

Cognitive Behavioural Approaches to Chronic Pain

"It's not things that trouble us but the views we take of them" Epictetus

During their lifetime most of the population will experience an episode of back pain that troubles them sufficiently to alter their ordinary function and seek some form of medical help. Anybody who has suffered from such a problem themselves or cared for someone who has, will know just how acutely painful a 'bad back' can be, with no doubting that in the grips of an episode the sufferer can do little save reach for the bottle of tablets and cry for help.

How extraordinary then that the factors that predict the development of chronic pain following an acute episode do not relate to any "biological" factors such as findings on physical examination, or change on X ray, but to what are termed 'psychosocial variables', such as mood, stress (as noted by depression scores and anxiety levels) and the social situation in which the pain occurs.

It is not just back pain for which this is true: it is now clear that even following routine surgical operations the amount of pain experienced by a person does not simply relate to the operation type or the length of the incision, but other factors such as past experience, age, sex, anxiety, fear and depression all have a bearing. So whilst we would all pay lip service to the idea that psychological factors are involved in appreciation and perception of pain, they seem to have a much bigger place in the pain experience than we might anticipate. Not surprisingly this has implications for treatment.

When pain persists in spite of medical treatment, as is the case in chronic pain syndromes, the issues become even more complex. To have pain day after day that does not resolve, and that doctors cannot seemingly solve is a terrible affliction by any measure. Indeed when doctors and scientists have attempted to measure it, it is clear that chronic pain sufferers score as poorly on quality of life scales as people with much more catastrophic illnesses such as chronic lung disease or AIDS. The problem is that matters get worse not solely due to progression of the disease (the pathology in the tissues) but to the vicious circle the people find themselves in. A person who has pain, especially on movement, tends to avoid doing things that provoke their symptoms. They rest but unfortunately this is not a helpful treatment as it leads to secondary stiffness and weakness, causing worsening of the symptom that the individual is trying to avoid. Inability to function leads to a loss of role and self esteem with the progressive intrusion of other problems such as financial hardship and strained relationships. Tablets may cause side effects, pain may prevent sleep, and all these difficulties cause worry and low mood which worsens the situation yet further. Treatments will be attempted through desperation rather than evidence of their effectiveness with a high risk of failure. This leads to further worsening of mood which fuels a sense of desperation.

Patients in this situation present a particular challenge to medical systems because the mix of physical and psychological difficulties cannot be neatly assimilated into the scientific categorical approach which has been so fruitful in other areas of medicine.

The person thus suffering who is sent to a psychiatrist is often sent away with the message that they are not mad and that they need a physical solution to their pain problem. However, when they visit the orthopaedic surgeon the failure to identify a clear-cut lesion leads to a suspicion of some poorly defined psychological difficulty with a re-referral back to psychological services. An unhappy stalemate develops

with the patient caught in the middle. It will be clear from the above that this type of chronic pain presents formidable problems for both the sufferer, and for the doctor or specialist trying to offer treatment.

Enter cognitive behavioural pain management.

Modern cognitive behavioural approaches to pain have developed from a number of linked models, all with some efficacy on their own but gaining from being delivered in combination. They have clearly been shown to be the most logical treatment for individuals suffering from chronic musculoskeletal pain where the pain is accompanied by disability and psychological distress.

In essence, cognitive behavioural approaches aim to improve the way that an individual manages and copes with their pain rather than finding a biological solution to the putative pathology. The approach is very much related to problem solving and returning control to the sufferer. Many patients state that the pain rules their lives and cannot see how this can change without a medical cure. However, with appropriate instruction in a range of pacing techniques, cognitive therapy to help identify negative thinking patterns and the development of effective challenges, stretching and exercising to improve physical function, careful planning of tasks and daily activities, and the judicious use of relaxation training, many people find the treatment enables them to take back control of their lives, to do more and feel better.

Cognitive behavioural approaches are delivered in a number of settings, with various differing protocols. Whilst the cognitive elements of the programme are usually the province of psychologists, other staff working alongside them such as physiotherapists, occupational therapists, nurses and doctors are required to improve their psychological understanding and skills to enable them to contribute to the treatment package. For example an exercise programme run by a physiotherapist will adopt a cognitive approach by ascertaining the persons fears and beliefs about the movement or activity they are undertaking. Frequently this will demonstrate that the caution exhibited by the person relates to fear of damage. This will be rectified by providing detailed information about the spine and how it functions, alongside a graded approach to movement using the behavioural principles of reward and reinforcement. Such an approach will move the person on both physically and psychologically in a way that coercion alone will never achieve.

Cognitive approaches have relevance for many other areas of pain management, and indeed other aspects of medicine in situations where people's behaviour is affected more by what they think and believe, than by the extent of pathology. Numerous studies attest to their efficacy, but many questions remain about the essential processes involved, and the most rational and effective modes of delivery. Research continues to throw light on this fascinating area of medicine. In any event it is likely that the CBT approach to pain with its humanistic emphasis, practical utility and demonstrable efficacy, is here to stay.