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Session: Health Coaching for Veterans with Complex Chronic Pain

Presenter: Lisa McAndrew, PhD, Nicole Sullivan, PhD

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Heidi: I just want to introduce our presenters for today. Our first presenter is Dr. Lisa McAndrew. Dr. McAndrew is a clinical health psychologist and the lead researcher in the Behavioral Health Research Laboratory with the War Related Illness and Injury Study Center at the VA New Jersey healthcare system. And she is joined by Dr. Nicole Sullivan. Dr. Sullivan is a clinical psychologist in the Behavioral Health Research Lab at the War Related Illness and Injury Study Center at the VA New Jersey healthcare system. And with that Dr. McAndrew, I am going to turn things over to you.

Dr. Lisa McAndrew: Okay, well thank you for that very nice introduction. Today we're going to be talking about health coaching for complex chronic pain. The normal disclaimer, the views are myself and Dr. Sullivan’s and not the U.S. Government’s. We also want to acknowledge and thank the generous support from the VA’s office of research and development that has allowed this work to happen.

So today we're going to be talking to you about chronic pain and chronic multisymptom illness. We're going to talk to you about the development of our health coaching for chronic multisymptom illness treatment. We are going to give you the results of a pilot study of our health coaching for Veterans with chronic pain. And we are going to talk to you about the next steps in this series of work.

So chronic pain is the largest source of long-term disability in the U.S. And pain predominant chronic multisymptom illness, or pain CMI, is particularly disabling.

Pain predominant CMI is characterized by widespread and poorly understood chronic pain with additional symptoms such as fatigue, and cognitive impairment. Examples of chronic multisymptom illness include fibromyalgia, Gulf War Illness, chronic fatigue syndrome. Well fibromyalgia is a specific example a pain predominant multisymptom illness. Pain predominant chronic multisymptom illness is disabling. Our research has found at 91% of Veterans with pain CMI have had to limit social activities. And 71% say they have to cut down on work or meaningful activities. This makes it difficult for them to perform social roles and daily activities. For example, complete their work task—which is the World Health Organization's definition of disability.

The VA has an obligation to help Veterans with pain predominant CMI. CMI including pain predominant CMI, is a presumptive illness for the more than 6 million military personnel who deployed to the Gulf from 1990 to 2021. We and others have found that about 30% of military personnel who deployed to the Gulf have CMI. And more than 80% of Veterans with CMI have chronic pain. The National Academy of Medicine has written 11 volumes on CMI among Veterans and has repeatedly tasked the VA to improve the treatment of CMI and pain predominant CMI.

Pain predominant CMI causes disagreement between Veterans and providers. So at the population level there's a growing acceptance that pain predominant CMI is caused by a complex interaction of genetic vulnerability and environmental triggers. For example, of combat exposure. And maintained by factors such as catastrophizing, or perceived pain control and limiting activity. However at the individual level there’s still significant disagreement between the Veteran and provider about which environmental triggers cause CMI. For example, was it exposure or a psychological stressor. And frustration that treatments focus on the maintaining factors such as catastrophizing, ignoring the patients’ causal belief, and treatment goals. We find that only 28% of Veterans agree with their provider about their CMI. And this disagreement leads to dissatisfaction. With only 20% of Veterans with CMI being highly satisfied with their care. In our qualitative research we find that Veterans with pain predominant CMI disagreement with their provider is often their most significant healthcare concern. The classic example of this is the Veteran focused on deployment as the cause and the provider focused on psychological contributors such as PTSD leaving the Veteran to feel that the provider is saying it is all in their head.

Current evidence-based nonpharmacological approaches for pain predominant CMI are recommended as the first line approach. But do not explicitly address the disagreement between the Veteran and provider. Instead they often focus on addressing the factors being maintained by pain CMI. For example a Veteran may be taught mindfulness or graded exercise and to restructure their cognitions. Nonpharmacological approaches are recommended as the first line approach by the VA DoD clinical practice guidelines, the European League Against Rheumatism guidelines and the Canadian guidelines. And there is strong evidence that cognitive behavioral therapy has a small to moderate effect with 42% of patients with fibromyalgia experiencing a clinically significant improvement in quality of life. There's also strong evidence for physical activity and initial support for emerging treatments including mindfulness and yoga.

While nonpharmacological approaches can work, no single treatment is or is likely to be acceptable, available, and efficacious for all patients with pain predominant CMI. Fortunately research also supports that offering multiple nonpharmacological approaches increases uptake. One gap is that existing nonpharmacological approaches are pre-prescriptive. They explicitly target the factors maintaining pain CMI. For example mindfulness to reduce catastrophizing. You’re respective of the patient’s beliefs or goals for treatments. This can feel invalidating for some Veterans and make it hard to engage some Veterans.

So I'm going to turn over to Dr. Sullivan now.

Sorry, I have to move the ball.

Dr. Nicole Sullivan: Great. All right, thank you, Dr. McAndrew. So we believe that health coaching is one promising approach. And health coaching differs from other behavioral treatment in that the intervention is based on the patients’ own beliefs and goals.

So if we apply health coaching to Veterans with pain predominant CMI it would be important for the health coach to accept the patients’ beliefs about the cause of their symptoms. For example, the Veteran may perceive their symptoms were caused by a vaccine. The health coach could agree that exposures are related to pain predominant CMI and are a common concern for Veterans. And that chronic inflammation is a common final pathway from exposure to the development of pain predominant CMI. The health coach and the Veteran can then turn their attention to developing a treatment plan that's based on the Veterans belief. And to develop this plan is a collaborative approach. The health coach would help the Veteran identify discrepancies between where the Veteran is in his or her life right now and where they would like to be. So for example the Veteran may want to improve their relationship with their daughter, or improve their sleep, or eat healthier. And any of these would be a valid goal for the intervention. The health coach helps the Veteran connect these goals to their shared understanding of pain predominant CMI. And then use a certain skill like motivational interviewing, goal setting, and problem solving to help the Veteran reach their goals.

So while health coaching is focused on targeting specific lifestyle changes and targeting specific Veteran's goals, it may indirectly improve factors that maintain pain prominent CMI or disability of pain predominant CMI. Specifically [inaudible 0:10:09] catastrophizing, activity level and pain control, as Dr. McAndrew mentioned earlier. For example as patients reached their goals such as spending more time with their children, they might increase their activity level and this might help them feel more in control over the pain and lower catastrophic thinking and stop a negative feedback loop that enforces disability.

And what's really great about health coaching is that it is acceptable and available. So in terms of acceptability, because health coaching is based on Veterans’ belief and goals, it addresses what expert clinicians and patients agree is a critical predictor of low satisfaction and adherence. Which is the disagreement between the patient and the provider about pain predominant CMI as Dr. McAndrew was speaking about. Health coaching uses the Veterans beliefs about their symptoms as equally important as those of the provider, which addresses those barriers to care. Health coaching also focuses on the Veterans’ goals for treatment. So rather than trying to convince the Veteran to spend significant time making behavioral changes that they're not motivated to make to really focus on the Veterans’ goals as treatment. Now in addition to acceptability, health coaching is particularly appealing because the VA Office of Patient-Centered Care and Cultural Transformation is working to provide one week on health coaching at every VA Medical Center. So the VA will soon have a workforce who knows the principles of health coaching and could be taught how to apply it to the pain predominant CMI. [Inaudible 0:11:57] access to care for the [inaudible 0:11:58] population. Additionally the VA's National CMI Center for War Related Illness and Injury Study Center is especially interested in determining the efficacy of health coaching especially for Veterans with pain predominant CMI and developing national education efforts. Now what is not known is if health coaching is efficacious for pain predominant CMI. But VA evidence-based synthesis found health coaching has the potential to produce small effects. But it didn't find any clinical trial studies conducted within the VA, or with patients with pain or pain predominant CMI. And we are aware of only one pilot study where a health coach has provided about 24 sessions to [inaudible 0:12:47] patients with fibromyalgia. And in that study patients did show clinically significant improvements in health-related quality of life, pain interference, and pain severity.

So our interest in health coaching began with the observation that Veterans with pain predominant CMI find health coaching acceptable. The War Related Illness and Injury Study Center in New Jersey integrates a one session health coaching intervention within their clinical evaluations. And we found that 95% of Veterans with pain CMI are satisfied with this health coaching. Given that there are such high satisfaction with health coaching, we wondered if health coaching could also reduce the disability of pain predominant CMI. And so in response, we collaborated with WRIISC clinical leaders and created a health coaching approach that’s specifically for this population.

Now I think what's really interesting about the development of this research is that it took a reverse engineering approach. So typically we would conduct research and if we had significant funding, we would try to translate that research into clinical practice. But we started with a clinical observation, that Veterans with pain predominant CMI are satisfied with health coaching. And so we worked with providers and leaders in the field to develop an intervention that was specific to Veterans with pain predominant CMI. And then we tested out that intervention in that pilot study.

And so what I would like to do is give you some information about what exactly that intervention looked like. So our intervention was a 12-session weekly intervention delivered via telephone. And the goal of the intervention was to educate Veterans on how their lifestyle can affect the physical health and pain predominant CMI symptoms, and then help them start implementing some health behavior changes.

The intervention has four main components. I'm going to go into more detail into each of these in the next few slides. One of the components are validation and concordance. Where a shared understanding of pain predominant CMI, like in the very start of the intervention the health coach is validating the Veterans’ experience [inaudible 0:15:30] developing that to your understanding of what’s causing those symptoms. And the second component is education. The first half of the intervention is focused on providing education on the different ways that Veterans can make changes to their lives to help them improve their health. So for example making dietary changes or changes to physical activity. And then the third component is behavioral change. And this is really a huge part of the intervention. We encourage Veterans to set goals and make behavioral change. And we teach different behavioral change techniques throughout the intervention. Really the last half of the intervention is focused on behavioral change. And then the fourth component is that this intervention is Veteran-centered. So Veterans set their own goals and they’re in control of what changes they would like to make in their lives.

So from the very beginning, the Veterans start by discussing their symptoms in the very first session. They talk about the impact of their symptoms on their lives. And they talk about their beliefs about pain predominant CMI. And the health coach validates the Veteran's experience by accepting that the Veterans’ symptoms are real, they accept that the symptoms are serious, and they accept that they could be caused by environmental triggers or exposures. And then the health coach works to develop a shared understanding with the Veteran about how environmental triggers as well as other factors can cause chronic inflammation, which can be a final halfway to pain predominant CMI. And the health coach then explains how the Veteran can start to regulate chronic inflammation by making changes to certain environmental factors like diet, and exercise, and sleep. And this is really an important part of the treatment because it's the underlying rationale of the treatment. So the shared understanding of the role that chronic inflammation [inaudible 0:17:36] CMI can help create buy-in for the treatment.

Now the first half of the treatment focuses on providing Veterans with education on the relationship between lifestyle, chronic inflammation, and chronic pain. And we focus on five specific lifestyle areas that map onto the whole health field. So we focus on diet, exercise, sleep, stress management, and social relationships. For diet focus specifically on the Mediterranean diet which is an anti-inflammatory diet and we provide information on what foods to eat, which ones to avoid, and also provide information on serving sizes. For exercise the education is focused on developing a graded exercise plan that incorporates low impact exercises and we also incorporate education on pacing and avoiding that push-crash cycle. For sleep we talk a lot about sleep hygiene as well as control. And for stress management we teach Veterans different relaxation techniques within the session itself. Like diaphragmatic breathing and progressive muscle relaxation. For social relationships we provide education on the research that shows social relationships are connected to physical health.

So about the intervention, we introduced Veterans to behavior change principles. Now the primary ones that we focus on are listed here. So we focus on SMART goal setting. We also focus on habit formation techniques such as pairing the goal behavior with the behavior that’s already done on a routine basis every day. We teach Veterans how to monitor their behaviors specific we teach them how to [inaudible 0:19:33] as well as behavior logs to track their goals. And we also teach problem-solving for goals. So we help Veterans identify obstacles that are getting in the way of their goals and these are both external obstacles like lack of time and internal obstacles like negative thoughts or emotions. And then we teach them how to brainstorm different solutions and come up with a plan for overcoming those obstacles. And Veterans practice these different behavior changes throughout the intervention by setting goals every week and making small changes to each lifestyle area. And then during the last half of the treatment Veterans home in on the two lifestyle behaviors that they most want to change. Then during the last session Veterans develop a long-term plan to maintain behavioral changes after the 12-week program and they identified the skills that they could utilize moving forward.

So we try to make this intervention Veteran centered and personalized in a number of different ways. During the first session and really throughout the intervention he asked the Veterans just spend some time thinking about their motivations for change. And during that first session we have the Veteran fill out the personal health inventory. And those that are familiar the personal health inventory helps the Veteran identify discrepancies between where they are now and where they want to be in different lifestyle areas and we focused on those five lifestyle areas of diet, physical activity, [inaudible 0:21:06], sleep and social relationships. And so the Veterans are the ones identifying the areas where they’re in the most need of change. And then each week the Veteran [inaudible 0:21:17] what changes to make or doesn’t make. So they set their own goals. I know I have been emphasizing this a lot, but I think it's a really important piece of the intervention because although we are providing education and guidance this intervention is really driven by the Veterans’ own values and goals. And I should mention I think I forgot to mention this earlier but this whole intervention was based on the WRIISC’s health education materials as well as the VA whole health program. So we drew a lot from those two sources. So now I will hand it back over to Dr. McAndrew.

Dr. Lisa McAndrew: Okay, thank you, Dr. Sullivan. So after we worked with WRIISC clinical leaders to develop this treatment and we piloted it clinically with three Veterans we did a small clinical pilot, clinical trial to see if we could understand the acceptability of this health coaching intervention and if we could start to estimate the affect size of telephone based health coaching for Veterans with complex chronic pain. So our primary aim was to determine acceptability of telephone health coaching. And we hypothesized that Veterans randomized to this telephone health coaching would report greater satisfaction as compared to those randomized to usual care. We also hypothesized that at least 85% of Veterans that randomized to health coaching would attend nine or more sessions. And lastly, we hypothesized that Veterans randomized to health coaching would have greater reductions in pain and disability as compared to Veterans randomized to usual care. And because this was a clinical pilot, we weren't looking for statistically significant differences we were looking to estimate the effect size.

So this was a small clinical pilot. It was a randomized control design. Veterans with chronic pain were randomized to either health coaching delivered over the telephone with 12 sessions as Dr. Sullivan described, or to usual care. And then we followed up with them at 12 weeks.

Our inclusion criteria is that the Veterans had to have a VA primary care provider. And that's because this was an initial clinical pilot and we wanted to make sure that they were connected into care if there are any problems that came up. They had to have pain that was musculoskeletal, so either regional pain in their joints, limbs, back, neck, or more generalized—so fibromyalgia or chronic widespread pain. And they had to have it be moderately severe and persist for greater than three months. We excluded Veterans with severe physical conditions or psychiatric conditions that may limit the generalizability or indicate the study may not be safe for them, or Veterans with suicidal plan or intent.

Our intervention was the 12-session weekly intervention delivered by telephone. The sessions lasted for about an hour each week and the goal of the intervention was to educate Veterans on how their lifestyle can affect their physical health and pain symptoms. And help them start implementing some health behavior change. The intervention was largely based on the VA's whole health material and was infused with motivational interviewing techniques, behavioral change techniques, to increase Veterans motivation and confidence in their ability to achieve their goals.

Our usual care-control arm Veterans did not receive any additional treatment from study providers. They were allowed to continue with their existing care and make changes, as necessary.

So our primary measures that we were interested in seeing change in was that brief pain inventory. So the pain severity and the interference measures and the World Health Organization Disability Assessment Schedule which captures the World Health Organization's definition of disability which is impairment in social roles and daily activities. And it has six domains including cognition, mobility, self-care, getting along, life activities, and participation. And this scale is summed to one overall measure disability.

So for this pilot we screened 53 Veterans. We randomized 40 Veterans into the treatment and 33 Veterans were outcome completers. Although we had a very wide inclusion in terms of chronic pain most of the Veterans who were randomized into this study met criteria for chronic multisymptom illness. And this is really a function of where we did the study. We did this at the War Related Illness and Injury Study Center which commonly works with Veterans with chronic multisymptom illness. So that's the population that were attracted to this study.

So the mean age at baseline of the Veterans who participated was 53, 90% were male, 38% were employed full-time, 55% were White, 30% were Black or African-American, and 13% were Hispanic. So this is a little bit more diverse in terms of racial and ethnic background than you might see at other sites and this is because it was done in New Jersey which has a very diverse population of Veterans.

So acceptability, we were hoping to find that 85% of the Veterans randomized to health coaching would complete more than eight, so at least nine sessions of the health coaching intervention. And we found about 82% completed eight or more sessions and almost 70% completed all 12 sessions. A little bit less than we were hypothesizing, but still close to what we hypothesized would complete all the sessions. We only had two Veterans who started the treatment who didn't finish, and we have two Veterans who dropped out before they started the treatment.

So in terms of satisfaction, we had hypothesized that Veterans in the health coaching intervention would be more satisfied with their care overall than Veterans who were in the usual care. And we actually did not find that. So we found that there were several similar levels of satisfaction for Veterans randomized to health coaching and Veterans randomized to usual care. In fact satisfaction rates were very high in both arms. So Veterans reported at follow up that they were satisfied with their care irrespective of which arm they were randomized to.

So then we looked at estimates of effect size for changes in our outcome measures. And so the effect size we looked at was Cohen's d, comparing pre- and post- in between the two arms. So our effect size in terms of pain interference was a Cohen's d of point 75 which is a large effect. And what we see is that the health coaching arm had reductions in pain interference and usual care stayed around the same at the baseline level.

So this was our estimate of effect size in change in disability. So again we found that those in health coaching had a reduction in disability, while those in the usual care had a slight increase in disability levels. And the overall effect size comparing the change in disability between the two arms was a Cohen's d of 1.04 which again is a large affect size.

So we also looked at some secondary outcomes to see if we could start to understand the effect size. And again, because this is a pilot the goal is not to say with certainty that this is the effect size, but what we wanted to see is at least some indication that we were moving these things in the right direction to start to understand if it was worth pursuing further. So we found for secondary outcomes that we reduced pain catastrophizing in our health coaching arm. Where our usual care arm stayed around their baseline level. And again that's a large effect size for reduction in pain catastrophizing. We also looked at sedentary behavior activity and we got quite an unexpected result here. What we found is that we actually increased sedentary behavior in our health coaching arm and decreased it in the usual care arm or the usual care arm decreased. Typically sedentary activity if you're thinking of something like obesity is something you want to decrease, right? You want to decrease people sitting at their computers all day—so many of us are doing that especially with COVID sitting at our computers all day, and not getting up. And you want to increase the amount we’re getting up and moving around. And so we had anticipated that would be reducing sedentary activity, but we found we increased it. And when we looked at the items, I think what we're seeing here is that this population was so sedentary, right? Most were not working, many of them had very, very few to no activities in their life. And what we see is that they increased things like listening to music or talking on the phone with a friend or playing a game on their computer. So even though this is still sedentary behavior, I think what we found is that the health coaching helped them add in things into their life activities that were meaningful to them even though they were still sedentary. We did not change sleep we, did not find it affected sleep, so both arms are right around their baseline levels of sleep with no difference. And I don't have it on this, but we actually also didn't change their healthy eating according our measure of healthy eating. And we see a small indication that maybe we are having reductions in pain. The effect size was point 50 which can be large, but this is not really reaching what's considered clinically significant change in pain. So that would be something we would need to certainly look at more in future studies.

This slide is not coming up, but in conclusion what we found is that in our pilot is that our health coaching was fairly acceptable to Veterans. It wasn't as acceptable as we anticipated. We thought we would really be seeing that this was beloved by the Veterans, and our indicators that we a priori hypothesized we're okay. We had 83% completing what we had a priori estimated they would complete in terms of treatment sessions. And their satisfaction at least wasn't lower than usual care. So there was some indication that it was acceptable to the Veterans, although not as acceptable as we had originally hypothesized. But I will say we didn't have this as the primary aim of this study, but one thing we have found is that this clinical trial and the follow-up which Dr. Sullivan will tell you a little bit about have probably the most easily studies that we have ever recruited for. So Veterans are very eager to participate in this and want to receive it. And so we are able to recruit a lot of Veterans into this study. There is evidence, this preliminary study showed evidence that we are improving or may be improving pain impairment and disability, which is what we hypothesized we would improve. It seems to be the mechanism; it is suggested that through things like reducing pain catastrophizing and maybe a changing activity levels more than necessarily changing sleep and healthy eating. So in helping them achieve their goals we seem to be possibly impacting these psychological mechanisms. So this pilot study suggests that this may be efficacious. But that it is deserving of future study. And I'm going to again turn it over to Dr. Sullivan who is going to tell you about our next steps for this.

Dr. Nicole Sullivan: Great, thank you, Dr. McAndrew. Okay. So in terms of the next steps we are actually already up and running with a much larger clinical trial that is funded by the Office of VA Rehabilitation Research and Development. And this larger clinical trial is comparing health coaching to and intentional control supportive arm. And we have an anticipated sample size of 250 Veterans. And as Dr. McAndrew mentioned we are seeing that this is a very popular clinical trial and we are exceeding our enrollment goals which is very exciting. And the intervention itself is very similar to what I presented here today. The only difference is that in this larger trial, we are using video to home technology rather than administering the intervention via telephone. And our hope is that with a larger trial we can determine the efficacy of remote delivered health coaching in reducing disability and pain impairment for Veterans with pain predominant CMI. And we also hope with this larger sample size that we can more fully explore these mechanisms of change. Specifically catastrophizing, activity level, and pain control. And we can really test whether these mechanisms of change do mediate the relationship between health coaching, disability, and pain [inaudible 0:38:09] and we are well underway with that.

Now we are also developing an online health coaching intervention and again it's based on the intervention that we presented here today. Although, there are some changes given its translation into an online format. So for example, we have condensed the website into eight modules rather than the 12 sessions. So we have an introduction module, we have one module on each of the five lifestyle areas of diet, exercise, et cetera. We have a module around problem-solving obstacles and then a module around maintaining progress. And as you can see here, we've already started the website development. So here's a screenshot of the home page. And we are projected to finish the website by the end of September. So we'll really be excited about this. [inaudible 0:39:15] I have [inaudible 0:39:20] information about the website [inaudible 0:39:26] the second module which is on food and drink. Oh I think it didn’t change, let me see.

There we go. So here is a screenshot of the second module that is on food and drink. And you can see there it begins with a goal check in. So at the beginning of every module we have a goal check in where we check in with the Veterans about their goals from the previous module. And there's just so many exciting features in this website. We have the Veterans track their symptoms, their emotional well-being, we have a food blog, we can send out email reminders for goals. So we're excited to get this up and running.

And on the next slide here we have just example of the personal health inventory. So we are going to give the opportunity for the Veterans to fill out the personal inventory during the first module and the last module of the website and they can track their progress. So we are working on finishing up the website. And once it is completed, we plan to conduct usability testing. And then hopefully our long-term plan is to conduct a clinical trial to assess its efficacy as well.

So that is it in terms of the next steps. Before we end today, I just want to acknowledge our team. We have such a wonderful team of people that makes all of this work possible. So a big thank you to our team and I want to thank all of you for your attention today. And I do believe we have some time for questions.

Heidi: Fantastic. And I think we have Robin on the call. Robin, can we hear you?

Dr. Robin Masheb: Heidi, can you hear me?

Heidi: We can hear you. Yes.

Dr. Robin Masheb: Yay. My apologies to everybody that I was having some technical difficulties. But I just want to thank our presenters, Dr. McAndrew and Dr. Sullivan. This has been an amazing presentation and so exciting to see your work summarized here. And some of the details about your findings in the pilot study. I just want to encourage everybody in our audience to feel free to write in with some questions in the Q&A. And I'd be happy to share them with our presenters. But I thought I would just start out and maybe ask a few questions myself and ask you what have the challenges been like in terms of training the coaches to do this kind of work?

Dr. Lisa McAndrew: Yeah, so Robin, I think that's a great question. And I also saw a question pop up about the level of training the providers have. With this initial pilot work we have been using either licensed clinical psychologists or doctor level clinical psychologists because that is who’s on our team. And so I think they have a lot of transferable skills in terms of transferring over to health coaching. And we do a three-day training and then we have a biweekly supervision to help them ensure they're doing coaching and not just standard cognitive behavioral therapy. We in this larger clinical trial are expanding it to look at bachelor and master level providers. And so we're just starting that up. And looking forward to doing some of that work.

Dr. Robin Masheb: Yeah, and could you, that's a very interesting question in terms of this type of intervention versus a CBT. And I know sometimes those distinctions are not very clear, but it seems like your team has a certain clarity about how this differs from a CBT and a therapy, but maybe you could share some of that with our audience.

Dr. Lisa McAndrew: Yes, and Nicole I hope you jump in also here, I think this is less directive. So while we're providing education to the Veterans it's really trying to follow the Veterans’ conceptualization of their health and also their particular goals for treatment. And sometimes those goals are not what you would necessarily think are going to be beneficial as a provider. Or explicitly what we would initially think we were going to target. But the idea is that by following the Veteran and working on their goals and their beliefs about it that we will be able to engage them more and help them. Now I'm a cognitive behavioral therapist so I agree with you, this is not cut and dry, it's not that CBT doesn't do those things but it's just that health coaching in this case is even more in that direction. Nicole, do you want to add anything?

Dr. Nicole Sullivan: I think what you said is accurate and I think [inaudible 0:45:07] that in my experience with doing health coaching [inaudible 0:45:12] it's more behavioral than cognitive. So it's interesting that I do think that it's [inaudible 0:45:19] got some cognitive change with that pain testing results that we found. So I feel [inaudible 0:45:28] not really directly adjunctions within health coaching as you would in CBT. It's interesting that we might still be getting at that change indirectly. But I do think that's one of the differences. We don't really address directly address cognitions around pain, or you know cognitions generally within the health coaching it tends to be more behavioral than cognitive.

Dr. Robin Masheb: Mm-hmm, yeah. And it seems to be kind of also more lifestyle oriented as opposed to exactly what you’re saying, it’s not focused on the pain kind of focused on other aspects of one's life.

Dr. Lisa McAndrew: Yes, that's exactly right. Yep, it's more about helping them improve their daily life. And I think that's really interesting right, so I've never woken up and thought I want to challenge my cognitions today. And I think the Veterans have the same place and so even though that can be really helpful, and I think a lot of us on the call have found that helping people change their cognitions to be powerful. Often what Veterans come in wanting to do is eat healthier, sleep better, increase their activity—the kinds of things a lot of us are working on. And so meeting them where they're at we're finding is very powerful.

Dr. Robin Masheb: Mm-hmm. Could you talk a little bit about that? Like a case where you know a Veteran or Veterans like when they’re really connected to the treatment what that's like? And then can you also talk about kind of you know a Veteran or Veterans where it doesn't connect for them, it doesn't seem like it's a good fit?

Dr. Lisa McAndrew: Yes, so I'm going to, Nicole can I turn this question over to you? Nicole has been the lead in providing this treatment.

Dr. Nicole Sullivan: Sure. Yeah, I think that in our experience we find that this does connect with Veterans more so than it doesn't. And so we see people jumping in and being very motivated from the get-go. Now that being said typically you will find that people have certain areas that they're more focused on. So they might be more focused on diet and exercise than sleep and social relationships or vice versa. So we really do meet the Veteran where there at, but usually what we find is that there is at least two or three areas that Veterans are saying yes, I really want to focus on this. And so a reached Veteran certainly will run into obstacles along the way, but they are excited about [inaudible 0:48:10] they’re excited to do this, and they're really engaged in the problem-solving process. Now that being said there certainly are Veterans that we've worked with that don't see the need to change so much. And that is where motivational interviewing comes in. So we really rely on motivational interviewing skills to help Veterans get motivated or explore their motives for change and that's been really helpful for those Veterans who haven't been as engaged. But for those who are, I mean they just kind of take the intervention and run with it. It's wonderful to see.

Dr. Lisa McAndrew: Yeah, I think Robin, one of the reasons that we've actually only had one Veteran who didn't complete at least 11 sessions who started the treatment. So we haven't had, we have had a couple of Veterans who didn't want it, right? And then we only had one who started and then didn't finish it. So we don’t have a lot of good examples of those who aren't excited about it.

Dr. Robin Masheb: Right. So once people engage, they’re really invested?

Dr. Lisa McAndrew: So far yes.

Dr. Nicole Sullivan: Yes.

Dr. Robin Masheb: I would imagine too, I mean you know there's a very kind of general aspect, the whole health approach, focusing on people eating and physical activity and sleep, that Veterans maybe could get a type of intervention like this someplace else, but that the piece of it that really connects for them is the validation of you know the Gulf War Illness. And then that probably serves as a motivating factor of feeling like, oh, here's a place where I belong, where I'm accepted, where people understand what I'm going through. I'm willing to engage in what they have to offer.

Dr. Lisa McAndrew: Yeah, I think that's exactly right. It's a really careful balance, right? Because it would be really easy for the Veterans and we hear this from Veterans that they been told just eat healthier, right? And that puts the blame on the Veteran. Or it’s just your depression. Right? And so this is really anybody who’s worked in this population really common themes that you hear that Veterans have heard from their providers. And so I think you’re exactly right. We have, it’s so critical that we validate and engage the Veteran and help them feel heard from the beginning. Because we’re certainly not saying that if only you were eating healthier or lost weight this wouldn’t be happening to. Right?

Dr. Robin Masheb: Right.

Dr. Lisa McAndrew: So we have to make sure that that is really heard and that the Veteran feels that. And I think our team has worked with this population for so long we’re able to do that. And so the team is going to be translating that as we move beyond just our core team.

Dr. Robin Masheb: Yeah, that’s great. This is a tricky question kind of without getting into generalizations between male and female Veterans. But I’m going to ask it anyway, because I know a lot of people have concerns about you know are they meeting the needs of women Veterans in the VA. But what as your experience been like, I mean I’m assuming that you do, do this intervention with both male and female Veterans. And have you noticed in general anything about that? Any differences?

Dr. Lisa McAndrew: So I’m going to turn this question over to Nicole. Nicole, have you noticed differences?

Dr. Nicole Sullivan: Yeah, that’s an interesting question. [inaudible 0:51:55] certainly have more males participate than females. But we have had some females participate. In terms of differences, you know I think that, again I don’t want to make any generalizations, but from what I have observed in our small sample size is that women do tend to be more focused on some of the social relationship goals, whereas I feel like that’s not as big of an interest with some of the men. And again I don’t want to generalize.

Dr. Robin Masheb: Right it’s hard to do that without, right.

Dr. Nicole Sullivan: Yeah, yeah, but that has been what I have seen personally with my work. Also, I mean diet goals seems to be a big one across the board. But that also seems to be a big one for women as well. But it seems like there is a bit more focus on social relationships. And if not social relationships, how social relationships interfere with other goals. So a focus on, we don’t want to put other people out by having to change what my family eats. Right? Or I don’t want to have to be a burden on others if I need to take some time for myself, right? I have to take care of other people. So that can be a [inaudible 0:53:27] from time to time as well.

Dr. Robin Masheb: Yeah, in terms of the diet, I’m curious about kind of how detailed you get into the Mediterranean diet specific food recommendations? Or are you just kind of staying in more a behavioral level of kind of trying to have a well-balanced diet, you know and getting your fruits and vegetables in, making sure you’re not having beverages with too many calories. How detailed or not do you get into the specific diet?

Dr. Nicole Sullivan: Yeah, so we start with a general overview of what, an anti-inflammatory diet in general would look like. So eating more vegetables. Eating more fruits. Reducing processed [inaudible 0:54:23] out those sugars, those processed sugar sodas, fast foods. And then what we do is we introduce the Mediterranean diet as one type of anti-inflammatory diet that they could follow. And we do provide some specific recommendations about what is included within the Mediterranean diet and what is not. With that being said, I think it’s [inaudible 0:54:50] because so far, we have been psychologists [inaudible 0:54:56] be able to give them general guidelines around the Mediterranean diet and what the research has shown about the Mediterranean diet and reducing inflammation. And then again, the Veterans can take that information and set their own goals. So I hope that answers your question.

Dr. Robin Masheb: Yeah, that’s great. Anything else either of you would like to share to the group before I wrap up?

Dr. Lisa McAndrew: I don't think so, other than this is, we really appreciate the invitation and the opportunity to speak to you. This was a great opportunity for us. Thank you.

Dr. Robin Masheb: Yeah, I want to thank the two of you for bringing this work out today. We have new technology that we’re using for hosting the Cyberseminar WebEx and we had an even larger audience than we normally have. So I think that speaks to the interest that our clinicians and researchers have in terms of trying to help Veterans with Gulf War Illness. And we are really appreciative of the work that the two of you and your team are doing. It’s quite amazing. Just one more reminder to everybody to hold on for another minute or two for the feedback form that’s going to pop up. If you’re interested in downloading the PowerPoint slides from today or from any of our previous VA Cyberseminars, you can just go to the HSR&D Cyberseminar Archive and there are some pulldown menus where you can select previous sessions. Our next Cyberseminar is going to be, oh geeze, I had the date and I just lost it. I think it’s the first Tuesday of October at 11:00 with Dr. Marianne Matthias. The title of that talk is going to be Evaluation of a Peer Coach-Led Intervention to Improve Pain Symptoms. Results from a Study of Peer Supported Pain Self-Management for Veterans with Chronic Pain. So this will be somewhat of a similar topic, but this is going to be peer coaching with chronic pain in general. And I just want to thank everybody for attending this HSR&D Cyberseminar. And we hope that you will join us again. Thank you everybody.

Heidi: Thanks everyone.

[ END OF AUDIO ]