Pain management: application of cognitive behavioural methods

Assoc. Professor Michael Nicholas PhD
University of Sydney
Pain Management & Research Centre
Royal North Shore Hospital
Starting point

- For people with persisting (chronic) pain unless something specific and treatable has been overlooked, curative treatment is very unlikely and its very pursuit may not be risk-free.

Prediction of non-RTW / disability in injured workers: **risks** rise with:

- Persisting pain
- Distress (depression, anxiety, stress)
- Fears/beliefs (eg. ‘of re-injury’, or that ‘can’t do things due to pain’)
- Passive coping (avoidance, escape)
- History of pain
- Work issues: ‘satisfaction’, conflicts, work availability, transferable skills
- Demographics: older, female

As with all interventions

- Assessment of problem(s) is first step
- Use history, medical reports, interview, observation, questionnaires
- Develop ‘working hypothesis’ about case
- The intervention is a test of the hypothesis (so, review progress and adjust hypothesis and intervention as needed)
- Avoid ‘one size fits all’ approach
Key Tasks in CBT for pain patients

- Reconceptualise pain problems (hurt/harm) (chronic pain model) - use Socratic technique
- Clarify roles, expectations (collaborative vs directive)
- Agree on achievable goals (short-term/long-term)
- Work out steps towards those goals (eg. prioritizing; pacing)
- Systematic encouragement for progress towards these goals
- If necessary, teach skills/coping strategies
- Identify likely obstacles + plan for solving them
- Develop maintenance plan
Socratic Technique

- A way of eliciting information from patient
- Yields more specific information than if you ask patient for explanations
- Instead of asking questions that start with ‘why’...
- Use words like ‘when’, ‘how’, ‘what’
- Eg. “Tell me what happened next...”
- Or “What do you think is happening in your body when your pain gets worse?”
Reconceptualise the problem

- **Reduced Activity**
- **Unhelpful Beliefs & Thoughts**
- **Repeated Treatment Failures**
- **Long-term Use of Analgesic, Sedative Drugs**
- **Loss of Job, Financial Difficulties, Family Stress**
- **Physical Deterioration** (e.g., muscle wasting, joint stiffness)
- **Feelings of Depression, Helplessness, Irritability**
- **Side Effects** (e.g., stomach problems, lethargy, constipation)

© M K Nicholas
What if we could…?

- REDUCED ACTIVITY
- UNHELPFUL BELIEFS & THOUGHTS
- REPEATED TREATMENT FAILURES
- LONG-TERM USE OF ANALGESIC, SEDATIVE DRUGS
- LOSS OF JOB, FINANCIAL DIFFICULTIES, FAMILY STRESS
- PHYSICAL DETERIORATION (e.g. muscle wasting, joint stiffness)
- FEELINGS OF DEPRESSION, HELPLESSNESS, IRRITABILITY
- SIDE EFFECTS (e.g. stomach problems, lethargy, constipation)

CHRONIC PAIN → REDUCED ACTIVITY → UNHELPFUL BELIEFS & THOUGHTS → REPEATED TREATMENT FAILURES → LONG-TERM USE OF ANALGESIC, SEDATIVE DRUGS → LOSS OF JOB, FINANCIAL DIFFICULTIES, FAMILY STRESS → PHYSICAL DETERIORATION (e.g. muscle wasting, joint stiffness) → FEELINGS OF DEPRESSION, HELPLESSNESS, IRRITABILITY → SIDE EFFECTS (e.g. stomach problems, lethargy, constipation) → EXCESSIVE SUFFERING

© M K Nicholas
Clarify roles, expectations

- Collaborative vs directive (all stakeholders)
- Patient must play an active role (not expecting healthcare provider to fix all)
- Patient must work towards own goals and tasks between sessions at clinic
- Healthcare provider will provide information, support, guidance (not all the answers)
- A written manual and charts can help
Agree on Achievable Goals

Putting it simply:

Goals = motivation

Without motivation no one is going anywhere
Goals vs Pain & Impairment
Double amputee conquers Mount Everest, despite breaking artificial limb on ascent

One of the carbon-fibre legs snapped while climbing at around 6,400 meters, but he was able to repair it with spare parts
Wife: “He’s dreamed of this all his life, probably. He’s over the moon”
Setting goals

- Specific (eg. walk to shop)
- Measurable (can see when it’s done)
- Achievable (not unrealistic)
- Relevant (to the patient = motivation)
- Timely (within a reasonable time-frame)
<table>
<thead>
<tr>
<th>Short term</th>
<th>Long-term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase sitting time</td>
<td>Return to work 8 hrs/day</td>
</tr>
<tr>
<td>Increase walking time</td>
<td>Cook all family meals</td>
</tr>
<tr>
<td>Mop floor</td>
<td></td>
</tr>
<tr>
<td>Stir a pot on stove</td>
<td></td>
</tr>
</tbody>
</table>
Systematic encouragement for progress towards these goals

- We all respond to feedback
- Learn faster
- Strengthen learning

- HCP’s must provide consistent and positive reinforcement for efforts by patients (praise, recognise difficulties)
- Encourage patient to self-reinforce
But motivation is not enough
We need a plan: Pacing up an activity despite pain
Motivation + a plan may still not be enough

The skills to carry it out are also required
Problem-solving is a key skill

Main steps:
- Identify (clarify) problem
- Identify possible options (solutions)
- Select best option
- Try it
- Evaluate (may need to revise initial perception of problem)
Controlling emotional arousal (stress, anxiety)

- Cognitive strategies (eg. Identify and deal with catastrophic thoughts)
- Behavioural strategies (eg. Relaxation, meditation, desensitization/habituation, Tai Chi, yoga)
Dealing with flare-ups in pain

- Flare-ups should be expected
- Not a threat, but need to be managed
- Helps to have a basic plan ready
Flare-up plan

- Recognise pain is worse
- Check my reactions (thoughts, feelings – am I catastrophizing?)
- Remind myself that I’m OK – “it’s just a flare-up, not a new injury” (I’ve had these before, I expect them and I know they will settle)
- Calm myself (relaxation, desensitisation/meditation)
- Check activities (have I been over-doing things?)
- Plan for day – make sure I pace activities, but don’t stop everything
Identify and plan for likely obstacles

- **Patient’s usual responses**
  - Get upset (“I’ve failed again”, “no point trying”)
  - Fear of failure (“what if it doesn’t work?”)
  - Perfectionism (“not good enough”, “lower standards”)

- **Family responses/ expectations**
  - “can’t be much wrong if no drugs/surgery”
  - “why don’t you try this other treatment…?”
Maintenance

- This is a chronic condition
- Fluctuations in pain expected
- Just like diabetes or asthma, need for a long-term management plan
- Ideally, plan supported by patient’s family, doctor, employer
Ideal pain self-management skills

- Maintain most normal activities despite pain, using pacing
- Recognise functional limits, but gradually extend them
- Maintain a high level of self-reliance
- Use alcohol for recreation only (normal social use)
- Use analgesics sparingly (as an aid, not primary treatment)
- Deal with increases in pain without becoming distressed
- Develop and maintain good sleep habits
- Deal with set-backs, hassles without becoming depressed or despairing
- Interact with significant others as normally as possible (avoid sick-role)
- Play an active and informed role in the management of own pain (able to communicate effectively with doctors)
Maintenance Plan – must include

• Specific goals (may change over time, but provide direction)

• Flare-up plan

• Regular activity pacing

• Regular monitoring of cognitions/mood/relationships

• Regular use of calming strategies

• Regular use of basic exercises (fitness, stretching, Tai Chi)

• Regular self-reinforcement of efforts (make sure some ‘fun’ activities included)
Conclusion

- CBT methods can be used by all health professions
- Assessment is critical
- Always use a collaborative approach
- Change is seldom smooth, so patience and consistency are important