Expanding Targets for Intervention in Later Life Pain

What Role Can Patient Beliefs, Expectations, and Pleasant Activities Play?

M. Carrington Reid, MD, PhD

KEYWORDS

• Beliefs and attitudes • Patient expectations • Pleasant activity scheduling

KEY POINTS

- Certain pain beliefs and attitudes negatively affect older adults' willingness to engage in and/or adhere with treatment, can adversely impact treatment outcomes, and are amenable to change. Clinicians should assess older patients' beliefs and attitudes prior to initiating treatment.
- Patient expectations can impact treatment outcomes and are potentially malleable. Clinicians caring for older adults with chronic pain should routinely assess patients' treatment expectancies (eg, degree of pain relief expected and the degree of functional improvement the patient hopes to achieve) prior to initiating treatment.
- Pleasurable activity restriction is common in older patients with chronic pain and constitutes an important target for intervention. Clinicians should include pleasant activity scheduling as part of their multimodal treatment plan, particularly for those patients who endorse cutting back or eliminating pleasurable activities.

Pain is one of the most common conditions health care providers encounter when caring for older patients. Treating pain in older patients is challenging because of a variety of physical (eg, age-related physiologic changes; onset of sensory and cognitive impairments or gait and balance problems; and multimorbidity and associated polypharmacy) and psychosocial (eg, affective disorders, care-rejecting behaviors, or social isolation) factors that constrain treatment choices.[1] A limited evidence base to guide treatment also constitutes a significant barrier to effective geriatric pain management.[2] Pain generators such as spinal stenosis or advanced osteoarthritis often can not be

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Division of Geriatrics and Palliative Medicine, Weill Cornell Medicine, 525 East 68th Street, #39, New York, NY 10065, USA
E-mail address: mcr2004@med.cornell.edu

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targeted because of the factors noted previously or because of patient concerns about undergoing a surgical procedure.

As described in previous articles in this series, targets for intervention include

1. Pain reduction using pharmacotherapies (see Jennifer Greene Naples, Walid F. Gellad, Joseph T. Hanlon's article, "The Role of Opioid Analgesics in Geriatric Pain Management" and Zachary A. Marcum, Nakia A. Duncan, Una E. Makris's article, "Pharmacotherapies in Geriatric Chronic Pain Management," in this issue), interventional approaches that do not involve surgery (see Amber K. Brooks, Mercy A. Udoji's article, "Interventional Techniques for Management of Pain in Older Adults," in this issue) and/or non-drug therapies,
2. Preservation of function by means of exercise and other physical therapies (see Sean Laubenstein, Katherine Beissner's article, "Exercise and Movement-Based Therapies in Geriatric Pain Management," in this issue), and
3. Coping skills training as a way of helping patients to adapt to pain and its consequences (see Christopher Eccleston, Abby Tabor, Rhiannon Terri Edwards, Edmund Keogh's article, "Psychological approaches in geriatric pain management," in this issue).

Augmenting the number and type of targets clinicians have at their disposal is important to do. These targets can be factors that amplify the adverse effects of pain or mediate its effects and help providers to broaden their portfolio of pain management options. For example, among patients with depressed mood and pain, clinicians often direct treatment at the depressive symptoms, particularly when the patient cannot be prescribed (or tolerate) a pain medication, achieving positive results in the form of reduced depressive symptomatology and pain. Similarly, targeting sleep problems in patients with comorbid pain and sleep disturbance often leads to reduced pain and improved functioning.

This article highlights 3 additional targets clinicians should consider when initiating treatment plans for older patients with chronic pain: (1) patient attitudes and beliefs about pain and pain treatments, (2) patient expectations regarding treatment outcomes, and (3) pleasurable activity scheduling. Evidence supporting these recommendations is provided, as well as practical strategies to intervene on each in the outpatient setting.

PAIN ATTITUDES AND BELIEFS

Older adults can maintain attitudes and beliefs about pain and pain treatments that negatively influence expectations regarding treatment outcome, impact specific health behaviors, and negatively affect their willingness to engage in and/or adhere with specific treatments. Many theories of health behavior (eg, social cognitive theory) highlight the important role that patients' attitudes (a settled way of thinking or feeling about something) and beliefs (a feeling or thought that something is true) play regarding behaviors such as engaging in physical activity or taking a prescribed medication as directed.[3] Patient attitudes and beliefs about pain and specific pain treatments come from varied sources, including friends and other members of their social network, family, social media, patients' health care providers, and their own experiences living with chronic pain, often over many years.

What types of pain-related beliefs and attitudes do older adults endorse, and how common are they? In 1 survey of community-dwelling older adults, more than 50% of participants considered arthritis-related pain to be a natural part of getting old.[4] In a large study of veterans, those who were older (65 and above) were far more likely