PSYCHOLOGICALLY COPING
PAIN THAT WON'T GO AWAY

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Abstract: Pain is a major distractor and strongly challenges, not only the patient, but also the treating practitioner to understand what psychological effects are generated. People cope differently with pain especially chronic pain. Enquiry into the patient's personality-based psychological needs at this time of stress and ill health will often give clues as to how they need to change their approach if better coping is to result. By using co-operation and open dialogue between professions, treating practitioners can encourage a strong measure of complementary care and encourage greater understanding of complex patient needs.

Key Words: Chronic pain, psychological coping, whole person approach.

In cases of mild injury or illness with associated pain, patients can display a tolerance for their disturbing pain symptoms because they expect to get better. When they do recover, life can return to normal and there is a sense of satisfaction generated by "beating the odds". Treating health practitioners will have noticed good compliance in the patient with strong motivation, and of course, increasing improvement in physical terms. Providing there is reasonable care taken in the future, re-occurrence might be avoided.

Pain that won't go away however is a different proposition. Any tolerance initially present can be quickly eroded by a condition which does not respond to treatments. Anecdotal evidence will suggest that the longer pain persists, the greater will be the frustration, depression, worry, dependence, anger and assorted other problems of adjustment felt by the patient. Instead of having one problem (the pain) to contend with, the person now has a collection; a chain reaction effect. Many aspects of normal life can be disrupted including family, social relationships, work capacity, sexual performance, etc. Coping takes on the proportion of a major task at the same time as the patient's internal and external resources are being progressively stretched and depleted.

HOW DO PEOPLE COPE
Affleck et al (1) noted "pervasive individual differences in daily pain coping" with patients drawing on personality-determined approaches. People can often be seen to be personally "choosing" whether they adopt a particular attitude, approach, technique, reliance on external help and so on. Clearly, the more pain sufferers understand about their condition and the more access they have to coping ideas, the better chance they have of managing. Yet multiple stressors occur in most pain patients and it is often quite impossible to determine whether the pain itself or the enforced lifestyle changes are the most salient source of stress (2).

Recommended psychological strategies usually include mention of physical relaxation and stress release, the establishment of day to day routines which promote a "well role", reduction in negative emotions, limitation of pain behaviours, thought and attitude remodelling and the all important symptom control. Self help and self management are offered as worthwhile goals for the pain sufferer. Not everybody will take up the challenge however and there are retarding factors postulated by authors eg. spousal response (3), denial of anger and aggressiveness (4), employee appraisal rating (5).

WHO COPES BETTER
Chronic pain is a complex problem (6). The personality and coping repertoire of the afflicted person is equally complex. There have been attempts to isolate factors which if present would produce higher levels of coping, yet there exists the continuing problem with reliance on patient "self-report" which
can remain vulnerable to bias and inaccuracy (7). Nobody can “know” what another is experiencing and it does remain a matter of testing out psychological strategies to see whether they “fit” the sufferer or not. Just as one person will be a better hypnotic subject (and therefore gain more relief from suggestions of dissociation from pain), another will adjust quicker if she/he alters their level of domestic tasks in line with practical limits imposed by the injury or illness. Choices are important. What is curious is the extent to which patients can resist their own good advice. For example, the person might intuitively realise it is not of their intentional doing that their performance (work, home etc.) is falling below pre-injury standards yet their self criticism does not accordingly reduce. Clinical experience reveals a tendency in some to actually increase pressure to perform, resulting in naturally poor outcomes. The challenge in psychological treatment is to explore ways of re-directing the “pressure” into sensible, achievable goals such as relaxation and symptom relief.

WHAT DOES THE CHRONIC PAIN PATIENT NEED

Relief from nagging depressing hard-to-shift symptoms is high on most patients’ lists along with confirmation that they are not “imagining” the pain. Because pain is essentially a private sensation of hurt, help needs to be tailored to the person, not the other way around. What devastates one individual, may seem minor to another. Psychological investigation looks for the personalised "stumbling blocks" preventing a sufferer from relaxing more, from banishing destructive worry (which is regularly implicated in reports of increased perceived pain), from adjusting their expectations and from removing anger within themselves (as well as with their God, their treatment providers and anybody else with whom they interact).

Pain, the powerful underminer of confidence, demands attention and will test the patient’s patience. Every time there is a relapse in condition, more courage, determination and perseverance are called for. While some people can find those qualities when needed, others struggle and feel worse for their “failure”. A great part of psychological treatment is devoted to helping the patient "believe in themselves”, to understand that the results they want depend on their application of positive thought not on some magical transfer from the treating practitioner. Naturally anxiety is experienced when a condition has become chronic, and that emotional state has to be seen as “unhelpful” and its removal a high priority.

Techniques frequently used for psychologically-guided symptom reduction (8,9) include hypnotherapy (based on imaginal changes to perceived pain), biofeedback (using physiological indicators such as muscular tension in relation to the pain state), cognitive restructuring (altering thought patterns to others of coping), relaxation, confidence boosting, empowerment (the patient gaining control even though they have felt weakened in the past by their experiences) and help in planning for the future challenges in life.

SUCCESS OR OTHERWISE

Pain patients show great variability in their capacity to manage. Most immediately the “distraction” produced by pain itself ought not be underestimated especially when psychologically-based coping depends on the person attaining focussed positive thought. Nobody likes being in pain and a common reaction is for the patient to become angry with being restricted, hurt, slowed down or destined to change their life plans.

Psychological treatments can specifically target negative emotions or thoughts and help the pain sufferer regain "control" in the way they cope. In cases from chronic pain, the important message is one of management, not cure. Expectations need to be set at realistic levels in view of medical indicators and the possibility of irreversibility of the injury/damage state. However, some patients "fight" the condition lest they display weakness and predictably develop worsened symptoms. Their recovery or rehabilitation period is often lengthened.

IMPLICATIONS FOR TREATING PRACTITIONERS

Except for the occasional well-experienced, multiple-incident patient, it could be assumed that people who develop pain conditions are "shocked" even traumatised at the onset of a pain producing condition. General emotional unpreparedness is a familiar feature of presenting psychological symptomatology and the earliest attention to this area is recommended. Reskilling via recommended texts, face to face instruction, meeting with fellow sufferers and diary keeping is essential.

Not only will the severity of the change in people's health and prospects influence the likelihood of coping but also will the individual's knowledge of how to cope be paramount.

Treating practitioners might find better response to their recommendations when the patient is involved in "shaping" the content of such to suit the person's...
particular way of thinking, their knowledge needs, the extent of "guarantee" being sought and by building in control by the patient in their application to treatment tasks.

Each practitioner brings to treatment competencies in their own area of training yet the "whole person" approach to managing chronic pain states regularly suggests that the physical, medical, emotional, psychological, spiritual and interpersonal dimensions all require emphasis. Greater co-operation and dialogue therefore between practitioners will encourage complementary care and more understanding of the complexity of patient needs.

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