Cognitive Behavioral and Motivational Approaches to Chronic Pain

Joseph Merrill MD, MPH
University of Washington
October 14, 2017
Motivational and Cognitive Behavioral Approaches

- Assessment basics
- Components of a chronic pain treatment plan
- Cognitive behavioral strategies
- Motivational strategies
- Role of primary care provider is supporting patient self-management while coordinating a care team
First, Get the Pain Story

• “Before we talk about treatments, can you tell me more about your pain?”
• Listen for **and reflect**:  
  – How pain is affecting life, function, mood  
  – Past perceived poor treatment or disrespect from medical providers  
  – Efforts at self-care  
• “What goals would you pursue if your pain did not interfere so much?”
Cover the Basics

• Multi-modal assessment (Pain Tracker)
  – Pain and function
  – Mental health: PHQ-9, GAD-7, PTSD screen
  – Sleep, substance use (ORT), activity

• Distinguish central syndromes – fibromyalgia, chronic headache, non-specific back pain, chronic pelvic pain

• Looking to create a problem list
Policies Help!

- State, clinic, and/or individual MD policies help structure pain care:
  - No opioids on first visit – get old records
  - Urine toxicology for anyone considering opioids
  - Dose limitations
  - No changes in dose without prior discussion
  - Care plan is broader than opioids
The Chronic Pain Plan

• **Opioids**? Includes monitoring (urine, PMP)

• **Non-opioid medications**? For depression, anxiety, PTSD, sleep, pain

• **Non-medication treatments**?
  – Passive
  – Active

• Goal is spending more time on active strategies that the patient implements
Assessing Pain Treatments

- Passive
  - Medication
  - Surgery/injections
  - Acupuncture
  - Massage
  - Chiropractic
  - TENS
  - Myofascial release

- Active
  - Exercise
  - Physical therapy
  - Coping skills
  - Sleep hygiene
  - Biofeedback

- It’s about behavior change!
Behavior Change in Pain Care

- Initiating or increasing physical activity
- Using coping skills instead of medication
- Activation strategies for depression
- Trying non-opioid medications
- Exploring non-medications treatment options
- Reducing opioid dose
Cognitive Behavioral Strategies

• Looking beyond passive treatments to help patients with chronic pain
• Changes the focus of the encounter toward what patients can do for themselves
• Gives insight into dysfunctional beliefs and medication-taking behavior
• Can use Managing Chronic Pain: A Cognitive Behavioral Therapy Approach by John Otis
Introducing CBT to Patients

• “Pain is often worsened by poor sleep, too much or too little activity, stress, anger, or never doing anything fun. How about for you?”
• “Pain often leads to tight muscles, tight or shallow breathing, and negative thinking about your life and future. How about for you?”
• “This program gives you many ideas you can try to address these issues. It is a long menu of things you can do to manage your own pain. Maybe you have already figured some of this out.”
First Three Chapters

• Overview of the program
• Education on chronic pain
• Theories of pain and diaphragmatic breathing
  – Pain ≠ tissue damage: “Some patients with lots of tissue damage do not have chronic pain and some patients have no clear tissue damage, but lots of pain, like fibromyalgia patients.”
  – “Pain can restrict breathing a lot and this tool helps you respond to that.”
Follow Up

• “Did you read the chapters I gave you?”
• If no, be supportive and offer another copy.
  – “It’s up to you how much of this you learn and apply. “
• If yes, “what did you think?”
  – Ask about goal setting and the use of the breathing exercise.
  – “This is just one tool you can use when your pain is bad. Some patients find doing it every day really reduces pain flares.”
• Offer more
Second Three Chapters

• Muscle relaxation and visual imagery
  – “Here are two more tools that some find very helpful for muscle tightness and tension.”

• Automatic thoughts and pain

• Cognitive restructuring
  – “Negative thinking can really make pain worse. Here are some tools to deal this that.”

• “You may have already figured some of this out. This is just part of the menu of tools.”
Follow Up: Provide a Menu

**Pain Modifier**
- Poor sleep?
- Too much or too little activity?
- Increased stress?
- Anger?
- Not having any fun?

**CBT Module**
- Sleep hygiene
- Time-based pacing
- Stress management
- Anger management
- Pleasant activity scheduling
Time-Based Pacing

• “Both too much exercise and too little exercise makes pain worse. How about for you?”
• “Everyone with chronic pain needs an activity they can do pretty much every day.”
• Assess current activity level and find one that they can commit to trying nearly every day.
• Rating ability to do this is an important functional metric
Sleep Hygiene

• “These tools have been shown to be more effective than pills”
• Review some with patients, then provide the checklist
• Check in at follow up about how it went
Managing Flare Ups

• Patients with chronic pain can present in the midst of a pain flare, acute or sub-acute
• “What has been going on in your life?”  
  – More often stressful event than “injury”
• “Have you tried any of the tools?”  
  – Common for tools to help, but then stopped  
  – Maintaining behavior change is hard  
  – Make a list of tools that have worked in the past
Other CBT Resources

• The Pain Survival Guide: How to Reclaim Your Life by Dennis Turk and Fritz Winter
• YouTube video: “Understanding pain: what to do about it in less than five minutes”
  – Entertaining summary of CBT approach
  – Consider watching it with patients in clinic
  – A patient’s reaction can illuminate areas of misunderstanding
  – https://www.youtube.com/watch?v=C_3phB93rvI
CBT in Primary Care

- Patients need time and repetition to start to understand the role of active therapies in pain care
- Physician support for CBT concepts will help other providers make the case for self-care
- See patients more often (monthly) when trying to incorporate CBT into a pain plan or momentum is easily lost
Motivational Strategies

- Based on motivational interviewing
- Change comes from the patient
- Enhancing motivation and commitment is key
- Provides options for dealing with resistance
- Practicing these techniques increases the effectiveness of behavior change discussions and is fun!
Behavior Change Counseling

• Step 1: Enhancing motivation to change
  – Eliciting change talk
  – Rolling with resistance
  – Tip the decisional balance

• Step 2: Developing a collaborative care plan
  – Steps after motivation in place
  – Engaging patients in self-management
Change Talk and Resistance

• “As I hear myself talk, I learn what I believe”
• Change talk is patient language in support of behavior change
• Resistance language opposes behavior change
• Patients who express more resistance are less likely to change, and confrontational clinician style can promote resistance
• Motivational techniques seek to promote change talk and minimize or diffuse resistance talk
Meeting Resistance

• *Never meet resistance head on (no arguing!)*
• The best response to resistance talk is reflection:
  – Validates the patient’s experience
  – Can soften resistance talk, open up change talk
  – Amplification can be useful: “You can’t imagine life without drinking…”
• Explore the pros and cons of the status quo
  – What are some of the good things about…?
  – What are the less good things…?
Avoid Resistance Talk – Promote Change Talk

Example of contrasting reflections:

Patient: “I was worried there at first, but I don’t think I really have a drinking problem. My liver tests came back OK.”

- “You feel fine and you don’t think you really have drinking problem” – is an example of promoting Resistance Talk
- “You don’t want to develop liver problems; that worries you” – is an example of promoting Change Talk
Rolling with Resistance

Patient: “I can’t imagine myself not drinking. It’s part of who I am, part of what I like to do for fun.”

Resist the urge to educate about the harmful effects of alcohol

Responses might include:

• “You might not be you without it! It’s so important that you may have to keep on drinking no matter what the cost.”

• “It’s certainly your choice. No one can make you stop drinking.”
Asking for Change Talk

- “Tell me what concerns you about your…?"
- “Say you continue on without changing. What do you imagine are the worst things that could happen?”
- Follow up with:
  - Open question: “Tell me more about that”
  - Reflection: “So you are worried about…”
  - Probing: “What else?” can probe for other common related problems
The “Importance” Scale

- “On a scale of 0-10, how important do you think it is to change your…?”
- Follow with “Why is it not less important?”
- Once a concern is stated, encourage further change talk:
  - Open question: “Tell me more about that”
  - Reflection: “So you are worried about…”
  - Probing: “What other concerns do you have?”
Developing a Collaborative Plan

• Step 1: Enhancing motivation to change
  – Asking for change talk
  – Rolling with resistance
  – “Importance” scale

• Step 2: Developing a collaborative plan
  – Steps after motivation in place
  – “Confidence” scale
Transition to Making a Plan

• Signs that patient is not ready:
  – Missed visits, guarded, hesitant, indecisive, resistant
  – If coerced, has that been dealt with?

• Signs that patient is ready:
  – Stops resisting, change talk, settled, resolved
  – Begins to imagine what it would be like after change
Behavior Change is Hard!

- Patients with chronic pain frequently have multiple chronic conditions
- Many lack confidence, knowledge and skills to manage their conditions and are easily overwhelmed
- Summarize pros and cons of behavior change and ask an open ended question, like “so where do we go from here?”
Steps in Building a Collaborative Care Plan

• Help the patient focus on a specific goal
  – “Can you think of a goal…?” Weight loss
• Brainstorm activities to accomplish the goal
  – “What ideas do you have?” Patient ideas first
• Choose an activity
  – “Start with one activity” Exercise
• Focus the activity
  – “What kind of exercise?” May need brainstorming
Steps in Building a Collaborative Care Plan

• Identify how often/long activity will occur
  – “How often will you exercise?” Specific, realistic

• Identify when the activity will take place
  – “When do you want to walk?” Time, day

• Consider barriers
  – “What barriers do you foresee?” Rain, feel lonely and want company
The “Confidence” Scale

- “On a scale of 0-10, how confident are you that you could make this change?”
- “Why are you not less confident?” encourages expression of self-efficacy
- “Why are you not more confident?” can identify important barriers to change
At Follow-Up Visit

• Review the plan and any progress
  – Documenting the plan helps
• Spend some time renewing motivation
  – “Remind me what led you to want to change”
• Communicate free choice
  – “It’s up to you what you do about this”
• Information and advice
  – Balance advise-giving with emphasis on choice and patient preference
For Further Study

• Motivational Interviewing in Healthcare by Stephen Rollnick, William Miller and Christopher Butler
• Building Motivational Interviewing Skills by David Rosengren
• Mauksch L, Safford B. Engaging patients in collaborative care plans. Family Practice Management. 2013 May-June 20(3) 35-9
Cognitive Behavioral and Motivational Approaches

• Rapport, broad assessment, and policies help structure a positive chronic pain plan
• A plan should address opioids, non-opioid medications, and non-medication treatments
• Cognitive behavioral and motivational strategies can promote self-care and increase provider effectiveness and satisfaction