Barriers and Facilitators to Chronic Pain Self-Management: A Qualitative Study of Primary Care Patients with Comorbid Musculoskeletal Pain and Depression

Matthew J. Bair, MD, MS
VA HSR&D Center of Excellence for Implementing Evidence Based Practice, and Regenstrief Institute, Inc
Assistant Professor of Medicine, IU School of Medicine, Indianapolis
Co-authors

- Marianne S. Matthias, PhD
- Kathryn A. Nyland, BS
- Monica A. Huffman, BS
- DaWana L. Stubbs, MD
- Kurt Kroenke, MD,
- Teresa M. Damush, PhD

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Background

- Pain accounts for 20% of all clinic visits
- Analgesics = 12% of all prescriptions (# 2)
- $100 billion dollars/yr in health care costs
- Excessive surgery (e.g., back pain)
- Leading cause of work loss & disability
- Leading reason for alternative medicine
Self-Management Defined

- The ability to manage the symptoms, treatment, physical and psychosocial consequences and life-style changes inherent in living with a chronic condition

Self-management for pain

- Damush et al. showed enhancing patient self-management skills decreased pain severity and improve functional status

Self-management for pain

- Newman et al. found “strong evidence” clinical trials that self-management programs are effective for both low back pain and osteoarthritis

Pain self-management programs

- **Arthritis Self-Management Program**
  - Trains both professionals and lay leaders
  - Standardized program for patients with chronic pain

Premise of PSMP

- Teach skills that patients can use to better manage their pain on their own and to encourage participation with providers in deciding their treatment plan.

Potential Challenge

• Patients who have depression—
  • Present in 30% to 50% w/ chronic pain
  • May interfere w/ self-management of pain

Gap in Literature

- Little research on pain self-management among patients with medical and psychiatric comorbidity
- Challenges patients face, particularly when pain is accompanied by depression?
Study Objective

• To identify barriers and facilitators to self-management of chronic musculoskeletal pain among patients with comorbid pain and depression
Study Design

• A qualitative study of focus groups
Participants (N = 18)

• Recruited after participation in a clinical trial
Stepped Care for Affective Disorders and Musculoskeletal Pain (SCAMP)

- To determine if a stepped-care approach improves:
  - Both pain and depression outcomes
  - In primary care patients

SCAMP Trial Design

PAIN and DEPRESSION

Stepped Care

Step 1: Optimized antidepressant therapy
Step 2: Pain self-management program

Usual Care

Assessments at baseline, 1, 3, 6, and 12 months
Pain Self-Management Program
(6 sessions over 12 weeks)

- Education – pain; vocabulary; red flags;
- Identifying / modifying fears and beliefs
- Goal-setting and problem-solving
- Exercise – strengthening; aerobic; etc.
- Relaxation; deep-breathing;
- Handling pain flare-ups
- Working with clinicians and employers
SCAMP Study Findings

- Substantial improvements in depression severity, response, and remission rates

- Moderate benefits in pain severity and disability

Kroenke K, Bair MJ, Damush TM, Wu J, Hoke S, Sutherland JM, Tu W. Optimized Antidepressant Therapy and Pain Self-Management in Primary Care Patients with Musculoskeletal Pain and Depression: A Randomized Controlled Trial. *JAMA* 2009;301:2099-2110
Rationale

• To complement the quantitative data from SCAMP
• Help explain reasons underlying the intervention effect
• Why particular aspects may have worked and did not work
Focus Group Protocol

- Stratified by gender and clinic site (VA vs University)
- 3 to 6 patients participated
- Experienced moderator
- Semi-structured questions
Data collection

• Same moderator facilitated all four focus groups
• 2 note-takers
• Sessions were both audio- and video-recorded
• Audio-tapes were professionally transcribed
• Sessions were 2 hours
• Moderator and note-takers met to discuss overall impressions
Data analysis

• 1st read of transcripts independently
  • Created a preliminary list of salient quotes
• Preliminary list of themes
• Development of agreed upon code list
• MAX.QDA 2007 software
Participant Recruitment

• All patients who completed the 12-month SCAMP trial intervention were eligible.
• Close-out survey, participants were asked if they were interested.
• Participants received $40 for their time and travel expenses.
Setting

- Veteran Affairs (VA) and University primary care clinics
Participants

- 11 from University, 7 from VA
- Age 27 to 84 years old (M = 54.8)
- 61% women
- 72% white and 22% black
Participants

• 101 patient completed the 12-month trial
• 52 randomly contacted
• 18 refused and 14 could not be scheduled or were no-shows
• All 18 participants had completed the self-management program
Broad themes

- 12 unique barriers
- 10 unique facilitators
- Self-management practices used by participants
Barriers to pain self-management
Pain is disabling and interferes with self-management

• “A lot of those things I love to do, but I can’t do. Like, I love to walk. I use to walk every evening; and, now, I’m like, it takes me forever to go down three blocks and back.”
Patients fear they will hurt more with exercise and physical activity

- “There have been times I have been in pain, and I don’t want to exercise. I don’t want to end up hurting myself.”
PCPs prescribe medications as the only modality to relieve pain

• “My doctor just wants to push prescription after prescription, and I didn’t want to hide the pain, I wanted to fix it. So, you know, the different techniques, like the relaxation exercise, working, and gardening, anything . . . I didn’t want to take a whole bunch of medicine”
Depression and Stress Negatively Affect Self-Management

• “Well, I mean, when you are depressed, you just don’t want to do nothing. You just want to . . . I just want to lay there and just wallow in my pity.”

• “And down in the hole was where you were focusing on how bad you hurt, and it felt like you were the only one with pain.”
Other barriers

• Some strategies don’t work or are not tailored
• Lack of social support
• Not having the time
• Lack of self-discipline
• Limited financial resources
Facilitators to pain self-management
Relief of depression symptoms helped patients with pain self-management

• “The depression went away and I was able to do more.”

• “Okay, so once you got out of the depression, you were able to, start to think about strategies to help your pain.”
Having the Support of Others

• “It makes a world of difference . . . Nothing works better than support.”
• “she (nurse care manager) can get me back on track” and provide “positive reinforcement.”
Other facilitators

- Social comparison
- Being a proactive patient
- Positive thinking
- Having different options for self-management
Discussion

- Identified patient perceived barriers and facilitators to pain self-management

- Barriers:
  - Disabling effects of pain
  - How PCPs use medications as the sole modality for pain
  - Negative effects of depression and stress
  - Fear that exercise and activity exacerbates pain
  - Lack of efficacy of some self-management practices
  - Lack of social support
Discussion

- Facilitators
  - Treatment and relief of depression symptoms,
  - Having support
  - Comparing one’s pain with that of others
  - Being a proactive patient, having a
  - Positive attitude and using positive
    thinking/affirmations
  - Having a menu of options
Limitations

• Possible we did not capture possible perspectives on what makes self-management more or less difficult
• Possibility of self-selection bias
Implications

• Identifying barriers and “needs” is helpful in the development and implementation of successful self-management programs for patients with chronic illness (Glasgow)

• Providers should be aware of what interferes with or helps patients engage in these activities

• Effective treatment of depression should be a goal to optimize outcomes from self-management interventions

• Interventions need to be developed to equip providers with brief, yet tailored self-management tips
Implications

• Modifications that better address barriers and facilitators may be needed

• Cross-cutting relevance of patient self-management

Conclusions

- Future studies should consider ways to capitalize on the facilitators identified while at the same time addressing the barriers to pain self-management.
Thank you

Matthew.Bair@va.gov