Chronic Pain Self-Management: Psychologically Guided Core Competencies for Providers

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Introduction

Maria has significant, chronic knee pain from osteoarthritis that she feels has worsened through years of bending over and kneeling during her career as a licensed practical nurse. Nothing has successfully offered lasting relief. Medications make her feel woozy or upset her stomach. She doesn’t feel safe outside alone in her neighborhood, so she does not exercise. Maria has heard there might be other options like yoga, mindfulness, and physical therapy, but she doesn’t know how to find these services, doesn’t think she can afford them, and isn’t convinced they will work.

In the meantime, Maria powers through her pain because she needs to work. She’s depressed, and pain dominates her life.

Millions of people like Maria (a fictitious patient) experience chronic pain and seek help from providers of various types. The dominant biomedical model and longstanding societal norms reinforce the idea that health problems require the attention of a healthcare provider who can identify the source of the problem and “do something” to eliminate it, typically via medications or surgery. However, the traditional patient-provider encounter is impractical and inefficient for managing multidimensional conditions like chronic pain. The ways individuals manage chronic pain are highly personal and driven not only by provider-based information and interventions, but also influenced by a lifetime of internalized views and behaviors, written or online information of variable quality, guidance from family and close social ties, and highly funded marketing efforts that reinforce biomedical approaches to health, in general, and pain, specifically.
Self-management of chronic pain reflects intentional, active efforts to manage pain and its effects on physical and emotional function [1]. A patient’s adoption of a chronic pain self-management approach is predicated on perceptions of self-efficacy: the belief in one’s own capacity for self-management. However, we know that pain self-management is a continuous process that requires sufficient motivation, knowledge, and skills necessary to maintain effective physical and psychosocial function [2]. Ideally, these skills include use of cognitive, emotional, and behavioral strategies to manage personal, family, and social roles and responsibilities and the emotional consequences of chronic pain. Ultimately, self-management of chronic pain is specific to an individual and controlled by her or him. For this reason, providers of every type must consider factors beyond provider-initiated interventions that have the potential to shape an individual’s ability to manage pain effectively and thus contribute to quality of life long-term.

Previous work has affirmed the value of provider empathy and effective communication about management of chronic pain and barriers that interfere [3]. Successful pain self-management thus grows from a strong, dynamic, collaborative relationship among individuals with chronic pain and providers that prioritize patient empowerment, activation, self-efficacy, and which can evolve over time [4]. One example of such a strategy is the Department of Veterans Affairs (VA) Stepped Care Model for Pain Management that emphasizes general health-promoting behaviors including nutrition and weight management, exercise and conditioning, sleep quality, engagement in meaningful activities, and family/social support [5]. The VA-based model also
provides guidance for use of patient-controlled pain-reducing activities, such as use of ice and stretching, mindfulness-based meditation, and relaxation strategies, among other evidence-based modalities. Other resources have been developed by the American Chronic Pain Association and the Centers for Disease Control and Prevention. Clinical practice guidelines promulgated by the American College of Physicians and other entities have also specifically encouraged use of evidence-based nonpharmacological approaches consistent with pain self-management.

Although existing guidance emphasizes broad health-promoting behaviors as well as pain-specific approaches toward patient-driven self-management for chronic pain, clinicians across disciplines are often not aware, not incentivized, or not skilled to help patients learn and adopt these practices. Lack of provider training, time, and reimbursement models for self-management activities (such as health coaching) likely prevents opportunities for millions of individuals with chronic pain to learn to better self-manage symptoms and improve quality of life.

**Chronic Pain Self-Management: Ideal but Elusive**

We are investigators from different health professions with unique clinical and scientific experiences and expertise related to chronic pain. Collectively, we are conducting pragmatic trials of nonpharmacological approaches to pain management within large, integrated health systems that serve military and veteran populations, comprising the National Institutes of
Health (NIH)-Department of Defense (DOD)-Department of Veterans Affairs (VA) Pain Management Collaboratory [6]. We are well-aware of the value of promoting chronic pain self-management, as well as challenges faced by practitioners aiming to guide patients in these activities. These challenges came into sharp relief when COVID-19-inspired rapid shifts to virtual care affected delivery of evidence-based chronic pain management approaches commonly associated with in-person and hands-on care, such as physical therapy and chiropractic care [7].

Despite our different clinical perspectives, however, we are remarkably well-aligned with the importance of fostering patients’ capacity for self-management of chronic pain. Herein, we articulate a call to action for core competencies that are provider-agnostic and grounded in evidence-based psychological principles and specific approaches foundational to building self-management skills, such as promoting positive behavior change and motivational interviewing [8]. Recognizing that pain self-management is a higher-order construct, spanning specific disciplines and interventions, self-management competencies are akin to other critical clinical skills such as diagnosis and intervention delivery that should be adopted by all healthcare professions to better help patients manage chronic pain.

As noted, we recognize that providers may not be well-prepared to help their patients acquire the knowledge, skills, and motivation to manage their pain long-term. Hurdles include longstanding patient and provider preferences for medication-based treatment; insufficient training/resources; lack of health system algorithms for multimodal care; variable awareness of, access to, and acceptance of nonpharmacological treatments for chronic pain; and financial
incentives for procedure-oriented approaches as opposed to integrated, multimodal care incorporating educational, physical activity, healthy diet and sleep practices, and psychological approaches designed to support chronic pain self-management. Moreover, for a range of reasons, many patients are either unaware of, or unable to adopt, evidence-based options available for people living with chronic pain, such as recommended behavior changes associated with positive health outcomes [9].

A critical aspect of effective self-management of chronic pain is managing behavior, which requires sustained personal effort. Patients may see a behavior like yoga as beneficial but not be well equipped, or ready, to take necessary action. This is an essential reality for providers to recognize and address when helping patients develop pain self-management capabilities, skills, and self-efficacy. Even individuals who may initially be unprepared to contemplate behavior change can benefit from interventions designed to promote pain self-management [10], aided by a strong therapeutic alliance and a growing perception of self-efficacy [11].

**Provider Core Competencies for Self-Management of Chronic Pain**

The concept of core competencies for pain management is not new and has been articulated as a set of 25 skills arrayed across four domains: i) the multidimensional nature of pain; ii) pain assessment and measurement; iii) pain management; and iv) clinical context [12]. These core competencies were developed through interprofessional consensus targeted to prelicensure requirements, but they do not explicitly address self-management strategies in detail. We
believe all healthcare professionals involved in pain care have a responsibility to their patients to exhibit core competencies for guiding chronic pain self-management. The details of these competencies are beyond the scope of this Commentary, but we have summarized key principles and processes in Figure 1.

The multidimensional nature of pain and pain assessment domains encourage consideration of the fact that chronic pain is multifaceted and exists along a spectrum of severity from mild intensity and limited impact on routine functioning to high-impact chronic pain, defined as chronic pain that interferes with work and daily functioning on most days. Also important to consider are the multiple factors associated with the development and perpetuation of chronic pain (e.g., underlying pain conditions, co-occurring physical and mental health conditions, fear avoidance, pain catastrophizing, health risk behaviors). Education and motivational interviewing can support patients’ reconceptualization of chronic pain as a problem that can be self-managed, in part or in whole. These types of approaches help build a foundation for discussing current pain self-management strategies and opportunities for acquiring and practicing new approaches designed to enhance self-management capacity. Explicit attention to the clinical and social context of pain self-management includes efforts to promote integration of care and coordination across settings and providers. It is also important to address issues of equity and disparities in pain and pain care, within the context of the biopsychosocial model, recognizing experiences of racism and discrimination within and outside healthcare as well as individual differences in pain coping. Providers should aim to provide equitable care overall, as well as identify opportunities to address inequities and injustice.
Psychologically guided pain self-management – which includes psychological training, lifestyle modification, pain education, physical activity, and some complementary and integrative therapies – is informed by the biopsychosocial model and social cognitive theory, similar to self-management of chronic illness, and evidence suggests that it helps improve patient-centered pain outcomes [13]. Irrespective of health profession, provider core competencies built around psychologically informed pain self-management can contribute to a framework for helping patients achieve desired outcomes. Honest discussions about unique barriers and real-world challenges to changing and sustaining behaviors that contribute to important patient outcomes are critical. Example strategies include use of the Behavior Change Wheel [14] and motivational interviewing techniques, such as those employed by the VA Whole Health [15] and DOD Move to Health [16] programs, which are used to highlight actionable strategies and goals. These approaches consider the emotional, social, and psychological barriers to changing behavior, in addition to assessing whether a patient feels ready to make changes.

As healthcare systems evolve to support self-management capacity-building activities, in which health coaches, peers, and non-clinicians assume more prominent roles, pragmatic clinical trials can begin studying the effectiveness and implementation of these approaches in real-world clinical care scenarios. To that end, we recognize that, as any management approach has the potential for harms, self-management-building activities can lead to adverse effects, particularly if a strategy is not well-matched to a patient. These might arise from insufficient clinical oversight, communication skills, follow-up, or understanding of providers (e.g.,
recommending exercise that is too vigorous) or when patients misinterpret or stray from
instructions or fail to report new or progressing symptoms. To minimize potential risks,
providers that help their patients engage in self-management-building activities should
consider the range of recommended strategies and communicate frequently with their patients
about adverse events, practicality, and level of use.

Our collective clinical experience reveals that effective evidence-based, nonpharmacological
pain management approaches should include engaging patients with self-management tools.
One example is the use of psychologically informed physical therapy to promote structured
exercise and valued activities [17]. Others, such as acceptance and commitment therapy,
mindfulness-based stress reduction, and biofeedback, are generally consistent with this
perspective [13]. While some evidence-based provider-delivered interventions (e.g.,
acupuncture, spinal manipulation, massage) require little or no commitment on the part of the
patient to making behavior change, these clinical encounters can provide pain relief while
simultaneously offering a valuable opportunity for providers to promote a more integrated and
sustainable approach to chronic pain self-management. Augmenting typically passive
approaches to pain management through psychologically informed pain self-management
strategies within a treatment plan should form the basis for an improved standard of care.

Conclusion
We authored this Commentary because, although it is widely accepted that effective self-management of chronic pain is important, empowering patients to implement it remains elusive in practice. Complicating factors include how providers are trained and reimbursement models that often favor a procedure-based approach (contributing to dependency on providers) rather than helping patients manage their pain long-term. Through this call to action, we aim to shine a brighter light on the need to operationalize self-management strategies within health systems, which will of course require acceptance and adoption by multiple stakeholders. Consistent with well-studied theories of behavior change, through consistent application of provider core competencies for self-management of chronic pain, providers can help patients discover and address barriers, as well as provide support, encouragement, and reassurance. Such activities represent clinical goals focused toward creating environments for patients to become the principal agents of long-term pain management success.
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Figure 1. Patient-centered application of core competencies to support chronic pain self-management

Competency Domains (From Fishman et al., 2013)

**Multidimensional nature of pain**
- Show respect, empathy, and reassurance for a person’s subjective and unique pain description
- Promote a complex and nuanced conceptualization of chronic pain through active listening and motivational interviewing
- Promote the objective of reducing pain interference on physical and emotional functioning, not just reducing pain intensity
- Promote the concept of chronic pain as complex with multiple contributors (including biological, psychological, and social) with no single cause and no single pathway to relief
- Consider behaviors associated with pain such as disturbed sleep
- Promote self-control by eliciting and reinforcing examples of how thinking and feeling/mood influence pain and pain interference
- Promote self-efficacy; “I’m in charge; I can manage my pain and its effects on my life”

**Pain assessment**
- Elicit factors that increase or decrease pain and pain interference
- Identify personal strengths and weaknesses (or vulnerabilities)
- Identify key values and associated behaviorally specific goals (e.g., SMART goals)
- Identify potential barriers and facilitators

**Pain management**
- Promote the idea that chronic pain treatment is patient-centered chronic pain self-management
- Develop a shared plan for achieving personal goals, including goals and steps/subgoals and a timeline
- Consider a multimodal and interdisciplinary approach; use empirical and anecdotal evidence and values; educate patients about alternative approaches, including potential benefits and risks/inconveniences, availability, and other factors relevant to choosing approaches
- Acknowledge personal strengths and weaknesses, and personal values and goals, in developing a shared pain self-management plan
- Promote healthy behaviors (e.g., regular exercise, good nutrition) and health-damaging behaviors (e.g., tobacco and excessive alcohol use; use of other risky substances)
- Promote optimized disease management (e.g., diabetes management and painful conditions; mental health and substance use disorders)
- Consider and discuss the role of pain medications (within the scope or privileges of providers)
- Clarify patient and provider responsibilities (and potential roles of significant others and family members)
- Clarify plans for follow-up

**Clinical and social context**
- Focus on quality of provider-patient communication and therapeutic alliance
- Address factors relevant to management of specific painful conditions (e.g., nociceptive, nociceptive, and neuropathic pain conditions) and overlapping pain conditions; address co-occurring medical and mental health conditions, including histories of trauma
- Promote care coordination and integration
- Promote access to community resources
- Address social determinants of health, especially barriers to accessing, engaging, and sustaining participation in care
- Address impact of racism and discrimination on pain and pain treatment
- Engage significant others and family members, as needed