PERSPECTIVE PEER REVIEWED

Chronic pain
Encouraging non-pharmacological self-management

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Chronic pain should not be managed as if it were acute pain. By focusing on active management rather than passive interventions, healthcare providers can help patients achieve lasting improvements in both function and wellbeing more effectively.

Nonpharmacological approaches for chronic pain often include ‘passive treatments’ in which the person experiencing pain is the passive recipient of applications that focus on pain relief, such as acupuncture, massage, manipulation of joints, electrical stimulation, heat, hypnosis and traditional herbal remedies. In contrast, an ‘active self-management’ approach engages the person directly via active participation in managing their pain and associated problems. Healthcare professionals provide high-value care for chronic pain when they support active self-management and low-value care when they distract from it.

Passive treatments may ease pain briefly for some people with chronic pain, but any effects will be temporary and unlikely to resolve the cause of chronic pain (unless there is a clear peripheral driver, such as hip osteoarthritis requiring joint replacement). Generally, passive treatments for chronic pain are aimed at the periphery if the problem is likely to involve the central nervous system and endocrine mechanisms.[1,2] In addition, chronic pain is likely to be the result of multiple contributors and only addressing one makes little sense.[3] Although a desire for even a temporary reduction in pain is understandable, passive treatment is rarely a solution for a chronic condition, especially if provided in isolation. Such an approach also carries risks for the person experiencing chronic pain, leaving them to face the prospect of ongoing treatment sessions and associated costs, as well as the likelihood of poor outcomes. Accordingly, it is argued that healthcare providers caring for patients with chronic pain should focus more on an active self-management approach aimed at enhancing functional activities, rather than expecting a passive treatment to resolve the presenting problems. This article compares active self-management strategies and passive treatments for chronic pain, discussing their roles in improving long-term function, quality of life and patient self-efficacy.

Key points

- **People with chronic pain value help that promotes their independence and quality of life.**
- **Care for chronic pain is of low value when pain relief is the primary focus. High-value care for chronic pain includes a primary focus on improvement in functional activities, which is more likely when patients are encouraged to take an active self-management approach to their pain.**
- **Active self-management strategies for chronic pain should be tailored to the individual patient, but commonly include basic education about chronic pain, identifying and working towards functional goals, graded exercises, activity pacing, stress reduction techniques, problem-management skills and use of a weekly activity timetable.**
- **All healthcare practitioners can learn to support their patients in implementing these active self-management strategies and success is more likely when two or more practitioners (e.g. a GP and practice nurse) work collaboratively with their patient.**

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Impact of chronic pain

When pain persists and potentially curative treatments have not helped or are not indicated, pain is typically recognised as chronic. The *International Classification of Diseases 11th Revision* defines this as three months since onset.[4] It also differentiates between chronic pain that is secondary to a chronic disease, such as rheumatoid arthritis, and chronic primary pain that is not attributable to an underlying disease (e.g. most cases of low back pain). The reality is that once pain becomes chronic, it is likely to persist and may increasingly interfere in a person's daily life. It is also likely to be intractable to pain-focused, passive treatments. In cases of chronic secondary pain, treatment of the underlying disease may ameliorate the pain to some extent, but this is very unlikely if the person has chronic primary pain. The risk for patients with chronic pain and their treatment providers is that persisting with attempts to achieve symptom relief includes not just the disappointment of recurring treatment failures, but also escalating frustration, despair, long-term disability and even mortality. The opioid crises in Australia and the USA provide graphic lessons of the traps associated with this approach for both patients and prescribers.[5]

Fruitlessly pursuing the goal of reducing pain severity via passive treatments in patients with chronic pain can also become an obstacle to their recovery and rehabilitation. It risks keeping the focus on the pain, which may not change or may persist after short-lived relief, resulting in more frustration and distress for the person in pain, even before escalating costs are considered.[5] At the same time, there are what might be called 'opportunity costs' whereby the focus on pain severity as the main goal of treatment may come at the cost of failing to implement more effective interventions that promote the restoration of function. This is a problem for all pain-focused treatments for chronic pain, whether they are medical, pharmacological or nonpharmacological. Assuming nonpharmacological treatments are risk-free is a mistake, not because of their potential for side effects or drug interactions, but because they can act to keep the patient's attention on their pain rather than on more functional goals. This has been termed 'low-value care'.[6] Importantly, people with pain have reported they value help that promotes their independence and quality of life, and not just more trials of pain-focused, passive treatments.[7]

Active self-management of pain

People with pain often find that their pain becomes less troublesome as they achieve their desired goals, such as resuming a normal family and social life, as well as other activities like returning to work and sports. Outcomes from the interdisciplinary pain management program (ADAPT) at the Royal North Shore Hospital in Sydney have shown that patients with a range of chronic pain conditions can be helped to cease their use of opioids while increasing their use of active self-management strategies aimed at increased function rather than pain relief directly. The outcomes of this management approach often include reduced levels of disability and pain, along with improved confidence and mood.[8] Approaches such as the ADAPT program are based on cognitive behavioural therapy principles aimed at not only reducing a patient's reliance on opioids, but also on training patients to use effective self-management skills that enable them to achieve these results. Of course, not all participants in such programs respond in this manner, but our research has shown that those who do adhere to the active self-management methods perform significantly better afterwards than those who do not.[9] This can be likened to the observation that getting fit and staying fit requires maintaining an exercise program.

An important outcome of implementing pain self-management methods is the achievement of enhanced self-efficacy beliefs by the patient. Such gains in confidence (or self-efficacy) have been found to be predictive of reduced disability more than a year after participating in programs, such as the ADAPT program.[10] Treatments that do not enhance a patient's self-efficacy beliefs carry the risk of poorer outcomes, as they may well be promoting a reliance on external support or agents rather than self-reliance. In this sense, the question about nonpharmacological treatments should not be whether they 'work' (i.e. reduce pain levels), but rather, do they assist a person with chronic pain to resume a more normal lifestyle despite their pain, with minimal side effects? Of course, the same question applies to pharmacological treatments for chronic pain.

What is involved in active self-management of pain?

Active pain self-management refers to actions or strategies that the person with pain can use to minimise the impact of pain on their life and to regain a higher quality of life and sense of wellbeing. Before engaging the patient in this approach, it usually helps to devote some time to preparing them, as they are likely to be expecting clinicians to prescribe a pain-relieving treatment, rather than helping them to develop a management plan they need to implement. This is referred to as 'collaborative management' and is characterised by a discussion with the patient to clarify some key expectations.[11] These include reaching agreement with the patient on the goals of their pain management plan and establishing a mutual understanding of both the patient's and the clinician's roles and responsibilities in this approach.

Not all self-management strategies are the same

Some self-management methods, such as prolonged resting and avoidance of activities that might aggravate pain, are common responses to chronic pain; however, their passive nature is likely to worsen pain overall, cause more disability and promote a depressed mood and sense of helplessness. As such, they are not recommended.

In contrast, more active self-management methods, such as regular exercise, relaxation methods and the gradual upgrading of functional activities can be very effective in reducing pain, distress and pain-related disability. However, these must be tailored to the needs of each person and their specific goals. Other components of this management plan should include some basic education about chronic pain and discussion about the limits of available treatment options, as well as advice on pacing activities to avoid the common tendency to 'overdo things' when pain is reduced, and problem-management strategies for predictable stressors (e.g. flare-ups in

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pain, sleep disturbance, unsympathetic employers, etc.). For many patients, it can be helpful to assist them in creating a weekly activity timetable to provide structure to their week, and to encourage them to implement self-monitoring in a diary or chart to record their exercises and other agreed activities. A management plan such as this can readily accompany a planned reduction in pain medication as the person's sense of confidence in their self-management abilities improves. Having established the plan with the patient, this approach makes it much easier at the next visit for the clinician to help the patient focus on what they have been doing, rather than how their pain has been.

Achieving success using active self-management strategies

To be effective, these active self-management strategies and methods must be practised frequently by the person with pain until they are proficient in their use. This can be challenging and progress will fluctuate. There will also be many obstacles to be overcome, which may include:

- a fear of pain
- low pain self-efficacy beliefs (e.g. 'I don't think I can do these things when I'm in pain')
- concerns about pain (e.g. 'increased pain means I might be causing more tissue damage')
- expectations that self-management will not work or will take too long to get anywhere
- feelings of depression or hopelessness, grief and loss.

Ideally, such obstacles should be identified early in management planning, and whenever the person's progress seems to be faltering.

Given the number of tasks and time involved in an active pain self-management approach, it is preferable if at least two healthcare professionals can work with the patient as a coordinated team with agreed roles and responsibilities. This is referred to as interdisciplinary care and is generally more efficient and effective than relying on a single provider to do it all. Depending on availability, in addition to the GP, suitable team members may include a practice nurse, physiotherapist, occupational therapist and clinical psychologist, but training in these methods is strongly recommended.

Conclusion

Although passive treatments for chronic pain may offer temporary relief, they are unlikely to address the root causes of pain or lead to long-term solutions. Active self-management, on the other hand, empowers patients to regain control over their lives and improve their overall quality of life through targeted strategies and enhanced self-efficacy. By prioritising active self-management over passive interventions, healthcare providers can better support patients in achieving sustained improvements in both function and wellbeing. PMT

References

1. Borsook D, Youssef AM, Simons L, Elman I, Eccleston C. When pain gets stuck: the evolution of pain chronification and treatment resistance. Pain 2018; 159: 2421-2426.
2. Loeser JD. A new way of thinking about pains. Pain 2022; 163: 1670-1674.
3. Nicholas MK. The biopsychosocial model of pain 40 years on: time for a reappraisal? Pain 2022; 163: S3-S14.
4. Treede RD, Rief W, Barke A, et al. Chronic pain as a symptom or a disease: the IASP classification of chronic pain for the international classification of diseases (ICD-11). Pain 2019; 160: 19-27.
5. Ballantyne JC, Sullivan MD. Intensity of chronic pain – the wrong metric? N Engl J Med 2015; 372: 22.
6. NSW Health. What is value based healthcare? Sydney: NSW Government; 2019. Available online at: https://www.health.nsw.gov.au/Value/Pages/about.aspx (accessed December 2024).
7. Slater H, Jordan JE, O'Sullivan PB, et al. 'Listen to me, learn from me': a priority setting partnership for shaping interdisciplinary pain training to strengthen chronic pain care. Pain 2022; 163: e1145-e1163.
8. Nicholas MK, Asghari A, Sharpe LM, et al. Reducing the use of opioids by patients with chronic pain: an effectiveness study with long-term follow-up. Pain 2020; 161: 509-519.
9. Nicholas MK, Asghari A, Corbett M, et al. Is adherence to pain self-management strategies associated with improved pain, depression and disability in those with disabling chronic pain? Euro J Pain 2012; 16: 93-104.
10. van Hoof ML, Vriezekolk JE, Kroeze RJ, et al. Targeting self-efficacy more important than dysfunctional behavioral cognitions in patients with longstanding chronic low back pain; a longitudinal study. BMC Musculoskelet Disord 2021; 22: 824.
11. Von Korff M, Gruman J, Shaefer J, et al. Collaborative management of chronic illness. Ann Intern Med 1997; 127: 1097-1102.

Further reading

Ambrose KR, Golightly YM. Physical exercise as non-pharmacological treatment of chronic pain: why and when. Best Pract Res Clin Rheumatol 2015; 29: 120-130.

Hayes-Skelton SA, Roemer L, Orsillo SM, et al. A contemporary view of applied relaxation for generalized anxiety disorder. Cog Behav Ther 2013; 42: 4, 292-302.

Maguire P, Pitceathly C. Key communication skills and how to acquire them. Brit Med J 2002; 325: 697-700.

Pain Management Network. Chronic pain toolkit for clinicians. Sydney: NSW Health, Agency for Clinical Innovation (ACI); 2024. Available online at: https://aci.health.nsw.gov.au/chronic-pain/health-professionals (accessed December 2024).

Pierce D. Problem solving therapy: Use and effectiveness in general practice. Aust Fam Phys 2012; 41: 676-679.

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