President's Message

Carolyn McManus, MPT, MA

Greetings members! The Pain SIG Board continues to advance our priority initiatives. In October 2019, Derrick Sueki, PT, DPT, OCS, along with 8 physical therapy pain leaders from across specialty areas met with consultant Jeannie Bryan Coe, PT, DPT, PhD, at the Academy of Orthopaedic Physical Therapy office in LaCrosse, WI to begin to develop a Description of Specialty Practice. This document will provide a framework to develop a survey to determine the need and elements involved in pain specialty practice and those required for residency and fellowship training. The target goal is to have a pilot survey ready for distribution in Spring 2020. In addition, Education Chair, Mark Shepherd, PT, DPT, OCS, is leading an initiative to develop a DPT Pain Curriculum course, manual, and resource packet for educators consistent with the International Association for the Study of Pain Physical Therapy Curriculum Guidelines.

At CSM 2020, the Pain SIG will sponsor an educational session on *Assessing and Classifying the Challenging Patient With Maladaptive Pain Behaviors* with presenters Yannick Tousignant-Laflamme, PT, PhD; Chad Edward Cook, PT, MBA, PhD, FAPTA; and Timothy H Wideman, PT, PhD.

In addition, a multidisciplinary team from the AOPT and the Academy of Physical Therapy Education has completed their systematic literature review and developed best practice recommendations for including education and counseling in the treatment of patients with musculoskeletal pain. Members of the guideline development team, David Morrisette, PT, ATC, PhD; Joel Bialosky, PT, PhD; Derrick Sueki, PT, DPT; and Joseph Godges, PT, DPT, MA, will present a summary of the process along with evidence-informed recommendations in the educational session, *Clinical Practice Guideline for Education as an Intervention for Individuals with Musculoskeletal Pain*. More information on all of these programs can be found at: https://www.apta.org/csm/. Hope to see you there!

As I reach the final weeks in my role as Pain SIG President, I find myself filled with gratitude for the assistance and guidance I received from several colleagues over the past 3 years. I want to especially thank Scott Davis, PT, EdD, OCS, and Joe Donnelly, PT, DHSc, OCS, who served as my AOPT Board liaisons. They provided me with advice and encouragement as I learned the ropes of SIG leadership and led our group through the development of our strategic plan and the efforts to accomplish our goals. I would also like to send a special thanks to Derrick Sueki, PT, PhD, OCS, and Katie McBee, PT, DPT, OCS, who, during my first year when I felt especially green in my role, were always checking in and cheering me on. I want to thank the entire Pain SIG Board who have both been in my corner and taken leadership roles. I am forever grateful for your energy, efforts, and kindness. And of course, I could not have had a successful term without the wonderful support of the AOPT administrative team. Finally, I want to thank the full membership for this opportunity to serve you.

In this, my closing message, I would like to encourage us all to take a broad view of pain treatment. Although some in our field may shy away from adopting treatment strategies that require expanding their skill set beyond a biomedical model, the evidence that pain is a perception resulting from complex sensory, cognitive and affective processes is indisputable and invites a diagnosis and treatment approach that addresses all contributing components, while remaining within our scope of practice. To be successful, we need to be open to models of psychologically informed care, body awareness training, relaxation and stress self-regulation, as well as health coaching skills and motivational interviewing for those patients identified to be at high risk for developing chronic pain conditions and those already suffering from these conditions. I was recently struck by a comment made by a participant in my preconference course at NEXT 2019. He owns a private practice with multiple offices and tracks patient outcomes. He said, "The practitioners with the best outcomes are not the ones with the advanced manual therapy training. The ones with the best outcomes have better therapeutic relationship skills." Again, this comment speaks to the importance of recognizing and valuing the elements essential for successful treatment that are outside biomedical factors. As we go forward in developing models of treatment, we need to be willing to take a broad view, stepping out of our comfort zone when necessary, and appreciate the multiple factors that contribute to the successful treatment of pain.

I would now like to introduce you to PSIG member Katie McBee, PT, DPT, OCS, MS, CEASII. Katie is the Regional Director of WorkStrategies for Select Medical based in Louisville, KY. In addition, she is a member of the Motivational Interviewing Network of Trainers. She has a passion for learning and sharing new information on pain science and best practices for the treatment of pain for physical therapists. Katie spends a portion of her professional time developing new strategies to prevent and manage pain effectively and efficiently in outpatient practice under current payor models. I want to thank Katie for contributing the following article, *Motivate to Rehabilitate: The Use of Motivational Interviewing in Physical Therapy Practice.*

Motivate to Rehabilitate: The Use of Motivational Interviewing in Physical Therapy Practice

Katie McBee, PT, DPT, OCS, MS, CEASII

As clinicians in physical therapy practice, we can find ourselves in challenging situations with patients who demonstrate distressing emotions and maladaptive behaviors in addition to the medical complexity of their injury or illness. Sometimes it seems no matter how much a patient is told what they should do, they are just not compliant with instructions and their passivity becomes a barrier to meeting their health goals. Some patients are extremely angry about their situation and may even be angry about getting referred to physical therapy instead of their desired procedure or prescription. Other patients feel hopeless about their ability to do anything for themselves. These situations and many other patient behavior challenges can come up in the clinic that can be difficult to navi-

gate successfully, especially with a busy schedule and a lack of time for one-on-one communication periods. Building a strong therapeutic alliance with patients may assist with managing challenging emotional and behavioral situations. One skilled and billable tool that can potentially assist with building a therapeutic alliance and overcoming modifiable psychosocial risk factors that present in the clinic is Motivational Interviewing.

Motivational Interviewing (MI) is defined as "A collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."[1] Motivational Interviewing was first established in 1983 by William Miller as a counseling technique for addiction rehabilitation. It is now integrated into many clinical as well as non-clinical settings including dentistry, wellness, and leadership training. Although the literature in the physical therapy arena is limited and still building, there are over 1,000 controlled clinical trials for MI and about two-thirds of those trials show a beneficial effect.[2] In some cases, when MI is added to other evidence-based treatments, both can become more effective and the effect size is sustained over a longer period of time.[2] As indicated above in the definition, MI is a technique that promotes autonomy and self-efficacy in the patient by eliciting positive change talk from the patient as to why they should make changes to improve their health. Promoting self-efficacy in patients with chronic pain can positively influence treatment adherence and physical activity.[3,4] Motivational interviewing has also been shown to be more effective in patients that are less motivated, angry, or marginalized.[2] A study by Steven Linton demonstrated that MI, education on the biopsychosocial model, problem solving skills, and communication skills training combined to create a Worker and Workplace Package to treat low back pain that was more effective than usual evidence-based medical care for low back pain in the workplace.[5]

Learning a structured technique for communication to assist in promoting healthy change for complex pain patients with psychosocial risk factors may take a little time and potentially be uncomfortable at first but it could make a difference in some of our more challenging patient populations and has little chance of doing any harm. Adding MI to clinical practice starts with knowing the basics. Then it takes practice and preferably some mentorship by an experienced MI practitioner to be able to practice MI with integrity. To practice MI with integrity there must be an empathetic, client-centered style and MI skills that elicit positive change talk from the client.[2] Even a clinician new to MI can immediately begin adding basic skills and the spirit of MI into clinical interactions to assist with improving the therapeutic alliance.

The two key beginning elements of MI are the MI Spirit and MI Skills. The MI spirit is a way of being with patients that respects their autonomy and shares the driver's seat of the clinical decision-making to ensure a patient-centered approach. The key is to partner with the patient wherever they are and together come up with viable solutions for their care in a collaborative manner. The basis of partnering with a patient instead of telling them what to do as per a more traditional medical interview model is based on the likelihood of behavior change being greater when a patient has intrinsic motivation, hears themselves speak of change, and feels respected by the clinician.[1] By allowing the patient to problem solve and offer solutions, they can take more ownership of their care and develop further self-efficacy. Table 1 summarizes the 4 inter-related elements of the MI spirit.

Table 1. Motivational Interviewing Spirit[1]

Partnership	Building a collaborative relationship with the patient that respects his/her ideas and thoughts for care instead of an authoritarian role.
Evocation	Working to build intrinsic motivation by pulling from the patient's own resources instead of educating him/her on why he/she should do something.
Acceptance	Approaching the patient with respect for one's values and imperfections. Having empathy and promoting autonomy. Working to identify the patient's own strengths and efforts.
Compassion	Unconditionally seeking the patient's best interests, well-being, and growth.

The second key element is the MI skills. These skills are used throughout the interaction to increase the patient's motivation for change. Table 2 summarizes the MI skills. Learning to use all of these skills in the correct ratios with the MI spirit while achieving positive change talk from the patient is how MI is practiced. However, each of the skills can be used as a stand-alone method to assist with better patient interactions. The acronym for the MI skills is OARS.

Table 2. Motivational Interviewing Skills[1]

Open Ended Questions	Ask questions that cannot be answered with one word, a number, or a date. Questions that start with what, how, and tell me more are common open-ended questions. The goal is to decrease reflexive responses and encourage communication.
Affirmations	Affirmations are a statement that points out strengths or values the patient is demonstrating.
Reflections	Repeating back what the patient says in different words. Reflections are a way to ensure the patient is heard and understood.
Summary	A summary is a type of reflections that acknowledges the barriers the patient has stated but reiterates his/her reasons for change and any potential next steps to pull the interaction together and make sure the patient hears his/her own words stated back.

The O from the OARS acronym is for open-ended questions. When practicing MI, about 70% of the questions in the interaction are open-ended questions. An open-ended question is one that keeps the conversation going and makes the patient think about the answer instead of answering reflexively. Open-ended questions begin with words or phrases like "what," "how," and "tell me more." When dealing with a highly emotionally charged interaction, open-ended questions can be a life saver. When a person is emotionally charged, they may be mainly operating from emo-

tional centers of the brain. By asking an open-ended question, the patient has to stop and think about an answer that can bring higher level brain centers back online and calm or at least distract from the negative emotion. Good open-ended questions can also focus the conversation on the positive. For example, "Tell me what you like about exercise" is an example of an open-ended question. This contrasts with "Do you like exercise?"

The A in OARS is for affirmations. Affirmations are a way of identifying and acknowledging the strengths the patient brings to the situation. The focus is on a behavior or value more than an attitude or a decision made. An affirmation is different from a compliment. A compliment would be "nice shoes." A good affirmation would be "you demonstrate a lot of perseverance to keep showing up to treatment despite all of the challenges going on in your life right now." A well timed and quality affirmation can assist with promoting change talk, increase the patient clinician connection, and completely change the mood of the patient if he/she is feeling powerless and down.[5]

The R is for reflections. Reflections are a way to ensure that the patient feels heard and that the clinician can ensure he/she heard the patient correctly. To practice MI, a 3:1 ratio of reflections to questions is recommended. Reflections are a core skill in MI. The goal of the reflection is to state the patient's comment back to him/her in different words and possibly dig a little deeper to take a guess at the underlying feelings or meanings of the statement. I can give a simple example of the skill of reflections in deamplifying a situation. When I get home from work, sometimes I feel overwhelmed with the things still on my to do list and occasionally I will tell my husband this in an emotionally charged manner. Historically his response had been something along the lines of "Why did you spend 2 hours on social media last night if you had so much to do?" You can imagine my reaction. I felt invalidated and shamed. After a few years of MI training, I decided to start teaching my husband how to do reflections. Now when I have one of those days and come to him about my stress, his response is more along the lines of "sounds like you are working hard but you still have a lot on your plate." Reflections have assisted in maintaining a much happier household. Often when people speak of their problems, they are not looking for the obvious solution. They are looking to be heard and validated. Reflections can assist the clinician in helping the patient feel heard and understood. This can be a very powerful patient engagement tool. Reflections can also be very helpful with angry or disgruntled patients. Reflections help the angry individual feel heard but not challenged and can assist with de-escalating a situation and helping a patient get to a calmer state.

Finally, the S in OARS is for Summary. A summary is a type of reflection that basically summarizes the entire interaction to highlight the challenges the patient has faced, the reasons he/she is motivated to make the targeted change and the things that have been agreed upon as next reasonable steps. Summaries are an important way to let the patient hear what was said rephrased again to further increase the motivation for change.

The MI spirit and the MI skills can be easily learned through readily available resources. A great starting place is the Motivational Interviewing Network of Trainers website.[6] Motivational Interviewing is a fairly new practice in physical therapy but used well can assist in improving the therapeutic alliance with complex pain patients and increase their adherence to treatments. Motivational interviewing is also a great tool to assist with mitigating common modifiable psychosocial risk factors like low self-efficacy, depression, and perceived injustice that can be barriers to successful outcomes. When we can get clients past barriers and get them motivated, then we can focus on our traditional rehabilitation skills and drive successful outcomes. What reasons do you have to give motivational interviewing a chance?

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