The Clinical Experience of Treating Chronic Pain

by Wendy Tayer, Ph.D.

Pain is a multivariate, multifaceted syndrome that presents in complex ways in outpatient psychology settings. Pain can be the result of a variety of illnesses or injury, including (but not limited to) sports injuries, rheumatoid arthritis, lupus, chronic fatigue, spinal stenosis, automobile or workplace accidents, and so forth. Often, the psychotherapist's office is the end of the line for pain patients after physicians and pain experts have not been able to alleviate or eliminate their pain through medical interventions. If you have ever treated patients with pain disorders, you know that they present with a range of emotional symptoms, including depression, anxiety, irritability, anger, resentment, guilt, sadness, and fear. These cases can be daunting and often challenge our strength, resilience, skill and boundaries as practitioners.

Pain affects more people in the United States than cancer, heart disease and diabetes combined. According to the Institute of Medicine of the National Academies, 100 million Americans live with chronic pain (The American Academy of Pain Medicine www.painmed.org/patientcenter/facts_on_pain.aspx#chronic). The economic burden of chronic pain is enormous: the cost of treating pain and the loss of work productivity due to disability and sick days ranges from $560 billion to $635 billion. These numbers are astounding.

The personal costs of living with pain are similarly staggering. In the behavioral medicine literature, chronic pain is defined as pain that is persistent and, at the same time, unpredictable. When I ask my pain patients if there is a pattern to their pain, they are hard-pressed to predict and anticipate their pain episodes; indeed, they often experience a sudden onset of pain during office visits, evidenced by their pain behaviors. The unpredictability of pain episodes interferes with the ability to plan one's life activities. Unexpected losses can negatively affect finances, relationships, work productivity, entire careers, ability to ambulate and/or exercise, and cognitive function, among others. Often, one's life focus shifts to the management of pain to the detriment of overall quality of life.

What is the physiology of a chronic pain episode? Pain signals start and continue to fire in the nervous system for weeks, months, even years. It is as if there is a malfunction in the body's pain signaling system. Some people can tie their pain to an accident or disease process while others experience pain with no apparent physical cause. According to the CDC, back pain is the most common pain complaint followed by headache/migraine, neck pain, and facial pain. Most chronic pain patients have more

than one pain complaint or pain site. Adults with low back pain tend to fare worse in terms of mental and physical health than those who do not have pain conditions. They report severely limited physical activity and tend to experience severe psychological distress to a much greater degree than people without low back pain. Particularly disturbing is the fact that 20% of Americans complain of disrupted sleep 3-4 nights a week due to pain or bodily discomfort. According to the National Health Interview Survey in 2009, women in general are higher pain symptom reporters than men, and they report headache and facial pain at twice the rate of men.

How do chronic pain patients present in therapy?

There is no aspect of any of pain patients' lives that is not affected by pain. They are often referred by the primary care providers, pain doctors or other specialists because they appear to be depressed, irritable, anxious and/or adapting poorly to their pain condition. Most pain patients who engage in outpatient psychotherapy are or have been high functioning, bright, successful adults with careers and families or relationships who have experienced a sudden, dramatic shift in their lives due to their pain; often, it causes them to give up their job, livelihood, social life, travel plans, love relationships, and recreational activities such as sports and physical fitness. The degree and multifaceted nature of loss for this population is often palpable and overwhelming. Out of nowhere they are forced to rethink their personal identity, purpose, goals, and future at times in their lives when they otherwise would be at their prime in terms of productivity and activity. They come in with detailed stories to tell, asking to be heard, validated, supported, helped to rebuild their lives and redevelop their self-perceptions. It is a daunting task from a clinician's perspective.

What is my role as a psychologist?

I work at the University of California, San Diego (UCSD), a giant healthcare system, where many of our patients are referred through the medical group. My background as a behavioral medicine psychologist has trained me to conceptualize chronic pain cases from a biopsychosocial perspective that is inherently holistic and multidimensional. Chronic pain patients often present to my office as the last resort after having exhausted standard pain treatment modalities; a subset of these patients are seeking therapy because a mental health visit has been deemed a condition of further treatment. In many cases, physicians sense that their patient has a psychological condition that is related to their pain syndrome; or they refer the patient for a psychological evaluation to aid in their decision-making about whether the patient is able to effectively manage or cope with a particular treatment. In some instances, physicians are not able to definitively diagnose the root cause of the pain and sometimes tell the patient and write in the chart that the patient has a psychosomatic disorder which necessitates a psychiatric evaluation. These patients, usually women, often leave these appointments in greater distress than when they arrived. I have seen many of these patients in my practice, who tend to be high functioning, insightful women who stay in therapy, are not interested in "secondary gain," and have a

rare genetic or autoimmune disorder that is difficult to diagnose or does not meet full criteria for a common autoimmune disease such as MS or lupus. I have challenged their physicians' "patient-blaming" chart notes, and advocated for these patients in my own chart notes; I have also, on occasion, referred them to physicians and other allied health professionals who are empathic, open-minded, align with their patients and think broadly about their symptom presentations. Opioid dependence is another common occurrence with this population.

What does an initial visit with a chronic pain patient entail?

After obtaining written informed consent for psychotherapy, I typically ask for releases of information to collaborate with other treating practitioners as a team approach is optimal due to the complexity and variability of pain relief and treatment outcomes. (To that end, I also attend a monthly multidisciplinary pain management grand rounds meeting.) My working relationship with other treatment providers allows me to advocate for my patients who often are perceived as "difficult" or "demanding."

My first visit with a chronic pain patient entails a complete biopsychosocial history which includes a standard intake as well as questions about medical/health history, coping style/history, disability status, use of substances and medications for pain management, pain rating scale, observation of pain behaviors, existence of caregivers, and often a multidimensional pain questionnaire such as the McGill Pain Questionnaire. I pay special attention to consistency of pain complaints with medical history and pain behavior, pain ratings, degree of cognitive flexibility, psychiatric history and response to the initial interview as predictors of patient prognosis and therapy outcome. I also educate the patient about psychotherapy as a process of self-exploration and reflection in addition to pain as a challenging life experience, normalizing the patient's complaints.

What does psychotherapy entail?

Therapeutic alliance is crucial to successful psychotherapy outcomes in chronic pain patients, as are regular, weekly sessions and taking responsibility for the work of therapy. Pain patients often do not have partners or friends who understand their experience, or know how to respond or support them. A patient's premorbid level of self-worth often has plummeted, and they need a safe place to vent and reality-test their current cognitive-emotional response to their disabling pain. The therapist is one of the most potent sources of support in these patients' lives.

What treatment approaches are utilized and effective?

Empirical literature abounds with evidence supporting the efficacy of Cognitive Behavioral Therapy (CBT), operant conditioning, mindfulness and Acceptance and Commitment Therapy (ACT). CBT, owing to its long history, is supported by a large body of research; in particular, studies support the efficacy of problem-solving, therapeutic journaling, cognitive restructuring and operant conditioning for managing patient

"catastrophizing" of their pain symptoms as well as pain-related fear responses to various stimuli. Although the efficacy of positive therapeutic alliance is well established in psychotherapy research in general, there are no studies examining this element specifically among chronic pain patients.

In my own practice, I strive to be present with my patients, and to create a non-judgmental and supportive space where they can safely express and work through their emotions and pain experience. My goal is to help my patients discover their own individual strengths and to thus empower those who feel greatly disempowered by their pain. If amenable, I practice meditation with them in order to facilitate acceptance and to reduce reactivity to their symptoms. Different approaches work for different patients; some merely want to vent and be heard, others want concrete coping strategies that they can practice at home. Regardless of technique, the ultimate goal is acceptance of this "new normal" and all that it entails; this process takes much time, commitment, patience, empathy, and attention. Therapy must be tailored to the individual patient, and usually is worthwhile and rewarding as most patients experience important changes in their expectations, view of themselves, ways of coping, reality testing, decision-making approaches, and reasoning abilities.

What are the common themes in therapy for chronic pain?

People with chronic pain struggle with what is often an invisible symptom or syndrome, and evident only via self-report and pain behaviors. A common theme among this population is their anguish about not being believed or acknowledged by others for having a pain condition. In fact, they frequently have to deal with insensitive comments such as "get over it," "push through it," "stop complaining," or even are openly confronted for having a handicapped placard and have to defend themselves to righteous strangers. These patients need empathy, and often, therapists are the only ones who will provide it to them. Simple interactions with loved ones or acquaintances become quandaries that must be addressed in therapy. To a chronic pain patient, the question, "How are you?" presents quite a dilemma: should he or she give a cursory response, i.e., "fine" or be honest about the fact that he/she feels miserable and/or exhausted?

Further, these patients are used to functioning independently and accomplishing a lot in a given day. They experience much difficulty lowering their expectations for their daily goals, pacing themselves because of their pain, learning to accomplish tasks in subsections due to limited periods of pain free functioning, not being able to make plans due to their pain and making decisions based solely on their pain level. Pain intensities vary for people; thus, on "good" days, people with pain tend to overexert because they desire a sense of normalcy and to meet their goals. However, as is often the case, they pay the price by finding themselves in increased pain, fatigue and anergia on the days that follow. This experience is demoralizing and literally, a painful reminder of their chronic condition.

Another common theme is the question of how one relates to one's pain condition/ experience. Specifically, we discuss whether an individual is defined by his/her pain or whether it is something they "have." Exploration of this relationship can open pathways for more personal reflection and cognitive flexibility in the process of adaptation. These issues represent the most prevalent topics among this population group. There are other therapeutic topics which this article space does not allow but that are discussed readily in the pain treatment literature.

Addressing pain and its emotional repercussions is undoubtedly the main goal of therapy. However, also important is my role in mediating the relationship between my patients and their physicians. As I mentioned in an earlier section, chronic pain patients are often perceived as "difficult." For physicians whose ultimate goal is to "cure" their patients, chronic pain patients are an enormous challenge and reminder of the limits of modern medicine. Besides, these patients can be demanding, needy and sometimes present with irritability, impatience and cognitive deficits or lapses. As part of a multidisciplinary treatment team, my goal is to facilitate fruitful communication between my patients and their treatment providers. To that end, therapy can also involve teaching enhanced appointment preparation strategies (such as writing a list of questions, taking notes, affect and body language coaching, etc.) to patients so that they can communicate more effectively with their doctors and develop functional, goal-oriented working relationships with them.

What is the typical course of therapy? Treatment can range from participation in an Intensive Outpatient Program (IOP) or a six-week structured pain treatment group to years of individual psychotherapy, depending on many factors. In my experience, the need to be validated and understood is paramount in this population; also important, is the desire for hope and a functional future for these patients. Working with this population has challenged me to expand my repertoire of skills to help my patients, and also regularly tests my clinical skill set. I find that I am more present and compassionate as a result of my years of experience with chronic pain patients. It is ultimately humbling to know that as a clinician and an empathic human being, I have played such an important role in my patients' lives.

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UCSD Center for Mindfulness web page which lists courses and offers free guided meditations https://health.ucsd.edu/specialties/mindfulness/Pages/default.aspx

Chronic Pain Treatment Program and IOP at UC San Diego Health: https://health.ucsd.edu/specialties/psych/clinic-based/chronic-pain/Pages/default.aspx

National Fibromyalgia and Chronic Pain Association: http://www.fmcpaware.org/support-groups/browse-support-groups.html?pid=60&sid=140:San-Diego

U.S. Pain Foundation: https://www.uspainfoundation.org/resources-2/

Local pain support groups and informational resources can also be found at local chapter websites or offices for The Arthritis Foundation, The Lupus Foundation of American and The American Cancer Society. Also check local hospitals for patient support programs.