



The Five Coping Skills Every Chronic Pain Patient Needs

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Recognized as



“distinguished
comprehensive
multidisciplinary
pain care”



Disclosures

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Learning Objectives

- Name the 5 essential pain coping skills
- Explain how each skill is important in coping with chronic pain
- Describe an easy way to teach relaxation to a patient

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The Current Situation

- Multidisciplinary pain treatment is generally considered to be the best way to treat chronic pain.
- However, the number of multidisciplinary pain treatment programs has dropped dramatically over the last two decades.
- Most patients don't want to attend them, insurance won't pay for them, and they are difficult to organize and administer.

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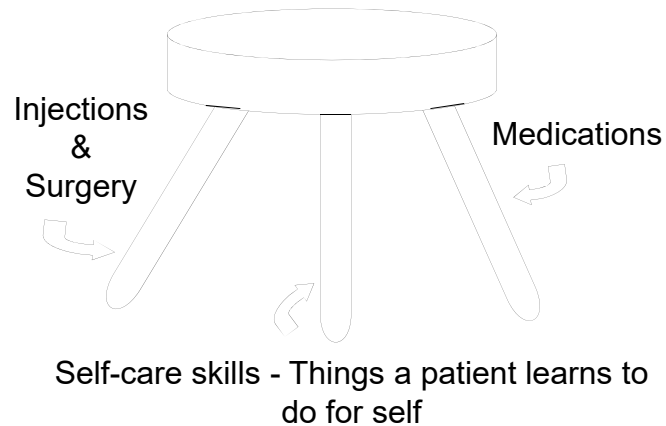
What we need to do

- Our practices need to offer patients more than pills or shots.
- These can be in one location or practice, or networked together within a community.
- Other services need to be available, physically and financially.
- These are generally not new treatments. These are old treatments that need to be made available to our patients in new ways.

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Conceptual Overview

The “Three-Legged Stool” of Pain Treatment



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Cognitive Behavioral Therapy

- Cognitive behavioral therapy (CBT) is a mainstay component of multidisciplinary pain treatment.
- Multiple studies and reviews have documented its effectiveness in treating chronic pain, as well as associated problems such mood, function and activities (e.g., Morley et al, 1999; Ehde et al, 2014).

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CBT

- Falls into the category of “self-help.”
- While the name implies changes in thoughts, actual CBT often also addresses relaxation, activity pacing, problem solving and other areas involved with pain.
- There is no standard protocol for CBT, and there lots of variations.
- It can be anywhere from 1-12 sessions, or more.

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Downside to CBT

- There is significant shortage of psychologists and mental health practitioners that understand and treat chronic pain.
- Likely it is hard for you to find someone to refer to for CBT for chronic pain.
- Classic CBT is done in 8-12 sessions, and most of our pain patients will not complete this many sessions, for a host of reasons.

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What we do at our practice

- Our program has worked to develop a CBT-based schema (outline) for patient pain treatment that is:
 - Relatively brief,
 - Fairly easy to understand for patients and healthcare staff,
 - Offers a brief focused outpatient version of multidisciplinary pain treatment.

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The Five Self-Care Skills

1. Understanding
2. Accepting
3. Calming
4. Balancing
5. Coping

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1. Understanding

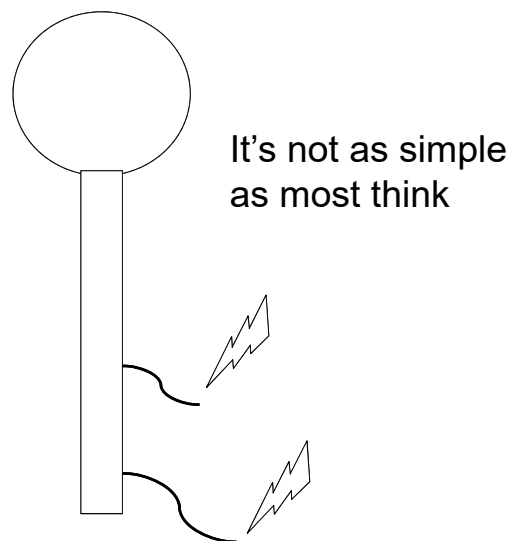
In general patients need information about:

1. pain and their pain condition
2. treatment and treatment options

- This is true for all health issues, and it is the first step.
- It creates a working partnership.

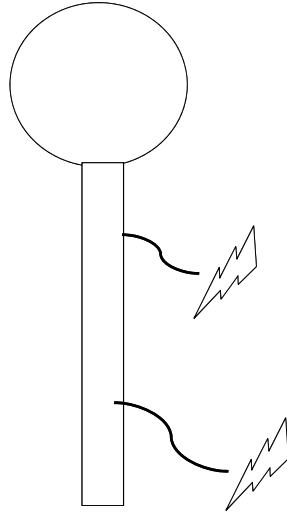
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How Chronic Pain Works



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Three Kinds of pain: From a User Perspective



From a user perspective
there are 3 kinds of pain:

1. Nerve
2. Joint (Inflammation)
3. Muscle
 - Spasms
 - Tightness/ “knots”
 - Deep soreness
(referred pain)

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Pain ≠ Damage

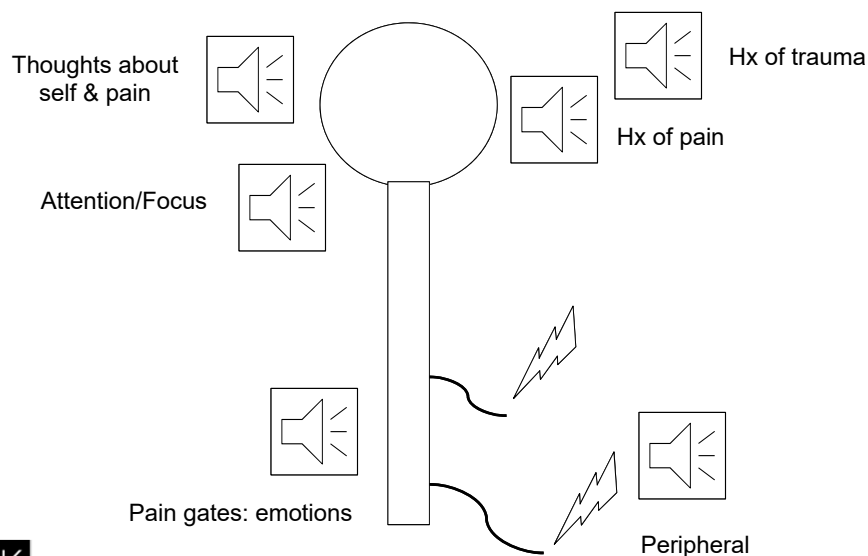
- Pain is an alarm. A “harm alarm” (Beth Darnall). It does not equal damage.
- If the fire alarm goes off in here, and it’s very loud, that doesn’t mean there is a large fire. There may be a large fire, or there may be a very small flame near the sensor, or it may be a malfunctioning alarm system.
- It’s the same with pain.

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- Phantom limb pain, CRPS and fibromyalgia are a few of the more clear examples that pain is not the same as tissue damage. All chronic pain is an alarm, not damage.
- Your patient likely has some sort of tissue damage, but the pain is more complicated than that.
- There are several “volume control knobs” that affect the pain signal.

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Modulation: “Volume Control Knobs”

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So?

- Pain is NOT simply a reflection of tissue damage.
- It is a signal that is altered by several factors.
- “We can help you decrease your pain even if we can’t fix the damage.”
- Most of the volume control knobs are up to the patient to control, which has its pros and cons.

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Education

- So we go over these general concepts of chronic pain.
- I also address the sea change in pain treatment the last few years, and the de-emphasis on opioids the patient will be experiencing.
- We do not bemoan the situation but state it as an immutable fact and as an opportunity.

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2. Accepting

- Cognitive behavioral therapy (CBT)
- Acceptance and commitment therapy (ACT)
- Supportive psychotherapy
- Usually aimed at catastrophizing—a key variable in outcomes

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Catastrophizing: The main driver of outcomes

- Catastrophizing: focus on the negatives, often with beliefs that are not true.
- Outcomes in surgery and outcomes in chronic pain treatment are more related to catastrophizing than to any other variable, including tissue damage.
- If there is one single variable to focus on for pain patients, it is catastrophizing.

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Examples of Catastrophizing

- “This pain is awful – I can’t stand it any more!”
- “My pain is always a 10/10 – it’s a 15/10!”
- “I think there is something very wrong with me that no one has discovered yet!”
- “Someday I’ll be unable to walk.”
- “I should be able to do more!”
- “My body is very damaged; all that can be done is give me a lot of medication.”

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Quick pointers

- It’s not about right or wrong thoughts. It’s about what is most helpful to think.
- “Should’s” are not helpful and cause misery.
- Progress is moving from “Woe is me” to “What now?”
- Finding helpful thoughts: certain others, reading, internet, faith traditions...

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Changing these thoughts

1. Journal to figure out common thoughts.
2. Examining these thoughts.
3. Looking for more helpful thoughts.
4. Practicing these, while knowing that old thoughts will occasionally return at times. Progress, not perfection.
 - Sometimes thoughts have roots in childhood, and these can be a bit harder to change.

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For you, the provider

- Know this is going on.
- Don't argue with the patient about their "attitude."
- Listen, and notice.
- Look for opportunities to notice and praise positive change.
- Refer out for formal CBT when you can.

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3. Calming

- Decreasing stress can take many forms:
 - CBT
 - Tai chi
 - Progressive muscle relaxation
 - Meditation
 - Biofeedback
 - And more....
- A good and easy start: Breathing

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Let's try it.

**Count your breaths
for 30 seconds**

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About breathing

- Breathing is the only part of the stress response that you can control.
- Most adults breathe with their shoulders.
- Infants and young children breathe with their diaphragm.
- You get more air when you breathe with your diaphragm. Singers and musicians know this.
- Diaphragm breathing slows your breathing down.
- This slows down the whole stress system.
- “Central sensitization” is a big issue for many patients.

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Diaphragmatic “belly” breathing

- Lay down and put your hand or a book on your belly.
- Breathe with your belly (diaphragm).
- Wait until you need to breathe, and then breathe.
- Try it.

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**OK, now count your breaths
again for 30 seconds**

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See? You've learned it.

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Relaxation: Going “below normal”

- It’s more than just calming down.
- It’s creating an endorphin response in yourself.
- It is triggered by focusing on one thing.
- All relaxation techniques do this.
 - Beach, nature, tai chi, meditation, yoga...
- The best relaxation method? The one that fits you.

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A Simple Relaxation Technique: “The Benson Method”

- Take slow, deep breaths
- Pick a word, or a short prayer or a short phrase for a mental focus.
- Repeat it with each breath.
- When your mind wanders, as it will, gently bring it back to the focus point.
- Don’t try to do it “well” – just do it.

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Mindfulness

- Mindfulness-based stress reduction (MBSR) is increasing in popularity.
- Many MBSR practitioners I have met feel that it takes many hours of training to be able to teach others this skill.
- Traditionally MBSR is taught with an 8-week course with nightly practice for an hour.

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MBSR and Its Impact

- Fadal Zeidan at Wake Forest has looked at brief MBSR treatment – 3 sessions of 20 minutes each.
- He has gathered pre-post fMRI data looking at pain correlates in the brain.
- He has found that 3 sessions can produce changes in brain pain patterns.
- So even short-term MBSR treatment “rewires the brain.”

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4. Balancing

- Getting into helpful routines and decreasing pain flares
- There are many issues involved in this:
 - Sleep hygiene
 - Saying “no”
 - Time management
 - Nutrition (an anti-inflammatory diet)
- The biggie: activity pacing

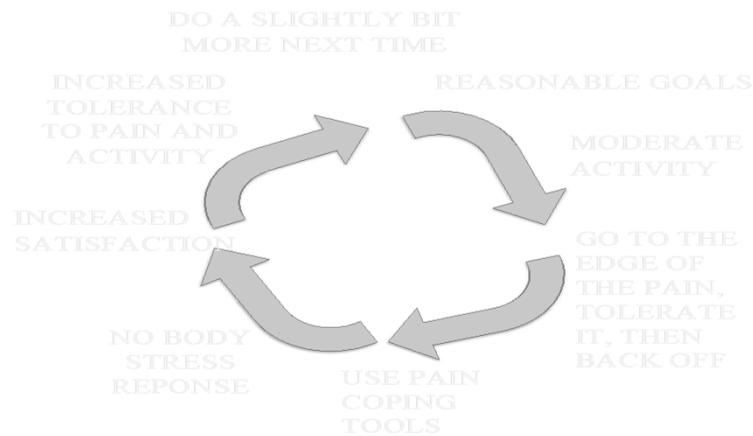
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Activity pacing

- Some patients stop moving due to pain and thus have increased pain over time due to inactivity.
- Some patients try to push through the pain – and cause themselves frustration and more pain flares.
- Moderation is the key.

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BREAKING THE PAIN CYCLE



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“Be a Turtle”

- The solution is to back off earlier and not push it.
- But also not fear having a pain sensation.
- It’s not a sprint; it’s a marathon. Pace yourself.
- Don’t be the hare, be the turtle. Slow and steady.
- You’ll get more done, and not have so much pain.
- “Up time” and “down time.”
- Ask any successful pain patient and they will say they have learned this.

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“An Energy Budget”

- “You are on an energy budget – you have limited resources.
- You need to make some decisions and choices. Say “no” to some things.
- Likely your family is the most important thing in your life.
- Are you saving time for them? For the end of the day when they come home?”

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And

- Resuming some leisure activities,
- Finding a (new) purpose in life,
- Having good sleep hygiene,
- And eating an anti-inflammatory diet are all also helpful.

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5. Coping

- Remember there are 3 kinds of pain:
 - Nerve pain
 - Joint pain (inflammation)
 - Muscle pain

- What kind of pain am I having?
- What can make this better?

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A List of Coping Tools

- Nerve pain: Not much. Rubbing it.
- Joint pain: Ice, rest, elevation.
- Muscle pain – spasms
 - Cold
- Muscle pain – tension, “knots”
 - Heat, massage

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Trigger points

- They are triggers because pressure makes them release.
- Patients can learn point massage.
 - Look up point massage tools
(tennis balls in a sock, Thera-cane, Back Buddy)
- We have found pretty much every pain patient has “knots” and can benefit from these tools.
- You get paid for trigger point injections but teaching the patient to cope can be more helpful in the long run.

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Distraction is a key tool

- Distraction is the most effective analgesic there is.
- On many burn units for bandage changes they do not use high doses of opioids. They use a video game (virtual reality).
- So all patients should have a coping plan that includes distraction (and TV is not an effective distraction).

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Virtual reality?

- There are some emerging virtual reality products for pain relief.
- New devices and new applications are being developed.
- You will see more and more tested products for pain relief and relaxation training that providers and patients can buy.

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Again, The Five Skills

- Understanding
 - Decreased pain despite damage
- Thinking
 - Decreasing catastrophizing
- Calming
 - Breathing and relaxation
- Balancing
 - Routines, activity pacing and choices.
- Coping
 - Muscle pain help, distraction

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Use as a Diagnostic Tool

- “Doc, I had a terrible weekend and I need more breakthrough medication.”
 - “I spent five hours in the garden” [pacing]
 - “My pain is 15/10. I can’t do anything. I will never get any better.” [catastrophizing]
 - “My stress is through the roof” [pain gates]
 - “I have a huge painful knot in my back” [trigger points]
 - “I didn’t know what to do so I took extra of those long-acting pills” [no coping plan]

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Make time. Make room.

Teaching These Skills

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Offering brief treatment

- We have had 3 treatment models.
 1. We have offered individual sessions that target specific issues.
 2. We also offered a single 2-hour group session, quickly reviewing the 5 skills.
 3. We are currently offering a short group series: 5 consecutive weekly groups, 90 minutes each, each one focusing on a skill with some practice time.

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Tips, for Group or Otherwise

- Use handouts.
- Without handouts patients will forget what you said.
- We give them a 39 page handout and Beth Darnall's book (which has a relaxation download).
- Keep it simple. Fancy words will not be understood.
- Consider becoming a Certified Pain Educator.

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Comments about our classes

- “I enjoyed this class and learned quite a bit about coping with my pain without meds”
- “I learned to balance my work with a timer. Learned to meditate in a different aspect. I have learned more in this class than any other mental relaxation [sic].”
- “It was good talk about my experience. I don’t talk about it usually. The knowledge is very helpful.”

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And

- “Handouts will be helpful for my flare management pain— wish I’d had this 2 years ago”
- “I believe any doctor’s office prescribing any pain medications should by law require classes such as this. People with chronic pain have the right to be educated as to options we have to not only pain medication but pain education.”

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The Five Coping Skills Every Chronic Pain Patient Needs

Thank you!

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