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Psychiatry and Addictions Case Conference

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CBT 1-2-3

EMPOWERING CHRONIC PAIN SELF-MANAGEMENT:

Cognitive behavioral strategies for care managers

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project ECHO

SPEAKER DISCLOSURES

None

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose; other disclosures have been mitigated.

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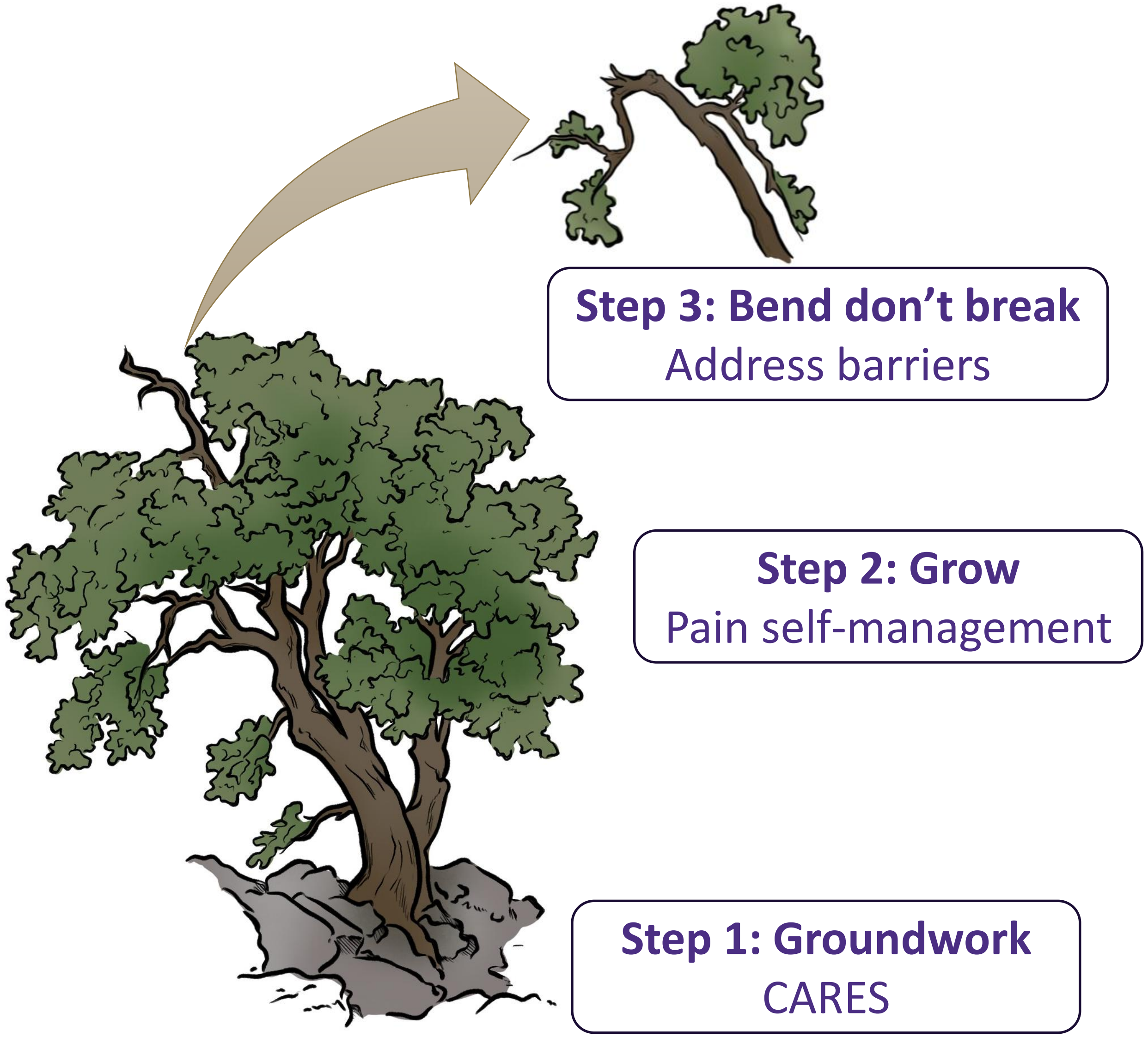
OBJECTIVES: CBT 1-2-3

Describe 3 steps to using CBT to help with chronic pain

Use the CARES steps to engage and set patient centered goals

Identify barriers to triage care



CHRONIC PAIN

- 25% of the U.S. population suffers from CP
- ~1/2 seeks care in primary care
- Multidisciplinary care is what works best to improve quality of life and reduce interference in life from CP
- CP increases with age
- National economic burden of ~$560-635B annually

WHAT HELPS?

- CBT decreases pain chronicity through safe, non-pharmacologic, guided behavioral interventions
  - How? Behavioral and thought challenging skills
- Regular exercise can reduce pain and improve related challenges in function including sleep, depression, anxiety, and inflammation
  - How? Probably pain desensitization, endogenous opioid enhancement and exercise-induced hypoalgesia
- Most primary care providers tend to prescribe medications, recommend life-style changes, and refer to behavioral health experts

Ehde DM, Dillworth TM, Turner JA. Cognitive-behavioral therapy for individuals with chronic pain: efficacy, innovations, and directions for research. Am Psychol. 2014;69(2):153-166. doi:10.1037/a0035747
Ambrose KR, Golightly YM. Physical exercise as non-pharmacological treatment of chronic pain: why and when. Best Pract Res Clin Rheumatol. 2015;29(1):120-130. doi:10.1016/j.berh.2015.04.022
Dydyk AM, Conermann T. Chronic pain. In: StatPearls. StatPearls Publishing; 2024.

WHAT'S HARD ABOUT TREATING CHRONIC PAIN?

Designed CBT 1-2-3 for training nurses in rural primary care settings

Table 2 Pre-intervention and post-intervention patient outcomes.

Outcome	Measure	Pre *N*= 29 Mean (SD)	Post *N*= 23 Mean (SD)	Post-pre difference (95% CI)	Effect size
Pain interference and intensity	PEG Scale	6.8 (1.5)	5.9 (1.9)	–0.9 (–1.7 to –0.1)*	0.50
Physical functioning	PROMIS physical functioning	14.4 (5.0)	14.4 (3.4)	0.5 (–1.3 to 2.2)	0.11
Sleep disturbance	PROMIS sleep disturbance	20.9 (6.3)	20.0 (6.5)	–1.3 (–3.8 to 1.2)	0.22
Pain catastrophizing	Pain catastrophizing scale	12.5 (4.9)	9.3 (5.0)	–3.2 (–5.4 to -1.0)**	0.62

Tong ST, Keiser B, Cortez K, Hoffman E, Wang J, Stephens KA, Welch SS, Tapp H, Holtzer C, Reeves KW, Jawort S, Humbert AT, Belza B, Ludden T, Ang DC, Patel KV. Integrated nurse care management to reduce pain interference for primary care patients in rural communities: results from a pilot study. Pain Med. 2026 Aug 1;27(8):934-937. doi: 10.1093/pm/pnag032.

3 STEPS

CBT 1-2-3

Step 1
Groundwork

CARES
- **C**ollaborate
- **A**ssess
- **R**eflect
- **E**ducate
- **S**et the goal

Step 2
Grow

CBT Pain Modules

Body	Brain	Behavior
• Relaxation • Sleep • Medications	• Cognitions • Mindfulness	• Movement • Pacing • Valued activities

Step 3
Address Barriers

Mental Health

- Depression
- Anxiety
- Trauma
- Substance / Opioid Problems

STEP 1: Groundwork

LAY THE GROUNDWORK FOR SUCCESSFUL PAIN SELF-MANAGEMENT

CARES will provide the groundwork through a step by step approach to your first CBT session

- Maximize patient engagement
- Learn about their story and their goals
- Educate and set up care management for success

CARES

- <u>C</u>ollaborate
- <u>A</u>ssess
- <u>R</u>eflect
- <u>E</u>ducate
- <u>S</u>et the goal

CARES: *WE WILL TEACH YOU THE STEPS*

Collaborate: Use validation skills, be patient-centered, and use non-judgmental and empathic interactions that will build trust.

Assess: Ask the patient to share their pain story, what areas of their lives have been changed and impacted, and what is most important to them going forward.

Reflect: Review what has worked for the patient so far and what hasn't worked. Create a shared list using screenshare, worksheet and reflective listening.

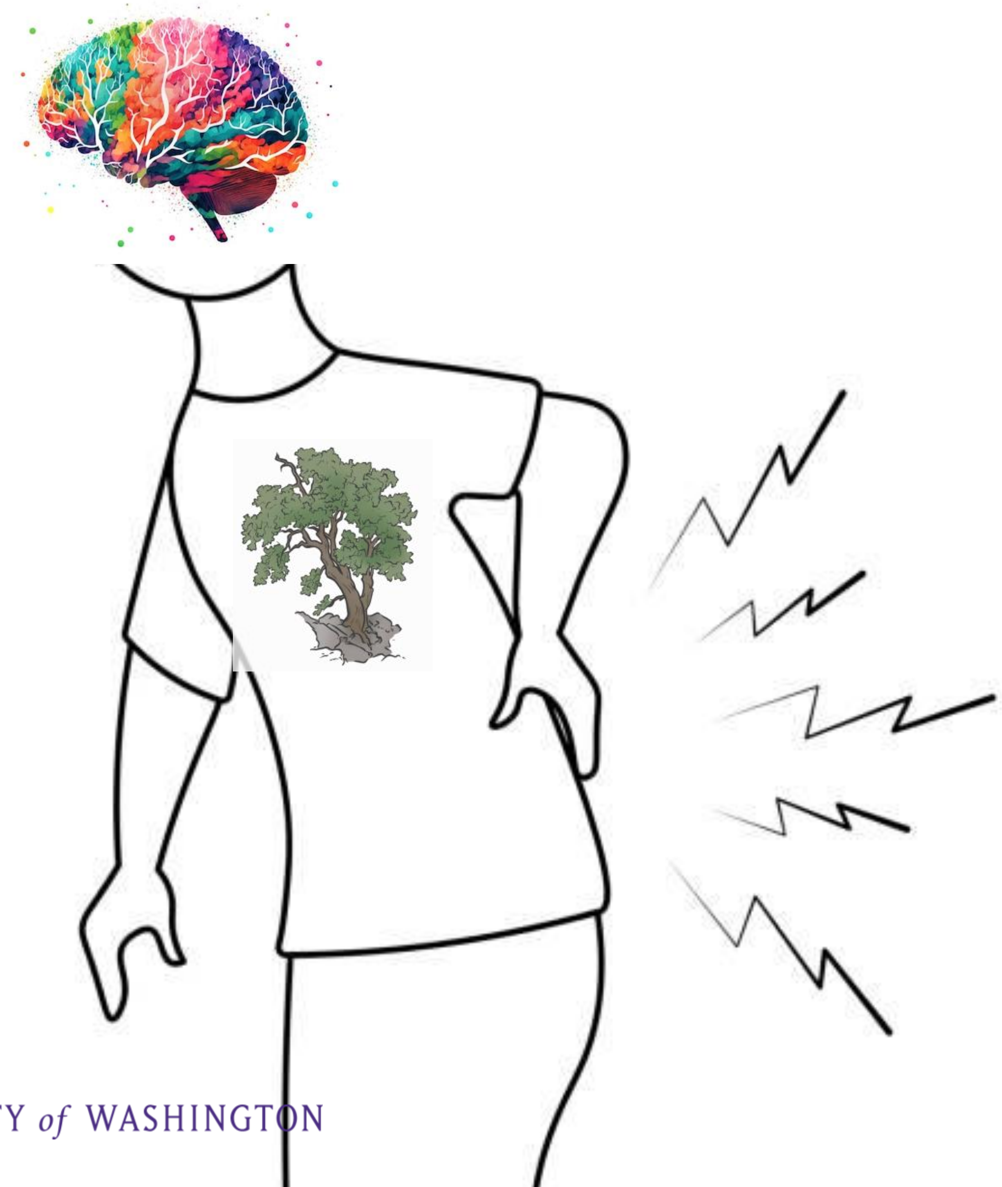
Educate: Share back basic information about chronic pain.

Set the goal: Create shared goals for CBT-123 program and assign self-monitoring homework if appropriate.

CHRONIC PAIN

- 3+ months
- Can’t be completely alleviated
- Comes and goes or is persistent
- Persists long after recovery from illness or injury
- Exists for no obvious reason –OR– for multiple reasons
- No simple cause-and-effect process
- One of the most common reasons people seek medical care
- 25% of adults in the US

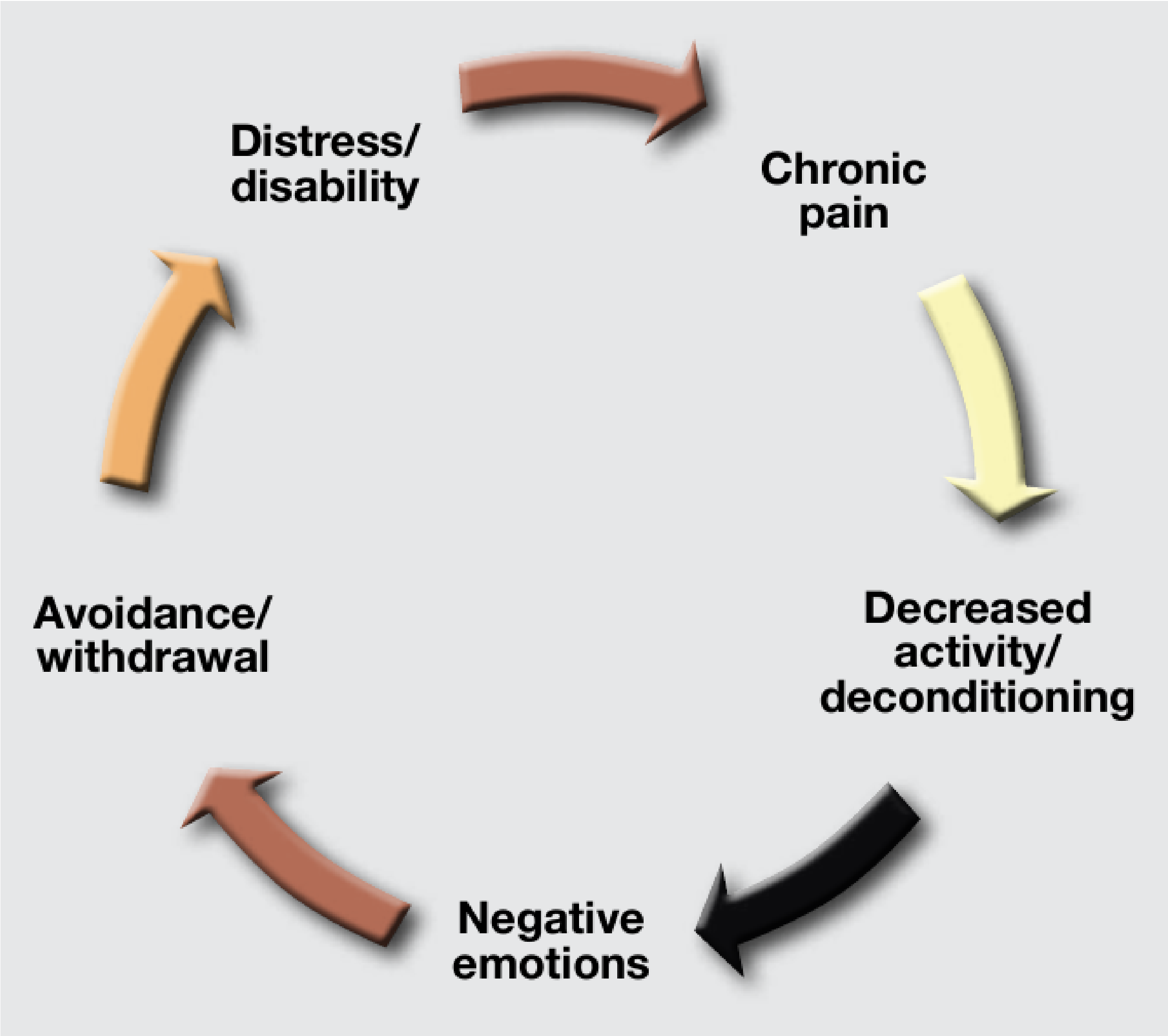
CHRONIC PAIN AND THE BRAIN



- Emotional and physical pain – both are generated from the brain (and they intersect!)
- Depression and anxiety can make chronic pain worse
- Both often get better together
- Neurobiology of pain and depression overlap - so do treatments

GOALS OF CBT 1-2-3

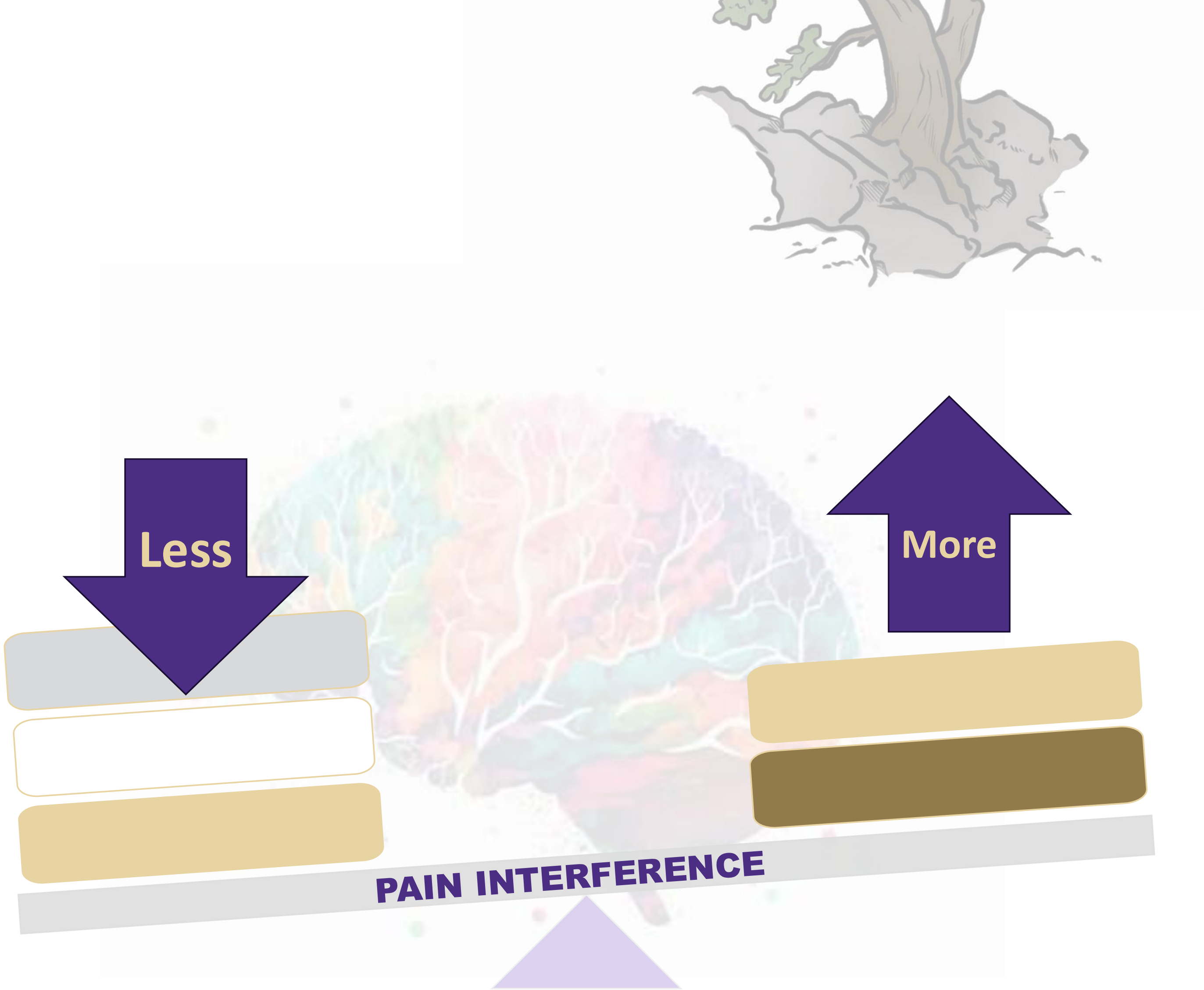
- Reduce negative impact / interference in daily life
- Improve physical and emotional functioning
- Increase effective coping skills
- Reduce pain intensity



Murphy et al. (2022). Cognitive Behavioral Therapy for Chronic Pain. Psychological Services, 19, 95-102.

EDUCATION ABOUT CHRONIC PAIN

- Share the goals of CBT
- Many things can improve pain or make them worse
- Small changes lead to big improvements over time
- We will teach you how to educate patients, assess what they already use, and set new goals for learning



TREATING CHRONIC PAIN = ↑ QUALITY OF LIFE

STEP 2: Grow

COGNITIVE BEHAVIORAL THERAPY (CBT) STRATEGIES

CBT BASICS!

STEP 2: CBT GOALS

3 B's

Body

Emotional and physical pain creates sensations in the body.

We teach strategies to **calm, soothe or activate the body**

Chronic Pain

Brain

Emotional and physical pain can create unhelpful thinking patterns, and often a "pain story"

We teach tools to **think in ways that help manage pain, and its deeper meanings** in patient's lives

Behavior

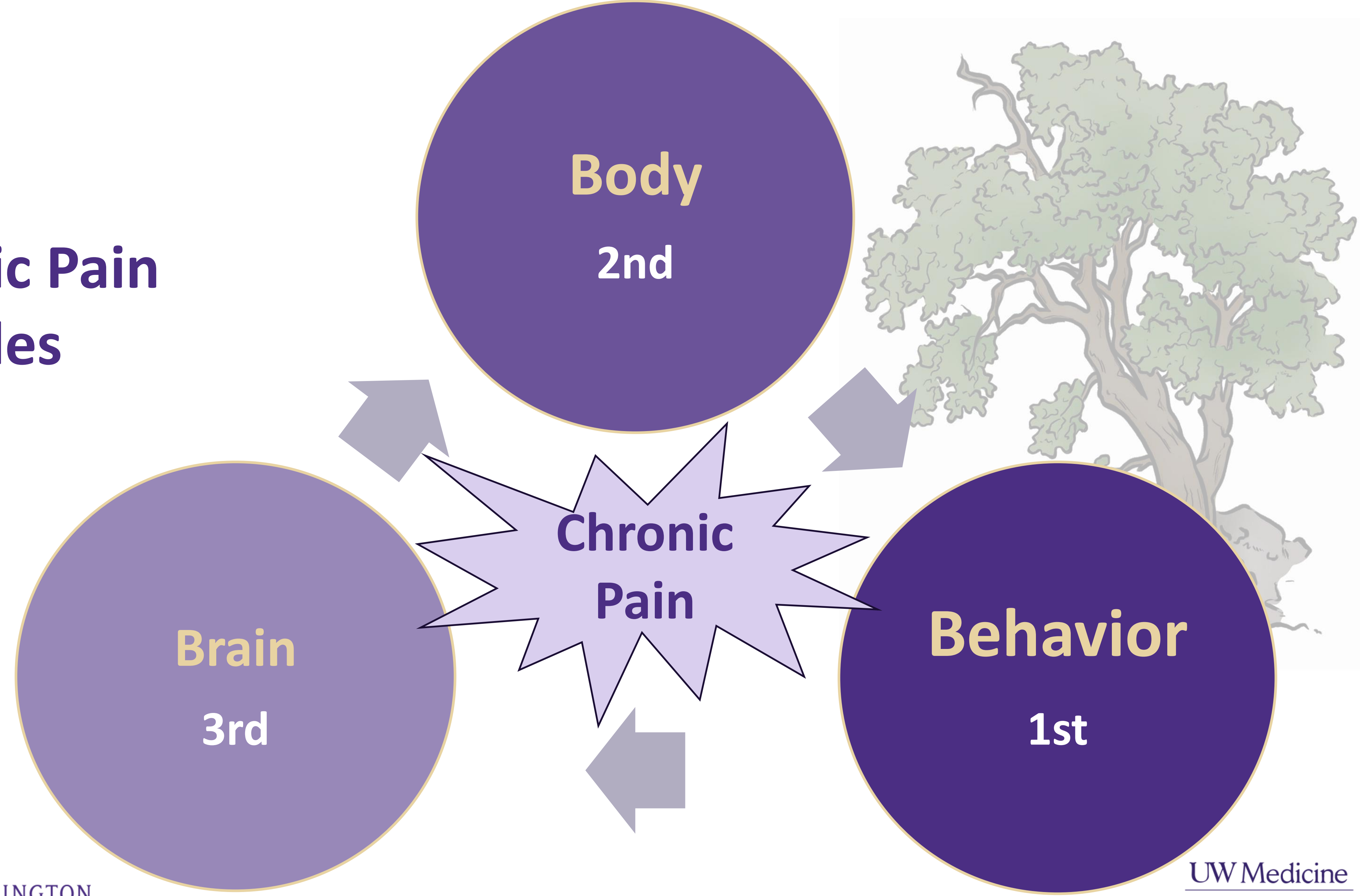
Emotional and physical pain causes changes in behavior to avoid pain.

We teach strategies to **calm, soothe or activate the body**

WHICH STRATEGIES DO YOU USE MOST IN PRACTICE AND TEND TO START WITH?

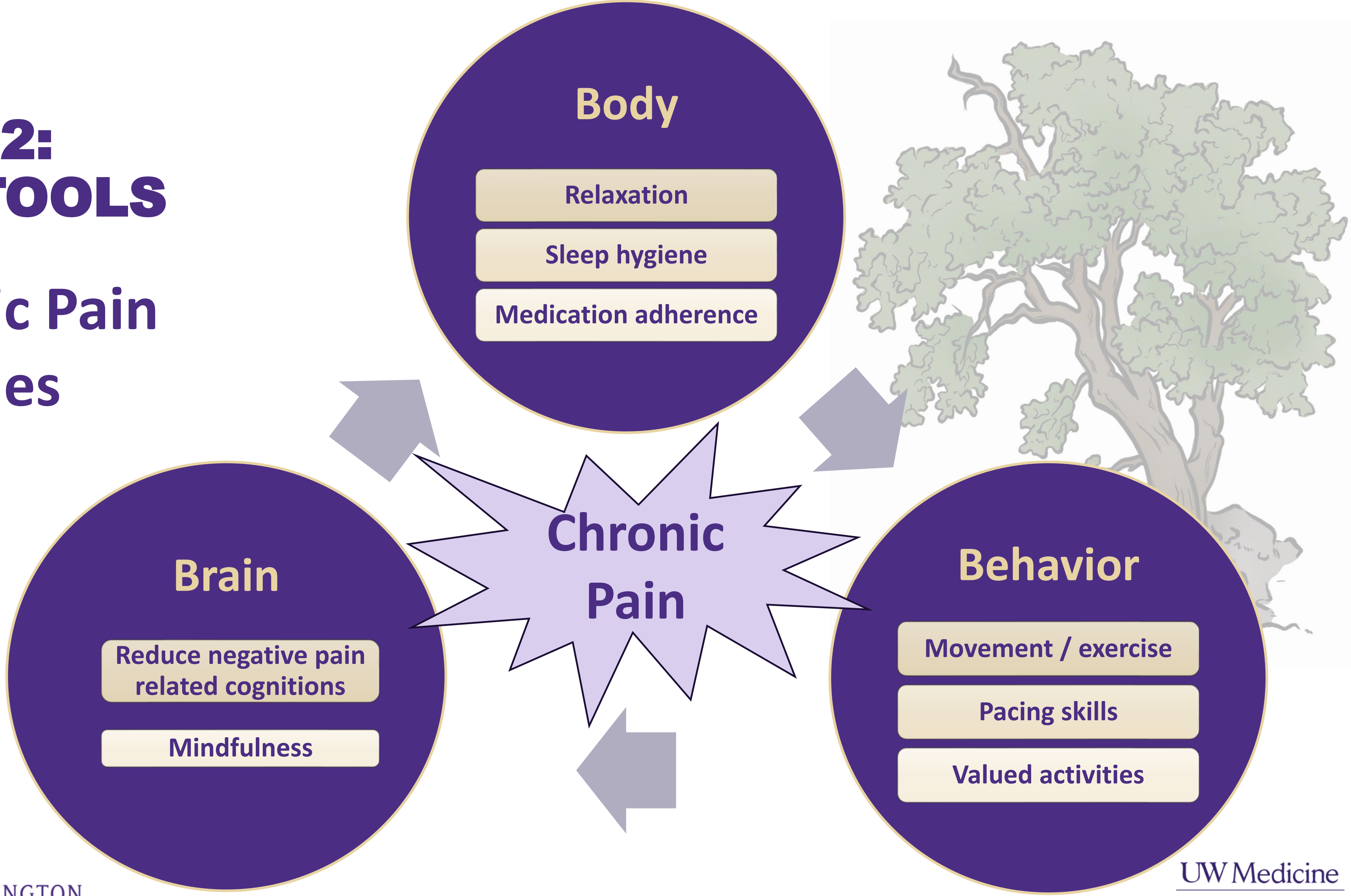
1. Body
2. Brain
3. Behavior

Chronic Pain Modules

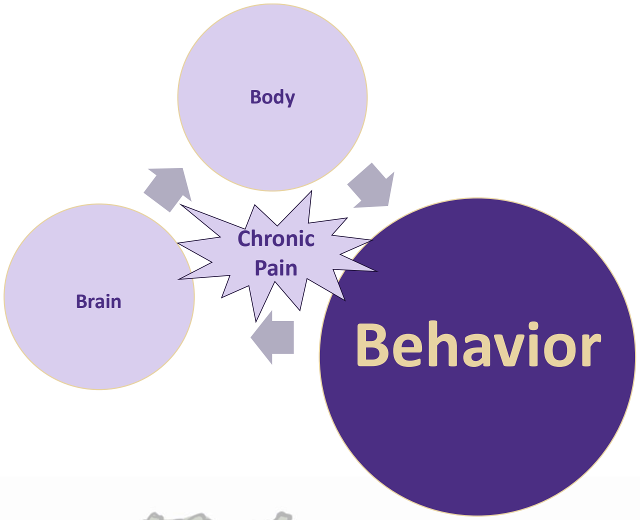


STEP 2: CBT TOOLS

Chronic Pain Modules



Chronic Pain Modules: Start with behavior targets



Movement / exercise

Based on patient's physical ability and motivation… move from light activity to **intensive remote exercise program**

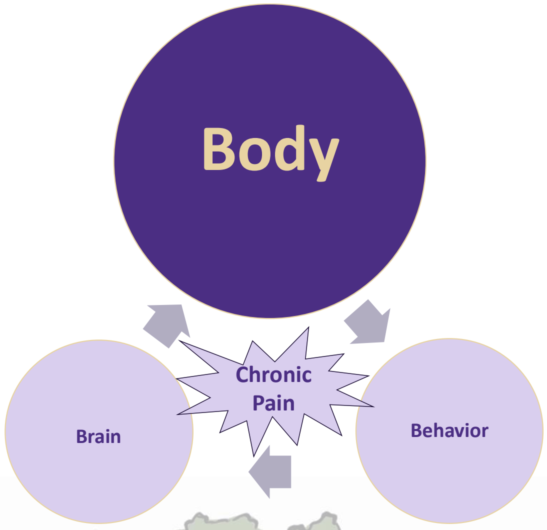
Pacing skills

Break the boom-and-bust pattern of activity and reduce pain flares

Valued activities

Identify and target mastery and pleasure related activities aligned with personal values

Chronic Pain Modules: Step to Body targets



Relaxation

Decreases muscle tension, counters stress responses, helps manage sleep, take a break, and impacts areas of the brain involved in pain perception and modulation: **diaphragmatic breathing, progressive muscle relaxation, guided imagery**

Sleep Hygiene

Screen for sleep problems, target sleep hygiene, and refer as needed for evaluation for sleep disorder

Medication Adherence

Case management support for medication treatment and support communication with the prescribing provider

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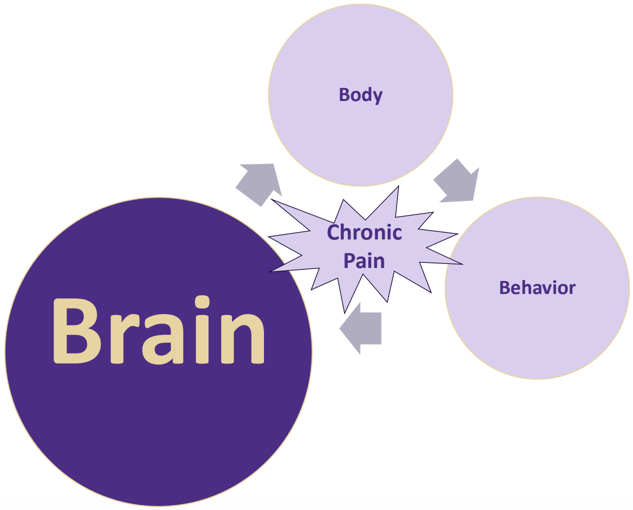
Chronic Pain Modules: Start with behavior targets



Cognitive Therapy

Calm thinking - help us catch and release thoughts that are unhelpful, and start thinking in more adapting ways

Examples of common unhelpful thoughts:

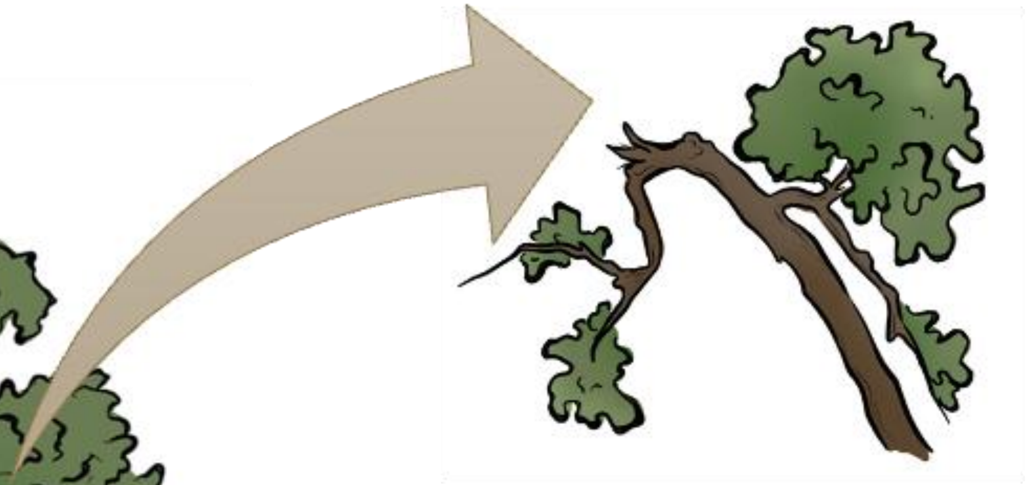
- Pain = harm
- We don't have control over pain or consequences
- We can't manage
- It's not fair (injustice appraisals)

Cognitive Restructuring:

- Keep unhelpful thinking patterns in check, and think about pain in a way that helps them manage it effectively
- Explore the deeper meaning of their "pain story" and find ways to recognize and center their own resilience and strength

Mindfulness

- **Notice and describe negative thinking, practice non-judgmental stance**

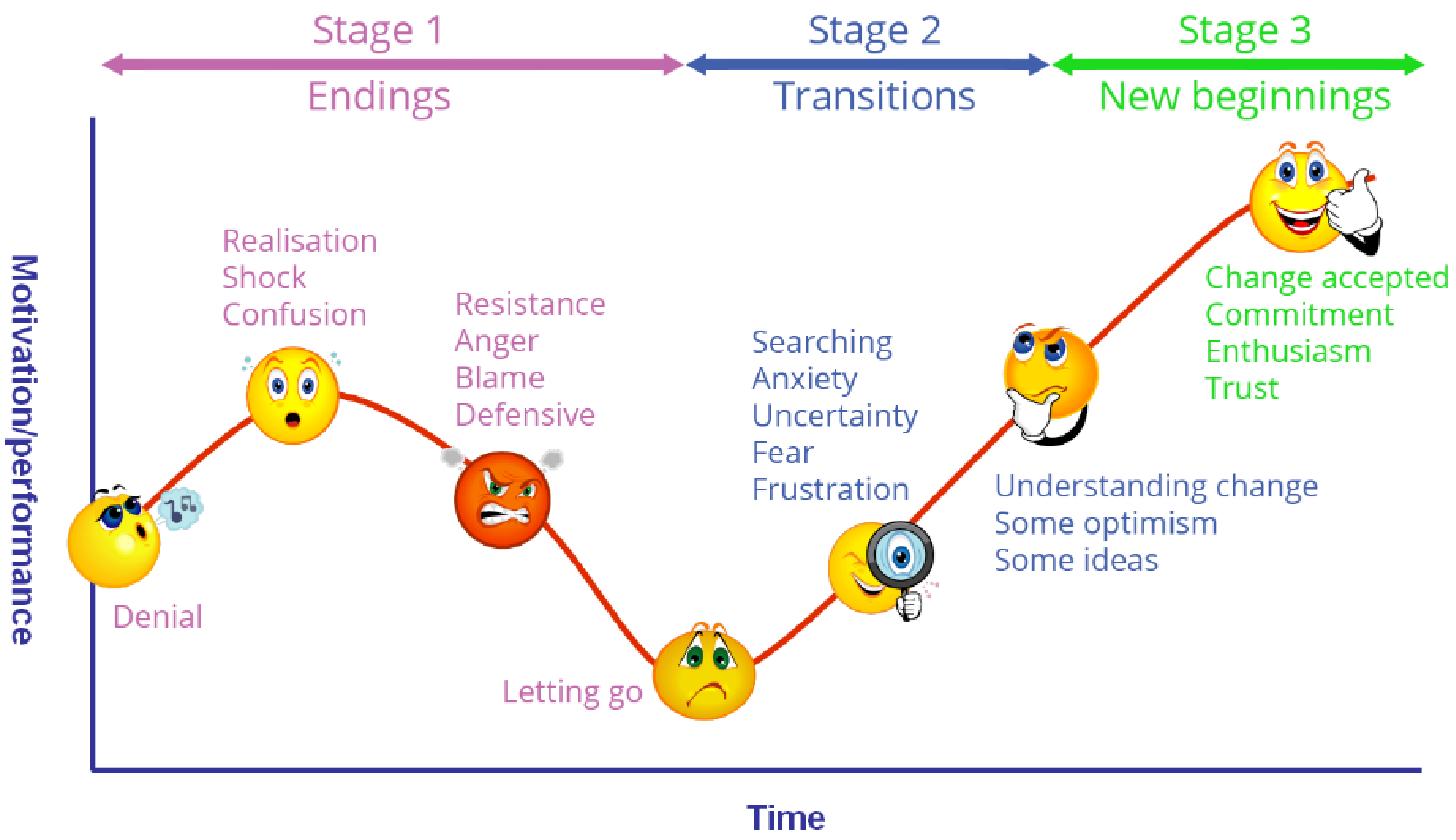


STEP 3: BEND DON'T BREAK

ADDRESS MENTAL HEALTH BARRIERS – DEPRESSION, ANXIETY, TRAUMA AND OPIOID PROBLEMS

WHEN DO BARRIERS COME UP?

Not everyone is ***ready to engage*** in pain self-management right away



ADDRESSING COMMON MENTAL HEALTH ISSUES AS BARRIERS

Start with depression and anxiety first

Depression → Anxiety → Trauma → Opioid problems

DEPRESSION AND ANXIETY

- Limits engagement in pain self management
  - Reduce motivation to engage in meaningful activities
  - Cause a pattern of catastrophizing
  - Cause a fear of movement and meaningful activities
- Cause stress, reduce energy, and exacerbate pain
- Often associated with more severe chronic pain

STEP 3: CBT GOALS FOR DEPRESSION

3 B's

Body

Depression creates sensations in the body (fatigue, lack of interest or pleasure, etc.).

We teach strategies to calm, soothe or **activate the body**

Depression

Behavior

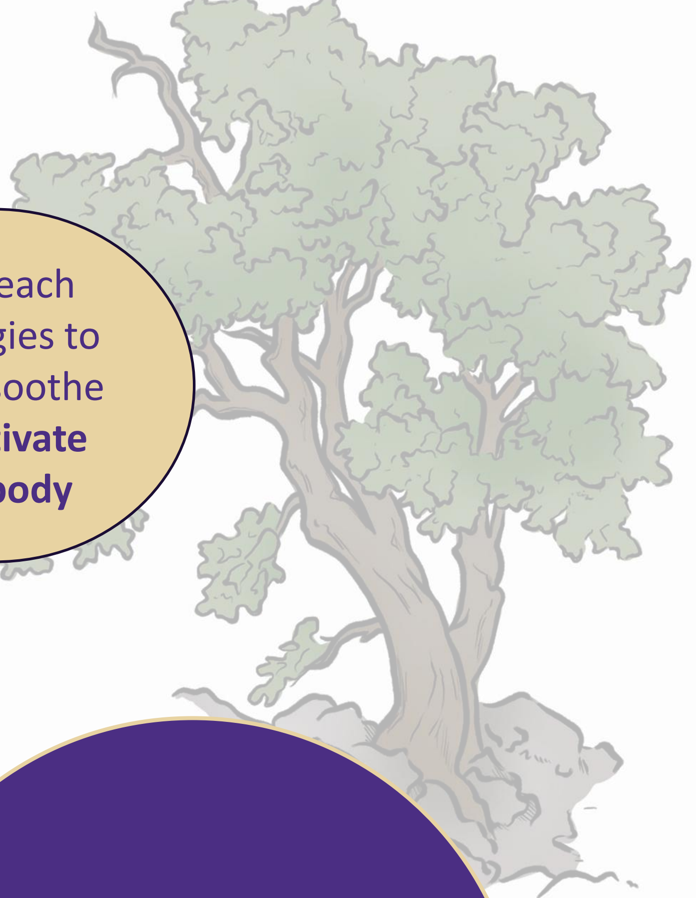
Depression causes avoidance (stay in bed, etc.).

We teach strategies to **activate behavior**

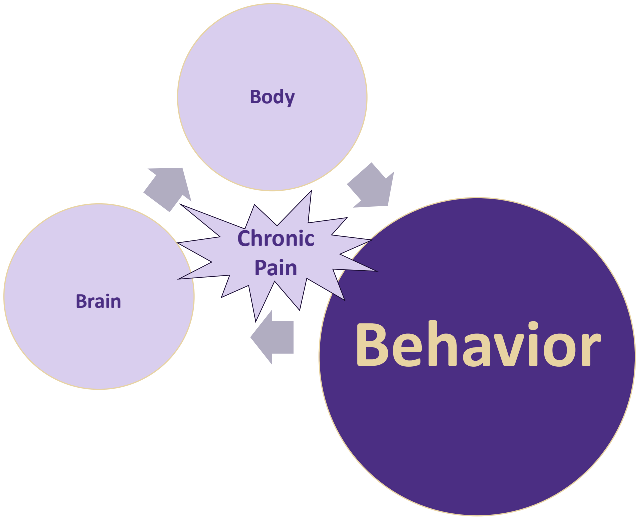
Brain

Depression can create unhelpful thinking patterns, often mixed with the "pain story"

We teach tools to **think in ways that challenge depressed / hopeless thinking**



BEHAVIORAL ACTIVATION FOR DEPRESSION



Valued activities

Identify and target mastery and pleasure related activities aligned with personal values

1. Increase adaptive activities, preferably for mastery and pleasure
2. Decrease activities that maintain depressive symptoms
3. Problem solve barriers to rewarding things

STEP 3: CBT GOALS FOR ANXIETY

3 B's

Anxiety

Body

Anxiety creates sensations in the body (heart rate, breathing, etc.)

We teach strategies to calm and soothe the body

Behavior

Anxiety causes avoidance of feared cues (even when safe)

We teach strategies to **approach safe situations (exposure)**

Brain

Anxiety makes us assume the worst and forget our own coping

We teach tools to **think in ways that challenge anxious thinking**

LEARNING CBT FOR ANXIETY

What is anxiety?

Understanding stress, "normal" anxiety, fear, and anxiety disorders

How to deliver psychoeducation and "The Pitch"

Differentiating TREATING vs. MANAGING anxiety

Getting patients/clients to engage treatment

TREATING ANXIETY: Reducing it through *EXPOSURE*

Making the hierarchy, getting started

Imaginal and in vivo (real life) exposure → lifestyle of exposure

MANAGING ANXIETY: Learning to live better with it

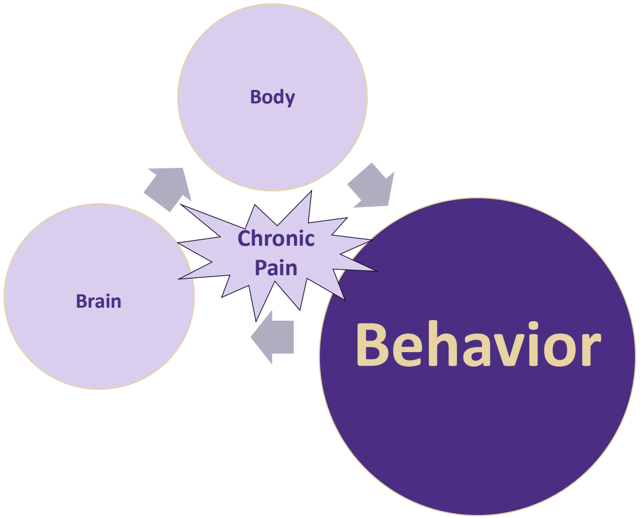
Breathing and PMR

Other Physical Strategies

Cognitive restructuring

Other Thought Strategies

EXPOSURE FOR ANXIETY



- Fear of pain, pain triggers and movement
- Common anxiety disorders

Hierarchical Exposure

Step 1:
- Determine Explain the CBT model of anxiety

Step 2:
- Determine treatment goal: how is anxiety interfering most with your patient's life

Step 3:
- Give the treatment pitch: management vs. treatment

Step 4:
- Develop and work on an exposure hierarchy
- Anxiety management strategies as needed

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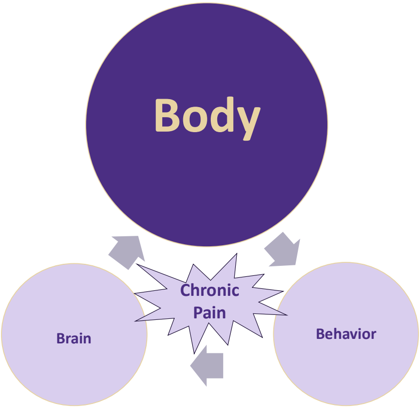
MANAGING SYMPTOMS OF ANXIETY



Relaxation

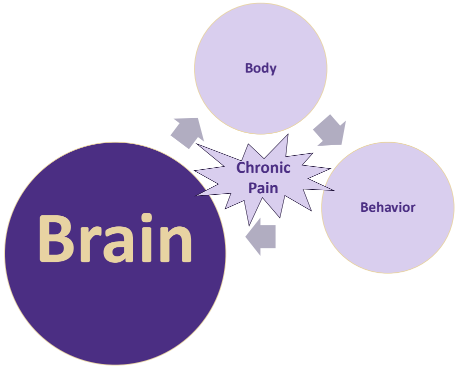
Reduce anxiety: **diaphragmatic breathing, progressive muscle relaxation, guided imagery**

Sleep Hygiene

Screen for sleep problems, target sleep hygiene, and refer as needed for evaluation for sleep disorder

Medication Adherence

Case management support for medication treatment, support communication with the prescribing provider, schedule benzodiazepines



Cognitive Therapy

Cognitive Restructuring:

- Challenge anxiety related cognitions / thoughts

POSTTRAUMATIC STRESS DISORDER (PTSD) AS A BARRIER

How do chronic pain and PTSD overlap?…

7-8% (NCS-R) (Beck & Clapp, 2011) Rates likely higher among ethnic minorities (Buchwald et al., 2005) PTSD cohort with pain → 20-80% Pain cohort with PTSD → 10-50% (Fishbain, 2016)	More likely in chronic pain patients with: • Headache / facial pain • Pelvic pain • Miscellaneous pain • Pain after MVA • Veterans (Fishbain, 2016)	Higher pain: • more affective distress • more disability (Asmundson et al., 2002; Geisser et al., 1996; Turk & Okifuji, 1996)	Neuro-biological overlaps to improve tx (Scioli-Salter et al., 2014, 2015) • pharmacologic-al approaches that target relevant NPY or GABA • deacetylase inhibitors or exercise • Neuroactive steroid therapeutics	Negative beliefs about self mediated pain interference (Porter et al., 2013)

STEP 3: CBT GOALS FOR PTSD

3 B's

Body

PTSD creates sensations in the body (hypervigilance, startle, etc.)

We teach strategies to calm, soothe or **activate the body**

PTSD

Behavior

PTSD causes avoidance of situations and memories

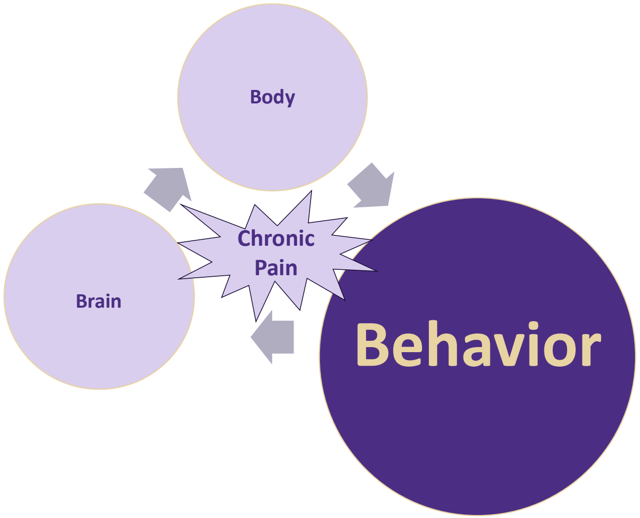
We teach strategies to **approach safe situations and face memories**

Brain

PTSD can create unhelpful thinking patterns, often related to guilt and shame

We teach tools to **think in ways that challenge unhelpful thinking and increase self-compassion**

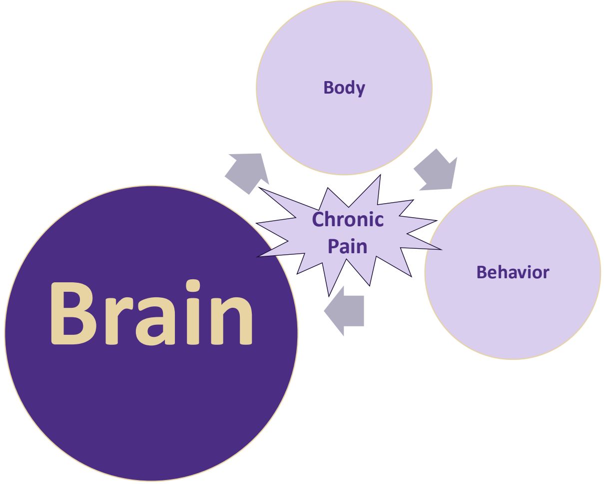
TRAUMA TREATMENT



Narrative Writing

- Patients learn about the common reactions to trauma, and the importance of processing trauma memories so that they can gradually become less intense and overwhelming
- Patients will write for 20 minutes over five sessions, exploring their thoughts and feelings about the event
- They may write about what they would tell a friend who was going through the same thing, how the event has changed them, and include details if they wish

TRAUMA TREATMENT

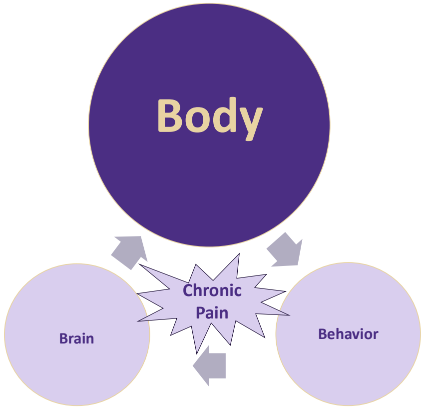


Cognitive Therapy

Cognitive Restructuring:

- Challenge negative thoughts about self and blame
- Work on increasing self-compassion

TRAUMA TREATMENT



Grounding

54321…

Relaxation

Reduce anxiety: **diaphragmatic breathing, progressive muscle relaxation, guided imagery**

Sleep Hygiene

Screen for sleep problems, target sleep hygiene, and refer as needed for evaluation for sleep disorder

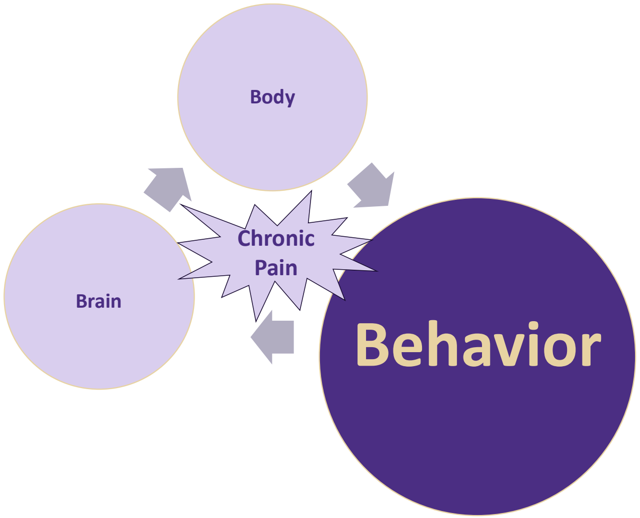
Medication Adherence

Case management support for medication treatment, support communication with the prescribing provider, schedule benzodiazepines

OPIOID PROBLEMS

- Long-term Opioid Therapy (LtOT) – definitions vary, but generally taking prescribed opioid class medications, daily for 90+ consecutive days
- Problems include:
  - Increased risk for Opioid Use Disorder, overdose, death
  - Hyperalgesia = increased sensitivity to feeling pain and an extreme response to pain
  - Withdrawal related side-effects
  - Patient-provider alliance issues

OPIOID PROBLEMS



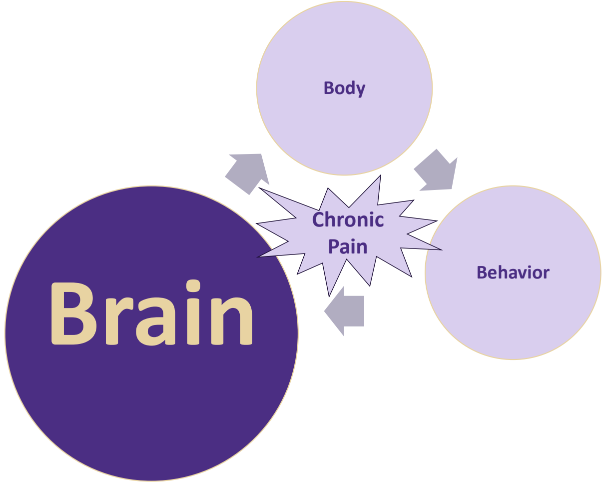
Taper opioid use or support adherence with prescribing provider

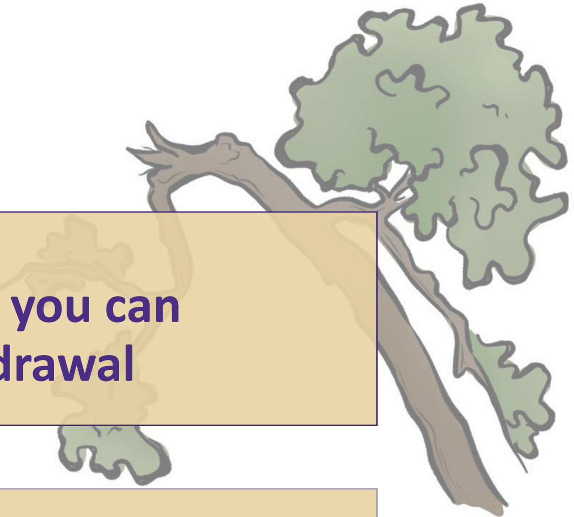
Support engagement, adherence, and communication with provider

Meet the patient where they're at with considering opioid tapering, identify drivers of ambivalence

Check in with prescribing provider to align care management with medication treatment plan

OPIOID PROBLEMS



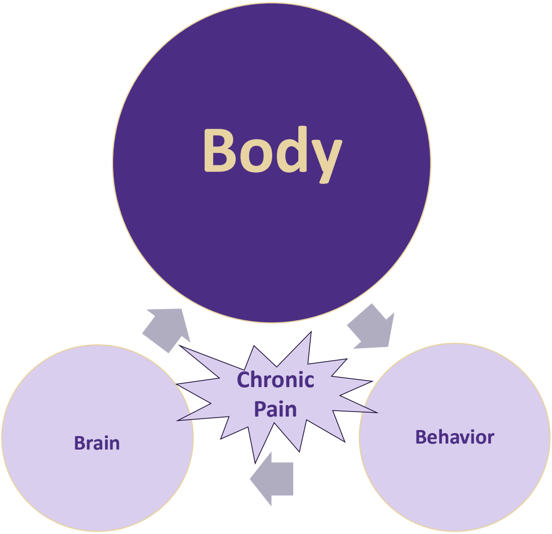


Psychoeducation

Educate about hyperalgesia, opioid risks, ways you can support tapering if desired, avoiding withdrawal

Negative thoughts

Challenge negative cognitions about medication dependence and increase self efficacy, reduce stigma, and reduce negative cognitions about self and medication use



Medication Scheduling

Target goals to reduce withdrawal and opioid overdose risks

Create pain flare plan

Target pain coping and using distress tolerance skills to expand skills for coping beyond rescue medications

WHAT'S SOMETHING NEW YOU MIGHT TRY IN PRACTICE BASED ON WHAT YOU LEARNED TODAY?

THANK YOU!

Special thanks to Dr. Stacy Shaw Welch who co-developed this approach with Dr. Kari Stephens
&
Dr. Sebastian Tong who is leading the AIM-CP study that helped fund development of this approach