

Psychological Dimension of Pain Management

A comprehensive approach to pain management must address the psychological dimension with special emphasis on the patient's own unique psychological response to chronic pain.

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Providing treatment services for chronic pain patients requires a complex set of skills and awareness. There are unique challenges, approaches, and outcomes that need to be considered both in the physical and psychological dimensions. The following article is designed to provide an understanding of the psychological issues faced by providers and patients alike. Being sensitive to these issues and integrating respective approaches when working with pain patients can go a long way toward having a positive and therapeutic outcome for all concerned.

Myths and Misunderstandings about Pain

A recent telephone survey in 2002 demonstrated that Americans have little understanding about pain and its treatment. The Partners for Understanding Pain surveyed 1,000 adults and found that many held beliefs contrary to established facts about pain and its treatment.¹ A few examples cited by the survey are as follows:

- Although pain is the primary cause of disability in the U.S., almost two-thirds of those surveyed attributed it to some other cause.
- Although most physicians have very little training in the treatment and diagnosis of pain, the majority of respondents were confident that their primary care physician could effectively diagnose (79%) and treat (83%) any pain problem they might have.
- Although most pain medications, including opioids, rarely cause addiction when prescribed for pain, more than 75% surveyed were concerned about addiction resulting from prescribed pain drugs.
- Although 80% of those who have ongoing pain are in the 24-64 age group, respondents mostly believed that the typical person with chronic pain is 65 or older.
- Little understanding that “doctor shopping” may be more related to issues of “pseudo-addiction” (i.e., under-treatment) and the lack of sympathetic care from providers.

Evolution of Pain Management

The field of pain management evolved out of the frustration of physicians and surgeons who were faced with the fact that many patients were not responding to the usual types of medical intervention. Even though new and evolving surgical procedures were being used more frequently, many patients were experiencing poor outcomes. Even for those patients who had a positive surgical intervention, continuing pain and problems in functioning were frustrating both patients and providers alike.

Added to this quandary is the fact that, in recent years, medicine has become more of a business due to the influence of managed care in limiting care, limiting the amount of time that physicians can spend with patients, and limiting the problem focus that is allowed to be discussed in any one physician visit. Patients feel that they have not had enough time with their physicians who, in turn, feel the pressure to see more patients in less time.

Pain management is a field that was first developed by the field of psychology in helping patients focus on finding solutions to complex health care problems. While the technical aspects of medicine rightly have a focus on disease prevention, treatment of acute problems, and diagnosing specific problem

issues, psychology offers treatment modalities for those problems that do not clearly fit the purely technical model.

Because “health psychology” has had a strong tradition in the learning and academic models, the focus has been somewhat different than traditional medicine approaches. Though study, diagnosis and treatment are important, the emphasis in health psychology and behavioral medicine is on finding multiple-model solutions that can involve the patient in a more active manner of self-care.

Much of what patients experience in the medical system is as a recipient of passive modalities of treatment, i.e., patients “receive care.” In a pain management/behavioral medicine approach, however, the patient is involved in a bio-psycho-social-cognitive-behavioral-practical approach to treatment that is active, educational, directive, and evolving relative to the needs of each patient.

Rather than label an individual’s condition, the focus is on finding active solutions through the use of information, discussion, direction, homework assignments, various active (not passive) biofeedback instruments and related modalities. The object is for the patient to learn how to control muscles, nerves, blood vessels, and other bodily systems, in addition to learning what exercises work for them to reduce tension, spasms, etc. For example, the patient learns, and is able to demonstrate, active techniques for myofascial soft-tissue care to reduce tight muscles, trigger points, and to improve stretching abilities. This approach includes learning relaxation, relaxed breathing, and other techniques to reduce internal anxiety as well as high autonomic arousal. However, behavioral medicine interventions for pain management that do not employ a directed, structured, focused, and active approach that incorporate all of these (and more) modalities, is typically ineffective and misdirected.^{2,3,4}

Psychological Component

Psychological testing can be used not only to diagnose but, more importantly, to also identify areas that are blocking the patient’s progress. Such tests can also be used as part of the therapy process to assist the patient in coming to understand how their style, issues in handling problems, etc., are complicating their recovery. This is based partially on the premise that when there is an injury, the trauma not only affects the injured area, but actually affects the entire person. Such a response is an expected adjustment reaction to any stressor/injury process which need not progress to a chronic condition as long as the individual is involved as an active participant in the entire process.

A comprehensive pain management approach to treatment requires information that can help the patient in dealing with relapses and flare-ups. This helps empower the individual to know that they can handle the expected times when their symptoms return so that they do not feel like a helpless victim. It is crucial to note that these pain management techniques do not rule out a coordinated approach involving physical and medical therapies. The addition of psychological approaches as a central component of a pain management strategy assists the patient in removing blocks to progress so that they can make better use of the physical treatment approaches.

The primary goal is to assist the patient in moving forward toward resolution, achieve closure, and become functional again—at least to some extent. This approach does not focus on other non-injury related psychological issues even though these are considered, discussed, and dealt with as they relate to the style and manner of how the patient responds to life and functioning. The purpose is to assist the patient in understanding how their own personal style of coping, interacting and handling blocks or problems may affect them in the course of their recovery.

Many times a patient has been “diagnosed” as having personal psychological issues that are impacting their recovery from their injury. This should not mean that the identified problem is “psychological” and, therefore, not real in nature. All it indicates is that there is a need to have a more coordinated team approach to providing pain management, behavioral medicine, physical therapy, medical interventions and alternative interventions. Blocks to progress often happen when only one, or the other, type of

approach is used in the treatment recovery process. Using a coordinated team approach helps to reduce any blocks that may arise and help the patient make the best use of treatment and become functional again.

Psychological Impact of Illness/Disability/Injury

Traditional treatment often fails to recognize that when an individual is diagnosed with a serious illness, or chronic problem, their whole life changes dramatically. There is an immediate attitude of “why me,” or “my life is over as I knew it.” It is a serious life crisis forcing the person to perceive life differently and confront mortality. Beyond this, the person is embarrassed that they are not able to perform and function as they had done previously since much of one’s identity in society is tied to what they do. This is even more of a problem for males who work in positions involving physical labor and feel the need to maintain a macho, independent image of self-sufficiency. Many are reluctant to reach out for help until they are so exhausted and overwhelmed that they do not know what else to do.

Beyond this, health care professionals may forget that the impact of a health care problem forces the affected individual to interact with “foreign beings and in a foreign language.” Professionals must remember that their professional lives revolve around “an alien language” that is confusing to the average person. There is usually an assumption that patients understand the terminology and professional jargon, but instead it leaves the patient feeling confused, overwhelmed, and uncertain about what to do. It is important that the professional discuss issues and problems in terms that the patient can understand. Further, the professional has to take time to periodically summarize what has been said since the crisis situation makes it difficult for the patient to remember everything.

Crisis theory suggests that in the “face of a crisis” individuals tend to “fall apart” or to regress to previous levels of dysfunction or functioning. As a matter of fact, patients in the midst of a crisis tend to look sicker than they really are. Crisis intervention treatment is based on the concept that the focus needs to be on helping the patient to cope again, find solutions, and to stabilize the situation. The patient needs to focus on putting one foot in front of the other, one step at a time.^{5,6,7}

Considering Secondary “Victims”

When illness, disability or chronic pain enters a patient’s life, not only has the individual’s life changed, but the lives of those the patient is closest to have also changed. The family members, as “secondary victims,” need to be understood in relation to their own emotional reactions to the crisis and towards the patient as well. Despite these emotional reactions, the family is still critical—and needed—as part of the primary support system to the patient. It is important to find ways to help stabilize the family’s functioning as it relates to helping the patient become more functional in life.

The situation is further complicated by the response of friends, employers and colleagues to the injury/disability situation. A research report by Strunin, et al⁸ points out that those who suffer on-the-job back injuries face hostility or indifference when they return to work. Though some employers are more supportive, others will terminate injured employees when they return to work in direct or more subtle ways. This lack of support systems in the work environment leaves the person feeling undervalued and rejected. This can dramatically complicate recovery and functioning issues for the patient.⁸

The “Purpose of Symptoms”

Illnesses, injuries, pain problems, etc., are signs that one’s life course is changing. Until the patient is made to understand that they have to do things differently, nothing will change. They have to “make friends with their pain” and come to understand what the body is trying to tell them about what they need change in their lives to improve. Those patients who do not get better tend to be those who have a hard time “pacing” themselves and their activities. They are the ones who work too hard, take on too

much, are overly helpful, and do the jobs of several people. They are the “overly-codependent people” who are addicted to working hard in order to help others. They are the ones whose self-esteem is based on being busy, being helpful, and never taking time for themselves.

One way of conceptualizing the “benefits of symptoms” is that they “force the person to slow down.” It is almost as though one’s body is telling the person that “if you don’t stop, I will stop you.” We are “human beings” and not “human doing machines.” However, there are some people who do not know how to “stop themselves from doing” unless they are injured and unable to function due to the accompanying pain. Such patients need to learn that if they are to get better they have to be able to demonstrate to their bodies that they have “learned their lessons” and will pace themselves appropriately. Problems arise when the patient starts to feel better and then “rushes” around to do everything they missed out on. This almost insures that they will have further problems again and that their body will “crash into more pain” in the end.

“It’s All In Your Head” Model

Chronic pain patients who are seen by a health psychologist, psychiatrist, or clinical social worker, are usually not voluntary patients. They are “sent” by their physicians because “nothing can be found” or that there is little more that can be done for them. Records frequently indicate that the disorder is “psychogenic” or that the problem has a “strong functional overlay.” Some patients are even directly told that it is “all in their head.”

As a result, many patients are defensive, confused, and feel that no one understands them or their problem. They feel “blamed and labeled.” They feel forced to choose between accepting the psychological versus the organic component to their problems. Even if the patient is told that there is an interaction between the organic and psychological interfering with their recovery, they still feel they must choose one or the other. Many feel that the decision has already been made for them by the refusal of the conventional medical system to be able to accept and help them.

Patient’s who feel that no one will listen to them in a medical context, present to the office of a mental health, and other, professional with a great deal of anger and hostility. It is difficult to get them to relax and be cooperative. They are defensive, confused, and are waiting for more rejection. They are troubled about a perceived stigma of seeing a “shrink” and feel very vulnerable in interacting with this “new” professional on unfamiliar ground.^{3,8,9}

Psychological Language

Patients who are referred with chronic pain syndromes usually do not have the psychological understanding and language to adequately deal with, or explain, their problems to themselves or others. They have very little understanding of the internal mind/body connection, and, in fact, usually tend to reject such ideas. They are “internalizers” who hold in their feelings, deny problems, and rationalize their way through life. This is one of the reasons that they present with a combination of psychological and somatic symptoms. They are “alexithymic”— having a poor understanding, and poor language, for internal bodily processes. They tend to express their emotions through action, movement, denial, and avoidance. Suddenly, their world view is disrupted. They are faced with “culture shock” in having to deal with health strategies and accompanying jargon that is alien to them.

By contrast, the typical patient who voluntarily presents to the office of a mental health professional is observed by the professional as motivated, oriented to the problem, has goals, utilizes verbal skills to solve things, and understands the mind/body connection. This is not true with pain syndrome patients. The latter can easily disappoint the therapist who is used to talking in psychological terms and is now faced with having to slowly educate a patient on how to utilize the medical and psychological system appropriately. This can take time, education, patience, persistence, and what appears on the surface to be resistance. In fact, however, it may be no more that just a lack of understanding of what to do and

how to accomplish the delineated goals.

This does not make psychotherapy impossible, but it does suggest that a new direction for treatment must be employed. The therapist must become more flexible in employing a multitude of different strategies and approaches. It also forces the psychologist to rely on “active versus passive models” of care where the patient learns how to understand what is happening in their body, develop the “language” to understand their condition, and communicate with caregivers, family, and friends.

Task-Centered Psychology

The integration of psychological and medical services requires that some of the old ideas about psychology and mental health services be changed. Traditional views of psychological services have focused on the out-dated idea that mental health services are related to psychoanalysis or psychotherapy services that treat diagnostic labels with a mental illness/disease attached to them. This old idea suggested that patients presented with specific psychopathologies which needed to be diagnosed and treated through a lengthy psychotherapy process. Some of these beliefs have been continued by popular beliefs that psychological problems are a consequence of serious mental illness and needs inpatient psychiatric hospitalization. Further, this view of mental health services has been reinforced by the fact that psychiatrists have worked traditionally with the more seriously mentally ill patients requiring medications and hospitalizations.

If the medical community is to transform and integrate medical/health care services, it is critical that a psychological therapy approach be conceptualized as having a “task-centered, problem-focused” orientation as a central part of realistic health care services.³ In other words, psychological therapy must be integrated as part of a pain management team by dealing with the mind-oriented issues and opportunities in promoting a positive emotional environment during other treatments and typically improve the chances of successful outcomes.

Multidisciplinary, Multimodel Perspective

In reality, it is more helpful to have a coordinated multi- disciplinary approach so that the patient learns from different perspectives at the same time.

Treatment for patients presenting with chronic pain problems requires a multi-model treatment perspective and approach. Psychologists have to be aware that they must employ a number of active skills and interventions designed to assist the patient in learning new ways of being. This requires an active therapist who is willing to try “whatever” approach fits the individual patient. The concept of “starting where the client is at...” requires the professional moving out of their comfort zone into a more active, innovative approach to care. Since psychologists come out of a “learning model” and academic tradition, they have unique skills to assist the patient in “learning” new ways of dealing with complex problems.

Many patients will “try” one approach or another only to find that “nothing works.” In reality, it is more helpful to have a coordinated multi-disciplinary approach so that the patient learns from different perspectives at the same time. Further, this multi-disciplinary approach offers the advantage of working on several symptoms at the same time. Having a coordinated approach allows the patient to deal with each aspect of their problem at the same time and offering a better chance of a positive outcome. This requires that all professions work together, coordinate their care, share notes, have conferences, and discuss the issues involved in the case. It also helps in that the patient does not “split,” or “play,” one professional against another. All are working at the same purpose and direction for the health and functioning of the patient.

Mobilization of Emotions

Mental health professionals are aware that the most creative moments in therapy happen when the patient is able to experience the most emotions. In 1982 psychologist and psychoanalyst Nicholas Cummings, Ph.D. wrote on research concerning brief interventions with complex health care patients and the cost savings in mental health interventions.¹⁰ He noted that those patients who were referred for psychological intervention reduced their medical over-utilization. However, he also noted that patients remembered not liking their therapist, were angry about what happened, and had forgotten the psychological reasons provided about their symptoms. Dr. Cummings attributed the successes to a “mobilization of the patient’s rage.” Patients may become more emotional, angry, reactive, and upset with different providers at various times in treatment. It is critical that other providers not “buy into the blaming and upset with others” at these times. It is important to remember that something important is happening which ultimately can be curative for the patient.^{11,12} Otherwise, patients may be unable to find healthy ways of expressing their frustrations with the problem, limitations, and other issues, and instead internalize these issues and thereby aggravate their physical problems and symptoms.¹⁰

Other research has compared “warm and fuzzy treatment” provided by non-professionals with the treatment provided by professional therapists.¹³ The results indicated that each group of patients ended up as improved by the end of treatment. However, those patients seen by mental health professionals got worse about half way through treatment. “Warm and fuzzy treatment” patients, on the other hand, showed consistent improvement throughout the course of therapy. One could conclude that being nice to patients produces the best results. However, with a six month follow-up of treatment, the patients in “warm and fuzzy treatment” actually regressed in their treatment gains back to their original levels of problems and functioning. In contrast, those patients receiving professional treatment continued to improve once they had completed treatment. The results suggested that mental health professionals confronted the issues early in treatment and helped to resolve internal conflicts that allowed for long term improvement. However, in the midst of treatment their patients became more upset, regressed, and found treatment difficult.

In another study, the “pivotal moments” in therapy occurred during discussions about their presenting problems.¹¹ However, the emotional awareness and changes happened after repeated discussions of the same topic. These “emotionally charged moments” were highly personal and private experiences. They were based on the motivations, agendas and personal meaning systems of each person.¹¹ This suggests that therapists need to be attuned to each patient’s own theory of change. This research pointed to the importance of repeating, focusing, and refocusing on subject materials that are emotionally important to patients if they want to exploit these “emotionally charged pivotal moments” for healing.

What this all suggests is that providers must be “united” in working to help the patient continue to improve—even when they are upset and reacting emotionally to the patient’s behavior during the treatment process. The goal is to continue to help the patient re-label what they are experiencing and refocus their efforts, rather than getting caught up in emotional upsets and panic. These periods of emotional upsets are of key therapeutic importance relative to bringing about changes in the person’s functioning.

Fear of Movement

One problem with patients who have experienced injuries and chronic pain is that they are very fearful of movement of any type. They worry about aggravating their pain problems. They reflexively brace to protect their bodies from pain. They try to avoid movements and, in so doing, insure that when they do move the pain will be greater. Part of the focus of pain management treatment by any professional is to assist the patient in starting to move, stretch, and use their muscles and body again even in the face of pain and suffering. This is not a “pain or no gain” idea. It is helping them to overcome their fears of “further harm” which makes the patient into a “phobic responder.”^{14,15,16,17}

Part of the focus of pain management treatment by any professional is to assist the patient in starting to move, stretch, and use their muscles and body again even in the face of pain and suffering.

Depression and Pain: Cause or Effect?

An article in the 1999 issue of the Journal of Pain⁶ explored the issue of why chronic pain patients so frequently experience depression. The article explored whether or not depression was the cause of the pain syndrome or was a direct result of the stress of living with chronic pain. The results of this study suggested that living with chronic pain contributed to the elevated levels of depression. Chronic pain syndromes were found to be risk factors for developing various major depressive disorders,⁶ but not the reverse; depression was not found to be the cause of pain syndrome.⁶

MMPI-2 Psychological Test Interpretation Issues

The MMPI-2, first developed in 1939 and later updated and revised in the 1990's, is geared to understanding psychopathology, behavioral issues, and problems in functioning. It is one of the more researched assessment instruments with over 365 research articles being published annually since its first development. Interpreting the MMPI-2 test now involves more than the basic three validity and ten clinical scales. There are numerous subscales that allow for a more in-depth understanding of an individual's functioning, motivation, prognosis, issues of chemical abuse potential, traumatic responding patterns, and an understanding of the psycho-social issues impacting the patient's functioning.

Unfortunately, some evaluators have utilized this test inappropriately as a way of finding fault with suggestions of "permanent pathology" that should be used to discredit a patient. Such an approach violates the research on this important assessment instrument. It should be used as a guide for treatment interventions that helps to guide the clinician towards ways of intervening and assisting the patient in therapy. In chronic pain management treatment, the MMPI-2 has proved useful in identifying the issues that are blocking the patient's progress in treatment interventions. In 1999, Kevin C. Murphy, Ph.D. published an article titled "Psychological Assessment—MMPI Changes Following Interdisciplinary Pain Treatment"¹⁸ which supported how patients involved in pain management treatment showed positive and dramatic changes (decreases) on the MMPI scales following treatment compared to assessments prior to when the patient started treatment.^{18,19,20,21}

The use of the MMPI-2 in the diagnosis and understanding of chronic pain patients requires a more full understanding of how to assess such a patient population. Recent research on this subject was covered by Alexander Vendrig, et al, in their 1998 article²¹ which surveyed a number of research articles. Their research concludes that "...the elevations on the depression (D) and hysteria (Hy) scales among chronic pain patients may primarily be the result of distress and somatic preoccupation (related to the situation of present pain problem) rather than psychopathology....high scores on the schizophrenia (Sc) scale to reflect the symptoms and consequences of physical problems, including decreased coping defenses and abilities, and not necessarily indicating severe psychopathology (p 180)." This suggests that the elevations of scales on the MMPI-2 tells more about the degree of fear and distress experienced by the patient in reaction to the injury, disability, and pain situation. Other research has confirmed that these scales have returned to normal once the patient has completed a pain management treatment program. The MMPI-2 has proved to be helpful as a guide to understanding the patient's distress, manner of coping, and fears and, in so doing, helps to guide treatment directions for optimum treatment outcome.

Provider as Psychological Health Educator & Skill Builder

Health care providers working with chronic pain patients often find that they need to modify their approach from that used with other types of patients. The more successful approaches educate the

patient about the health care system, the body, active self-care skills, and ways of helping the patient feel more active in their own healing. Specific education goals include skills and knowledge in the following areas:

1. inter-professional interactions
2. informational support
3. interpersonal support
4. community support
5. empowerment to navigate through the medical, insurer, and legal systems
6. assistance in communicating with medical providers
7. issues of recovery and maintenance skills
8. clarification of thinking during a crisis
9. decision and choice-making skills
10. healing, and balancing relationship issues
11. active pain management skills
12. spiritual, and complementary, healing issues.

Patients also need to recognize that pain management is a process that happens over time; progress will evolve somewhat slowly over time and many techniques need to come together in order for the patient to recover at least partial functionality.

Cognitive and Coping Strategies

Research into how one's thinking can complicate recovery and healing issues has shown that such issues need to be addressed if the patient is to improve. Panic anxiety, catastrophizing ("the sky is falling" or "I am falling into an even more painful situation from which there is no hope"), issues of negative self-talk, a pessimistic attitude, and being overly-codependent (taking care of others and forgetting to take time to help the self), all lead to a patient having a poor outcome. Focusing more on the needs of others blocks learning and internalizing of new skills needed to cope with pain and work towards recovery.

Despair, hopelessness, and uncertainty has been shown to have a negative impact on an individual's internal body chemistry at the cellular level. Therapy to help the patient feel hope, control, and more of an active participant in their care is critical to having a positive outcome of any type.²²

Issues in Treatment Outcome

All treatment efforts need to be focused on the goal of an outcome that has the patient being functional in some manner. In particular, workers' compensation patients need to focus on resolving the case in some manner since the patient's case will be "closed" at some time in the process. It may be that the patient cannot return to their former occupation even though most therapeutic efforts need to be focused in that direction. However, alternative employment can be found for some patients in different settings if they are unable to handle the same degree of physical demands of the former occupation. When treating chronic pain patients, the caregiver must differentiate between finding a satisfactory outcome in a case versus the often unrealistic goal of total cure. The unrealistic stance of many pain patients is that a focus on a cure is the only acceptable solution to their condition. In actuality, many pain patients may never return fully to their former level of functioning. Patients who have learned to accept the concept that they may have to live with a certain level of pain and limitations in their lives

achieve improved functionality and quality of life. When the patient only has a focus on the cure, then they are never fully satisfied with any changes or progress outside of a total resolution of their pain problems. The key concept in pain management is not cure—it is ‘management.’ Chronic pain is likelier to be managed to a tolerable level than cured. This requires that the patient learn a variety of skills and techniques rather than relying on just one type of approach, or professional, to solve all their issues.

No one technique works best with all pain patients; often a variety of techniques must be employed over time in order to effectively manage their pain syndromes. Such techniques can reduce the degree of pain, the level of limitations, and the hopelessness of the situation. Patients can transform their lives and achieve a level of functionality if they learn to manage themselves differently and pace their daily activities to avoid over-stimulation and regression.

Pain Management Outcomes

It is critical to remember that not all patients will be able to return to full functioning again. A positive outcome from pain management therapy may be an acceptance of limitations. This requires “grief work therapy” that works through the denial, anger, and other stages toward the level of acceptance that is required. Again the focus is not on the cure, but instead is teaching patients ways of managing their pain within a realization of “acceptance” of what has happened to change their lives. Therefore, a successful outcome from therapy may be managing to function on a daily basis. This also may mean that some patients will need long-term therapy, periodic follow-up contacts, and continuing therapy as part of helping them to cope, over time, with the limitations that the pain/injury/disability/illness condition has imposed on their lives. In other words, it is the manner in which they use therapy, and what they have learned for active self-care, that determines a successful outcome from pain management therapy. This means that even professionals have to avoid a focus on “cure” as the criteria for determining whether the patient has appropriately and successfully used pain management therapy.

Relapse Prevention and Flare-up Planning

One critical area for pain patients and providers in general is the knowledge and expectation of setbacks and flare-up of pain problems. Psychological research into how one maintains their gains over time suggests that, regardless of the problem, the person must fully expect periodic setbacks. Healing is a “cyclic process” and so setbacks should not be construed as failure but, instead, positive learning experiences. At least initially, the patient may need the provider’s help in identifying the “learning experiences” in the setback. Understanding that setbacks will happen, and are not a time for panic and upset—by either the patient or the provider—makes a major difference.

Setbacks will happen in the face of:

1. strong emotions
2. interpersonal conflict
3. problems in pacing activity
4. not stopping every twenty minutes to move and stretch
5. at times of PMS and other mood changes—even for men
6. pressures from others
7. not saying “no” to the requests of others
8. the lack of sunlight, especially in the Pacific Northwest where there is a higher incidence of SAD
9. at the times of full moon, weather barometric changes, etc²³

Conclusion

Psychologists have long known that patients do not “intentionally” develop psychological problems and

difficulties. Patients would prefer to be healthy and functioning. Many times, though, they become “stuck in a system” that reinforces and hinders their recovery and recognition of the problem. As a result, patients continue to repeat past patterns because these patterns are familiar habits and are at best only semi-conscious. A clear way of integrating psychological services into regular health care services helps patients—and others—to understand that there are treatment services which can be provided to help deal with the broad range of bio-psycho-social-environmental-cultural issues presented by patients in medical clinics on a daily basis. The focus is not on “finding fault,” “diagnostic labels,” or the assignment of blame. The focus is on “finding solutions” that involve the patient as an active participant in their own care. Some patients, after completing pain management therapy, can become better candidates for appropriate medical interventions if that is indicated.²⁴

It is important to understand that any illness, disability, or injury is a serious life changing trauma that impacts the person’s whole life. It is a time when they are exposed to professionals who appear to be “aliens who speak another language.” It is a confusing time. However, it can be a growth experience for everyone concerned if they work together as a “team,” focused on helping the patient to become functional again. The focus is not on “finding the cure” but on learning “active” ways to manage the pain, its cyclic course, setbacks, and related issues. Pain, injuries, chronic illnesses, are all life changing events for everyone concerned. It is by working together that there is hope and a “new future.” As the medical community moves toward integrating psychological services as a part of health care services, all can work to remove the labels and negative stereo-types often associated with those who access psychological services. It is crucial for successful outcomes that psychological services be included as a central and essential component in the normal course of medical care of chronic pain patients.

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