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Podcast Script
Interview with Dr. Thorn

Part 3: Cognitive Behavioral Therapy (CBT)

Jessica

Welcome back, or if you are just joining, I'm Jessica Boles, Licensed Social Worker with Global Healthy Living Foundation and ArthritisPower. Today I'm joined by Dr. Beverly Thorn, former professor, and chair of the department of psychology at the University of Alabama. In this podcast session, Dr. Thorn will be providing us with a brief introduction into Cognitive Behavioral Therapy or CBT and the tools patients and their doctors may use to help address the psychological impacts of chronic pain. Beverly thank you again for taking the time to share all your great work and for speaking with me today.

Dr. Thorn

Sure, thank you!

Jessica

Would you mind kind of giving us a little, kind of an overview, about Cognitive Behavioral Therapy or CBT and maybe tell us a little bit about your research projects related to this topic as it's connected to chronic pain?

Dr. Thorn

Sure! So, I think, first and foremost, the most important thing to realize is that getting a referral for cognitive behavioral therapy or for any kind of psychological therapy for that matter does not mean you do not have real pain. These techniques work for people with real pain and we know that we're working with people with real pain. So, just because you're going to a psychologist or a social worker or a licensed professional counselor to help you manage your pain does not mean that your pain is on your head and it does not mean that medical treatment is not appropriate or won't be effective. This is part of a comprehensive treatment program, but if we just ignore the psychological and the social, if we just treat every pain as if all it is, is a tissue damage signal that's going to that brain and ringing that pain bell we're only treating a small part of the pain problem and we're not going to be as effective. What we have found out with cognitive behavioral therapy is that it can actually enhance the effectiveness of other treatments, biomedical treatments. So, it can be a part of the treatment team approach

and actually enhance the overall effectiveness. Cognitive behavioral therapy capitalizes on the idea that our thoughts and our emotions and our behaviors, our actions, make a great deal of difference in how we actually manage chronic pain. Just as one example, if you have chronic pain and you wake up in the morning and you're stiff and you don't feel like getting out of bed and you really don't feel like doing much of anything and you go back to bed because you have pain, is that going to serve you well? In the short term it might. In the short term it might be exactly what you need to do to take care of yourself. Imagine if you did that every single day when you woke up in pain. Most folks with arthritis do wake up in pain, I wake up in pain. But if I stayed in bed every day when I woke up in pain eventually, I wouldn't be able to get out of bed. So, we know that it doesn't serve us well, that's an action kind of thing. If our thought processes are saying to ourselves, "I'm just, I'm a loser. I'm damaged goods. I'm no good to anybody anymore," what do we think is going to happen to our pain levels? Well, we know for sure. People that are saying those kinds of things to themselves actually have greater levels of pain and certainly higher levels of depression. So, to pay attention to those thoughts, to pay attention to one's emotions, to acknowledge that they're angry that they have to deal with this, but to channel that anger ultimately and to pay attention to how all of that folds into your thoughts feelings, how it folds your actions. It makes a huge difference in how well you're going to cope with a chronic condition like chronic pain.

Jessica

Yeah, and I heard you say a really key point about who a person maybe connected with if they want to start considering cognitive behavioral therapy or other similar supports, but would it be through their doctor that would get this process started? I know you mentioned social worker. Then, another kind of part 2 to that question, and we get this question a lot from our patients is about cost. Is this something that's not unobtainable or could it potentially be covered by one's insurance plan.

Dr. Thorn

It depends upon your insurance we'll start with that. It depends upon someone's insurance, but most insurance companies have mental health coverage. So, mental health practitioners can bill for cognitive behavioral therapy and the patient can be covered in that way. Also, they're called procedural codes that billers pay attention to and mental health practitioners, and I'm most familiar with psychologists because I'm a psychologist, but mental health practitioners don't have to give you a mental illness diagnosis to treat you for real pain. They can give you a diagnostic code that are psychological therapies for people with *real* biological illnesses. We work with cancer patients, for example, to help them manage the stress associated with cancer. They don't have a mental illness diagnosis. We work with people who have had a traumatic amputation. They don't have a mental illness diagnosis. Those procedural codes allow us to bill and allow us to get reimbursed and a lot of patients have coverage for those. I will say not all insurance companies pay and the way we carve it out between mental illness and organic illness, or biological illness is a silly distinction, because any organic illness is always

psychological. I mean that's just part of it because it's all happening inside our brain and so the whole thing needs to be treated not just a small part of it.

Jessica

Would you say that cognitive behavioral therapy should be necessarily used alongside other therapies, like medication for instance, or can it be used by itself to treat chronic pain or what are your thoughts on that?

Dr. Thorn

Well, I think that all therapies should be multimodal. If you're just treating your chronic pain with medication and not anything else, you're only treating a sliver of the problem. So, when I say cognitive behavioral therapy, I think it would be silly to say, “No, you don't need any medical treatment at all. We don't need to pay any attention to anything else, but this cognitive behavioral therapy,” I think it is part of the treatment. Now whether we call it complementary or not, complementary therapies are often referring to therapies that aren't in the mainstream and don't have a lot of research backing. We know that now CBT is in the mainstream and has a tremendous amount of research backing. It is helpful to a certain extent, but just like if we treated your pain only with medication, we are only treating a sliver. If we treat your pain only with CBT, we are treating a sliver. We know through research that interdisciplinary multimodal treatment program for chronic pain have the most efficacy. They are the most effective. That's what insurance companies don’t like to pay for. They would rather just pay one individual, unfortunately.

Jessica

And, Dr. Thorn, could you tell us a little bit about some of your resources or how patients can access them?

Dr. Thorn

Yes, I think you're going to provide the link to the free download for the patient workbook?

Jessica

Umm hmm.

Dr. Thorn

That they certainly can certainly download for free and use. That patient workbook was constructed to help us deliver a 10-week 90-minute per week group therapy program, where we worked with 5 to 7 patients with chronic pain, coming together, going through the materials, teaching skills and interacting with a lot of the discussion. Because one of the things

we know for sure is experts in pain management, or chronic pain patients, they know a lot about dealing with chronic pain. In a group situation, they're sharing with each other techniques and they're pushing each other in a way that they can do that somebody without chronic pain doesn't have as much legitimacy can do. So, those materials that can be downloaded and used are fine, I think, but they're just a part of the program. It would give you a sense of what goes on in a treatment program like this. There are things to think about and write down and worksheets, very simplified worksheets to go through that might be helpful to a patient. As I said previously, there's a bunch of self-help books now on managing chronic pain and they can also be useful. I have two previous books, not workbooks but books, that are written really for the practitioner, for the mental health practitioner to help patients with chronic pain, but I have received feedback from patients that they have just gone ahead and gotten the book and work the program themselves and found that to be useful. Now I'm a big believer in group treatment because I'm a big believer in getting patients together so that they don't feel alone, and they don't feel dismissed by the health care system and they feel more empowered with other patients. If you don't have access to that, there's a lot of great stuff on the web and there's a lot of great stuff that's downloadable or purchasable, and the self-help books are purchasable.

Jessica

Great and to your point, yes, we will certainly share all your wonderful materials. I find them helpful myself, so I think it's great to look at. Like you said, even if folks can maybe use them just as a starting point, just to consider. Another thing you mentioned that I thought was interesting, in your delivery of cognitive behavioral therapy with chronic pain patients in low income clinics, I'm just curious what would you say surprised you the most about the patient's improvement?

Dr. Thorn

So, let's talk a little bit about low-income clinics and why I made that distinction there. One of the problems has been, in research up to this point, a lot of research has excluded let's just say patients who can't read and write very well. For example, if I'm doing a cognitive behavioral therapy program, I have worksheets, I have homework, I'm giving you written homework to do and if you can't read and write very well I exclude you from the program because you're not going to be able to keep up with us and you're not going to be able to do what you ask you to do. And I for a good 15 years now, maybe more than that, felt like that was very unfair, that we're cutting out a big segment of the population. If you know the most recent statistics about literacy in the US alone, 52% of people in the US are reading at the 3rd or 4th grade level or below. That's a staggering, it's an unbelievable statistic to me. So, we need to simplify our treatments and make them effective for all people. That's why I went into this simplification and that's what you'll see with the downloadable workbook is a simplified version of more complicated cognitive behavioral treatments, but it's the same thing. It's just that we don't rely on the reading and writing so much. I focused my research in low-income clinics because low-income clinics have a greater proportion of people with low educational attainment and people

with low literacy. It doesn't mean there aren't people with high literacy and high education at those low-income clinics as well. There's lots of reasons people have low income, but I wanted to specifically reach people who didn't necessarily read and write so well to make sure that we adapted our materials so that they could be useful for everybody and not just the upper 50% of the population. That's why we did our research in low-income clinics. What surprised me. In this most recent research project, we compared group pain education where we taught people about the Gate Control Theory of pain, which I talked about in the last podcast. We talked to people about how important it was to self-manage, to help yourself, not just only you but to help yourself manage your pain. We talked about ways that people do that, but we did not offer any skills training necessarily. We didn't put any pressure on the person to do anything. It was just a group discussion and we compared that to cognitive behavioral therapy with these patients. What surprised me is that cognitive behavioral therapy takes more effort. If we compare just the lowest level of people, in terms of literacy and education in pain management, they did better in cognitive behavioral therapy than they did in pain education. At first that surprised us because it takes more effort and it does take some abstract ideas as well. So, we thought, why is this? We think it was because we offer a very structured skills-oriented program, Step 1, Step 2, Step 3, and we did offer a lot of support. Whereas in group education we give them the information and they take it and run with it or they don't. What we found is the people with the lowest level of cognitive function probably do need to benefit from that extra attention, the extra structure, the extra skills training, so that was the most surprising for us and very interesting for future research, I think.

Jessica

So, a lot of times our patients will tell us they wait so long before they can talk to their doctor or their rheumatologist and they have so little time with them. I'm just thinking you know do you think patients should bring this up to them or do you think it's more about patient sort of finding their own way of getting connected with this type of support. Because it sounds like from your research the evidence is there that it's helpful, and we all know that CBT has been, you know, a proven support. What do you think would be a suggestion for patients in how they approach getting connected?

Dr. Thorn

I think it’s always important to bring questions to their healthcare providers and say, “I want to try this.” Their health care providers are going to be more connected to resources than they necessarily are, or we hope that they would be. I think it's important also not to be surprised if their health care providers say something like, “Oh I don't know anybody who does that that” or “I don't know enough about it” or even “Oh, that's not a kind of treatment for you, you have real pain”. That's really important to educate everybody about. These are treatments for people with real pain. I still have physicians who say, “Oh, that person shouldn't be in your group Dr. Thorn, they have real pain”. I’m thinking, Hmm, and what does he think about the other people who can be my group. That's not a good thing. So, I think, yes, it's important always to ask and then it is also important to get out there and do your own research. Luckily,

we can do Internet searches for those people who have access to them. Luckily, every Public Library has computer access for people who might not necessarily have connectivity at home. To do those kinds of searches, it's a little intimidating or it can be a little intimidating because there's *so* much on the web right now, but to look around and to get a sense of what is out there. For just one example, meditation, which has been shown to be very promising for helping somebody manage their chronic pain, not just meditation, but as part of a component of a component of multimodal treatment. There are lots of free applications that people can download, you know, or get them on CD's and play them that don't require anything. Well, most of them are free. So, those are the kind of things that patients can do immediately and to experiment with it and see how it works.

Jessica

Do you have any final thoughts or tips maybe that we haven't covered?

Dr. Thorn

Yeah, one thing that I would say that is CBT takes effort and just like any skill. Any skill that you learn takes effort. One of the problems is when we are feeling downtrodden, defeated by our chronic pain, we don't want to do anything effortful. So, in some ways it's more attempting to just take a pill and be done with it, but we also know in the back of our mind just taking a pill isn't helping us regain any function or do things in our lives that are meaningful to us. What I would tell yourself when you start on any kind of CBT-like program, let's just say you download some meditation tape or something to try it's not a one shot deal just like riding a bicycle isn't a one shot deal. It's a skill and it takes effort and it takes persistence, so you have to be patient with the techniques because it's not an instant fix like a pill, but as we know a pill isn't an instant fix either.

Jessica

Well, amazing information. Thank you so much, Dr. Thorn. You know we really just want to share with our listeners that there's a lot of materials that we'll include. They're available for free - all through the good hard work of Dr. Thorn and her team. We thank you so much Dr. Thorn for that. I'd also like to thank PCORI the Patient-Centered Outcomes Research Institute for supporting this project. If you have any questions certainly let us know and we appreciate you, Dr. Thorn, thanks again.