Practical Pain Management

Self-Management of Chronic Pain in Primary Care

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December 2018

Opioid overuse has led to federal, state, and local initiatives to reduce its serious consequences on health and healthcare costs.¹ Yet, patients with chronic pain face an immense burden. Given the adverse effects on their mental, physical, and social wellbeing, they often live with a diminished quality of life, functional limitations, and loss of productivity.²,³

Despite the complexity of chronic pain, at least half of all patients receive their healthcare from a primary care clinician. This raises a striking conundrum since primary care practitioners (PCPs) have been found to harbor negative attitudes toward patients with chronic pain, driven by a sense of insufficiency in addressing this patient compliant;⁴⁻⁶ this hesitancy may be explained at least in part by limited training in pain management.⁶

The challenge faced by PCPs in managing chronic pain has been hampered further by limited resources, especially among low-income patients who are under- or uninsured. As shown in recent studies led by Turner, et al, managing these patients has been made all the more difficult because their families and friends have a limited understanding of chronic pain conditions.⁷

In one study, a representative sample of Hispanics who did not have a diagnosis of chronic pain were surveyed from five southwestern states; only 12% of respondents said they “knew a lot” about chronic pain.⁸ This small group was more likely to endorse the need for pain medications to manage pain at increasing doses. This belief reflects a common acceptance of relying on opioids and other prescription medications to treat chronic pain conditions that may respond at least as well to multimodal, non-pharmacologic interventions to control pain and reduce the myriad negative effects on daily living.

Turning to Biopsychosocial Approaches to Manage Chronic Pain

Employing a biopsychosocial model to pain management in the primary care setting would introduce PCPs to a valuable conceptual framework that captures biological, somatic, cognitive, and affective dimensions of chronic pain. This approach has the ability to positively address “central pain processes” and amplify its negative effects on activities of daily living, interpersonal relationships, social expectations, work history, and social support/isolation.⁹,¹⁰

To effectively address the multidimensional effects of chronic pain, patients need self-management training about behaviors, strategies, and activities that may help to control the destructive effects of pain on their quality of life. Use of self-management methods have proven highly effective for people with diabetes mellitus, a similarly complex condition, and has become a well-accepted component of diabetes care, covered by
Diabetes self-management training, for example, typically involves certified trainers and a team-based approach. To date, this disease approach has not been implemented broadly to assist patients with chronic pain to more effectively manage this severely disabling condition, even as its value has been recognized by the Institute of Medicine, which defines self-management of chronic pain as involving the following:

- Adhering to medical treatment
- Managing personal, family, and social roles and responsibilities through cognitive and behavioral strategies
- Managing emotional consequences of conditions associated with chronic pain.

Successful self-management requires the patient to develop a mastery of transferable skills and strategies for many aspects of living with chronic pain, such as: goal setting, activity pacing, relaxation, thought challenging, positive self-reinforcement, self-monitoring, problem-solving, decision-making, and resource identification.

A review of 46 randomized controlled trials of pain self-management education identified these common components: psychological training, lifestyle modification, pain education, physical activity, and mind-body therapy. Each component has the potential to transform primary care pain management by providing efficient, affordable approaches that can be integrated into clinical practice. Further, recent guidelines from the Centers for Disease Control and Prevention and the US Department of Health and Human Services’ National Pain Strategy endorse multimodal, non-pharmacologic interventions as first-line treatment for chronic pain. The following hypothetical case demonstrates the challenges patients may face without this training.

**Patient Case: “I’m stuck, what else can I do?”**

John D is a 44-year-old Hispanic male married for 15 years to Violet. They have two teenage sons. John and Violet own a busy restaurant. However, John injured his lower back in an accident at home. After three months on acetaminophen and ibuprofen, he visited his PCP who found no neurologic impairment upon examination. The PCP prescribed cyclobenzaprine and Tylenol with codeine (60 mg every 4 to 6 hours). The PCP also referred John for physical therapy (PT). He returned to the office one month later for a follow-up appointment. He reported running out of the prescribed medications and being “too busy” to go for a PT consultation. His PCP administered a steroid injection in the lumbar spine that provided temporary relief, renewed his opioid prescription, and ordered an MRI, which revealed no abnormalities. Over time, however, John continued to report disabling pain, and asked for stronger medication for pain relief, which the PCP refused. John exhibited frustration, as did his wife, who accompanied him on visits and complained about her husband’s inability to function at work or to help with the children. When the PCP suggested that John see a pain specialist, both he and his wife indicated that they did not have the financial means for this type of care and needed to continue to receive their care at the primary care practice.
Discussion

This hypothetical case demonstrates the limited options available to manage common cases of chronic pain in the primary care setting. Until recently, the usual solution has been to continue to prescribe opioids. However, John’s situation makes an excellent case for offering multimodal, self-management chronic pain training in primary care.

Primary care providers faced with a growing number of chronic pain patients often report feeling “stuck,” with limited options for their patients. Ideally, education and training could be made accessible in the primary care setting to help patients like John learn to function better with their pain and to reduce the cycle of complaining and reliance on increasing medication as the only solution.

Sources


