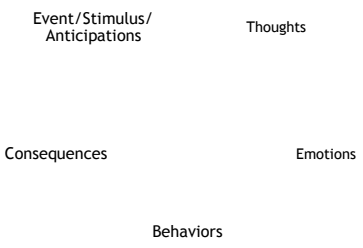
Cognitive Behavioral Approaches to Managing Chronic Pain

Daniel O'Connell, Ph.D.
danoconn@me.com
206 282-1007

Objectives

- Briefly describe the foundational basis for Cognitive Behavioral Therapy in practical terms
- Show how CBT strategies can be applied in interactions with chronic pain patients

A Model of Thought, Emotion and Behavior and Consequences



Events are the Stimuli: Internal and External

- Sensation:
  - "I felt a twinge…"
  - "I can sense another headache coming on."
- Anticipation:
  - "I will have to go back to work at some point."
  - "I have a doctor's appointment coming up."
- Event:
  - "My wife is complaining about me."
  - "I just got a letter from my disability insurer."
  - "Another year has passed since I last worked."

Thoughts (Cognitions) can be adaptive (accurate) or maladaptive (distorted)

- Adaptive thoughts lead to the most effective coping
  - More accurate perceptions and assessments of risks, opportunities and intentions
- Maladaptive thoughts limit coping resources and skills
  - Distort the size and extent of risk, minimizing opportunities for improvement and fuel suspiciousness about others' intentions

Feelings/Emotions

- Thoughts and emotions are intertwined
  - Thoughts can trigger emotions or extend their intensity and duration.
  - Emotions can cue up habitual thoughts.
- What emotions would you expect a patient to have who thought that way?
  - It is normal to feel that way when you are thinking that way.
  - Allows clinician to empathize rather that distance/criticize

Changing emotions typically involves changing any of: thinking, behavior or neurochemistry

- E.g.., If the patient is catastrophizing less about the intolerability of discomfort, then he/she is more likely to wholeheartedly participate in PT.
- E.g.., If the patient goes to PT, he/she may have a direct experience that counters fears and builds hopefulness.
- If a patient tries relaxation/meditation/acceptance practices they may be surprised at the shift in emotion.
- Medication may reduce distressed emotions such as anxiety and depression and associated thoughts may change as well, reducing resistance to constructive behavior

Behavior

- Many different behaviors possible in chronic pain
  - Destructive/Limiting
    - Avoidance of feared situations
    - Pain medication over-reliance
    - Descent into constriction of normal life roles, goals
    - Justification of disability, Blaming pain for everything
  - Constructive Coping
    - Tolerating/distancing/distracting from painful sensations
    - Engaging in closest approximation of normal roles and activities despite "discomfort"
    - Making habit of the least "disabling" way of thinking about one's situation.
      - Avoiding disability identity with its coherent and restricting story about life's possibilities and choices

Consequences

- If pain becomes overshadowing (in part because of distortions that magnify its power) then consequences are somewhat predictable.
  - Activity, return to work, relationship, mood, life satisfaction, medication use
- If pain can be managed as constructively as possible consistent with reality then
  - Best approximation of normal roles, values, activities is discovered and maintained and adapted to

And those consequences…

- Becomes the next stimuli/events/situations that further energize and shape the next round of thoughts, emotions, behaviors and consequences
  - Which is how the spiral either descends or ascends.

Types of Maladaptive Cognitions

- Catastrophizing
- Emotional Reasoning
- All or nothing thinking
- Mind reading/projection/jumping to conclusions
- Postponement
- Entitlement
- Magnifying/Amplifying
- Victim-Persecutor-Rescuer
- Fear Avoidance
- Mental Filter
- Hopelessness

Key clinician attitude and behavior:

- Help the patient reflect on cognitions and their impact.
  "When you find yourself thinking that way…"
- Do not argue with the patient.
  - But do ask the patient to debate within himself and re-assess rationality of thoughts and dispute/replace as needed

  "On the one hand…on the other hand…"
- Empathy: Seeing from the patient's perspective does not mean agreeing. "No wonder…"
  - Patient owns the problem and the clinician remains "second most motivated person in the room"

  "I can really see how the way you are thinking about this leaves you with very few alternatives.

  Remember: the problem is the way they are **thinking** about the situation as much as it is about the situation itself.

  Example of childhood sexual abuse

Exploring maladaptive cognitions

- What makes them maladaptive?
  - Interferes with best recovery and accommodation possible
- Is there a distortion working here? Which one(s)?
  - Labeling distortions/teaching labels can be helpful tool
- Focus most on cognitions that affect functioning.
  - Let's examine some now…

Setting rationale/adaptive boundaries

- Lean towards patient's preference as starting point
- Respectfully set limits on yourself using clear criteria
  - Medications
    - Safe?/Effectiveness?/More harm than good?
  - Disability Forms/Evaluations:
    - "There are 4 criteria that the state/province requires us to use in assessing the extent to which a person is disabled. Let's go over those criteria in light of your situation."
  - Further testing, surgery, procedures
    - Safe?/Effective?/More Harm than Good?

CBT consistent: Handling Impasses

- Avoid arguing/acknowledge impasses
  "I think we have reached an impasse and I am wondering if there is anything I could say that would change your mind?"
- Use short summaries
  "Let me see if I understand your perspective…"
- Set rational boundaries
  - **Safe-Effective-More Harm Than Good?**

"I could not let myself prescribe that medication/order that test/recommend that procedure when there is this much evidence that it might not be safe/effective/could do more harm than good. Are you open to any alternatives?"

- *If the patient is not open to alternatives, consider ending the conversation.*
  - *"I guess we will not be able to agree on this. Perhaps we should stop here for now."*

CBT consistent: Concern not Criticism

- Express *concern* about current and future consequences
  - *"I am concerned that if you continue in this way you will look back on this as a mistake. That the way you responded to the pain/injury kept you from having as much of a normal life as you might have if you took it head on. What do you think?"*
  - *"It is possible that you will find another doctor who will perspective these medications/offer this procedure/complete this disability form and I respect that it is your decision to pursue that. I am just concerned that it could well end up causing you more harm than good."*

References

- www.Painaction.com
- www.theacpa.com
- www.painedu.org
- O'Connell, D. (2014). Behavior Change. In Behavioral Medicine: A guide for clinical practice 4th Edition. MD Feldman and Christensen JF eds. Lange: McGraw Hill, Pages 185-194.
- Elmer B (2008) Hypnotize yourself out of pain. Book and CD
- Turk D (2005) The Pain Survival Guide
- Caudill M (2008) Managing Your Pain Before It Manages You.
- Steven Hayes (2005) Get Out of your Mind and into Your Life.
- Dahl J and Lundgren T (2006) Living Beyond Your Pain: Using Acceptance and Commitment Therapy