



Recovery to Practice
Resources for Behavioral Health Professionals

Transcript: The Role of Pain Management in Recovery

Complex Clinical Decisions Podcast Series

Hello and welcome to the Recovery to Practice Podcast series on complex clinical decisions in psychopharmacology. I'm Curley Bonds, the chief deputy director for clinical operations at the Los Angeles County Department of Mental Health as well as the clinical professor of psychiatry at UCLA and a professor of psychiatry at Charles R. Drew University of Medicine and Science. This series is hosted by the Substance Abuse and Mental Health Services Administration's Recovery to Practice Initiative. Our goal is to help our fellow clinicians explore recovery related issues so that we can all help the individuals we work with reach their goals. In today's podcast we're going to explore the role of pain management and recovery for individuals with serious mental illness. We'll explore this complex topic from a clinical and research perspective and also be able to bring in the perspectives of a person with lived experience and a specialist in cognitive behavioral therapy. First, we'll be talking with two doctors with a lot of insight on issues related to pain management, Dr. Robert McCarron and Dr. Leticia Travaglini.

Dr. McCarron is the residency training director in the Department of Psychiatry and Human Behavior at the University of California Irvine School of Medicine and the co-director of the Train New Trainers Primary Care Psychiatry Fellowship. Dr. McCarron, welcome to the Recovery to Practice Podcast.

Well thank you glad to be here.

Dr. Travaglini is a post-doctoral fellow in the U.S. Department of Veteran's My Research Center in Baltimore, Maryland where she studies pain in individuals with serious mental illness and methods to support and enhance the recovery and community functioning of veterans with serious mental illness. Dr. Travaglini, welcome to the Recovery to Practice Podcast.

Thank you for having me and I'm excited to be here today.

Dr. McCarron, how did you become interested in the intersection between serious mental illness and also pain?

Curley my first love in medicine is primary care medicine. As an internist I soon learned that about 40% of all the patients that are coming into a primary care center have significant emotional pain, psychiatric issues. And then I soon realized that becoming a psychiatrist as well as an internist would be a way in which I could really most effectively address these issues and help these folk who are dealing with both physical and emotional pain. And over the last eight or nine years, I've started practicing chronic pain management as well as your chronic pain psychiatry or behavioral health.

Dr. Travaglini, how did you become interested in studying chronic pain and serious mental illness?

So a lot of my work that I did in graduate school really focused on the intersection of mental health and physical health problems. And part of my clinical training too has really been focused on adults with co-occurring disorders and I noticed a lot of high rates of co-occurring physical health problems, especially pain among the individuals that I was working with. So for my post-doctoral fellowship I have been at the My Rec, the Mental Illness Research Education and Clinical Center here in Baltimore, Maryland. And I

really wanted to continue that line of research looking at co-occurring mental health and physical health disorders. The more I looked into it the more I realized that this is a really important topic, chronic pain is so prevalent in the United States and for me working in the Department of Veteran's Affairs, very prevalent among veterans.

Well, through your work with veterans what have you learned about the incidents and co-morbidity of pain and serious mental illness?

So what I've been noticing is there's really high rates of chronic pain among individuals with serious mental illness. Thinking about chronic pain and the general population it's about 30% of individuals. And then when we look at mental health populations it's so much higher, estimates can range anywhere from 50% to 60%, even sometimes higher depending if you look at specific chronic pain diagnoses.

Can you explain the difference between chronic and acute pain?

Yes, so acute pain is something that you may experience if, you know, you twist or break your ankle, or if you've recently had a surgery in the last day or two. Anything past three months or so is usually considered chronic pain and at that point it's usually treated much differently than acute pain.

So do you understand them both as being disease states? Or how are they different in terms of management?

Well, I don't know if they're exactly disease states. I think they may be sequelae of disease states. It's also important to keep in mind that pain is normal, pain is something that we should all experience to some degree, hopefully a relatively low degree. But they are different in terms of how a provider is going to, you know, present or deal with these two different types of conditions. Acute pain usually can be treated with medications and pretty successfully. Chronic pain thought, oftentimes requires a multi-disciplinary multi-focal approach as opposed to just dealing with medication management alone.

So if I'm hearing you correctly, the two are separate entities, but is it common for acute pain to transform or to extend and become chronic pain?

It is common, all chronic pain at one point was acute pain. But with that being said, much of the pain that we experience as human beings will eventually subside. Most acute pain is going to be self-limiting. An example is, you know, you have a hot appendix, and then you get your appendix taken out, it's going to hurt before the surgery, it's going to hurt immediately after the surgery; but eventually it fades away and does not become chronic pain. But certainly all chronic pain emerges from folks having an acute flair up of pain.

You've made the distinction between chronic and acute pain; can you talk for a moment about how the approaches to these two situations might be different?

Well they are very different, and I think with acute pain or pain that's lasting less than three months, and oftentimes acute pain is just going to last a week or two weeks, in those settings you can really rely more on analgesics. And in some cases, particularly post-surgical opioids are certainly indicated and effective; right. So for those who have chronic pain or pain that's lasting longer than three to six months we now have much more data and evidence showing us that the use of opioids are just not going to be routinely effective in terms of lowering pain, the feeling of the chronic pain and also improving overall function.

What are some of the reasons that somatic health issues often go unaddressed or are otherwise complicated by a serious mental illness?

We do know in general, like you mentioned, there's really high rates of physical health problems among individuals with serious mental illness and it could have some serious implications in terms of their health, their functioning, as well as their ability to live and survive, so really high mortality rates because of this. One thing to think about is this idea of diagnostic overshadowing, so this is this idea that when individuals

with a serious mental illness go to the emergency room or go to a primary care location, talk to primary care providers, oftentimes what's initially noticed or identified is the mental health piece rather than the physical health piece. So someone with a serious mental illness might go in to a more physical health related setting and automatically a lot of their symptoms might be attributed to the mental health diagnosis, rather than looking at their physical health concerns as something that is separate from what might be going on with them psychologically or emotionally. There can be a lot of physical health symptoms that are related to the mental health diagnosis, things like fatigue and sleep problems and even pain itself can be a component of their mental health concerns.

You bring up some excellent points, why is it important to assess for pain? And what tools can be used to accomplish this, like are there any specific pain assessment scoring tools that you would recommend?

Yeah, this is a good question and something that always comes up because right now the standard of care that we have in our system is using these subjective ratings. Now the most common ones are, on a scale from zero to ten how would you rate your pain, zero being absolutely no pain, ten being that worst pain you've ever been in in your entire life. So that's kind of the most common and typical that people receive, but again it has its flaws because pain is subjective, so there's a lot of other scales out there, things like the Brief Pain Inventory, The West Haven Yale Multi-dimensional Pain Inventory that really get into these more nuance questions asking about not only are you experiencing pain and it's pretty bad pain, but how is it effecting your ability to complete day-to-day tasks, your ability to go to work, your ability to sleep, your ability to manage stress, your ability to socialize with individuals. So really thinking about how is it interfering with your life? And that's kind of a really important thing to address, especially as we're moving away from the medication piece and more into self-management approaches to chronic pain. There are two really great tools that have been developed over the past couple years, the first one is the Defense and Veteran's Pain Rating Scale, the DVPRS and it combines kind of this numeric rating scale that zero to ten with very clear anchors for each number to get a better rating of a person's pain intensity as well as some of those supplemental questions about how pain is impacting functioning related to mood, sleep, stress and daily activities. The NIH also put out this awesome system, it's called the Promise System and it looks at aspects of pain and physical health functioning's such as sleep and fatigue, but it also addresses things like mental health functioning and social functioning. So it kind of pulls together these different aspects that might be related to pain to really see how pain is interfering with individual's lives and how they might be doing not just physically, but also emotionally, mentally and socially. And one of the nice things about the Promise System is it's free through the NIH website and there are opportunities to integrate this system into electronic health records and opportunities to complete this questionnaire in a computerized form that it could take people as little as three to four minutes to complete this assessment to give you richer data in terms of how pain is affecting their life.

Would you be able to briefly explain how pain can impact someone's mental health?

Many folks who have chronic pain also have depression or anxiety, for example. Conversely, many patients who have depression and anxiety may experience a heightened level of physical pain. So there's a lot of crossover in between. For example, those who have fibromyalgia often have depression. So as high as 60% of patients with this particular general medical condition will experience depression and oftentimes that depression can worsen or exacerbate the physical pain associated with fibromyalgia or any other type of chronic pain.

What about other psychiatric illnesses? I know that as a psychiatrist I see people more so than a primary care practitioner who might have a chronic psychotic illness. How does that intersect with pain in your experience?

The main thing to consider is those who have what we call severe mental illness are probably more likely to suffer from the pain and therefore, become maybe more dysfunctional in terms of day-to-day activities like getting a job, maintaining a job, participating in meaningful relationships.

When we talk about management of individuals with serious mental illness in the context of their wants, needs and values and choices, how would you recommend that mental health and behavioral health providers, those of us who don't work in primary or physical health care have a conversation with an individual with chronic pain in the context of their mental health and recovery?

Well, I think the key things you brought up there is, you know, in the context of their wants, needs, choices, values I think it's important to initially recognize that individuals with serious mental illness have needs, they have values, they have choices. So sometimes there might be an initial conversation around pain, but then it's kind of, "Oh I don't know what to do about this, this is physical health, let me just refer them to a primary care physician." But then, as we talked about a little bit ago, what happens is they go to primary care and then the primary care provider says, "Oh, you have a serious mental illness, you need to go talk to mental health." Or, "Let's get your mental health in check, and let's get that taken care of before we address any additional physical health concerns." But in reality, there's a lot that mental health providers can do to help individuals manage chronic pain. I think the first thing is doing a pain assessment, you know, if someone's coming in complaining of low back pain or headaches, or neuropathic pain, whatever it might be having a conversation with that person and from a mental health perspective those questionnaires that really ask about how is it interfering with your life? And especially a mental health perspective, how's it affecting your recovery? Is the pain impacting your ability to get out in your community, to socialize with other people? Is it impacting your ability to really manage your stress and manage your depression symptoms, manage your anxiety, whatever it might be. To kind of have that conversation to begin kind of creating those links between the chronic pain piece and the psychological and emotional piece I think can be really helpful.

So I'm wondering about this as a provider, is there any algorithm that that you follow, or questions that you ask when you're thinking about, say you have the person in front of you who needs to have something to help with their anxiety or sleep and they may also need to have something to treat their pain. Is there some way that you could maybe help our listeners walk through that scenario?

Yeah, no that's a tricky question. Once pain, you know, goes on past three, or four, or five months, it becomes more difficult to treat. And one thing I really would want to stress to the listeners is that although analgesics can be effective and are certainly indicated in both acute, sub-acute and chronic pain, once you reach the state where patients have had pain for greater than three, four or six months you often want to think about a multi-disciplinary approach, or multi-dimensional approach for which only one of those dimensions would include analgesics, and that's going to be important. So for example, use of cognitive behavioral therapy, or supportive psychotherapy designed to beef up or add to existing coping strategies. Make sure we're addressing maladaptive coping strategies and trying to work as a team with the patient to try and reverse those maladaptive coping strategies. So again, very important to look at this from a multi-factorial, multi-dimensional, multi-disciplinary approach. I find that to be the most effective.

How can providers bridge the gap between pain treatment and serious mental illness treatment?

Those struggling with severe mental illness already, right off the bat are much more vulnerable than the general patient population. They're more likely to actually die decades earlier, relative to the general patient population. They're more likely to not get screened for common cancers, for diabetes, for hypertension. They're more likely to not get treated for those same disorders. So I think from a provider's standpoint very important to make sure that we work as a team with those who we're treating, if they have severe mental illness keep it in mind that they're more likely to not get treatment for chronic pain. And right off the bat if we know that, we're going to be ahead of the game and able to advocate for those who need it most.

Chronic pain, it's a huge stressor. So even thinking about, you know, one of my favorite things when I'm working with someone with chronic pain or thinking about how to help them manage chronic pain is thinking about the stress management piece. Chronic pain is a chronic stressor and if there's ways that we can talk to them about how to better manage stress in their lives, how to manage that tension in their

muscles that can make the pain worse or just the negative thoughts and feelings around stress and negative experiences that might be able to help reduce that perception of pain intensity or at least get them feeling better to get out and do the things that they want to do. So encouraging mental health providers to work with individuals or clients with serious mental illness to be able to do relaxation exercises, deep breathing exercises, problem solving interventions to really help kind of manage that stress, that can really go a long way in managing the chronic pain.

If a provider determines that the person they're working with has chronic pain, how does this affect treatment planning?

The use of opioids for the treatment of chronic pain, for whatever the cause of the pain is was mainstream just ten, 15 years ago. In fact, providers were expected to treat chronic pain with opioids and there was no limit, there was no ceiling. Now we know that the use of opioids for the treatment of chronic pain is not necessarily an evidence-based approach. In fact, there's plenty of data now showing that that's pretty much not the way to start the treatment for chronic pain management. Usually you want to use a stepwise approach and you start off with non-opioids depending on the nature of the pain, for example, is it visceral pain, is it neuropathic pain, is it acute, is it chronic, is it related to cancer, non-cancer? So there are many different things to consider in terms of which agents you're going to use in terms of analgesia. But at the same time, screening for anxiety, screening for depression, screening for bi-polar disorders, screening for psychotic disorders and substance misuse is of paramount importance. We teach our students the mnemonic AMPS, A-M-P-S, A-M-P as in Paul- S; Anxiety, Mood, Psychosis, and Substance Abuse, definitely important. To screen for those common psychiatric disorders in the context of treating someone with chronic pain.

Would you be able to explain how pain medication may interact with the psychotropic and other type of psychoactive medications that we prescribe?

Yeah, and I know currently the first thing that comes to mind is use of opioids; right. So the use of opioids in the context of treating insomnia or treating high levels of anxiety. That's the first thing that comes to mind for using for example, benzodiazepines, like Ativan or Xanax, or Klonopin; Or sedative hypnotics like Lunesta, or Ambien, or many others there could be a problem in terms of interactions with opioids, the increasing the potential for decreased respiratory drive, which is concerning given the fact that opioids now are the number one cause of accidental deaths in this country. And adding a benzodiazepine or sedative hypnotic or some other agent that can cause sedation can be problematic.

Are there any non-pharmacological solutions that you would recommend that could be helpful to an individual with pain and a serious mental illness?

There's a lot of psychological interventions out there that have been tested to manage chronic pain. So the three big ones that have the most evidence, cognitive behavioral therapy for chronic pain has a lot of evidence backing it in terms of improving functioning and quality of life in individuals with chronic pain. Acceptance and commitment therapy is another one that has a lot of promising evidence, as well as, mindfulness-based stress reduction. So I think there could be some things that are very practical and built into day-to-day life as well as some other strategies and solutions that might require intervention with some type of trained professional to be able to manage chronic pain. But I think more and more there's a lot of stuff out there, a lot of things emerging on how to manage chronic pain without the use of medications.

So it reminds me of a patient who I worked closely with for several years who really complained of pronounced depression, frequent thoughts of suicide, overall just feeling demoralized with low levels of energy and low self-esteem, but also with a sort of unusual atypical almost head to toe chronic and severe pain that was largely refractory to any type of treatment. And our approach was to use cognitive behavioral therapy, to use antidepressants in a targeted way and also intermittently to use physical therapy all to address the depression and do everything we could to address this very long standing and

severe depression. As the depression lowered, the need for opioids decreased to the point where after a long course of cognitive behavioral therapy, both in terms of individual therapy and group therapy, we were able to completely stop all use of analgesics including opioids. Again, this illustrates I think the connection between depression, anxiety and other emotional pain with physical pain as well.

Thanks so much for sharing your knowledge and also some information about good resources. Dr. McCarron, Dr. Travaglini. thanks for taking the time to be with us and for sharing your insights.

Thanks Curley appreciate being here.

Again, thank you for having me.

Next up we're going to shift perspectives and talk with someone who has experienced chronic pain in the context of a serious illness. Amber Guerrero is a therapist and an executive member at a transitional living program for women and children who are experiencing homelessness usually as a result of trauma, mental illness, or addiction in Tulsa, Oklahoma. Ms. Guerrero, thanks for joining us.

I'm happy to be here, thank you so much. And you can call me Amber.

Thanks so much.

So, would you be able to provide a brief overview of how you've gotten to this point in your recovery?

Sure, I have always experienced some level of pain that was not what you would expect an individual at my age, whether it was as a child or a young person in my 20's, early 30's. And people just kind of always blew me off, "Oh you're exaggerating, it can't be that bad" et cetera. And then when I was diagnosed with depression and PTSD, people started to chalk it up to, "Oh, it's anxiety." It has been a long journey, but when it really got to the point where we were at critical mass, then I knew that something was desperately wrong, was after my mother died by suicide in 2002. My pain just was off the charts, physical and obviously emotional. But again, I go to doctors and they would say, "Oh, well you're just grieving. It's just depression, it's just anxiety. Let's give you some benzodiazepines." And they'd try to send me on my way. Well, I didn't want to take those because my family has a pretty serious family history of addiction and I knew that given the amount of emotional distress I was in that would not be a good combination for me. So, it took a lot of arguing and begging and pleading on my part and I really feel like advocating for myself to finally get to a point where somebody was hearing me. It took about eight years, I want to say, before finally someone agreed to hear what I had to say about the research that I had done, which led me to the diagnosis of fibromyalgia and I was sent to a rheumatologist who confirmed it. And in addition to the fibromyalgia they discovered that I have scoliosis, so I had both of these issues on top of the depression and PTSD, so it was just like one big ball of string that was just terribly tangled up. One of the things that we know specifically about fibromyalgia is that after there's been a traumatic event that is when it really kicks into gear, so to speak, and that's what happened with me. Like I explained, you know, I had always had these widespread body aches and all this all-over pain and there would be times that I'd just be so tired I couldn't get out of bed, but after Mom died it was like I had been ran over by a train.

Thank you so much for sharing your story with us. It sounds like you went through, as you described it, a journey but it sounds like it had a lot of difficult moments and it also occurs to me that instead of people understanding better your pain when you were diagnosed with a mental health problem that then they kind of were even more dismissive, if I'm hearing you correctly.

Absolutely. People just wanted to, I guess, send me on my way is really how it felt, I felt like I just talked to myself a lot, that I just went away from appointment after appointment feeling more and more unheard. Which added to my depression and my anxiety and added to my distress which added to the pain.

I want to shift gears a little bit and ask how do you think the mental health community not understanding or addressing the issue of pain may have an impact on people who are in recovery?

When we don't feel heard in all areas of our life, it makes us feel diminished and I know that I certainly felt that way a lot. I felt that people were treating me like I was med seeking and when I would tell them how much pain I was in, having it swept under the rug added to my distress a great deal. I felt that no one was listening to me and no one was hearing me completely, which made it very difficult for me to, I feel, achieve the level of recovery that I could have achieved a lot sooner. Things weren't getting addressed together so I just would do things that you're not supposed to do, which is decide to go off my meds. And it really did take losing my mom for me to realize that, hey, I really do need to be on these mental health meds and I'm just going to have to keep screaming from the rafters until somebody listens to me.

I wonder in terms of some of the ways that people frame questions or conversations for you when you were having your experience and trying to get help. Were there things that were helpful or less helpful for you?

Yes, I can certainly think about the things that my doctor does now that are very helpful. We don't just have the one pain scale question of where's your pain on a scale of one to ten or whatever, he breaks it down through everything. He really tries to look at the whole person, so he asks me questions about where is my depression, how has it been. How has my pain been? How has my experience with any number of other symptoms been? So that we are not just all or nothing in one basket.

I wonder if there is anything else you've tried or that you'd recommend to someone else who may be having a similar experience communicating about their pain?

One of the things that I think helped was that I was very fortunate enough to have an advocate in my spouse. So I think having that support system was very helpful. If someone doesn't have a spouse then I would say your best friend, or someone who you feel like could advocate for you and that you trust to help you through that. Tracking my symptoms was very helpful. What was worse, what made it worse, what made it better, how did I manage symptoms. I had a WRAP plan, the Wellness Recovery Action Plan, I had one of those. What were the things that I knew I needed to do every day to feel better? I need to eat or I'm one of those people who get, you know, hangry. I need to make sure I sleep enough, which sometimes that means going to bed at seven o'clock, even though I'd rather stay up until one o'clock in the morning because I'm much more of a night owl. I have to make sure I do something for myself like read for fun, not just for work or school or whatever it was. I went to support groups for a while. I talked to friends. I talked a lot, a lot about my loss and losing my mom. I became an advocate which was very helpful. It's a good thing for me to help fight for other people.

It sounds like you've done a wonderful job of incorporating different modalities. You've mentioned advocacy from outside in the form of a spouse or friend. And then also later becoming an advocate yourself and including for others who have experienced loss. And I really like the part about self-care, I try to talk with the people that I work with about making some space to do the things that you're discussing, like sleeping well, eating well, even making a space to meditate or just to take care of yourself, I think those holistic approaches are really important.

Amber Guerrero, thank you so much for sharing your experiences with us.

Thank you very much for allowing me the opportunity to do so.

Next up, we're going to focus our conversation on cognitive behavioral therapy for pain. Joining us for this segment we have Dr. Jennifer Murphy who is a pain psychologist with the U.S. Veteran's Administration. She is a nationally recognized expert in chronic pain management and authored the VA's Therapist Manual for Cognitive Behavioral Therapy for Chronic Pain Among Veterans. Dr. Murphy is a master trainer in cognitive behavioral therapy for pain. Dr. Murphy welcome to the Recovery to Practice Podcast.

Thank you for having me, I'm very happy to be joining you today.

So you're a national trainer and literally wrote the book on cognitive behavioral therapy for chronic pain. Please tell us how your practice has let you to working with people with serious mental illness and chronic pain.

Well, early in my career in behavioral medicine I was very fortunate to be hired by Dr. Michael Clark at the Tampa VA to develop a pain program for veterans from Iraq and Afghanistan and while I was doing that I was able to work in the system's only truly in-patient chronic pain rehabilitation program, which was the best education and experience I could have hoped for. It's the model of an interdisciplinary, comprehensive approach to pain care, which is really the ideal to work in a team like that. So I quickly developed a true passion for working with individuals with chronic pain and was struck by the high level of medical and psychiatric co-morbidities among the population it tended to be a pretty highly complex population in that way. Their pain had often been approached from a pretty purely biomedical perspective up to that point, often without addressing many of the psychosocial factors that really directly impacted their pain experience. So while serving as the director of that program I had the opportunity to work on the VA's CBT for chronic pain protocol and eventually author that manual and begin to train other mental health clinicians in how to better address the needs of those with chronic pain from a whole-person perspective.

We heard earlier about not one size fitting all, so it's certainly to have this extra tool in the tool box. Please tell us about the people you serve with chronic pain and mental illness and how that shaped the development of your CBT protocol.

Well, within the VA and certainly outside the VA we see a broad range of mental health diagnoses as co-morbidities of pain, it's something that we know that individuals with chronic pain are more likely to have mental health issues. Most commonly those would be depression and anxiety as well as PTSD, we also see, of course, many people with bi-polar disorders, schizophrenia who may be struggling with pain related issues and have often been overlooked because maybe their mental health needs have been on the front burner and something like pain has been left behind. The other thing that we really see, unfortunately, is that suicide and pain have a high correlation. In fact, a recent VA behavioral health report from 2015 actually found that the most frequently identified risk factor in the veteran population for those who died by suicide was pain. And so I think that kind of first and foremost as far as this question goes, it really is about recognizing pain, asking about it, assessing it properly, and really doing an evaluation that is a bio-psycho social evaluation where we are looking at the whole individual and making sure that we are addressing things adequately. And so I think one important piece is speaking to the education around pain and the treatments around pain in a very kind of concrete grounded common sense way so that we're not talking over people, but we're really connecting with them and drawing the connection to why is this important in their lives, what are their goals, what's their motivation, and really staying in touch with that. And then the final point I think in terms of the training and the approach and kind of the mental health overlay with pain is really the importance of getting these kinds of messages in as early as possible so that people from the beginning, primary care all the way up through specialty care are providing a consistent message to people with pain and kind of providing that basic education and creating realistic expectations and really talking about the role of the individual in managing their own pain.

So this finding that pain can be associated with suicide is very alarming and it highlights the need for us to have effective interventions. I want to talk with you more about the one that you've designed. Most of us are familiar with kind of the behavioral therapy as a psycho-therapy tool to help those people look at their thoughts and their behaviors. How can cognitive behavioral therapy, or a CBT be applied to chronic pain though?

Well, in the context of individuals with chronic pain, CBT really helps people to better understand how various factors in their life impact and are impacted by the pain experience. So I think the first piece is just gaining an awareness of there's all of the variables that come into play, oftentimes we're not fully aware of those. So first is kind of identifying what are the variables that are there. CBT in the context of chronic pain, it's really about empowering people to respond to pain in a more helpful way so that they can turn

down the volume on their pain experience and really live their best life possible. So a lot of the things about CBT that we know, of course, are very consistent when applying it to individuals with chronic pain, it's a structured approach that really focuses on building skills that equip people to change their relationship with pain. So instead of being at its mercy, which is how a lot of people feel, people learn techniques and ways to retrain their brains and retrain their bodies. And this doesn't mean that pain disappears or goes away, if we were able to do that we would really be miracle workers. But what it does mean is that pain doesn't have the same overwhelming power that it once did. We're really seeking to decrease pain related suffering by increasing the skills and tools that people have. So much of what a CBT therapist does with individuals with chronic pain is to help facilitate certain lifestyle changes, behavioral changes that are similar to other areas of health psychology. So oftentimes when I'm talking about it I think of it in similar way as say someone with Type 2 Diabetes, they've been told to make various changes, perhaps to exercise, eating, things like that; but they may not fully understand why or know how to make those changes. So somebody who does CBT for chronic pain is really mapping out how do we make those changes. And it's really an opportunity to work with people, find out what motivates them, what are their goals, and how can we work together to impact the trajectory of their pain experience in a positive way. And so by using many of the CBT tools that we have we can actually decrease the intensity of pain. This isn't just about, you know, "coping better with pain" and in fact I think that sort of minimizes what we're doing here. We're helping people respond in a more adaptive way so that we can actually decrease their pain intensity, meaning pain level, the literature supports that, that we see changes in pain intensity. But also to really decrease the negative impacts that come along with pain, so shifting our focus, shifting our minds, shifting our physiological responses to pain in ways where we can actually impact it very directly. And this has been applied in a variety of ways, you know, individual therapy, group therapy, as well of course, in multi-modal treatment teams or interdisciplinary programs like the ones that I've been fortunate to work in, you know, we're really talking about treatment that's informed by these cognitive behavioral principles.

That's really interesting. What are the other key tasks when using cognitive behavioral therapy with individuals in chronic pain?

The pieces that we always do that are critically important to the process is; one, a lot of education around pain, so there's a lot of things that we think of as foundational and almost basic information around pain but oftentimes the individual themselves and of course their family members haven't heard these messages. And so these are things about, you know, the difference between acute and chronic pain and understanding the benefits and need for safe paced movement, the importance of moving around and not avoiding activity. This is all driven by goal identification which is a very important part of keeping it very patient centered. As you mentioned, there's also the very important role of reframing unhelpful pain related thoughts. One of the most important pieces of CBT for chronic pain is the use of relaxation techniques to undo the stress response, that is something that's sort of stuck on, if you will, in people with chronic pain and it works against their entire process. And so coming in at the ground level and really working on changing that physiological response not only decreases muscle tension and pain, but of course it also helps on a psychological level. So that's critically important. Once we cover all of those pieces what we really want to do then is how do we integrate all of these and figure out a maintenance plan, you know, sometimes they call it relapse prevention. But that's always an important piece too, we're trying to again, increase self-efficacy, increase ownership, have people kind of be the coach of their pain team if you will. So those are the kinds of language, things I like to use so instead of it being a very, you know, authoritarian or the doctors and the doctor, you know, we're on a team together and we have to work together to get you in the best position that you can be in and have the best quality of life. You're telling us what's most important to you and we're trying to help you get there.

Can you share an example of the types of improvement you've seen when using the CBT with individuals with chronic pain?

I feel so incredibly fortunate to have had so many positive experiences with people using these cognitive behavioral principles and approaches. One of the most wrecking examples is with individuals who have significant fear of movement and have taken to avoiding the majority of people, places and things in their life. So one of the hallmark responses for pain is avoidance and avoiding not only physical activity, but often avoiding social situations, avoiding other situations that may be difficult can lead to a number of negative impacts for individuals. So oftentimes you may have someone that will present and have difficulty walking for even say five or ten minutes, because they become highly deconditioned from inactivity. And it hurts to do things, it hurts to move and so they stop moving and this is a very understandable response. The problem is, it's not a very helpful response and so it can take some time, but if you can help them kind of see that avoidance has led to a variety of these negative consequences and get them to become slowly reengaged with life by making really small changes, parking farther away at the grocery store, or starting to walk even five minutes, ten minutes a day, something like that, work very gradually with them with the assistance of a physician, a physical therapist, things like that. It's amazing that within a few months you can picture this person who walked in and had a hard time getting to your office and within a few months they may be walking for 30 minutes or more and they're not only more active, but they have a pride about them, a brighter affect, maybe they've become reengaged with family and friends, and so it's interesting to see this evolution occur because often people are very down when they get there. And you have to be a bit of a cheerleader in the beginning and really, not only provide the support for what you know in the evidence and what you've seen as a clinician, but also, you know, I can't tell you how many times we say things like, "I know you can do more than you think you can so let's just try it for this week, let's just try it for this week." And then incredibly over the course of a few months you see huge changes in people, both physically and psychologically that are really striking. And then best-case scenario is that you then have those people kind of champion the cause and help out with other people who have chronic pain and kind of say, you know, "I used to be there." And help pull people up, that's what happens in groups a lot of the time which is really lovely to see.

Can you tell us about the CBT manual and whether or not a prescriber who wants to incorporate some of these techniques into their practice might be able to access it? And if so where would they go and how might it be used?

Sure, so in the VA the manual was created and used in the context of a larger training program, it is freely and publicly available it was created through the VA and so that makes it a public facing resource for people who are interested.

We're including a link to your CBT therapist manual in the show notes for the recording.

Dr. Jennifer Murphy thank you so much for joining us for this podcast.

Of course, I really hope that we're able to increase the availability of things like CBT for individuals with chronic pain to get them living their best lives.

Thank you for joining us for this clinical decisions support podcast. Links to relevant studies and sources of information for clinicians are included in the show notes. I hope you will listen to the other podcasts in this series. RTP is focused on improving the knowledge and skill of the behavioral health workforce to help expand the principles and practices of recovery oriented behavioral health care across multiple service settings. If you would like more information on this topic or other topics related to recovery from serious mental illness, please visit the Recovery to Practice website where you can watch archived webinars, subscribe to our newsletter, or learn more about our discipline-based curriculum.