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Chronic Pain and Psychology in Florida

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There has been a great deal of publicity and media coverage in Florida regarding chronic pain. Many psychologists in Florida have had experience dealing with patients who have chronic pain and are familiar with the various issues they bring to treatment. However, a number do not have much training or experience with this population. It is important for all psychologists to be aware of the basic ramifications of chronic pain since the incidence is high and the impact can be quite extensive. Even psychologists who do not specialize in chronic pain will invariably have patients whose family has been impacted by it.

At some point in life, everyone experiences pain. It can range from the sharp and agonizing, to the dull and aching. Most people are familiar with acute pain which comes on suddenly, is considered temporary, and resolves with treatment in due time (Kannerstein & Whitman, 2007).

For some people, pain induced by disease or injury lasts long after treatment ends. This is the world of those living with chronic pain, i.e., pain which persists for more than 3 – 6 months after an injury or illness has resolved (Mackey, 2011). Chronic pain involves physical as well as psychological components. People with chronic pain typically must adapt to physical limitations, social changes, and work disabilities. As a result, they often feel depressed, anxious, and/or angry. Loved ones of chronic pain patients commonly experience frustration and a sense of helplessness. Often they must assume the patient's prior responsibilities and they are unable to relieve the debilitating pain and emotional turmoil that can envelope the entire family (Kannerstein & Whitman, 2007). The Institute of Medicine of the National Academies (2011) estimates there are 116 million Americans suffering from a chronic pain condition. That is roughly equivalent to the populations of California, Texas, New York, Florida, Illinois, and Pennsylvania *combined* (http://www.census.gov/population/cen2000/phc-t2/tab01.txt).
Chronic pain also poses an incredible economic strain with costs of medical care, disability payments, and lost productivity of over $90 billion per year in the U.S. (http://www.chronicpain.org). Pain's tremendous medical, psychological, and economic involvement creates a complicated set of issues for pain management specialists to consider when seeking adequate diagnostic and cost-effective care.

Diseases and Conditions that Lead to Chronic Pain

There are a variety of conditions that can cause pain and in time can develop into chronic pain. The back and neck are the most common sites. There may be an identifiable event with resulting injury, or degeneration of tissue may occur over a period of time. Other chronic pain

conditions may be the result of disease or are secondary to other health problems. There are also times when chronic pain may be exacerbated by treatment efforts, such as failed back syndrome. In essence, chronic pain can be the result of illness or injury to bones, soft tissue, or nerves.

The Subjectivity of Pain

Pain is a subjective experience of nociception, and can be considered a state of consciousness (Moskovitz, 2011). The degree of nociception as a result of tissue damage varies greatly among individuals. It is possible for someone to break an arm, feel little pain and continue to function for a while. However, the same injury sustained in another person could cause excruciating pain with the individual being unable to function. This subjectivity makes it very difficult for healthcare professionals to objectively assess the patient's level of pain. It is common for patients to be asked to "rate" their pain from 1-10 (10 is the most severe) and to have this rating be recorded as a valid measure. Clearly, while many patients attempt to give an honest assessment, the method lends itself to manipulation, abuse and criticism.

The Goals of Chronic Pain Management

In general, the goals of chronic pain management are simple: (1) reduce pain, and (2) increase functioning. Of course, in working toward these goals any limitations of the patient must be taken into account, and, unfortunately, chronic pain often burdens individuals with more limitations than they had before.

Patients often hope for elimination of all pain; therefore, patient education is necessary to help establish realistic expectations for treatment. Although it is still subjective, reduction in pain can be achieved by improvement in the perceived intensity, frequency or duration of pain episodes or experiences. The key is achieving a reasonable balance between pain that is at least tolerable, and minimally adequate functioning. Sometimes being able to make the transition from a goal of eliminating pain to reducing the pain and focusing on function can be a critical first step for a patient.

Medical Interventions in the Treatment of Chronic Pain

Medical treatment often starts with the focus on the pain as acute and the initial effort is geared toward pain reduction and healing. In fact, the focus on "functioning" may be "temporarily suspended." For example, a sprained ankle may be treated with anti-inflammatory medication, analgesic medication, ice, and elevating the foot while trying to "stay off it." The patient may be told to take a few days off work in order to rest the injury and allow it to heal. This is a short-term protocol and would generally be viewed as acceptable.

Once pain is determined to be chronic the focus of management shifts. Now functioning – returning to work, getting off light duty, resuming household tasks, etc. – becomes important again. Medical interventions may begin with medications such as muscle relaxers, anti-inflammatories, analgesics, and opiates. Occupational and physical therapy will be tried. Chiropractic, massage and acupuncture therapies will be explored. Vitamins, supplements and other "alternative" medicine approaches will be considered too.

Interventional methods become a possible option when the more conservative treatments have not provided adequate pain relief. These may include epidural and other injections, and nerve blocks. More invasive procedures would include a spinal cord stimulator implant, which sends pulsed electrical signals to the spinal cord, or an intrathecal pump implant (Spinal Pain Pump), which administers medications directly to the spinal fluid, and, of course, surgery. Each carries with it a set of advantages and disadvantages. For example, a spinal cord stimulator, while requiring a device to be implanted in the body, may reduce pain and allow one to avoid the side effects of higher doses of opiates (DeAngelis, 2008).

The Double-Edged Sword - Issues with Medical Interventions

Naturally, the goals of treatment for chronic pain are to decrease suffering and increase functioning. In order to accomplish this, a progressively "stronger" and more invasive list of options and interventions can be attempted. Of course, if the more conservative interventions are effective, there is no need to "progress" up the list. However, when they do not work, there may be more willingness to try more aggressive approaches.

Perhaps the most complicated intervention concerns the various medications available – particularly the opiates and other pain medications. Will the patient be able to tolerate the medication and the side effects? Will the dose required to achieve an adequate level of pain relief compromise the patient's ability to function physically or mentally? As opiates are considered, one must be concerned about the potential for addiction.

Interestingly, there is also the potential for underprescribing medication for pain. Ethical physicians may be concerned that they will be fostering addiction or dependence – or that they will be viewed as "pain pill pushers" because they prescribed opiates. They may fear that "word" will get out and their waiting room will be populated by "drug seekers" and "doctor shoppers" who feign pain conditions in order to get prescriptions for opiates. Physicians may also fear having their prescribing habits investigated. As a result, some become reluctant to treat pain with adequate doses of medication.

Psychological Interventions

As noted earlier, most chronic pain conditions begin as acute pain. As such, the focus is on the identification, diagnosis, and treatment of the medical condition, illness or injury causing pain.

Intervention generally involves medical treatment, along with prescriptions for pain medication, if needed, on a short-term basis.

Problems begin to occur when the pain persists after the condition, illness or injury resolves. At some point, the patient's focus shifts to paying more attention to the pain itself. It may be several months before the pain is labeled as chronic and it may be quite a bit longer before the patient is referred to a pain management specialist or a pain center.

Many multidisciplinary pain centers have psychologists on staff and may even involve them in the initial evaluation of the patient. Unfortunately, in most other settings, the focus will often stay on medical interventions for quite a while before a psychologist is consulted. By this time, the patient may be suffering with pain, depression, anxiety, and not coping well with what can be dramatic life changes. S/he may no longer be able to work at his/her job – or perhaps any job. S/he may no longer be a "bread winner" or be physically able to participate in recreational activities. How does this affect one's mood, self-esteem, social life, relationships, finances, family, sexual functioning, or future? At this point, the role of the psychologist may involve a thorough evaluation to understand the current state of the patient. This can lead to a more objective assessment, including determining issues of exaggeration or malingering. Following this, the psychologist may work therapeutically with the patient on pain management, setting reasonable and realistic goals, and working on motivation and adaptive coping, as well as adjusting to the changes in life and re-establishing roles.

A Word about Florida's "Pain Pill Mills"

It is no secret that drug abuse and addiction has been a problem in our society for a long time. While the potential for abuse is high with illegal drugs such as heroin or cocaine, there have been many problems caused by "legal" drugs as well. People can and do abuse medications prescribed by their physicians; pain medications are high on this list.

Until recently, laws in Florida have allowed the proliferation of "pain pill mills" – generally storefront "clinics" that provide cursory examinations (at best), prescribe and dispense pain medications (opiates) in large quantities as a "cash and carry" operation, all from the same location. While some "mills" advertise on billboards and other places, it really is not necessary as "word of mouth" travels fast. It was not uncommon for people to drive from other states, park their cars in the parking lot of the "clinic", and wait for the doors to open. While some customers were individuals with actual pain conditions, the majority were drug users, abusers and dealers who were mainly interested in obtaining the drugs without medical tests and exams.

Dr. Sanford Silverman, a Pompano Beach anesthesiologist certified and specializing in pain management, estimated that about 7 people died each day in Florida from abuse and overdose

of these pain medications. Many still had large quantities with them that they had recently obtained from a "mill".

There was quite a bit of controversy over whether to enact legislation to tighten controls over these "mills". After much publicity, often spurred by families of victims who had died of overdose, the Florida legislature passed legislation that made it more difficult for these "mills" to operate. A database was also established to keep better records of who is getting prescriptions – and who is writing them. This makes it easier to track those who are abusing the use of pain medications and those who might profit from unethical prescribing practices. The majority of legitimate pain management specialists already have strict guidelines in place for the use of these medications by their patients. At this time, it seems that this legislation has minimal impact on these physicians, their prescribing habits or their availability to their patients.

Summary

Chronic pain is a common problem and the co-morbidity with psychological problems is very high. Patients with chronic pain often do not get referred to a psychologist until much later in the treatment process. Patients themselves may be reluctant to accept a referral as they may interpret this to mean that their doctor does not believe their pain is "real". Doctors may delay making a referral for fear patients will be insulted. Patients themselves, or a family member, may finally request a referral for all the other "usual" reasons – depression, anxiety, marital problems, or family problems. In these cases, while chronic pain is not the presenting problem, the psychologist soon learns about the role it is playing.

Clearly, there is much psychologists can do to help those with chronic pain. What does it take to work with chronic pain patients? The psychologist who works effectively with individuals who suffer chronic pain will:

1. Understand the mechanisms of pain and the adjustive demands made on the patient who has pain,

2. Work collaboratively with physicians as members of an interdisciplinary team,

3. Remember that patients with chronic pain were medical patients first,

4. Be skilled evaluators on many levels,

5. Have an understanding of the impact chronic pain has on the patient's family,

6. Help assess and measure pain more objectively,

7. Help determine when someone is malingering,

8. Work collaboratively with patients to establish reasonable and realistic goals, and

9. Help patients improve their coping skills.

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