Beyond the Pill: Biopsychosocial Approaches for Helping Complex Chronic Pain Patients
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Disclosures
• No disclosures to declare

• The views expressed in this talk are solely those of the author

• I am a pain psychologist with pain medicine/management and substance use disorder expertise, not a prescriber

Outline and Objectives
• Understand and recognize complex chronic pain

• Explore limitations of biomedical approach’s to pain care

• Discuss strategies to foster collaborative pain self-management

• Provide general recommendations surrounding opioids
Scope of the problem

- Approximately 30% or 100 million people in the US struggle with chronic pain
- More prevalent than heart disease, diabetes, & cancer combined
- Cost: $560 to $630 Billion

Recognize that not all pain is the same

Key Distinctions

- **Pain**
  - **Acute**
    - Goal: Palliative
  - **Cancer**
    - Goal: Palliative
  - **Chronic**
    - Goal: Functional
Key Distinctions

Patients with Chronic Pain
90% of patients
Easily managed
“Simple” chronic pain

Chronic Pain Patients
10% of patients
Very difficult
“Complex” chronic pain

An Important Distinction

“Simple” chronic pain
- Responds to standard medical treatments
  - Pt. is generally functional
  - Interactions are mutually satisfying
  - Acknowledge problems other than pain and benefit from treatment for comorbidities like depression, PTSD, etc.
  - Benefit from pain-specific psychological treatments like CBT, Biofeedback, or behavioral activation

“Complex” chronic pain
- Does not respond to standard medical treatments
  - Declining function over time in spite of progressively more aggressive, expensive, and risky medical treatments
  - Hx “enigmatic” presentations to multiple providers
  - Mutually unpleasant interactions
  - Perceived to be demanding, dissatisfied, and, often, drug-seeking

Providers feel stuck because all rational and appropriate medical options have been exhausted
Understanding Why We Get Stuck

• More than any other medical condition, complex chronic pain challenges our ability to deliver truly integrated patient-centered care

• Patients and providers share assumptions about chronic pain that fail to appreciate the complexity of the problem

The Way You Define the Problem Dictates the Solutions

Models of Care

Ancient Greece

• Definition
  • Illness/pain a result of angering the gods

• Solution
  • Appease the gods

Ancient Aztecs

• Definition
  • Hallucinations due to spirits trapped in cranium

• Solution
  • Trephination
The Way You Define the Problem Dictates the Solutions

**Models of Care**

- Medieval Times
  - Definition
    - Illness a result of "bad blood"
  - Solution
    - Blood letting

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The Way You Define the Problem Dictates the Solutions

**Models of Care**

- Descartes
  - Mind/Body Dualism
  - Led to the biomedical model

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Biomedical Model: Pain as Symptom

Nociception ➔ Pain ➔ Suffering Disability

Identify the cause ---- Treatment ---- Cure or solve
Dramatic increase in medical expenditure

Medicare population increased by only 12%

Are we really helping them?

Biomedical model: problematic beliefs

- Dualism: “mind” and “body” are separate
- Pain is a symptom of an underlying condition that can be objectively identified
- Pain is the primary problem
- Medical solutions are possible
- Provider is the expert responsible for fixing the problem
- Patient is a helpless victim of a disease or injury
The Patient/Provider Experience of Complex Pain in Primary Care

Stage 1: Hopeful

Treatment begins:
Patients are hopeful their new doctor can help
Doctors, who are successful with 9/10 pain patients, are confident they can help

The iatrogenic cycle of chronic pain

Stage 1: Hopeful

Standard approach to pain
Based on a biomedical model
Urgent pain relief is the goal
Standard treatments tried
Diagnostic tests ordered
Consultations are made

The iatrogenic cycle of chronic pain

Hopeful Phase

Patient
Other Problems
Pain

Provider
Other Problems
Pain
The Enigma of Complex Chronic Pain: Maximum Disability/Minimum Pathology

What they say does not match up with what we see

“In chronic pain, when the cause remains lost…the patient becomes the lost cause” (Eccleston, 1997)
Doubt sets in
Tests are negative
Standard treatments are not working
Patients are returned unchanged and more frustrated

Stage 1: Hopeful
Stage 2: Doubt
The iatrogenic cycle of chronic pain

Hopeful Phase

Provider concludes pain is not the primary problem and that they have little more to offer.
The iatrogenic cycle of chronic pain

The Patient/Provider Experience of Complex Pain in Primary Care

The iatrogenic cycle of chronic pain

Stage 1: Hopeful

Stage 2: Doubt

Provider doubts they have “real pain”
-Lazy
-Crazy
-Drug seeking

The Patient/Provider Experience of Complex Pain in Primary Care

Stage 1: Hopeful

Stage 2: Doubt

Refer to Mental Health
-Invalidating
-Barrier to getting “real” treatment
-Distracting from their primary problem

Pain Patients reaction to Mental Health

• “Why am I seeing you? I have real pain. My pain is not in my head”.

• “Of course I’m depressed. You would be too if you had my pain”.

• “If they would just give me what I need I will be fine”.

• “If someone doesn’t do something about my pain my life is not worth living”.

• “Why am I seeing you? I have real pain. My pain is not in my head”.

• “Of course I’m depressed. You would be too if you had my pain”.

• “If they would just give me what I need I will be fine”.

• “If someone doesn’t do something about my pain my life is not worth living”.

The iatrogenic cycle of chronic pain

**Patient**
- Rejects MH referral, returns to primary care
- Increased demands for validating tests that pain is "real"
- Increased demand for urgent pain relief

**Provider**
- Experiences significant personal and social pressures to "help" by urgently reducing pain
- More of same
  - Repeat tests
- Agree to just about anything to get them out of the office
  - Escalate meds

**Mutual Rejection**
Provider: another crock
Patient: another quack

Stage 1: Hopeful
Stage 2: Doubt
Stage 3: Conflict
Stage 4: Rejection
Fundamental Problem

- Problem is not provider or the patient
- Both share a biomedical model that is inadequate to address the complexities of complex chronic pain
- Conflicts develop because they doubt each other rather than doubting their assumptions about chronic pain and its treatment

Breaking the Iatrogenic Cycle

- Reconceptualize the problem
- Redefine...
  - helping
  - methods
  - goals

Stage 1: Hopeful
Stage 2: Doubt
Stage 3: Conflict
Stage 4: Rejection

When you redefine the problem you redefine solutions

- Provide care within the context of a biopsychosocial model of chronic pain
- Chronic pain is a complex human experience that can only be understood in the entire context of the person's life
- Pain Experience = Nociception X Suffering X Disability
If you treat complex chronic pain from a biomedical perspective you can make patients worse.
Collaborative Self-Management: What it is

• Supporting the patient as a person while challenging the belief that pain is the primary problem and that medical solutions are possible

• Full range of medical interventions are employed but in a context that emphasizes the far greater importance of the efforts the patient makes in his or her own long term rehabilitation

• Goal is to shift the locus of hopefulness from medical treatments to your patient’s own rehabilitation efforts.

• Focused on long term function and quality of life

Collaborative Self-Management: What it isn’t

• Not focused on urgent and absolute pain relief as the primary goal of treatment

• Not an effort to convince pt that their pain is “caused” by psychosocial factors

• Not a grim alternative to failed medical treatments

Moving Towards Collaborative Self-Management

Change the patient’s experience of chronic pain by changing their experience of healthcare
Co-disciplinary care

- Efficient: one interview, no need to meet separately to discuss case
- Effective: legitimizes role of psychologist and expands scope of inquiry
  - Give ‘em what they want and slip ‘em what they need
- Embodies biopsychosocial model
  - Medical provider = bio
  - Mental health provider = psycho/social

Through your interactions, problems are defined and solutions are offered

Avoid “Hot” Phrases

- There is nothing wrong with you
- Accept your pain
- You’ll have to live with the pain
- Nothing can be done
- You have a “degenerative” condition

Redefine while providing validation and hope

- We can’t measure pain with tests
- Expect pain to be a small part of you life and it won’t be a big one
- I want to help you live better with the pain
- No medical solutions does not mean no solution
- Getting older and these are normal changes

Moving Towards Collaborative Self-Management

- Patients who are overwhelmed by chronic pain are also overwhelmed by life problems independent of pain
  - Pain can’t be treated separately of the problems “caused” by pain
- Encourage acknowledgement of problems other than pain
  - Metaphor of “erosion”
- Help the team better understand the patient by always asking, “What problems other than pain are contributing to suffering and disability?”
Moving Towards Collaborative Self-Management

- Overwhelming pain is not the primary problem for our most “difficult” patients, it is a self-defeating, short-term solution for other life problems.
- “Secondary gain” is primarily thought of as access to compensation or drugs. It is for a very small minority of patient.
- For most patients, pain primarily serves to protect self-esteem, moderate family dynamics, or is deeply embedded in a history of childhood trauma.

Moving Towards Collaborative Self-Management: VEMA Model (Valeu)

**V = Validate**
- Complex pain patients feel “trapped in the helping system”
  - Their sense of being rejected is usually very real.
  - Begin to repair the relationship with the health care system
  - Acknowledge their frustration with medical care
  - Convey understanding of their struggle.

**E = Educate**
- Basis of long-term, effective care is a shared understanding of chronic pain
  - How problems other than pain contribute.
  - Cure is not possible, but rehabilitation is.

“*You cannot solve a problem with the same mind that created it.*” ~ Albert Einstein
Moving Towards Collaborative Self-Management: VEMA Model

Why Validation and Education Come First

- As long as complex pain patients believe that medical solutions are possible or perceive that the validity of their complaints is in doubt they will vigorously pursue medical treatment and reject psychosocial/self-management options.

M = Motivate

- Complex pain patients are often hopeless and perceive themselves to be helpless.
- Challenge their decision to “do the same thing over and over while expecting different results”.
- Teach your patient that “pain may be inevitable but suffering and disability are optional”.
- Increase self-efficacy for self-management.
- Deemphasizing cure and medical solutions.
- Affirm small steps.
- Adaptive choices
- Sustained effort
  Improved function
  and
  Quality of life.

A = Activate

- Primary clinical focus is change the way patients respond to pain.
- Not just physically.
  - multiple areas of patients lives.
- In a paced, sustained fashion.

Mark “pushes through” the”

Mark reduces pain in moderation.

Without medication, Mark keeps a steady pace to avoid pain flares.

The pain gets so severe that it results in extended rest (“crash and burn”).

Mark again “crashes and burns.”
Opioids: Past to Present

**1980’s**
- Providers reluctant to prescribe opioids for terminal conditions

**1990’s**
- Aggressive marketing of opioids by pharmaceuticals
- Pain designated the 5th vital sign

**2000’s**
- Americans, constituting only 4.6% of the world’s population, have been consuming 80% of the global opioid supply, and 99% of the global hydrocodone supply

Opioid prescribing by state
Opioid Overdose

Opioid Epidemic

- Opioid Overdose is now the #1 cause of accidental death
- The CDC has declared that we are in the middle of an epidemic of deaths from prescription drug overdose

Bohnert, et al. Med Care 2011;49:393-396;
Bohnert, et al. JAMA 2011

For every 1 death there are:
- 10 treatment admissions for abuse
- 32 emergency dept visits for misuse or abuse
- 130 people who abuse or are dependent
- 825 nonmedical users
Pain, Addiction, and Opioid Misuse

- Pain and SUD
  - Overall prevalence 3 to 48% (Morasco, 2010)
  - Life time prevalence 16 to 74% (Morasco, 2010)

- 78% of patients with chronic pain report 1 or more past-year indicator of misuse (Morasco & Dobscha, 2008)
  - Borrow pain medications from others – 8%
  - Take more medication than prescribed – 53%
  - Multiple requests for opioid dose increase – 56%
  - Ran out of pain meds and requested early refill – 30%
  - Doctor shopping – 3%

Pain vs. Addiction

- Confusion arises when attempting to decipher why misuse occurred
  - “Is this under treated pain or addiction?”

Consequences of labeling aberrant behaviors pain or addiction

<table>
<thead>
<tr>
<th>If it is undertreated pain</th>
<th>If it is addiction</th>
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</thead>
<tbody>
<tr>
<td>Often results in opioid escalation</td>
<td>Patients’ pain is invalidated</td>
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<tr>
<td>Keeps patients focused on urgent pain relief through opioids</td>
<td>Patients are given a pejorative label</td>
</tr>
<tr>
<td>Keeps patients focused on pain to the exclusion of other problems</td>
<td>Patients are referred to addictions treatment, which they reject</td>
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<td></td>
<td>Patients defend/argue against addiction</td>
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Cutting through the confusion: Be mindful of model’s

- View addiction and pain through the same lens

Cutting through the confusion

- Avoid tendency to devolve to simplistic explanations
  - Is this “real pain”
  - Or is this patient simply an “addict”
- Pain and addiction are complex problems
- Tolerate ambiguity that can dominate initial evaluation
  - With observation and time, more information will become available to inform treatment

Cutting through the confusion: Effective focus

- Separate the motive from the behavior
- More effective to focus on the problematic behavior (overusing) rather than debating the motive behind it (e.g., pain, addiction, chemical coping)
Cutting through the confusion: Importance of the relationship

- Patients w/ chronic pain often feel invalidated by health care system
  - Especially true of chronic pain patients with an SUD history
  - Once therapeutic rapport is gone, so is our ability to effectively help the patient

- Roll with resistance
  - Emphasize patient autonomy and choice

- Put opioids on trial, not the patient
  - Opioids tend to be a big part of the problem because they are such a small part of the solution

Opioids are neither...

- A gift from heaven
- The devil's drug

Opioids and Chronic Pain

- Opioid can be a useful tool when...
  - Prescribed at safe doses
  - Are part of a comprehensive rehabilitation plan
  - That reinforces positive change rather than further deterioration

- Safety always trumps pain relief
Facilitate a Truce

- Pain is not the “enemy”
- Goal is not to “kill” the pain
- Goal is to help the patient stop fighting a war they cannot win and live a full and productive life...even if they hurt.

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Questions