

What can we do for our chronic pain patients as mental health clinicians in limited time?

Dr. Benjamin Sandler

Michael was a truck driver for his whole life – he went straight from high school into driving for a living and now he is in his 60's. All of this was great for him until one day he slipped on a patch of ice at work. He fell hard and hurt his back leading to him being unable to continue working as a driver as he couldn't sit for very long. He received dozens and dozens of physical therapy sessions but his pain seemed to continue to the point he ended up with two back surgeries. Unfortunately this only reduced his pain a small amount at first but now the pain is worse than ever. Now he has financial stressors of not being able to work, he is having anger outbursts at his family, he feels useless to everyone around him, and he has no energy during the day to be active. You've been told you have 6 sessions authorized to treat this patient with psychotherapy. He walks in your door and says "nothing has worked and talking about my pain certainly won't help me at all."

Sound familiar?

If you've felt that moment of being at a bit of a loss to help someone with chronic pain, you're not alone. Working with individuals that have chronic pain is certainly not the easiest clinical work you can find but it can be highly rewarding. When people slowly begin to realize they can still live and thrive despite their chronic pain, it is an amazing and hopeful thing to see.

Nonetheless, the difficulties of working with this population are very real. One particular difficulty with our work is the worker's compensation system and the constraints that it imposes on our therapeutic relationship and efficacy with patients.

In the context that we personally see patients with chronic pain, they usually are undergoing approximately 6 to 10 sessions of psychotherapy (which is usually assumed to be cognitive behavioral therapy of some kind) or undergoing our interdisciplinary chronic pain program known as the functional restoration program which lasts 8 weeks.

Either way, the average amount of time spent with patients is approximately 6-10 weeks.

Let's be realistic about the prognosis: We are most likely not going to cure lifelong issues such as depression or anxiety that were exacerbated by their chronic pain within 8 weeks. We are most likely not going to have enough time to properly deal with deep trauma within this time span either. So what is realistic? It is common for clinicians to feel defeated, feeling the limitations of our system prevent us from providing real care to our patients.

There are still many things that can be done with patients within 8 to 10 weeks or so to better equip them to manage chronic pain, whether in individual psychotherapy or through FRP. Consider identifying a few of these as treatment goals when you are working with a patient. Of course, your clinical judgment must come into play to determine which of these is most salient for the patient's current needs. This list is not exhaustive by any means, but is intended to help clinicians that are struggling to formulate realistic treatment goals.

1. Validation

Listen to the patient and take their pain seriously. A chronic pain clinician should work on the assumption that all pain is real. Even if there's absolutely no apparent physical basis or people believe they are "imagining" the pain... if they experience pain, that pain is real.

Chronic pain is an invisible illness for most people, which makes it very difficult for other people to understand that their pain is real. Aside from their family, friends, and the public, many of these patients have experienced invalidation from their doctors and surgeons. Many are outright hostile and accusatory toward patients (as if they want to not be able to work and are fabricating their pain). When a chronic pain patient walks in your door, they are therefore inherently guarded about their experience of pain.

Psychotherapy may be the first place where the patient truly feels that someone is taking them seriously. Most of these people are constantly getting the message that people do not believe them: "it doesn't look so bad", "why don't you snap out of it", "it's all in your head", "you must be exaggerating", as well as passive aggressive comments like "I can't believe you can't even pick *that* up!"

You will find many patients are stuck at exactly this point, perseverating on the fact that no one believes they are suffering as badly as they feel they are. This often comes in the form of repeating similar themes over and over. You'll find many patients repeatedly explaining the severity of the injury, wanting to point to MRIs or X-Rays validating the damage to their body, and expressing anger and desperation that others do not believe

they are in pain. Often this comes out of the need for validation of one's pain and one's reality in general.

Consider the sheer amount of stress and frustration with dealing solely with this one issue of others not believing your experience of pain. You feel the suffering of pain daily and deal with the frustrations of your functional limitations, such as not being able to work or do things you enjoy like play with your children... yet people constantly send the message that you are a liar and/or a weak person. This alone is the source of an immense amount of tension, stress, and anger when dealing with chronic pain.

It may seem like a simple or even trite thing to provide validation in psychotherapy as a treatment goal. However, it truly is an important goal and a difficult process for those with chronic pain. There is no guarantee that the patient will be sufficiently ready to accept even your validation within the 10 weeks or so that you see them. But at the very least you can plant the seeds that *someone* believes their experience is true and valid.

2. Psychoeducation

Provide education about the nature of chronic pain and its impact on physical and mental health. The truth is that most of these patients have not had anyone take the time to slow down and explain the difference between acute pain and chronic pain to them. No one has explained the biopsychosocial nature of chronic pain to them. In other words, no one has bothered to explain to them what is happening to them.

Aside from the information itself being helpful, evidence indicates that psychoeducation about chronic pain actually helps reduce pain intensity itself. From a clinical perspective, learning about chronic pain helps to disambiguate what is a very mysterious and confusing subject. The less unclear and ambiguous their chronic pain is to them, the less anxiety (and related symptoms) they will feel about it.

Psychoeducation in this way is meant to be empowering. They have a stronger grasp on what is happening to them and what they need to do. The patient who is equipped with a realistic understanding of their chronic pain is also naturally more likely to avoid things we know that make chronic pain worse (such as inactivity, poor nutrition, etc) and engage in the things we know improve chronic pain (such as learning to relax, socialize, and finding meaningful activities).

In the FRP program, we often teach many hours worth of psychoeducation material about chronic pain and related issues such as depression, anxiety, stress, sleep disturbances, etc. This kind of material is not just for people lucky enough to be in a fancy interdisciplinary program: it is entirely appropriate to spend time educating the patient about chronic pain itself or its related issues in individual psychotherapy as well.

In fact, the psychoeducation of explaining the biopsychosocial model of chronic pain may be the necessary onramp to gaining the patient's buy-in about psychosocial methods being worthwhile in the first place. Most people are stuck in a bio-medical understanding of their own pain and therefore reject even the possibility of being helped by psychotherapy. They may not understand the connection between their ways of thinking and the ways they are feeling and therefore see no reason to change their thinking. In a way, psychoeducation can be part of the process of the patient building trust in the clinician which eventually will allow them to be open enough to other potential interventions.

3. Get the basics together

There are innumerable psychological treatments for chronic pain with many different fancy names and acronyms, but in the end there are some core things that are important for everyone no matter what: Exercise, nutrition, sleep, and medication adherence. It is important to explore any lifestyle changes or accommodations that may help the patient better manage their pain.

Regardless of one's type of chronic pain, the patient absolutely needs to find a way to exercise or have some kind of physical activity on a regular basis. There is no alternative: anyone will inevitably become deconditioned and have even more pain and stiffness if one doesn't remain active. We are always trying to help our patients to become more active, get outside more often, and use their bodies (especially their injured body parts): increasing physical activity is a fundamentally central goal for anyone with chronic pain.

Eating regularly and eating healthily also has no alternative: if you eat irregularly your metabolism will be thrown off and likely have digestive issues, low energy, and irritability. If you do not eat healthy foods, your body (and your brain especially) will not be supplied with the nutrients it needs to function optimally. Consider giving basic psychoeducation around this issue and collaboratively formulating goals around this to mutually develop a plan and accountability for the patient.

In general, we all also need to be as regular as possible about our sleep. Sleep is inevitably an issue for basically anyone coping with chronic pain. Especially when someone is no longer working due to their pain or functional limitation, one of the things that gets thrown off is the time of fall sleeping and waking up. Many patients are falling asleep at 9pm one night, 2am the next... and waking up at similarly disjointed times. Though it is not easy or quick, helping to regulate their sleep cycles and circadian rhythm is one thing that can only benefit the patient.

Medication adherence is also very difficult for many patients for a variety of reasons. Leaving aside painkillers for a moment, many chronic pain patients do not adhere to their medications that are prescribed for other issues such as high blood pressure,

diabetes, or thyroid issues. Patients can benefit with some basic guidance and accountability around being consistent with their medication use and adherence to their doctor's prescriptions.

Analgesic medications of all types such as opioids or NSAIDs must be treated with caution, of course. Although some people will need some level of pain medication in order to function, overall we as clinicians want to reduce patient reliance on medications for managing pain because they are not viable long-term solutions for many people. This is done by teaching other coping skills, such as those mentioned in the next section, which can help replace medications as tools for pain management. We know now that long-term use of opioids runs the risk of further sensitizing the nervous system to pain which makes the underlying issue worse. Regular use of NSAIDs and other pain medications can lead to stomach pain, ulcers, liver issues, and more. Overall, most patients will benefit from the clinician helping the patient adhere to their regular medications while reducing reliance on painkillers as much as possible.

4. Develop coping strategies

The core of the cognitive behavioral approach to chronic pain is the development of coping strategies that will help the patient manage their chronic pain and related issues such as depression, anxiety, stress, and sleep issues. These are basic skills such as relaxation techniques (deep breathing, visualization, progressive muscle relaxation, etc), pacing for physical activity, sleep hygiene, planning enjoyable activities, and challenging negative thoughts.

These skills should be imparted within the context of a compassionate therapeutic alliance where the clinician has built sufficient rapport and done some psychoeducation so the patient is ready to at least try some techniques. Without rapport, many patients don't understand we are on their side: they may think we are part of "the system", think we have ulterior motives, or think we simply do not care about them as individuals as if they were just another number to us. Without psychoeducation, patients may not understand the need for or importance of these coping skills.

Regardless, these coping strategies are not panaceas that work on everyone, nor are they something that you can throw at a patient and expect them to work without the context of a supportive therapeutic relationship. Learning these skills is one piece of the puzzle, but the issue with many patients is they do not have the follow-through necessary to stay consistent with "homework", at least at first. The clinician's job is therefore not simply to impart these skills, but to also help the patient overcome obstacles and remain accountable to themselves.

5. Connect with resources

Many of the patients we see lack a basic knowledge of or access to the systems that provide resources that we need. It is often worthwhile to help patients think about where they might receive mental health treatment outside of the worker's compensation system which can be fickle and uncertain in terms of treatment authorizations. Other basic resources such as local food banks are often easy to find with internet searches or other methods. For example, within California calling "211" is a great way to be connected with basic services such as shelters and food pantries.

It may also be worth your time to help patients clarify misunderstandings or frustrations with the medical-legal systems they're involved in, such as worker's compensation. This may require educating yourself first about these systems so you can help them navigate in basic ways, or at least know the best person to point them toward if they need more direction.

It also may be important to determine whether the patient needs help being more assertive and communicative with their doctors and lawyers. If they feel they are not getting the treatment they need, they may need guidance and language to help them advocate for themselves to their doctors.

Overall, we want to advocate a proactive, independent, and self-reliant mindset in patients so that they learn not just where to get services but how to find them. They should build confidence in themselves to have their basic material needs met.

6. The rest of the work...

When most of us think of psychotherapy, I think the general idea is that we are here to help the patient process any difficult feelings of fear, anger, worry, or sadness that may be associated with the chronic pain. The way our work is structured often reinforces this: many of our psychological tests measure things like depression and anxiety but do not measure anything like the patient's levels of validation, psychoeducation, or level of coping skills. Clinicians tend to glorify the idea of giving perfect or clever interpretations, intelligently explaining patterns we are noticing in the patient's presentation that are contributing to being locked in negative cycles.

However, part of my intent in writing this is to make the case that all of the things mentioned in previous sections – validation, psychoeducation, basic coping strategies, getting the basics together, and connecting with resources – represent significant interventions in themselves. You may be the first (and possibly last) person that ever spends time to validate their pain, psychoeducate them on chronic pain, teach basic coping strategies, connect with resources, and help them get their basics together. If you were to be successful in any one of these interventions whereby the patient feels more validated, educated, more self-efficacious from coping skills, regulated through getting the basics together, and/or more supported through having various resources available to them, I believe that would inarguably represent a significant treatment gain.

Of course, these interventions I've outlined above are not meant to be sequential. Different patients have different issues which make different interventions more or less salient for them. Some patients may require specific attention to holding and processing difficult emotions around their pain before they're able to be open enough to certain psychoeducation, for example. The clinical judgment of the clinician who has established an understanding of the patient through their lived experience in the sessions will have a better grounding to understand which parts are of more importance for the brief time we spent with patients.

Also it is important to understand that, to the patient, these interventions may be precisely the piece they were missing; they be the thing that helps them to take a step forwards after they've taken so many steps backward. Though we may fantasize of understanding the patient completely – having a flawless and penetrating analysis of their character and perfect application of interventions to move them toward health – in the end it is not the clever interpretations that stick with patients. It is the compassionate regard and validation you demonstrated to them when they communicated their experience to you, the relatable language and images provided to understand chronic pain, and the concrete skills you helped facilitate them learn and apply to their lives.

Overall, I hope this provides some clarity on the ways we can still effectively work with patients in the worker's compensation system;. Unfortunately, the nature of the system constrains our ability to treat most of these patients long-term but there are still many ways to provide beneficial knowledge and skills to patients to hopefully help them for the rest of their lives.