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- Any questions about L.A. Care Health Plan's Provider Continuing Education (PCE) Program and our CME/CE activities, please email Leilanie Mercurio at lmercurio@lacare.org

Presenter's Bio

Katherine Bailey, PhD, is a licensed clinical psychologist at the West Los Angeles VA Healthcare Center and Deputy Chief of the Behavioral Health Division for SUD at the VA Greater Los Angeles Healthcare System. She is a Health Sciences Assistant Clinical Professor for the UCLA Department of Psychiatry and Biobehavioral Sciences.

Dr. Bailey provides clinical services and supervision in the outpatient Substance Use Disorders (SUD) and Pain Clinics with a focus on evidence-based psychotherapies. She earned a PhD in clinical psychology from the University of Illinois in Chicago, completed a clinical internship at the West LA VA Healthcare Center, and a clinical fellowship in health psychology at the San Francisco VA. She is a trainer for the national VA CBT-Chronic Pain evidence based psychotherapy rollout, and also certified in acceptance and commitment therapy (ACT), and mindfulness.

Dr. Bailey's research interests include chronic pain, SUD, and smoking.

Cognitive Behavioral Therapy (CBT) for Chronic Pain (CP)

Live Webinar, November 16, 2023

12:00 pm – 1:30 pm PST, 1.50 CME / CE Credits

Directly Provided CME/CE Activity by L.A. Care Health Plan

Katherine Bailey, PhD

Clinical Psychologist & Deputy Chief Behavioral Health;

GLA VA Healthcare Center

Health Sciences Assistant Clinical Professor; UCLA Department of Psychiatry & Biobehavioral Sciences

Trainer, VA Training Program in CBT-CP; Mental Health Services, VA Central Office

Disclaimer: These slides do not represent the VA

Disclosures

The following CME planners and faculty do not have any financial relationships with ineligible companies in the past 24 months.

- Leilanie Mercurio, L.A. Care PCE Program Manager, CME Planner.
- Katherine Bailey, PhD, Licensed Clinical Psychologist, Deputy Chief of the Behavioral Health Division (SUD Subdivision) at the Greater Los Angeles VA Healthcare System, CME Planner and Faculty.

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Commercial support was not received for this CME activity.

Learning Objectives

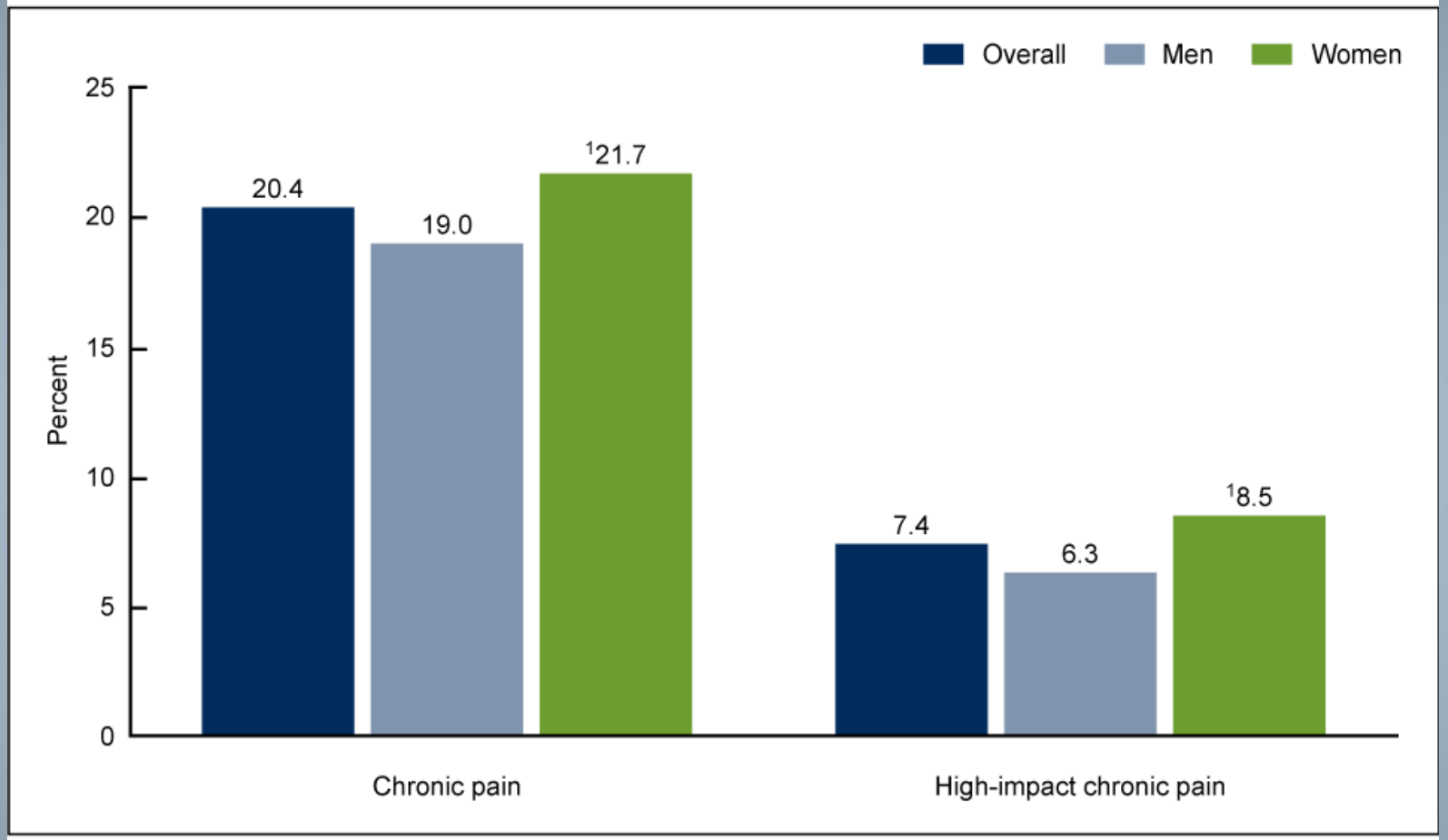
- Specify two (2) factors when to use CBT as an evidence based treatment for chronic pain.
- Summarize two (2) differences between the biomedical and biopsychosocial models of chronic pain.
- Describe the construct of pain catastrophizing as a predictor of pain and disability.
- List two (2) CBT-CP skills that can be utilized for pain management.
- Specify one way that CBT-CP can be tailored to people with diverse ethnic and cultural backgrounds.

Chronic Pain Prevalence & Impact

- Prevalence – 21% of Americans experience chronic pain and 8% experience high-impact chronic pain (Nahin, 2023)
  - One of the most common reasons to seek care
  - Linked to opioid use disorder, depression, anxiety
  - Most common cause of long-term disability
  - New cases occur more often than diabetes, depression and high blood pressure
- Conservative cost to US Economy is $560-630 billion (IOM, 2011)

Gender Differences

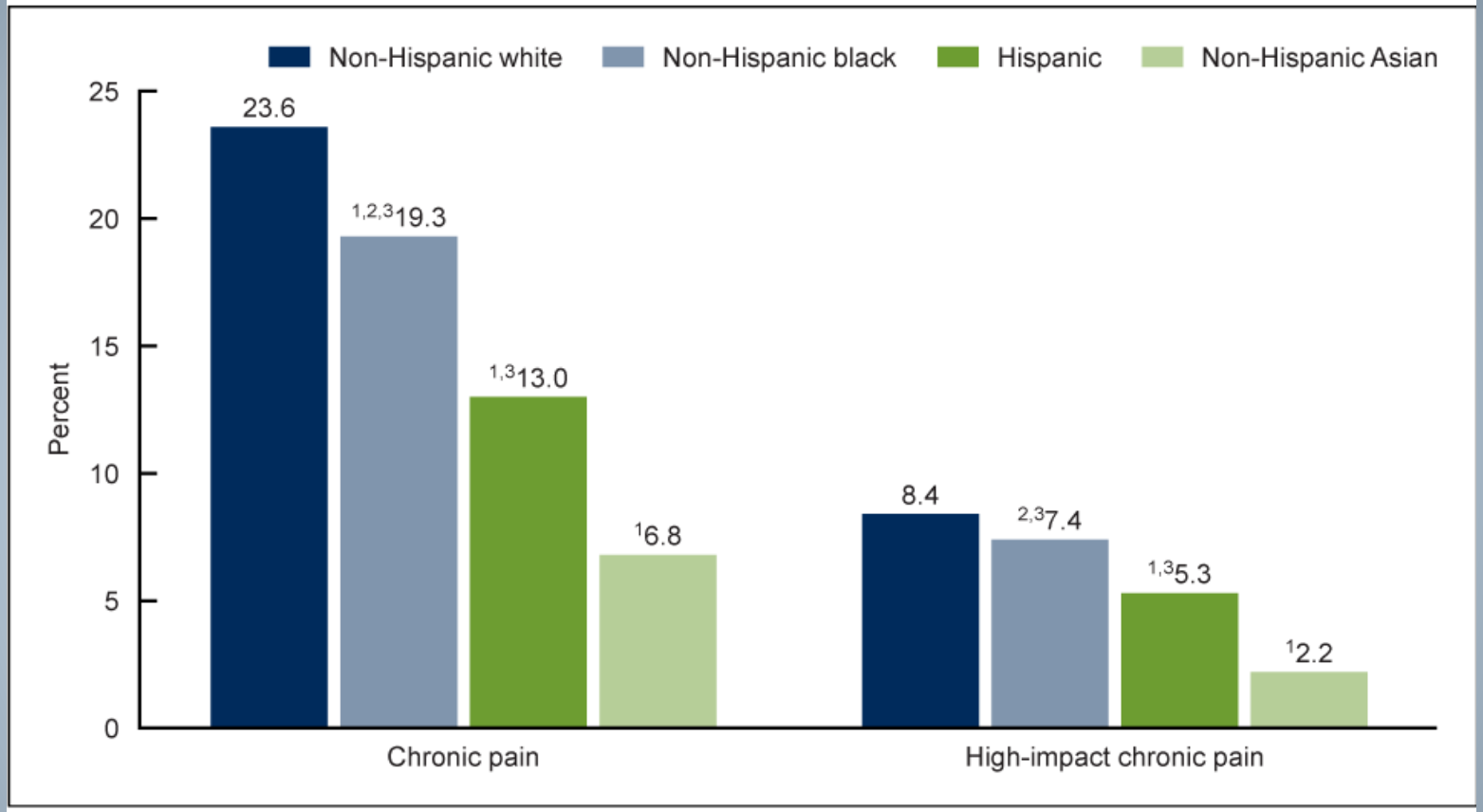
Figure 1. Percentage of adults aged 18 and over with chronic pain and high-impact chronic pain in the past 3 months, overall and by sex: United States, 2019



[1]Significantly different from men ($p < 0.05$).
NOTES: Chronic pain is based on responses of "most days" or "every day" to the survey question, "In the past 3 months, how often did you have pain? Would you say never, some days, most days, or every day?" High-impact chronic pain is defined as adults who have chronic pain and who responded "most days" or "every day" to the survey question, "Over the past 3 months, how often did your pain limit your life or work activities? Would you say never, some days, most days, or every day?" Estimates are based on household interviews of a sample of the civilian noninstitutionalized population. Access data table for Figure 1 at: https://www.cdc.gov/nchs/data/databriefs/db390-tables-508.pdf#1.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019.

Race & Ethnic Differences

Figure 3. Percentage of adults aged 18 and over with chronic pain and high-impact chronic pain in the past 3 months, by race and Hispanic origin: United States, 2019



[1]Significantly different from non-Hispanic white adults ($p < 0.05$).
[2]Significantly different from Hispanic adults ($p < 0.05$).
[3]Significantly different from non-Hispanic Asian adults ($p < 0.05$).
NOTES: Chronic pain is based on responses of "most days" or "every day" to the survey question, "In the past 3 months, how often did you have pain? Would you say never, some days, most days, or every day?" High-impact chronic pain is defined as adults who have chronic pain and who responded "most days" or "every day" to the survey question, "Over the past 3 months, how often did your pain limit your life or work activities? Would you say never, some days, most days, or every day?" Estimates are based on household interviews of a sample of the civilian noninstitutionalized population. Access data table for Figure 3 at: https://www.cdc.gov/nchs/data/databriefs/db390-tables-508.pdf#3.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019.

Chronic Pain Disparities

- Race and ethnic related differences in pain experience and coping:
  - Black people report greater pain/suffering, lower pain threshold & more disability compared to white people
  - American Indian/Alaska Natives higher prevalence of pain compared to whites (Jimenez et al., 2011)
  - Asian-Americans report lower pain threshold and tolerance
  - Ethnic differences in acceptability of emotional expression related to pain (i.e. Latino and Italian American believe emotional expression is appropriate compared to Polish and other non-Latino whites) (Campbell et al., 2012)
  - Preference for prayer as coping among Black people
- Communication is diminished for minority patients when provider encounters are race discordant
- Higher education associated with lower pain-related disability
- Black people 3x and Latinos 2x more likely to view racism as a major health care problem
  - Racism and implicit biases limit access to treatments (e.g. opioids)
  - PCPs more likely to underestimate pain in Black people than other sociodemographic groups
  - Interferes with expectations of benefits and participation in treatment

(Tait et al., 2014)

Language Related Disparities

- Non-native speakers have barriers to health care (Bekanich et al., 2014)
  - limited health literacy
  - difficulties navigating healthcare system
  - communication challenges including privacy issues when translation is needed
  - Less than 20% of professionals treating Spanish-speakers report advanced Spanish proficiency (Chiauzzi et al., 2011)

Tailoring CBT-CP to Culture

- Critical to examine personal attitudes and biases regarding chronic pain and diversity
- CBT-CP should be culturally adapted as appropriate
  - Assess diversity factors -- ADDRESSING
  - Look for opportunities to tailor treatment (i.e. including prayer, or meditation, eliciting values, discussing when skills don't fit with cultural, spiritual and/or gender values)

ADDRESSING Model

ADDRESSING Model Framework and Overview

Cultural characteristic	Power	Less power
Age and Generational Influences	Adults	Children, adolescents, elders
Developmental Disability	Temporarily able-bodied	*Individuals* with disabilities
Disability Acquired Later in Life	Temporarily able-bodied	*Individuals* with disabilities (e.g., multiple sclerosis or dementia caused by stroke)
Religion and Spiritual Orientation	Christians	*non-Christian*
Ethnicity/Race Identity	White or Caucasian	*Persons* of color
Socioeconomic Status	Owning & Middle Class (access to higher ed.)	People of lower status because of occupation, education, income, or rural habitat
Sexual Orientation	Heterosexuals	Gay, lesbians, and bisexual people
Indigenous Heritage	Non-native	Native
National Origin	U.S. born	Immigrants, refugees, and international students
Gender	Male	Women, transgender, and intersex people

Hays, P. A. (2001). Addressing Cultural Complexities in Practice: A Framework for Clinicians and Counselors. Washington, D. C.: American Psychological Association.

**Please note: The influences and examples of corresponding minority groups provided within the A.D.D.R.E.S.S.I.N.G. model are applicable within United States and Canada.*

CBT for Chronic Pain

- CBT-CP is an evidence based, behaviorally oriented psychotherapy that can be delivered in an individual or group format
- Current VA/DOD Clinical Practice Guidelines (CPG) recommend CBT-CP for chronic low back pain, with strong evidence
- Of note, VA/DOD CPG also recommend:
  - For MBSR, though evidence graded as weak
  - Against benzodiazepines
  - Against initiation of long-term opioid therapy
  - Evidence is too mixed to recommend for or against short-term opioid therapy for acute exacerbations of LBP
- American Pain Society (APS) Guidelines 2009 also recommend CBT as part of intensive interdisciplinary pain rehab for back pain

Efficacy of CBT for Pain

- Cochrane review (2020) suggests small effects on pain and disability (compared to TAU, waitlist), and moderate effects on mood and catastrophizing, posttreatment (Williams et al., 2020)
- Meta-analysis on CBT for chronic back pain shows (Hoffman et al., 2007):
  - CBT intervention superior to waitlist control for pain intensity, but no impact on depression and quality of life
  - Self-regulatory treatments (mindfulness, relaxation, biofeedback) superior to waitlist control on pain intensity and depression
- CBT, Exercise/PT, and Exercise/PT + CBT all showed improvement compared to control (Smeets et al., 2006).
- Group CBT shown superior to education + PT at 12 months (Lamb et al., 2010)
- Mechanisms of CBT benefits on pain (Turner et al., 2007):
  - Decreased catastrophizing (Smeets, 2006; Lamb, 2010)
  - Perceived control over pain
  - Decreased kinesiophobia (Lamb, Hansen et al., 2010)
  - Level of disability
  - Belief that pain signals harm

Effectiveness of CBT-CP

- CBT-CP provides benefits for pain and related outcomes with medium effect sizes (Murphy, Cordova & Dedert, 2020; Stewart et al., 2015).
- Murphy et al., n=1331 (81% male; 69% white, mean age = 52.3):
  - large effect size (Cohen's *d* 0.78) for pain catastrophizing
  - medium to large effect sizes (*d* 0.60) for worst pain intensity, pain interference, depression, and physical quality of life
- Stewart et al. (2015): 148 Veterans received at least one CBT-CP treatment session (ITT sample)
  - 117 (79%) completed a full course of treatment through Termination
  - 31 (21%) non-completers
- Basic participant demographics
  - **Gender:** Male = 77%; Female = 21% (no response = 2%)
  - **Age:** Mean = 50.6 yrs/o (SD = 11.7); Range = 25-69
  - **Ethnicity:** Caucasian = 70%; African American = 16.5%; Other = 13.5%
  - **Service Era:** Vietnam = 28%; Post-Vietnam = 26% OEF/OIF/OND = 26%; Other = 20%
- ITT sample demonstrated significant improvement on nearly all outcome measures (except pain ratings)

Factors when to use CBT-CP

- Chronic pain condition that causes impairment AND distress
- Able to engage in some form of physical activity
- Has mood and/or quality of life related goals
- Absence of severe cognitive impairment
- Absence of psychiatric problems that interfere with participation
- Will practice between sessions
- Those willing to make behavior changes do benefit!

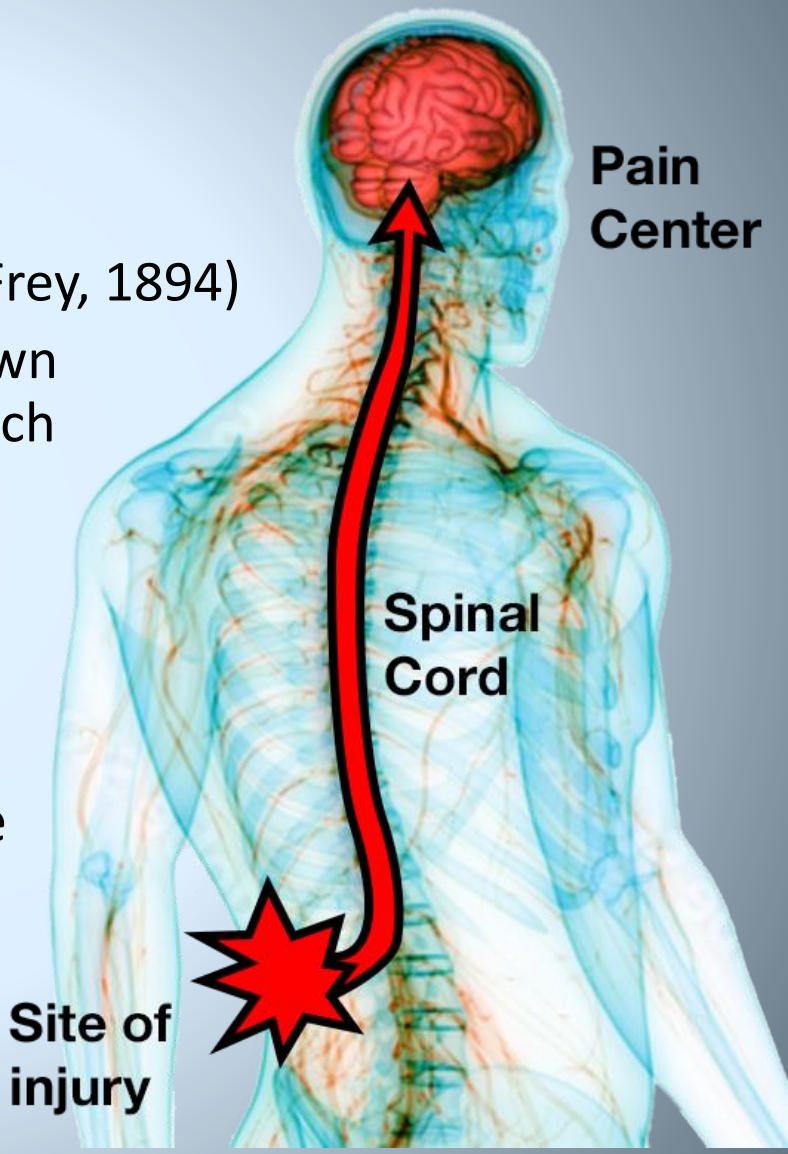
Pain Theories & Models

Specificity Theory

- Pain intensity = severity of injury
- Old theory with intuitive appeal (von Frey, 1894)
- Pain is “a specific sensation, with its own sensory apparatus independent of touch and other senses”

Biomedical Model

- Pain explained by bio factors only
- Treatment focused on tissue & disease
- Largely passive treatments performed by experts



Challenging Specificity Theory

- Gunshot wound v. papercut
- Examples from battlefield and athletic fields
- Scans in older adults may reveal changes that aren't perceived, don't impact functioning
- Phantom limb pain

Pain: Theories

Gate Control Theory

- Ronald Melzack & Patrick Wall, 1965
- Integrates a physiological explanation with psychology of pain perception
- Nerve fibers transmit pain signals to spinal cord and then brain -- signals can be suppressed
- “Gate” in dorsal horn of spinal cord – how wide the gate opens to let pain signals in is affected by factors such as:
  - Positive/negative thoughts and emotions
  - Attention/distraction level
- Combining the physiological and psychological was groundbreaking

Pain: Theories

Neuromatrix Model – Melzack, 1999

- Gate control plus stress models (Selye, 1950; Selye, 1976)
- No single pain center
- Pain is multidimensional experience related to pattern or *neuromatrix* of nerve impulses that are impacted by factors such as sensory experiences and learning
- Chronic pain as chronic stressor – less input needed to produce pain over time

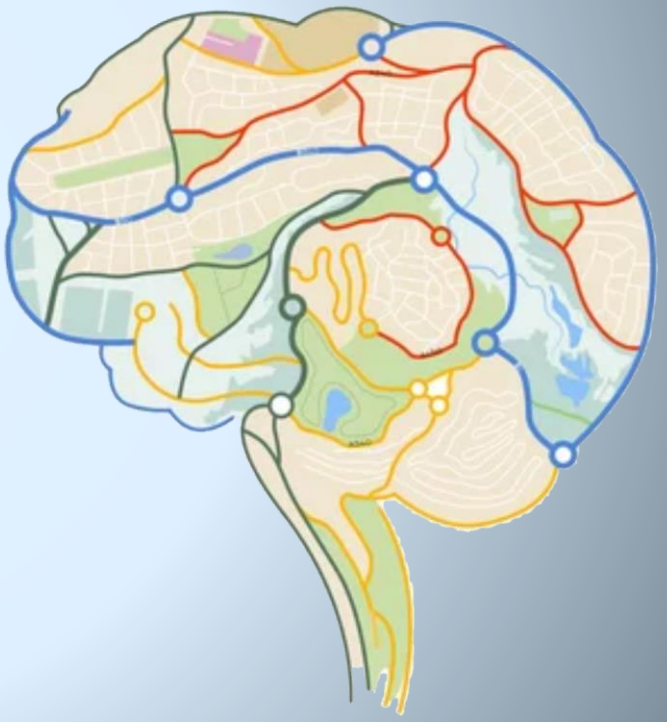
- Brain areas that process pain include those that underlie psychological process
  - Prefrontal cortex process meaning of pain
  - Anterior cingulate cortex process emotional or affective response to pain
  - Insula processing info related to sense of physical condition
  - Treatments that alter thoughts, sense of comfort and calm alter activity in prefrontal cortex, sensory cortex and limbic system (including ACC and insula)

- Pain relief occurs when these systems are disengaged or interrupted

Pain: Theories

Neuroplasticity

- Nervous system is adaptable/changeable
- In chronic pain neuroplasticity works against us -- reorganization is maladaptive
- Pain signals are more easily triggered and perception of painful input is exaggerated
- Part of why pain persists after injury has resolved
- CBT seeks to:
  - build ‘new’ roads in the brain to promote positive changes
  - reduce use of ‘old’ roads



Theoretical Underpinnings of CBT-CP

Operant Conditioning Model for Pain (Fordyce et al., 1968, 1973)

- All behavior is sensitive to environmental response to that behavior
- Pain behaviors (i.e. grimacing, guarding, resting) reinforced by social support, sanctioned time out from responsibilities
- Adaptive for acute pain but maladaptive for chronic pain

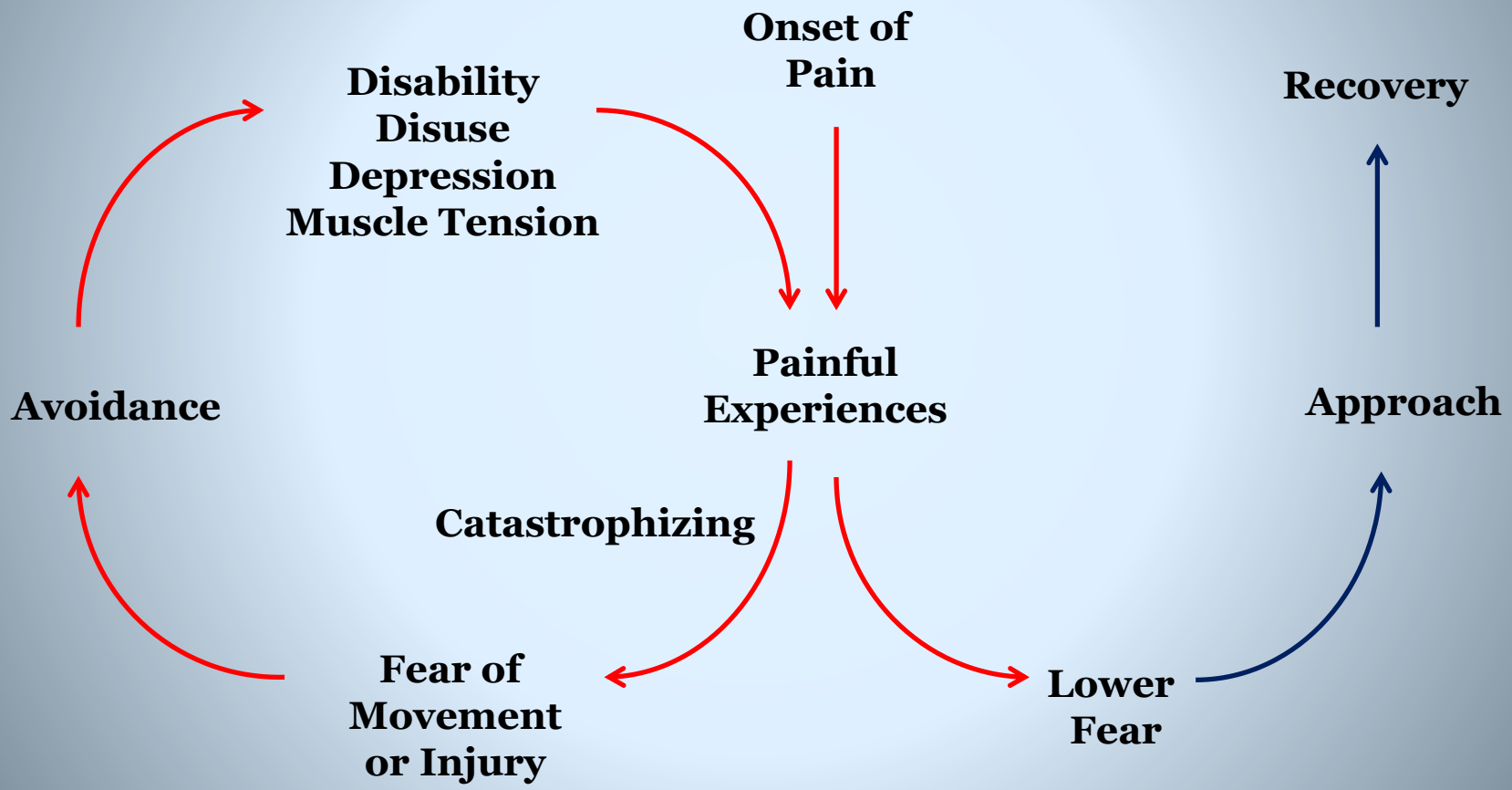
Treatment Strategies:

- Ignore pain behaviors and reward well behaviors
- Educate, change environmental reinforcers or remove from the environment
- Focus on life goals and functioning, change focus to time rather than pain (i.e. medication taking, pacing)

Theoretical Underpinnings

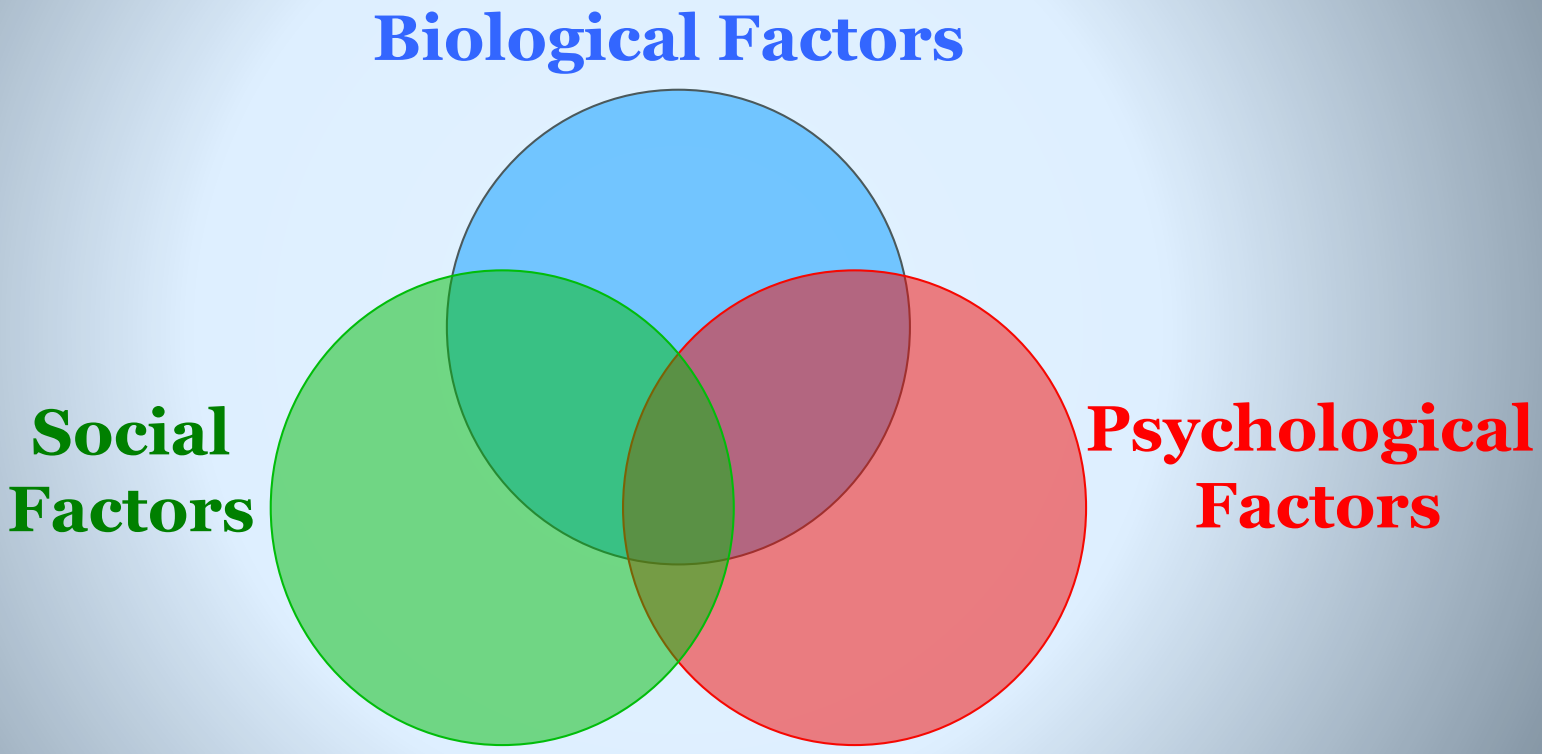
- Peripheral Physiological Models
  - Relaxation Training (Jacobson, 1938; Schultz, 1932)
  - Self-Regulation Language
  - Techniques include diaphragmatic breathing, PMR, autogenic training, biofeedback
  - Used for anxiety disorders in 1950s, for pain in 1970s
  - Good buy in, fits medical model of acting on perceived cause (i.e. muscle tension) of underlying pain
  - Mechanism appears to be increased self-efficacy (Blanchard et al., 1986; Holroyd et al., 1984)
  - Limited benefit to stand alone self-regulation techniques for pain (Jensen et al., 2009, Thorsell et al., 2011)

Fear Avoidance Model



Vlaeyen & Crombez, 1999

Biopsychosocial Model of Pain



(Gatchel, Peng, Peters, Fuchs, & Turk 2007)

Biopsychosocial Model

Distinguishes between disease and illness:

- *Disease* = objective biological event involving disruption of specific body structures or organ systems caused by anatomical, pathological, or physiological changes
- *Illness* = broader concept encompassing disease state AND subjective experience of the individual

Consistent with IASP definition of pain:

"An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage"

- Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.
- Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.
- Through their life experiences, individuals learn the concept of pain.
- A person's report of an experience as pain should be respected.
- Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.

Etymology: Middle English, from Anglo-French peine (pain, suffering), from Latin poena (penalty, punishment), in turn from Greek poine (payment, penalty, recompense).

Differences between Biomedical & Biopsychosocial Models

Biomedical Model	Biopsychosocial Model
-linear relationship between tissue damage and pain	-complex relationship between tissue damage and pain
-pain largely explained by biological factors (i.e. tissue damage, disease)	-pain influenced by biological, psychological, social factors
-focus of treatment is symptom elimination	-focus of treatment is improved quality of life
-treatment of tissues/disease	-treatment of the whole person
-treatments typically passive (i.e. medication, injections, surgery)	-treatments are active, require consistent participation from patient

Biopsychosocial Variables

Thoughts	Emotions	Behaviors	Social
Hurt = Damage	Depression	Resting	Loss of Status
Self-Efficacy/ Control	Anxiety	Attention/Pleasant Activities	Social Support-Solicitousness
Fear of Movement	Post-traumatic Stress	Guarding	Social Support-Distraction
Pain as Mystery		Over-Activity	Isolation
Catastrophizing		Exercise	Social Support-Punishing

Psychological Factors-Beliefs About Pain

Hurt = Harm (leads to kinesiophobia or catastrophizing)

- Pain interpreted as evidence of active tissue damage (rather than stable problem)
- Perception of damage can lead to higher report of pain

Pain as a Mystery (leads to catastrophizing)

- Source of pain unknown
- Lack of buy in for biopsychosocial understanding of pain
- Can lead to distress, increased pain intensity
- Repeated seeking of medical tests/invasive interventions

Pain Self-Efficacy

- Pain can be managed/controlled -- ”I can influence my pain”
- Adaptive–increases in this belief suggest positive outcome

Psychological Factors-Catastrophizing

Thinking the worst about pain or its implications

- *My pain will never stop*
- *I can't cope with this pain*
- *Nothing can be done*

- Prospectively predicts pain ratings (Sullivan & Neish, 1999; Sullivan et al., 1995; Keefe et al., 1989)

- Associated with increased:
  - Physical and emotional distress (Spanos et al., 1979; Chaves & Brown, 1978; Rosenstiel & Keefe, 1983; Sullivan et al., 1995, 2006).
  - Disability and unemployment (Sullivan, 2009)
  - Depression (Sullivan, 2009)

Pain Catastrophizing

- Catastrophizing is common
- Over training (i.e. media, special groups including Vets and trauma)
- Language supports catastrophizing
  - Degenerative disc disease
- Context of pain leads to catastrophizing

Psychological Factors – Depression

- Levels of depression predict LBP 3 years following initial assessment (n=148 Vets without baseline LBP)
- Depression at baseline 2.3 times more likely to report back pain
- Depression stronger predictor of back pain than any other clinical or anatomical risk factor
- Incidence of new MRI findings only 9%

Jarvik et al., 2005

Social Factors- Solicitous Significant Other

- An individual highly responsive to a patient's pain/pain behaviors
  - May actually increase a patient's pain level (compared to spouses/partners who suggest helpful but distracting coping strategies)
- Demonstrations of increased pain may garner additional attention/assistance
  - May also be secondary gains
- Solicitous Spouse Study
  - Presence of partner increased report of pain from a mild shock to primary pain area by three-fold (Flor et al., 2002)

Social Factors- Punishing Responses

- Punishing responses involve either angry or ignoring responses
- This dynamic can occur with significant others and with providers
  - Can lead to dramatic/dynamic (loud) expressions of pain experience in an effort to“be heard” by significant others or providers
  - Can also lead to resignation and stoicism about pain

(McCracken, 2005)

Social Factors-Social Roles

Chronic pain can negatively impact a number of social status variables including:

- Employment
- Finances
- Household roles
- Isolation

Behavioral Factors-Coping Style

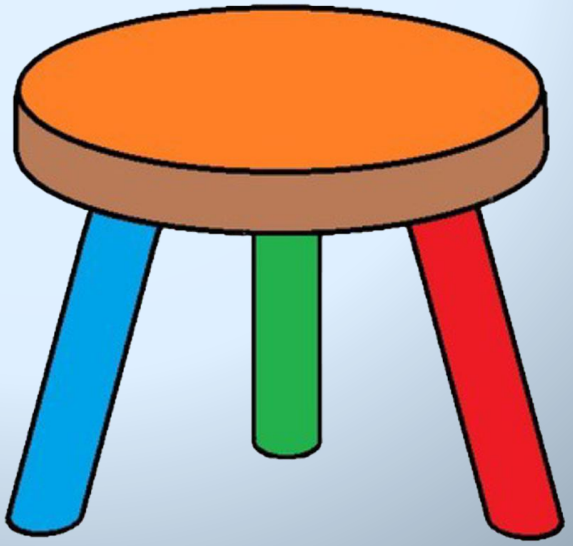
Note: Adaptive coping in **blue**, maladaptive in **red**

CBT for Chronic Pain

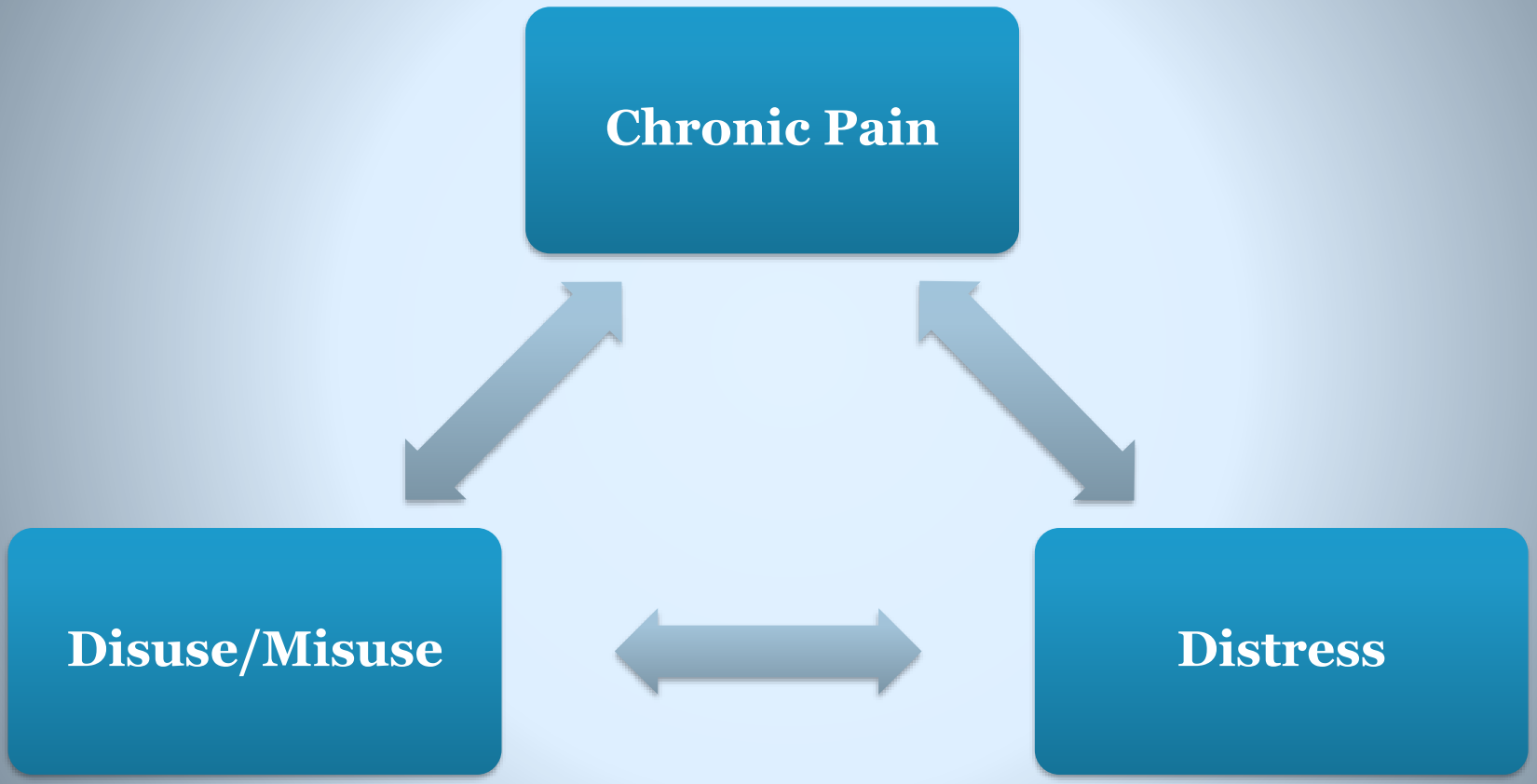
- Focuses on interaction between thoughts, feelings (physical and emotional) and behaviors that contribute to development and maintenance of chronic pain experience
- Immediate targets:
  - Catastrophizing
  - Perceptions of disability
  - Functional impairment
  - Quality of life
  - Self-efficacy
- Goal is to help patients to "turn down the volume"

Presenting CBT for Pain

- Pain isn't in your head
- Behavioral/psychological treatment helps
- Evidence based
- Doing rather than knowing leads to change
- Three-legged stool approach to pain



The Chronic Pain Cycle



CBT-CP Protocol

- 11 sessions (plus optional booster)
- Individual or group therapy format
- Addresses medically stable, non-malignant, ambulatory (can be adapted for spinal cord injury), chronic pain disorders
- Individual sessions are 50 minutes; group sessions are 60-75 minutes

General Goals of CBT-CP

- Teach skills that improve pain and quality of life
- Build motivation to practice
- Encourage an active, problem-solving approach
- Increase self-efficacy, or ability to self-manage pain
- Decrease catastrophizing
- Primary target = decreased pain and improved quality of life

CBT-CP Sessions

1. Interview and Assessment
2. CBT-CP Orientation (*chronic pain cycle, personal factors)*
3. Assessment Feedback and Goal Planning (*SMART goals*)
4. Exercise and Pacing (*includes "mandatory" walking program*)
5. Self-regulation techniques (*diaphragmatic breathing, PMR, visualization*)
6. Pleasant Activities (1) (*behavioral activation*)
7. Pleasant Activities (2)
8. Cognitive Coping (1) (*cognitive distortions and restructuring*)
9. Cognitive Coping (2)
10. Sleep (*sleep hygiene with an emphasis on stimulus-control*)
11. Coping with Flare-ups and Discharge Planning
12. Booster Session *(as needed*)

Murphy, J.L., McKellar, J.D., Raffa, S.D., Clark, M.E., Kerns, R.D., & Karlin, B.E. *Cognitive behavioral therapy for chronic pain among veterans: Therapist manual*. Washington, DC: U.S. Department of Veterans Affairs.

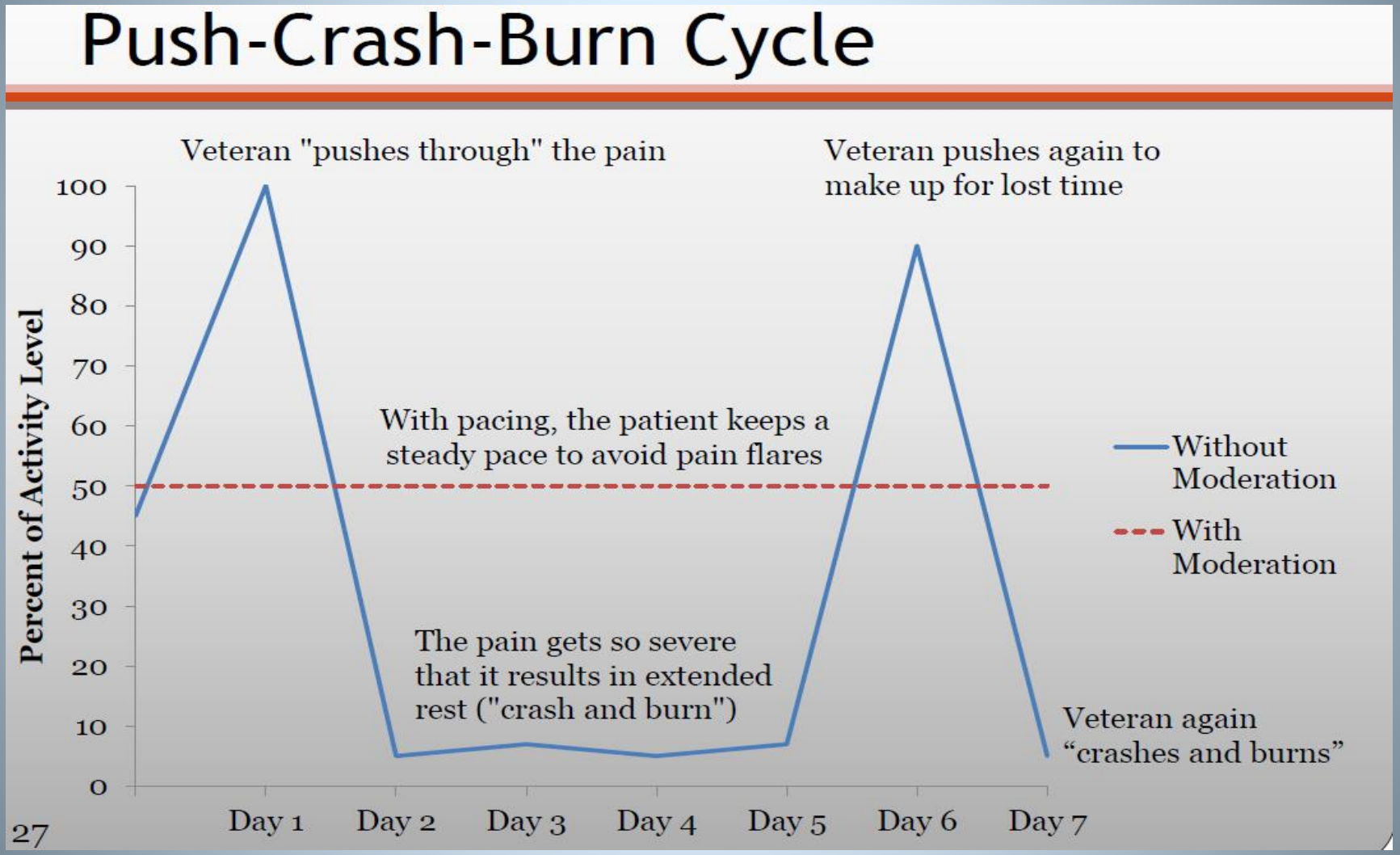
CBT Early Sessions

- Pain Education (Acute v. Chronic & Flares)
- Pain-Distress-Disuse Model
- Setting expectations
  - Active treatment requires activity and practice
  - Pain is biopsychosocial problem requiring comprehensive approach
- SMART goals and MI
  - Assess identity and develop personal and culturally congruent goals

CBT Skills – Walking

- Walking program
  - Accessible to most but tailor to personal, SES, or cultural barriers
- Hurt v. harm
- Avoidance leads to harm
- Check engine light metaphor

CBT Skills – Time Based Pacing



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CBT Skills – Time Based Pacing

HOW TO PACE

Estimate how long you can safely do one of your regular activities (e.g., yardwork, dishes) without causing a severe pain flare and set that minus one minute as your "active" goal time for the activity. Approximate the amount of "resting" time you will need in order to safely resume activity or continue your day.

Remember:

- Approximated times may need to be adjusted after pacing begins.
- Stick to time-based pacing goals whether you are having a 'good' or a 'bad' pain day to avoid the crash-burn/over-activity cycle or the avoidance/inactivity cycle – moderation is the key.
- Spread out activities during the week and be reasonable with the schedule so you can succeed.

Use the table below to record how you pace activities this week. Use the sample as your guide, where each period of activity and rest equals one cycle. In the examples provided, **10 : 15 (1)** indicates *working for 10* minutes and *resting for 15* minutes for *one cycle* of pacing.

	Sample	Activity 1	Activity 2	Activity 3
Activity	Rake leaves			
Active Goal	10 minutes			
Rest Goal	15 minutes			
Day 1	10 / 15 (1)			
Day 2	10 / 15 (2)			

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Time-Based Pacing Considerations

- Try using the term “time-based”
- Refrain from pairing with exercise
- Identify barriers (i.e. not feeling satisfied, concerns about length of time)
- Choose culturally congruent activities
- Best to pair with chores or ADLs, not pleasant activities


NATIONAL GEOGRAPHIC
FINE ART
GALLERIES

CBT Skills – Self-Regulation

- Chronic sympathetic activation (fight/flight/freeze)
  - Increased heart rate, BP, breath, muscle tension, blood sugar, digestive disturbance, impaired immune functioning
- Promote self-regulation to induce parasympathetic response (rest/digest)
  - Decreased heart rate, deeper breath, decreased muscle tension, optimizing blood sugar, digestion, immune functioning
- Diaphragmatic breathing, Progressive Muscle Relaxation & Visual Imagery
- Opportunities to tailor to culture and spirituality (i.e. pair with prayer)

Useful Apps


Carrier
7:41 AM
Virtual Hope Box
VIRTUAL HOPE BOX
Remind Me
Distract Me
Inspire Me
Relax Me
Coping Tools


Personalize
Tip
BREATHE
RELAX
DHA
Defense Health Agency
Show Me How
Breathe
Setup
Results
Learn
About

CBT Skills – Pleasant Activities

- Behavioral activation to intervene on distress and disuse
- Making space for grief and loss
- Selecting activities based on the essence of personally and culturally valued activities
- Be creative!

CBT Skills – Cognitive Coping

This is Alex

CBT Skills – Cognitive Coping

- Thoughts directly related to pain perception (Lawrence et al., 2011)
- ABC Sheet (neutral and pain examples)
- Highlight catastrophizing
- Evidence for, evidence against
- Coping statements – rely on quotes that resonate with culture and/or spirituality

CBT Skills – Cognitive Coping

Activating Event	Belief	Consequence	Evidence that supports the worst thought	Evidence against the worst thought	Balanced thought that incorporates all evidence
(who, what, where, when)	(What are the exact thoughts? Circle the most distressing?)	Emotions/Behaviors			
I woke up in pain	-Today is going to be terrible and I won't be able to do anything	Depressed Cancel plans	Pain Previous days of pain	-I've been walking even with pain -Something could improve	I'm in pain and I'm worried it's going to be a hard day but I can try to go for a walk

CBT Final Sessions

- Sleep
  - You can influence sleep
  - Emphasize stimulus control
- Written flare plan
  -include culturally sensitive activities like prayer, meditation, drumming or dance
- Booster

Tailoring CBT-CP to Culture

- Develop individualized, culturally tailored SMART goals
- Tailor walking program
  - Plan where someone feels safe
  - Assess whether gender or cultural beliefs are barriers
- Incorporate prayer or meditation into self-regulation skills and/or flare planning
- Identify personal, valued activities that are culturally congruent
- Rely on personal quotes consistent with culture and/or spirituality for coping statements

On the last page, we learned about evidence-based treatments. Now, let's take a look at one of these proven treatments for pain, called CBT for Chronic Pain.

Let's learn about

Proven Treatment for Chronic Pain

What is CBT for Chronic Pain?

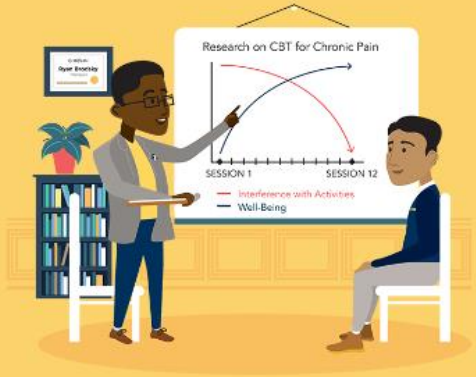
Cognitive Behavioral Therapy for Chronic Pain (CBT-CP) is an evidence-based treatment option for chronic pain shown to be effective in helping people better manage and take control of chronic pain and its effects. CBT-CP teaches proven skills for changing thoughts, emotions, and behaviors that affect how people experience pain.

Watch this video to learn more about CBT-CP treatment. And check out the wheel at the bottom of this page to learn about the specific parts of treatment!

HELP

TREATMENT WORKS FOR VETS

MENU



Many years of research have shown that CBT-CP is effective in **improving how people experience and manage chronic pain.**

Overall, Veterans who complete CBT-CP report **fewer negative effects of pain** on their daily lives ...

and **fewer unhelpful thoughts** related to pain.

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Frequently Asked Questions (FAQs)

1. Does CBT actually reduce pain?

Answer: CBT is associated with small changes in pain ratings and bigger changes in mood, and quality of life.

2. Is it safe to encourage physical activity for clients with chronic pain?

Answer: Yes, exercise is a recommended treatment for chronic pain. Please consult with a medical provider or physical therapist if you are concerned about specific exercises. The vast majority of ambulatory patients are cleared for walking.

FAQs

3. How do you address substance use in the context of CBT for chronic pain?

Answer: Though substance use may provide temporary pain relief, it is associated with increased mental health problems and disability, which exacerbate pain over time. Chronic and severe substance use is associated with increased vulnerability for injuries and can impede healing and recovery for chronic pain. Education, motivational interviewing along with other treatments can be incorporated with CBT to address substance use.

4. Can CBT for chronic pain be delivered in a group setting?

Answer: Yes! CBT for chronic pain lends itself well to both individual and group treatment. Some studies show that group treatment may even be especially effective for older adults.

Q & A Session

L.A. Care PCE Program Friendly Reminders

Friendly Reminder, a survey will pop up on your web browser after the webinar ends. Please do not close your web browser and wait a few seconds, and please complete the online survey.

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Thank you!