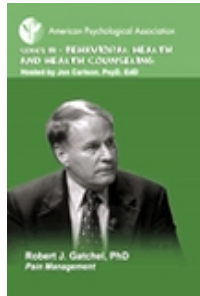


Pain Management Using a Biopsychosocial Perspective

A review of the video



Pain Management with Robert Gatchel

Washington, DC: American Psychological Association, 2006. American Psychological Association Psychotherapy Videotape Series III, Item No. 4310589. \$99.95

Reviewed by
[Kirk D. Strosahl](#)

— A recent nationwide survey of approximately 25,000 working Americans revealed that, at any point in time, 25 percent experience some type of chronic pain complaint. Chronic pain is a universal problem, as an estimated 80 percent of the U.S. population will suffer from back pain at least once, which makes it the second most common reason for seeing a doctor, following coughs and other respiratory infections. Given medical expenses to treat pain complaints, disability payments, and lost productivity and time at work, the costs of back pain add up to more than \$100 billion per year. Pain complaints are so pervasive in primary medicine that many health care accreditation organizations require pain ratings as the “fifth vital sign” during medical visits.

— Prior to the appearance of psychological approaches to chronic pain 20 years ago, the field of pain treatment was inordinately biomedical and dominated by subspecialties such as neurology, neurosurgery, anesthesiology, and orthopedic surgery. The biomedical approach to chronic pain historically has been an intensely parochial undertaking, with millions of dollars in revenues accruing to hospital specialists for what are now widely regarded as non-evidence-based procedures. As an example of this closely guarded financial turf, a project in the early 1990s by the formerly named Agency for Health Care Policy and Research to develop an evidence-based practice guideline for the treatment of chronic back pain was gutted in part because of intense congressional lobbying by the American Medical Association. The reason for this intense opposition was that the initial evidence-based reviews of the clinical literature showed that neurosurgery, orthopedic surgery, trigger point injections, and other commonly used biomedical procedures were no more effective than chiropractic treatment in improving long-term outcomes. We are now witnessing similarly comparable effects between surgery and acupuncture, massage therapy, and a range of complementary medicine approaches (Cherkin et al., 2001). In my role as a behavioral health consultant on a primary care team, I routinely discourage patients from undergoing neurosurgical procedures such as spinal fusion because of the very limited, conflicting scientific evidence for the efficacy of such procedures.

— It is fair to say that the major breakthrough in the field of chronic pain has been the introduction of cognitive and behavioral treatments. The seminal work of William Fordyce (e.g., Fordyce, Brockway, Bergman, & Spengler, 1986) in developing and testing a sociobehavioral model of chronic pain and subsequent refinements by second generation scholars such as Dennis Turk and Robert Gatchel (2002) have led to widespread acceptance of psychological approaches to pain in the medical community. Clinical trials have, by and large, supported the effectiveness of cognitive-behavioral procedures such as attention diversion, pacing, and cognitive restructuring. Newer approaches to chronic pain management incorporate mindfulness, acceptance, and value-based motivational interventions (Robinson, Wicksell, & Olsson, 2005). Currently, most interdisciplinary pain treatment centers provide psychological services as a core element of pain management. It was thus with much anticipation that I viewed the videotape *Pain Management*, with

Robert Gatchel as the resident expert, hosted and moderated by Jon Carlson. The video is composed of three parts: an introductory discussion, a clinical demonstration, and a question and answer segment.

Introductory Segment

☞ The first part of the tape involves an introductory discussion of why chronic pain is a problem that psychologists must be prepared to treat (i.e., it is a nearly universal problem, cognitive and behavioral treatments work, and it is highly comorbid with mental health conditions and addictions) and how to best conceptualize the problem of chronic pain. Gatchel does a splendid job of describing the biopsychosocial framework for understanding and treating pain.

☞ The “bio” part is the understanding of the pathophysiology of pain and central concepts such as the theory of gate control. It also involves being knowledgeable about somatic therapies and the effects of various drug regimens. At several points in the video, Gatchel states that most general physicians know little about how to treat pain and are not up-to-date on the best medicines to use. Therefore, psychologists often encounter pain patients who are undergoing unnecessary polypharmacy regimens that could easily be simplified. Gatchel believes that psychologists must be intimately familiar with drug therapies for pain disorders and be able to advise patients about these issues.

☞ The “psycho” part is the client's psychological reaction to pain and how it affects the client's life space. This includes assessing for comorbid conditions, such as depression, and evaluating adaptive versus maladaptive coping styles. The “social” part is the effect that the client's social networks, relationships, and supports will have on the immediate and long-term course of the pain syndrome. Gatchel correctly points out that the experience of pain often becomes the centerpiece of social relationships and that friends and family can be overly solicitous of the pain patient.

☞ Despite the many positive aspects of this segment, I was disappointed by what is not addressed. The experience of pain is never really defined or described in a way that would be useful to a general clinician, nor do we get a scientifically acceptable definition of *chronic pain*. The experience of pain is normally described by experts as involving nociception (the mechanical stimulation of nerve endings), pain (an unpleasant experience involving the brain's interpretation of neural messages), pain behavior (the verbal and nonverbal communication of pain to the outside world), suffering (the client's evaluation of pain as intolerable and affecting quality of life), and disability (restrictive behavioral, emotional, and cognitive adaptations that lead to a pattern of decreasing functional status over time).

☞ Second, there is no mention of the role substance abuse plays in chronic pain treatment. The fact that narcotics have very high street value often draws pain patients into patterns of drug diversion and polydrug abuse. Some clients have a premonitory substance abuse history, and narcotics simply become one more drug to abuse and sell. For others, narcotics are oversold as the principal treatment for pain, and thus the patient not only becomes legally addicted to the drug regimen but is psychologically dependent on the drugs as the key to a better life. This is such a basic part of treating chronic pain that I was surprised it is not a central focus of this videotape. Finally, the issue of disability is never really addressed as part of the social aspect of the biopsychosocial model. How does the clinician deal with a situation in which the client is receiving disability payments and may have financial incentives for not getting better? This is a pervasive theme in working with this type of client and a source of unending frustration for clinicians. A few tips on how to address this cross-current in treatment would have added a lot to the product.

Review of Clinical Demonstration

☞ The bulk of the tape is a clinical interview involving Gatchel and a middle-aged woman diagnosed with fibromyalgia. Gatchel does a superb job of demonstrating a biopsychosocial assessment with this patient and effortlessly glides among domains. His manner is friendly, empathic, validating, and designed to create a positive alliance with the patient. He points out in a debriefing discussion with Carlson that most pain patients have been beaten up by the medical system. Their pain complaints are often glossed over by the medical provider, or they are told that because all of the specialty exams are negative, the pain must be in their head. What Gatchel

demonstrates over and over in the interview is the ability to listen to and validate the client's pain experience while incorporating it into the fabric of the client's life. The interview also demonstrates how intertwined the biopsychosocial domains are. For example, the patient developed fibromyalgia shortly after her children had left home and she was plunged into an unworkable, loveless, and touch-free marriage with an abusive husband suffering from bipolar disorder. She subsequently lost a very close friend to cancer, which again highlights the importance of social support as a buffering agent against the stress of being in pain and having an unmanageable home life. I was really impressed with Gatchel's ability to reframe these events as stressors and to have the client accept the stance that unmitigated stress increases one's susceptibility to pain.

☞ There are some limitations in this portion of the video as well. First, the client is a fairly high-functioning pain patient and is certainly not representative of the type of patient over whom many of us tear our hair out. I would have liked to see a more "hardened" chronic pain patient. Second, the choice of a client with fibromyalgia is a bit interesting, because there are still mixed opinions about whether this is a really a pain (as opposed to psychological) disorder. It tends to be dramatically overrepresented in middle-aged women, as was the case with chronic fatigue syndrome when that was in vogue. I think the tape would have been improved with a mainstream type of pain syndrome, such as back pain, myofascial pain, or headache. Finally, perhaps out of respect to the client and the situation, Gatchel seemed hesitant to aggressively intervene on a number of levels. For example, the client reported several strategies for managing her pain, including pacing herself, but that was not reinforced and integrated into her exit treatment plan. I was left feeling that this session was really an assessment session rather than a treatment session. As I mentioned previously, just the modeling of a competent biopsychosocial assessment would make this tape worth purchasing.

Review of Question and Answer Segment

☞ The clinical demonstration is followed by a debriefing question and answer session between Carlson and Gatchel in which they deconstruct smaller parts of the original interview (30- to 120-second segments). I really like this method of highlighting key principles in pain management because the limited video exposure keeps attention focused on the attribute that is being taught. Some interesting concepts are brought to light in this phase of the tape. First, Gatchel rarely mentions the word *pain* during the entire interview and actually engages in very few sequences with the client about her pain syndrome. He points out that focusing on the biopsychosocial "surround" allows the patient to understand pain as something that is part of the surround rather than separate from it. One cannot understand pain without understanding the context it is embedded in. This is a very important principle that every psychologist should understand when treating pain patients.

☞ Gatchel makes some other points during this segment that I think highlight the general difficulties we are having as a country in addressing the needs of patients with chronic pain. First, he correctly points out that interdisciplinary pain centers produce the best outcomes but that most patients in the United States have no access to this type of treatment. By and large, the primary care physician plays the lead role in managing pain syndromes and is required to do so in a 15-min exam. Recommending that a patient seek the services of a pain physician is unrealistic in many areas of the country, where such specialists are few and far between. It is important to remember that 80 percent of the land mass of America is either rural or pioneer in population class, yet it is precisely in these agricultural and forest product economies that a very high percentage of pain injuries occur. My main complaint with the pain treatment community is that it has failed to come to grips with this important reality. Instead of criticizing the treatment provided by primary care physicians, perhaps we need to develop integrated care treatment programs that fit the realities of primary care practices (cf. Robinson et al., 2005). These programs will never provide the complex array of services available in pain treatment centers, but we might be surprised by the clinical impact of integrated medical teams working collaboratively in a biopsychosocial framework (Moore, Von Korff, Cherkin, Saunders, & Lorig, 2000).

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