Problematic Pain:
Non-Opiate Options

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This material will be the basis for an upcoming workshop series offered to primary care physicians in 2006.

Many of the rehabilitation techniques used to treat patients with chronic non-cancer pain (CNCP) in difficult-to-assess multidisciplinary pain programs can be transferred to the primary-care setting.

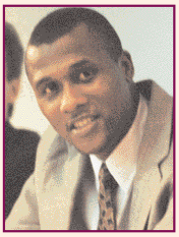
Rehabilitation focuses on the restoration of the patient's function, lost capabilities and self-sufficiency. From this perspective, pain is only one barrier standing in the way of improved function, and medication management is only one treatment strategy. Teaching skills in relaxation, pacing and goal attainment scaling (GAS) helps patients change their focus from their level of pain to their level of activity.

Relaxation skill training

Relaxation skill training is a critical ingredient in pain management, providing patients with an alternative to withdrawing from activity in response to pain. The physician actively teaches their patient the script for relaxation under optimum conditions.

The family physician takes an active role in teaching the patient such techniques as autogenic training and visualization. Relaxation tapes are not used and progressive muscle relaxation is not taught because it causes patients to become tense and can increase their pain. The key to learning relaxation skills is practice. First, under optimum conditions, which include lying down in a dark, quiet room. Once skills such as guid-

Xavier's case



- Xavier, 35, has failed back syndrome following surgery at L4-5.
- Antidepressant and opioid therapy have been maximized.
- He avoids all activity in fear of causing himself more pain.
- He spends most of his day lying down.
- How would you treat Xavier?

For more on Xavier, turn to page 78.

FAQ

Can patients with chronic non-cancer pain (CNCP) be managed in the primary-care setting?

Yes. Although multidisciplinary pain programs are considered the gold standard for treating patients with CNCP, they can be difficult to access. There is evidence that individual, in-office treatment can be effective.

More on Xavier

- Xavier trusts his family physician and he is willing to learn how to do more activity, despite his pain.
- He is taught relaxation skills, progressing from lying down to being active and still being able to relax.
- He is taught pacing (breaking up a task into time based units). At the end of each unit he takes a break, even if he does not want to, before returning to the activity.
- Finally, Xavier learns how to do goal attainment scaling.
- He identifies his catastrophic thoughts about his pain.
- Xavier is given information about the difference between acute and chronic pain.
- His family learns to encourage him to do more.
- Xavier pushes himself to do more, despite his fears.
- He discovers that he can do more with his family and still manage his pain.

ed imagery or autogenic training have been mastered, the physician gradually encourages the patient to practice these skills under less than optimum conditions, moving from sitting to standing, until the patient can relax while being physically active.

Pacing

Pacing is the technique of wisely using a limited amount of energy and physical capacity and is not equivalent to doing less activity. Patients with CNCP need to learn how to spread out a given activity over

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a longer period of time, as compared to their pre-illness days, and schedule brief rest/relaxation periods. These rest periods should not be stimulated by increased pain or fatigue, rather, they should be scheduled into the activity and taken regardless of the patient's level of fatigue or pain.

GAS

GAS offers the clinician a concrete method for helping patients identify malleable barriers and supports to increase function. The first step is to help patients identify a meaningful functional goal. Goals need to be specific, measurable, attainable, realistic and timely (SMART). "I want less pain," is not a SMART goal, whereas, "I will practice relaxation 10 minutes a day," is a SMART goal. The focus of treatment is to identify supports and barriers to the acquisition of the goal, to reduce barriers, and to increase supports. Barriers and supports fall within the categories of cognitive, emotional, physical and systemic factors.

Cognitive factors deal with what the patient

FAQ

How should I approach the treatment of patients with CNCP?

A rehabilitation approach is central to the management of this patient population. After medical management has been maximized, treatment should focus on helping patients increase their level of function, in spite of the pain they experience.

FAQ

What skills can I teach my patients with CNCP that will help them increase their level of function?

Relaxation training, pacing and goal attainment scaling are three skills that are central to chronic pain management. They are best learned through the active involvement of the physician, who helps the patient identify solutions to barriers that stand in the way of increasing function, despite pain.

thinks. If the patient thinks more pain means they will be crippled, it is not surprising that this cognition will lead to immobility. The task of treatment is to solicit these cognitions and challenge them with new information, alternative positive cognitions and new positive activity-based experiences. New information can be provided by the physician.

Patients often have distorted beliefs about what is causing their pain. Cognitions that counter negative thoughts are often referred to as positive self-talk. Patients can get into the habit of self-depreciation. The physician helps the patient recognize the positive aspects of their lives and their efforts. New activity-based experiences are provided by such programs as low impact aqua therapy, tai chi, a walking program or by increasing socialization. Through the experience of doing, patients challenge their own beliefs about their fragility.

Family psychoeducation is used to educate the family about the patient's condition, the importance of activity despite pain and that encouraging pain avoidance can be harmful in the long-run.

Emotional factors can have a significant impact on function. Depression and anxiety must be actively treated, often with pharmacotherapy. However, fears about self-injury and anger about losses need to be identified and managed in psychotherapy.

Physical barriers to increasing activity are important to identify and solve. Such physical devices as braces, assistive devices for ambulation, and reaching aids, can help the patient overcome major barriers of function.

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Systemic factors deal with social organizations, such as family or insurance providers. Family members can inadvertently reduce a patient's function by responding to pain behaviours by encouraging withdrawal from activity. Family psychoeducation is used to educate the family about the patient's condition, the importance of activity despite pain and that encouraging pain avoidance can be harmful in the longrun. The family can go from being a barrier to being a support for increased function. In regards to insurance providers, the primary-care physician can provide advocacy on behalf of their patients with CNCP.

In GAS, all goals, barriers, supports and solu-

tions are recorded. An attempt to reach the goal is initiated. Barriers and their solutions are re-evaluated and recorded and the goals are approached again. This process continues until the goal is reached. Then, a new goal is identified and the process repeats.

Conclusion

The primary-care physician reviews goals and provides feedback, direction and insight in regards to the management of barriers and supports to goal acquisition. Patients are taught how to get on with their lives in spite of their pain and the clinician learns to ask the patient, "What are you doing?" instead of, "How do you feel?" Dx

Take-home message

- Once analgesia and the treatment of co-morbid psychiatric illness are maximized, a rehabilitation approach is used.
- The focus moves from pain reduction to increasing function.
- Relaxation skills are taught using guided imagery and autogenic training. Eventually, patients can use these skills while being physically active.
- Pacing strategies allow patients to do more, in spite of reduced energy and physical capacity.
- Finally, goal attainment scaling provides the patient and physician with the means of identifying suppports and barriers to increased function and of finding strategies to increase the supports and break through the barriers.