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Chronic Pain Counseling

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Description of Chronic Pain

Definition

- Pain is commonly defined as being caused by physical and/or mental distress and is further classified into two separate groups.
  The first classification, acute pain, is characterized as being temporary and directly linked to tissue damage, existing for the purpose of preventing further injury, and lasting for no longer than 3 months.
- The second classification, chronic pain, is defined as pain without apparent biological value that has persisted beyond the normal tissue healing time of 3 months.
- Because chronic pain serves no productive function and does not remit as acute pain does, clients experiencing chronic pain commonly experience extensive medical treatments and procedures.

Resources: National Institute of Health NINDS Chronic Pain Information Page: http://www.ninds.nih.gov/disorders/chronic_pain/chronic_pain.htm
American Chronic Pain Association (ACPA): http://www.theacpa.org/default.aspx

Prevalence

Approximately 35% to 57% of the adult population in the United States reported experiencing chronic pain in the past year (Pain Medicine, 2005; Pizzi, Carter, Howell, Vallow, Crawford, & Frank, 2005; Turk & Burwinkle, 2005), which costs society more than $70 to $ 100 billion annually in direct health-care costs and lost productivity (Holmes et al., 2006; Libby, 2006; Pain Medicine, 2005). In addition to monetary losses, the client's suffering can include divorce, alcoholism, drug abuse, family violence, absenteeism, job loss, depression, and suicide (Renshaw, 2007).

IDENTIFICATION/ASSESSMENT STRATEGIES

Initial Pain Assessment Tools

When working with a client in chronic pain, it is important to conduct an assessment of the client's pain history including the pain's impact on social, occupational, physical, and psychological functioning.

Chronic pain identification and assessment forms can be found at the following website: http://www.icsi.org/pain__chronic__assessment_and_management_of_14399/pain__chronic__assessment_and_management_of__guideline_.html

Multidimensional Pain Readiness to Change Questionnaire (MPRCQ)

A more specific scale that can be used by the counselor to identify the client's specific coping skills is the Multidimensional Pain Readiness to Change Questionnaire (MPRCQ). The MPRCQ is a self-report questionnaire comprising 46 items that relate to nine separate categories of coping skills most often used in CBT when treating clients experiencing chronic pain. Although the MPRCQ is a relatively new measure, preliminary research supports its reliability and validity (Heapy, Stroud, Higgins, & Sellinger, 2006; Nielson, Jensen, Ehde, Kerns, & Molton, 2008).

Resource: Further Development of the Multidimensional Pain Readiness to Change Questionnaire: The MPRCQ2 (The instrument and scoring procedure is located in the appendix): http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2758642/

INTERVENTION STRATEGIES

Despite the broad range of theories and treatments discussed in this section, common treatment themes for clients experiencing chronic pain are a focus on the mind-body connection, problem-solving skills, cognitive restructuring, exposure to previously avoided activities, and psychoeducation.

Pain Stages of Change Model (PSCM)

The Pain Stages of Change Model (PSCM) can be useful in evaluating a client's willingness to adopt a self-management program (Heapy et al., 2006). The PSCM can be a useful tool in measuring the client's commitment to treatment, and how the client's behavior has changed over time because of pain or environmental cues. The PSCM Model can also be useful in enhancing clients' willingness to make changes to effectively cope with and manage pain. The PSCM closely follows the Transtheoretical Model's stages of change; however, the PSCM eliminates the preparation stage of change (Heapy et al., 2006).

Resources: Pain Stages of Change Questionnaire (pages 16-18): http://www.painpoints.com/patients/downloads/patient_questionnaire.pdf
Transtheoretical Model Stages of Change: http://www.prochange.com/transtheoretical-model-of-behavior-change

Focusing

As a therapeutic modality, focusing allows the client to deepen and explore the mind-body connection to facilitate somatic shifts and strength-based coping with illness (Wagner, 2006). Gendlin (1981) recommended the following focusing technique to create a deeper mind-body connection (Fiasca 1993; Krycka, 1997). First, focusing begins with the client allowing her or his body to be comfortable and free from outside distractions. Next, the client is instructed to ask the body, "How am I doing right now? What is between me and feeling fine?" and list orally to the counselor what the body suggests is making the client tense in the moment. After creating a list of tensions, the client is instructed to ask the body, "What is the single biggest problem right now?" Once identified, the client is asked, "What word, quality, or image symbolizes what is going on?" Next, the client is asked to verify that the word, quality, or image is correct or that it needs to be adjusted or clarified. Then the client is instructed to ask the body the following questions, allowing ample time to explore each question in depth: "What is it about that is such a struggle?" "What is the worst of this?" "What does the body need?" and "What does the body want to express?" Finally, the counselor helps the client to be fully present with what has been verbalized regardless of the

client's judgment of what was expressed. After a time of contemplation, the counselor and client process the experience together.

Resource: Focusing as a Therapeutic Modality: http://www.katjewagner.com/documents/Focusing_KW.pdf

Cognitive Behavioral Therapy

CBT has been particularly useful with individuals who experience chronic pain (Pigeon et al., 2012; Trafton et al., 2011). There are four main goals the counselor needs to address through the use of CBT with clients living with chronic pain (Adams, Poole, & Richardson, 2006). First, the counselor helps the client shift from believing that her or his problems are unmanageable to learning how to be a creative problem solver. Second, the counselor helps the client monitor thoughts, emotions, and behaviors to demonstrate the connection between internally controlled events and pain, emotional distress, and psychosocial difficulties. Helping the client develop and maintain adaptive and flexible ways of thinking, feeling, and acting (the third goal) assists in the development of problem-solving skills and reduces catastrophizing. Finally, the counselor uses psychoeducation to inform the client about the use of relaxation techniques, postural correction, and exercise. This assists the client in coping effectively with pain, emotional distress, and psychosocial difficulties as well as shifting the focus away from medical treatment and procedures as the only option to reduce pain levels.

Resources: Cognitive behavioral approach to chronic pain problem solving: http://www.wellcome.ac.uk/en/pain/microsite/medicine3.html

Perceived control and health: http://www.vanderbilt.edu/nursing/kwallston/perceived%20control%20and%20health.pdf

Acceptance & Commitment Therapy (ACT): http://contextualpsychology.org/act

Relaxation exercises to manage chronic pain: http://my.clevelandclinic.org/heart/prevention/alternative/bodymind.aspx

Exposure (In Vivo) Treatment

Clients experiencing chronic pain often overgeneralize pain and believe that if a specific movement was painful once, it will remain painful in the future. This fear then prevents them from engaging in normal activities. Leeuw et al. (2007) explored using exposure (in vivo) treatment to gradually confront the fear of physical movements that clients avoided because of the belief that the activity would be painful or physically damaging. Exposure treatment consists of (a) the client choosing a functional goal (e.g., walking on a treadmill for 30 minutes a day), (b) psychoeducation about the irrational outcome of overprotection (e.g., fear getting in the way of walking on the treadmill reduces the chances of improved functioning in the future), (c) establishing a fear hierarchy (e.g., on a scale of 1 to 10 (one being little; ten being severe) 1 = walking to the bathroom, 5 = walking for a half hour on a treadmill, and 10 = going running), and (d) graded exposure to previously feared and avoided activities by using behavioral experiments (e.g., walking for 5 minutes a day on the treadmill to slowly increase to 30 minutes) (Leeuw et al., 2007). Individual exposure treatment can provide clients with compelling evidence that feared activities are actually overestimated, which helps to promote increased function and self-efficacy along with a decrease in catastrophizing. Studies have suggested that in this population, successful exposure to a specific movement or set of movements does not generalize to other dissimilar movements (Leeuw et al., 2007). Therefore, exposure treatment will need to be performed several times to address all feared movements.

Resource: Exploring exposure in vivo in chronic pain http://arno.unimaas.nl/show.cgi?fid=21303

Multicultural Considerations

Cultural competence when working with clients experiencing chronic pain includes recognizing what impact family and societal influences have on the client's experience of power and control (Eriksen & Kress, 2006). Clients with less power have fewer resources and experience a greater number of stressors, which prompts biological predispositions to activate physical symptoms more quickly than will occur for those in a position of dominance (Eriksen & Kress, 2006). The power differential felt by women; people of color; the gay, lesbian, bisexual, transgender, questioning, intersex community; and those in low socioeconomic status groups places them at a greater risk of experiencing chronic pain (Croteau, Morgan, Henderson, & Nero, 1992). Externalizing the problem using narrative therapy can help clients in non-dominant positions (Eriksen & Kress, 2006) separate themselves from the symptoms of chronic pain.

Resources: Externalizing – commonly-asked questions: http://www.dulwichcentre.com.au/externalising.html

Religious and Spiritual Considerations

Chronic pain intensifies existential dilemmas and provokes introspection regarding spiritual and religious values. For some religions, pain is considered to be punishment for sin, and for other religions it is the path to redemption and eternal salvation (Renshaw, 2007). The client's spiritual and religious values need to be explored because the cultural approaches to managing pain can range from wailing to the philosophy that life is pain (Renshaw, 2007). Helping clients establish the cultural/spiritual/religious purpose and meaning of the chronic pain condition allows them to tolerate negative events and setbacks, which often lessens the physical stress response and reduces the intensity and duration of chronic pain symptoms (Savolaine & Granello, 2002). Activities could include creating culturally relevant alliances with indigenous healers or utilizing folktales, storytelling, dance, music, poetry, and other spiritual and religious healing processes to reduce stress and solve problems (Constantine, Myers, Kindaichi, & Moore, 2004).

Resources: Spiritual pain: Chronic non-malignant pain: http://www.paincommunitycentre.org/article/spiritual-pain-chronic-non-malignant-pain

Pain, Spirituality, and Meaning Making: What Can We Learn from the Literature? www.mdpi.com/2077-1444/2/1/1/pdf

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