

Journal of Clinical Psychology Practice

Chronic Pain In Context: Some Observations from 25 Years in the Field

Michael R. MacDonald
MacDonald & Bryant
London ON

It is not easy coming to see a psychologist when you have physical injuries and pain. Most people do not know why they were referred to us. Most people are not sure there is even any point to showing up. To help them feel comfortable, I usually start with a simple overview.

First, I explain that if you have short-term pain, you would never end up coming to see a psychologist like me. If your pain settles down within a few months, you can return to work, return to your normal life. Not much stress is involved. If your pain and injuries continue, month after month, with little improvement, then the stresses start to build. Maybe your work is disrupted and you are having trouble getting income replacement benefits. Maybe your pain and limitations interfere with your family life, and your spouse and children are having difficulties coping with the extra load on them. At this point, people start tearing up. They can see that I am speaking about their struggles and everyday experience. We are on the same page. This is where treatment starts -- within the first few minutes of meeting each other.

This is a brief example of my work with each new patient. My work, for the past 25 years, has been in the field of rehabilitation psychology. My wife and I run a small practice group. There are eight of us now. Over 90 percent of my patients suffer from various forms of long-term or chronic pain, usually caused by car or work accidents. This has been a great career for me. Aside from working with individuals, I get to collaborate with other health professionals, rehabilitation case managers and consultants, and lawyers. I enjoy this work, the collaborations, even the adversarial parts -- even going to court.

Before I get into the details, let me step back for a moment

Summary

A contextual approach is discussed for the psychological and rehabilitative treatment of chronic pain. Motivational interviewing, reframing, therapeutic tactics and some examples of unbelievable pain control are highlighted.

Keywords

Chronic Pain
Rehabilitation Psychology
Motivational Interviewing
Grief
Loss

Contact

Michael R. MacDonald
MacDonald & Bryant
Suite 110
339 Wellington Road South
London ON N6C 5Z9
Telephone: (519) 660-8139
Fax: (519) 660-8149
michael@renfordbooks.com
www.ChronicPainLetter.com

and give you an overview of the pain population I serve. This group is a very specific subset of the overall chronic pain population. Millions of people in our society suffer from persistent pain but are able to continue functioning reasonably well (Gureje, Simon, & von Koroff, 2001). Even though they experience long-term pain, and some degree of suffering related to their injuries or illnesses, they never end up getting referred to a psychologist for treatment or rehabilitation. Many are not referred to specialists. Some do not even seek treatment from their family doctor (Turk & Winter, 2006).

The people that do get referred, to our practice group, typically have multiple sources of long-term pain, serious losses, and widespread disruption to their lives. They are often diagnosed with depression, anxiety and sleep disturbance, occasional post-traumatic stress disorder, and generally are having difficulties with coping, adaptation, and pain tolerances. Most of our patients also have ongoing stresses related to dealings with various types of insurance companies -- often several at the same time, stressful interactions with lawyers, consultants, private investigators, independent medical assessments, and stressful dealings with case managers with the Workplace Safety and Insurance Board. It is important to remember that this patient sample is a specific one and not necessarily representative of the chronic pain population as a whole, nor of the chronic pain population you may read about in the literature. On the other hand, if you work regularly in rehabilitation, this population may be very recognizable to you and similar to the group of real world patients you are used to treating.

Let me confess one of the core beliefs that guide my work. I believe that chronic pain is best understood in terms of the specific source of physical pain and related limitations that an individual experiences. Chronic or long-term neck pain creates different kinds of problems for individuals and their lives than does chronic or long-term back pain, for example. I do not believe that chronic pain is a single entity, although there are some strong similarities in the experiences of individuals across different types of long-term pain. I believe that psychological causes for long-term or chronic pain are very rare. Turk and Melzack, in their *Handbook of Pain Assessment* (2001), expressed this view very succinctly. They stated, "The search for a pain-prone personality and for psychogenic pain has been futile" (Turk & Melzack, 2001, p. 7). There are many psychological factors that play a role in the experience of pain, the suffering involved, and a person's overall level of disability. I have not seen any compelling evidence, though, for any psychological causes. This view has been supported by the large scale literature review, funded by the Workplace Safety and Insurance Board (Chronic Pain Initiative, 2000).

I do believe that psychological factors play an important role. For example, factors such as poor sleep, depression, and anxiety, can lower people's tolerances for pain and weaken their capacity for coping and adaptation. There has been a considerable amount of research to support this view (Chronic Pain Initiative, 2000; Keefe, Rumble, Scipio, Giordano, & Perri, 2004; Linton, 2000). Additional evidence comes from Nadine Foster and her colleagues in a large prospective study looking at factors that may play a role in predicting outcomes for individuals with persistent low back pain (Foster, Thomas, Bishop, Dunn, & Main, 2010). In this study, measures of disability as well as 20 psychological variables thought to play a role in recovery were assessed at baseline and again at six months. The Foster et al. (2010) study was more comprehensive than most and had a large sample size of over 1,500 subjects. As one might predict from the previous literature (Keefe et al., 2004), there were several usual suspects that showed up as significant results. Factors such as fear avoidance, catastrophizing, and depression explained close to 50 per cent of the variance on the disability measure at six months. With further analyses, the authors found that these variables showed correlations with each other and with variables related to feelings of personal control and ability to regulate their symptoms. The authors then proceeded with multivariate analyses to try to bring together a unifying theory. In their conclusions, they proposed two theoretical frameworks,

self-efficacy and self-regulation, to account for most of the variance in the outcome measures. Specifically, individuals who expect their back problems to last a long time, who hold weak beliefs and low confidence in their own ability to control their back problem, and who perceived that many symptoms are related to their back problem, are more likely to have poor clinical outcomes.

In my clinical work, it is important to investigate individuals' fears and anxieties about their pain symptoms. For example, if patients are frightened that each flare-up of pain will lead to higher levels of disability and lead to levels of pain beyond their control, then this will limit their capacity for coping and ability to move on with their life. If patients believe that each flare-up of pain will become permanent, as opposed to understanding that flare-ups are temporary by nature, this, too, will limit their ability to stay active and to move forward toward recovery. This is the fear avoidance model. The more people are frightened by their pain, especially escalations of pain, the more they will avoid activities, movement, and exercise, become de-conditioned and more limited. This pattern will, in turn, lead to even more fear, more avoidance, and ultimately, higher levels of pain and disability. Basically, substantial research, to date, shows that fear and avoidance of pain can lead to higher levels of disability (Crombez, Vlaeyen, Heuts, & Lysens, 1999; Linton, 2000).

The Foster et al. (2010) study is a better than average example of investigations into the role of psychological variables related to chronic pain. But, even a fairly high level investigation, such as this one, has one fatal flaw. It provides a wide context looking at many psychological variables that relate to disability and recovery. For example, the investigators look at fear of pain as an important variable. They look at feelings of confidence and self-efficacy relative to coping efforts and attempts to try to control pain. Similar to most studies in this field, though, they did not look at the role of loss. Loss and grief play an important role in coping and adaptation to any long-term or chronic health problem. This is especially true for chronic pain. The fear avoidance model emphasizes individuals' fear of pain. But, patients are not just afraid of their pain. They are also afraid of losing their homes. They're afraid that their children will not be able to go to college or university. They are afraid that their employers will fire them. They are afraid that their spouses will get fed up with their pain and limitations and that this will have serious consequences for the security of their marriage and family. These anxieties can be just as debilitating and paralyzing as specific fears of pain. Such anxieties can trigger serious pain flare-ups. They play an important role in recovery and are an important target for treatment.

A lawyer once asked me, rather bluntly, "what do you do?" What he was really asking was this: You are a psychologist. My client has physical injuries and real pain from a car accident. What do *you* do? My answer, in a nutshell, was pain and loss. Pain and loss is really the wider context and necessary and important for understanding and treating chronic or long-term pain. This is true, at least for the type patients we see in our group -- people with long-term pain that leads to widespread losses and life disruption. Now, it is not hard to understand that many of our patients have suffered substantial losses and disruption to their lives, following the onset of their injuries. But, how does that really affect the pain they experience and their efforts to get better?

First, pain and loss creates additional burdens for individuals to try and manage. Significant loss causes increased suffering and interferes with patients' efforts to implement strategies for recovery and rehabilitation. Significant loss causes sadness, anger, grief, and often depression. Fear of further loss brings anxiety, sometimes panic, additional fear of pain, and often helplessness (Corbett, Foster, & Ong, 2007). With these high levels of emotion, individuals in pain are often overwhelmed and have difficulty controlling their emotions. This was the variable of emotional regulation that Foster and her colleagues investigated (Foster et al., 2010).

Second, when individuals are grieving heavily, they can become stuck in their grief. They can become focused on the life they had -- their jobs, income, security, and freedom to participate and do everything for their families. Coping with grief, in the context of chronic pain, is especially

difficult. Each flare-up of pain is a vivid reminder of injury, limitations, and losses. Powerful feelings of grief are repeatedly stirred up. Tackling grief, under these circumstances, is like trying to catch a moving target. Rehabilitation can become very slow and difficult in these cases. Rehabilitation is about the past, and rehabilitation is not about the future, or trying to create new lives, even with limitations (Richardson, Ong, & Sim, 2006).

In my preparation of this paper, I came across an insightful quote about the recurrent nature of grief by C. S. Lewis:

In grief, nothing 'stays put'. One keeps emerging from a phase, but it always recurs. Round and round. Everything repeats. Am I going in circles, or dare I hope I am on a spiral? ... But, if a spiral, am I going up, or down it? (Lewis, 1961, p. 46; as cited in Bruce and Schultz, 2001).

In a recent review, Lebel (2009) described some of the stages that individuals may go through in their attempts to manage or resolve their grief. I believe that these concepts are useful in understanding how people cope and adapt to chronic pain and related losses. Some of these stages have been described as: (1) numbness and disbelief, (2) yearning and searching, (3) disorganization and despair, and finally, (4) reorganization. While the view that individuals need to follow through predictable stages of grief has been debunked over the years, it seems clear that these stages do appear in various forms in almost all individuals going through the process of grief and bereavement (Bruce & Schultz, 2001; Stroebe, Hansson, Schut, & Stroebe, 2008). Even these simple descriptors will seem familiar to many of you, if you think back to your patients that have had the most difficulty coping and managing their injuries, illness, and pain.

Let us take a brief look at some of these stages, as they relate to adaptation to injury, pain, and loss. Take numbness and disbelief, as an example. Many of my patients are still struggling with these feelings about their injuries and losses, even years after their accident. I recently assessed a young woman in her early 20s, with a moderate back injury and related chronic pain. She had an accomplished history in sports, even for such a young person. In basketball, volleyball, and soccer, she had been a team leader and usually became the team captain. Sports were her life, identity, and source of most of her social world. With chronic back pain, she could no longer perform these sports at a high level or even participate like other players and friends. Every flare-up of back pain stirred up powerful feelings of anger and grief. It became very difficult for her to manage her pain, acknowledge and accept her losses, and work toward a future that did not include a life full of sports.

A related stage is that of yearning and searching. Sometimes in the rehabilitation literature, this is referred to as the search for a cure. Oftentimes, this persistent and maladaptive search is driven by individuals' powerful feelings of grief and loss. This is a significant obstacle, since it is difficult for individuals with these feelings to commit, fully, to rehabilitation. Such patients are often so overwhelmed that they only want someone to take their pain away. They do not have the emotional strength or resilience to be active in their own rehabilitation or recovery.

A third descriptor, or stage, refers to disorganization and despair. This occurs when a person becomes further impaired by serious levels of depression. Usually their functional level is very low, not only in relation to their efforts to cope with their pain, but often, in most areas of their life. It is not hard to see how grief and depression present additional problems, not only for the psychologist and the affected individual, but also for all health care providers. These are the patients that we often seem to work the hardest for and get the fewest results.

The final stage, which has been called reorganization, is when most of the good things of rehabilitation happen. Sometimes, individuals, even early on, are able to take charge of their own treatment and to start reorganizing themselves and their lives. These are really the easiest patients

to help. They are more than willing, and able, to do most of the work themselves and the results show.

Recently, other stage models have been investigated within the chronic pain and fibromyalgia populations. The ideas are similar here. These models propose that people pass through specific stages as they try and change their behaviour, or adapt to pain and injury (Jensen, Nielson, Romano, Hill, & Turner, 2000; Nielson, Jensen, Ehde, Kerns, & Molton, 2008). Results from these studies look quite promising. It is important for individuals to gain some type of control, or feelings of control, over their pain, but also to regain some sense of control over their lives. To do this, it is necessary for individuals to reduce as many losses as possible, to work through feelings of loss and to reduce fears of more losses. These are some of the main themes in my recent book, *Unbelievable Pain Control* (MacDonald, 2009). Let me turn, now, to consider some ways that these ideas can be used to help people in pain.

Motivational Interviewing and Rehabilitation

The first job of assessment and treatment, right from the first few minutes of meeting each person, is to connect with them (Poston & Hanson, 2010). This means connecting with them at their level and connecting with where they are at in their rehabilitation. With words, posture, and tone, this means connecting with their feelings, their resistances, their hopes and their fears. You have to begin from their position and then slowly help your patients to move to where you want them to go.

This is a simple rule of communication. More recently, it has been researched under the model or context of motivational interviewing (Miller & Rollnick, 2002). It also has a long history in the hypnosis literature. The central idea, here, is that it is difficult to get much compliance from your patients, if they are actively trying to resist your ideas and your recommendations. In the language of motivational interviewing, treatment works much better when you “roll with their resistance”, rather than try to challenge it head on.

Motivational interviewing, as a treatment approach, was initially developed to help individuals with alcohol and substance abuse problems (Arhein, Miller, Yahne, Palmer, & Fulcher, 2003). Resistance to change is a huge problem found commonly, in this territory. Motivational interviewing has been quite successful, as a treatment model and approach. Over 80 randomized studies have found positive results. It has since been applied to other health problems, including chronic pain, also with promising results (Jensen, Nielson, & Kerns, 2003). A simple example can be found on any type of legal or crime television show. When the lawyer approaches the witness for cross-examination, the lawyer usually begins with a comment designed to disarm the person’s defenses and make them more open to influence. The lawyer may start with a comment such as, “I know this has all been very hard for you”. He pauses to let this sink in. Then he moves in for the kill.

Psychological treatment and the process of change are not that simple. And, of course, as health care professionals, we do not really move in for the kill. We have to stay with the therapy process -- always trying to roll with the resistance and looking for openings to help our patients move forward. With motivational interviewing, therapists try to accept patient reluctance to change as natural and understandable, rather than pathological. The goal is to try to use the patient’s resistance as a stepping stone, to increase intrinsic motivation for change (Jensen et al., 2003).

This is what I try to do in the first few minutes of meeting each new person. As I explain what I do as a psychologist, I show the person that I understand that they have physical injuries and pain, that their pain has continued for many months or often years, and that over time, this has become more difficult for them, with more and more stresses disrupting their lives. I do this connecting and

motivating each time I meet with people, and throughout each session. I am constantly looking for ways to reduce resistance, enhance motivation and move forward.

Rehabilitation and motivational interviewing both emphasize helping patients to build self-efficacy and independence. Most other therapeutic models also highlight this goal. Independence is particularly important for accident victims with chronic pain, as they try to overcome physical limitations and reduce their reliance on others' help. As equally important, is helping patients to escape the demands of having so many professionals in their lives. Many people feel that their lives are controlled by health care providers, insurers, lawyers and case managers. Part of our rehabilitation work is to help people to understand and manage these demands, in ways that preserve their integrity and independence. In the long run, the goal of rehabilitation is to have individuals regain control over their own lives, with as little assistance as possible from professionals.

The next step of motivational interviewing is to create discrepancy. Here, you want to show that your patient's current way of trying to solve his or her problems may, in fact, interfere with your patient's desired goals (Miller & Rollnick, 2002). This step is vital to the process of rehabilitation. Here are some examples.

Reframing the Problem

What makes adaptation and rehabilitation sometimes difficult is an individual's limited view of the problem. I say problem because people often see their complex difficulties in terms of a single problem. This narrow view looks like this: An accident or illness caused my pain. I just need a cure or some way for my pain to be taken away. I do not want to make any changes to my life. I just want my old life back.

This makes perfect sense, of course, and many others buy into, and reinforce, this narrow view. Family members want to know when the pain will end and when will they get their spouse or parent back. Employers and insurance adjusters want to know the same thing. Of course, this is foremost on the mind of individuals who are suffering from long-term injury, illness, and pain. They frame their problem in terms of having an accident, having pain, and needing a cure. This approach is not very useful, however, for long-term problems. In fact, it is discrepant with patients' overall goals -- of trying to reduce their losses and increase control over their pain and their life.

Consider one of my typical patients for a moment. Francis was involved in an accident at work, about one year before I first saw her. She had slipped and fell on a wet floor. She experienced high levels of pain in her neck, with headaches, as well as in her lower back and down her left leg. For the previous year, she had been trying to force herself to continue, part-time, in her work as a Grade One teacher. Her pain symptoms were continually aggravated and flared-up. This had led to persistent sleep problems, generalized anxiety, and depression. She had also been trying to fight several new battles, after her benefits had been cut-off from her long-term disability insurer and the Workplace Safety and Insurance Board. The loss of her benefits had led to serious financial difficulties. These additional stresses were interfering with her sleep, triggering more pain flare-ups, more time off of work, and then a clinical level of depression.

At the start of treatment, her only goal was to have her pain taken away. If this could be accomplished, she could have continued in her career and not lose her home. Part of our initial work, was to help her to expand and reframe her problems. She did not have just one problem, she had, instead, multiple problems, and all of these would need to be addressed before she would have the success she wanted at managing her long-term pain.

My main message to her, over and over again, throughout the course of treatment, was this: It is almost impossible to control your pain until you gain more control over your life. Your daily life

is not only causing you stress, but other powerful stressors are repeatedly aggravating your physical injuries and pain symptoms. Your injuries are constantly being flared-up. You cannot get better, until you stop getting worse. Over time, and with the help of many others, we began to reduce most of these additional problems, reduce many of the aggravations of her multiple injuries and pain, increase her tolerance, decrease her depression, and help her save her career and home. This took several years and was certainly a cooperative effort.

I was willing to do my part, to help reduce her aggravating stressors. In my reports, I clarified all of the problems she was struggling with. This helped my patient, as well as her health care team and lawyer, to see the whole picture. Reports are a great tool in helping to earn patients' trust. In my reports, I was very clear about her diagnoses, the causal connection to her accident, and my opinion about her capability to work. When insurers or workers' compensation become part of the problem, I do not hesitate to say this in each and every report I write. In fact, if people have been cut-off of their benefits, I make restoration of benefits one of my first goals of treatment. It is almost impossible for individuals to get better, when they are still being made worse by conflicts, stressors, and escalating losses.

Therapeutic Tactics

In my work with individuals, I focus on practical ways to solve any additional problems that interfere with pain control, emotional control, life control, and rehabilitation. I am always focussed on ways to help people move forward in their lives and to be more active and motivated. Here are some tactics that I find helpful.

There is one idea I use to try to help people move forward in their recovery: You can't get better until you stop getting worse. This is my Dr. Phil approach to treatment. It is a little cheesy, but it works -- especially when I say it over and over. I use this message in two general ways. First, I use this idea to help people to be more motivated to pace their activities and not become overly active. The message goes like this: Needlessly causing yourself more pain is not the way to end up with less pain and more control over your life. You have to start getting better, at least a little, before you can start getting better a lot. Pacing is one of the best ways to improve function and to gain some type of control over pain. However, it is not always easy to get patients to slow down and follow this basic technique. So, I keep telling them, you can't get better until you stop getting worse. This idea can also help people to accept a wider view of their problems. This means looking at the many factors that can aggravate their physical pain symptoms and interfere with their capacity for coping and adaptation. Here, I want patients to recognize and understand that there are many additional stresses in their lives, in addition to their pain, which are interfering with their recovery and rehabilitation.

The harder part is trying to sell this idea to people who live every day in pain. For many people, any recognition of stress in their lives is really beside the point. Their lives are about physical pain and limitations. Talk of stress tends to invalidate their experience. You have to be very careful, when wading into such dangerous waters. Such discussions can easily deteriorate into a broken connection and loss of trust between you and your patient. Many individuals still fear that discussion of stress means that their pain is all in their heads. They are still at the stage of wanting a cure for their pain. They want to focus on their main goal of having no pain. Only then can they get back to their old life. These beliefs are very powerful in many injured people.

To help counter these fears and resistances, I rely on another simple idea. First, I reassure people that I do not think that their pain is caused by stress. Their pain is physical and real. In fact, their pain is so real that it causes incredible stress in their lives. This is the hook. Most people can

accept this argument. Then I introduce a simple formula to them -- pain causes stress, which leads to more pain. Very simple: in fact, so simple, it creates little resistance (MacDonald, 2009).

I explain that most of the stressors in their life are caused by their pain and injury. It is because of their chronic or long-term pain that they are having trouble at work, trouble at home, financial troubles, battles with insurance companies and lawyers, and high levels of fear for their future. Then I explain that these kinds of serious stress can aggravate physical health problems, such as heart disease, diabetes, or high blood pressure. So understandably, the stress caused by pain can lead to even higher levels of physical pain. With this common sense logic, it is hard for patients to deny or resist the necessity of trying to minimize the stress in their life. In fact, these discussions are usually quite validating. The goal, here, is to help prevent patients from getting worse, so we can have a realistic shot of helping them to get better. When I talk about stress, I emphasize how difficult it is to try and cope, not only with relentless physical pain, but also the stress of multiple losses and forced changes to their lives. This also helps us to work on reducing their grief and depression, which can be aggravating factors.

Unbelievable Pain Control

In my daily work, I use a fascinating story. This is highlighted in my book, *Unbelievable Pain Control* (MacDonald, 2009). This is a real-life story about the unbelievable accomplishments of Dr. Victor Rausch. Many years ago, Dr. Rausch, a dental surgeon from Waterloo Ontario, willingly underwent gall bladder surgery without any anaesthetic or medication. After a 75 minute surgery, he was assisted off the operating table, helped to walk back to his room, took a few days to recover and then returned to work. His surgery, documented and written up in a peer-reviewed journal (Rausch, 1980), took place prior to the days of minimally invasive arthroscopic surgery.

Several years later, Dr. Rausch videotaped himself undergoing several complex dental surgeries, again without anaesthetic or medication. Dr. Rausch sent me a copy of the videotapes. Here is my description of what I saw from the tape of one of his surgeries:

This dental surgery involved the removal of an impacted molar. Incisions were made in his gum. A flap was cut open. There was drilling of the bone to break up the large molar into pieces. It was necessary to dig out the molar and the nerve root. Stitches were put in after this was done. Throughout this process, Dr. Rausch was able to communicate with the dental surgeon, even while under hypnosis and while controlling the pain. This did not seem to be a problem for him. He showed no signs of fear or stress. It was fascinating to watch his skills in action (MacDonald, 2009, p.145).

These examples are extreme. I do not expect anyone, including myself, to ever be able to attain such control over pain. But, they do get peoples' attention and are helpful in generating discussion about the true nature of pain control. Pain control is not what most people think it is. It is not true grit -- a whiskey drinking cowboy biting a bullet and toughing out his pain.

Dr. Rausch's techniques offer many practical lessons for people struggling to live with pain in their lives. He used simple relaxation and imagery techniques that are relatively easy for the average person to learn. Most importantly, Dr. Rausch described a very open and non-aggressive attitude toward pain control. He did not try to overpower, deny, block or directly minimize any painful sensations. His approach did not involve gritting his teeth or trying to fight off the pain. In fact, his actions were the opposite and were centered more on observation and detachment (MacDonald, 2009).

In some ways, Dr. Rausch's work represents a powerful demonstration of newer theoretical formulations of mindfulness and Acceptance and Commitment Therapy. Here, people are encouraged to notice, accept and learn from their symptoms, sensations, and feelings. Unlike traditional approaches, there is little emphasis on direct attempts at control (Hayes, Luomo, Bond, Masuda & Lillis, 2006). These approaches, I believe, are particularly well-suited to helping people with chronic pain or any type of chronic incurable condition. Helping people accept their injuries and symptoms is an important part of this process. Helping people to move forward in their lives is really a main goal -- a main goal, not just for psychologists, but for all health care providers in the rehabilitation field. Historically, acceptance has been a cornerstone of rehabilitation for all types of chronic impairments. Studies on mindfulness and acceptance arc back to the old theories of rehabilitation that look at acceptance of injury as well as acceptance of loss. While acceptance is a relatively new trend in psychological treatments -- the third wave -- it is, partially, a recycled view of theories that have been around for fifty years in the field of physical rehabilitation (Hofman & Asmundson, 2008).

Acceptance (?)

Acceptance sounds like a nice practical idea. But, how can we really help people with long-term pain and injuries to move forward? What do we do when people get stuck? What happens when a person's pain does not get better? No cure is available. Not even time helps. What do we do then? Earlier on in my career, I was more direct and confrontational with patients. My first job involved working with people who suffered from amputations, strokes, and various types of chronic pain. This was in a physical medicine and rehabilitation inpatient hospital program. With these individuals, I wanted to help them to face the fact that there were no easy fixes or cures for their pains and limitations. I was in a hurry. I wanted them to get to work, right away, and try to get on with their lives. Occasionally, this was helpful, but most often it lead to more resistance and less progress. It was really doing the opposite of motivating them. Sometimes, I was just making them more depressed with an even lower functional level. This is the opposite of independence, the opposite of moving on.

Now, I work in a more indirect way and try to make sure that my patients and I are on the same page. I first focus on figuring out where they are at and then I start from there. I try to help individuals move along, move forward, at pace they are ready for. I search for the pace that is the most productive for each person. This is the approach I discussed earlier using techniques from the motivational interviewing literature. Rolling with resistance is helpful when you are focussing on reducing pain, as well as reducing secondary grief, depression, and anxiety.

Part of the stress reduction process includes helping individuals to work through their grief and feelings of loss. Grief work is hard work (Bruce & Schultz, 2001). In a rehabilitation context, this process is a practical one. We are always focused on the present and trying to work toward the future. This involves helping people to move to the point where they can become more realistic and accept their injuries and losses. The more success we have in reducing stresses, reducing flare-ups, and helping to make pain more manageable, the easier it will be for individuals to experience less grief and depression. They will gain more control over their emotions, have more energy, and be more able to take the steps necessary to make changes in their lives. We are working toward the point where individuals are ready to take the next steps in planning for return to work or return to school, volunteer activities, or whatever structure their new life may involve.

It helps all of us to recognize that grief and loss may be significant components of an individual's overall problems. And to recognize, that sometimes, by necessity, this process takes time -- and often more time than we had anticipated. Acceptance is necessary for health care

providers, as well as for people in pain. It can be very hard to accept how slow this process can be. Realizing this can help us all and reduce blaming ourselves, or our patients, for the slowness of progress in treatment. An attitude of acceptance helps patients to avoid blaming themselves for their limitations and difficulties. Such blame only adds to depression and despair. Sometimes, these emotional difficulties are the real driver of individuals' efforts to push themselves too hard, causing further flare-ups and more setbacks in the treatment. When individuals are still struggling to find a way to cure their problems, some people may believe that more and more effort will do the job, even if that effort results in more pain and depression. This is the *no pain no gain trap* that many patients fall into. Often, this process is driven by grief and denial, and can be a difficult pattern to change. It helps us all to recognize that patients are at their own individual stage of recovery. Within each stage there is a different level of readiness and capacity to change and adapt. This includes a varying capacity to tackle all of the multiple problems and stresses that come with long-term pain.

I try not to work in isolation. There are many problems to be worked on -- problems that can aggravate the person's pain and suffering, problems that can trigger escalating losses, and problems that can interfere with the main goal of moving forward. Usually, there are too many problems for one psychologist to address. Rehabilitation works best in the presence of a well-coordinated team of professionals -- all on the same page and all pulling together. Even lawyers and adjusters can work toward common goals. This is the exciting part. When everyone works together, good things may happen. At these moments, rehabilitation becomes one of the most rewarding fields for a psychologist. I know it has been for me.

I think it will always be hard for individuals with physical injuries and pain to come and see a psychologist. Most individuals will still present with a limited view of their problems. Most people will still want a cure -- a fix, to happen as fast as possible. I know I would. Once a real connection has been made, however, and we start to identify the many layers of each person's situation, the benefits become obvious. Patients begin to see that there are many problems that they want solved. They begin to realize that their psychologist has much more to offer than simply pain management. And, as doctor and patient work together on each of the many interrelated problems, control over pain increases, as does control over one's life. Pain control, stress control, and life control go hand in hand. To me this is what rehabilitation is all about.

References

- Arhein, P.C., Miller, W.R., Yahne, C., Palmer, M., & Fulcher, L. (2003). Client commitment language during motivational interviewing predicts drug use outcomes. *Journal of Consulting & Clinical Psychology, 71*, 862-878.
- Bruce, E.J., & Schultz, C.L. (2001). *Nonfinite loss and grief: A psychoeducational approach*. Baltimore, Maryland: Paul H. Brookes Publishing.
- Chronic Pain Initiative. (2000). *Report of the chronic pain expert advisory panel. Volumes 1-3*. Toronto, Ontario: Workplace Safety & Insurance Board.
- Corbett, M., Foster, N.E., & Ong, B.N. (2007). Living with low back pain - stories of hope and despair. *Social Science and Medicine, 65*(8), 1584-1594.
- Crombez, G., Vlaeyen, J., Heuts, P., & Lysens, R. (1999). Pain related fear is more disabling than pain itself: Evidence on the role of pain-related fear in chronic back pain disability. *Pain, 80*, 329-39.
- Foster, N.E., Thomas, E., Bishop, A., Dunn, K.M., & Main, C.J. (2010). Distinctiveness of psychological obstacles to recovery in low back pain patients in primary care. *Pain, 148*(3), 398-406.
- Gureje, O., Simon, G., & von Koroff, M. (2001). A cross-sectional study of persistent pain in primary care. *Pain, 92*, 195-200.
- Hayes, S.C., Luoma, J., Bond, F., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research & Therapy, 44*(1), 1-25.
- Hofman, S.G., & Asmundson, G.J. (2008). Acceptance and mindfulness-based therapy: New wave or old hat? *Clinical Psychology Review, 28*(1), 1-16.
- Jensen, M.P., Nielson, W.R., Romano, J.M., Hill, M.L., & Turner, J.A. (2000). Further evaluation of the Pain Stages of Change Questionnaire: Is the transtheoretical model of change useful for patients with chronic pain? *Pain, 86*, 255-264.
- Jensen, M.P., Nielson, W.R., & Kerns, R.D. (2003). Towards the development of a motivational model of pain self-management. *Journal of Pain, 4*(9), 477-492.
- Keefe, F.J., Rumble, M.E., Scipio, C.D., Giordano, L.A., & Perri, L.M. (2004). Psychological aspects of persistent pain: Current state of the science. *Journal of Pain, 5*, 195-211.
- Lewis, C.S. (1961). *A grief observed*. London: Faber and Faber.
- Linton, S.J. (2000). A review of psychological risk factors in back and neck pain. *Spine, 25*, 1148-1156.
- Lebel, S. (2009). Review of handbook of bereavement research and practice: Advances in theory and intervention. *Canadian Psychology, 50*(4), 297-298.
- MacDonald, M.R. (2009). *Unbelievable pain control: How to heal and recover from chronic pain and fibromyalgia*. London, Ontario: Michael Renford Books.
- Miller, W.R., & Rollnick, B. (2002). *Motivational interviewing: Preparing people to change*. New York: Guilford Press.
- Nielson, W.R., Jensen, M.P., Ehde, D.M., Kerns, R.D., & Molton, I.R. (2008). Further development of the Multidimensional Pain Readiness to Change Questionnaire: The MPRCQ. *Journal of Pain, 9*(6), 552-565.
- Poston, J.M. & Hanson, W.E. (2010). Meta-analysis of psychological assessment as a therapeutic intervention. *Psychological Assessment, 22*(2), 203-212.
- Rausch, V. (1980). Cholecystectomy with self-hypnosis. *American Journal of Clinical Hypnosis, 22*(3), 124-129.
- Richardson, J.G., Ong, B.N., & Sim, J. (2006). Remaking the future: Contemplating a life with chronic widespread pain. *Chronic Illness, 2*(3), 209-218.
- Stroebe, M.S., Hansson, R.O., Schut, H., & Stroebe, W. (Eds.). (2008). *Handbook of bereavement research and practice: Advances in theory and intervention*. Washington, DC: American Psychological Association.
- Turk, D., & Melzack, R. (2001). *Handbook of pain assessment: Second Edition*. New York: Guilford Press.
- Turk, D., & Winter, F. (2006). *The pain survival guide*. Washington, DC: American Psychological Association.