



The 5 Coping Skills Every Chronic Pain Patient Needs

By Ted Jones, PhD

When I first began work in the field of pain psychology, I wanted to be as helpful as I could be to my patients and to be seen as fully prepared and competent by my referral sources. However, as I began to read books and attend conferences “to get up to speed,” I was overwhelmed by the variety of services and offerings that experienced practitioners offered. Along with ever-present traditional cognitive-behavioral psychotherapy, I also learned about a variety of other interventions: progressive muscle relaxation; guided imagery; hypnosis; technology-assisted treatments such as virtual reality; activity pacing; sleep hygiene; patient education; psychodynamic psychotherapy; interpersonal therapy; assertiveness training; family therapy; desensitization. ... The list went on and on.

When I traveled to pain conferences to learn new skills, I had trouble deciding which sessions to attend. I had no plan or schema to organize my training or my psychology services. I also did not have unlimited resources to attend every conference and learn every possible pain intervention technique.

After several years of clinical practice (it’s been 16 years now), I began to construct a schema to help organize where to start—where I should start in my continuing education and where I should start with my patients when they presented for therapy. I have presented this schema at professional meetings a few times and others tell me they have found it helpful. The following is a summary of my experience.

The Big Picture

In general, one method that helps me organize my thinking about pain treatment is Dr. Herbert Benson’s oft-used analogy of a 3-legged stool., Dr. Benson, a

Harvard cardiologist who has been a pioneer in the field of mind-body interventions, has proposed that health care treatment for any chronic condition can be conceptualized as a 3-legged stool.

The first leg of the stool is made up of interventional treatments, or “passive patient” approaches. These include surgeries, injections, manipulations, and other similar treatments. For these, all the patient has to do basically is show up and be still. I refer to it as “the auto repair school of medicine.”

The second leg of the stool is made up of pharmaceutical approaches. These treatments call for action on the part of the prescriber and the patient. The prescriber writes a prescription for some sort of medication and tells the patient how to take it. The patient then is supposed to take (or apply) the medication as prescribed. It’s a joint endeavor of the provider and the patient.

Many pain practices start and end with these 2 general approaches, and offer nothing else. However, just as a stool would fall over with only 2 legs, pain treatment is truly successful only when the third leg of the stool is offered. The third leg of the stool is made up of “active patient” approaches—skills and changes that patients make to help them cope with their condition. In the treatment of heart disease and diabetes, these are often referred to as “lifestyle changes,” and providers know that they are essential to bring a chronic condition under control.

It is a similar situation in treating chronic pain disorders. While interventional and pharmaceutical interventions are important, the third leg of the stool is critical to successfully coping with pain. This third leg of the stool generally is where psychologists play a role. While a few psychological interventions are not in this domain (hypnosis in and of itself is an interventional treatment until the practitioner begins to teach self-hypnosis techniques), most psychological treatments fall into this third leg of the stool: teaching skills to patients for their ongoing practice and use. This 3-legged stool analogy has helped me organize my treatments within the context of overall treatment for chronic pain.

Once I had placed my work within the overall treatment plan for pain patients, I still needed to determine the most important lifestyle habits to teach patients.

Rather than determine what the most important skills were, I found a way to organize all the possible helpful treatments into a schema that made sense to me and which then could direct my treatment planning. Thus, what I developed was a conceptualization of the 5 basic or general skills that every patient with chronic pain should work to master to have the most success in dealing with their pain condition: understanding, accepting, calming, balancing, and coping.

The First Skill: Understanding

Today, when a patient receives a medical diagnosis, one of the first things they do is go to the Internet and search for the diagnosis. (People used to go the library, but now we use search engines.) They are likely to search and read about 2 things: what is this diagnosis/condition and how is it treated. To better understand their conditions, people also seek out advice from others they trust, such as friends and family, and they ask the same 2 questions: What is this condition and how is it treated? This also leads to prognosis questions: Will I ever get better? Can this be cured?

Patients with pain conditions are no different, and by the time they seek treatment, they likely have already done some Internet searches and talked to family or friends about these issues. Sometimes they have gotten correct information and sometimes they have not. Sometimes patients have appropriate knowledge and expectations about their pain condition and sometimes they do not. So, often the first order of business is to educate the patient about his or her condition and offer a plan of care he or she will accept.

Issues that can come up in this skill area are reflected in comments such as “My body is damaged very badly and I need strong pain medication,” “I do not want any opioid medication because it is highly addicting,” “I just want someone to do surgery on me and fix this problem,” “I don’t want an injection—I hate needles and I hear the relief doesn’t last any way,” and “I have already had that (treatment) and it didn’t work” when they really didn’t have the same treatment. Questions and comments of this type often indicate that the patient needs some education to better understand some aspect of their condition or their treatment.

As a psychologist, I often receive comments similar to “I don’t need a psychologist; my pain is real and it is NOT in my head.” One major educational point I need to make with many patients is how psychology services fit into the treatment of “real pain.” I have had much success going over the concept of pain gates.³ Having patients understand the pain gates concept (an overview is usually sufficient) helps them see the value of psychological interventions in treating chronic pain. This validates why it will be helpful to address such issues as depression, anxiety, and sleep hygiene. It shows that a holistic approach to their pain may be of value and it likely is a new approach that they have not been offered before.

Psychologists and other providers often also address such issues as fear avoidance of pain, how in chronic pain “hurt does not mean harm,” and how a downward cycle of dysfunction and immobilization often is overlaid on chronic pain conditions. The sensation of pain usually means that there is bodily damage. A natural reaction to pain is to stop moving, a tactic that helps decrease the pain temporarily. But this stopping of movement can lead to more muscle contraction, altered body mechanics, increased pain, and more inactivity. This can become a downward spiral of inactivity and increased pain. Patients need to understand that with chronic pain “hurt does not mean harm.” The pain sensation is basically a false or over-amplified sensation and does not reflect new or more tissue damage. One important step for pain patients then is to realize that it is okay to move and to feel some pain. By slowly increasing movement, patients realize that the pain is indeed bearable and need not be avoided as much as they may have been doing. This can start a positive cycle upward of more activity and increased tolerance of pain. Addressing this and other issues surrounding a patient’s diagnosis and treatment plan are, for me, the first steps in creating a working treatment relationship and moving forward with the patient to address his or her pain.

The Second Skill: Accepting

How the patient thinks about his or her pain is critical to successful outcomes. “Catastrophizing”—the behavior of patients telling themselves that their pain is

the worst imaginable, that relief is impossible, and that this is the worst situation of their lives—has been shown to be an important predictor of negative pain treatment outcomes.⁴ An important skill for the patient is be able to accept his or her situation and decrease their emotional struggle with the situation. This can be a tricky skill to discuss because it is not helpful for the patient to just give up and not put in any effort to deal with making his or her life better. What “acceptance” means is a worthy of discussion with every patient. Acceptance and having appropriate attitudes and expectations about chronic pain are central to cognitive-behavioral therapy (CBT), which is the most commonly used psychological therapy for pain patients and has been shown to be effective in treating chronic pain conditions.⁵ Acceptance and Commitment Therapy (ACT) also has been shown to be effective for chronic pain conditions.⁶ These treatments reflect the overall patient skill of what I have termed accepting.

Accepting is a major issue for all pain patients and will be a part of any treatment of chronic pain, whether one is a psychologist or not, and whether one is doing CBT or not. There are many counseling and motivational techniques that can help in this area, in addition to CBT and ACT. On a simple level, I tell many patients that the basic issue is changing from thinking “woe is me” or “why me” to “what now.” When a patient begins to focus on what he or she can still do and what role in life he or she will have from now on, then this reflects increased acceptance. One basic approach to foster this type of thinking is gratitude. By helping the patient focus on the skills and resources he or she still has, despite the pain, this can help refocus them from the loss to moving forward. While the patient’s “glass” may not be even half full, there is usually some amount of water left in the glass, and focusing on what is left and where to get new sources of water is a key skill for pain patients.

Avoiding “shoulds” is important (and is central to CBT). Many pain patients, and most of us as human beings, think with “shoulds.” “I should be able to help my family more,” “I should be able to work a full-time job,” “I shouldn’t have this much pain because I am so young,” and “I should not let the pain get to me like it does” are common statements that pain providers hear routinely. Working with the patient to help them have appropriate and realistic expectations is important

to any pain treatment. A patient's level of acceptance will vary from day or day or even minute-to-minute, but it is important for a pain clinician to know where a patient is overall with respect to acceptance.

The Third Skill: Calming

Pain is meant to stimulate the body into action and to avoid danger. This is the well-known "fight or flight" response. The natural reaction of patients with pain is to be in a state of physiological arousal. The problem is that, because the pain is ongoing, the body can be damaged by this ongoing stress. Therefore, an essential skill for any pain patient is to learn how to calm the body down. I usually use the word "calming" rather than "relaxation" because the word "relaxation" has so many different meanings and uses in our culture that it can get hard to determine exactly what we are talking about.

There are a wide array of relaxation techniques that have been used in patients with chronic pain conditions: progressive muscle relaxation, mindfulness, guided imagery, yoga, tai chi, qi gong, and many more. In the past, I have found it difficult to know where to start in this area. In our practice, my colleagues and I differentiate 2 aspects of calming. We first talk about calming down the body's stress reaction—decreasing stress. This is taught most easily by teaching the patient diaphragmatic breathing. Inhaling with the diaphragm rather than the chest and shoulders (ie, shoulder breathing) can be taught quickly and easily. To demonstrate the impact on the body, I have patients first count their breaths for a 30-second period and write down the number. Then we talk about diaphragmatic breathing and have them put their hand on their abdomen and feel what it is like to breath with the diaphragm rather than the chest. After only a few minutes of discussing this, I ask the patients to again count their breaths, and this time breathe with the diaphragm to the extent they can. Almost invariably the number of breaths has decreased, usually by 20% to 50%. This gives immediate feedback that the body has changed with this type of breathing and how this likely also reflects a decrease in the fight-flight response.

After teaching the importance of decreasing stress, we go on to discuss triggering the body's calming (or relaxation) response. We talk about the difference

between decreasing stress (decreasing adrenaline) versus triggering the body's calming response (stimulating endorphins). This sets the stage for further education about relaxation techniques and how all relaxation techniques trigger this endorphin response. In some groups, we teach a specific relaxation technique (body scan or modified tai chi); in others we ask patients to explore and choose their own relaxation technique—one that best fits their personal philosophy. We believe that there is not one “right” or “best” relaxation technique, but it is an important skill and all pain patients should be familiar with some sort of calming technique to use as needed, if not regularly.

The Fourth Skill: Balancing

This skill is a collection of various techniques and skills that revolve around creating a balanced and sustainable lifestyle. Patients with pain who describe themselves as being successful in managing their pain all report that they have developed a pattern of living that works for them, but they also report being adaptable to episodes of pain.

One specific skill within this category is “activity pacing.” This involves learning not to overdo activities. Patients who are coping well describe how they have learned to do a little bit at a time and not overdo it, while also staying fairly busy. In the pain groups that we lead at our practice, we remind patients of the parable of “The Tortoise and the Hare.” Sometimes we give out turtle pictures or turtle magnets for the refrigerator as reminders to take it slow and steady. This also involves breaking large tasks into smaller ones that can be performed one at a time. Maintaining movement with gentle exercise and activity while not doing too much is a delicate balance, but it is a very important skill.

Another element of a balanced lifestyle includes good sleep hygiene and getting enough rest. This can be difficult for patients with pain, but when patients take naps in the day or go to bed at all hours, their internal sleep cycle is disturbed and often this makes things worse. This area also includes assertiveness, time management, and goal setting. In my experience, many patients with pain feel guilty about not being productive enough and, thus, they often easily give in to requests from family or friends to help. It is a good thing to feel productive and

help out when you can. But some patients find themselves routinely helping others when they really don't want to, or using up their "good time" helping others and not on themselves.

Some patients feel exhausted by the time the evening meal comes around and go to bed early. However, this often is when families spend time together and talk about how their days have been, so a patient who often goes to bed early misses out on this quality bonding time. Sometimes not being so giving to others during the day enables a patient with pain to have enough energy to be fully physically and emotionally present in the evening and keep a connection with a spouse and/or children. The ability to say "no" can be a new but important skill to help patients set boundaries and spend their limited "good time" on the things and people that are the most important to them.

The Fifth Skill: Coping

The fifth and final skill is coping—that is, having tips, techniques, and plans to use when the pain becomes more severe. Surprisingly, sometimes this area is overlooked in professional psychology, but coping is a very important skill and often one of the first ones pain patients begin to develop. Often pain patients have limited skills in this area, so when pain increases the only coping skill they can think of is to take a pain pill. This can lead to all kinds of other problems and has been described as "chemical coping."⁷ Pain patients need more coping techniques.

To address this, our pain program reviews the many different ways that can be used in addition to or instead of taking more medication to reduce pain. We discuss the patient's condition and whether heat, ice, or alternating heat and ice will help. We discuss over the counter creams, which many patients use already, and give patients information about which creams are more likely to be more effective for their pain condition. In patients with myofascial pain, we offer multiple helpful techniques and products to help with muscles spasms, tight muscles, and painful "muscle knots" (trigger points).

We also discuss the pain relieving qualities of distraction. One educational technique that I use frequently is the "hand in the box" technique. I initially ask a

patient what his or her pain is on the 0-10 scale. Then I introduce the task in which I have a box that contains 10 miscellaneous items from around the office. I offer them a ruse explanation that I am assessing their skill at tactile identification and ask them to identify the 10 items only by touch by inserting their hand in the closed box (I demonstrate to show it is safe). After they work to guess the items, we stop and just before we look in the box to get their “tactile score,” I stop and suddenly ask, “Oh, what happened to your pain when you did that?” I have found that 90% of patients report that their pain decreased, usually by 20% to 50%. Some patients are completely taken by surprise by this decrease and express wonder at the power of distraction. Letting the patient see and feel the power of distraction from his or her own pain can be a very powerful experience. They now know they have power and control over their pain. Some sort of distraction is a technique that all pain patients should have.

This Conceptual Framework

There is no way that I can think of to directly test the validity or helpfulness of this framework of pain patient skills. However, we published data from a pilot study last year in which we found that having patients attend a single 2-hour group session that went over these 5 skills was associated with a reduction in pain catastrophizing at 3-month follow-up.⁸ It appears to us that even a brief introduction to these 5 skills can have a positive and enduring impact.

One can see by looking at the framework that there are some techniques that overlap and that these “compartments” interact with each other. Mindfulness techniques teach calming as well as acceptance. Guided imagery, in addition to eliciting a calming response, is a form of distraction and coping. Understanding that feeling pain is OK and not a sign of further damage helps a patient engage in a balanced lifestyle that includes gentle exercise. If one’s pain is myofascial in nature, understanding the specifics of that type of pain helps the patient choose what sorts of pain coping techniques might be more helpful. So it matters less which skill to teach first because they all interact and will likely come to the surface in treatment at one point.

These skills are not solely in the realm of pain psychology and all can be addressed and taught by non-psychologists. As helpful as a pain psychologist (if you can find one) might be to your practice, you do not need a psychologist to begin to address these skills with your patient. There also is the possibility that you can find a “regular” psychologist or licensed clinical social worker with some interest in chronic pain and have them learn what they need to know by following this rubric.¹

I’ve found this framework to be a helpful guide to what issues to address with patients in their pain treatment (Table). Consider the following: a patient comes in on Monday morning and says he or she has had increased pain for the last several days. A presentation of “I have had a bad pain flare, I struggled all weekend and didn’t know how to get out of it” suggests that addressing the coping area and a review of pain coping techniques might be in order. A presentation of “I have had a bad pain flare—I am so miserable and unhappy about this pain” suggests that addressing accepting are may be in order. A presentation of “I have had a bad pain flare—I was so stressed out that it sent me spinning out of control” suggests that calming may be the issue to address. A presentation of “I have had a bad pain flare—I overdid it and paid the price” suggests that balancing is the skill to be addressed. Finally, a presentation of “I have had a bad pain flare—please give me more medication, you’ve got to help me and relieve my pain!” suggests that you might need to address the patient’s understanding about medications, expectations for chronic pain, and underscore the patient’s responsibility in their process of getting better.

Summary

As we pain practitioners offer our patients injections, modalities, and medications, let us not forget the “third leg of the stool.” We need to also find a

way to offer our patients the 5 essential skills they need to deal with their chronic condition.

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