Psychological Approaches to Facilitate Rehabilitation for Chronic Pain & Disability

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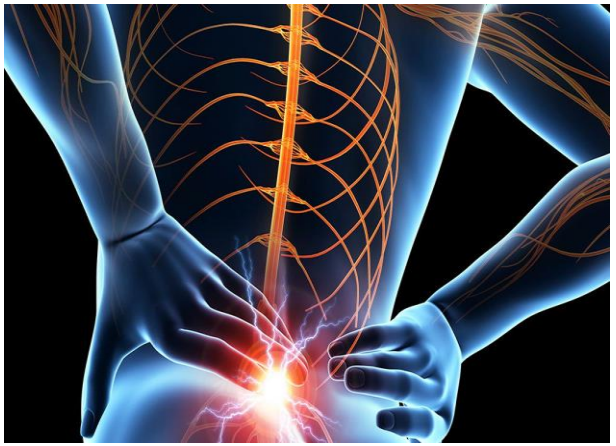
Overview

- Psychological theories of chronic pain and chronic disability
- Psychological and rehabilitation approaches for treating clients with chronic pain
- Working with the especially challenging client

Defining Chronic Pain



Definition of pain (IASP):

- “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage“

Defining chronic pain:

- Pain that lasts longer than 6 weeks, 3 months, 6 months
- Pain that persists longer than time expected for healing

https://www.iasp-pain.org/index.aspx

Defining Chronic Disability

According to the WHO, disability has three dimensions:

- **Impairment** of body structure or functioning
- **Activity limitation** – difficulty seeing, hearing, walking
- **Participation restrictions** – can't work, engage in social/recreational activities

Labor & Industries:

- **Permanent Partial Disability** – can still work, permanent loss of function
- **Total disability** – injury prevents gainful employment

https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html

http://www.lni.wa.gov/IPUB/242-104-000.pdf

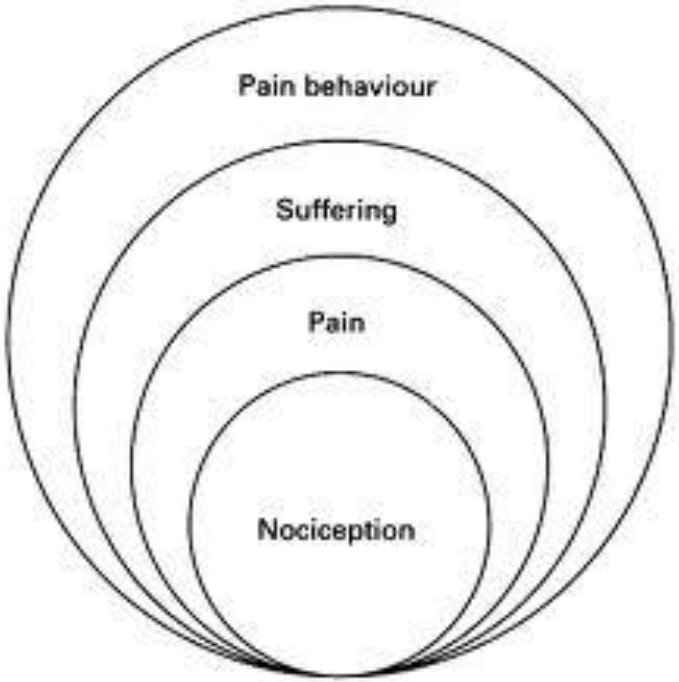
Chronic Pain and Disability

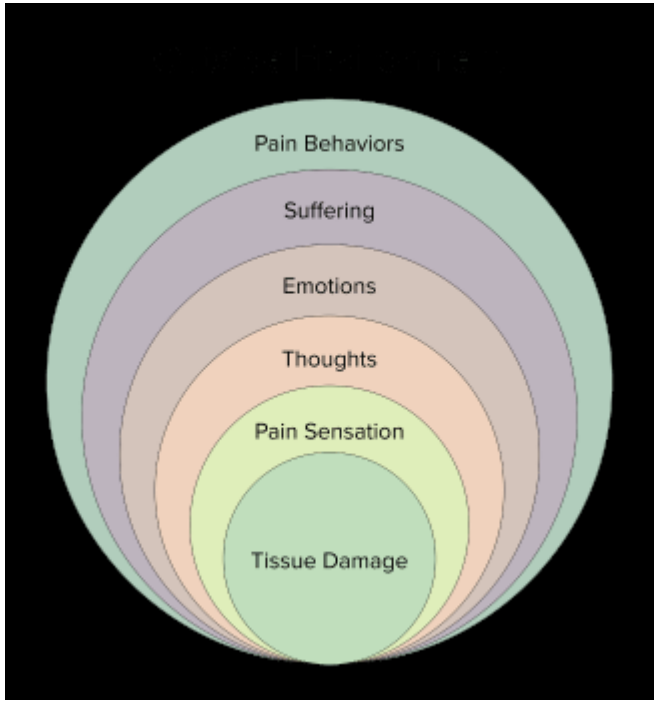
Beyond laws, benefits systems, and objective measurement,

There is an element of subjectivity to chronic pain and disability

Theories and models of Chronic Pain & Disability

Biopsychosocial model

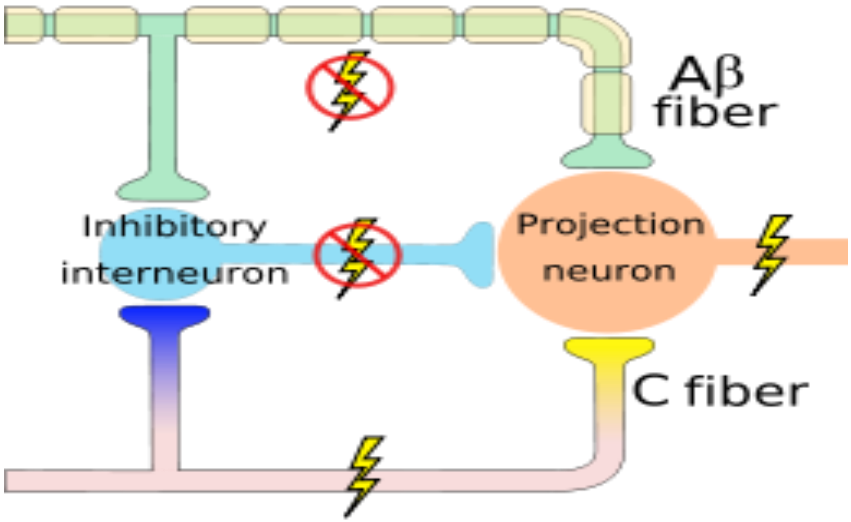




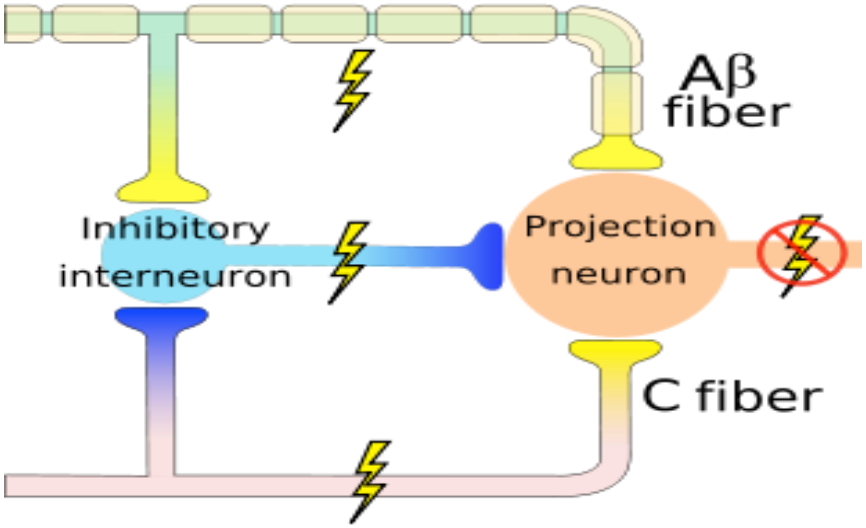
Loeser, 1980

Theories and models of Chronic Pain & Disability

Gate Control Theory



A pain fiber activating the pain signal to the brain



A non-pain fiber blocking the pain signal to the brain

Melzack & Wall, 1965

Theories and models of Chronic Pain & Disability

Behavioral Models

Pain as a learned behavior

Experience of pain

↓

Pain Behavior

↓

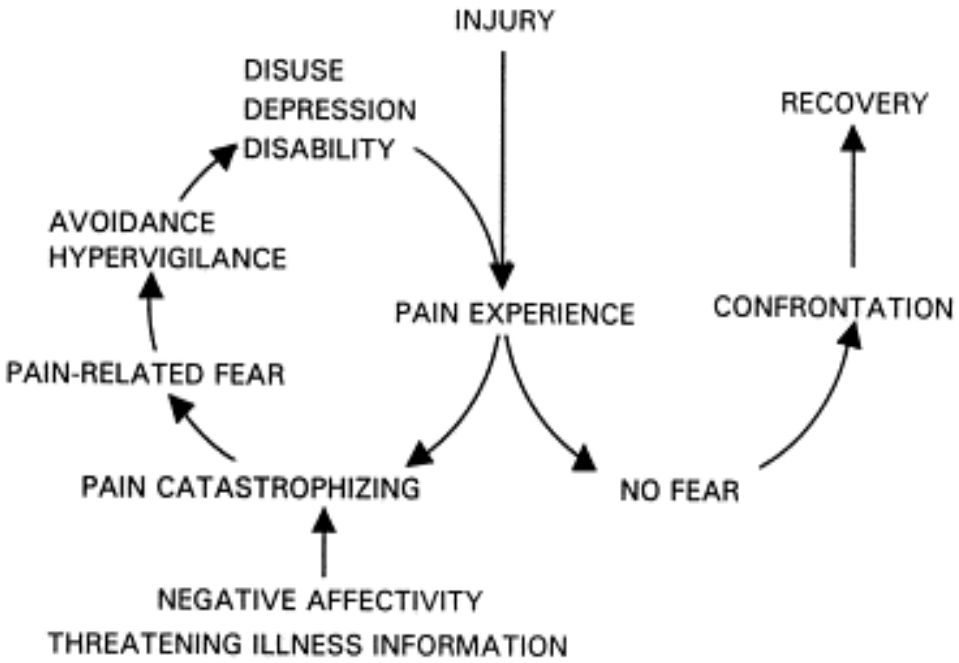
Reinforcing Consequences:

Attention

Help

Excused from unwanted tasks

Pain fear and avoidance → more disability



Fordyce, 1976; Vlayen & Linton, 2000

Expression of pain and disability

- Verbal expression
  - Talking a lot about symptoms
  - Expressing limitations in functioning
  - Declining to try or do something
- Disability and pain behavior
  - Affective: wincing, grimacing, crying, moaning/groaning
  - Movement: limping, guarding
  - Using assistive devices: canes, crutches, braces

Normal vs. more than expected

These behaviors get reinforced

Theories and models of Chronic Pain & Disability

Socioeconomic

- Culturally-driven disorders
  - Need for legitimacy of illness
  - Resolution is the appearance of an excuse to make it face-saving
    - Expression of distress as pain/injury → the latter is more acceptable
- Premorbid factors
  - Excessive self-sacrifice
  - Hyperactivity
  - Over-achievement
  - Started work at early age
- Somatic fixation
  - Insistence on diagnostic tag fosters dependence on medical system

Aceves-Avila, Ferrari, & Ramos-Remus, 2004

Treating Chronic Pain & Disability

Goals and values to facilitate direction of treatment:

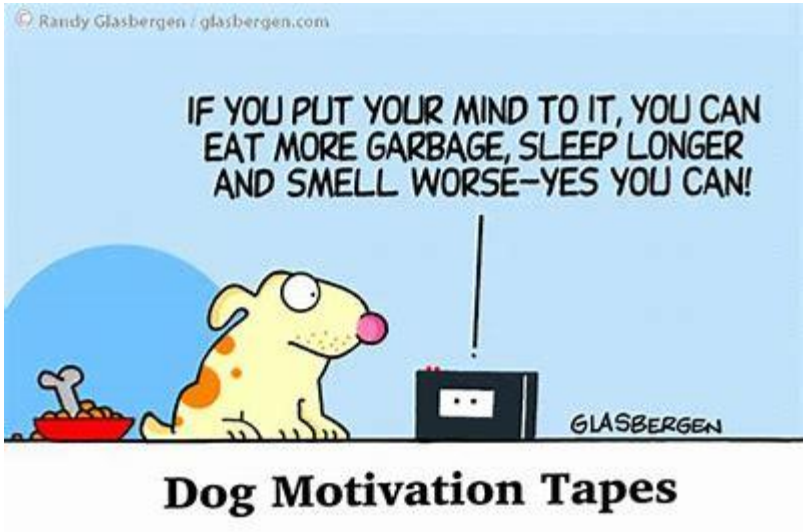
- Difference between goals and values

Goals as a state to achieve	Values as choices for direction

Treating Chronic Pain & Disability

Goals and values to facilitate direction of treatment:

- Using SMART goals
  - **S**pecific
  - **M**easurable
  - **A**chievable
  - **R**elevant
  - **T**ime defined



Treating Chronic Pain & Disability

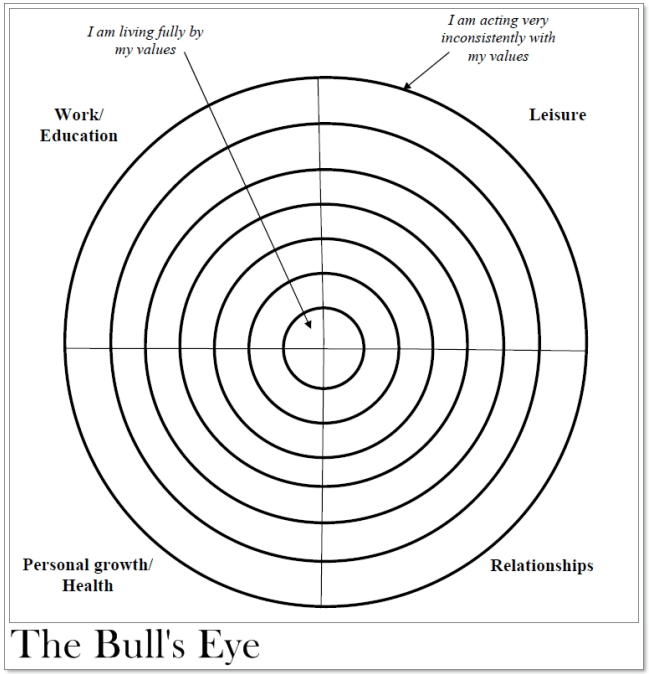
Goals and values to facilitate direction of treatment:

- Art of extracting goals from those who don't give them
  - Can be identified during structured or semi-structured interview
  - Identify affective changes to tune you into interests of person
  - Can ask questions that are designed to get at goals implicitly
    - Where do you want to be in 6 months, one year, etc?
    - What changes are you hoping to make?

Treating Chronic Pain & Disability

Goals and values to facilitate direction of treatment:

- Values to facilitate goal setting and treatment engagement



The Bull's Eye

Actions you can take to live those values (now)

- Work: collaboration → invite opinions
- Leisure: spontaneity → go for a drive
- Personal growth/health: discipline → call about working with personal trainer
- Relationships: openness → tell spouse what is bothering me

Russ Harris, 2008

Treating Chronic Pain & Disability

Treatment targets:

- Deconditioning/Deactivation
- Fear of movement/re-injury/catastrophizing/hypervigilance
- Disability beliefs
- Experience of loss and anger
- Reinforcement of pain/disability behavior by social supports
- Socioeconomic distress

Treating Chronic Pain & Disability

Addressing deconditioning/deactivation:

- **Graded reactivation**
  - Assess baseline and start with minimal activity
  - Engage in graduated progression with programmed success at each step
  - Achievement helps people see that they can function better than they thought
  - Changes beliefs by creating evidence that is counter to disability
- **Behavioral activation**
  - Pleasant activity scheduling
  - Do despite feeling
  - Do based on experience

"You need to stop flying and start jogging."

Treating Chronic Pain & Disability

Addressing deconditioning/deactivation:

- **Motivational intervention**
  - Explore ambivalence and facilitate change talk
    - Ask open questions
    - Reflective listening
    - What is working and not working?
    - What is it that you would like to be different?
    - How would you go about making that happen? How can I help?
  - Reinforce change
    - Be very vigilant to recognize change effort/change talk
    - Be careful to not be overly reinforcing or arbitrarily reinforcing

Miller & Rollnick, 2002

Treating Chronic Pain & Disability

Addressing fear and disability beliefs:

- **Graded exposure**
  - Systematic desensitization to the feared or avoided activity
    - Having a better outcome than initially anticipated (didn't hurt so bad, didn't fall)
    - Identifying feared activities, rate them, and start with least distressing
    - Doing the activity until distress subsides
  - Changing appraisals from threat to safety (hurt vs. harm)
  - Taking into account context (now vs. then)
  - Can be done in conjunction with behavioral activation

Treating Chronic Pain & Disability

Addressing fear and disability beliefs:

- **Thought management**
  - Cognitive restructuring
    - Evidence for and against a belief
    - Develop more adaptive beliefs
    - Developing more moderate beliefs (rather than extreme)
    - Identifying and challenging irrational fears/pain catastrophizing
  - Cognitive defusion
    - Recognizing you are not your thoughts
    - Can choose to 'buy' thoughts or not
    - Distancing oneself from thoughts
    - Calling a spade a spade "there goes my mind ruminating about pain again"

Treating Chronic Pain & Disability

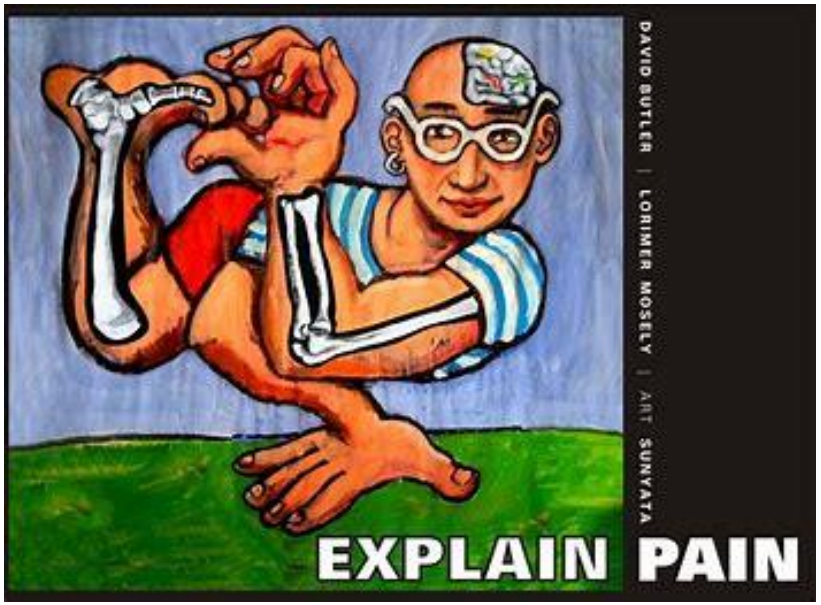
Addressing fear and disability beliefs:

- **Managing awareness and physiological reactivity**
  - Mindfulness & Acceptance
    - Raising awareness of tendency to focus on pain and threat
    - Learning to be able to move attention
    - Bring objectivity to aversive experience
    - Allowing, even embracing aversive experience
    - Facilitating ability to enjoy
  - Relaxation, visualization, and hypnosis
    - Reducing hypervigilance
    - Increasing ability to cope
    - Increasing engagement and focus on pleasant experience

Treating Chronic Pain & Disability

Addressing fear and disability beliefs:

- **Education**
  - Biology
    - Learning about pain pathways
    - Sensitization
    - Physiological reactivity and pain
  - Psychology
    - Catastrophizing/hypervigilance
    - Anticipation of pain
    - Mood and pain
  - Social aspects of pain
    - Pain behavior
    - Changes to social dynamic



Butler and Mosely, 2013

Treating Chronic Pain & Disability

Coping with loss and anger:

- **Validation**
  - Joining statements: "This has been so difficult" "This has taken a lot out of you"
  - Be present in demeanor
  - Resist the righting reflex
- **Cognitive behavioral therapy**
  - Emotional processing/labeling
  - Rediscovering sense of self, build up self-worth
- **Forgiveness**
  - Explore blame and impact it has
- **Self-Compassion**
  - "How would you talk to a loved one?"
  - Soothe and allow

Treating Chronic Pain & Disability

Addressing pain/disability behavior:

- **Education**
  - Identify pain behaviors and social impact
  - Short term effectiveness vs. long term effectiveness
- **Identifying alternative coping behaviors**
  - Learn to reduce maladaptive pain behaviors
  - Learn to implement use of more adaptive pain behaviors
- **Communication**
  - Expressing needs in more direct ways
  - Monitoring how much one talks about pain
  - Getting people to listen
- **Shaping behaviors**
  - Reinforcing adaptive behaviors

Treating Chronic Pain & Disability

Addressing socioeconomic distress and cultural factors

- **Providing culturally relevant services**
  - Facilitate access to care
  - Understand and use culturally relevant approaches
    - "How are these kinds of injuries treated where you are from?"
    - "How do you define healing?"
  - Inquire about beliefs related to western medicine

https://ethnomed.org/

Treating Chronic Pain & Disability

Addressing socioeconomic distress

- **Learning about available resources**
  - Programs and services: 2-1-1
  - Community centers
- **Education**
  - The rehabilitation process
  - Claims process
- **Facilitating return to work**
  - Increasing readiness for the vocational process
  - Increase awareness of return to work supports: adaptive equipment, preferred worker program, DVR

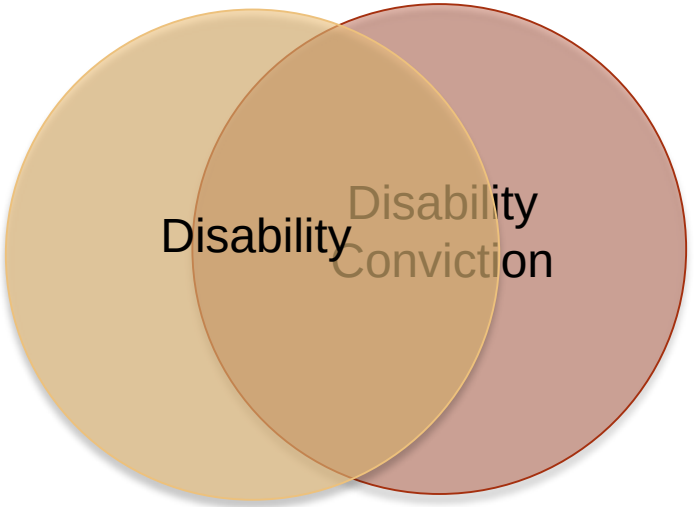
The especially challenging client

The especially challenging client

- Barriers that can hinder rehabilitation
  - Adversarial relationship with employer & or claim
  - Litigation
  - Limited education
  - Singular work history
  - Facing significant loss of wage
  - Being an undocumented worker
  - Opioid dependence and addiction
  - Cognitive deficits
- Refer to barriers assessment
  - Can be done with injured workers through the Centers of Occupational Health and Education (COHE)

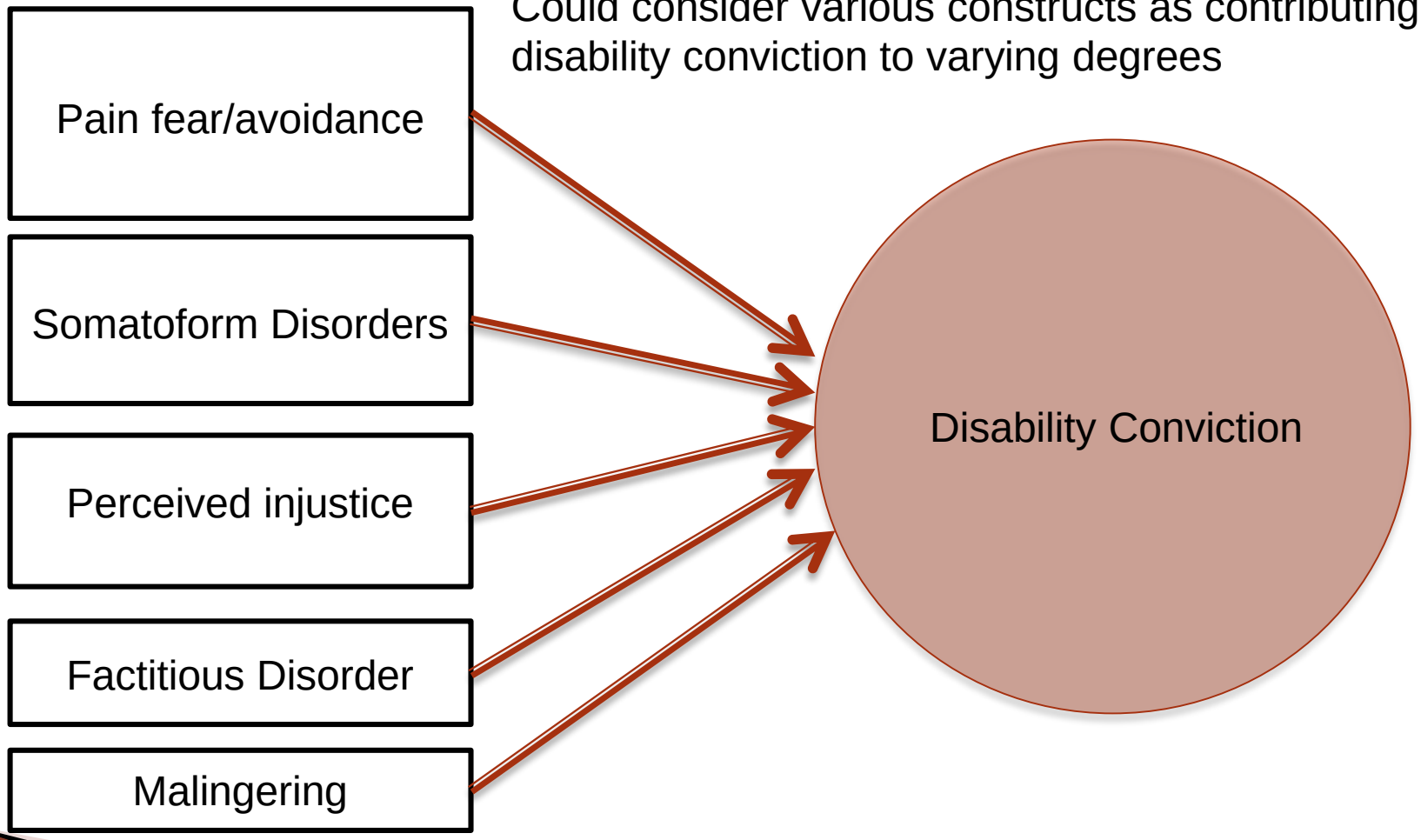
The especially challenging client

- **Disability conviction** is the belief one is unable to meet occupational demands and personal responsibilities, and is unable to engage in avocational and recreational activities (Aronoff & Livengood, 2003)
- The problem arises when the person's belief of his/her disability is incongruent with the social community's norms for level of disability given the cause



The especially challenging client

Could consider various constructs as contributing to disability conviction to varying degrees



The especially challenging client

Factors playing a role in disability conviction

- Cognitive factors:
  - **Change in self-perception**: "I was_____, Now I am _____."
  - **Confirmation and disconfirmation bias**: attend more to and accept evidence of disability
    - Client is preoccupied with failing at one task and overgeneralizes this as an example of overall dysfunction
    - Client wants more diagnostic testing despite numerous tests revealing little objective pathology

The especially challenging client

Factors playing a role in disability conviction

- Experience:
  - Not being believed about an injury (especially with less obvious injuries)
- Social reinforcement:
  - Doctor (expert) sends message of disability
  - Social supports enable/reinforce disability beliefs and behaviors

The especially challenging client

Sociocultural factors in disability conviction

- Beliefs about what is happening to the body after injury and meaning of being healed
  - Not being able to get culturally relevant treatments
- Cultural norms about life role changes after injury
  - Norms about expectations of being cared for by family
  - Change in financial status as change in social status
- Stigma about injury
  - Injury as a punishment for a wrongdoing
  - Work culture of “suck it up, ” being ridiculed, being alienated

Working with the especially challenging client

- The terms we use can have a significant impact on how clients feel they are viewed by their providers
- “Disability conviction” can have a negative connotation
- Can use other terms that are less pejorative
  - Endorses levels of perceived disability incongruent with demonstrated levels of functioning
- Use language allowing for context and that is not absolutist
  - Client appears to engage in behaviors to impress on others she is disabled, however, some of these behaviors may be accounted for by anxiety of her vocational future

Working with the especially challenging client

Getting you in the right place

- Stabilizing yourself before stepping into the storm
  - What do you think or feel before seeing this client
  - Mindful empathy
  - Grounding
  - Re-affirm your values
  - Self-compassion
    http://self-compassion.org/

Working with the especially challenging client

Building and improving rapport

- Motivational Intervention
  - Clients are more receptive to talking about work based on the verbiage
    - "When do you plan on going back to work?" instead of "Do you want to return to work?"
- A little bit of collusion with the client
- Backing off the agenda
- Monitoring and working with your own reaction to someone with a high disability conviction

"It's the relationship, stupid!"

Working with the especially challenging client

Other approaches

- Careful to not give message of excess disability
- Validate what's valid
- Avoid pushing agenda of proving one is not disabled
- Promote client sense of agency in his/her treatment
- Sometimes there are more complexities to healing
- Help them better understand their rights but also their obligation in terms of their responsibilities

Working with the especially challenging client

Communication: you are not alone

- Seek consultation
  - With colleagues within your profession
  - With colleagues providing health services
    - Physician
    - Psychologist
    - Therapists
    - Nurse case manager
  - With interpreters
- Get at the stuck points
  - Wizard of Schenectady (Charles Proteus Steinmetz)
  - Examples

Working with the especially challenging client

Facilitate referral to active rehabilitation

- Low level of disability (perception)
  - Work conditioning and work hardening
  - Progressive Goal Attainment Program (PGAP)
- High level of disability (perception)
  - Structured Intensive Multidisciplinary Program (SIMP)
- Excessive focus on cognitive deficit
  - Neuropsychological evaluation
  - Brain Injury Rehabilitation Program

Working with the especially challenging client

Learn more about chronic pain

- Videos
  - What is chronic pain video: https://www.youtube.com/watch?v=gy5yKbduGkc
  - Lorimer Mosely Ted Talk: https://www.youtube.com/watch?v=gwd-wLdlHjs
  - Avoiders/Confronters video: https://www.youtube.com/watch?v=-mJbAgNOEqM

- Websites
  - American Pain Society: http://americanpainsociety.org/
  - American Chronic Pain Association: https://www.theacpa.org/
  - International Association for the Study of Pain: https://www.iasp-pain.org/
  - Pain Action: https://www.painaction.com/

- Books
  - Explain Pain (Butler & Mosely, 2013)
  - Managing Chronic Pain: A CBT Approach (Otis, 2007)

Questions?

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