**Chapter 2**

**Psychological Treatment with Chronic Pain Patients from a Seasoned Clinician’s Perspective**

There are three different aspects discussed in this chapter; the evolution of pain treatment over the past 40 year, the important role worker’s compensation and Social Security disability play with pain patients, and nontraditional behavioral treatments in managing headaches. Each is briefly summarized below.

*Pain Treatment Evolution.* In the 1970’s and 1980’s I dealt with both research-oriented and clinical treatment programs. To avoid confounding, pain patients with ongoing litigation were typically excluded as subjects in research-based programs on the belief that there may be external incentives to maintain pain behavior in the presence of litigation. During my internship I had a 3-month rotation in a chronic pain program that involved only psychological treatment. The primary components involved behavioral pacing (i.e., having patients systematically control how much up time was done with activity prior to down time involving rest), progressive muscular relaxation, and individual psychotherapy with the goal of having the patient accept the permanency of their chronic pain and letting go of the belief that there may be a cure because they had exhausted all possible curative treatment. Although not mentioned in my discussion, the cognitive-behavioral treatments were still not completely accepted by behavioral training programs in 1979.

The clinical pain program in which I worked in the 1986 was an inpatient, multidisciplinary one. The primary referral sources were worker’s compensation carriers which meant there was litigation and patients who were early in the chronic pain experience. At that time long-term use of opiate medications were discouraged and one aspect was to eliminate opiates over the 4-week program. Pain cocktails in which liquid medications were used with a masking solution so that patients would be unaware (i.e., lack of visual cues based on changes in their pills) of when there were reductions in their opiate medication. The two sessions of physical therapy (PT) each day were primarily directed toward increasing activity via stretching, exercise, and teaching body mechanics. Each day there was a different educational class with topics from PT, nursing, nutrition, and psychology. Psychologists handled the two daily group relaxation sessions and the daily motivational group therapy, as well as doing individual supportive therapy once a week. Despite having positive effects for many patients, the program largely failed to reduce medical costs and return patients to their jobs. Thus, carriers eventually stopped approving treatment and the program closed by the early 1990’s. Outpatient back school and work hardening programs predominated at that time, but these also folded due to carriers not approving treatment. The result was that there was no centralized multidisciplinary programs and each specialty worked independently from others in the area where I had my practice.

It was in the 1990’s that the long-term use of opiates was allowed based on the belief that reducing the pain allowed many patients to be more active and have a better quality of life. I understand the American Pain Society was instrumental in this change. As became apparent with the “opiate crisis” in the recent past, pharmaceutical companies heavily marketed opiates and there was little oversight in which medical professionals prescribed opiates and under what conditions it was done. Psychology’s role expanded to include doing opiate risk assessments with the goal of determining which patients should be treated by primary care independently or in consultation with an addiction specialist versus being referred to pain management programs who prescribed pain medications and performed other procedures such as injections, ablations, and spinal cord stimulator trials. In addition to opiates, prescriptions were written for antidepressants, muscle relaxers, and anxiolytic (e.g., benzodiazepines) medications. Due to widespread addiction, there were many guideline changes by governing bodies (e.g., medical boards, DEA) and there is now a large increase in referrals to pain management programs. In our state patients receiving opiates are no longer allowed to receive benzodiazepines and there are stricter regulations on the maximum amount of pain medication that can be prescribed.

*Worker’s Compensation and Social Security Disability Benefits.* The chapter explains the importance of gaining knowledge about both of these systems by clinicians. Chronic pain strongly impacts many patients’ ability to work which leads to financial distress. Each state and the federal system vary in their worker’s compensation laws. My practice was in South Carolina where the insurance companies have great power and it is not a mandatory rehabilitation state (meaning the insurance company does not have to provide training or other services to return the injured worker to alternate employment if they cannot return to their original job). The insurance carrier chose the treating doctors. The so-called “company doctors” were the ones who first saw injured workers and served as gate-keepers who controlled what services and referrals were made. As was obvious to me, there is pressure placed on those physicians to keep costs at a minimum which can lead to limited referrals to specialties whose involvement could increase costs and identify problems that could increase the amount of settlements. Another frequent problem was that most insurance carriers frequently failed to pay weekly benefits on time with the explanation always being that the patient was “dropped out of the system” by the computer. In some cases, this could last for several consecutive weeks and most injured workers lived week-to-week, lacking the funds to pay bills. The only logical explanation was to discourage and demoralize injured workers in an attempt to have them return to work or settle claims prematurely. This commonly led to the hiring of an attorney by the injured worker, although the attorney had limited power to take action. A hearing had to be requested which was several months later, and if the carrier paid what was owed or agreed to the requested referral or medical procedure, the hearing was cancelled. Otherwise, there was little involvement by the attorney until the case was approaching settlement. For most of my patients in this system, they became angry at their own attorneys. Case managers were sometimes involved to expedite treatment and increase the chances of faster case resolution, but they were paid by the insurance carrier who expected the case manager to reduce total medical costs. Thus, they were often not an advocate for patient care due to this conflict of interest. I believe the role of the psychotherapist is to provide objective logical information to the patient related to worker’s compensation and then assist the patient in determining how to use that information to his/her best interest.

The key points related to Social Security disability are assisting the patient in understanding when they can apply, what to include as the problems, and what to expect in relation to the processing and decisions of their claim. It is advantageous to pain patients to apply within 5 years of when they last worked in order to get benefits based on what they paid into the system while employed. It is okay to apply regardless of any other benefits (e.g., worker’s compensation, veteran’s) currently received. All physical and psychological problems should be listed as those preventing the patient from working (not just the primary problem such as pain) because those can influence favorable decisions in awarding benefits. Psychological problems are often those resulting in the awarding of benefits in chronic pain patients. If awarded, Medicare can be obtained in a little over 2 years and any juvenile dependents can also receive benefits beyond those received by the patient. As a general rule, the first decision is made in about 4 months, and can be reconsidered if benefits are not awarded. The next decision is done about 4 months after the first. If denied, the next step is to appear before an administrative law judge which in my location occurs about 18 months after the second denial. It is at that point hiring an attorney is recommended.

*Headache Management.* There are two different aspects discussed: headaches related to oral habits and those related to sleeping beyond the body’s sleep needs. I proposed in the 1980’s that temporal headaches (with or without jaw pain) related to oral habits resulted with an interaction with internal derangement of the temporomandibular joint (TMJ). In addition to oral habits such as clenching of teeth, biting of lips or inside of mouth, resting chin on hands, etc., voluntary behaviors such as gum chewing or ice chewing can also contribute to temporal headaches. The treatment discussed is to use external reminders, such as stickers placed in places one often views, as a reminder to check whether one is doing an oral habit. If so, one is to practice relaxing the jaw with teeth slightly apart and lips together for 15 to 30 seconds. Voluntary behaviors such as chewing gum are to stop. Practicing progressive relaxation twice a day is also recommended.

In relation to excessive sleep, baseline monitoring of the time of awakening and headache days can be done for 2 weeks for patients without daily headaches. If the patient shows more headaches on days with later awakening times, then there is a basis for a sleep intervention. If the patient experiences daily headaches, it is reasonable to start an intervention immediately. Using the awakening times on non-headache days, the patient is instructed to consistently arise 30 minutes earlier. For daily headache patients, they are instructed to arise an hour earlier than their earliest awakening time. The patients should get out of bed immediately and avoid drifting back to sleep which is a pattern I have seen with many morning-onset headache patients. If the sleep manipulation leads to improvement, on days (e.g., weekends) the patient may wish to sleep later, they may stay awake a few minutes and then go back to sleep which appears to be effective for some in avoiding headaches. If patients wish to consistently arise at a later time, they can consistently go to bed later.