SCOPE of Pain Podcast Season 5

The Behavioral Pain Management Specialist as a Resource and Colleague

Daniel P. Alford, MD: Welcome to the *SCOPE of Pain* Podcast Series, Season Five, entitled *Behavioral Pain Management Specialists as a Resource and Colleague*. I'm your host, Dr. Daniel Alford, Professor of Medicine and Associate Dean of the Center for Continuing Education at Boston University Chobanian & Avedisian School of Medicine, and a general internist at Boston Medical Center. I'm also the course director for Boston University's *SCOPE of Pain* program. I am really pleased to be joined by two psychologists who specialize in behavioral approaches to pain management, Dr. Robert Jamison and Dr. Sara Edmond.

Dr. Jamison is a professor at Harvard Medical School with appointments in the departments of anesthesiology, psychiatry, and physical medicine and rehabilitation. He is a clinical psychologist assigned primarily to the Pain Management Center at the Brigham and Women's Hospital in Boston, Massachusetts. And Dr. Edmond is an assistant professor at Yale School of Medicine. She's a clinical health psychologist investigator at the VA Connecticut Health Care System. Her primary interests include improving the delivery and uptake of evidence-based non-pharmacologic treatments for chronic pain.

Okay, let's get started. So Bob, can you talk about the overlap and bidirectional relationship between chronic pain and mental health comorbidities?

Robert Jamison, MD: Dan, thanks for inviting us. Nice to join this podcast and glad to share some experiences we've had. Just a quick reminder for all your listeners, everybody experiences pain and we all know this experience. It's been a survival strategy for mammals forever.

But not everybody has chronic pain. In my practice I see mostly people with low back pain. And that's kind of the model that I kind of work with. So, you know, you've invited two psychologists here, so maybe you'd expect to hear this, but really pain is all about the brain. And we know that sensations go through the amygdala. And then to your question, the amygdala has a lot to do with fear and anxiety, but it's also an alarm system for anything in the body.

So there's actually a very close tie between anxiety and depression and chronic pain. And in most primary care practice, anybody with chronic pain, 50% of those people have diagnosed anxiety and depression. You're going to find a higher percentage in specialty care of almost up to 75%. So there's a real close relationship between people who and present with chronic pain and also unfortunately have a significant mood disorder like anxiety and depression.

DA: Thanks, and I know the bidirectionality is that pain makes these mental health conditions worse and these mental health conditions make pain worse. And so I know that we try to co-manage them to the best of our ability.

I would want you to now kind of address some of the maladaptive behaviors such as fear avoidance of activity or catastrophizing and kind of cognitive distortions and how they affect the pain experience, but also how they impact how patients may respond to the treatments that we offer them.

BJ: Well, by the time they get to me, all the people that I see have really gone through their primary care. They've seen a neurologist, they've seen an orthopedist, they might have had surgery that didn't go well. They've seen all kinds of different specialists. So then now they've finally reached me and sometimes they reach me just because the provider notices that they're not doing well. They get anxious or depressed in front of them or just not coping well.

And as you can imagine, pain is a negative experience and it drives a lot of different behaviors. It hurts them to be active, so they get deconditioned at times. Their memory is affected and they're very emotional. And so they go through major mood swings. And then we see a lot of people have been virtually unlucky. They've fallen off of ladders and they've had car accidents and they've had surgery. didn't go well. So as a result, they have recurrent worried thoughts. We invent words in this business, but they catastrophize. You know, they have recurrent thoughts that something bad is going to continue to happen to them. A lot of them are deconditioned because it's really hard to get up and move and because it hurts them. So these are people that are not doing well in a lot of different ways, both the behavioral and emotional fronts.

DA: Sara, do you have anything to add to that?

Sara Edmond, PhD: Yeah, sure. I think Dr. Jamison summarized all of that really well. And sometimes when I talk to patients or to primary care providers, talk about this cycle that we get in where when somebody experiences pain, acute pain, they might be told to rest So you rest, you become less engaged in activities that probably drives problems with mood initially and low activity levels. And no one really tells patients, actually this pain is chronic and that's not the right treatment approach. And the less you move, the more deconditioned you get, the more deconditioned you get, the less you do, you start to withdraw from activities. And this is just a cycle that feeds itself, right? And so I think a lot of behavioral pain treatment, the kind of work that Dr. Jamison and I do is to try to interrupt that cycle to help people start moving again, start engaging again so that they can stop sort of this negatively reinforcing experience that's worsening pain over time.

DA: So who are behavioral health specialists? What is their background? Are they all psychologists? And are all psychologists able to treat pain?

SE: Yeah, so any licensed mental health professional can deliver behavioral pain treatment like CBT for chronic pain. I think we most commonly hear about psychologists doing that and that's maybe because Bob and I are psychologists or because there's training programs for psychologists, but counselors or social workers or anyone who does therapy can learn how to do this therapy. I'm a pain psychologist. I have a doctoral degree in clinical psychology and I did a fellowship focused on health psychology, but we're somewhat of a rare breed.

I think a lot of times people who are trained to be therapists in other domains, they don't necessarily get the background in health and pain the way that health psychologists or pain psychologists do. So they might feel like they're not well equipped to do that treatment. But the principles that therapists learn when they're doing CBT for depression or insomnia or anxiety are very, very similar and widely applicable to the things that we do when we do CBT for chronic pain. So a lot of mental health providers don't see pain as within their wheelhouse, but I would argue that for most it really could be or should be.

BJ: Yeah, just to add that a study both at Duke and North Carolina took physical therapists and taught them to offer cognitive behavioral therapy for chronic pain[1]. And the results are pretty much equivocal to any of the other providers. So in other words, as Sara suggests, this is something that many different providers could be taught to administer.

DA: Great, thanks. Well, I think this is a good segue to asking you, Bob. I know there are lots of different types of behavioral treatments for pain, including cognitive behavioral therapy or CBT, acceptance and commitment therapy, mindfulness, meditation, relaxation, biofeedback, and a whole host of others. And I'll tell you, as a general internist, I likely won't remember the specifics of each of these different treatments. So I'm wondering if there are some general kind of concepts, principles, strategies that these different treatment approaches take advantage of and are some more evidence-based for pain than others and are there any risks to these therapies?

BJ: All right, a lot of good questions there. So I'll try to break down some of those titles. But the truth is a lot of the different interventions that we offer have a lot in common. And maybe the overall focus is to how do you help people with an invisible disability and have poor quality of life to basically get better control of what's going on. And I see everybody and I tell them that, you know, very similar to people with diabetes or asthma or blood pressure. I mean, you've got a real true clinical problem that you didn't invent and it does affect all aspects of your life, but you have to figure out a way to keep going, especially if it's not a life-threatening disease.

So I think most of my colleagues do cognitive behavioral therapy. And as the terms imply, the cognitive part is how people think about what's going on. And often, unfortunately, they

1 Bryant C, et al. Can physical therapists deliver a pain coping skills program? An examination of training processes and outcomes. Phys Ther. 2014 Oct;94(10):1443–1454.

have recurrent worried thoughts and they obsess and they ruminate and they kind of worry about what's happening. And then the behavioral side is what people do in response to the pain. And so they, tend to, as Sara pointed out, you know, be less active and they brace and they hold and they guard and they do all the things that potentially can make the pain worse. So, so the idea of cognitive behavioral therapy is to help people make some changes, both in the way they perceive what's going on – their thinking – and also some of the behavioral parts of what they do. And then we'll talk about this, but basically problem-solving or pacing and basically making some changes to make sure that they're not making their situation worse.

Acceptance commitment therapy is newer, and in fact, it fits very well with the old concept of mindfulness meditation. And the thinking is you just really try to have people focus on the present. And the trouble with people with chronic pain is they anticipate what may happen. In other words, they're way down the road in terms of things going bad and wrong, or they ruminate about what happened and all the things that's sort of out of their control. So the idea of acceptance commitment therapy is to help them to stay in the moment and also be aware of what's going on, but without judgment. So in other words, take the emotional component away from them.

And that's probably the theme of all these. If we can help people to understand that they have a true problem they didn't invent, but if they can be less reactive to it and less emotional about it, there's a better chance that they'll cope better.

So relaxation training is a big component of all the things we do. We tell people, as Sara pointed out, to be more active in a smart way. But also you have to manage some of those involuntary reactions of bracing and holding and guarding and staying tight and getting people just to learn to relax. Because we know when they're more relaxed, they actually report less pain and they can cope better, have less stress.

A newer therapy that's sort of kind of caught on recently is this idea of pain reprocessing therapy. It's an interesting concept. And the concept is that pain is a signal usually by the brain that something's wrong. If you break your leg or, you know, sprain your ankle, you know, you just don't walk on it. And the brain translates pain as an alarm system of saying something's wrong. But unfortunately, we also see a lot of people that have chronic pain that just is unrelenting. The pain is the problem.

And so, it's very simply the pain reprocessing therapy is an idea of actually talking to your brain to say, listen, I know the pain's real, but I don't have to be upset about it. You don't need to keep protecting me the way you are. So it's a kind of a little bit manufactured in some ways, but getting people to talk to their brain to say, you know, you don't have to react that you would otherwise if it was a life-threatening condition or something else going on.

So you mentioned biofeedback. I did biofeedback for many years and that's basically using sensitive equipment to measure what your body's doing to basically teach them to learn to relax. So, well, Sara, you want to add to any of those therapies?

SE: Sure. Thanks, Bob. That was a really comprehensive overview. You know, what you said at the very beginning that pain is processed in the brain, right? All pain goes through the brain. And that's true whether you have pre-existing mental health conditions or you develop mental health symptoms after you have pain or you really don't report any of them at all. All of your pain is always processed in the brain. And think that's what pain reprocessing therapy is really targeting is some of the pain patients experience when they have chronic pain is really generated by and amplified by the brain. And so to the extent that we can retrain the brain or create new neural pathways in our brain and reinforce different pathways in our brain, we can get rid of that pain. And I don't know that it's really important for a primary care provider to know the difference between CBT and ACT and pain reprocessing and all of those things.

I don't really know that patients perceive the difference all that much either, although maybe with some of the newer therapies they do, or if they get biofeedback equipment, they would remember that. Some of the treatments focus more on changing behaviors. Some focus more on changing thoughts. Some of them are conceptualizing the goals of treatment as accepting your pain or it's pain relief. I want to have less pain intensity or improved function. But in actuality, they all target all of those things. So I kind of like to think about this menu of treatments as flavors of ice cream, right? Like CBT is one of the oldest and tried and true. So that might be your vanilla ice cream, and then along the way, different people have developed all of these different ways that might be a good fit for different patients, but there's not a lot of data that really guide which one is best for whom. And a lot of the practitioners who do one of these therapies incorporate principles from multiple of them. So I think as an internist, it's really about selling just the general idea that pain is generated by and amplified by and changed by your brain. And that's why working with somebody who is an expert in the brain might be helpful.

DA: Really very, very helpful and informative. Thanks guys. And I'm curious, how strong is the kind of evidence basis for behavioral therapies for pain?

BJ: Yeah, if I could respond. So, we published an article in JAMA last fall[2]. This was a large multi-centered trial looking at the difference between cognitive behavioral therapy and mindfulness meditation with people with back pain on chronic opioid therapy. And we had 750 people; we followed them for over a year, a massive study.

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2 Zgierska AE et al. Mindfulness vs Cognitive Behavioral Therapy for Chronic Low Back Pain Treated With Opioids: A Randomized Clinical Trial. JAMA Netw Open. 2025 Apr 1;8(4):e253204. doi: 10.1001/jamanetworkopen.2025.3204. PMID: 40193079; PMCID: PMC11976494.

And the results were that everybody got better and there was no difference between cognitive behavioral therapy and mindfulness meditation. It helped reduce their reliance on opioids, it improved their activity, it improved their mood, and they reported less pain. So, that doesn't help in terms of saying, one person should go one way or not. I think all these treatments have been shown to be very helpful. The evidence is pretty strong.

By the way, we don't cure very many people. And we tell them that. I mean, we're not going to make your pain disappear. But unfortunately, nobody else is either. In that sense, we don't have many strategies to give everybody a new body and make the pain go away. So now, the goal is how do we help you have a life and improve your ability to keep going? And if that's the goal, then we can offer these treatments that have been shown to be very helpful for doing that.

SE: Yeah, I'll just add that the effect size for most of these things is comparable to or a little better than really any other pain treatments we have, including medication. So I think, you know, Bob mentioned earlier that a lot of times when he gets referrals, these are patients who've been through lots of different specialties before they wind up. And I think that's an unfortunate common experience for pain psychologists that we get referrals from patients who seem to have tried everything else first.

When really, because there aren't a lot of adverse effects or harms that are associated with these therapies compared to other pain treatments we have, should be more like a first line treatment. The evidence is just as strong as if not stronger than other pain treatments that we have, and there are less side effects and less risks involved. So if you're able to access somebody who can do these treatments, I would argue they should be the first thing you try instead of the last thing you try.

DA: Are there known patient characteristics that can predict response to behavioral approaches? And the reason why I ask is because I know these therapies take time often, often they take time, and they require active participation on the patient's part, as opposed to asking them to take a medication or show up for an injection, which is much more passive. So are there patient characteristics that I should be looking for before I send them to you or not?

BJ: So we have a lot of people that don't want to see us. They don't want to see a psychologist. And they really believe they have a medical condition and they have a medical model of what's going on. They can point to their pain in their back or their leg or their knee or their head. And they just want somebody to make it all go away, even though they've seen 10 different providers and they've exhausted all the different interventions.

So I think what the provider says is real important in terms of why a multidisciplinary approach is important and the whole concept of having a bio-psycho-social approach to managing this condition. So I think it's important to say that the pain is real, you didn't

invent this, but there are some ways to deal with any chronic condition that would help them cope better. So the way it's couched, I think is important.

And then there just some subtle differences. There are some people who like to be in control and see what's going on, are very objective-minded. Those people tend to like biofeedback a lot better. There are some people that are real compliant about keeping track of their activity or doing journaling or things that they suggest to do. Others that just don't want to spend time documenting their pain and activity interference. So I think it's good to kind of read where they are and also what's their motivation. And there's a whole bunch of other things that drive behavior that can interfere with people fully engaging in a therapy.

DA: I do think we need to spend a little time talking about how do we make the best referral? How do we talk to our patients before they land at your doorstep? I'm going to give you an example of a way not to do it, which is from my own practice.

My patient was 65 years old. He had severe low back pain due to osteoarthritis and spinal stenosis. He had had back surgery, multiple injections, a variety of medications. Nothing was helpful. He was severely disabled, very depressed, and I referred him to a psychologist for CBT. And when I saw him after his first visit for CBT, he was furious. And I said, you know, what's wrong? What happened? And he said, the guy didn't even prescribe any medication. He didn't give me any injections. He didn't examine me. And then I responded saying, it would have been completely inappropriate if this psychologist examined you or gave you an injection. So it was clear to me that I had not made an effective referral.

So Sara, can you kind of talk to us about some of those elements?

SE: Yeah, this is so important. And I think I'll start by saying that you as the PCP have to believe that what you're referring to is going to be effective. And you as a PCP have to believe that pain is best conceptualized and treated from a bio-psycho-social perspective. Because if you don't, your patients will see right through that. And I see so many times that, you know, I think PCPs are trained in the biomedical model and those are the tools that they have most widely available to them. And so a lot of times without realizing it, they're sort of reinforcing this idea that a biomedical model is the best way to think about and treat pain. And then it falls, their referrals to CBT fall flat.

So I think the first thing you want to do is convey that you believe your patient's pain is real. That's important. Because I think a lot of people when they're referred to a psychologist think you think it's all in my head, you think it's not real. And as we've talked about a little bit already it is in your head, right? The experience of pain is modified by and sometimes generated by the brain so pain is happening in the brain, and I think telling your patients that in a way that conveys to them that this isn't because you have a mental health problem or your crazy or something's wrong with you. This is just chronic pain, is something that is modified by and generated by the brain and pain psychologists are

experts in the brain. And that's why I'm sending you here because what's going on with you is primarily something that we need to treat in your brain. And so I'm going to send you to somebody who's an expert on the brain.

And then I think telling them what to expect. Sometimes I get patients who are very nervous to meet with a therapist because they don't want to rehash their childhood, they don't want to lay on a couch. They have this idea of psychoanalysis. And that is typically not what you will get when you are referred to pain psychology. In CBT and other behavioral pain treatments, you're going to learn skills that will retrain your brain so that it generates less pain or modifies the pain signals to not be as strong. And you'll also learn skills that will help you cope with or manage the pain, such as changing the way you approach activities to reduce the likelihood that you have a pain flare.

So think if you can find ways to explain that to your patients, they will know, I'm going to go talk to somebody about the way that my brain is reacting to pain and about how my day-to-day activities might be influencing my pain. So it'll make sense that they won't be getting a medication or an injection or a physical exam. And they'll also be primed like this isn't about, this isn't meant to be stigmatizing, this isn't supposed to go back into the childhood and all of those kinds of things that people might be afraid of. I think that sets patients up for a better sense of what to expect and a better experience.

I also think it's good to convey to patients that most of these therapies are active approaches. Patients have to do the work to see the benefit. So there's 168 hours in a week. If you see your pain psychologist for one out of those hours out of that week, and then you don't think about or do anything with the things that you learned during that hour, you're probably not going to see great effect, right? You have to practice the skills that you learn or try to implement some of these changes.

I think the other thing I like to remind PCPs is that if you really believe in the bio-psycho-social model, you want to reinforce that when you see your patient back again. So when you have a follow-up with your patient and you've got 20 minutes to cover everything that's going on with them and you're spending 15 of those 20 minutes on pain, if you spend 14 of those 15 minutes asking about medication and medication side effects, you've reinforced, whether or not you meant to, that the medication or the biomedical model is the most important part of their pain treatment. And then you say, by the way, did you go to CBT? How's that? Okay, great, right? That sends the message, this must not be that important. So really think about what kind of messaging you're communicating intentionally and sometimes unintentionally to your patients, both with the referral and with following up. Did you go? Are you practicing the skills? How's it going for you? Those kinds of things.

DA: Extremely, extremely helpful and good advice. Bob, you look like you wanted to say something.

BJ: Yeah, I just add that the message that some people hear is I have nothing else to offer you, so I'm going to send you to the psychologist. So by the time we see a lot of people that referred to us, so they're quite angry. They feel like they've been let down and no one's taken them seriously. And so then all of a sudden it's a sanity hearing. I have to convince them that, you know, it's real and what you've gone through is real. And then to Sara's point, I mean, the first time I see somebody, I ask them to set goals for themselves. I said, what would you like to see happen? What are some specific goals? We talk about smart goals. It has to be specific, measurable, achievable, realistic, and time contingent. So in other words, it's What can I, if we keep meeting in the next three months, can we look back and say, this is something that you've been working on and have been able to reach those goals. And then being able to pass that on.

DA: I think you both bring up really important points. And I know from personal experience with some of my patients who are on opioids, I think they believe that just showing up at the referral, behavioral health or whatever, is the hurdle they needed to go over in order to continue to get the opioids or whatever they think they need. They're just needing to kind of be compliant with whatever I'm recommending, but they're not really buying in. And I think to your point about the actual PCP buying in is really important. And I think that's hopefully the goal of this podcast is to give people some insight as to what these treatments are and what they do and that they shouldn't be the last line therapy, that they should be part of the multimodal therapies that we should be offering patients and talk to patients about it.

So can you shed a little more light on what happens in that visit? Sara, you mentioned it's an hour a week, but what actually are you doing during that hour?

SE: I like to describe CBT as, you know, it's typically time limited, maybe a few months of treatment, weekly, sometimes bi-weekly, and it's very skills-based. So when a patient comes in for a follow-up session, I'm going to ask them, how did they do with whatever SMART goal we had set at the previous session or skills practice? So if I taught you progressive muscle relaxation last week, did you practice it this week? Was it helpful? How many times did you practice?

If it wasn't helpful, can we problem-solve around different ways you could try it to see if it might be more helpful? Then I'm going to teach you a new skill. So we're going to talk about a new skill and how it could help you and why, and do some planning around how you might practice it between now and the next time I see you.

And we sort of go through this cycle of learning different skills, practicing them, problem-solving around how best to implement them to make them effective for you. And my goal really in treatment is to give patients a toolbox full of different tools and skills that they can use to help them cope with and manage pain so that they get to a point where they feel like they don't need me. And then they've sort of worked, I've worked my way out of a job. Now, unfortunately, chronic pain is quite prevalent, so I'll always have another referral waiting for me. But that's really the goal is to learn these skills in session, talk about how to

implement them, let them go practice the skills in their real life, come back and problem solve so that we can keep going until they feel really confident that they've got a set of tools that will be useful for them.

BJ: So I can add that for many years, I did a pain management group. I actually wrote a book a long time ago, *Learning to Master Your Chronic Pain*. And then thanks to COVID, we were able to start doing it virtually. But it's very structured in the sense that we cover a topic every week and we have everybody connect with what's going on with their homework.

And I just found that with having people connect with others in a very positive but a structured way helps them in terms of being able to get through some of the challenges. So pain can be very isolating and to know that some people are going through the same issues. We try to avoid a moan and groan group and everybody comes and complains how bad life is, all the things that's happened to them. Try to keep it directed and positive, but also, you know, specifically what can you do for yourself and others to make things better?

And we talk about things that are real important because unfortunately pain is a, you know, we have no "painometer" and I can be sitting here with a terrible back pain or something's hurting me and you wouldn't know unless I told you or you could see me act that way. So we talk about how do you communicate that with family members and friends and how do you share in a way that doesn't cause 50 questions of what's going on and also just, you know, help let others know kind of what's going on in terms of what kind of progress is going, but the ones that really want to know. Anyway, so we cover different topics every week, stress management, weight management, how to be healthy in terms of diet and exercise – the E word – how to do it in a way that doesn't make things worse, to do it gradually.

And then how to challenge kind of recurrent worried thoughts because everybody anticipates bad things happening. So we talk about the concept of self-talk, you know, when you have a flare-up and all the bad things that you're thinking and what could happen and how do you challenge them? How can you have alternate thoughts? So those are some of the things that we do, both as a group and also individually.

DA: I know we alluded to or someone mentioned, it may have been you Sara, that these treatments take time. You know, when the patient comes back to me and says, I went, it didn't work, or I've gone a couple of times and I don't think I need to go back anymore, it's just not working. So how long do these treatments take to show an effect?

SE: Yeah, I think in most clinical trials data that collects data throughout the treatment, usually you start to see a response after about four sessions. That's typically when we start to see improvement. So I would encourage patients, you know, go at least four times, really try to practice those skills before you kind of start to make a judgment about whether or not this is helpful for you. And then of course, sticking with the treatment longer and learning

all of the skills and finishing the treatment is probably even more beneficial and those treatments, the different treatment models that we've talked about are usually between maybe six and 16 sessions depending on the specific treatment and the therapist.

DA: Well, I hope the folks listening are convinced that behavioral therapies are a wonderful option for our patients, especially in the kind of, in light of focusing on multimodal care. But I guess the elephant in the room, so to speak, is how do I find a behavioral pain specialist? Bob, do you have some thoughts about it?

BJ: Well, if you're a provider close to any university-based or large medical center, it's good to actually then consider going to the pain management center there; they would know where to refer, but they are looking for someone with a behavioral medicine background.

There's some information online. *Psychology Today* has got a very good website[3] with a list of all the people that could be potentially helping each individual with a short bio and name and contact information. So highly recommend *Psychology Today*. Society of Behavioral Medicine also has a link that could be useful for identifying a behavioral medicine person to help with people with chronic pain. But I think locally sometimes it helps just to be aware of the centers that are available to the person. I think when you're working with someone locally, giving some resources locally, I think that could be a better chance that that person would follow up with any kind of referral made.

SE: I think I use *Psychology Today* quite a bit as well. I know here in Connecticut, our state psychological association has a list of providers that are trained in different therapies. So you could check with your state's psychological association or other mental health organizations in your state to see if they have similar lists.

DA: Bob, you had mentioned earlier a study that trained physical therapists to do behavioral treatments. And I'm wondering, can a PCP learn to do treatments? Do you know anything about how that could happen or any studies or any ways that PCPs could learn to offer that themselves in their treatment?

BJ: Well, the answer is yes, but it does take time. I mean, there are some people out in the rural areas where they're the only provider and they don't have many resources and they have to do it all. And they have to be the neurologist and the psychiatrist and, you know, they have to manage all the different issues. So then there's a question of time and efforts. And by the way, I'll be very frank about this. A lot of times there's not reimbursement for somebody in primary care or others doing something like that. But obviously being knowledgeable and knowing how to direct things so they know what to ask for. They know, have you been tracking your activity levels? Have you been tracking your mood and medication use and those kinds of things. And then also just keeping track of what's going on with their mood.

3 https://www.psychologytoday.com/us/therapists

There's a lot of really interesting guides out there in terms of, you know, cognitive behavioral therapy for pain so I think anybody interested, I would encourage them to learn as much as possible about what goes on. Well, I think the short answer, Dan, is absolutely I think anybody could learn some of this.

SE: What Bob says is absolutely right. Anyone could learn to do this, but is it practical in your setting from a reimbursement and time perspective to be doing CBT for chronic pain? Probably not. I think that there are small pieces of this that you can implement in primary care.

So a lot of CBT for chronic pain protocols include a walking program. Typically when we do walking programs, we have someone track their walking for a week or their movement for a week and then that's their baseline. We ask them to increase 10% per week so that they're doing it in a slow way. You can do that as a PCP and just sort of prescribe walking and tell patients to increase their walking slowly. I think you can teach relaxation or mindfulness practices relatively quickly or find video resources online, links to send to your patients if they can access the internet to watch or practice relaxation independently on their own. And those smaller bits might not be as effective as an entire course of CBT for chronic pain, but when there isn't access to other treatments, they can be helpful.

I work at the VA. So the VA is required to have pain management teams at every medical center, and those teams are required to have a behavioral pain expert like me. So if you happen to work at a VA, you definitely should have access to these resources.

The VA also has two apps that I'll mention, *VA Pain Coach* and *VA Mindfulness Coach*. They are sort of tailored to veterans, but they can be downloaded by anyone freely on any mobile device. And they go through some of these things with patients in sort of a more self-management way. And I think a PCP could download *VA Pain Coach*, get a sense of what's on there, tell their patient, download this, practice the mindfulness and practice the, you know, see what it says about walking or SMART goals and get some of the benefit.

Also, when I was in graduate school, I worked on a web-based CBT called *Pain Trainer*. *Pain Trainer* is now widely available for free in the VA. And it's about 30 to 60 minutes of content that you go through per week for 10 weeks, totally asynchronously. I think it's best done when you have a practitioner supporting you, checking in on you, making sure you're really practicing. But a PCP could say, you should go through pain trainer and tell me what you're learning. And again, like we talked about, what are you reinforcing in the bio-psycho-social model? When you see that patient back, of course, probably not weekly in primary care, you can ask them, how was that? Did you practice those skills? So there are things out there that if you don't have access to behavioral pain treatment, like a pain psychologist or another therapist trained in CBT, that you can do to get your patient some of these resources and skills.

DA: Bob, do you have other resources that you would recommend that we could refer our patients to?

BJ: Yeah, so I definitely know about *Pain Trainer*. There are some very interesting and useful apps out there and it's okay to refer them. *Curable*[4] is a good app. There's *Manage My Pain*[5]. It gets dizzying if you go to the app store and put in pain apps because you're going to come up with 20 names. There's actually a way to evaluate them and it's called the MARS, the Mobile Application Rating Scale[6]. 4.5 or five is the highest scale rating. So you want some app that that kind of meets all the criteria for what a good pain app could do.

But I'll just share one last thing and that is we just now published an article just last month in *Clinical Journal of Pain* on the use of an app[7]. And unfortunately, most people download an app and are just curious and they'll just stop using it. So we were just curious, what is it that kept people using an app? And we looked at, did they have a bio-psycho-social model? they, were they more medically focused? Did they have a lot of mood issues?

The number one reason they kept people using an app, and we were looking for somebody who used it more than a month, was whether they liked their provider or not, whether they liked their primary care physician. And what that meant to us means that if they liked their provider and they trust that person, and that person says, here's an app that I'd like you to keep using, they tend to use it. And all the other theories that we had for why someone would use an app didn't flesh out. That was the number one thing we learned from it. So that was a good take home message for your audience, I think.

DA: That's a wonderful message and it just highlights the importance of us being engaged as well and following up with our patients and being convinced that what we're sending them to is something worthwhile and beneficial. So that's incredibly affirming in my opinion.

So I'm wondering kind of as we close up here if you have some parting kind of take-home messages for our audience on this topic of behavioral therapies for pain. And I'll start with you, Sara, and then we'll go to Bob.

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4 Fee for use after 14-day trial

5 Free

6 https://cndhe.womenscollegehospital.ca/wp-content/uploads/2023/02/3526bbd2c3a46ee3b729590a41d6516f77f3.pdf

7 Eagle, H. et al. Engagement With a Mobile App for Chronic Pain: Role of Pain Beliefs, Pain Self-Efficacy, and Perception of Providers. The Clinical Journal of Pain 42(3):e1346, March 2026. | DOI: 10.1097/AJP.0000000000001346

SE: Well, thank you so much, Dan, for having us on this podcast. And I'm really happy that more primary care providers are going to learn more about behavioral pain management and the benefits of it. And I think if I had to have just sort of one parting message, it would be just to remember what we've just said, right, that how important it is that you believe in the message that you're passing along to your patients when you're making these referrals or recommendations, that pain really is something that's a bio-psycho-social phenomenon. It's happening in the brain and therefore treatments that target the brain are the ones that are most likely to be helpful for our patients.

And so anything you can do to reinforce and encourage that messaging with your patients, even that alone for some patients is enough to help them change the way that they're behaving and thinking about their pain in a way that can really help their quality of life. And it most certainly will help if you're trying to make referral and get your patients to be willing to engage with clinicians like Bob and I.

DA: Thanks, and Bob?

BJ: Yeah, I'll double that. Thank you for the invitation and hope there is some information that everyone's gleaned from this. So I'm definitely the old guy here, but I think it's also worth just highlighting the fact that we got some exciting things happening down the road, including artificial intelligence and what that might look like. One thing that it might look like is to be able to get a lot of information on each individual and then come up with a way best way to treat that person. They actually call it a digital twin.

So if you have access to all that person's medical history, maybe even some of their genetic information, but basically family history and what they've responded to best for their treatment, then you can outline a pain management strategy, including medications and other kinds of treatments, but also including behavioral interventions that would help them.

DA: So, I just want to take a moment and thank you both, Bob and Sara, for taking some time out of your busy schedules and talking to us at this *SCOPE of Pain* podcast about behavioral pain management specialists as a resource for treating patients suffering from chronic pain. So thank you again so much for sharing your thoughts and wisdom.