Psychological Treatments (Cognitive-Behavioral and Behavioral Interventions)


A. Understand relaxation strategies: progressive muscle relaxation, autogenic training, guided imagery, cue controlling and other strategies (Bernstein et al. 2000; Turner and Romano 2001).

B. Know the cognitive-behavioral treatments of pain: cognitive therapy, cognitive restructuring, problem solving, and communication skills training (Keefe et al. 1996a; Turk and Okifuji 1999; Turner and Romano 2001).

C. Be familiar with the techniques of operant therapy, e.g., contingency management for pain behavior and well behavior, reinforcement, stimulus and response generalization, quotas and goal setting, and medication management (Fordyce 1976; Keefe and Lefebvre 1994; Fordyce 2001; Flor et al. 2002; Sanders 2002).

D. Be familiar with the use of graded exposure in vivo to reduce the effects of pain-related anxiety or fears of pain and disability (McCracken et al. 1992; Vlaeyen et al. 2001, 2002).

E. Be familiar with the use of biofeedback in pain management, e.g., using electromyographic (EMG) and temperature feedback (Flor and Birbaumer 1993; Jessup and Gallegos 1994; Schwartz 1995; Arena and Blanchard 2002).

F. Understand the potential for and methods available to produce hypnoanalgesia and other hypnotic effects (Spanos et al. 1994; Syrjala and Abrams 2002).

G. Be familiar with psychological strategies for preparing patients for painful medical procedures and implantation of neuroaugmentative devices including spinal cord stimulators and drug delivery systems (Williams 1999).

H. Be familiar with the potential benefits of stress management via private emotional disclosure (including expressive writing) among patients with rheumatoid arthritis and other stress-exacerbated pain conditions (Kelley et al. 1997; Smyth et al. 1999).

I. Be familiar with the integration of psychological therapies with rehabilitation therapies, e.g., physical therapy, occupational therapy, and vocational rehabilitation (Feuerstein and Zastowny 1996).

J. Be aware of group therapy and how to assess patients for the likely efficacy of group therapy approaches (Keefe et al. 1996a; Keel et al. 1998).

K. Be aware of cognitive-behavioral interventions used to treat pain in children and adolescents (McGrath and Hillier 1996).

L. Understand the behavioral interventions used to improve sleep in patients with persistent pain (stimulus control, sleep hygiene, cognitive-behavioral therapy) (Morin et al. 1993, 1994).
M. Understand strategies used to involve spouses, caregivers, and significant others in behavioral and cognitive-behavioral pain management interventions (e.g., Keefe et al. 1996b).

N. Be familiar with behavioral and motivational strategies for enhancing patient adherence and preventing relapse (Keefe and Van Horn 1993; Myers and Midence 1998; Martin et al. 2000; Turner and Romano 2001; Kerns et al. 2002).

O. Be familiar with the behavioral interventions used in primary care settings to prevent chronic pain (Linton and Bradley 1996).

P. Be familiar with the use of early intervention techniques for helping patients cope with chronically painful diseases such as rheumatoid arthritis (e.g., Sharpe et al. 2001).


II. Have a basic understanding of the medical/physiological aspects of the pain problem, e.g., disease severity, prognosis, common medical and surgical treatments. Recognize behavioral components and the importance of the social context of all biological interventions (motivational factors, relationship factors, suggestion, trust, and adherence) (Turk and Rudy 1991). Be able to recognize the psychological effects of biological interventions, e.g., effects and side effects of medications that can compromise functioning or impair psychological test performance.

III. Be aware of the need to treat comorbid psychological problems that may accompany pain (DeGood and Dane 1996).

IV. Recognize the application of various cognitive and behavioral strategies to specific pain syndromes such as temporomandibular disorder pain, neck and back pain, fibromyalgia, arthritis pain, burn pain, and postoperative pain (Kendall 1983; Keefe et al. 1990a,b; Dworkin et al. 1994; Linton and Ryberg 2001; Williams et al. 2002).

V. Be familiar with how the various separate approaches can be integrated including different cognitive-behavioral treatments and combined behavioral and drug treatments (Flor and Birbaumer 1991; Holroyd et al. 2001; Turk 2001; Polatin and Gajraj 2002), and be aware of the economic benefits of integrating cognitive-behavioral and drug treatments (Conrad and Deyo 1994; McCarberg 2000; Gatchel 2001).

VI. Be familiar with the transtheoretical model of behavioral change and with motivational interviewing techniques used to address patients at different stages of change (Kerns et al. 1997; Keefe et al. 2000; Dijkstra et al. 2001).

VII. Recognize common process factors in cognitive-behavioral and self-management interventions including rapport, engendering hope and positive expectations, developing a therapeutic alliance, communication strategies, support, and suggestion (Lorig and Holman 1993).

VIII. Be familiar with placebo effects and nonspecific effects on treatment outcome (Turner et al. 1994; Turner 2001).

IX. Understand the racial, ethnic, and cultural factors to consider in the psychological treatment of pain (Edwards et al. 2001).

X. Know the role of clinical decision-making in matching interventions to patients’ needs (Turk 1990; Rudy et al. 1992; Turk and Okifuji 2001).