode of delivering treatment</td>
</tr>
<tr>
<td>Kristjansdottir 2013</td>
<td>Does not use the Internet as primary mode of delivering treatment</td>
</tr>
<tr>
<td>Kroenke 2010</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>Larsman 2010</td>
<td>Does not use the Internet as primary mode of delivering treatment</td>
</tr>
<tr>
<td>Leboeuf-Yde 2012</td>
<td>Not a randomised control trial</td>
</tr>
<tr>
<td>Leveille 2007</td>
<td>Not a randomised control trial</td>
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<tr>
<td>Leveille 2009</td>
<td>Intervention has insufficient psychotherapeutic content</td>
</tr>
<tr>
<td>Lorig 2002</td>
<td>Intervention has insufficient psychotherapeutic content</td>
</tr>
<tr>
<td>Lorig 2006</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>Macedo 2012</td>
<td>Does not evaluate a self-management psychological intervention</td>
</tr>
<tr>
<td>Miller 2010</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>Naylor 2008</td>
<td>Does not use the Internet as primary mode of delivering treatment</td>
</tr>
<tr>
<td>Reference</td>
<td>Comment</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Naylor 2010</td>
<td>Does not use the Internet as primary mode of delivering treatment</td>
</tr>
<tr>
<td>Oerlemans 2011</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>Premi 1993</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>Russell 2011</td>
<td>Used a non-inferiority hypothesis</td>
</tr>
<tr>
<td>Sandsjo 2010</td>
<td>Does not evaluate a self-management psychological intervention</td>
</tr>
<tr>
<td>Sciamanna 2006</td>
<td>Does not evaluate a self-management psychological intervention</td>
</tr>
<tr>
<td>Spunt 1996</td>
<td>Not a randomised control trial</td>
</tr>
<tr>
<td>Steel 2011</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>Taieb-Maimon 2012</td>
<td>Not chronic non-cancer pain</td>
</tr>
<tr>
<td>Vonk Noordegraaf 2012</td>
<td>Does not use the Internet as primary mode of delivering treatment</td>
</tr>
<tr>
<td>Weingart 2008</td>
<td>Not chronic non-cancer pain</td>
</tr>
</tbody>
</table>
## DATA AND ANALYSES

### Comparison 1. Headache post treatment

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Pain</td>
<td>2</td>
<td>131</td>
<td>Risk Ratio (M-H, Random, 95% CI)</td>
<td>7.28 [2.67, 19.84]</td>
</tr>
<tr>
<td>2 Disability</td>
<td>2</td>
<td>241</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-0.65 [-0.91, -0.39]</td>
</tr>
<tr>
<td>3 Depression</td>
<td>4</td>
<td>617</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-0.26 [-0.87, 0.36]</td>
</tr>
<tr>
<td>4 Anxiety</td>
<td>3</td>
<td>546</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-0.48 [-1.22, 0.27]</td>
</tr>
</tbody>
</table>

### Comparison 2. Headache follow-up

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Depression</td>
<td>2</td>
<td>425</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-1.03 [-3.18, 1.12]</td>
</tr>
<tr>
<td>2 Anxiety</td>
<td>2</td>
<td>425</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-0.46 [-1.09, 0.18]</td>
</tr>
</tbody>
</table>

### Comparison 3. Non-headache post treatment

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Pain</td>
<td>11</td>
<td>1785</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-0.37 [-0.59, -0.15]</td>
</tr>
<tr>
<td>2 Disability</td>
<td>5</td>
<td>1149</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-0.50 [-0.79, -0.20]</td>
</tr>
<tr>
<td>3 Depression</td>
<td>9</td>
<td>1013</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-0.19 [-0.35, -0.04]</td>
</tr>
<tr>
<td>4 Anxiety</td>
<td>10</td>
<td>1144</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-0.28 [-0.49, -0.06]</td>
</tr>
<tr>
<td>5 Quality of life</td>
<td>3</td>
<td>202</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-0.27 [-0.54, 0.01]</td>
</tr>
</tbody>
</table>

### Comparison 4. Non-headache follow-up

<table>
<thead>
<tr>
<th>Outcome or subgroup title</th>
<th>No. of studies</th>
<th>No. of participants</th>
<th>Statistical method</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Pain</td>
<td>4</td>
<td>1202</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-0.48 [-1.18, 0.22]</td>
</tr>
<tr>
<td>2 Disability</td>
<td>2</td>
<td>850</td>
<td>Std. Mean Difference (IV, Fixed, 95% CI)</td>
<td>-0.15 [-0.28, -0.01]</td>
</tr>
<tr>
<td>3 Depression</td>
<td>3</td>
<td>551</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-0.53 [-1.84, 0.78]</td>
</tr>
<tr>
<td>4 Anxiety</td>
<td>3</td>
<td>551</td>
<td>Std. Mean Difference (IV, Random, 95% CI)</td>
<td>-0.39 [-1.25, 0.47]</td>
</tr>
</tbody>
</table>
### Analysis 1.1. Comparison 1 Headache post treatment, Outcome 1 Pain.

**Review:** Psychological therapies (Internet-delivered) for the management of chronic pain in adults

**Comparison:** 1 Headache post treatment

**Outcome:** 1 Pain

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Favours Internet therapy</th>
<th>Favours Control</th>
<th>Risk Ratio M-H,Random,95% CI</th>
<th>Weight</th>
<th>Risk Ratio M-H,Random,95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>n/N</td>
<td>n/N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Devineni 2005</td>
<td>15/39</td>
<td>3/47</td>
<td>74.1 % 6.03 [ 1.88, 19.31 ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strom 2000</td>
<td>10/20</td>
<td>1/25</td>
<td>25.9 % 12.50 [ 1.74, 89.61 ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td></td>
<td>59</td>
<td>72</td>
<td>100.0 %</td>
<td>7.28 [ 2.67, 19.84 ]</td>
</tr>
</tbody>
</table>

Total events: 25 (Favours Internet therapy), 4 (Favours Control)

Heterogeneity: $\tau^2 = 0.0$, $\chi^2 = 0.40$, df = 1 ($p = 0.53$); $I^2 = 0.0$

Test for overall effect: $Z = 3.88$ ($p = 0.0001$)

Test for subgroup differences: Not applicable

### Analysis 1.2. Comparison 1 Headache post treatment, Outcome 2 Disability.

**Review:** Psychological therapies (Internet-delivered) for the management of chronic pain in adults

**Comparison:** 1 Headache post treatment

**Outcome:** 2 Disability

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Mean(SD)</td>
<td>N</td>
<td>Mean(SD)</td>
<td>IV,Random,95% CI</td>
<td>IV,Random,95% CI</td>
</tr>
<tr>
<td>Bromberg 2011</td>
<td>68 42.48 (5.08)</td>
<td>87 46.04 (4.8)</td>
<td>-0.72 [-1.05, -0.39]</td>
<td>63.5 %</td>
<td>-0.72 [-1.05, -0.39]</td>
</tr>
<tr>
<td>Devineni 2005</td>
<td>39 38 (19.5)</td>
<td>47 49.6 (23.1)</td>
<td>-0.53 [-0.97, -0.10]</td>
<td>36.5 %</td>
<td>-0.53 [-0.97, -0.10]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td>107</td>
<td>134</td>
<td>-6.5 [-0.91, -0.39]</td>
<td>100.0 %</td>
<td>-6.5 [-0.91, -0.39]</td>
</tr>
</tbody>
</table>

Heterogeneity: $\tau^2 = 0.0$, $\chi^2 = 0.45$, df = 1 ($p = 0.50$); $I^2 = 0.0$

Test for overall effect: $Z = 4.89$ ($p < 0.00001$)

Test for subgroup differences: Not applicable
### Analysis 1.3. Comparison 1 Headache post treatment, Outcome 3 Depression.

Review: Psychological therapies (Internet-delivered) for the management of chronic pain in adults

Comparison: 1 Headache post treatment

Outcome: 3 Depression

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean(SD)</td>
<td>N</td>
<td>Mean(SD)</td>
<td>IV ,Random,95% CI</td>
</tr>
<tr>
<td>Bromberg 2011</td>
<td>68</td>
<td>20.39 (0.97)</td>
<td>87</td>
<td>21.44 (0.9)</td>
<td>25.5 % -1.12 [-1.46, -0.78 ]</td>
</tr>
<tr>
<td>Devineni 2005</td>
<td>39</td>
<td>12.4 (10.7)</td>
<td>47</td>
<td>14.3 (12.1)</td>
<td>24.4 % -0.16 [-0.59, 0.26 ]</td>
</tr>
<tr>
<td>Hedborg 2011</td>
<td>46</td>
<td>7.35 (6.54)</td>
<td>25</td>
<td>5.8 (7.7)</td>
<td>23.5 % 0.22 [-0.27, 0.71 ]</td>
</tr>
<tr>
<td>Ruehlman 2012</td>
<td>162</td>
<td>22.37 (12.51)</td>
<td>143</td>
<td>21.49 (12.61)</td>
<td>26.6 % 0.07 [-0.16, 0.29 ]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>315</strong></td>
<td></td>
<td><strong>302</strong></td>
<td></td>
<td><strong>100.0 % -0.26 [-0.87, 0.36 ]</strong></td>
</tr>
</tbody>
</table>

Heterogeneity: Tau^2 = 0.35; Chi^2 = 36.35, df = 3 (P<0.00001); I^2 =92%

Test for overall effect: Z = 0.82 (P = 0.41)

Test for subgroup differences: Not applicable
### Analysis 1.4. Comparison 1 Headache post treatment, Outcome 4 Anxiety.

Review: Psychological therapies (Internet-delivered) for the management of chronic pain in adults

Comparison: 1 Headache post treatment

Outcome: 4 Anxiety

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Mean(SD)</td>
<td>N Mean(SD)</td>
<td>IV(Random,95% CI)</td>
<td>IV(Random,95% CI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bromberg 2011</td>
<td>68 18.89 (0.8)</td>
<td>87 19.85 (0.76)</td>
<td>-1.23 [-1.57, -0.88]</td>
<td>33.2 %</td>
<td></td>
</tr>
<tr>
<td>Devinini 2005</td>
<td>39 18.4 (15.7)</td>
<td>47 20.8 (17.2)</td>
<td>-0.14 [-0.57, 0.28]</td>
<td>32.1 %</td>
<td></td>
</tr>
<tr>
<td>Ruehlman 2012</td>
<td>162 4.5 (4.62)</td>
<td>143 4.82 (4.74)</td>
<td>-0.07 [-0.29, 0.16]</td>
<td>34.7 %</td>
<td></td>
</tr>
</tbody>
</table>

**Total (95% CI)**

-2 -1 0 1 2

-2 -1 0 1 2

<table>
<thead>
<tr>
<th>Favours Internet therapy</th>
<th>Favours control</th>
</tr>
</thead>
</table>

Heterogeneity: $\tau^2 = 0.40; \chi^2 = 31.61, \text{df} = 2 (P<0.00001); I^2 = 94\%$

Test for overall effect: $Z = 1.26 (P = 0.21)$

Test for subgroup differences: Not applicable

### Analysis 2.1. Comparison 2 Headache follow-up, Outcome 1 Depression.

Review: Psychological therapies (Internet-delivered) for the management of chronic pain in adults

Comparison: 2 Headache follow-up

Outcome: 1 Depression

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Mean(SD)</td>
<td>N Mean(SD)</td>
<td>IV(Random,95% CI)</td>
<td>IV(Random,95% CI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bromberg 2011</td>
<td>46 19.67 (1.21)</td>
<td>74 22.03 (1.02)</td>
<td>-2.14 [-2.60, -1.68]</td>
<td>49.6 %</td>
<td></td>
</tr>
<tr>
<td>Ruehlman 2012</td>
<td>162 21.98 (12.45)</td>
<td>143 21.25 (14.36)</td>
<td>0.05 [-0.17, 0.28]</td>
<td>50.4 %</td>
<td></td>
</tr>
</tbody>
</table>

**Total (95% CI)**

-2 -1 0 1 2

-4 -2 0 2 4

<table>
<thead>
<tr>
<th>Favours Internet therapy</th>
<th>Favours control</th>
</tr>
</thead>
</table>

Heterogeneity: $\tau^2 = 2.37; \chi^2 = 70.61, \text{df} = 1 (P<0.00001); I^2 = 99\%$

Test for overall effect: $Z = 0.94 (P = 0.35)$

Test for subgroup differences: Not applicable
Analysis 2.2. Comparison 2 Headache follow-up, Outcome 2 Anxiety.

Review: Psychological therapies (Internet-delivered) for the management of chronic pain in adults

Comparison: 2 Headache follow-up

Outcome: 2 Anxiety

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Mean(SD)</td>
<td>N</td>
<td>Mean(SD)</td>
<td>IV(Random,95% CI)</td>
<td>IV(Random,95% CI)</td>
</tr>
<tr>
<td>Bromberg 2011</td>
<td>46</td>
<td>18.66 (0.99)</td>
<td>74</td>
<td>19.39 (0.85)</td>
<td>-0.80 [-1.18, -0.42]</td>
</tr>
<tr>
<td>Ruehlman 2012</td>
<td>162</td>
<td>4.26 (4.08)</td>
<td>143</td>
<td>4.93 (4.67)</td>
<td>-0.15 [-0.38, 0.07]</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>208</td>
<td>217</td>
<td>100.0%</td>
<td>-0.46 [-1.09, 0.18]</td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: Tau^2 = 0.18; Chi^2 = 8.19, df = 1 (P = 0.004); I^2 = 88%
Test for overall effect: Z = 1.42 (P = 0.16)
Test for subgroup differences: Not applicable

-2 -1 0 1 2
Favours Internet therapy Favours control
## Analysis 3.1. Comparison 3 Non-headache post treatment, Outcome 1 Pain.

Review: Psychological therapies (Internet-delivered) for the management of chronic pain in adults

Comparison: 3 Non-headache post treatment

Outcome: 1 Pain

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean(SD)</td>
<td>N</td>
<td>Mean(SD)</td>
<td>IV,Random,95% CI</td>
</tr>
<tr>
<td>Berman 2009</td>
<td>41</td>
<td>3.68 (2)</td>
<td>37</td>
<td>4.02 (1.81)</td>
<td>8.4 % -0.18 [ -0.62, 0.27 ]</td>
</tr>
<tr>
<td>Buhrman 2004</td>
<td>22</td>
<td>2.4 (1.1)</td>
<td>29</td>
<td>3.2 (0.8)</td>
<td>6.8 % -0.84 [ -1.42, -0.26 ]</td>
</tr>
<tr>
<td>Buhrman 2011</td>
<td>26</td>
<td>3.15 (2.2)</td>
<td>28</td>
<td>3.35 (2.6)</td>
<td>7.3 % -0.08 [ -0.62, 0.45 ]</td>
</tr>
<tr>
<td>Buhrman 2013</td>
<td>36</td>
<td>3.72 (1.1)</td>
<td>36</td>
<td>4.18 (1.21)</td>
<td>8.2 % -0.39 [ -0.86, 0.07 ]</td>
</tr>
<tr>
<td>Buhrman 2013a</td>
<td>38</td>
<td>4.3 (1.04)</td>
<td>38</td>
<td>4.29 (1)</td>
<td>8.4 % 0.01 [ -0.44, 0.46 ]</td>
</tr>
<tr>
<td>Carpenter 2012</td>
<td>63</td>
<td>5.2 (1.5)</td>
<td>68</td>
<td>5.7 (1.7)</td>
<td>9.8 % -0.31 [ -0.65, 0.04 ]</td>
</tr>
<tr>
<td>Chiauzzi 2010</td>
<td>95</td>
<td>5.13 (0.2)</td>
<td>104</td>
<td>5.35 (0.19)</td>
<td>10.4 % -1.12 [ -1.42, -0.83 ]</td>
</tr>
<tr>
<td>Dear 2013</td>
<td>30</td>
<td>4.68 (1.7)</td>
<td>30</td>
<td>5.81 (1.85)</td>
<td>7.5 % -0.63 [ -1.15, -0.11 ]</td>
</tr>
<tr>
<td>Lorig 2008</td>
<td>310</td>
<td>5.86 (2.44)</td>
<td>331</td>
<td>6.34 (2.31)</td>
<td>12.2 % -0.20 [ -0.36, -0.05 ]</td>
</tr>
<tr>
<td>Ruehlman 2012</td>
<td>162</td>
<td>22.75 (4.14)</td>
<td>143</td>
<td>22.93 (4.25)</td>
<td>11.4 % -0.04 [ -0.27, 0.18 ]</td>
</tr>
<tr>
<td>Williams 2010</td>
<td>59</td>
<td>4.3 (1.6)</td>
<td>59</td>
<td>4.9 (1.5)</td>
<td>9.5 % -0.38 [ -0.75, -0.02 ]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>882</strong></td>
<td></td>
<td><strong>903</strong></td>
<td></td>
<td><strong>100.0 % -0.37 [ -0.59, -0.15 ]</strong></td>
</tr>
</tbody>
</table>

Heterogeneity: Tau² = 0.10; Chi² = 43.57, df = 10 (P<0.00001); I² = 77%

Test for overall effect: Z = 3.32 (P = 0.00091)

Test for subgroup differences: Not applicable

---

Favours Internet therapy | Favours control
---

-2 | -1 | 0 | 1 | 2

---

*Psychological therapies (Internet-delivered) for the management of chronic pain in adults (Review)*

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Analysis 3.2. Comparison 3 Non-headache post treatment, Outcome 2 Disability.

Review: Psychological therapies (Internet-delivered) for the management of chronic pain in adults

Comparison: 3 Non-headache post treatment

Outcome: 2 Disability

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean(SD)</td>
<td>N</td>
<td>Mean(SD)</td>
<td>IV,Random,95% CI</td>
</tr>
<tr>
<td>Carpenter 2012</td>
<td>63</td>
<td>13.5 (5.8)</td>
<td>68</td>
<td>16.3 (5.2)</td>
<td>-0.51 [-0.85, -0.16]</td>
</tr>
<tr>
<td>Chiauzzi 2010</td>
<td>95</td>
<td>42.62 (1.88)</td>
<td>104</td>
<td>44.09 (1.72)</td>
<td>-0.81 [-1.10, -0.52]</td>
</tr>
<tr>
<td>Dear 2013</td>
<td>30</td>
<td>10.1 (5.23)</td>
<td>30</td>
<td>14.77 (5.33)</td>
<td>-0.87 [-1.40, -0.34]</td>
</tr>
<tr>
<td>Lorig 2008</td>
<td>310</td>
<td>1.97 (1.32)</td>
<td>331</td>
<td>2.19 (1.07)</td>
<td>-0.18 [-0.34, -0.03]</td>
</tr>
<tr>
<td>Williams 2010</td>
<td>59</td>
<td>58.9 (8.7)</td>
<td>59</td>
<td>61.1 (8.6)</td>
<td>-0.25 [-0.62, 0.11]</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>557</strong></td>
<td><strong>592</strong></td>
<td></td>
<td></td>
<td><strong>100.0 %</strong></td>
</tr>
</tbody>
</table>

Heterogeneity: Tau² = 0.09; Chi² = 19.01, df = 4 (P = 0.00078); I² = 79%
Test for overall effect: Z = 3.26 (P = 0.0011)
Test for subgroup differences: Not applicable
### Analysis 3.3. Comparison 3 Non-headache post treatment, Outcome 3 Depression.

**Review:** Psychological therapies (Internet-delivered) for the management of chronic pain in adults

**Comparison:** 3 Non-headache post treatment

**Outcome:** 3 Depression

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Stat. Mean Difference</th>
<th>Weight</th>
<th>Stat. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean(SD)</td>
<td>N</td>
<td>Mean(SD)</td>
<td>IV,Random,95% CI</td>
</tr>
<tr>
<td>Berman 2009</td>
<td>41</td>
<td>8.56 (6.53)</td>
<td>37</td>
<td>10.07 (6.36)</td>
<td>9.3 %</td>
</tr>
<tr>
<td>Buhrman 2004</td>
<td>22</td>
<td>6 (4.7)</td>
<td>29</td>
<td>5.4 (4)</td>
<td>6.6 %</td>
</tr>
<tr>
<td>Buhrman 2011</td>
<td>26</td>
<td>4.9 (3.6)</td>
<td>28</td>
<td>6.3 (5.2)</td>
<td>6.9 %</td>
</tr>
<tr>
<td>Buhrman 2013</td>
<td>36</td>
<td>6.95 (4.07)</td>
<td>36</td>
<td>8.19 (3.68)</td>
<td>8.8 %</td>
</tr>
<tr>
<td>Buhrman 2013a</td>
<td>38</td>
<td>8.85 (4.4)</td>
<td>38</td>
<td>10.52 (3.77)</td>
<td>9.1 %</td>
</tr>
<tr>
<td>Chiauzzi 2010</td>
<td>95</td>
<td>11.15 (1.08)</td>
<td>104</td>
<td>11.44 (0.98)</td>
<td>17.5 %</td>
</tr>
<tr>
<td>Dear 2013</td>
<td>30</td>
<td>7.55 (5.54)</td>
<td>30</td>
<td>11.32 (5.93)</td>
<td>7.3 %</td>
</tr>
<tr>
<td>Ruehlman 2012</td>
<td>162</td>
<td>22.37 (12.51)</td>
<td>143</td>
<td>21.49 (12.61)</td>
<td>21.8 %</td>
</tr>
<tr>
<td>Williams 2010</td>
<td>59</td>
<td>16.4 (11.9)</td>
<td>59</td>
<td>17.5 (11.5)</td>
<td>12.7 %</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>509</strong></td>
<td><strong>504</strong></td>
<td><strong>100.0 %</strong></td>
<td><strong>-0.19 [-0.35, -0.04 ]</strong></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: Tau^2 = 0.02; Chi^2 = 11.27, df = 8 (P = 0.19); I^2 = 29%

Test for overall effect: Z = 2.41 (P = 0.016)

Test for subgroup differences: Not applicable
Analysis 3.4. Comparison 3 Non-headache post treatment, Outcome 4 Anxiety.

Review: Psychological therapies (Internet-delivered) for the management of chronic pain in adults

Comparison: 3 Non-headache post treatment

Outcome: 4 Anxiety

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean(SD)</td>
<td>N</td>
<td>Mean(SD)</td>
<td>IV,Random,95% CI</td>
</tr>
<tr>
<td>Berman 2009</td>
<td>41</td>
<td>10.9 (4.77)</td>
<td>37</td>
<td>11.32 (3.88)</td>
<td>9.5 %</td>
</tr>
<tr>
<td>Buhrman 2004</td>
<td>22</td>
<td>7.2 (4)</td>
<td>29</td>
<td>6 (3.3)</td>
<td>7.6 %</td>
</tr>
<tr>
<td>Buhrman 2011</td>
<td>26</td>
<td>5.8 (3.5)</td>
<td>28</td>
<td>7 (6)</td>
<td>8.0 %</td>
</tr>
<tr>
<td>Buhrman 2013</td>
<td>36</td>
<td>7.24 (3.93)</td>
<td>36</td>
<td>9.11 (4.36)</td>
<td>9.1 %</td>
</tr>
<tr>
<td>Buhrman 2013a</td>
<td>38</td>
<td>8.97 (4.33)</td>
<td>38</td>
<td>9.67 (3.5)</td>
<td>9.3 %</td>
</tr>
<tr>
<td>Carpenter 2012</td>
<td>63</td>
<td>1.23 (0.86)</td>
<td>68</td>
<td>1.85 (0.9)</td>
<td>11.1 %</td>
</tr>
<tr>
<td>Chiauzzi 2010</td>
<td>95</td>
<td>7.72 (0.98)</td>
<td>104</td>
<td>8.42 (0.89)</td>
<td>12.4 %</td>
</tr>
<tr>
<td>Dear 2013</td>
<td>30</td>
<td>7.23 (4.76)</td>
<td>30</td>
<td>9.03 (4.78)</td>
<td>8.4 %</td>
</tr>
<tr>
<td>Ruehlman 2012</td>
<td>162</td>
<td>4.5 (4.62)</td>
<td>143</td>
<td>4.82 (4.74)</td>
<td>13.6 %</td>
</tr>
<tr>
<td>Williams 2010</td>
<td>59</td>
<td>18.1 (7.1)</td>
<td>59</td>
<td>18.4 (5.9)</td>
<td>11.0 %</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>572</strong></td>
<td><strong>572</strong></td>
<td></td>
<td></td>
<td><strong>100.0 %</strong></td>
</tr>
</tbody>
</table>

Heterogeneity: Tau² = 0.07; Chi² = 26.55, df = 9 (P = 0.002); I² =66%
Test for overall effect: Z = 2.54 (P = 0.011)
Test for subgroup differences: Not applicable
Analysis 3.5. Comparison 3 Non-headache post treatment, Outcome 5 Quality of life.

Review: Psychological therapies (Internet-delivered) for the management of chronic pain in adults

Comparison: 3 Non-headache post treatment

Outcome: 5 Quality of life

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buhrman 2011</td>
<td>26 -1.7 (1.4)</td>
<td>28 -1.1 (1.6)</td>
<td>-0.39 [-0.93, 0.15]</td>
<td>26.5 %</td>
<td>IV,Random,95% CI</td>
</tr>
<tr>
<td>Buhrman 2013</td>
<td>36 -1.3 (2.07)</td>
<td>36 -0.61 (1.65)</td>
<td>-0.36 [-0.83, 0.10]</td>
<td>35.5 %</td>
<td>IV,Random,95% CI</td>
</tr>
<tr>
<td>Buhrman 2013a</td>
<td>38 -0.56 (2.07)</td>
<td>38 -0.39 (1.77)</td>
<td>-0.09 [-0.54, 0.36]</td>
<td>38.1 %</td>
<td>IV,Random,95% CI</td>
</tr>
<tr>
<td><strong>Total (95% CI)</strong></td>
<td><strong>100</strong></td>
<td><strong>102</strong></td>
<td><strong>-0.27 [-0.54, 0.01]</strong></td>
<td><strong>100.0 %</strong></td>
<td>IV,Random,95% CI</td>
</tr>
</tbody>
</table>

Heterogeneity: $\tau^2 = 0.0$; $\chi^2 = 0.99$, df = 2 ($P = 0.61$); $I^2 = 0.0\%$

Test for overall effect: $Z = 1.88$ ($P = 0.060$)

Test for subgroup differences: Not applicable

---

Psychological therapies (Internet-delivered) for the management of chronic pain in adults (Review)

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Analysis 4.1. Comparison 4 Non-headache follow-up, Outcome 1 Pain.

Review: Psychological therapies (Internet-delivered) for the management of chronic pain in adults

Comparison: 4 Non-headache follow-up

Outcome: 1 Pain

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buhrman 2004</td>
<td>21</td>
<td>26</td>
<td>-0.08 [-0.65, 0.50]</td>
<td>22.6%</td>
<td></td>
</tr>
<tr>
<td>Chiauzzi 2010</td>
<td>95</td>
<td>104</td>
<td>-1.70 [-2.02, -1.37]</td>
<td>25.2%</td>
<td></td>
</tr>
<tr>
<td>Lorig 2008</td>
<td>307</td>
<td>344</td>
<td>-0.14 [-0.29, 0.02]</td>
<td>26.3%</td>
<td></td>
</tr>
<tr>
<td>Ruehlman 2012</td>
<td>162</td>
<td>143</td>
<td>0.02 [-0.21, 0.24]</td>
<td>25.9%</td>
<td></td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>585</td>
<td>617</td>
<td>-0.48 [-1.18, 0.22]</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: Tau² = 0.48; Chi² = 83.42, df = 3 (P<0.00001); I² = 96%
Test for overall effect: Z = 1.34 (P = 0.18)
Test for subgroup differences: Not applicable
Analysis 4.2. Comparison 4 Non-headache follow-up, Outcome 2 Disability.

Review: Psychological therapies (Internet-delivered) for the management of chronic pain in adults

Comparison: 4 Non-headache follow-up

Outcome: 2 Disability

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N  Mean(SD)</td>
<td>N  Mean(SD)</td>
<td>IV,Fixed,95% CI</td>
<td>IV,Fixed,95% CI</td>
<td></td>
</tr>
<tr>
<td>Chiauzzi 2010</td>
<td>95  44.51 (2.08)</td>
<td>104 44.53 (1.87)</td>
<td>23.5 % -0.01 [ -0.29, 0.27 ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long 2008</td>
<td>307 1.9 (1.15)</td>
<td>344 2.11 (1.04)</td>
<td>76.5 % -0.19 [ -0.35, -0.04 ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>402</td>
<td>448</td>
<td>100.0 % -0.15 [ -0.28, -0.01 ]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: Chi² = 1.25, df = 1 (P = 0.26); I² =20%
Test for overall effect: Z = 2.17 (P = 0.030)
Test for subgroup differences: Not applicable

-2 -1 0 1 2
Favours Internet therapy Favours control

Analysis 4.3. Comparison 4 Non-headache follow-up, Outcome 3 Depression.

Review: Psychological therapies (Internet-delivered) for the management of chronic pain in adults

Comparison: 4 Non-headache follow-up

Outcome: 3 Depression

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N  Mean(SD)</td>
<td>N  Mean(SD)</td>
<td>IV,Random,95% CI</td>
<td>IV,Random,95% CI</td>
<td></td>
</tr>
<tr>
<td>Buhrman 2004</td>
<td>21  5.3 (3.2)</td>
<td>26 4.8 (3.4)</td>
<td>32.3 % 0.15 [ -0.43, 0.72 ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiauzzi 2010</td>
<td>95 10.55 (1.24)</td>
<td>104 12.65 (1.12)</td>
<td>33.7 % -1.77 [ -2.10, -1.45 ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ruehlman 2012</td>
<td>162 21.98 (12.45)</td>
<td>143 21.25 (14.36)</td>
<td>34.1 % 0.05 [ -0.17, 0.28 ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>278</td>
<td>273</td>
<td>100.0 % -0.53 [ -1.84, 0.78 ]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: Tau² = 1.29; Chi² = 85.64, df = 2 (P<0.00001); I² =98%
Test for overall effect: Z = 0.80 (P = 0.43)
Test for subgroup differences: Not applicable

-2 -1 0 1 2
Favours Internet therapy Favours control
### Analysis 4.4. Comparison 4 Non-headache follow-up, Outcome 4 Anxiety.

Review: Psychological therapies (Internet-delivered) for the management of chronic pain in adults

Comparison: 4 Non-headache follow-up

Outcome: 4 Anxiety

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Experimental</th>
<th>Control</th>
<th>Std. Mean Difference</th>
<th>Weight</th>
<th>Std. Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>N</td>
<td></td>
<td>IV,Random,95% CI</td>
<td></td>
<td>IV,Random,95% CI</td>
</tr>
<tr>
<td>Buhrman 2004</td>
<td>21</td>
<td>26</td>
<td>30.8 %</td>
<td>0.30</td>
<td>[ -0.28, 0.88 ]</td>
</tr>
<tr>
<td>Chiauzzi 2010</td>
<td>95</td>
<td>104</td>
<td>34.3 %</td>
<td>-1.25</td>
<td>[ -1.55, -0.94 ]</td>
</tr>
<tr>
<td>Ruehlman 2012</td>
<td>162</td>
<td>143</td>
<td>34.9 %</td>
<td>-0.15</td>
<td>[ -0.38, 0.07 ]</td>
</tr>
<tr>
<td>Total (95% CI)</td>
<td>278</td>
<td>273</td>
<td>100.0 %</td>
<td>-0.39</td>
<td>[ -1.25, 0.47 ]</td>
</tr>
</tbody>
</table>

Heterogeneity: $\tau^2 = 0.54; \chi^2 = 39.38, df = 2 (P<0.00001); I^2 = 95\%$

Test for overall effect: $Z = 0.89 (P = 0.38)$

Test for subgroup differences: Not applicable

### APPENDICES

#### Appendix 1. Search strategies

**CENTRAL search strategy**

1. MeSH descriptor: [Telecommunications] explode all trees
2. (telemedicine or tele-medicine)
3. (telehealth or tele-health)
4. (ehealth or e-health)
5. (mobile health or mhealth or m-health)
6. ICT
7. ((inform* or communicat* or interact*) near/6 (computer* or technolog* or software))
8. (health* or treat* or therap* or intervention* or assist* or selfmanag* or self-manag*) near/6 (computer* or technolog* or software)
9. MeSH descriptor: [Internet] explode all trees

---

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MEDLINE search strategy
1 exp Telecommunications/
2 (telemedicine or tele-medicine).mp.
3 (telehealth or tele-health).mp.
4 (health or e-health).mp.
5 (mobile health or mhealth or m-health).mp.
6 ICT.mp.
7 ((inform* or communicat* or interact*) adj6 (computer* or technolog* or software)).mp.
8 ((health* or treat* or therap* or intervention* or assist* or selfmanag* or self-manag*) adj6 (computer* or technolog* or software)).mp.
9 exp Internet/
10 (internet* or world wide web or www or web-based or email or e-mail or online).mp.
11 (telephone* or phone* or mobile* or cellphone* or apps or text* or SMS or smartphone*).mp.
12 (virtual reality or augmented reality or VR or AR).mp.
13 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12
14 exp Pain/
15 Pain Measurement/
16 exp Headache Disorders/
17 Fibromyalgia/
18 (pain* or headache* or migraine* or fibromyalgia* or neuralgia*).mp
19 14 or 15 or 16 or 17 or 18
20 randomized controlled trial.pt.
21 controlled clinical trial.pt.
22 randomized.ab.
23 placebo.ab.
24 clinical trials as topic.sh.
25 randomly.ab.
26 trial.ti.
27 20 or 21 or 22 or 23 or 24 or 25 or 26
28 13 and 19 and 27

Key:
mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier
ab=abstract
ti=title
pt=publication type
sh=subject heading

EMBASE (OVID) search strategy
1 exp Telecommunications/
2 (telemedicine or tele-medicine).tw.
3 (telehealth or tele-health).tw.
4 (health or e-health).tw.
5 (mobile health or mhealth or m-health).tw.
Psychological therapies (Internet-delivered) for the management of chronic pain in adults (Review)

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CONTRIBUTIONS OF AUTHORS

CE conceived the idea, and led the design and delivery of the review, and contributed to the writing. CE, EF, LC, GBD, BAR and EK contributed to the design and writing of the protocol. CE, GBD, EF and LC selected studies for inclusion. EF and LC extracted data and assessed risk of bias. CE, EF and LC analysed data. EK contributed to writing and oversaw the review process.

DECLARATIONS OF INTEREST

None known.

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- No sources of support supplied

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D I F F E R E N C E S  B E T W E E N  P R O T O C O L  A N D  R E V I E W

There are no differences between the protocol and the review.