

*Counseling People*

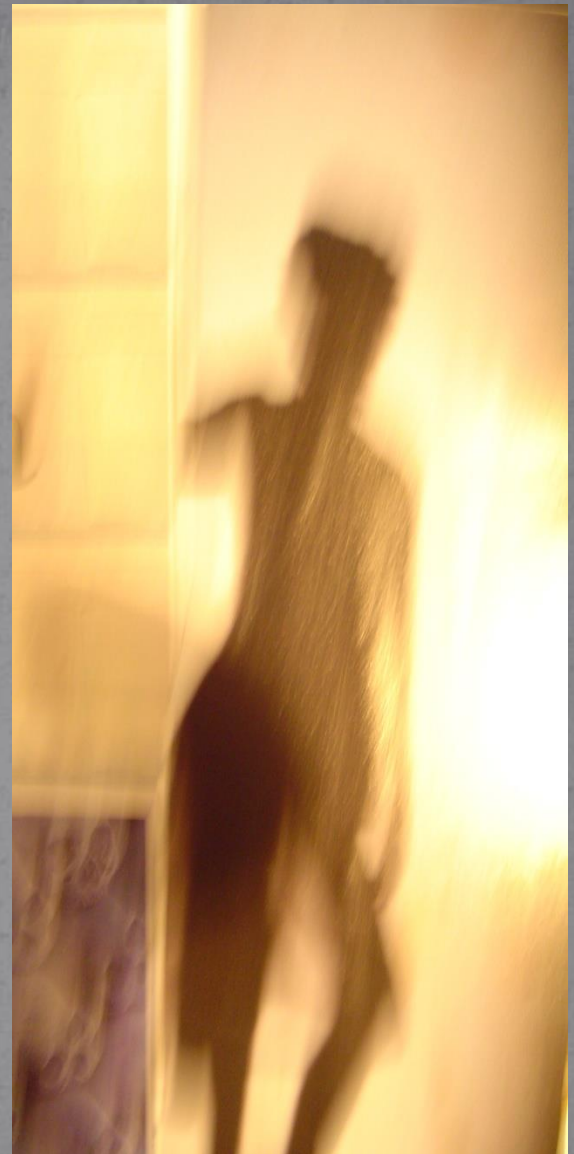
*With*

*Chronic Pain*

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# What is pain, anyway?

- “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage” (International Association for the Study of Pain)
- “That which has no words, that which cannot be seen” (Lous Heshusius)
- “something that hurts” (Beth Christensen)

# What is pain, anyway?

Pain- has an Element of Blank  
It cannot recollect  
When it begun – If there were  
A time when it was not –  
It has no Future – but itself  
Its Infinite realms contain  
Its Past – Enlightened to perceive  
New Periods – of Pain

- Emily Dickinson

# What is pain, anyway?

Virtually everyone has had some sort of pain, most likely as the result of an injury or accident, or maybe in childbirth. We all know what pain is, or at least we know what *our* pain is. But pain has no objective referent, like temperature or blood pressure. We can only know another person's pain in terms of our own pain experiences. Very little is known about chronic pain, so let's review what we know about acute pain.

# Theories of Pain

- 1644: Descartes theorized a direct channel from the skin to the brain
- Early 19<sup>th</sup> century: von Frey postulated specialized pain receptors in the periphery that all led to a central pain area in the brain (specificity theory)
- Late 19<sup>th</sup> century: Pattern theory of pain theorized that pain results when certain nerves are stimulated in a particular pattern, they are transmitted as a lump sum into the spinal cord, a process called central summation.

# Pain Perception and Processing

- Nociception: The stimulation of a nerve ending that is sensitive to painful stimuli such as heat, pressure, or chemicals released by injured tissue (such as bradykinins)
- Pain signals are sent to the limbic system for immediate response; the information then relays to the cerebral cortex for interpretation and rational decision-making
- The individual responds to the pain and its cause
- If all goes well, the pain goes away

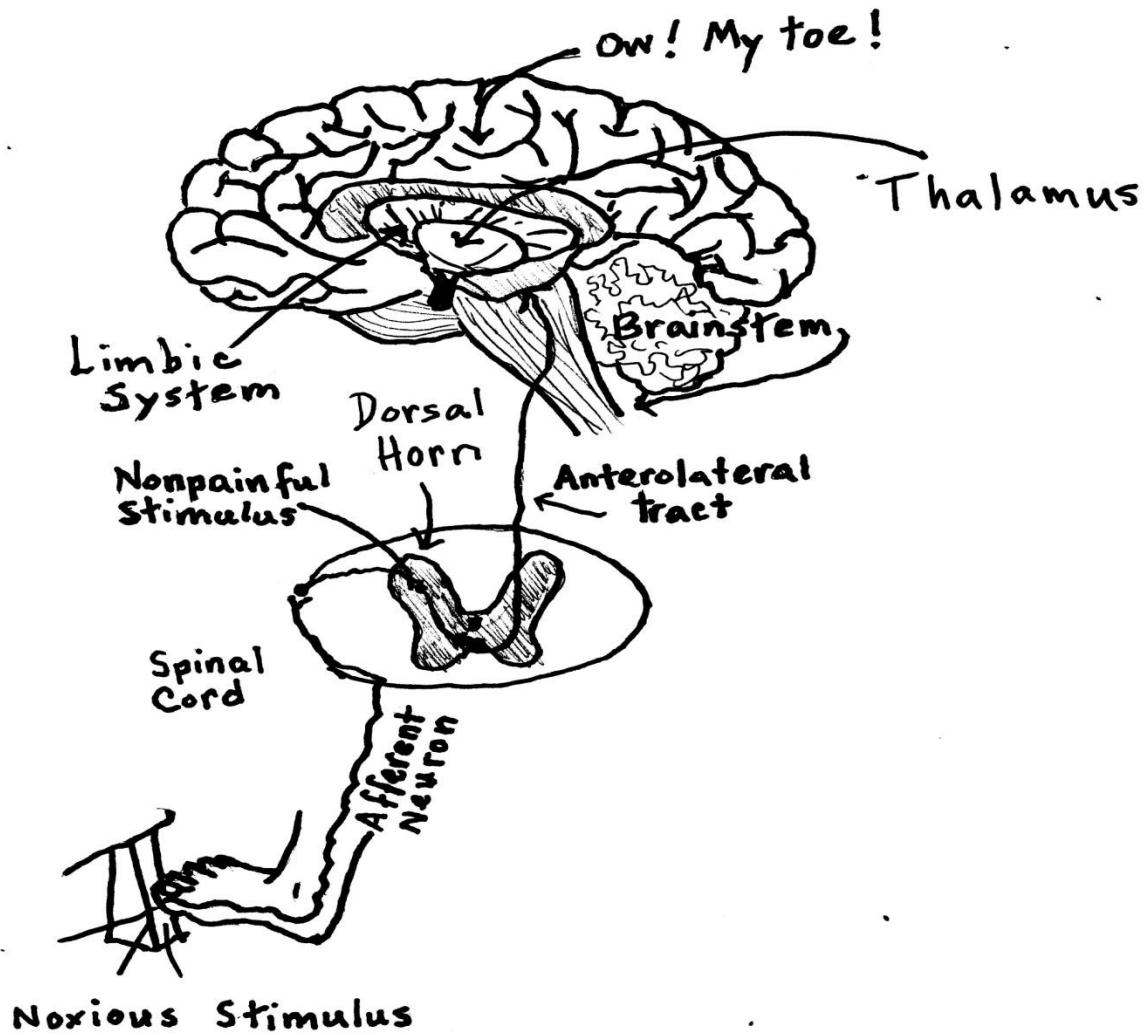
# Gate-Control Theory

- Introduced in the 1960s by Melzack and Wall
- Noxious stimulus trigger nociceptive cells, which send signal toward the spinal cord and ultimately to the brain (afferent neural transmission)
- Efferent signals diminish the pain perception somewhat by closing “gates” in the afferent pathways
- This model focuses on the nature of the stimulus and the spinal transmission more than on the brain

# Neuromatrix Model

- Melzack & Wall , 1999
- Brings more of the brain, specifically the brain-body unity, into the concept of pain
- The neuromatrix can be considered as a scaffolding, genetically designed, upon which experience constantly builds and remodels the brain-body experience of the self into a unique “neurosignature”
- *The neuromatrix model is one of the first that attempts to explain the neurophysiology of chronic pain*





# Types of Pain

- **Acute:** Immediate response to tissue injury or threat of injury, and pain occurring during the healing phase
- **Long-Term:** Pain that is long lasting, but is associated with an identifiable pathology, such as cancer
- **Chronic:** Pain that has outlasted the normal healing period, is disproportionately severe relative to the injury, or that has no identifiable cause.

# Acute vs Chronic Pain

- Acute pain is an unpleasant sensation caused by actual or potential tissue damage
- Acute pain serves a purpose: It motivates the person to seek help and, ideally, cure the cause of the pain
- Acute pain is often caused by visible injuries or diseases that are well-recognized and accepted by society as real (e.g., heart attack, broken bone), therefore,
- Acute pain elicits sympathy and concern from others, and permits the person to assume the sick role.

# Chronic Pain: Definition

- Pain that extends beyond the healing period for an injury or illness; generally >3 months duration
- Pain that has no identifiable cause, or that exceeds the severity that would be considered appropriate for the degree of tissue injury
- Poor or no response to treatment
- Pain that is, or eventually becomes, associated with emotional, psychological, and relationship problems (at which point it may be called “chronic pain syndrome”)

# Pain that extends beyond the expected healing period for an injury or illness

- Chronic pain may be caused, at least in some cases, by poor pain management during the acute phase
- This may allow for a pain template that becomes “hard-wired” in the peripheral pain receptors, the spinal cord and the brain
- Both afferent and efferent neurons may be remodeled for increased sensitivity to pain

Pain that has no identifiable cause, or that exceeds the severity that would be considered appropriate for the degree of tissue injury

- Remember, no pain is visible on any kind of scan or test; pain is *always* subjective
- In other words, ALL PAIN IS IN YOUR HEAD.
- No head = no pain!

# Poor or no response to treatment

- Suggests blame or other deficiency on the part of the client/patient
- Often leads to strained doctor-patient relationship, leading client to seek care elsewhere – interpreted by some as “doctor-shopping,” which is interpreted negatively by many health-care providers
- Reinforces the notion that the client is either experiencing psychosomatic ailments or is malingering

# Poor or no response to treatment

- This doesn't stop pain interventionists to keep trying, by administering lots of reimbursable procedures:
  - Cortisol and/or Lidocaine injection into the painful areas or "trigger points"
  - Epidural cortisol injections
  - Rhizotomy
  - Minimally invasive discectomy
  - Nerve blocks
  - Surgery: Laminectomy , discectomy, and spinal fusion
- **If these don't work, it may be called "failed back" syndrome (but not "failed doctor" syndrome – go figure!)**



# Pain becomes associated with emotional, psychological, and relationship problems

- This is where we come in: Our goal should be to maximize the client's ability to cope with, manage, and integrate chronic pain into their lives, and to set realistic goals, and improve overall quality of life
- Effective counseling requires an acknowledgement of the reality of the client's pain, appropriate advocacy, and teaching the client effective coping skills

# Pain becomes associated with emotional, psychological, and relationship problems

- “Catastrophizing”
  - Attempts to suppress pain
  - Avoidance or distraction
  - Irritability, isolation
  - Weakening of social support
- *Ironically, these responses often result in an increase in pain, muscle tightening, and psychological distress*

# Pain as/vs Somatic Symptom Disorder

- “The previous criteria overemphasized the centrality medically unexplained symptoms... The reliability of determining that a somatic symptom is medically unexplained is limited, and grounding a diagnosis on the absence of an explanation is problematic and reinforces mind-body dualism.”
- DSM-5, p.309

# Chronic Pain As a Distinct Entity

“Pain may be the warning signal that saves the lives of some people... but it destroys the lives of countless others. Chronic pains, clearly, are not a warning to prevent physical injury or disease. They *are* the disease – the result of neural mechanisms gone awry.”

Melzack, 2005

# Severe/Traumatic Stress and Chronic Pain

- PTSD is strongly correlated with chronic pain syndromes
- Ongoing activation of the sympathetic nervous system and adrenocortical system may lead to destruction of muscle, bone, and nerve tissue
- Muscular tension associated with stress can induce the accumulation of lactic acid and diminished microcirculation in muscle tissue

# Some Common Chronic Pain Syndromes

- Back/spinal pain; radiculopathy
- Recurrent migraine or cluster headaches
- Neuropathies (nerve pain)
- Fibromyalgia
- Reflex Sympathetic Dystrophy
- Phantom limb pain
- Chronic pelvic pain
- TMJ pain
- Arthritis (osteo- or rheumatoid)
- And so on....

# Assessment of Clients with Chronic Pain

- Mood; sleep & appetite
- Impact on ADL, work, and other functions
- Relationships and role confusion/role strain
- Intimacy
- Experiences with medical care providers and systems
- Self-Esteem
- Overall quality of life
- Meanings & belief systems; impact of CP on spirituality

# Obstacles for People with Chronic Pain

- Being disbelieved: When no physical lesion can be found to explain the pain, the person may be dismissed or disbelieved – “it’s all in your head”
- Being believed: If the person’s claim of pain is believed, they may be subjected to multiple invasive, possibly dangerous procedures that likely won’t help, and could exacerbate their condition



# Obstacles for People with Chronic Pain

- Chronic pain is more common in women, as are associated conditions such as chronic fatigue syndrome, irritable bowel syndrome, temporal-mandibular joint disorder, and many autoimmune syndromes such as multiple sclerosis, lupus and others
- Chronic pain is significantly correlated with histories of trauma, such as childhood sexual abuse, and depression

# Obstacles for People with Chronic Pain

- Medical treatments for chronic pain, particularly with opioid drugs, raise suspicions that the person with pain is abusing or addicted to these drugs. In other words, the treatment becomes primary, while the illness becomes secondary
- While addiction can occur, it is not likely. It is important for professionals to understand the differences among tolerance, physical dependence, and addiction

# Medications for Chronic Pain

Medications: Acetaminophen, NSAIDs, Cox-2  
Inhibitors, opiates, muscle relaxers, anticonvulsants,  
antidepressants

Concerns re: side effects, abuse, addiction

Tolerance

Dependence

Addiction

Medication monitoring

# Tolerance

- Refers to a pharmacologic/physiologic phenomenon in which the person requires increasing doses of a substance in order to achieve the desired effect
- Caution: Tolerance to certain effects (e.g., pain relief) may occur at different rates than others (e.g., respiratory depression)
- Tolerance is not necessarily a sign of addiction

# Withdrawal

- A syndrome of symptoms that occur when blood or tissue concentrations of a substance that has been used regularly are suddenly decreased
- Withdrawal symptoms vary among different classes of drugs

# When Does Drug Use Become Abuse?

- “Symptoms of tolerance and withdrawal occurring during appropriate medical treatment with prescribed medications (e.g. opioid analgesics, sedatives, stimulants) are specifically *not* counted when diagnosing a substance use disorder.” DSM-5, p. 484
- Substance use disorder can occur in individuals taking certain medications, but cannot be diagnosed based on tolerance and/or withdrawal. The behavioral components of compulsive and deleterious use must also be present.

# Addiction

- DSM-5 does not use the term “addiction” as a diagnostic term, partly because of its “uncertain definition and its potentially negative connotation” (p.485)
- When substance use meets the appropriate criteria, a diagnosis of “substance use disorder” is applied.

# Risk Factors for Addiction/Abuse of Prescription Opiates

- Past history of substance abuse, (not just opiates, but other drugs & alcohol)
- Co-occurring mental health problems independent of the pain problem
- Poorly monitored in treatment (Should be under the care of a pain management specialist with strict protocols)
- Pain is under-treated early in the process



# Signs of Possible Opiate Abuse

- Escalating dosages of narcotics
- Requesting early refills
- Cravings
- Hoarding
- Going to multiple providers and pharmacies
- Urine drug screening inconsistent with expected findings

# When a Person with Chronic Pain Develops an Opiate Abuse Disorder

- Recognizing and confronting the problem
- Acknowledging and addressing the continuing need for pain management
- Developing a treatment plan with the client
- Choosing safer medications
  - Buprenorphine – Naloxone (Suboxone)
  - Methadone
  - Long-acting preparations
  - Transcutaneous preparations
  - Limiting prescription size
- Using complementary and alternative therapies

# Multidisciplinary Approaches to Chronic Pain Management

- Reasonable medication use
- Physical therapy/exercise
- Manipulative/massage therapy/trigger point tx
- Acupuncture
- Movement therapies such as tai chi, Feldenkrais
- Reiki, yoga, and other energy field therapies
- Nutritional treatment
- Counseling/Psychotherapy

# Tasks in Coping with Chronic Pain

- Understanding the nature and course of CP
- Challenging the misconceptions of others
- Understanding and dealing constructively with others' reactions to them and their pain
- Exploring reasonable treatment options
- Adapting activities and physical environment
- Expressing and processing anger & grief
- Acceptance

# Themes in Counseling

- Advocacy; promoting self-advocacy
- Encouraging self-care
- Stress management, relaxation
- Identify and challenge distorted cognitions (e.g., catastrophizing)
- Building and reinforcing resiliency
- Facilitating family and social supporting

# Mindfulness-Based Approaches to Chronic Pain Management

- Mindfulness has become a core concept in many therapeutic approaches
- Rooted in Buddhist meditation practices
- Used to treat a variety of emotional and physical problems

# What is Mindfulness?

- Paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience
- An interesting marriage of cognitive-behavioral therapy and Buddhist religious and philosophical traditions
- The exact opposite of what we have learned in Western approaches to solving problems: Rather than attacking it, we accept it for what it is

# What is Mindfulness?

- A way of opening our awareness to not only the unpleasant, “negative” sensations or emotions, but also to the pleasant, positive ones
- Becoming aware of thoughts, emotions and sensations, but allowing them to drift by like a leaf floating on a stream of water
- Generally accomplished through meditation and breathwork



# What is Mindfulness?

- A central concept in several fairly new therapies, including:
  - Acceptance and Commitment Therapy
  - Mindfulness-Based Stress Reduction
  - Mindfulness-Based Cognitive Therapy
  - Dialectical Behavioral Therapy
  - Loving-Kindness Meditation

# Mindfulness Based Interventions for People with Chronic Pain

- Basic breathwork
- Cognitive defusion/De-centering: Learning that the pain exists within the person but is not, itself, the person. This allows externalization of the pain
- In a purist practice, MBIs would be used instead of efforts to control or reduce pain; in reality, it more likely to be used in addition to pain control efforts

# Acceptance and Chronic Pain

- Acceptance in the present moment, without giving up hope that the pain can be reduced or eliminated in the future
- As a component of the mindfulness approach, it is not judged; the feeling in itself is neither good nor bad, it just “is”
- This kind of acceptance creates space for the possibility of change (remember Carl Rogers?)

# Goals for Living with Chronic Pain

- Understand bodymind unity and challenge distorted thinking regarding role of the brain/mind in the experience of pain
- Become informed about pain management options and approaches to treatment
- Continue seeking and accepting appropriate medical management from a trusted pain specialist
- Learn and use cognitive-behavioral skills that positively affect the experience of pain

# Goals for Living with Chronic Pain

- A shift from trying to “conquer” pain to learning to maximize quality of life in the presence of pain
- Energy is shifted from fighting to adapting
- This does not mean that the person should give up on medical and other treatments, or pursuing reasonable new treatment options

# Goals for Living with Chronic Pain

- Identify people whose attitudes and behaviors negatively impact quality of life, and support client's decisions to modify or eliminate toxic relationships
- Work through grief and anger over the loss of a past healthy self, fears of a future life with unremitting pain

# The Counselor's Contribution

- Accept the client's reality *as* reality
- Unconditional positive regard
- Support the client in exploring treatment options and choosing those treatments that best meet the client's individual wants, needs, abilities, and beliefs
- Support the client in developing self-advocacy skills, choosing and maintaining healthy relationships, and dealing with toxic people and relationships
- Keep learning