Question 1

A woman in her 40s with chronic lower back pain presents in the pain clinic very upset. Another specialist has told her that, as all the investigations of her spine (including MRI and CT) are unremarkable, that she should consider seeing a counsellor. The patient says that the specialist told her that she must accept that emotions play a part in pain conditions. The patient demands to know whether you agree. Helpful and therapeutic responses would include:

a. Agree that she might benefit from seeing a counsellor; she is clearly upset and any help for her emotional problems is a good thing.
b. State plainly that there is no role for psychological issues in her pain condition; anyone would be this upset, given the pain problem.
c. Explain that there are genuine subconscious mechanisms whereby suppressed emotion can manifest as pain symptoms. Such symptoms can feel very ‘real’ to an upset person.
d. State that seeing a counsellor will not cure her pain condition. However, in some situations, seeing a counsellor can help individuals to cope with the impact that pain has on their lives.
e. Reject the idea that psychological issues cause her pain condition, but explain that everyone has a unique way of coping with pain; exploring her coping style may be helpful.

Answers

a. False. The patient’s question is specifically about the connection between her pain and her emotions, and the answer matters to her a great deal. Given the frequency with which patients complain of feeling dismissed and disbelieved about their pain, evading the exact question with a generic comment about emotional distress is unlikely to help.
b. False. Individual coping styles, including beliefs and behavioural reactions to pain, are critical in determining a patient’s level of distress and disability.
c. False. Whilst there are obviously many ways in which psychological factors influence physical health, the idea of unconscious mechanisms causing ‘psychosomatic’ pain is discredited. It is an idea that is conceptually unclear, hard to prove or falsify, and there are other clearer ways of seeing the role of emotions in pain states.
d. True. Access to appropriate psychological support is often important in the management of long term pain conditions. Patients often do not access this because they see referral
as a suggestion that their pain is not ‘real’. Clear affirmation of the reality of pain symptoms can clear the way to accessing help.

e. True. In chronic pain, coping styles are usually more strongly predictive of distress and disability than actual pain intensity. However, this does not imply that a chronic pain condition would vanish if other emotional factors improved.
Question 2.

You are discussing possible referral to a PMP with a patient with widespread pain and a diagnosis of Fibromyalgia. You are confident that this is the correct choice. However, the patient is reluctant and has little faith in the approach. She says that she cannot understand how “talking about herself and doing sit ups” are going to improve her pain. Clinically helpful explanations about PMP philosophy and practice would include:

a. To confidently assert that these things may indeed help her pain; explain that the best philosophy is to ‘give it a go’.

b. Citing national guidance that exercise is a proven treatment for Fibromyalgia.

c. Give more information on the PMP approach in order to correct the simplistic portrayal of PMPs as all about “talking about yourself and doing sit ups”.

d. Discuss the likely goals and possible benefits of psychological and physical self-management. Agree that this is unlikely to immediately and reliably reduce pain, but that PMPs may help the patient become fitter and more proactive with regard to their pain condition.

e. Explain that PMPs require the patient to be motivated in order to succeed. Given that the patient is reluctant, agree that now is not the right time for PMP referral.

Answers:

a. False. This response does not challenge the patient’s inaccurate beliefs about PMPs, and also reinforces the idea that PMPs will provide pain relief. This is not reliably true and increases the likelihood that the patient will stop PMP treatment as soon as they experience any increase in symptoms. PMP philosophy and approaches need to be properly explained.

b. False. Whilst reference to evidence is commendable, the conversation about PMP referral is a complex mixture of education of the patient about PMPs, and helping them to see how this fits into the long-term approach to their condition. The patient will have strongly held beliefs about what may work. These need to be explored.

c. True. It is important that patients have an accurate picture of what PMPs may include, in order to support their decision-making, for informed consent, and also to support the PMP team by addressing unrealistic expectations.

d. True. It is helpful to be realistic about the agenda and likely benefits of PMPs, as well as what is unlikely to change after treatment.
e. False. The patient is declining treatment on the basis of an inaccurate understanding of the process. It is the clinicians’ job to address the inaccuracies rather than to validate them.
You see a patient with chronic lower back pain and unilateral neuropathic leg pain, three years after the car accident that triggered them. She is not currently able to work and is feeling quite low about her future. She is seeing you in a Pain Clinic, but is also in litigation. She says that, funded by an interim payment from legal action, she has been offered the choice between (1) an intensive PMP and (2) a Spinal Cord Stimulator (SCS). She wants your opinion, as a specialist independent of the court case, about which would be better for her. Helpful and accurate responses would include:

a. The Spinal Cord Stimulator would be better; this approach is recommended by NICE for unilateral leg pain.

b. The intensive PMP would be better, as the patient is clearly depressed. PMPs can address this, and severe depression is not a good indication for SCS.

c. Both are good choices; there is evidence to support each approach, and as such there is not much difference between them.

d. Explain that these approaches differ in their philosophy and approach; the patient would be wise to explore this. One approach is a technical, expert-led implantation of a medical device. The other is helping the person to take more control over their lives, and reducing the need for professionals.

e. Explain that each approach will place different demands on the patient and have different potential complications and side effects. Explain, for example, the greater physical / emotional demands of a PMP; the risk of malfunction / complication for SCS.

Answers:

a. False. There is no evidence that PMPs are less effective for this symptom pattern, or in general that they are less effective for the reduction of disability and distress, compared to SCS.

b. False. It is unclear whether this patient has severe depression. There is no evidence that feeling ‘low’ is a contraindication for SCS, and conversely severe depression can worsen outcomes for both SCS and PMPs.

c. False. Whilst there is evidence supporting both approaches, they are entirely different in their approach, goals, demands on the patient, and potential adverse events.

d. True. The patient faces a choice as to whether to invest in further expert medical / surgical intervention, or to invest in enhancing their own self-management skills in the service of
making experts redundant. PMPs include the patient as a highly active participant, whereas in SCS the patient is a more passive recipient of a medical device. Whilst this is not completely a binary choice, there are clear differences that the patient needs to consider.

e. True. Informed consent in decision-making requires an explanation of all of the likely impacts on the patient.
Question 4

A patient attends pain clinic describing generally increased levels of his chronic pain. He recently completed an outpatient Pain Management Programme (PMP). He describes the programme as positive and useful; he says that he learned a lot of skills, both physical and psychological, and got physically fitter over the programme. However, he has experienced a flare in his pain after treatment and now doubts that the PMP worked for him. He can recall the PMP skills but finds that he is now unable to exercise due to pain. Thus, he would like you to increase his analgesia.

Appropriate responses that will support long term self-management include:

a. Agree to increase his analgesia; this might help him get over the worst of the pain flare, and make him more able to exercise.

b. Listen carefully to the descriptions of increased pain. Then direct the patient to some of his psychological skills, and how they could be applied to this flare. What did he learn on the PMP about setback management and thinking patterns?

c. Reflect on the fact that PMPs do not have a 100% success rate. It may be that this was ‘the wrong time’ for the patient to approach self-management. Recommend that the patient should not be self-critical, and rather accept that some things work for some people and not for others.

d. After giving full attention to his symptoms, review the long term picture of his pain condition. Give the view that escalating analgesia may seem an attractive option in the short term but could lead to problems in the long term. Express faith in his abilities to come up with some options, however small, to self-manage this situation.

e. Say that this matter is best left to the PMP team, who are the experts in this area. You do not really have anything to offer in your consultation – it would be best if the patient directly contacted his treating PMP clinicians.

Answers:

a. False. Whilst well-intentioned, the Doctor has immediately taken charge, and has endorsed a medical (rather than self-managed) approach as the ‘first line’ response to a pain flare. Immediately after a PMP, a patient’s self-management skills are new and easily undermined. With this response, an inadvertent precedent has been set – ‘yes you can self-manage; but only with the help of a Doctor’. Or alternatively, ‘yes you can self-manage – but not when things get really bad’.

b. True. PMP skills are targeted at helping with bad times, as well as good. Also, patients are taught to see their immediate response to a situation – for example, that exercise is
‘impossible’ – as a belief rather than a certainty. Psychological skills need to be deliberately deployed, just as much as physical exercise.

c. False. There is clear evidence from the history that this patient responded well to the PMP prior to the recent pain flare, and he completed treatment quite recently. It would be more helpful to encourage the patient to use what he has learnt on the programme to cope with is current pain flare.

d. True. Redirecting the patient to his own problem-solving skills reinforces self-management skills, and avoids placing the Doctor back into the ‘expert’ position. Also, realism about long-term options reinforces the need for increased self-management.

e. False. Whilst PMP clinicians are indeed the experts in the realm of self-management, the attitude and authority of the doctor are important. It matters that you actively endorse PMP approaches, redirect patients to their skills, and use your authority to affirm PMP skills as core to the overall approach to the patient’s chronic pain. Redirection back to the PMP team is a good option, but avoid acting as if the Doctor has nothing useful to say about self-management, or takes little interest in it.