Key Behavioral Health Concepts

for the Treatment of Chronic Pain

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Pain related Beliefs

E.R.A.S.E. Emotions/Reflections

"Beliefs about the nature of pain, fears of hurting, harming and further injury, and self-efficacy beliefs are the most important beliefs to consider." (Main, 2010)

- **Fear:** Measurements of fear are better predictors of disability then imaging or other "physical" measurements, including pain ratings. (Crombez, 1998)
  - Fear is often complex and may be related to pain itself, the impact pain upon life, worry about reinjury, etc.
  - Can be addressed thought normalizing pain (hurt vs harm), providing education, behavioral experimentation, coping skills
- **Catastropization:** Beliefs and descriptions of pain that tend to be exaggerated
  - Can be addressed through pain neuroscience education, identification and reframing catastrophized statements, increasing objective descriptions of pain

The Case of Mark

- **The case of Mark and Disc Degeneration**

Age (Years)	20	30	40	50	60	70
Disc Degeneration MRI finding	37%	52%	68%	80%	88%	93%

Brinjiki W, et al. Am J Neuroradial. 2015, 36 811-816

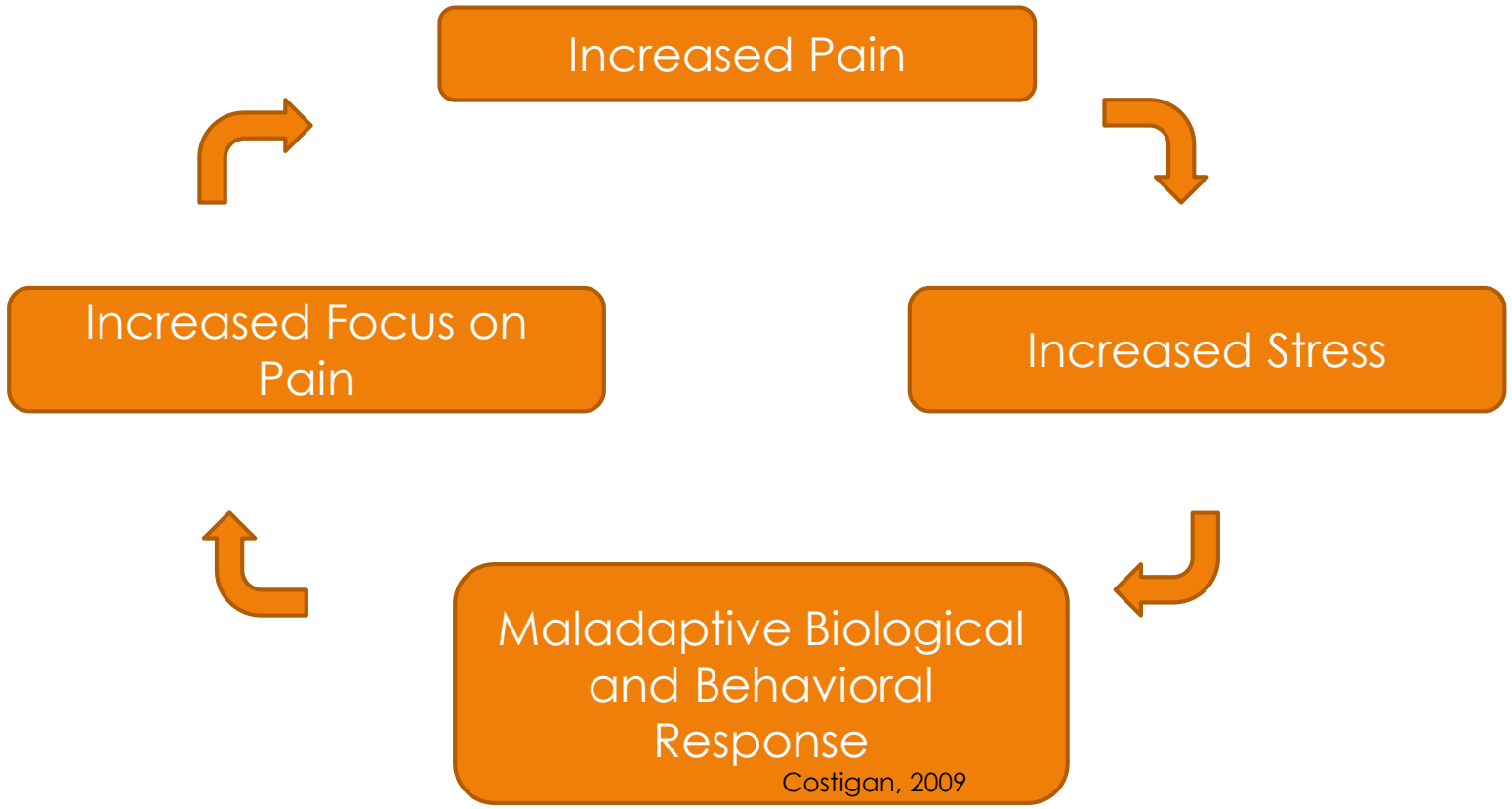
Dysfunctional Pain Behavior

E.R.A.S.E- Actions/Environment

Common Behavioral Changes related to pain

- Decreased leisure activities
- Decreased social interaction
- Missed work
- Reduced contact with family

Duenas, 2016



Costigan, 2009

Increasing Self Efficacy
E.R.A.S.E- Actions/Environment

- **Pain related behavior to target in treatment**
  - **Avoidance:** Anticipated pain leads to widespread reduction in behavior, which can increase rumination on pain, cause additional distress, and increase psychosocial stressors
    - Encourage exposure, behavioral experimentation, education on effect of reduced activity, normalizing pain
  - **Passive Coping:** A focus on passive or interventional procedures, poor follow through, focus on pain needing to be "fixed"
    - Encourage active coping (self efficacy), develop accountability and realistic goals, direct patient toward functional improvement
- **Increased Function vs. Pain Elimination**
  - Collaborate with patient on functional goals that can be implemented at the current time
  - Consider what the patient values, and what the patient is willing to do *despite pain*
  - *Acceptance of pain is associated with better mood, decreased functional impairment, and decreased pain intensity (Ramirez-Maestre C, 2014)*

Effective Behavioral Health Treatment

- **Evidence Based Practice for Chronic Pain:**
  - Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), Emotional Expression and Awareness Therapy, Mindfulness Based Stress Reduction (MBSR)
  - Relaxation Training
    - Biofeedback
- **Who to refer**:
  - Individuals who are not progressing in treatment as expected
  - High levels of stress
  - High Levels of pain focused thinking or behavior
- **Mental health issues are not a prerequisite for pain psychology**
  - Depressive and anxiety symptomology are common responses to pain
  - Mental health and substance abuse issues need to be addressed
  - Trauma: Individuals who have reported exposure to psychological trauma were 3 times more likely to have persistent pain, regardless of the type of trauma (Edwards, 2016)

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