Pain Science for Patients with Chronic Pain

- Psychology is built into the definition of pain (IASP definition of pain is that it is a negative sensory *and* emotional experience).
- Pain is a product of the nervous system, regardless of where it is felt in the body.
- The regions of the brain that process pain also process anxiety, fear, and emotions related to depression (e.g., sadness). Pain, anxiety and depression frequently co-occur. Treatment for one factor helps reduce the other factors, as well.
- Pain triggers "hard-wired" physiological and psychological responses that, over time, lead to lasting changes in the brain and body-- changes that prime you to have more pain.
- Everyday thoughts and feelings can impact pain. Negative thoughts and feeling serve to amplify pain whereas calming thoughts keep pain better controlled.
- Pain isn't something that just happens to you. Everyday experiences will contribute to pain intensity (e.g., stress, sleep quality, activity, worrying about pain).
- Through use of active skills (learned in pain psychology or behavioral medicine treatment) you can begin reducing these lasting negative changes in brain and body caused by chronic pain.
- The relaxation response triggers a physiological cascade that actually counteracts pain responses. These skills should be used daily to retrain mind and body away from pain.
- Avoiding activity out of fear of pain can actually lead to greater pain over time. You can partner with a therapist or physical therapy specialist to slowly begin restoring a degree of movement and function.
- By learning and using pain psychology skills, you will improve your response to medical treatments, including medications, procedures and surgery.

Fostering Engagement in Behavioral Pain Care: Talking Points

- Cognitive behavioral therapy for chronic pain (pain-CBT) is evidence-based, is very low-risk, and has been shown to improve outcomes equal to some medications – with no side effects!
- Pain-CBT is not an "alternative" treatment for pain—it is a *primary, evidence-based treatment* that helps patients become active members of their pain care team.
- Educate patients about pain psychology at the *beginning* of treatment: prevent the common pitfall of psychology being the treatment of "last resort" and indicative of medical treatment failure. Recommend pain psychology as a support to ensure success with health goals, pain management, and medication reduction.
- Neuroimaging research shows that pain-CBT leads to lasting changes in the central nervous system that cause pain relief and prime individuals for future pain relief.
- Provide brief education of pain (backed by neuroscience) so that patients will understand why a referral to behavioral medicine "makes sense" as opposed to it meaning that they are "crazy".
- Validate the patients experience of pain and that it is real - while instilling hope of restored functioning through a multi-faceted approach including behavioral medicine.
- Explain that while a physician tells you *what* to change to improve pain management, a pain psychologist helps with *how to make those changes.*
- Remind patients they will have *better medical outcomes* by learning and using self-management skills throughout their treatment.
- Affirm your commitment to gold standard, comprehensive pain care that emphasizes the patient as the most important person on the pain treatment team.

When to Refer to a Pain Psychology Specialist

The use of pain psychology is often helpful when the **patient seems stuck in a passive role**, relying on doctors to "fix" or cure their pain, without fully appreciating the factors that impact pain and what they can do to improve their own experience.

Refer to your behavioral medicine colleagues when one or more of the following is noted in the patient's presentation:

- **Focus on medications and procedures, often to the exclusion of partnering in self-management**
- **Imbalanced activity levels** (e.g., doing too little, too much, having difficulty prioritizing self-care within the context of pain and competing life demands)
- **Unsure how to move forward and improve quality of life**
- **Lack of pain education and understanding about the relationship between mind and body**
- **Fear of pain** or injury preventing movement/activity
- **Lack of pain and stress management skills**
- **Feelings of helplessness and despair about pain**
- **Observation of psychological distress and/or anger**
- **Social isolation**
- **Pain-related anxiety and/or depression**
- **Excessive health care utilization without obvious benefit (red flags may include "doctor shopping" or frequent visits to the emergency department**
- **Chronic use of opioids or other habituating medications without corresponding functional benefits**
- **Suicidal ideation or other high risk behaviors in the context of chronic pain**
- **An interest in self-management approaches to pain is expressed**

Transforming a Clinical Culture: Integrating Behavioral Medicine into YOUR Practice without additional resources

- MAKE PSYCHOLOGY A VISIBLE PART OF THE CLINIC CULTURE. Have brochures and flyers in your clinic that discuss the role of psychology in the management of pain.
- MAKE IT ACCESSIBLE. Have copies of books on chronic pain behavioral management or chronic pain self-management available in the clinic lobby for patients to see/read. Or keep copies prominently placed in your office so you can show patients.
- SET EXPECTATIONS ON DAY 1. At the first visit to address pain, explain that behavioral medicine and self-management are vitally important aspects of pain care. Let them know that you will partner with them to help them make lasting changes.
- MAKE IT EASY. Plug your patients into resources, including the single-session pain psychology class. Remind them that pain psychology isn't just about addressing problems, it's about helping them live their best life possible! Visit www.paintoolkit.org for a wealth of free resources.
- WALK THE TALK. *AT EVERY VISIT* engage patients in a discussion of their self-care practices, home exercise program, activity engagement, and what they are learning through behavioral medicine. You will shape their understanding of its importance by making self-management an important part of each patient contact.
- Consider including family in the education process so that they can better understand chronic pain while also changing behaviors that may engrain the patient in a "sick" or dependent/passive role.
- Consider establishing a free chronic pain support group in your clinic to further integrate on-site free resources for patients. The American Chronic Pain Association (ACPA) has provides information to help you identify a local peer leader who can lead these free groups. Visit www.theacpa.org to learn more.

Pain Psychology Resources

VIDEOS

- **"Understanding Pain and What You Can Do About in 5 minutes"** https://www.youtube.com/watch?v=RWMKucuejIs
  Excellent quick resource for patients!

- About **50 different videos on pain self-management** at this link, with separate categories for patients and medical providers: https://www.paintoolkit.org/resources/useful-videos

- **What Is Pain Catastrophizing?** (6:53) By Beth Darnall, PhD.
  https://www.youtube.com/watch?v=fnNAF4EPFzc

- **"Unlocking the Medicine Box in Your Mind"** (Beth Darnall, PhD; 2015): https://www.youtube.com/watch?v=GeqLbJRci1Y

- **"Understanding and Reducing Sensitization"** by Dr. Paul Hansma (3:21)

WEBSITES:

American Chronic Pain Association (ACPA)
http://theacpa.org
The ACPA is dedicated to peer support and education for individuals with chronic *pain* and their families so that these individuals may live more fully in spite of their *pain*. Their website includes free pain management tools (print and electronic), local support group information, and a resource guide for chronic pain treatments.

The Pain Toolkit
https://www.paintoolkit.org/
The Pain Toolkit website offers a wealth of pain self-management resources for free or for nominal print cost. Website includes resources for patients and specific resources for medical clinicians.

PRACTICAL RESOURCES: RELAXATION / MINDFULNESS / MEDITATION

(1) FREE Mobile Relaxation App: Breathe2Relax (from the Department of Defense)
http://t2health.dcoe.mil/mediakit/breath2relax-mobile-application

(2) "Enhanced Pain Management" Audio CD and MP3 file (20min)
(Binaural audiofile by Beth Darnall, PhD includes diaphragmatic breathing, progressive muscle relaxation, and autogenic training)

Mindfulness Meditation is evidence-based treatment for chronic pain. It involves helping calming mind and body, and learning to release the mental focus on pain that happens automatically. Research shows that mindfulness and meditation techniques work by changing how your brain responds to pain, thereby reducing pain intensity. Learning mindfulness and meditation can help you reduce your pain. Here are some resources to help you get started:

(3) Free Online Mindfulness-Based Stress Reduction (MBSR)
8 week course http://palousemindfulness.com/

(4) Free Mindfulness App and Guided Meditations:
http://counselingcenter.utah.edu/services/mindfulness.php

(5) Free Guided Meditations (English and Spanish)
http://marc.ucla.edu/body.cfm?id=22

LOCATING SKILLED THERAPISTS / COMMUNITY TREATMENTS

Acceptance and Commitment Therapy (ACT)
Locating a skilled ACT therapist:
https://contextualscience.org/civicrm/profile?gid=17&reset=1&force=1

Particularly useful for helping patients transcend perceptions of injustice of victimhood.

Certified Biofeedback Therapists
https://Bcia.org
Go to "Find a Practitioner" tab. Conduct a radius search based on the client's zip code.

Self-Management Courses

Chronic Disease Self-Management (CDSM) and Chronic Pain Self-Management Program (CPSMP) are 8-week evidence-based group treatments that are led by a therapist or 2 certified peer co-leaders. Courses are not typically covered by insurance but may be embedded into closed-payer networks (e.g., Intermountain Healthcare or the VA Healthcare System). Additionally, many municipalities may offer self-

management wellness courses through senior centers or other community services; the courses may be offered free of charge or fees may apply; be sure to check costs (if any). Self-management resources vary by region and community. To determine if self-management courses exist in your area:

- Check first with your healthcare system or insurance carrier.
- Google "Chronic Pain Self-Management" and your city to see if courses exist.

PATIENT BOOKS

Cognitive–Behavioral Therapy Based

Turk, D., & Winter, F. (2005). *The pain survival guide.* Washington, DC: American Psychological Association.
Lewandowski, M. (2006). *The chronic pain care workbook.* Reno, NV: Lucky Bat Books.

Darnall, B. (2014). *Less pain, fewer pills: Avoid the dangers of prescription opioids and gain control over chronic pain.* Boulder, CO: Bull Publishing Company.

Darnall B. (2016). *The opioid-free pain relief kit: 10 simple steps to ease your pain.* Boulder, CO: Bull Publishing Company.

Other Recommended Books

Dahl, J., Hayes, S. C., Lundgren, T. (2006). *Living beyond your pain: Using acceptance and commitment therapy to ease chronic pain.* Oakland, CA: New Harbinger.

Pain Science (Pain Education)
Butler, D., & Moseley, G. L. (2003). *Explain pain.* Adelaide, Australia: Noigroup.

Free book: Kopf, A., & Patel, N. B. (Eds.). (2010). *Guide to pain management in low-resource settings.*Seattle, WA: International Association for the Treatment of Pain. https://s3.amazonaws.com/rdcms-iasp/files/production/public/Content/ContentFolders/Publications2/FreeBooks/Guide_to_Pain_Management_in_Low-Resource_Settings.pdf

CLINICIAN BOOK

Darnall, BD (2018). *Psychological Treatment for Patients with Chronic Pain*. American Psychological Association Press. (available August 2018). This book provides an overview of evidence-based psychological treatments for pain and recommendations for clinicians. Case studies and practical resources for patients and clinicians included.

Patient-Centered Opioid Tapering

- Recognize that most patients are fearful.
- Become aware of your reactions; managing frustration is critical.
- Don't take it personally. Patients may resist a treatment plan; it's not about you.
- Explain the health benefits of reducing medications. Patients need to know why reducing opioids is good vs. likely to leave with suffering. (provide a handout)
- Highlight why reducing medications will specifically help *them.* Tailor a personalized, conversation for each individual patient.
- Anxiety about reducing medications undermines patient engagement and patient response to the taper. Helping allay patient concerns is paramount to success.
- Forced tapers yield suboptimal results relative to voluntary tapers.
- Connect. Validate patients' concerns. Feeling heard is the foundation for patients to trust you.
- Share the data on opioid tapering results: pain does not typically increase when done the right way; for many, pain improves.
- Explain how you will partner with them (follow-up schedule, micro-dose decrements to start, very slow taper over months to allow for psychological and physiological adaptation)
- Explain that the goal is to help them stay comfortable through the taper.
- Help them feel in control (consider micro dose decrements to start, ability to pause the taper if needed)
- Give them support (pain psychology resources, clinic staff support)
- Provide a resource reading list for opioid tapering and a skill set to manage taper-related anxiety (e.g., *Less Pain, Fewer Pills;* or *The Opioid-Free Pain Relief Kit*).

Addressing Opioids

When opioid reduction is the goal:

- **Assess motivation** and readiness to reduce opioids.
- **Assess any/all negative impacts** from opioid use (e.g., cognitive effects, fatigue, poor sleep, effort to obtain scripts, stigma, etc).
- **Shift paternalistic dialog**. Help patients understand the long term risks of opioids and why using less medication is in their best interests. Doing so will minimize perceptions of injustice and blame.
- **Ask**: What are your concerns about reducing your opioids?
- **Focus on a small goal**. Focus on less opioids, not *no opioids*. No opioids is often too high of mental hurdle.
- **Set positive expectations**. The biggest patient fear is greater pain. Review the data that when opioids are reduced slowly and sensibly, pain intensity tends to remain constant or improve. Sleep improves with opioid reduction and that facilitates reduced pain.
- **Assess and provide education** for how psychobehavioral factors can maintain greater use of opioids

  poor pacing → greater pain → opioids

  anxiety → greater pain → opioids

- **Provide specific resources** (e.g., books on opioid reduction).
- **Declare your philosophy:** Opioids may be *one part* of an overall care plan--not the whole story. And for many, long term opioids are contraindicated.
- **Emphasize self-management**. Partner with patients in reducing their opioids risks by emphasizing behavioral medicine. Doing so yields the best outcomes.

If possible, provide ongoing support. Self-management groups, support groups.

Opioid Tapering Tips for Physicians / Prescribers

Remind Your Patients About the Benefits of Opioid Tapering: Studies suggest patients get better, not worse with a VERY SLOW opioid taper. They actually have less pain and feel better overall! On top of that, they will enjoy fewer side effects and greatly reduced health risks.

Reassure your patients. Your patients are scared because they tried and failed before. Most patients have failed because they went too fast with their taper and had withdrawals. Remind them that the VERY SLOW taper will prevent withdrawals and keep them comfortable. Everyone can wean down on opioids but the trick is to go very slowly and use skills to keep yourself calm as your body adjusts.

GO SLOW. Most taper guidelines suggest taper schedules that are too aggressive for the real-world chronic pain patient on multiple meds and high opioid doses. We do not recommend a specific taper schedule to you, but if a patient has been on opioids for years and decades, consider taking about 6 months for cessation. A good target is substantial reduction at 4 months, as low as possible at 10 months.

Not Everyone Will Taper Completely. The goal is to get patients as low as possible in ~10 months.

Check In With Your Patients. At each follow-ups, ask how they are doing. Ask if they are ready to go down on *one* of their doses.

Engage Them in Their Pain Care. Ask if they have read the book you recommended to them or the online information. Ask them what they are learning about how to best keep their pain low so they naturally need less medication.

Narrative For Pitching Opioid Tapering to Your Patients

I was reviewing your chart and noticing that you've been on opioids for 5 years now without major improvement. New federal guidelines are asking doctors to reduce opioids for chronic pain because the data suggest they don't work well in the long term, and they cause a lot of problems and health risks. For instance, you have back pain, and data show that opioids don't help back pain and may make things worse. Interestingly, research also shows that when people like you who have been on opioids for years get off them, they do better! In general pain actually reduces. Mood improves. Side effects go away, and health risks decline. For all of these reasons, I think the best plan for your pain is to get you on a very, very slow opioid taper program. So slow your body will not even notice the medicine is being reduced, and you will have no side effects. We would take 6-10 months to get you down as low as possible. We will focus on treating your pain differently, getting you connected with self-management resources, and maybe using some lower risk non-opioid medications. I would like to partner with you on this. I will follow you closely and we will go very slowly to help you succeed.

Tips & Scripts for Communicating About Opioid Reduction with Patients

- "It's not about taking something away from you. It's about treating your pain better, with lower risks."
- Understand their concerns. Ask them if they are interested in reducing opioids. If not, why.
- Assess history of withdrawal symptoms. Patients often believe that they will experience withdrawals and increased pain if medications are reduced. "Have you ever missed a dose of medication, or had withdrawal symptoms before?"
- Educate patients about the distinction between withdrawal symptoms, "baseline pain", and what they can expect from a very slow opioid taper.
- "We can partner together and reduce your medications so slowly your body doesn't notice it. This keeps you comfortable and prevents withdrawal symptoms."
- "When done right, most people who reduce opioids do not have increased pain. In fact, pain actually improves for many people." Describe the 2018 *JAMA Internal Medicine* paper on this topic (Darnall et al)
- Patient videos can be a valuable tool. Visit www.empower.stanford.edu for several video vignettes of patients with successful lived experience with tapering opioids.
- "When opioids are tapered THE WRONG WAY (e.g., too aggressively), increased pain and withdrawals results. The data show that when opioids are tapered THE RIGHT WAY we can prevent both of these bad outcomes and help you lower your opioid dose without increasing your pain."

Communication Examples for Opioid Reduction

- **PATIENT: "I tried stopping once and my pain was terrible."**
  YOU: "That's a common experience that usually happens when medications are reduced too quickly and it triggers withdrawals. Our goal will be to prevent you from having negative symptoms. To address this, we begin with such a slow reduction that your body will not notice the difference and will not react to it. This sets you up for success."

- **PATIENT: "I don't want to reduce my opioids because if my pain is worse I will want them back and you won't give them to me."**
  YOU: "When done very, very slowly most people do not have more pain – and studies show that many find their pain actually gets *better*. Reducing opioids can be an effective way to actually reduce your pain; it's just got to be done the right way.
  Would you be willing to partner on a very, very slow reduction to see if we can get you reductions in your pain? For instance, we might try reducing (by 5%) over the course of a month or more. Meanwhile, we will focus on giving you other tools that will help all areas of your life that are impacted by pain."

- **PATIENT: "What if I find my pain gets worse. Then what?"**
  YOU: "Our goal is to prevent this scenario. We can prevent it by going super slow. But, chronic pain does flare from time to time, even with opioids. We will stay in close communication so in the unlikely event your pain increases we can learn from it and understand why it's happening. We can also pause the taper and work with your body."

- **PATIENT: "I'm really scared about this."**
  YOU: "You are not alone. It is common for patients to fear opioid reduction, even though most say that they would like to take less opioid medication. Our plan will set you up for success. We will go slow, communicate with each other, and I will help address your needs. Your job will be to help yourself be calm because that will help our plan work better. Let me connect you with some resources and tools to help you feel less anxious about this." (recommend the *Opioid-Free Pain Relief Kit*, direct them to www.empower.stanford.edu

Effective Communication for Partnering in Pain Care

Speak so that you will be heard by the patient:

- **Legitimize** that you believe they are hurting and their pain is real.
- **Focus on function**:
    - What concerns do you have about the quality of your life right now?
- **Redefine helping** as guiding the patient in effective self-management practices instead of curing pain.
- **Clarify** the patient's beliefs and expectations:
    - What would you like for me to do and what are you willing to do?
- **Shift** the locus of control to active instead of passive methods:
    - The more tools you have in your toolbox, the better equipped you will be to manage your pain.
- **Facilitate** collaboration:
    - I'm committed to working with you so that together we can develop a plan that's right for you.
- **Avoid** charged words and phrases that may provoke negative emotions or defensiveness (e.g., drug-seeking, nothing I can do).
- **Redirect** gently toward self-management efforts if patient continues to fixate on biomedical options:
    - Chronic pain is complex and medical answers are inadequate – let's focus on treatment options you are in charge of managing.
- **Provide support** by offering any other resources that will complement messages (e.g., written materials, videos).

Managing Reactions

- **Stay in control** of your interactions with all patients, even those that are more likely to elicit resistance and negative emotions
- **Monitor and manage** your own distress by increasing awareness and using tools to stay grounded:
    - **Observe internal state** throughout the experience
        - Use **mini deep breathing** to gain physical and mental balance
            - Take a deep breath in to a count of six → breathe in relaxation and calm
            - Take a deep breath out to a count of six → breathe out tension and toxicity
            - Repeat as needed, as often as needed
- **Be aware** of parallel process
    - **Avoid mirroring** patient's negative emotional state or being provoked by charged statements
    - **Emotions are contagious**
        - If you are calm, collected, and positive it will be more difficult for patients to maintain anger and frustration
- **Steer the conversation** by staying focused on the present and what we can do now to help the patient
- **Evaluate routinely**
    - Is the treatment therapeutic? If patient continues to resist committing fully, it likely is not the right time to engage