

Offering hope to clients with chronic pain

One in six and \$100 billion. What do these numbers have in common? They represent the number of Americans who currently suffer from chronic pain and the estimated annual cost to the nation from lost work productivity and increased health care resulting from unrelenting pain syndromes. As a mental health counselor, you may ask how this applies to your clinical practice. Good question!

The mental health connection

Traditionally, chronic pain has occupied the exclusive domain of the medical model, or the field known as behavioral medicine. Historically, pain that could not be medically determined or diagnosed was viewed as “psychogenic” (psychologically induced or somatization). There was no overlap between the mind and the body. However, recent theories and scientific research into pain genesis dispels the myth of mutual exclusivity between the mind and the body.

Introduced by Melzack and Wall, the *gate control theory* proposes that there are “gates” on the bundle of nerve fibers in the spinal cord. These spinal nerve gates control the flow of pain messages from the peripheral nerves to the brain. Once a pain signal reaches the brain, the pain messages take a pathway to the hypothalamus and limbic system. The hypothalamus is responsible for the release of certain stress hormones in the body, while the limbic system is responsible for processing emotions. This is one reason why chronic pain is often associated with stress, depression, and anxiety.

The brain also controls pain messages by attaching meaning to the personal and social context in which the pain is experienced. In times of anxiety or stress, descending messages from the brain may amplify the pain signal that moves up the spinal cord. Alternatively, impulses from the brain can “close” the nerve gate, preventing the pain signal from reaching the brain and being experienced as pain.

The science of *Psychoneuroimmunology* (PNI) further explains the link between the mind and the body. For example, unrelenting stress can cause decrease in the production of antigen cells (leading to increased susceptibility to autoimmune diseases) and to increased cortisol production (leading to fatigue, depression, and muscle or joint pain). Prolonged stress taxes the hypothalamus, adrenal, and pituitary axis of the brain, causing chronic psychophysiological sickness and pain. In essence, classically conditioning the immune system is possible.

Assessment of chronic pain

Mental health counselors working with chronic pain clients (potentially referred from worker compensation agencies or medical pain clinics) should familiarize themselves with the various DSM-IV Somatoform Disorders. They need to know how to conduct differential diagnosis of related pain syndromes. Pain clients can also present with depression, anxiety, sleep disorders, chemical dependency, and personality disorders. Mental health counselors need to acquire an advanced ability to screen for these various disorders and to conduct proper biopsychosocial assessment of client social, family, behavioral, emotional, and cognitive functioning.

Cognitive interventions

Mental health counselors can draw upon numerous cognitive skills to offer hope to clients suffering from chronic pain. Prochaska and DiClemente’s Stages of Change model and Miller and Rollnick’s concept of Motivational Interviewing are critical to positive outcomes. Chronic pain clients are often externally-oriented and personally demoralized. They feel helpless and hopeless. They lack self-efficacy and naturally look to outside sources for instant relief.

Chronic pain clients must be motivated to take control of the pain. This requires counselor patience, accurate empathy, developing discrepancies, rolling with resistance, and eliciting change talk from your client. For example, you might tell a chronic pain client “*Given all your treatment failures, what are your thoughts and feelings about a new approach? In this approach you stop looking to doctors for a diagnosis and a miracle pain cure, and begin to think about ways that you can manage the pain and get on with your life?*” You might also tell your client “*It seems pretty discouraging that you have lost your job and your spouse as a result to chronic pain. Are there other areas in your life that you have not let pain take control of?*”

Once your client is motivated for change and enters the action stage, negative cognitive schemas surrounding themes of autonomy, worthlessness, trust, and entitlement need to be restructured. Cognitive distortions also need to be challenged. Research tells us that the tendency to ruminate about catastrophizing events is the highest predictor of negative treatment outcome! For example, I had a client who presented with Fibromyalgia and lower back pain. She was convinced that excessive movement would cause her spinal cord to further deteriorate, eventually disintegrating into sand-like fragments, thus causing permanent disability, guaranteed job loss, social rejection, life as a vegetable, etc. For this client, she perceived pain as “harm or loss” that indicated tissue damage had occurred when it had not (some clients see pain as a “threat” and they perceive that the danger outweighs coping ability).

The goal of cognitive therapy is to change these deconditioning perceptions into a “challenge” (that their coping ability outweighs risks). A simple reframe can help a pain client develop a sense of personal control when pain is viewed as a positive signal. For example, you can tell a client, “*Pain means that your physical activity is testing muscles that need to be strengthened; it is good pain.*” The desired response from the client might be “*I am increasing my tolerance for standing; this will make it easier for me to return to work.*”

Other cognitive fallacies deserving attention include *dichotomous thinking* (i.e., either experiencing pain or being pain free—no middle ground), *disqualifying the positive* (i.e., ability to maintain gainful employment despite pain), *should/must statements* (i.e., life must be pain free, others should understand my pain), and *mind reading* (i.e., this doctor does not like me and is therefore withholding the cure from me). Further cognitive interventions may include attention diversion strategies, problem-solving skills, assertiveness training, and guided imagery.

Behavioral interventions

Pain can be immobilizing. We are conditioned that when our body experiences pain, to rest and relax so as to avoid further tissue damage. However, clients suffering from chronic pain get sucked into a trap of extended rest and relaxation; reinforcing the perception that immobilization is the solution to chronic pain. Essentially, pain ends up controlling the client’s activities—it tells the client when to stop cleaning the house, when to leave work, when to retire to bed, when to stop exercising, etc. A negative, self-reinforcing cycle is perpetuated. Prolong pain-induced immobility fuels learned helplessness, depression, and anxiety. Replacing this cycle with more positive behavioral functioning happens when a client begins to use *activity pacing*, or *time* as the controlling factor for active pain management.

For example, I had a client who suffered from Crone’s disease. Instead of taking breaks or leaving work when the pain flared up, he set a timer on his computer to go off every 60 minutes. This became his new signal to take a break. During this five-minute break he engaged in mini-passive/progressive muscle relaxation and breathing activities (to reduce work-related stress and to avoid pain flare-ups). After five minutes, his timer on the computer reminded him to return to work. He continued this process during the entire workday and used time as a controlling factor for home activities. The use of time gave him a sense of personal efficacy and replaced pain as the conditioned stimulus.

This behavioral intervention also works well for pain medication management. Pain clients usually take pain relief medication when the pain is at its peak. The same negative reinforcing cycle develops as with behavioral activities. Time contingent medication scheduling reminds pain clients to take medication-

based on pre-determined time schedules throughout the day—thus reinforcing time as the controlling factor rather than pain.

Other behavioral interventions for pain management include autogenic training, biofeedback, hypnosis, graded exposure in-vivo, stress inoculation training, physical exercise, expressive writing/journaling, emotion regulation, group therapy, and family/couple therapy.

Next steps

In summary, it is important to remember that all pain has a psychological component. The psychological factors are important at all stages in chronic pain management. If you are interested in learning more about psychological pain management interventions, please feel free to contact me at jking0964@msn.com.