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A Review of the Clinical Utility and Psychometric Properties of the Pain Self-Efficacy Questionnaire (PSEQ): Norms, Percentile Rankings, and Qualitative Descriptors

The Pain Self-Efficacy Questionnaire (PSEQ) is a 10-item self-report measure designed to assess the confidence individuals with chronic pain have in performing daily activities despite their pain. Originally developed by Nicholas (2007), the PSEQ has since become one of the most widely used and validated tools for evaluating pain-related self-efficacy. The questionnaire has demonstrated strong psychometric properties, including high internal consistency, test–retest reliability, and cross-cultural validity across multiple translations. Normative data provide percentile rankings that support meaningful clinical interpretation. The descriptive thresholds were drawn from several studies focusing on populations with chronic pain, offering evidence-based guidelines for treatment planning and monitoring. This technical paper reviews the clinical utility, psychometric evidence, and scoring methodology of the PSEQ, providing updated interpretative guidelines and practical resources for clinicians and researchers.

Click to view information on the PSEQ

September 2025

Developer & Author

The Pain self-efficacy questionnaire (PSEQ) was developed by Nicholas, M. K. (2007):

> Nicholas, M.K. (2007), The pain self-efficacy questionnaire: Taking pain into account. European Journal of Pain, 11: 153-163. https://doi.org/10.1016/j.ejpain.2005.12.008

This document was developed by NovoPsych to review contemporary literature and to describe original scoring methodologies and to provide interpretation material, enhance normative data and provide qualitative descriptors.

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Description

The Pain Self-Efficacy Questionnaire (PSEQ) is a 10-item questionnaire developed to assess the confidence people aged 18+ with ongoing pain have in performing activities while in pain (Nicholas, 2007). The PSEQ is applicable to all persisting pain presentations. It enquires into the level of self-efficacy regarding a range of functions, including household chores, socialising, work, as well as coping with pain without medication and is helpful in assessing the impact that pain is having on a respondent's life. Rather than relying on estimates of pain intensity alone, the scale can be helpful in developing a formulation around psychological factors that influence someone's response to injury or unpleasant physical sensations.

For clinicians, the PSEQ offers several practical advantages. It assists in screening and case formulation by highlighting the psychological factors that shape how patients respond to injury or unpleasant physical sensations, rather than relying on pain intensity ratings alone. The PSEQ can guide intervention selection and treatment planning, identifying patients who may benefit from targeted psychological support, pain education, or specific self-efficacy–building strategies. Additionally, the scale shows strong correlations with functional measures and is strongly associated with disability levels, demonstrating sensitivity to change following pain management interventions and programs (Nicholas, 2007; Williams et al., 1993). This is valuable for identifying patients at risk of poor outcomes or treatment dropout, and for gauging readiness for activity-based programs. As an outcome measure, the scale's sensitivity to change makes it valuable for monitoring progress over time and evaluating treatment effectiveness.

In essence, the PSEQ represents a brief yet comprehensive measure that captures patients' confidence in their ability to function despite pain—providing clinicians with essential information to guide treatment decisions, optimise intervention timing, and ultimately improve outcomes for individuals living with chronic pain conditions.

Psychometric Properties

The Pain Self-Efficacy Questionnaire (PSEQ) was developed by Nicholas (2007) using items adapted from the Pain Beliefs Questionnaire (Gottlieb, 1984) and informed by clinical experience with patients living with chronic pain. Initial psychometric evaluation was conducted with 103 patients undergoing a pain management program for chronic back pain at Westmead Hospital, Sydney. Test–retest reliability over a three-month interval produced a correlation of .73 ($p < .001$). Subsequent confirmatory analyses with a larger sample of 1,300 patients from the Royal North Shore Hospital pain clinic demonstrated strong internal consistency with a Cronbach's α of .93. Translations of the PSEQ into eight languages have also yielded comparably high reliability coefficients, maintaining Cronbach's α values around .92 (Asghari et al., 2001; Dubé et al., 2021).

Validity testing established strong associations with relevant clinical measures. Scores on the PSEQ were negatively correlated with the Beck Depression Inventory (BDI), with higher self-efficacy linked to lower depressive symptomatology ($r = –.59$, $p < .001$). Similar negative correlations were observed with the Pain Beliefs Questionnaire ($r = –.74$, $p < .001$), reflecting fewer maladaptive pain beliefs among individuals with greater pain self-efficacy. Positive correlations with adaptive coping strategies measured by the Coping Strategies Questionnaire (CSQ) provided further evidence of convergent validity, while higher scores on maladaptive CSQ subscales correlated with lower pain self-efficacy scores, supporting divergent validity.

Factor analysis confirmed a unidimensional structure accounting for 60.9% of variance (Nicholas, 2007). This single-factor solution has been consistently replicated across translations (Asghari et al., 2001; Van Der Maas et al., 2012) and across different pain conditions, including musculoskeletal, neck, and upper limb pain (Dubé et al., 2021). All items demonstrated high factor loadings, with Item 7 ("I can cope with my pain without medication") showing the lowest at .64. Despite this, the item exceeds the recommended minimum threshold of .30 and was retained due to its clinical importance, particularly in assessing reliance on pharmacological pain management.

Scores can be presented as percentiles derived from a comprehensive normative sample of 13,343 chronic pain patients from 36 pain clinics across Australia and New Zealand (Nicholas et al., 2019). This updated normative dataset represents the largest and most geographically diverse sample available for the PSEQ, with a mean PSEQ score of 20.7 (SD = 13.3). Percentiles help contextualise individual scores by comparing them to the typical range of experience among other chronic pain patients.

For clinical interpretation, these normative thresholds guide decision-making regarding treatment planning and monitoring. A total score of approximately 40 corresponds to the 90th percentile and indicates high pain self-efficacy, with individuals at this level typically resuming work and daily activities with minimal disruption from pain. Among injured workers, research suggests that pain self-efficacy scores of around 40 are associated with return to work and maintenance of functional gains, while lower scores tend to predict less sustainable outcomes (Adams & Williams, 2003; Coughlan et al., 1995). A score of approximately 29, corresponding to the 75th percentile, reflects moderate pain self-efficacy and is not consistently predictive of either return to or avoidance of work and activity. Scores of approximately 19, at the 50th percentile, represent average self-efficacy among chronic pain patients but still indicate substantial functional limitations. Scores around 10, at the 25th percentile, suggest very low self-efficacy and indicate the need for intensive intervention or comprehensive review of current management strategies (Coughlan et al., 1995).

Recent research has established that PSEQ scores below 22 are associated with twice the likelihood of daily opioid use in chronic pain patients, making this threshold (approximately 55th percentile) useful for identifying individuals who may benefit from targeted self-efficacy interventions before or alongside pharmacological treatments (Mo et al., 2023). This relationship between the PSEQ and pharmacological reliance is further supported by responses to Item 7, where lower scores correlate with higher doses of pain medication (Ralphs et al., 1994).

Scoring & Interpretation

In the Pain Self-Efficacy Questionnaire (PSEQ), self-efficacy is measured by a total score that can range from 0 (no self-efficacy) to 60 (complete self-efficacy). So higher scores on the PSEQ are indicative of more self-efficacy. Outcome can also be presented as percentiles to help contextualise scores in comparison to the typical range of experience of others experiencing pain. For example, a percentile of 50 represents average self-efficacy among chronic pain patients, corresponding to a raw score of approximately 19:

- Very Low Self- Efficacy (score of 0-4): 0.1 - 10th Percentile
- Low Self-Efficacy (score of 5-17): 12th: 45th percentile
- Moderate Self-Efficacy (score of 18-29): 48th - 75th percentile
- High Self-Efficacy (score of 30-39): 77th - 89th percentile
- Very High Self-Efficacy (score of 40-60): 90th-99.99th percentile

Among injured workers, research suggests that scores around the scores around 40 are associated with return to work and maintenance of functional gains, whilst lower scores tend to predict less sustainable gains (Adams and Williams, 2003) and are non-indicative of the individual returning to work (Coughlan et al., ,1995). Recent research has established that PSEQ scores below 22 are associated with twice the likelihood of daily opioid use in chronic pain patients, making this threshold (approximately 55th percentile) useful for identifying individuals who may benefit from targeted self-efficacy interventions before or alongside pharmacological treatments (Mo et al., 2023). The relation between the PSEQ and pharmacological reliance can also be supported with the response to item 7 (Ralph et al., 1994), where lower scores on this item correlate with higher doses of pain medication.

When multiple timepoints are available, changes in pain self-efficacy can be evaluated to determine significant change in pain self-efficacy. While the PSEQ lacks an established change threshold for general chronic pain populations, clinicians can combine empirical methods with clinical judgment to interpret meaningful change. The minimally important difference (a 0.5 standard deviation change) has demonstrated utility for assessing clinically significant

change across health-related scales (Norman et al., 2003; Turner et al., 2010). Applying this approach to the PSEQ, with a normative standard deviation of 13.3 (Nicholas et al., 2019), yields a meaningful change threshold of 6.65 points. An increase of 6.65 points or greater indicates clinically significant improvement in pain self-efficacy, while a decrease of 6.65 points or more suggests clinically significant decline. Changes less than 6.65 points in either direction represent non-significant variation that may reflect normal fluctuation rather than meaningful change. This threshold provides a standardised approach for interpreting PSEQ change scores while acknowledging that clinical context and individual patient factors should inform final interpretation of treatment response.

With multiple administrations, a line chart will be produced to observe progress of the client over time. The graph includes percentile-based threshold lines marking the boundaries between interpretive categories (very low, low, moderate, high, and very high self-efficacy) to provide visual context for score changes. These visual markers enhance interpretation by showing not only the magnitude of change but also the clinical significance of movement between functional categories over the course of treatment.

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Supporting Information

Percentile Calculations

Scores for percentiles in increments of 5 were taken from Nicholas et al. (2019). Using linear interpolation, a full percentile table was calculated to take into account the skewed nature of the distribution given by Nicholas et al., (2019). Descriptives thresholds were drawn from Nicholas (2007) and Nicholas et al., (2019), with the exception of the "very low" range, which was added to divide the bottom 50% of the scores, providing clinicians to separate the clients with extremely low scores (below the 20th percentile)

Percentile Table

Score	Percentile	Description
0	0.5	Very Low
1	2	
2	5	
3	8	
17	45	
5	12	Low
6	15	
7	18	
8	20	
9	22	
10	25	
11	28	
12	30	
13	32	
14	35	
15	40	
16	43	
17	45	
18	48	Moderate
19	50	
20	52	
21	55	
22	58	
23	60	
24	62	
25	65	
26	68	
27	70	
28	73	
29	75	

Score	Percentile	Description
30	77	High
31	79	
32	80	
33	81	
34	83	
35	84	
36	85	
37	87	
38	88	
39	89	
40	90	Very High
41	91	
42	92	
43	93	
44	93.5	
45	94	
46	95	
47	96	
48	97	
49	98	
50	98.5	
51	99	
52+	> 99	

Interpretive Text

The interpretative text report for the Pain Self-Efficacy Questionnaire (PSEQ) is constructed from components based on established norms and translated to be of relevance in a clinical context. The first administration will provide a baseline score for the client with a brief description of what the score may mean to the client:

"The Pain Self-Efficacy Questionnaire (PSEQ) was administered on [date administered]. The client obtained a total score of [total score] out of a possible 60, which falls at the [percentile] percentile. This score falls within the [descriptive] range. This suggests that the client [interpretation text related to descriptor]

Interpretation text is chosen based on the descriptor categories as follows:

- Very low (raw score of 0-4) - "has very high pain self-efficacy, indicating exceptional confidence and ability to function despite pain. Individuals in this range may demonstrate strong psychological resources 'and effective pain management strategies across all assessed domains."

- Low pain self-efficacy (score of 5-17): "has high pain self-efficacy, reflecting above-average confidence in managing activities despite pain. Individuals in this range may demonstrate strong coping abilities and maintain good functional capacity across most life domains"

- Moderate pain self-efficacy (score of 18-30): "has moderate pain self-efficacy, indicating average confidence levels compared to other chronic pain patients. Individuals in this range may demonstrate reasonable ability to manage some activities despite pain but may have specific areas of limitation or inconsistency."

- High pain self-efficacy (score of 31-39): "has high pain self-efficacy, reflecting above-average confidence in managing activities despite pain. Individuals in this range may demonstrate strong coping abilities and maintain good functional capacity across most life domains"

- Very high pain self-efficacy (score of 40-60): "has very high pain self-efficacy, indicating exceptional confidence and ability to function despite pain. Individuals in this range may demonstrate strong psychological resources and effective pain management strategies across all assessed domains."

The client's response to item 7 (I can cope with my pain without medication) has been shown to have clinical significance as it indicates the use of pharmacological pain management, and also correlates with dosage levels of analgesics used to manage pain. If the client indicates a low confidence (0 - 1) or a high confidence (5 - 6) in their ability to manage their pain without pharmacological intervention, the report will provide further interpretative text as follows:

- Low confidence item 7 (0-1): "Notably, the client indicated low confidence in managing their pain without medication (question 7), suggesting potential reliance on pharmacological interventions and possible need for developing alternative coping strategies."

- High confidence for item 7 (5-6): "Notably, the client indicated high confidence in managing their pain without medication (question 7), suggesting effective use of non-pharmacological coping strategies."

If the client has had multiple administrations the interpretative text will refer to the baseline PSEQ score to compare with their most recent score:

- Significant increase in PSEQ score: "The Pain Self-Efficacy Questionnaire (PSEQ) was administered on [current administration date]. Since the client completed the initial PSEQ on [date of initial administration] ([days between initial and current administration] days ago) the client's total score has increased by [score change] points, representing a significant improvement in pain self-efficacy."

- Significant decrease in PSEQ score: “The Pain Self-Efficacy Questionnaire (PSEQ) was administered on [current administration date]. Since the client completed the initial PSEQ on [date of initial administration] ([days between initial and current administration] days ago) the client's total score has decreased by [score change] points, representing a significant reduction in pain self-efficacy.”

- No significant change in PSEQ score: “The Pain Self-Efficacy Questionnaire (PSEQ) was administered on [current administration date]. Since the client completed the initial PSEQ on [date of initial administration] ([days between initial and current administration] days ago) the client's total score has changed by [score change] points, which indicates minimal change, suggesting relatively stable pain self-efficacy levels..”

Developer

Nicholas, M. K. (2007). The pain self-efficacy questionnaire: Taking pain into account. European Journal of Pain, 11(2), 153-163. https://doi.org/10.1016/j.ejpain.2005.12.008

References

Adams, J. H., & Williams, A. C. de C. (2003). What affects return to work for graduates of a pain management program with chronic upper limb pain? Journal of Occupational Rehabilitation, 13(2), 107-120. https://doi.org/10.1023/A:1022599731391

Asghari, A., Nicholas, M. K., & Blyth, F. M. (2001). Pain self-efficacy beliefs and pain behaviour: A prospective study. Pain, 94(1), 85-100. https://doi.org/10.1016/S0304-3959(01)00344-X

Coughlan, G. M., Ridout, K. L., Williams, A. C. de C., & Richardson, P. H. (1995). Attrition from a pain management programme. British Journal of Clinical Psychology, 34(3), 471-479. https://doi.org/10.1111/j.2044-8260.1995.tb01481.x

Dubé, M. O., Langevin, P., & Roy, J. S. (2021). Measurement properties of the Pain Self-Efficacy Questionnaire in populations with musculoskeletal disorders: A systematic review. Pain Reports, 6(4), e972. https://doi.org/10.1097/PR9.0000000000000972

Gottlieb, B. S. (1984). Development of the Pain Beliefs Questionnaire: a preliminary report. Association for the Advancement of Behavior Therapy, Philadelphia, PA.

Mo, K. C., Gupta, A., Movsik, J., Covarrubius, O., Greenberg, M., Riley, L. H., Kebaish, K. M., Neuman, B. J., & Skolasky, R. L. (2023). Pain Self-Efficacy (PSEQ) score of <22 is associated with daily opioid use, back pain, disability, and PROMIS scores in patients presenting for spine surgery. The Spine Journal, 23(5), 723–730. https://doi.org/10.1016/j.spinee.2022.12.015

Nicholas, M. K. (2007). The pain self-efficacy questionnaire: Taking pain into account. European Journal of Pain, 11(2), 153-163. https://doi.org/10.1016/j.ejpain.2005.12.008

Nicholas, M. K., Coulston, C. M., Asghari, A., & Malhi, G. S. (2009). Depressive symptoms in patients with chronic pain. Medical Journal of Australia, 190(7), S66-S70. https://doi.org/10.5694/j.1326-5377.2009.tb02473.x

Nicholas, M. K., Costa, D. S. J., Blanchard, M., Tardif, H., Asghari, A., & Blyth, F. M. (2019). Normative data for common pain measures in chronic pain clinic populations: Closing a gap for clinicians and researchers. Pain, 160(5), 1156-1165. https://doi.org/10.1097/j.pain.0000000000001496

Nicholas, M. K., Wilson, P. H., & Goyen, J. (1992). Comparison of cognitive-behavioral group treatment and an alternative non-psychological treatment for chronic low back pain. Pain, 48(3), 339-347. https://doi.org/10.1016/0304-3959(92)90082-M

Norman, G. R., Sloan, J. A., & Wyrwich, K. W. (2003). Interpretation of changes in health-related quality of life: The remarkable universality of half a standard deviation. Medical Care, 41(5), 582–592. https://doi.org/10.1097/01.MLR.0000062554.74615.4C

Ralphs, J. A., Williams, A. C. de C., Richardson, P. H., Pither, C. E., & Nicholas, M. K. (1994). Opiate reduction in chronic pain patients: A comparison of patient-controlled reduction and staff-controlled cocktail methods. Pain, 56(3), 279-288. https://doi.org/10.1016/0304-3959(94)90166-X

Turner, D., Schünemann, H. J., Griffith, L. E., Beaton, D. E., Griffiths, A. M., Critch, J. N., & Guyatt, G. H. (2010). The minimal detectable change cannot reliably replace the minimal important difference. Journal of Clinical Epidemiology, 63(1), 28–36. https://doi.org/10.1016/j.jclinepi.2009.01.024

van der Maas, L. C. C., de Vet, H. C. W., Köke, A., Bosscher, R. J., & Peters, M. L. (2012). Psychometric properties of the Pain Self-Efficacy Questionnaire (PSEQ): Validation, prediction, and discrimination quality of the Dutch version. European Journal of Psychological Assessment, 28(1), 68-75. https://doi.org/10.1027/1015-5759/a000092

Williams, A. C. de C., Nicholas, M. K., Richardson, P. H., Pither, C. E., Justins, D. M., Chamberlain, J. H., Harding, V. R., Ralphs, J. A., Jones, S. C., Dieudonné, I., Featherstone, J. D., Hodgson, D. R., Ridout, K. L., & Shannon, E. M. (1993). Evaluation of a cognitive behavioural programme for rehabilitating patients with chronic pain. British Journal of General Practice, 43(377), 513-518. https://.doi.org/0.1027/1015-5759/a000092

Williams, A. C. de C., Richardson, P. H., Nicholas, M. K., Pither, C. E., Harding, V. R., Ridout, K. L., Ralphs, J. A., Richardson, I. H., Justins, D. M., & Chamberlain, J. H. (1996). Inpatient vs. outpatient pain management: Results of a randomised controlled trial. Pain, 66(1), 13-22. https://doi.org/10.1016/0304-3959(96)02996-X

Assessment Questions

NovoPsych

Pain Self-Efficacy Questionnaire (PSEQ)

Instructions:

Please rate how confident you are that you can do the following things at present, despite the pain. To indicate your answer tap one of the options on the scale under each item, from "not at all confident" to "completely confident".

		Not at all Confident	1	2	3	4	5	Completely Confident
1	I can enjoy things, despite the pain.	0	1	2	3	4	5	6
2	I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.	0	1	2	3	4	5	6
3	I can socialise with my friends or family members as often as I used to do, despite the pain.	0	1	2	3	4	5	6
4	I can cope with my pain in most situations.	0	1	2	3	4	5	6
5	I can do some form of work, despite the pain. ('work' includes housework, paid and unpaid work).	0	1	2	3	4	5	6
6	I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite pain.	0	1	2	3	4	5	6
7	I can cope with my pain without medication.	0	1	2	3	4	5	6
8	I can still accomplish most of my goals in life, despite the pain.	0	1	2	3	4	5	6
9	I can live a normal lifestyle, despite the pain.	0	1	2	3	4	5	6
10	I can gradually become more active, despite the pain.	0	1	2	3	4	5	6

Developer Reference:

Nicholas, M. K. (2007). The pain self-efficacy questionnaire: Taking pain into account. European Journal of Pain, 11(2), 153-163.

Administer Now

Page 1 of 1

Sample Result

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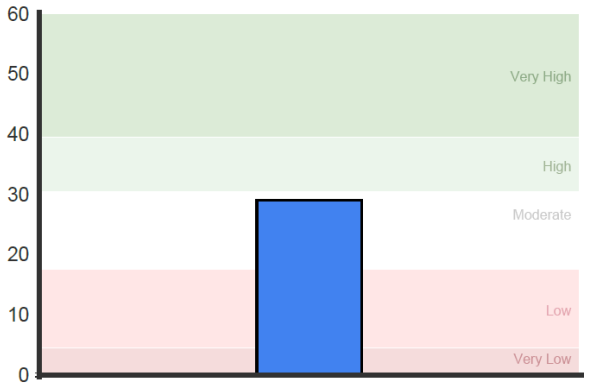
Pain Self-Efficacy Questionnaire (PSEQ)

Client Name	Generic Client	*Date administered*	1 Sep 2025
Date of birth (age)	1 Jan 1900 (125)	*Time taken*	2 min 8s
Assessor	Joseph Phillips		

Results

	Total Score (0 - 60)	Percentile	Descriptor
Pain Self-Efficacy	29	75th	Moderate

Pain Self-Efficacy Questionnaire Score



Interpretation

The client's pain self-efficacy score is 29 which falls in the 75th percentile. This score suggests that the client has moderate pain self-efficacy, indicating average confidence levels compared to other chronic pain patients. Individuals demonstrate reasonable ability to manage some activities despite pain but may have specific areas of limitation or inconsistency.

Scoring and Interpretation Information

For comprehensive information on the PSEQ, see here.

In the Pain Self-Efficacy Questionnaire (PSEQ), self-efficacy is measured by a total score that can range from 0 (no self-efficacy) to 60 (complete self-efficacy). So higher scores on the PSEQ are indicative of more self-efficacy. Outcome can also be presented as percentiles to help contextualise scores in comparison to the typical range of experience of others experiencing pain. For example, a percentile of 50 represents average self-efficacy among chronic pain patients, corresponding to a raw score of approximately 19:

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Client Name	Generic Client

Very Low Self- Efficacy (score of 0-4): 0.1 - 10th Percentile
Low Self-Efficacy (score of 5-17): 12th: 45th percentile
Moderate Self-Efficacy (score of 18-29): 48th - 75th percentile
High Self-Efficacy (score of 30-39): 77th - 89th percentile
Very High Self-Efficacy (score of 40-60): 90th-99.99th percentile

Among injured workers, research suggests that scores around the scores around 40 are associated with return to work and maintenance of functional gains, whilst lower scores tend to predict less sustainable gains (Adams and Williams, 2003) and are non-indicative of the individual returning to work (Coughlan et al., 1995). Recent research has established that PSEQ scores below 22 are associated with twice the likelihood of daily opioid use in chronic pain patients, making this threshold (approximately 55th percentile) useful for identifying individuals who may benefit from targeted self-efficacy interventions before or alongside pharmacological treatments (Mo et al., 2023). The relation between the PSEQ and pharmacological reliance can also be supported with the response to item 7 (Ralph et al., 1994), where lower scores on this item correlate with higher doses of pain medication.

When multiple timepoints are available, changes in pain self-efficacy can be evaluated to determine significant change in pain self-efficacy. While the PSEQ lacks an established change threshold for general chronic pain populations, clinicians can combine empirical methods with clinical judgment to interpret meaningful change. The minimally important difference (a 0.5 standard deviation change) has demonstrated utility for assessing clinically significant change across health-related scales (Norman et al., 2003; Turner et al., 2010). Applying this approach to the PSEQ, with a normative standard deviation of 13.3 (Nicholas et al., 2019), yields a meaningful change threshold of 6.65 points. An increase of 6.65 points or greater indicates clinically significant improvement in pain self-efficacy, while a decrease of 6.65 points or more suggests clinically significant decline. Changes less than 6.65 points in either direction represent non-significant variation that may reflect normal fluctuation rather than meaningful change. This threshold provides a standardised approach for interpreting PSEQ change scores while acknowledging that clinical context and individual patient factors should inform final interpretation of treatment response.

With multiple administrations, a line chart will be produced to observe progress of the client over time. The graph includes percentile-based threshold lines marking the boundaries between interpretive categories (very low, low, moderate, high, and very high self-efficacy) to provide visual context for score changes. These visual markers enhance interpretation by showing not only the magnitude of change but also the clinical significance of movement between functional categories over the course of treatment.

Client Responses

		Not at all Confident	1	2	3	4	5	Completely Confident
1	I can enjoy things, despite the pain.	**0**	**1**	**2**	**3**	**4**	**5**	**6**

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Client Name	Generic Client

Client Responses (cont.)

		Not at all Confident	1	2	3	4	5	Completely Confident
2	I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.	0	1	2	3	**4**	5	6
3	I can socialise with my friends or family members as often as I used to do, despite the pain.	0	1	2	**3**	4	5	6
4	I can cope with my pain in most situations.	0	1	**2**	3	4	5	6
5	I can do some form of work, despite the pain. ('work' includes housework, paid and unpaid work).	0	1	2	**3**	4	5	6
6	I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite pain.	0	1	2	3	**4**	5	6
7	I can cope with my pain without medication.	0	1	2	**3**	4	5	6
8	I can still accomplish most of my goals in life, despite the pain.	0	1	**2**	3	4	5	6
9	I can live a normal lifestyle, despite the pain.	0	1	2	**3**	4	5	6
10	I can gradually become more active, despite the pain.	0	1	**2**	3	4	5	6