

# SUPPORTING PATIENTS WITH PAIN: THE CLINICAL PSYCHOLOGY SERVICE AT THE ROYAL LANCASTER INFIRMARY

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The Journal has previously reported the usefulness of an outpatient group based 'pain management programme' for psychological and physiotherapy intervention in a group of chronic pain sufferers presenting with distress and disability that could not be addressed by conventional medical

therapy<sup>(1)</sup>. Five years after the programme, Dr Jennifer Ashcroft, Programme Director of the Clinical Psychology doctoral programme based at the Institute for Health Research, Lancaster University, interviewed members of the outpatient group to establish what long term benefits had been gained. Given lack of funding for group intervention from a multidisciplinary team at the pain clinic, a new service has been offered from 2005. This service constitutes individual assessment and psychological treatment for pain patients and the experiences of the first six months of this work are described.

## BACKGROUND TO THE ESTABLISHMENT OF THE SERVICE

For some years it has been the aim to try to establish a dedicated team of therapists at the Royal Lancaster Infirmary (RLI) offering group therapy for 'pain patients', headed by the consultant in Pain Management working in conjunction with a nurse therapist (specialising in cognitive behavioural approaches) and a physiotherapist. Indeed, such a group did operate for a period in 1997<sup>(1)</sup>. Long term follow-up interviews were conducted with patients from the group five years post treatment. Of those (the majority of the original group) who attended the interview, all reported benefits of one kind or another with some citing the physiotherapy sessions as the most useful, some the psychological input, some the more general educational aspect about their pain, and some the camaraderie inherent in group treatment. The consensus was that patients found it easier to cope with their pain as a consequence of their attendance at the group therapy sessions. Not all patients had continued to adhere to all aspects of the therapeutic recommendations, but that would appear to be fairly typical of pain treatments<sup>(2)</sup>. Two of the patients had returned to work as a result of attendance at the group. It was not possible to ascertain the views of all the patients who originally attended and it is acknowledged that, in evaluating the success of the group treatment, the study eliminated from the outcome those who did not attend for follow-up; this is a common problem with review of outcome within such studies<sup>(3,2)</sup>. Generally, overall success of a group intervention of this type to help patients cope with pain is not unexpected and the literature is replete with evidence for such success of group treatment with multiprofessional input<sup>(4,5)</sup>. Despite both immediate and long term success with this

intervention at the RLI and, consequently, extensive lobbying for funding, it has not proved possible to establish a dedicated team offering group therapy for patients with pain, based within the RLI.

However, currently within Lancashire there is an established group therapy programme offered by a multi-professional team based at Barrow-in-Furness.

### The Furness Pain Management Programme

#### Data:

- Measures of depression
- Measures of self-efficacy
- Type and severity of pain
- Attitudes of significant others

#### Programme content (one day a week for eight weeks):

- Relaxation training
- Value of exercise
- Lifestyle and its relationship to wellbeing
- 'Mind-body' links
- Managing as opposed to curing pain
- Educating patients to contextual issues

Results collected from the groups that have run over the years attest to the benefits of the group treatment<sup>(6)</sup>.

It is possible to refer patients from Lancaster and Morecambe to Barrow for group therapy. However, for a variety of reasons, not all patients are suitable for referral.

### Contraindications to group psychological therapy for pain

- Inability to travel to the centre or difficulty in committing to regular sessions
- Group discussion is too intimidating
- Language or educational barriers to working in a group
- Too dominant for group work
- Unresolved issues with physical or sexual abuse as adult or child
- There has been irreparable marital breakdown which is now the primary problem
- Post traumatic stress disorder as the primary psychological diagnosis

In such contexts, group therapy may not be the best forum to facilitate psychological change. Indeed, it might be argued that in order for group therapy to be both cost-effective and maximally beneficial for patients it is crucial, given limited financial resources, to have specific inclusion and exclusion criteria for participation in group treatment and to consider the cost-effectiveness of any treatment programme<sup>(7)</sup>.

For many reasons, therefore, both from the limited resource perspective and also in terms of wishing to offer optimal treatment to individuals, a clinical psychology

service (one-to-one therapy) has been added to the current medical treatment available in Lancaster.

## AIMS OF THE SERVICE

The primary aim is to provide psychological therapy as an adjunct to the medical treatment received by patients. The clinical psychology service constitutes a limited number of sessions throughout the year and the patients have therefore to be selected for inclusion in treatment. It is anticipated that the service will be available to around 20 patients a year as a minimum, with an average of eight hours of individual therapy for each person, with follow-up and booster sessions whenever this seems necessary and is possible. The general ethos of the clinic is similar to that expounded by Turk and Monarch<sup>(2)</sup>, that is to say, that chronic pain should be both viewed and treated as, potentially, a lifelong disorder, one that is unlikely to benefit greatly if treated as an acute condition. Therefore, after the initial block of sessions, booster sessions and follow-up appointments are considered by the service as desirable, if possible, in order to maintain progress.

The literature indicates that the relationship between chronic disease and the development of psychosocial problems and disability is not a simple one<sup>(8)</sup> and therefore to refer for psychological treatment on the basis of severity of illness is not the best method.

Although the relationship between extent of physical disability and ability to adjust psychologically and socially is not high, there are psychological and social risk factors associated with development of chronic problems<sup>(9)</sup>.

### Psychosocial factors associated with chronic problems

Depression  
Stress  
Inappropriate/dysfunctional pain-coping behaviour  
Avoidance behaviour  
Lack of social support  
History of substance abuse

Given limited resources, it is not possible to screen all patients at the clinic and, therefore, it is a matter of clinical judgement for the consultant to refer patients for psychological therapy. As the consultant knows the history and background of the patients well, works in conjunction with the psychologist, and given that they then consult about progress and outcome, this seems as efficient a method as any. Thus, patients with psychological and social problems as listed above are targeted for referral to the psychology service.

Some patients who are referred may not wish to proceed with psychological intervention; drop out is to be anticipated with any therapeutic intervention. However, with those who participate, the broad aim is to restore function such that psychosocial capability improves and, ideally, given better ways to cope with pain, there may be a concomitant decrease in reliance on medication. Although the specific target behaviours for modification may be different from patient to patient, intervention broadly follows a cognitive-behavioural therapy (CBT) approach, given this has been extensively evaluated and shown to be effective for a broad range of psychological problems including chronic pain<sup>(10)</sup>. In addition, for those patients who do not readily wish to do 'homework assignments' (which are an integral part of CBT) or who find

it difficult to reflect on cognitions or dysfunctional thoughts, such elements have been replaced or supplemented with increased behavioural interventions and also, for some, increased relaxation, dissociation, and imagery work. The elements of the therapy, therefore, have been tailored to individual need.

## CLINICAL PSYCHOLOGY SERVICE USERS

Although the common element in referral is, of course, pain-related behaviour, at presentation with the psychologist there have been a variety of key presenting themes raised by patients themselves and such themes have been a primary focus of therapy within the clinic.

### Psychological problems encountered in pain patients

Depression and suicidal thoughts  
Stress associated with pending disability compensation  
Alcoholism  
Inability to work and lack of social contact  
Marital difficulties as a consequence of pain behaviour  
Childhood sexual abuse and problems establishing appropriate social relationships in adulthood  
Worry about possible cancer  
Fear of pain associated with medical investigation, associated with avoidance of such investigation  
Post traumatic stress disorder and flashbacks  
Sleep disorder  
Loss of self-esteem

It is not unexpected that such a diversity of problems exist alongside pain itself<sup>(11)</sup>, with associated problems such as high incidence of depression having been known for some time<sup>(12)</sup>.

Although the clinic adheres to the view commonly cited within the literature<sup>(5)</sup> that the experience of chronic pain can usefully be conceptualised as stress-related (and therefore to change cognitive appraisal of pain is adaptive, and to learn stress control is equally adaptive) there is a focus on the particular stressful problem(s) brought to therapy by the patient. The patient referred with pain is considered from all perspectives: their individual medical condition, psychological, social and cultural background all come to result in a particular presentation for each individual. This approach is in line with much of the current thinking on approaches to understanding and treating pain<sup>(13,2)</sup>.

## PROCEDURE: INDIVIDUAL DIFFERENCES WITH TREATMENT APPROACH

It is interesting to note that for the majority of patients the pain itself is not a major topic that they have brought for discussion and resolution. Therefore, for the majority of patients referred thus far, pain itself has not been the only issue or, indeed, the main issue. With each patient, case formulation is a primary focus. Formulation is seen as the cornerstone of any cognitive therapy and ensures that understanding of the problem and subsequent interventions are not 'technique driven' but are guided by a working hypothesis established in collaboration with the patient<sup>(14)</sup>. With all the cognitive and behavioural approaches, the essence is to establish sufficient rapport and trust between the patient and the therapist that they come to a joint understanding of the presenting problem(s), their antecedents

and maintaining factors. Goals for therapeutic change can then be established; the interventions employed can be specific to the person and their individual circumstances. That is to say, the formulation, and the therapist's and patient's shared view of the problem as elaborated in the formulation, determines action, the way the therapy then proceeds<sup>(15)</sup>.

With all patients currently attending the clinic, it has been possible to develop sufficient rapport that an agreed formulation has been established. The formulation can then be modified, if necessary, as more information is revealed in the course of treatment. The process of formulation and consequent intervention is a dynamic process and it is frequently the case that information revealed in later sessions gives a greater understanding and insight into root causes of psychological problems and the patient's inability to cope with life events of one kind or another.

The primary aims of therapy, therefore, vary from one patient to another, depending on the formulation.

#### **A case-centred approach to psychological intervention in pain**

Post traumatic stress disorder:

- Dissociation from strong mental imagery
- Stop flashbacks
- Learn procedures to help sleep problems

Marital difficulties:

- Involve spouse
- Discuss the effect of pain on social and work function

Low self-esteem:

- New image of self
- Build new goals and different expectations

In addition to the primary aims, as established with each patient, there is always a focus at some point in treatment on the complex relationship between psychological and social variables and illness, pain, and associated behaviour. Methods to cope and control such variables are discussed in the context of each individual's life.

## **VALID MEASURES OF THERAPEUTIC EFFECTIVENESS**

To date, the service has not used a standard battery of tests to assess outcome, as is the norm with group interventions. The last six months have, in many ways, been a 'pilot' of the service that can be offered and a deliberate decision was made to approach the operation of the service in an exploratory way. Given that there are not, across patients, a standard number of sessions, standard aims or standard 'technique-driven' interventions, a standard battery of measurements seemed inappropriate. What has resulted, therefore, is a series of individual clinical cases with individual goals and individual outcomes. Success is gauged, as within most clinical practice, in terms of individual patient goals achieved, the subjective report of the patient and the observations of the clinician.

Of the patients who were initially seen by the psychologist in 2005, 25 percent have now stopped therapy, either because of success and an end to sessions for the time being or because (with two people) of drop out. For a small minority, it is notable that they were obtaining considerable secondary gains (such as high levels of sympathy and social support)

from their illness-related behaviour. With such patients, they typically sought repeated reassurance that the psychologist thought the pain was real. When asked to rate their level of pain on a 1-10 scale, some patients resisted because the pain was 'off the scale'. Given, therefore, an attempt to recalibrate the subjective scale and to provide indicators to the lower and upper figures, such that all pain might fit within the scale, the typical response from patients with high secondary gain for pain was to be affronted at what was perceived as an attempt to minimise the personal experience of pain. That problem, of course, is only possible to 'bring to the therapeutic table' if the patient continues to attend.

For therapy to have a significant and permanent effect on pain-coping behaviour it is essential for patients to perceive that there are sufficient benefits to be gained from working to make significant changes in their behaviour. For some people this is difficult, and without strong motivation and a desire to work in collaboration with the clinical psychologist it seems an inappropriate use of the therapy resource to try to prolong the number of sessions for such patients.

Twenty-five percent of the original referrals have now returned to work, albeit, in some cases, on a part-time basis. For the other 50 percent of the patients seen to date, whose ultimate goal may not be to return to work (because of age or other personal reasons), their goals have included activities related to living better within the social and family context in which they find themselves, given they have been able to resolve the problems they have brought to therapy. To date, these patients continue to attend occasional 'top-up' sessions and report considerable benefits.

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**“ 25% of the original referrals have now returned to work ”**

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## **THE FUTURE OF THE SERVICE**

It is early days for the service but we anticipate that, in addition to individual therapy from the clinical psychologist, it may be possible to use an assistant to help with elements of the treatment (such as relaxation training). We shall be monitoring the progress of the patients, including effects of psychological therapy on their reliance on medical treatments and physical interventions. We are considering the efficacy of more formal assessments as indicators of individual psychological wellbeing.

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