Nurse Coaching to Explore and Modify Patient Attitudinal Barriers Interfering With Effective Cancer Pain Management

Kathleen F. Fahey, RN, MS, CNS, Stephen M. Rao, PhD, Marilyn K. Douglas, DNSc, RN, FAAN, Mary L. Thomas, RN, MS, AOCN®, CNS, Janette E. Elliott, RN-BC, MSN, AOCN®, CNS, and Christine Miaskowski, RN, PhD, FAAN

Purpose/Objectives: To describe a complex coaching intervention to help patients with cancer pain explore beliefs and attitudinal barriers interfering with pain management. Patients were coached to explore beliefs about pain, communications about pain management, and the use of analgesics and nonpharmacologic interventions.

Data Sources: Published journal articles, abstracts, and psychology textbooks.

Data Synthesis: Personal beliefs, related attitudinal barriers, and associated behaviors impede patient adherence to and success with pain management treatments. Interventions targeting beliefs help patients overcome attitudinal barriers, improve treatment adherence, and obtain better pain relief.

Conclusions: Coaching patients to explore beliefs reduces ineffective behaviors and improves pain treatment adherence.

Implications for Nursing: A coaching intervention incorporating assessment of patient beliefs promotes self-management, self-efficacy, and adherence to pain management treatment plans. Advanced practice nurses should consider incorporating this intervention into their communications with patients experiencing cancer pain.

Key Points . . .

- Unrelieved cancer pain remains a significant problem for many patients with cancer despite numerous and varied treatment options.
- Research has demonstrated that attitudinal barriers can interfere with adherence to pain management treatment plans.
- Nurse coaching that incorporates techniques of motivational interviewing with an understanding of behavioral change theory can address attitudinal barriers effectively and improve treatment adherence and pain relief.

Unrelieved pain remains a significant problem for many patients with cancer despite the availability of numerous treatment options. Studies have shown that unrelieved pain has negative consequences on patients' and family caregivers' mood, functional status, and quality of life. However, patients with cancer are reluctant to report pain and to take opioid analgesics (American Pain Society, 2003; Cleeland, 1998; Jacox et al., 1994a)

Patients' personal beliefs and concerns about pain and its treatments and communicating with healthcare providers can negatively influence treatment adherence and pain management. When beliefs about pain interfere with managing pain, patients may have an attitudinal barrier to some aspect of pain management. Fears of addiction, feelings of stoicism, and desires to please providers have been associated with underuse of pain medication and inadequate pain relief (Jensen, Turner, Romano, & Karoly, 1991; Paice, Toy, & Shott, 1998; Riddell & Fitch, 1997; Turk & Rudy, 1992; Ward et al., 1993; Ward & Gatewood, 1994; Williams & Keefe, 1991; Williams & Thorn, 1989). In addition, Ward et al. found a positive correlation between high attitudinal barrier scores and high pain intensity scores.

In recent years, experts have developed clinical practice standards and guidelines for the treatment of pain in general and cancer pain in particular (American Pain Society, 2003, 2006; Department of Veterans Affairs, 2001; Jacox et al., 1994a; National Comprehensive Cancer Network, 2007; World Health Organization, 1996). Although these treatment guidelines provide valuable information for healthcare

Kathleen F. Fahey, RN, MS, CNS, is a clinical nurse specialist in palliative care at El Camino Hospital in Mountain View, CA; Stephen M. Rao, PhD, is an associate clinical professor in the Department of Psychiatry in the School of Medicine at the University of Southern California, San Francisco; Marilyn K. Douglas, DNSc, RN, FAAN, is the former associate chief of nursing service for research, Mary L. Thomas, RN, MS, AOCN®, CNS, is a clinical nurse specialist in hematology, and Janette E. Elliott, RN-BC, MSN, AOCN®, CNS, is a clinical nurse specialist in pain management, all at the Veterans Administration Palo Alto Health Care System in California; and Christine Miaskowski, RN, PhD, FAAN, is a professor and associate dean for academic affairs in the Department of Physiological Nursing at the University of California, San Francisco. *At the time this article was written, Fahey was a nurse interventionist for a nurse coaching study at the Veterans Administration Palo Alto Health Care System. This research was supported by the Department of Veterans Affairs, Veterans Health Administration, Health Services Research and Development Service (NRI-97026). The views expressed in this article are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs. (Submitted March 2007. Accepted for publication August 30, 2007.)*

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professionals, they place little emphasis on helping patients identify and address attitudinal barriers potentially interfering with treatment adherence and effective pain management.

The purpose of this article is to describe the use of a novel nurse coaching intervention that uses motivational interviewing techniques to explore patient beliefs about and attitudinal barriers to cancer pain management.

The coaching intervention was tested in a randomized clinical trial of 289 noninstitutionalized patients with a diagnosis of cancer who indicated the presence of cancer-related pain (Douglas & Thomas, 1999). The aim of the study was to test the effect of the coaching intervention on pain, functional status, and quality of life. After stratification by pain intensity and type of cancer therapy, eligible patients were randomized to one of three groups: usual care (n = 104), education only (pamphlet and video) (n = 94), and coaching (n = 91). The Brief Pain Inventory (BPI), Barriers Questionnaire (BQ), Functional Assessment of Cancer Therapy-General, and the SF-36® questionnaires were administered after randomization and 12 weeks later. The coaching intervention consisted of four 30-minute telephone sessions that included an exploration of beliefs about pain, communications about pain management, and discussions of the use of analgesics and nonpharmacologic interventions. Patients in the coaching group experienced significantly less interference in function from their pain than those in the other two groups. In addition, those who received the coaching intervention demonstrated improvement in vitality and mental health ratings. These differences were sustained 6–10 weeks after the intervention was completed.

Based on those preliminary findings, the specific components of the coaching intervention and its theoretical underpinnings are described in this article. In addition, a framework with sample exploratory questions for each component is provided for clinical application.

Background

Attitudinal Barriers

Attitudinal barriers to pain management exist when personal beliefs hinder the adoption of behaviors that would result in adequate pain relief. Research into the complex experience of cancer pain increasingly is focused on beliefs and attitudes that directly influence pain management behaviors (Jensen et al., 1991; Paice et al., 1998; Riddell & Fitch, 1997; Turk & Rudy, 1992; Ward et al., 1993; Ward & Gatewood, 1994; Williams & Keefe, 1991). For example, patients may believe that they are strong and can tolerate the pain, can handle the pain without strong medicines, or just have to be careful not to move too much. The consequences of those beliefs might result in behaviors such as inadequately communicating pain to clinicians, taking less medication than is prescribed, or becoming unnecessarily sedentary. Patients' reluctance to report pain or to use pain medications is a major barrier to effective pain management.

In a study that assessed concerns about reporting pain and the use of pain medications, Ward et al. (1993) found that 37%–85% of patients had concerns related to pain. Patients who were older, were less educated, or had lower incomes were more likely to have concerns, and higher levels of concern were correlated with higher levels of pain. In a study of attitudinal barriers to effective pain management in 114 hospitalized patients with cancer, Yates et al. (2002) identified three factors that affected patients' responses to pain: (a) poor levels of knowledge about pain, (b) low perceived control over pain, and (c) reluctance to discuss pain with providers.

Anderson et al. (2002) interviewed 14 African American and 17 Hispanic patients regarding communications about the meaning and treatment of cancer pain. Both ethnic groups reported severe pain and had numerous concerns about pain management. Most expressed a belief in stoicism, concerns about possible addiction, and difficulties communicating with their physicians, including a reluctance to complain of pain.

Coaching

Coaching can be defined as a patient education method that guides and prompts patients to be active participants in behavior change (Wilkie, Williams, Grevstad, & Mekwa, 1995). Coaching directs patients through an activity in an effort to improve outcomes. This direction might include education, goal setting, encouragement, and support of activities to reach personal objectives (Bandura, 1997). Coaching has been used successfully to address attitudes and behaviors (Gortner et al., 1989; Rimer, Levey, Keintz, MacElwee, & Engstrom, 1987).

Several studies have used coaching as a strategy to help patients change behaviors potentially interfering with attainment of optimal pain relief. Wilkie et al. (1995) demonstrated that coaching patients with lung cancer to discuss their sensory pain decreased discrepancies between patient self-reports and their providers' assessment of the pain. In a large randomized clinical trial, Miaskowski et al. (2004) compared the effect of a psychoeducational intervention, including a nurse-coaching component, to standard care to improve cancer pain management. Patients in the intervention group demonstrated significant increases in cancer pain

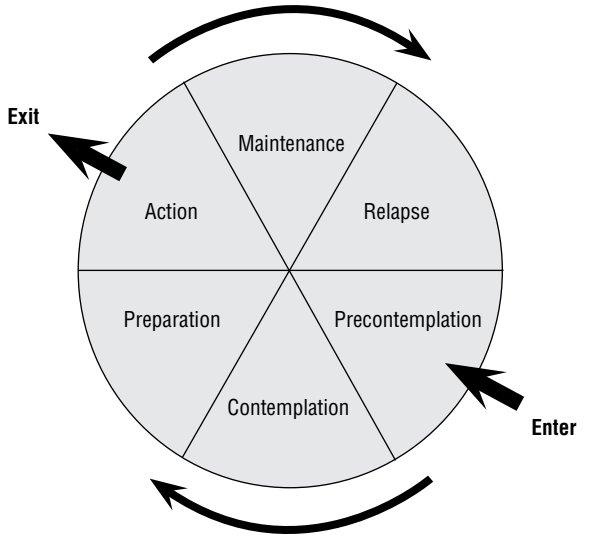

Figure 1. Transtheoretical Model About the Process of Behavioral Change

Note. From *Motivational Interviewing: Preparing People to Change* (p. 15), by W.R. Miller and S. Rollnick, 1991, New York: Guilford Press. Copyright 1991 by Guilford Press. Reprinted with permission.

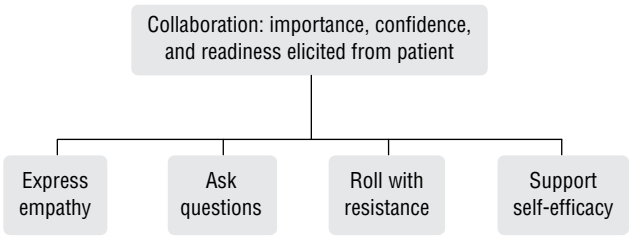

Figure 2. Motivational Interviewing Framework

Note. Based on information from Miller & Rollnick, 2002.

management knowledge and significant decreases in pain intensity scores; a higher percentage of the group demonstrated adherence to an appropriate analgesic prescription. In a randomized clinical trial of 189 ambulatory patients with cancer, Yates et al. (2002) evaluated the effectiveness of an educational intervention to help patients overcome attitudinal barriers and improve self-management of pain. The pain management intervention group demonstrated a significant increase in self-reported pain knowledge and perceived control over pain and a reduction in concerns about addiction, side effects, and being a "good" patient. Finally, Meyer and Mark (1995) used meta-analytic methods to evaluate the results of 45 published randomized ,controlled studies of psychological interventions, including coaching, with adult patients with cancer. They concluded that the brief psychosocial interventions had positive effects on emotional and functional adjustments, disease-related symptoms, and overall treatment outcomes.

Although findings from these studies support coaching as a useful intervention, a successful outcome is not achieved consistently in clinical practice. The remainder of this article describes a nurse coaching intervention that incorporates pain management education and support to patients with cancer pain and uses strategies of motivational interviewing. The use of motivational interviewing is directed by an understanding of Prochaska and DiClemente's (1984) Transtheoretical Model (TTM).

Implemented as part of a randomized clinical trial (Douglas & Thomas, 1999), the coaching intervention included the unique dimension of motivational interviewing to help patients explore personal beliefs and behaviors potentially interfering with adherence to effective pain management. When beliefs and behaviors were identified, discussions focused on identifying associated attitudinal barriers and strategies to overcome them.

Change Theory

An understanding of change theory is important to effectively coach people to explore beliefs, recognize attitudinal barriers, and pursue behavior change. Most human behavior theories and models describe behavior change as being influenced by two factors: the perceived importance of behavior change and self-efficacy (i.e., the belief in oneself that behavior change is possible) (Bandura, 1977, 1986, 1997; Jensen, Nielson, & Kerns, 2003). Prochaska and DiClemente's (1984) TTM describes and predicts behavior change as a function of a person's state of preparedness, readiness, or motivation to modify a behavior. As illustrated in Figure 1, the six stages of change-readiness in the TTM are (a) precontemplation (unaware of a need for change), (b) contemplation (thinking about change), (c) preparation (actively considering change), (d) action (engaged in behavior change efforts), (e) maintenance (maintaining already changed behavior), and (f) relapse (return to old behaviors).

According to the TTM, clinicians should recognize patients' particular stage of readiness and then intervene with a recommended set of approaches. Motivational interviewing (Miller & Rollnick, 1991) is a set of clinical skills designed to match patients' readiness to change and motivate them through the stages of the TTM. Therefore, an understanding of the TTM, an ability to recognize what stage patients are, and the timely deployment of stage-specific interventions will promote behavior change in the desired directions.

Motivational interviewing is a nonauthoritarian counseling approach originally designed for people with addictive behaviors to help them recognize and resolve ambivalence about making constructive behavior changes. The technique is now being used to increase recognition of problematic health behaviors and promote adoption of and adherence to adaptive health behaviors (Keefe et al., 2000; Kerns & Habib, 2004; Kerns, Rosenberg, Jamison, Caudill, & Haythornthwaite, 1997). Kerns et al. suggested that the TTM and the stages of change concepts might elucidate processes underlying adherence to pain self-management behaviors. Hence, the TTM and motivational interviewing may help explain as well as promote patients' adherence to pain management treatments.

As shown in Figure 2, motivational interviewing is based on three critical components of motivation: (a) importance or value of change, (b) confidence and self-efficacy, and (c) readiness to make a change. According to motivational interviewing principles, change is more likely to occur in the context of a collaborative relationship in which importance, confidence, and readiness are elicited from patients rather than through lecturing or giving advice, which minimizes patient autonomy. When clinicians adopt motivational interviewing principles, they express empathy, avoid arguments, "roll with" resistance, and support self-efficacy. When asking questions, clinicians elicit

1. **Greeting:** Initiate call by listening with empathy and outlining plan for coaching session.
2. **Current issue:** Consider and explore associated attitudinal barriers and listen. Promote patient's recognition of attitudinal barriers potentially interfering with adequate pain management.
3. **Problem:** Help patient describe and consider the nature and extent of problem that is interfering with better pain management, including associated attitudinal barriers.
4. **Problem impact:** Explore specifics about how the problem (and related beliefs and behaviors) is affecting the patient.
5. **Short-term goals:** Encourage identification of short-term goals and promote exploration of specific behaviors that might help the patient reach goals.
6. **Strategies:** List strategies and options for overcoming attitudinal barriers.
7. **Tasks:** Select tasks that will support the modification of attitudinal barriers, engage corrective actions, enhance self-confidence, and improve pain management.
8. **Summary:** Summarize the discussion and allow for questions and expression of opinions.

Figure 3. The Eight-Step Coaching Intervention

Table 1. Coaching Framework for Exploring Attitudinal Barriers to Adequate Cancer Pain Management

Coaching Intervention Step	Discussion Questions			
	Pain Beliefs	Communication	Medications	Nonpharmacologic Interventions
Current issue	Why do you think you have pain? What is causing your pain? What are your beliefs about the causes of your pain? Is anything preventing you from controlling your pain?	Do you choose not to discuss pain discomfort or forget to ask about it when at the clinic? What prevents you from talking with your physician or nurse?	Do you have concerns about your pain medications? Are you afraid of becoming addicted to your pain medications? Would you rather deal with pain than the side effects of your pain medications?	Do you think many options are available for treating cancer pain? Have you tried treatments other than medications for controlling pain? If not, what stops you from using or trying these methods?
Problem	If you learned what causes your pain, what might result? How would not knowing the causes of your pain be a problem for you?	What prevents you from talking with your physician or nurse? Do you know what questions to ask your physician or nurse? Is describing your pain difficult? Do you think your questions are important? What happens when you do not tell people how you are feeling?	How would being addicted to pain medication be a problem for you? What does addiction mean to you? What might happen if your pain medicine was prescribed as by the clock or only as needed?	What do you think might happen if you tried nonmedical strategies to reduce pain? Would using any of these strategies be a problem for you?
Problem impact	How would understanding the causes of your pain affect the level of your pain, your ability to function, and your quality of life? What are the best and worst possible outcomes?	How would more effective communication influence the level of your pain, your ability to function, and your quality of life? What are the best and worst possible outcomes?	How would using pain medication affect the level of your pain, your ability to function, and your quality of life? What are the best and worst possible outcomes?	How would using or not using nonmedical strategies affect the level of your pain? What are the best and worst possible outcomes?
Short-term goals	What would change in your life if the causes of your pain were identified and your pain was managed more effectively? What changes or short-term goals do you want to address? How would you know if a change was successful or if you reached your goal?	Do you think your pain will be controlled more effectively if you are able to communicate openly with the medical team? What would change in your life? What changes or short-term goals do you want to address? How would you know if the change was successful or if you reached your goal?	If your pain was controlled more effectively with medication, what would change in your life? What changes or short-term goals do you want to address? How would you know if the change was successful or if you reached your goal?	If your pain was controlled more effectively with nonmedication strategies, what would change in your life? What changes or short-term goals do you want to address? How would you know if the change was successful or if you reached your goal?
Strategies and tasks	What option for controlling pain are you most likely to use? How will this option help you better control pain, increase functioning, and improve the quality of your life?	What option for controlling pain are you most likely to use? How will this option help you better control pain, increase functioning, and improve the quality of your life?	What option for controlling pain are you most likely to use? How will this option help you better control pain, increase functioning, and improve the quality of your life?	What option for controlling pain are you most likely to use? How will this option help you better control pain, increase functioning, and improve the quality of your life?

statements from patients concerning discrepancies between their current behavior and desired goals by evoking reasons to change and exploring the risks associated with not changing behaviors. Attitudinal barriers often are identified in the process of the discussion. As soon as patients recognize attitudinal barriers as relevant, clinicians can encourage and support patients to address barriers and develop alternative, more effective behaviors.

The Coaching Intervention

The coaching intervention was conducted via telephone. Patients with cancer pain were encouraged to share their understandings, concerns, and fears about their pain and pain treatment plan. The telephone discussions often revealed beliefs and attitudes that interfered with effective pain management behaviors. The interventionist incorporated motivational interviewing strategies into the coaching intervention directed at exploring the effect of the beliefs and attitudes on behaviors. The goal of the coaching intervention was to promote adoption of more appropriate pain management behaviors and achieve optimal pain relief. The coaching intervention was used in a randomized clinical trial that evaluated the effectiveness of education, with or without individualized, telephone-mediated coaching, on pain management, functional status, and quality of life (Douglas & Thomas, 1999).

Each patient received four calls over a period of six weeks. Prior to the calls, patients were asked to complete a packet of questionnaires and view a 15-minute video titled "Relieving Cancer Pain" (Syrjala, Abrums, DuPen, Niles, & Rupert, 1995). In addition, each subject received a pamphlet titled "Management of Cancer Pain" (Jacox et al., 1994b).

Ninety-two outpatients with pain related to cancer or its treatment and a minimum six-month life expectancy received the coaching intervention. An advanced practice oncology nurse (the interventionist) with expertise in cancer pain management was trained in TTM and motivational interviewing. The psychologist who designed the coaching intervention also conducted the interventionist's training through supervision, practice, review of calls, and feedback. In addition, consultation with the psychologist was available to address any challenging and urgent clinical issues. Each coaching call was directed by an eight-step framework (see Figure 3). A documentation tool specifically designed for the intervention was used to record discussions of relevant themes, beliefs, and behaviors.

Prior to the first telephone call, the interventionist reviewed relevant information from the patient's disease and treatment profile and responses to pretest questions on pain beliefs and attitudes. This information provided the interventionist with data on existing attitudinal barriers and helped provide direction for the first call. The specific questionnaires used in the study that provided this information were the BPI (Cleeland & Ryan, 1994) and the BQ (Ward et al., 1993; Ward & Gatewood, 1994). The BPI is a 16-item self-report instrument that is brief, easy to complete, and designed to assess pain and its impact, including severity, quality, and interference in a person's life. The BQ is 27-item self-report instrument designed to measure eight barriers to cancer pain management, including concerns about medication side effects and tolerance, fear of injections, addiction, disease progression, fatalism, desires to be a good patient, and worries about distracting physicians from curing disease (Ward et al., 1993).

Four specific topics were targeted during the series of four coaching calls. Discussions were directed at exploring understandings of and beliefs about pain and pain management, communication with healthcare providers, medications, and nonpharmacologic pain management interventions. Scripts were developed using the eight-step coaching framework for each topic area and were used by the interventionist during each of the calls. Table 1 outlines some of the questions used to cover each topic. Considering the patients' level of readiness, choice and flexibility were offered in selecting the topic for discussion during the coaching session. Sometimes multiple topics were of concern for patients. In those cases, patients were encouraged to prioritize the most urgent topic.

As attitudinal barriers and associated ineffective pain management behaviors became evident, the interventionist considered where patients might be within the context of the TTM and explored how ready they might be to make behavior change. Motivational interviewing strategies were chosen to explore and encourage modification of the attitudinal barrier(s) and motivate and enhance self-confidence aimed at promoting behavior changes. Table 2 outlines Miller and Rollnick's (1991) suggested strategies based on assessed stages of change.

Finally, the interventionist encouraged patients to select the specific strategies or tasks aimed at adopting effective pain management behaviors. Subsequent calls began with follow-up on adherence to and the effectiveness of the selected strategy, reinforcement of successful outcomes, and exploration of new strategies. Examples of behaviors suggested were reflecting throughout the week on attitudinal barriers and associated behaviors and how those behaviors affected pain management, locating and reading the Agency for Healthcare Research and Quality pain management pamphlet, keeping a list of questions to be addressed at the next healthcare visit, role playing more effective communication behaviors with clinicians, contacting the physician before the next scheduled appointment with questions or concerns, taking medication as recommended, recognizing and reporting side effects, learning strategies to prevent or treat side effects, and learning about and using nonpharmacologic pain management strategies. Table 3 provides clinical examples of coaching interventions for each of the four topics discussed.

Discussion

The coaching intervention incorporated the techniques of motivational interviewing and represents a novel approach that oncology nurses can use to address attitudinal barriers and motivate patients to employ more effective pain management behaviors. The telephone-mediated coaching intervention encouraged and allowed patients to explore issues, raise and clarify questions, and identify attitudinal barriers that interfered with optimal pain management. The coaching intervention is unique in that it disseminated pain management information and advice and involved nurses' active participation with patients to promote confidence and guide patients in recognizing and addressing attitudinal barriers to implement more effective pain management behaviors.

The use of a telephone-based intervention has several advantages. First, the calls are practical for patients whose physical restrictions or lack of resources impede their access to an office-based intervention. In addition, the phone calls offer privacy that may facilitate the sharing of in-depth information and enhance

Table 2. Stages of Change and Related Motivational Tasks

Client Stage	Provider's Motivational Task
Precontemplation	Raise doubt: Increase the client's perception of risks and problems with current behavior.
Contemplation	Tip the balance: Evoke reasons to change, risks of not changing. Strengthen the client's self-efficacy for the change of current behavior.
Preparation	Help the client to determine the best course of action to take in seeking change and preparing for it.
Action	Help the client to take steps toward change.
Maintenance	Help the client stabilize behavior change and avoid relapse.
Relapse	Help the client to renew the processes of contemplation, determination, and action without becoming stuck or demoralized because of relapse.

Note. From *Motivational Interviewing: Preparing People to Change* (p. 18), by W.R. Miller and S. Rollnick, 1991, New York: Guilford Press. Copyright 1991 by Guilford Press. Reprinted with permission.

Table 3. Clinical Examples of Coaching Interventions

Belief	Stage of Change	Patient Concern	Attitudinal Barrier	Coaching Intervention	Outcomes
Pain	Contemplation	"When all the pain goes away, I'm afraid I'll do too much and wake up sore."	The patient believed that pain must be tolerated to avoid overextension and further injury.	The interventionalist guided the patient to see the discrepancies between his desire to engage in mobile activities (e.g., walking to church and the local store, throwing a ball to his dog) and his sedentary behavior. She examined the effect that excessive resting and protecting behaviors have on his mobility and pain levels and encouraged the patient to speak with a provider about pain and its effect on activity level. The patient's belief of further injury with movement was addressed by discussing pathophysiology of bony metastatic disease. The interventionalist encouraged the patient to increase exercise slowly, emphasizing that muscle soreness is a normal result of increasing daily exercise and that increased muscle strength would provide better bone support.	By the third telephone coaching session, the patient had spoken with a provider and gradually increased his activity level. He said, "Since I've talked to you I have walked to church [which he had not done for 10 months], and I walked around the store pushing a cart. I am increasing my pain to decrease my pain. I am careful, but I still do things." The patient expressed a shift in attitude, no longer believing that pain was the primary monitor of activity tolerance because intervention helped him move and gain physical strength. He expressed an interest in learning more about a transcutaneous electrical nerve stimulator, biofeedback, and other resources to enhance pain management and function.
Communication	Precontemplation	"Who wants to help a dead person . . . a person with cancer. My wife died fast from cancer years ago."	The patient believed that communicating problems and needs to providers was unnecessary.	The interventionalist discussed risks and benefits of the patient communicating with providers, family, and friends. She asked how the patient would feel if the roles were reversed and encouraged him to review Agency for Health Care Policy and Research (AHCPR) guidelines, especially regarding the role of communications with providers about medications and nonpharmacologic options. Reviewed risks and benefits of patient involvement in treatment decision making included when to start the next round of chemotherapy. The interventionalist also discussed the risks and benefits of emotion-focused communication and support from behavioral medicine psychologists. The patient had met and liked one psychologist in particular but had not had a formal conversation with him.	By the second telephone coaching session, the patient had communicated postchemotherapy difficulties with providers, who recommended a short delay before the next cycle. The delay allowed the patient to feel better and accomplish "simple things" like going to the post office. He prepared for the next round of chemotherapy by discussing pain medications with providers and arranging support from friends. In addition, he began to speak with a behavioral medicine psychologist and worked on stress management, guided imagery, and end-of-life palliative care planning. The patient conveyed surprise and satisfaction from the support received from communications with friends and healthcare providers. "I realize the benefit of talking to people. It matters to have a dialogue," he said. His new perspective illustrated an attitudinal shift in beliefs about the benefits of talking with others.
Medications	Preparation	"I don't want to get hooked on that heavy stuff; morphine is just one step away from heroin."	The patient was fearful of opiate analgesics and believed that narcotics were responsible for his confusion, addiction problems, and overall ineffective pain control.	The interventionalist explored the experience of the death of the patient's spouse from cancer and related subsequent attitudes and fears, particularly concerns about addictions to pain management medications. She discussed differences among tolerance, dependence, psychological addiction, and pseudoaddiction and referred to specific areas of AHCPR guidelines. In addition, the interventionalist discussed the benefit of effective pain management from a prescribed pharmacologic regimen on improved, increased, and maintained functioning.	By the completion of the telephone coaching sessions, the patient described considerably less fear about addiction and mortality. He began and routinely adhered with pain medications and a regimen schedule. The patient reported increased activities such as walking and other activities of daily living as a result of attitudinal shift and medication adherence.
Nonpharmacologic interventions	Precontemplation	"I don't want it if it doesn't help my medical problem. Talking about my pain is not going to help my pain."	The patient believed that nonpharmacologic interventions would not directly treat cancer and was not willing to accept them for that reason.	The interventionalist introduced potential benefits of counseling and exploring information regarding additional treatment options while allowing the patient to disclose anger, bitterness, and disappointment about the current situation. She discussed with the patient perceptions of the advantages and disadvantages in written materials, AHCPR guidelines, and related articles about counseling and supportive interventions available for patients coping with cancer and pain. In addition, she supported the patient's strengths of intelligence, expressiveness, and efficacy, which led to admittance of satisfaction, received just from being able to talk over the phone.	By the end of the telephone coaching intervention, the patient expressed appreciation for the calls and conveyed an attitudinal shift regarding the value and benefit of sharing and seeking support. In addition, the patient had started to see a behavioral medicine psychologist and disclosed information about stress management and pain control strategies he was learning.

the patients' comfort in disclosing and discussing beliefs, attitudes, and concerns. Not having face-to-face contact may reduce perceived vulnerability and allow for a sense of safety. Communicating with patients while they are in the comfort of home also may enhance their ability to share thoughts and beliefs.

The coaching intervention by phone is not without its share of challenges and problems. Some patients will be difficult to reach by phone, will forget scheduled calls, will not have an answering machine, or will not receive messages left for them. Also, a telephone call does not permit direct observation of nonverbal cues and physical gestures that might guide the interventionist. Finally, telephone coaching may be cost effective in some settings and not in others, depending on reimbursement practices and time constraints.

Several components are crucial to the successful implementation of a coaching intervention that incorporates motivational interviewing. One key component is the need to train the interventionist in the core principles and skills of motivational interviewing. Although many of the principles and skills may appear straightforward and logical in theory, the clinical application can be challenging because of a primary paradigm shift in how a provider approaches a patient. Instead of just delivering recommendations and advice directly following an evaluation as is typically done in most healthcare settings, providers must work to help patients recognize relevant issues and encourage self-efficacy in dealing with identified problems. Another critical component is an understanding of the level of patient engagement. Engagement can be defined within the context of the TTM as a level of readiness to change (Miller & Rollnick, 1991; Prochaska & DiClemente, 1984; Prochaska, DiClemente, & Norcross, 1992). By appraising patients' stages of readiness, clinicians are guided in selecting an intervention most likely to be effective. Equally important is an understanding of counseling skills, such as active listening, repeating, rephrasing, reflecting, and assertive communications. These skills help ensure that the needs and concerns of patients are best understood and offer providers an opportunity to express concern in a sensitive, nonconfrontational, and direct manner. Counseling skills assist providers in recognizing patients' readiness to make changes in the desired direction. For example, is the patient engaged in the intervention process as indicated by being actively involved with the coaching calls? Is the patient ambivalence about using recommendations? Has the patient demonstrated an interest or motivation to make changes?

Implications for Practice and Research

A comprehensive assessment of cancer pain and its management should routinely include the evaluation of attitudinal barriers and associated behaviors that may affect the use of effective pain management strategies. For example, providers might ask, What is your understanding of why you have this pain? What does the pain mean to you? Do you have any thoughts about the medications being prescribed? Do you have any concerns about addiction? What does addiction mean to you? Are you comfortable asking questions or speaking up if you disagreed with something I or your other healthcare providers say? Will you call me before your next visit if you have any questions or concerns? What would you think about using psychological strategies to manage your physical pain? Information elicited from these questions may direct providers to adjust treatment plans that enhance adherence and improve overall outcomes.

Implications for clinical practice suggest that providers (a) inquire about beliefs and attitudes, (b) help the patients recognize discrepancies and problem solve toward resolution, (c) encourage patients to explore obstacles preventing them from reaching goals, (d) routinely assess patients' level of readiness and suggest stage-appropriate tasks, (e) help patients determine priorities and set agendas accordingly, (f) establish a concrete task and be sure to follow up, (g) take time for communication, especially by listening to what is said, and, perhaps most important, (h) ask, do not just tell.

Author Contact: Kathleen F. Fahey, RN, MS, CNS, can be reached at kathleen_fahey@sbcglobal.net, with copy to editor at ONFEditor@ons.org.

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