Psychological Factors in Pain Management & Identity

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Introduction

- Overview of interaction between pain and identity
- How this can impact on treatment and support
- Not a focus on a specific model, but range of ideas (cognitive, attachment, PCP, dynamic)
Impact of early(ier) experience

“Is this all because my dog died when I was five?”

- We build up a model of ourselves, other people, relationships and the world
  - Core beliefs/constructs, schemas, Internal Working Model
- Rooted in our experiences
  - Can be robust, functional & adaptable
  - Can be brittle, inflexible, unhelpful model
    - Though would have been ‘useful’ at some point
Acceptance & Fit

• Any big change needs to be ‘fitted in’ – assimilated and understood as part of person’s psychological system.
• The worse the ‘fit’, or the greater the contradiction / invalidation, the greater the risk of difficulties.
  • Interference with a coping mechanism.
• If ‘fits’ or validates something unhelpful, can also lead to difficulties.

“At last I’ve found a Doctor who knows what he is talking about!”
Pain

- Persistent pain, either on its own or in conjunction with other health concerns can be a major disruption
- Unpleasant
- Provides physical limitations that impact on identity
- Hidden / unobserved
- Disbelief / minimised by others
- Little social/cultural understanding of persistent pain
- Can link to previous abuse / traumas (either directly or indirectly)
- Can be a good proxy / displacement for other issues
If struggling with acceptance...

- People not satisfied / agreeing etc with diagnosis
- Will often struggle to engage with interventions
  - Blaming of Doctors for not ‘curing’ or taking away
  - Psychologists think its ‘all in the head’
  - Physios give me a lot of pain...
- Getting caught up in cycle of constantly searching for ‘cure’ or relief
Why people struggle...

- Change the facts to fit the theory....
  - Preference for not changing the model
- Trying to get back to ‘old self’
  - Acceptance paradox – doing things that will help them means accepting reality of the pain
- Again, the more disruptive or more activates unhelpful aspects of the psychological model, harder it may be
  - There are costs to psychological change – often an increase in anxiety, uncertainty, trauma or depression as work through the change
- But also Pain may serve a function
  - Least bad option?
    - Psychologically and/or medically
A Working Model

- Initially will go through grief & loss over changes
- With a flexible, functional model may adapt quicker
- Often work well with more traditional practical & cognitive behavioural interventions
- Pain & related diagnoses may still cause particular difficulties for individuals
- If what happened completely devastating and overwhelming may still have large impact on their identity, and struggle to cope
  - E.g. PTSD
A Rigid Model

• A model that ‘works’ but lacks flexibility and adaptability
• Can often particularly struggle with pain
  • Can’t be problem solved
  • Perfectionist
  • Black and white thinking styles
  • Limited range of alternative activities, strategies or indeed understanding
  • May have been very successful model
• Can be very difficult to shift psychologically because of the success and rigidity
A Dysfunctional Model

- Early trauma, neglect or abuse
  - Though severe & catastrophic later traumas may also result in this
- Once ‘made sense’ in that early environment
- If severe attachment difficulties, often obvious as get clearly unhelpful, destructive patterns
- Basic model will tend to have unhelpful patterns in terms of self, others, relationships and the world
- However, can often be hidden
  - The ‘pusher’ who just keeps going (until pain prevents it)
  - Lack of self care – looking after everyone else (selfish vs selfless)
  - ‘Deserving’ the pain
  - Feeling a failure, and living up to those low expectations
Consequences

- May struggle to accept care
  - Not understood
  - Been manipulative in the past
  - Hopelessness about outcome
- Strong fear may be associated with change
  - Not uncommon to have a ‘safety = boredom’ view
  - Or that expressing own needs = unsafe
- Pain may directly connect to memories
  - Because of causation
  - Traumatic links
- Achievement & success as proxy for affection & love
Implications

- Not everyone can be helped
  - Potential cost to them or timeframe
- If patients seem stuck – what are the implications for them?
  - Acceptance
  - Something more fearful may be lurking
  - There model is so shattered, no idea where to go & desperately trying to get back to where before
Creating a Story

- Identity essentially ultimately a story, a way of framing and understanding something
- Got to be theirs & broadly make sense to them
- We can help, provide support & interventions – but only the person involved can ultimately make sense of the pain (and everything else)
- Consistency of message, a feeling of being supported & looked out for
Approaches

- Mindfulness, relaxation & distraction all helpful
  - Can be a good triage tool – if struggle to use at all then may be sign struggling with adjustment
- ‘Rehab’ vs ‘nothing else’

- Matching messages to stage...
  - E.g. If still struggling to accept, pacing often feels like giving up
  - Empathy, confidence & knowing got support early on
  - Confidence in diagnosis – certainty means can at least plan (helping them understand & construct that story)
Bringing it together

- Being not doing
- Avoiding the need to always intervene
  - E.g. cycle of increasing / constantly changing medication (frustration on both sides)
  - Equally physio, CBT etc
- Pain management a mutual approach
- Support while people accept the nature of the pain
  - What are they trying to achieve – move on or move back?
  - Can appear simultaneously compliant & not finding useful
- Will be very different reactions depending on a patient’s previous identity and beliefs
  - Not everyone will be able to assimilate the pain into that identity
    - Be kind to yourself - does not mean you have done something ‘wrong’
References

- **Pain focus and Identity**

- **Patient & Professional relationship**
  - Jarrrett, N., Payne, S., Turner, P. and Hillier, R. (1999) ‘Someone to talk to’ and ‘pain control’: what people expect from a specialist palliative care team; Palliative Medicine, 13(2), 139-44.
References 2

- **Attachment**

- **General Attachment Reading**
References 3

- **Acceptance and Identity**