

with daily life. Among behavioral coping strategies, self-efficacy for reporting pain and exercising were negatively correlated with pain worst while exercising was negatively correlated with pain interference.

Hypothesis 3: Relationships of Perceived Self-efficacy with the Use of Coping and Level of Distress

Patients' perceived self-efficacy to employ a coping behavior was consistently positively correlated with their use of that behavior (Table 3). However, patients' perceived self-efficacies for cognitive coping and behavioral coping were not found to be correlated with level of distress.

Hypothesis 4: Relationships of the Use of Coping and Level of Distress with Pain Outcomes (Pain Intensity and Pain Interference with Daily Life)

Correlations between the use of coping and reports of both pain intensity and pain interference are presented in Table 4. The total score for the use of cognitive coping was positively correlated with pain inter-

ference with daily life. Among cognitive coping, reinterpreting pain sensations and catastrophizing were positively correlated with pain worst. Catastrophizing was positively correlated with pain interference with daily life. The total score for the use of behavioral coping was not found to be correlated with either pain intensity or pain interference with daily life. Among behavioral coping, using pain medications was positively correlated with pain interference. Distress was significantly correlated with pain worst ($r = 0.36, p < 0.05$) and pain interference ($r = 0.48, p < 0.05$).

Hypothesis 5: Moderating Effects of Perceived Self-efficacy on the Use of Coping

Use of coping was regressed on outcome expectancies, perceived self-efficacy, and the interaction between outcome expectancies and perceived self-efficacy for 16 individual coping strategies as well as for total cognitive coping and total behavioral coping. Outcome expectancies were consistently positively correlated with the use of coping except for reinter-

Table 3. Correlations between perceived self-efficacy, pain outcomes, and use of coping ($N = 88$)

Self-efficacy for Using:	Pain outcomes		Use of coping
	Worst	Interference	
<i>Cognitive strategies</i>			
Coping self-statement	-0.11	-0.14	0.74*
Praying/hoping	-0.17*	-0.14	0.70*
Catastrophizing	0.11	0.09	0.33*
Ignoring pain	-0.09	-0.02	0.62*
Diverting attention	-0.18*	-0.15	0.26*
Reinterpreting pain	-0.03	-0.19*	0.31*
Using imagery	-0.10	-0.12	0.76*
Using hypnosis	-0.04	-0.09	0.71*
Total cognitive coping	-0.11	-0.08	0.37*
<i>Behavioral strategies</i>			
Reporting pain	-0.20*	-0.13	0.45*
Using pain medications	-0.12	0.01	0.42*
Increasing activity	-0.05	-0.08	0.23*
Exercising	-0.25*	-0.36*	0.59*
Relaxing	-0.09	-0.14	0.74*
Using heat	-0.15	-0.02	0.59*
Using cold	-0.15	-0.01	0.52*
Getting a massage	-0.15	-0.09	0.60*
Total behavioral coping	-0.22*	-0.08	0.30*

* $p < 0.05$.

Table 4. Correlations between the use of coping strategies, pain outcomes, and outcome expectancies ($N = 88$)

Coping strategies	Pain outcomes		Outcome expectancies
	Worst	Interference	
<i>Cognitive strategies</i>			
Coping self-statement	-0.03	-0.10	0.46*
Praying/hoping	0.05	0.10	0.43*
Catastrophizing	0.33*	0.37*	0.32*
Ignoring pain	-0.02	-0.07	0.30*
Diverting attention	-0.01	0.08	0.19*
Reinterpreting pain	0.22*	0.15	0.12
Using imagery	-0.06	0.11	0.61*
Using hypnosis	0.06	0.11	0.29*
Total cognitive coping	0.13	0.19*	
<i>Behavioral strategies</i>			
Reporting pain	-0.01	0.01	0.15
Using pain medications	0.17	0.21*	0.33*
Increasing activity	0.03	0.11	0.28*
Exercising	-0.11	0.06	-0.01
Relaxing	-0.03	0.09	0.53*
Using heat	0.04	0.13	0.50*
Using cold	-0.08	0.05	0.49*
Getting a massage	0.05	0.01	0.48*
Total behavioral coping	0.01	0.12	

* $p < 0.05$.