Chronic pain: communication skills and self-management

You may find it useful to read the NICE guideline article first!

Life is usually very difficult for people experiencing chronic pain, and many of us find it difficult to support them.

We are entering a new era.

We now know that:

- For the vast majority of patients with chronic primary pain (i.e. pain for 3 months or more that is associated with emotional distress and/or functional disability AND there is no other possible explanation for pain), there is no tablet cure.
- For people ***with*** an explanation for their chronic pain (due to conditions such as inflammatory arthritis, osteoarthritis, endometriosis, etc.), co-existing chronic *primary* pain is common.
- At Red Whale, we believe that all people with chronic pain would benefit from excellent communication skills and a holistic approach with supported self-management, **alongside** any other treatments that may be offered.

Primary care cannot do all this work alone. But we see these people regularly, and we can change the nature of the consultations we are having by applying skills that we use widely and comfortably in other contexts, e.g. mental health and long-term condition management.

This is a pragmatic article created using a range of resources and the experience of chronic pain clinicians working in the Red Whale team. It includes, with kind permission, details from Live Well With Pain, a fantastic resource for clinicians and people with chronic pain.

We don't have time…

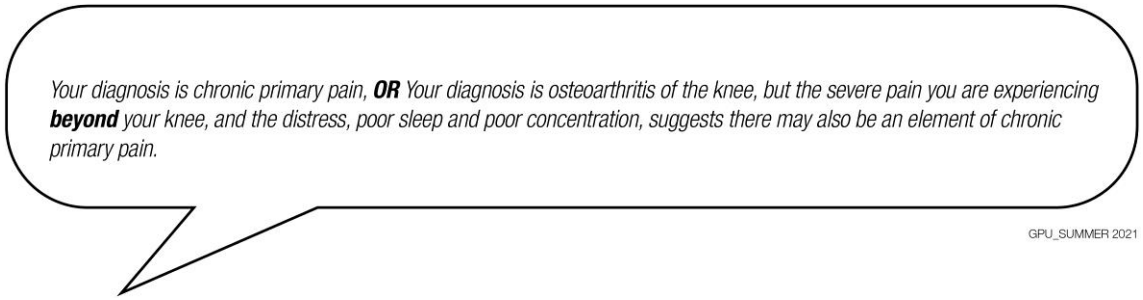
We have some time. People with long-term conditions, including chronic pain, use about 3 hours of healthcare time per year; for many of them, the bulk of this is in primary care. What if we used this time differently?

For the rest of the year, people are caring for themselves; our job is to coach them to enable them to do this effectively.

We do not have to do all this in a 10-minute consultation.

There are lots of small things we can work through as part of an ongoing clinician–patient relationship. This is a refreshing angle as it offers our patients choice and hope in a range of things that may make an impact. It also, over time, allows us to hand over responsibility and to coach rather than tell.

Give a clear diagnosis



It is also essential that we help our patients with chronic pain understand what is going on in their bodies, and change our consulting behaviours to reflect this.

Hear the person's pain story

And consider talking about adverse life events and trauma.

- Listen to the person's pain story from start to finish; this is REALLY worthwhile, and helps you get a clear understanding of the person you are working with.

"Can you tell me today how you have got to this point, and I will book another appointment to discuss what we do next. How did it start? What then happened and where are we now?"

- Check understanding of treatments and investigations so far.

A note about chronic pain and adverse childhood experiences/trauma

There is a clear dose-response relationship between traumatic events in childhood (such as physical or sexual abuse, neglect, dysfunctional home circumstances) and developing chronic pain as an adult. The largest effect size seems to come from emotional abuse. This may be as a result of persistent dysregulation of the central stress response.

These adverse childhood experiences (ACES) are increasingly recognised as a key determinant in health inequality and a whole range of negative health outcomes in later life, e.g. cardiometabolic disease, depression (Practical pain management 2020;20(3):24–28).

What should we do?

- We should ask about these issues as part of hearing the person's pain story. There is a link in the useful resources box below to a scoring system you can use.
- If asked sensitively, people are often willing to disclose these experiences, and, at a bare minimum, this offers us a chance to show empathy and gain a greater understanding of the person we are supporting.
- People who have experienced significant ACES are likely to have lower levels of self-efficacy and may not have developed adequate coping mechanisms and resilience.
- We may consider prioritising these people for support from social prescribing link workers and health coaches, and for psychological support alongside conventional primary care management.

If this is a new concept, you may find the full article on *Adverse childhood experiences and trauma-informed care* in the online handbook helpful.

Share a clear explanation

You can now use the information you have learned to create a clear explanation of chronic pain for your patients. As with all communication skills, we need to find our own way to do this. If you can incorporate aspects of the person's pain story and their own ideas and beliefs into the explanation, even better.

Here we offer some suggestions from our team that might get your creative juices flowing:

There are different types of pain. New pain is also called 'acute' pain. It's the body's warning system that helps to protect us from further harm – so the pain that you get when you pick up a hot pan handle means that you drop the pan and avoid further damage. The pain when you sprain your ankle means that you rest and take time to heal. This is how acute pain can be helpful, and it usually settles fairly quickly as you get better. But, sometimes, pain does not go away as we would expect. If you have had pain for 3 months or longer, it's no longer new or acute pain. It's now known as 'chronic pain' and it may be less helpful for recovery. In fact, chronic pain can become a real problem.

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Explaining chronic primary pain and sensitisation

When we experience pain for a prolonged period of time, our body and brain become increasingly expert at detecting that pain. This process is known as ***sensitisation****. We become highly sensitive to pain, and this can lead to it feeling increasingly severe, even though the body's tissues are not being further damaged.*

Unlike in acute pain, where the pain is a clear signal of an injury or problem, in chronic pain, there may not be ongoing damage, or the body may have healed itself as best it can. But because we are now sensitised to pain, we continue to experience highly distressing, and often severe, pain.

Chronic pain is trying to protect us. Our brain and nervous system are flashing a warning signal... only this time, there's no real danger. It's a bit like an over-sensitive car alarm that goes off every time someone walks past. And we continue to experience pain each time the alarm goes off.

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Explaining how chronic pain can cause 'the pain cycle' and deconditioning

One of the major problems with long-term pain is how it can affect your behaviour and how you live your life. Our reaction to pain is often to rest or to try and find ways to avoid causing ourselves more pain. In acute pain, this works well – we rest for a while and recover, and then get back to normal life.

But in chronic pain, we can get stuck in these patterns of behaviour for long periods of time, and this can make the problem worse. If we rest too much, we lose fitness. Our muscles and joints get weak and stiff, and it becomes even harder to do our daily activities.

If we do scans, they look pretty normal. The pain system doesn't show up on the scan. Neither do the tight muscles or the stiff joints. The scan only shows the normal healed tissues.

Each time we move our stiff joints and tight muscles, we are likely to trigger the sensitised pain nerves. Our brains tell us that movement is dangerous and painful, so we avoid it even more.

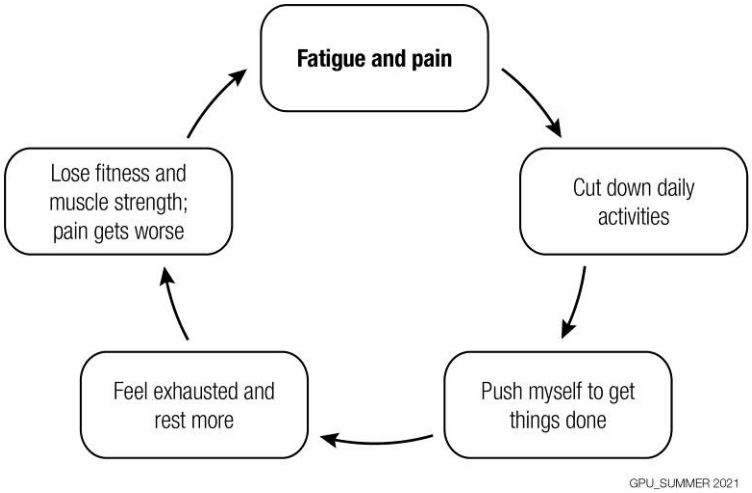
But avoiding activity and restricting movement is actually part of the problem. We need to get used to moving more normally, building strength and the confidence that we can cope with any pain that arises as we start to move, and recognising that experiencing pain does not automatically mean that we are doing more serious damage. As you understand more about your pain and how to cope with it effectively, you can start to take back control of your life. There may not be an easy or straightforward way to simply 'get rid of' chronic pain, but you can find ways to stop it taking over or dominating your life, and to enjoy and expand your life rather than being overwhelmed and restricted by it.

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Explain the 'boom-bust' cycle of over-activity and over-rest

We've seen how behaviours such as reducing daily activities and excessive rest can lead to vicious cycles where pain and tiredness get even worse. 'Boom and bust' patterns of activity are common in people with chronic pain. This involves overdoing things when you are having a 'good day' with more energy and less pain, followed by becoming exhausted and resting for prolonged periods. This also tends to lead to an overall increase in pain and fatigue in the longer term.

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The alternative to boom–bust is to build up your activity patterns using paced activity. Start slowly and build up gradually; try to balance activities across the week, including rest breaks when needed; and ensure that you stop activities before you are forced to through pain or exhaustion. Equally, it is important not to rest too much. Set a simple baseline of activities that are important to you, and try to carry these out on most days.

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Explaining how thoughts, feelings and behaviours can impact on the experience of pain

Pain signals between the body and the brain pass through the spinal cord in both directions. The spinal cord acts as a kind of a 'gate'. Closing the gate decreases signals and blocks pain, while opening the gate increases the signals that reach the brain and increases the level of pain.

Experiencing chronic pain can lead people to feel fed up, anxious and low. Emotions such as anxiety and depression have the effect of opening pain gates and increasing the level of pain experienced.

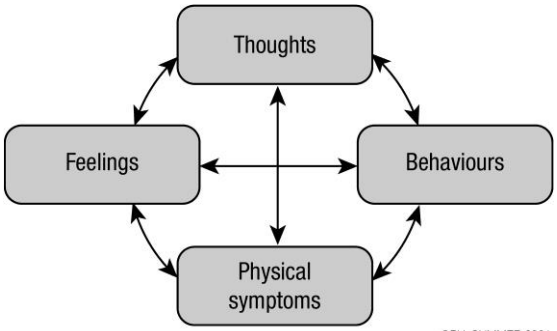
The opposite is also true. Factors which can help to close pain gates and reduce our experience of pain include relaxation, having a sense of control over our life, increasing enjoyable or meaningful activities, and gentle exercise.

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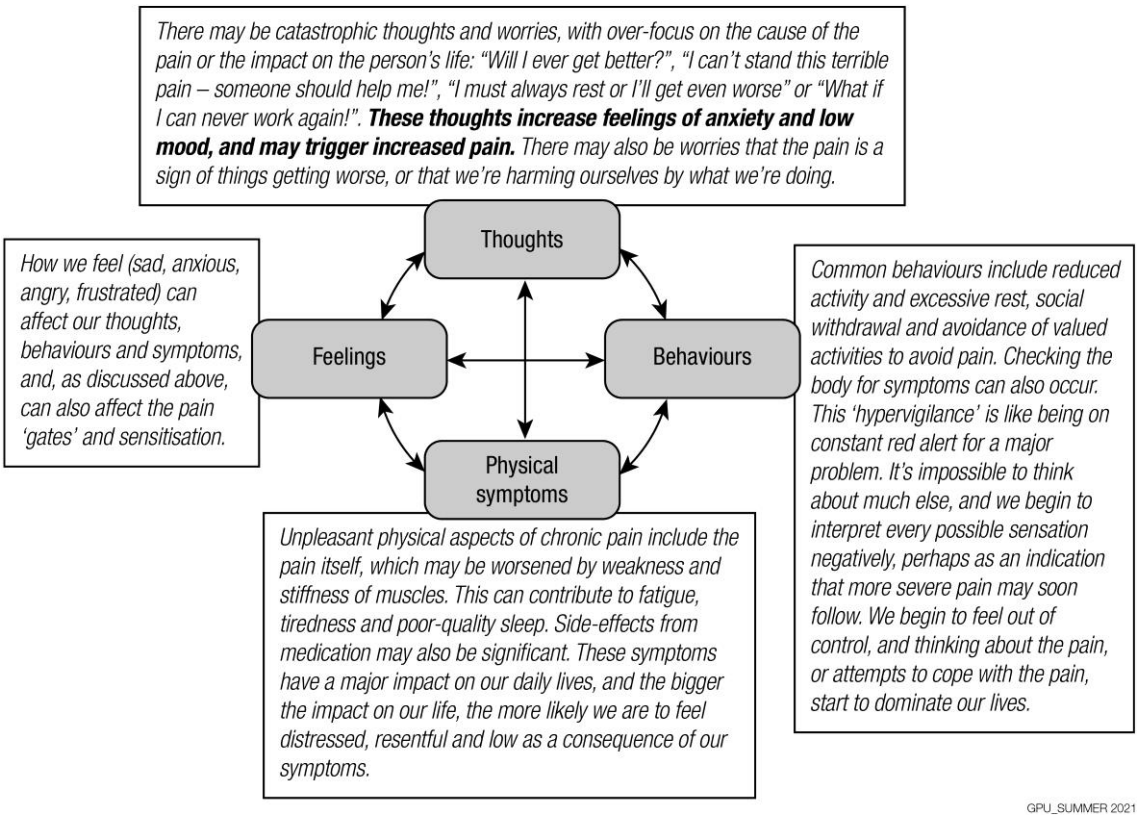
Or, you may find it helpful to use the 4-areas model used in the CBT framework:

When people experience persistent pain, this affects their thoughts, feelings and behaviour, which can influence how they cope with the condition.

At this stage, I often draw this diagram to explain how physical symptoms, thoughts, feelings and emotions all affect one another:



I then talk through each of the four elements in turn:



And then, to wrap up:

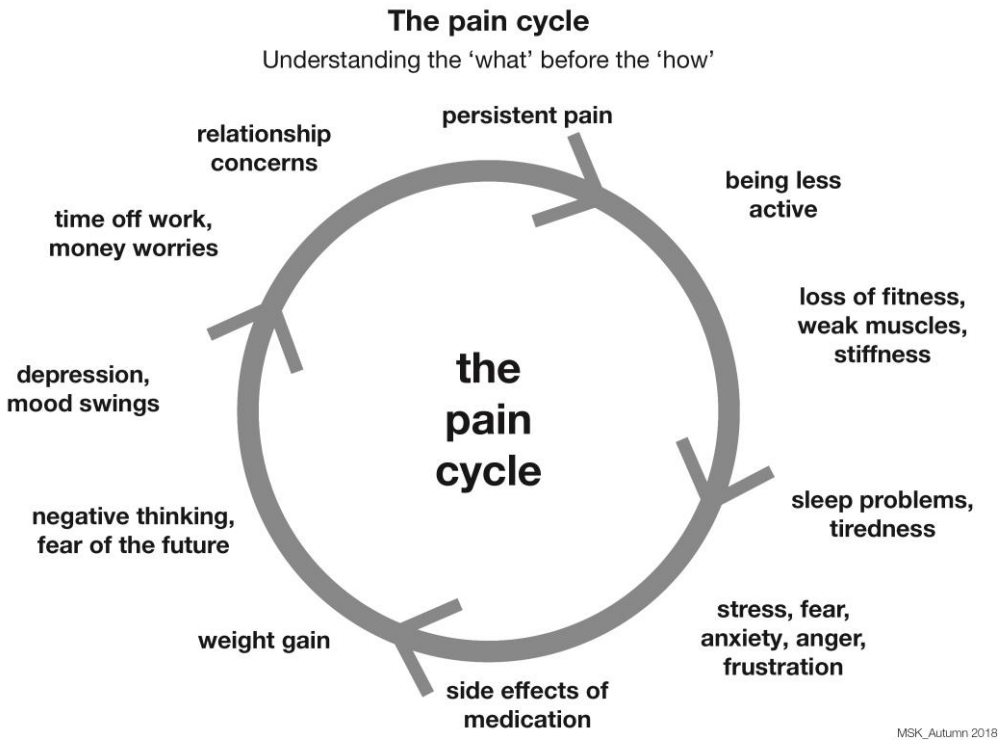
Helping people find ways to understand their symptoms, and manage anxiety and low mood, can help close the pain gates and reduce increased sensitivity to pain. It may also help shift attention from over-preoccupation with physical symptoms, and instead help focus more on improving quality of life by engaging in activities that you care about, such as physical activity, social interaction and hobbies. Other techniques such as relaxation and mindfulness can also help close pain gates and reduce our experience of pain.

Create a shared plan of supported self-management

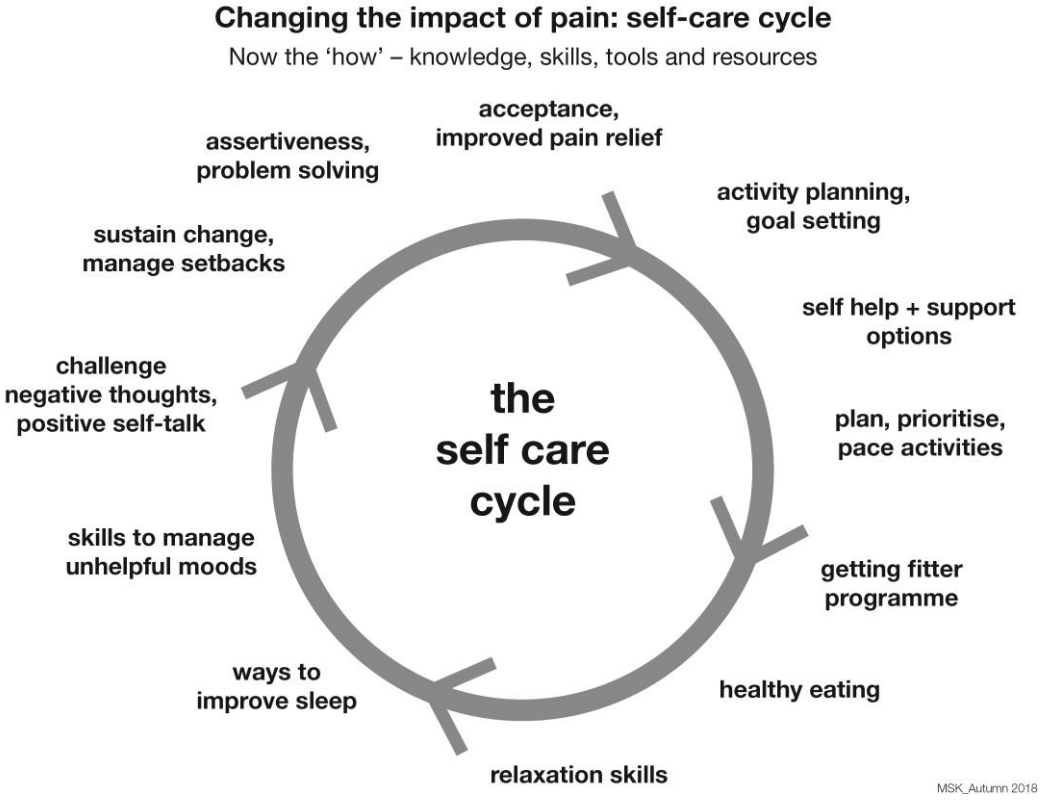
The pain and self-care cycles offer a good place to start, and can be a useful tool to get out in the consultation. This could be done by a range of primary care clinicians, including GPs, practice nurses, clinical pharmacists, first contact physiotherapists and social prescribing link workers. Better still – do it as a team!

Use the pain cycle to identify the most challenging problems/priorities for the person right now. You could use questions such as:

Looking at this cycle, can you pick 2 or 3 issues that are really holding you back at the moment and that you would like to do something about?



Then, you can match those issues to starting to develop some personal goals to work on, using the self-care cycle.



What could we look at in a personalised care plan for someone with chronic pain?

We treat the physical, psychological and social problems of our patients on a daily basis, and use the biopsychosocial model routinely for medical problems such as depression or anxiety.

But many of us ***do not routinely apply the biopsychosocial model to chronic pain***. Chronic pain is a complex interplay of physical, psychological and behavioural factors. Over time, patients need a management plan that considers factors in ALL these areas. In this table, we consider practical things that **we can do** to coach people with chronic pain in developing their self-efficacy for self-care:

Key areas	Strategies we can use
Pain	Helping patients have a clear understanding of their pain will make a big difference. Do not underestimate our role as the drug-doctor (or drug-primary care clinician, depending on your role!): • Identify and explain types of pain (nociceptive, neuropathic, chronic secondary and/ or primary). • Explain sensitisation. • Hear the whole 'story' of the pain from beginning to end; this may help us understand the bigger picture. Has the person been able to find any degree of acceptance of their situation? Sometimes, hearing the stories of others with lived experience, e.g. in the Pain Toolkit or on Live Well With Pain, can help to make a shift (see below).
Mood	Ask about mood. • Is there psychological distress? • Identify depression and anxiety (PHQ-9 and GAD-7). Both are more common in all types of chronic pain, and they interact with each other in terms of symptoms and function but also neurobiological pathways. Managing mood disorders improves outcomes in chronic pain. Psychological therapy and medication, as needed, are the mainstay of treatment, just as in any other context. Remember: NICE 2021 Chronic pain guidance suggests that for chronic primary pain, we consider offering a trial of antidepressants even in the absence of a diagnosable mood disorder. This is an off-label use and should be discussed with the person. It also recommends CBT or Acceptance and Commitment Therapy (ACT); this may be useful for those who are struggling if you have access to this through IAPT or local pain services.
Thoughts	Individuals think about their pain in different ways which can either help or hinder their ability to manage their symptoms. It is more difficult to change thoughts than behaviours, but helping people become aware of how these thoughts may be impacting their pain can be helpful. We might spot 'unhelpful thoughts' in our consultation in phrases such as: *"I can't stand this; it will never end." (catastrophising)* *"It's taking over my life." (magnification, rumination)* *"Something must be going on in my back and, until we find out what it is, I'm not getting more active." (fear-avoidance behaviours)* *"I can't cope with this; the physio didn't do anything." (passive coping)* *"I can't do this." (low self-efficacy)* **We can spot patients with persistent 'unhelpful' thoughts and prioritise psychological (usually CBT-based) referral.**
Behaviour	Encourage active coping strategies. People who use active coping strategies have less disability and distress due to pain: • Active coping strategies: people try to manage pain through their own efforts (exercise, meditation). • Passive coping strategies: people rely on other people (e.g. physiotherapist) or drugs to manage pain. To make use of active coping strategies, individuals need a belief in their own ability to perform a task (self-efficacy). This is not static, and we can enhance this through coaching, feedback and positivity. We can also support people in forming microgoals which are quickly and easily achievable, and create a positive feedback cycle. Group consultations, social prescribing link workers and health behaviour coaches may all be able to help. Encourage brief behavioural activation, setting small and achievable goals to increase activity; there should be a balance of activities which offer a sense of physical activity, achievement, relaxation, enjoyment and being close to others.
Family/social connections	Social support is generally a positive thing; it can act as a buffer against depression, build self-efficacy and encourage independence (Clin J Pain 1993;9(1):34). Family and social connections can be a help or a hindrance. Look out for: • Spousal criticism and hostility, which can increase pain intensity (Pain 2013;154(12):2715). • Solicitousness towards 'a partner in pain': this is overprotectiveness, e.g. offering excessive help, too much concern, discouraging activity, taking over usual tasks (they reward passive behaviours). • Punishing spousal responses (!) in the context of a loving relationship; these actually lower levels of disability, e.g. *Come on Jim, get off your backside and help with the washing up.* Discussing these things openly may help home dynamics. **Safeguarding and adverse childhood experiences (ACES)** We should also be aware of safeguarding issues that may be occurring (e.g. domestic abuse, past history of physical or sexual abuse), and remember to think about any children in the family – what is life like for them?

	Exploring this and the past may be helpful and, where available, so will signposting for additional support and psychological services.
Activity	Building confidence and self-efficacy in increasing activity in areas that align with the person's values is a cornerstone of the management of chronic pain. It can enhance quality of life even if the pain continues. We can support patients to use strategies of: • Goal-setting. • Pacing. • Grading. This will help build activity into everyday life and promote specific exercises that will help them to manage their pain (see Live Well With Pain resources below).
Work	Ask about work and what support individuals need to continue or return to work. Utilise occupational health if it is available. Use MED3 to look at a *range* of return options. Remaining or getting back to work despite chronic pain has better outcomes (Scand J Work Env Health 2006;32:257). Certain occupational factors are associated with an increased risk of disability from back pain: • Low job satisfaction. • Monotonous work. • Self-reported stress. • Impaired workplace relationships. External charities such as Versus Arthritis, Citizens Advice and ACAS are able to offer patients advice around employment issues, grants that may be available, etc. *Do you have a social prescriber who can signpost?*
Sleep	Poor sleep makes pain more difficult to manage. Strategies that may help include: • Sleep hygiene. • Building activity levels during the day. • CBT-I *(NICE recommended further research in this area for chronic pain).* We should avoid long-term sleep medication.
Medication	People with chronic primary pain may already be on medications that are now not recommended by NICE 2021. For this group, NICE recommends assessing whether the drug is helpful, whether it is prescribed at a safe dose and whether there are adverse effects. Remember, these drugs may have adverse impacts on function. We should then: • Agree a plan to continue **safely** if they report benefit at a **safe** dose and with **few harms** OR • Explain the risks of continuing if they report little benefit/significant harm, and encourage and support them to reduce or stop the medication if possible (see article on *Chronic pain: opiates and other dependence-forming medication*). Analgesics *may* still have a role in managing flares of pain but should be linked to a functional goal, be time-limited and generally not be on repeat prescription.
Interactions with healthcare systems	Offering passive treatments and encouraging patient dependence is NOT helpful. We need to avoid: • Mixed messages. • Excessive and inappropriate investigation. • Long periods on waiting lists. • Collusion!
Comorbidities	Chronic pain is often not a condition in isolation. Don't forget the bigger picture. For some long-term conditions, more aggressive management may improve the pain, e.g. in painful diabetic neuropathy, more aggressive control of blood sugar, BP and lipids may have an impact.
Substance misuse	Look for and recommend treatment for substance misuse, including alcohol.

Chronic primary pain: communication skills and self-management

- Hear the pain story.
- Create together a clear diagnosis, explanation and shared understanding.
- Use the pain and self-care cycles to identify what matters for this individual and what they are ready to tackle.
- The aim is to improve quality of life and function, even if we cannot improve pain!

Useful resources:

Websites (all resources are hyperlinked for ease of use in Red Whale Knowledge)

- Live Well With Pain (for all things 'chronic pain', Live Well With Pain is a fantastic resource for primary care clinicians and patients alike – it is well worth investing 15 minutes to familiarise yourselves!)
- STartT Back tool (designed to identify patients at risk of chronic back pain. Have a go at using it if you haven't already)
- STarT MSK tool (for chronic widespread pain)

Videos

- YouTube – Brainman: understanding pain in less than 5 minutes
- YouTube – Tame the Beast: it's time to rethink persistent pain

(these two videos offer a fantastic explanation of chronic pain – we have been using them patients in consultations and found them really helpful)

Useful resources for patients:

Websites

- Versus Arthritis – managing your pain
- Versus Arthritis – get help (helpline to offer support and information for patients with MSK pain)
- Pain Toolkit (written by a chronic pain patient, the Pain Toolkit features information and resources about effective self-management of chronic pain. It also has lots of great patient stories)
- Live Well With Pain (also has some really useful information leaflets that you could use as part of a QI project)
- Versus Arthritis - work

Videos

- YouTube – Brainman: understanding pain: Brainman stops his opioids (Brainman video explaining simply why opiates may make things worse!)

This article was published 30/03/2023. We make every effort to ensure the information in this article is accurate and/ correct at the date of publication, but it is of necessity of a brief and general nature, and this should not replace your own good clinical judgement, or be regarded as a substitute for taking professional advice in appropriate circumstances. In particular, check drug doses, side-effects and interactions with the British National Formulary. Save insofar as any such liability cannot be excluded at law, we do not accept any liability for loss of any type caused by reliance on the information in this article.