



Pain, Pain, Go Away

Psychological approaches help people cope with chronic pain.

What the Research Shows

Chronic pain due to disease, disorder or accident affects nearly a third of the U.S. population every year. With arthritis, fibromyalgia, and low back or muscle pain among the top offenders, chronic pain takes a toll in the pain itself as well as associated disability and emotional distress, lost productivity and high medical costs. Psychologists are working with other health-care providers on multidisciplinary, multimodal ways to help manage the hurt.

To more effectively treat chronic pain, practitioners first need to understand it. Over the last quarter century, researchers have found that pain is as individual as the people who have it, and that subjective assessments of pain do not necessarily match the degree of actual bodily damage.

That realization came in part after the 1985 publication of the West Haven-Yale Multidimensional Pain Inventory. This pioneering assessment allowed patients to report on many key aspects of their pain, including its severity, interference with daily life, their mood and sense of control over their life, and impact on activities. The inventory included observations from people close to the patient. Validated through strong relationships with other standardized measures of pain severity and depression, the inventory helped to open the door to research on the cognitive and behavioral aspects of pain - and revealed the true complexity of chronic pain. As a result, pain assessment and management standards issued by the Joint Commission for the Accreditation of Healthcare Organizations now emphasize pain's multidimensional nature and call for the comprehensive assessment of pain's psychosocial impact.

Once it became clear that psychosocial factors play a role in chronic pain, psychologists developed ways to work with these patients. A rigorous 2006 meta-analysis of 22 randomized studies published between 1982 and 2003, of people with non-cancerous chronic low-back pain, confirmed the beneficial value of psychological interventions. The therapies evaluated in the original studies included behavioral (operant or respondent approaches), cognitive-behavioral, self-regulatory (biofeedback, relaxation or hypnosis), or supportive counseling (non-directive lay or professional counseling). Physical therapies were excluded.

Varied therapies, but especially cognitive-behavioral and self-regulatory treatments, helped to reduce pain intensity, improve emotional and physical functioning, reduce pain-specific disability, improve health-related quality of life, reduce health-care provider visits and pain-medication use, and lower employment/disability compensation costs. Importantly, multidisciplinary programs that included psychological help were better to other active treatments at bettering short-term and long-term work-related outcomes. Self-regulatory treatments such as biofeedback and relaxation training showed relatively strong effects, and may be even better than cognitive-behavioral therapy at relieving both pain intensity and the severity of pain-related depression.

What the Research Means

Effective pain management now comes from multidisciplinary care teams that look at the whole "person with pain" rather than the pain itself. Two decades of studies now confirm the value of psychological interventions in reducing self-reported pain, pain-related interference, depression and disability, while increasing health-related quality of life. Not only do these outcomes help people feel better and cope better, but they also reduce dependence on potentially addictive pain medications and lower the burden on the health-care system.

How We Use the Research

Patients with chronic pain are now viewed from a broad, biopsychosocial perspective. Says psychologist Robert Kerns, PhD, a pioneer in the psychological management of chronic pain who helped to develop the West Haven Multidimensional Pain Inventory and co-authored the current meta-analysis, says, "For greatest effectiveness, we emphasize treating a whole person with both physical and psychological characteristics - not fixing 'broken' body part."

Sources & Further Reading

Altmaier, E. M., Lehmann, T. R., Russell, D. W., Weinstein, J. N., & Kao, C. B. (1992). The effectiveness of psychological interventions for the rehabilitation of low back pain: A randomized controlled trial evaluation. *Pain*, 49, 329-335.

Butler, R.W., Damarin, F.L., Beaulieu, C., Schwebel, A.J., & Thorn, B.E. (1989). Assessing cognitive coping strategies for acute postsurgical pain. *Psychological Assessment*, 1, 41-45.

Crawford, H. J., Knebel, T., & Vendemia, J. M. C. (1998). The nature of hypnotic analgesia: Neurophysiological foundation and evidence. *Contemporary Hypnosis*, 15, 22-33.

Drum, D. (1999). *The Chronic Pain Management Sourcebook*. Los Angeles: Lowell House.

Hoffman, B. M., Papas, R. K., Chatkoff, D. K., & Kerns, R. D. (2006). Meta-analysis of psychological interventions for chronic low back pain. *Health Psychology* (in press).

Jensen, M. P., & Karoly, P. (1991). Control beliefs, coping efforts, and adjustment to chronic pain. *Journal of Consulting and Clinical Psychology*, 59, 431-438.

Kerns, R.D., Turk, D.C., & Rudy, T.E. (1985). The West Haven-Yale Multidimensional Pain Inventory (WHYMPI). *Pain*, 23, 345-56.

Thorn, B.E., Boothby, J.L., & Sullivan, M.J.L. (2002). Targeted treatment of catastrophizing for the management of chronic pain. *Cognitive and Behavioral Practice*, 9, 127-138.

Turk, D., & Melzack, R. (2001). *Handbook of Pain Assessment*. New York: Guilford Press.

American Psychological Association, July 7, 2006

Find this article at:

<http://www.apa.org/research/action/pain.aspx>