Content of Treatment: CBT-CP Protocol

Session 1: Interview and Assessment

The focus of this session is the initial clinical interview, the patient assessment measures, and contact with the Veteran's PCP. During the interview, Veterans are able to share their chronic pain history and discuss how it has affected their lives. The assessment tools provide data that supplement information gained in the clinical interview. Finally, informing PCPs about CBT-CP and obtaining their support is a key to facilitate successful treatment. This important meeting establishes the first face-to-face contact with the patient and is vital in setting the tone for the rest of treatment.

Session 1 Agenda

√	Conduct clinical interview.
√	Have Veteran complete assessment measures.
√	Discuss next session.
√	Contact PCP.

Session 1 Materials

- CBT-CP Clinical Interview form
- All assessment measures except WAI-SR
- Communication with PCP

Clinical Interview

The initial clinical interview in CBT-CP is an opportunity to gather much of the general information that is acquired at the beginning of any psychotherapy course such as psychosocial status, mental health issues, and substance abuse history. However, since this intervention is specific to chronic pain, additional pain-specific information should also be obtained, such as:

- Pain location, onset, and intensity
- Current medications
- Previous and current treatments
- Areas of functional impairment

It is important to obtain detailed information about the Veteran's pain history. Begin with asking about the primary, or most significant, pain location. Secondary pain locations are also reported. Information on when and how the pain began (e.g., single precipitating event, gradual onset) as well as the quality of the pain (e.g., sharp, aching, tingling) should be obtained. In addition, discussing current and previous treatments for pain and their effectiveness, including medications, will help clarify what has been helpful or not helpful. When a Veteran states that a treatment modality has not been beneficial, inquiring about why it was not helpful is recommended. For example, if someone states that physical therapy (PT) did not help, they may report that it "just made my pain worse." If they have become highly inactive because of pain and only attended one PT session, this is a personal example that may be used at a later point to illustrate the connection between deconditioning and increased pain. Asking for details related to exacerbating or minimizing factors related to pain intensity and what a typical day is like will allow for a fuller picture of the negative influences of pain on the Veteran's life. Perhaps the most important pieces of pain-specific information gathered are the ways in which pain has functionally impacted the Veteran's life – mood, physical and social activities, sleep, mobility, recreational hobbies, and the like.

The information collected through the interview will help the CBT-CP therapist begin to develop hypotheses about the patient's core beliefs and patterns of thinking. In addition, the important alliance between therapists and patients will develop as Veterans share their personal experiences and struggles with chronic pain.

Assessment

Another important piece of the initial phase of treatment is the completion of clinical assessment measures by the patient. These tools will allow the therapist to better understand the Veteran's experience of pain and the functional domains that are impacted, as well as assess the gains that are made throughout treatment. Explain to patients that the questionnaires, while they may seem cumbersome, are another way for the therapist to gain a clearer picture of the effects of pain on their lives and will enhance the ability to tailor the CBT-CP to their specific needs. Again, focusing on completing the measures as a means to better understand the individual experience of the patient may be a helpful frame. The data may also be used as a way to demonstrate positive changes and treatment effectiveness to patients and others.

Measures

A brief description of the assessment measures that are incorporated into the protocol as a way to inform treatment and monitor progress is provided. Some measures may be available through the VA's Mental Health Assistant in the Computerized Patient Record System (CPRS). The recommended timing of administration follows the description of the measures. For the initial, mid, and discharge sessions where all measures are given, it may be helpful to ask Veterans to arrive 15-20 minutes early. This facilitates completion of the measures without interfering with the day's session content.

Some patients may find the completion of assessment measures aversive or feel it is a waste of their time. In these cases, discuss with Veterans any thoughts or concerns they may have about completing the assessment measures. Sometimes the Veteran and therapist can collaboratively brainstorm ideas for how to overcome any potential barriers to completing measures. Furthermore, providing a rationale for the measures is encouraged.

Here is an example of how the therapist might discuss the use of self-reporting measures:

TALKING TIPS: *Assessment*

I appreciate you taking the time to complete the measures that I provided. The information will help me better individualize this treatment to help meet your needs. I will also be giving you some direct feedback in a later session about what you reported and how we can incorporate it into our treatment.

I know that some people are hesitant about completing measures and view it as a waste of time. But the assessment actually serves a purpose similar to that of vital signs measured at a doctor's visit. The information is useful and can highlight an area that needs attention, like if your blood pressure was high. It can also help us measure the progress that you are making over time in a more concrete way – that is information that is helpful to us both.

Clinical Assessment Measures

Pain Numeric Rating Scale (NRS; Jensen & Karoly, 2001) Assesses pain intensity on a scale of 0-10 with 0 being "no pain" and 10 being "the worst pain imaginable." Ratings for average, worst, and least pain over the last week are obtained.

Pain Catastrophizing Scale (PCS; Sullivan, Bishop, & Pivik, 1995) Assesses tendency to ruminate, magnify, and feel helpless about pain (i.e. catastrophize). Level of catastrophizing is a primary predictor of disability level. Decreased catastrophizing is associated with decreased depressive symptoms and improved pain-related outcomes (Sullivan & D'Eon, 1990).

West-Haven Yale Multidimensional Pain Inventory-Interference Subscale (WHYMPI/MPI-INT; Kerns, Turk, & Rudy, 1985) Assesses interference of pain in various areas such as socialization, work, daily activities, and relationships with others including family/marital.

Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) Assesses the existence and severity of depressive symptoms, which have a high co-occurrence with pain. *Note:* Item 9 on the Patient Health Questionnaire-9 (PHQ-9) inquires about thoughts of death and suicidal ideation. It should always be checked during this session with follow-up care provided as clinically indicated.

World Health Organization Quality of Life-Brief Version (WHOQOL-BREF; Murphy, Herrman, Hawthorne, Pinzone, & Evert, 2000) Assesses perception of quality of life with general questions regarding overall health and satisfaction, and a series of four questions covering the following domains: physical health, psychological health, social relationships, and environment.

Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) Assesses the quality of the therapeutic alliance including level of agreement on the goals of therapy and patient-therapist bond. The therapeutic relationship is a strong predictor of psychotherapy outcomes.

Subjective Units of Distress Scale (SUDS; Wolpe, 1969) A one-item screen for clinical use that assesses level of overall distress rated from 0-10.

Figure 7. Timing for Administration of Assessment Measures

Session	SUDS Distress (0-10)	PCS	WAI-SR	Pain NRS	MPI-INT	PHQ-9	WHOQOL-BREF
Session 1 *(Baseline)*	SUDS	PCS		Pain NRS	MPI-INT	PHQ-9	WHOQOL-BREF
Session 2	SUDS		WAI-SR				
Session 3	SUDS						
Session 4	SUDS						
Session 5	SUDS		WAI-SR				
Session 6	SUDS						
Session 7 *(Mid-Point)*	SUDS	PCS		Pain NRS	MPI-INT	PHQ-9	WHO-QOL-BREF
Session 8	SUDS		WAI-SR				
Session 9	SUDS						
Session 10	SUDS						
Session 11 *(Termination)*	SUDS	PCS		Pain NRS	MPI-INT	PHQ-9	WHO-QOL-BREF
Session 12 *(Booster)*	SUDS						

Support from Primary Care Provider

Particularly when working with patients with chronic pain, it is important to have coordination with and support from their PCP as well as others who might be involved in their care (e.g., physical therapist, neurologist). CBT-CP typically is only one piece of a patient-centered, multimodal, multidisciplinary plan of care. Maintaining contact with providers by adding them to notes in the electronic medical record, sending emails, or having face-to-face discussions can be critical in developing a coherent treatment plan and delivering a consistent message to the patient. Alert those in Primary Care or the Pain Clinic to the services that are being offered through CBT-CP as well as the type of Veteran that is most appropriate for referral. Typically, those in other disciplines will be grateful for the assistance in offering alternatives for helping Veterans better manage their chronic pain.

After the initial meeting, the CBT-CP therapist must contact the Veteran's PCP directly via email or as an additional signer on the session note (see Appendix for template). The physician is made aware of the general nature of the intervention and told that the patient will be engaging in CBT-CP. Second, the PCP is asked to provide approval to indicate that the Veteran is physically capable of engaging in a mild, graduated, tailored walking program. If it is indicated that walking is not appropriate, the PCP is asked to provide an alternative activity. Make it evident to the physician that the importance of physical activation is a critical part of the CBT-CP process. The communication fostered between the CBT-CP therapist and the PCP will facilitate the Veteran's optimal management of chronic pain by providing a consistent message with a focus across providers on increasing activity and improving overall quality of life.

Support from Mental Health Provider

Communication among mental health providers is also important in the effective implementation of CBT-CP. Many of the referrals for this intervention will originate from mental health providers who do not have the specific skills to treat chronic pain in Veterans. Other healthcare providers such as a PCP or physical therapist, however, may also refer patients for CBT-CP. Since many Veterans will already have an established clinician treating other mental health issues (e.g., depression, PTSD), alerting that provider to the proposed plan for CBT-CP is recommended. Provide information on the content of the intervention such as the general structure and goals. In addition, confirming that CBT-CP will be complementary and synergistic rather than potentially deleterious to the ongoing mental health treatment is critical. For example, in the case of a Veteran who has only recently become engaged in substance use disorder treatment, legitimate concerns may be raised about the timing of additional treatment that could distract the patient from the primary goal of sobriety. When a shared decision is made to provide concurrent treatment, it is important to negotiate specific complementary objectives and roles. Plans for communication such as adding providers to notes in the electronic medical record, sending emails, or having face-to-face discussions can be critical in delivering a consistent and therapeutic message to the patient. Finally, if services are being provided in the community (i.e., outside VHA), with the consent of the Veteran, the CBT-CP therapist should engage in similar discussions with non-VA providers in order to facilitate the best possible outcomes.