A multistep program for an integrative self management intervention for chronic pain: preliminary results

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Pain Self Management Program


traditional relationship

Patients
- Passive
- Poor compliance
- with feelings of guilt if the therapy is ineffective
- With little awareness
- With poor self-regulation
traditional relationship

patient-professional partnership

• Bodenheimer et al. (2002)

collaborative care

• Holman e Lorig (2000)

Self-management education

- promotes problem solving
- Action plan drawn up by the patient
- Skills identification (medical, social, emotional)
- Confidence in their abilities
- Sustain self efficacy
- Have to deal with unrealistic expectations
Self Management Program

First coined by T. Creed in the 1960’s to denote a patient’s active participation in day-to-day treatment.

The goal is to maintain a wellness focus to improve quality of life despite the chronic condition (Lorig, 2003)

5 core self-management skills

- Problem solving
- Decision making
- Taking action for change
- Partnerships HCPs
- Using resources
The Stanford Chronic Pain Self-Management Program (SCPSMP)

Standard program

- 10-15 people per group
- 2.5 hrs/wk for 6 weeks
- Train the trainer model of dissemination
- Leaders peers or HCPs
- Pain work book and CD

TOOLBOX

- Pain self management
- Physical activity/exercise
- Pacing and planning
- Relaxation and better breathing
- Medication
- Working with health professional
- Problem solving
- Using your mind
- Communication
- Understanding emotion
- To find resources

Living a Healthy Life With Chronic Pain
Pain Self Management Program

References


Results of previous research

• **Strength**
SMCPP is a standard protocol applicable in different classes of populations

• **Weaknesses**
These results are inconsistent because:
  a) Some studies showed a short-term improvement in pain, life satisfaction, vitality and dependency compared traditional pain management
  b) Other studies showed an improvement of pain, depression and self efficacy at 12 months compared traditional pain management.
  c) All studies evaluated pain with regard to only intensity of pain, which does not describe the multicomponents of pain
Melzack R. And Casey Kl. Sensory, Motivational, And Central Control Determinants Of Pain


Pain-related decision making deficits (Ji et al., 2010)
IPQ (Italian Pain Questionnaire)

De Benedittis et al. 1988

The structure is the same as the McGill Pain Questionnaire (Melzack, 1983) but the standardization was conducted in the Italian Population.

Principal pain dimensions are:
- Sensorial
- Affective
- Evaluative
- Intensity
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AIM

Principal aim:
1. To check on which pain components the SMP should act

Secondary aims:
2. To check whether the action of SMP on pain is dependent on improving anxiety
sample

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Musculoskeletal
Neuropathic
Anxiety

8; 22%
5; 13%
24; 65%
Flowchart of participants in integrative multistep self management program (SMP)

Step 1
- T0 baseline

Step 2
- T2 8th week (Course of 8 hours)
- T4 16th week

Step 3
- T6 24th week

Step 4
- T9 36th week
- T12 48th week

Weekly call by the SMP trainer

Recorded CD with self-hypnosis and meditation

Booklet including Yoga exercises and the structured SMP for pain and anxiety

Drop out
- T4 A 1
- T6 CP 4
- T9 A 4

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Drug treatments at Baseline

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T0-T2: outcome with only drug treatments

Step 1: first two months

ANOVA repeated measures

Sensorial

Affective

Evaluative

P=0.004

p=0.007

n. 24

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T2-T4: integrative multistep self management program

Step 2: second two months

ANOVA repeated measures
T0-T4: integrative multistep self management program

Step 2: four months

ANOVA repeated measures
Step 3: Outcome at 6 months of anxiety and self efficacy with the integrative multistep self management program
Step 3: 6 months of integrative multistep self management program

F of ANCOVA

- Sens
- Affect
- Eval

<table>
<thead>
<tr>
<th>Variable</th>
<th>Sens</th>
<th>Affect</th>
<th>Eval</th>
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<tbody>
<tr>
<td>Age</td>
<td>1.43</td>
<td>0.08</td>
<td>0.82</td>
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<tr>
<td>Education</td>
<td>2.58</td>
<td>1.48</td>
<td>1.61</td>
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<tr>
<td>T0-T6 Depression HADS</td>
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<td>4.20</td>
<td>3.36</td>
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<tr>
<td>T0-T6 Anxiety HADS</td>
<td>2.54</td>
<td>4.78*</td>
<td>4.44*</td>
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<tr>
<td>T0-T6 Stai</td>
<td>1.20</td>
<td>0.43</td>
<td>0.40</td>
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<tr>
<td>T0-T6 Self Efficacy</td>
<td>0.65</td>
<td>0.20</td>
<td>0.39</td>
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<td>Total n. of Self-Hypnosis</td>
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<td>0.58</td>
<td>0.75</td>
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<td>Total n. of Meditation</td>
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<td>0.27</td>
<td>0.30</td>
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<tr>
<td>Total n. of Stretching</td>
<td>0.27</td>
<td>0.50</td>
<td>0.93</td>
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p = 0.03
p = 0.006
p = 0.004
conclusions

• Sensorial and evaluative but not affective dimension, have improved with drug treatment in the first step.

• Comparing baseline with the end of step 2, the IMSSMP showed an effect on improvement of all pain dimensions, including affective.

• Depression and anxiety show an influence on the improvement of affective and evaluative dimensions of pain after 6 months of IMSSMP

Anxiety and self efficacy improved with IMSSMP without differences between groups of people- those with anxiety only, and those with chronic pain