Cognitive-Behavioral Therapy for Managing Pain

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Michael Lewandowsk, Ph.D.

Assistant Clinical Professor
Department of Psychiatry
School of Medicine
Adjunct Faculty Psychology Department
University of Nevada
“Why CBT?”
“People are not disturbed by events, but rather the view that they take of them.”

Epictetus
Greek Stoic Philosopher
“Things are neither good or bad but thinking makes it so.”

*Shakespeare*
“There is usually a strong connection between how you think and how you feel. It may not be what happens to you that causes you to become anxious or tense but what you tell yourself about what happens.”

Gatchel 2007
The American Medical Association Agrees:

• Treatment of Chronic pain:
  • does not lend itself to strict, non-subjective, physical laboratory standards
  • Is not detectable or measurable on the basis of traditional, physical, tissue-oriented, medical disease model
  • Requires acknowledging and understanding a multifaceted bio-psycho-social model that transcends the disease model.

What we know

The past 2 decades:

• Clinical researchers studying pain emphasize the important role that certain specific sets of negative beliefs (such as catastrophizing and fear avoidance) play in the maintenance and exacerbation of chronic pain.

Overview and Goals

• Learn what is/isn’t CBT
• Understand Treatment Strategies
• What is the research behind CBT
• Identify the three different “waves” philosophies of CBT
• Learn strategies for impeding the onset of chronic pain
Words Matter?

It hasn’t been easy going through life with a name like mine, Dr. Feelgood.

It hasn’t exactly been a picnic for me, either, Mr. Smartypants.
WHAT CBT IS NOT

Cognitive behavioral therapy should not be confused with the following:

- ECT (joking)
- Psychoanalysis - This Freudian approach aims to get at the bottom of subconscious determinants of your actions/behavior.
- Person-centered/ humanistic therapy - This approach involves a mostly-passive therapist that says little during sessions in an attempt to have you resolve your issues independently.
WHY COGNITIVE BEHAVIORAL THERAPY?

• Because cognitive behavioral therapy helps provide pain relief:
  
  • It changes the way people view their pain.
  • CBT can change the thoughts, emotions, and behaviors related to pain, improve coping strategies, and put the discomfort in a better context.
  • You recognize that the pain interferes less with your quality of life, and therefore you can function better.
Cognitive-behavioral therapy (CBT)

• A psycho-social intervention
• Most widely used evidenced-based practice for improving mental health.
• Guided by empirical research, CBT focuses on the development of personal coping skills that target solving current problems and changing unhelpful patterns in cognitions (e.g. thoughts, beliefs, and attitudes), behaviors, and emotional regulation.
• Originally designed to treat depression
• Our thinking gets sticky = “Stuckness” = no blame
The Challenge of Pain

Over time, negative thoughts and beliefs about pain and behaviors related to pain (pain behaviors) can become very resistant to change.

- Thoughts
- Behaviors
THOUGHTS about PAIN

• “My pain is going to kill me”
• “This is never going to end”
• “I'm worthless to my family”
• “I’m disabled”
• “There is nothing I can do for myself”
BEHAVIORS

• Staying in bed all day
• Walking with a limp/holding your head/frowning
• Sleeping all day
• Staying away from friends
• Decreasing activities that have the potential to increase pain
• Taking more medication than prescribed
• “Pain behaviors” and Wilbert Fordyce
Critical Educational Points

• What are the critical components of the CBT model that need to be communicated to the person with persistent pain:

  • Pain includes: physiological sensations, AND emotions, behaviors, thoughts.
  • Pain includes: personal, social and environmental influences or stresses in our lives (e.g., personality, physical limitations, relationships, medical care, life roles, physical environment-weather and climate)
  • These thoughts often are negative and unrealistic about having pain and the future given the pain
  • In turn, these can impact how we feel emotionally and what we do when in pain - (withdraw and avoid)
  • Traps in our thinking that negatively impact pain
  • There are underlying beliefs about pain: automatic thoughts and core beliefs.
“Medical” versus “Rehabilitation”
Views of Pain

- Another critical component of pain management
- People with persistent pain may be inclined to look for relief through medical procedures
- They need to be regularly reoriented towards implementing self-care strategies.
CBT: Event => Thoughts => Feelings => Behavior

Event: Traffic jam
Thoughts: I don’t deserve this
Feelings: ANGER
Behaviors: Irritated driver
Case Examples: Phil and Sally

- Phil is a 32 year old Caucasian male
- Experiences burning and numbing – LB and legs
- Is frustrated/sad – thinks: “this pain is horrible; it’s unbearable; I can’t go on like this”
- He imagines pain taking over his whole body
- His pain worsens; he becomes absorbed in his pain, frustration and sadness

- Sally is a 49 year old Japanese female
- Experiences burning and numbing – LB and legs
- She feels slightly irritated - thinks “here comes the pain again-I know it’s gonna hurt so what can I do?”
- “I need to catch my breath and focus on something else; distract myself; I have to remember the pain will subside if I take steps to manage it.”
- “I have to focus on relaxing my body and moving through the pain. It’s not time for my next pain pill.”
Cognitive Errors

• A negatively distorted belief about oneself or one's situation

• The role of Catastrophizing

• “Of all of the psychological factors that have been studied and shown to be associated with pain and its impact on our lives, the single most consistent (and to date – among the strongest) factor associated with pain is catastrophizing” Jensen (2015)
A recent survey of *Practical Pain Management* readers (2017) revealed that 66% of the respondents were unfamiliar with the construct of pain catastrophizing.
Classic Beliefs about having Persistent Pain

• Pain catastrophizing “an exaggerated negative orientation toward actual or anticipated pain experiences…current conceptualizations most often describe it in terms of appraisal or as a set of maladaptive beliefs.”


• This pain is awful. I will be stuck with this pain forever.
• I can’t stand this pain. What if my pain never gets better? My future is shot.
• If I have this kind of pain now, it is going to get worse, and it will be terrible by the evening.
Catastrophizing

• Pain catastrophizing has been found to intensify the experience of pain and depression.

• A recent meta-analysis concluded that higher pain catastrophizing often is associated with higher self-reported pain and disability, and may lead to delayed recovery in patients with low back pain.

• A separate meta-analysis determined that decreased catastrophizing during treatment for low back pain was associated with better outcomes.

Patients beliefs about pain or disability are better predictors of ultimate level of disability than are physician ratings of disease severity.
What Can CBT Do?

- CBT can change the physical response in the brain that makes pain worse.
- Pain causes stress, and stress affects pain control chemicals in the brain, such as norepinephrine and serotonin.
- CBT reduces the arousal that impacts these chemicals.
- This, in effect, may make the body’s natural pain relief response more powerful.
- Self management approach to pain - Moving people with pain toward self-Management
What Can CBT Do?

• CBT is used together with other methods of pain management.
  • include medications, physical therapy, weight loss, massage, acupuncture or in extreme cases, surgery.

• Three shifts in perspective for patients with chronic pain to effectively self-manage their condition:
  • accepting diagnosis of chronic pain;
  • understanding the mind/body connection with regard to pain symptomatology; and
  • changing to an active orientation regarding self-management.

• CBT is almost always as least as good as or better than other treatments.
• CBT has far fewer risks and side effects than medications or surgery.
How does CBT help with Pain Relief?

- **Encourages a problem-solving attitude.** The worst thing about persistent pain is the sense of learned helplessness -- ‘there is nothing I can do about this pain.”
  - If you take action against the pain (no matter what that action is), you will feel more in control and able to impact the situation.

- **Involves homework.** CBT always includes homework assignments,”
  - keeping track of the thoughts and feelings associated with your pain throughout the day in a journal

- **Encourages life skills.** CBT is skills training.
  - It gives patients coping mechanisms they can use in everything they do. You can use the tactics you learn for pain control to help with other problems you may encounter in the future, such as stress, depression or anxiety.

- **Allows you to do it yourself.** Unfortunately, good qualified cognitive behavioral therapists aren’t available in all areas.
  - You can conduct CBT on your own as a method of pain control. Literature supports that these self-help methods can be just as effective for pain management as one-on-one sessions.
Cognitive Behavior Therapy - Pain
Three interrelated phases

• Emphasis on a distinction between acute versus persistent/chronic pain; pain as manageable and controllable; emphasis on learning a pain self-management approach

• Skills acquisition; behavioral activation and learning adaptive cognitive and behavioral pain coping skills

• Maintenance and relapse prevention; problem-solving
Common Components of CBT

• Adoption of a self-management approach
• Behavioral activation
• Pacing/rest-activity cycling/avoiding pain-contingent rest
• Cognitive coping skills training
• Relaxation/stress reduction skills training
• Problem solving skills training
• Cognitive restructuring
CBT is a collaborative effort between the therapist and the client.

- Client role - define goals, express concerns, learn & implement learning
- Therapist role - help client define goals, listen, teach, encourage.

CBT teaches the benefit of remaining calm or at least neutral when faced with difficult situations. (If you are upset by your problems, you now have 2 problems: 1) the problem, and 2) being upset.)
CBT is based on "rational thought." - Fact not assumptions.

CBT is structured and directive. Based on notion that maladaptive behaviors are the result of skill deficits.

Based on assumption that most emotional and behavioral reactions are learned. Therefore, the goal of therapy is to help clients unlearn their unwanted reactions and to learn a new way of reacting.
Critical Elements of Treatment

- Enhancing motivation
- Relaxation exercises
- Education about Sleep Management
- Hypnosis and Imagery
- Cognitive Therapy
- Family Interventions
Relaxation Strategies

- Progressive muscle relaxation
- Deep (diaphragmatic) breathing
- Biofeedback
- Autogenic training
- Caveats and contraindications
  - Psychotic patients
  - Relaxation-induced anxiety
  - Panic attacks
CBT Typical Sessions

• Session 1 Rationale for Treatment
• Session 2 Theories of Pain, Breathing
• Session 3 PMR Visual Imagery
• Session 4 Cognitive Errors
• Session 5 Cognitive Restructuring
• Session 6 Stress Management
• Session 7 Time-Based Activity Pacing
• Session 8 Pleasant Activity Scheduling
• Session 9 Anger Management
• Session 10 Sleep Hygiene
• Session 11 Relapse prevention
### Elements of Cognitive and Behavioral Therapies for Chronic Pain

<table>
<thead>
<tr>
<th>Cognitive Methods</th>
<th>Behavioral Methods</th>
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</thead>
<tbody>
<tr>
<td>Socratic questioning and guided discovery</td>
<td>Monitoring pain and activity levels</td>
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<tr>
<td>Keeping thought change records</td>
<td>Activity pacing</td>
</tr>
<tr>
<td>Identifying cognitive errors (automatic thoughts)</td>
<td>Relaxation training</td>
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<tr>
<td>Generating rational alternative thoughts</td>
<td>Breathing retraining</td>
</tr>
<tr>
<td>Imagery</td>
<td>Pleasant activity scheduling</td>
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<tr>
<td>Role play and rehearsal</td>
<td>Distraction techniques</td>
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Concept of Self Efficacy

• A personal conviction that one can complete a course of action to produce a desired outcome

• Low self efficacy ratings of pain control are related to low pain tolerance (Dolce, Crocker, Moletteire, Doleys, 1986)

• High SE experiences less anxiety and physiological arousal when experiencing pain
  • Is better able to use distraction
  • Can persist in the face of noxious stimuli (stoicism)
CBT’s Historical perspective

• Behavior therapy – first wave (Skinner)
• Cognitive therapy – second wave (Ellis)
• Third wave – ACT, DBT, EMDR - a blending of cognitive- and behavior-based elements. (Hayes)
Second Wave: Focus of Cognitive Behavior Therapy with Chronic Pain

• Most all pain treatments have *pain reduction* as its primary purpose.
• CBT also takes a philosophically similar approach.
• CBT is a “control based” model (gaining control over your pain and getting away from pain)
• CBT is about changing *the content of* thoughts
  • Reducing irrational non-productive thinking (Catastrophizing)

Second Wave CBT leads to Third Wave

• Pain “Control based strategies” are effective in alleviating emotional and physical suffering.

• However, in some patients, potential problems:
  • May leave the patient vulnerable to frustration
  • May demoralize and lead to an endless preoccupation with reducing pain.
Third-generation (Wave) of Cognitive Behavior Therapy

• Third-generation cognitive and behavioral treatments place an emphasis on changing awareness of and relationship to thoughts
• No emphasis on changing the content of thoughts
• Some call this “Mindfulness-based cognitive therapy” ACT-acceptance therapy

GOALS

• Attempts to control pain or accept pain are not ends in themselves

• Rather they may be a means of preventing pain from interfering with living the life one desires, regardless of the experience of pain.

• Learn to “Coexist” with pain rather than focus of ”getting rid of it”
Do Personality factors influence pain?

• How do personality disorders fit in?
  
  • No specific personality disorder is associated with poorer coping with pain
  • However, the presence of any personality disorder predicts less adaptive coping.
EVIDENCE FOR CBT

- Numerous RCTs, Reviews and Meta-analyses:
  - Strong support for the efficacy of CBT for improving
    - pain, physical functioning and mood
Referral to Psychology

• Top objections to seeing a psychologist for pain management:
  • I’m not crazy
  • I've done this before
  • The pain is in my back, not in my head
  • Does this mean that you are taking away my medication?
  • The bad handoff Prescriber: “You must see psychology before I prescribe your pain medications.”

• Consider using the term, “Behavioral Medicine Specialist.”
Cognitive Therapy with Chronic Pain Patients

Carrie Winterowd
Aaron T. Beck
Daniel Gruener

Springer Publishing Company

A NEW HARBINGER SELF-HELP WORKBOOK

The Chronic Pain Care WORKBOOK

LEARN NEW SKILLS TO:
- Personalize & individualize your pain care treatment
- Recognize pain triggers & reduce flare-ups
- Exercise more, sleep better & improve your mood
- Return to productive work & enjoyable leisure activities
- Strengthen relationships with family, friends & coworkers
- Enhance your quality of life

A Self-Treatment Approach to Pain Relief
Using the Behavioral Assessment of Pain Questionnaire

MICHAEL J. Lewandowski, PH.D.
Foreword by RICHARD J. KROENING, MD, PH.D.,
former director of the UCLA Pain Management Center