Dynamic Chiropractic

PAIN RELIEF / PREVENTION

The ABCDEs of Chronic Pain

Mathew DiMond, DC, DACRB

After receiving some new weights in my clinic, a colleague recently questioned why I would need 55- and 70-pound kettlebells. These daunting mounds of metal serve as more than heavy lifting loads. They are some of the psychological tools I use to shatter walls of impossibility in my patients. Let me explain.

Pain science is coming out with a lot of great information. The way patients perceive pain, interestingly, is less the direct activation of nociceptive fibers and more how the brain processes the received information. Even when there is direct trauma to a tissue, the intensity of the pain experience is still extremely varied. Small nicks and cuts can result in serious pain or discomfort if the brain has been primed to interpret it as such, and vice versa.

These kinds of findings are also seen in imaging studies. Time and time again, we see low correlation between an MRI scan and the pain intensity experienced by the patient. The biological and anatomical findings simply are unable to explain the level of experienced pain.

And so, with increased perception of pain, there is often an attributed level of disability. Those suffering with pain feel forced to change their activities as an attempt to find some relief, whether real or imagined.

Why is this important? Psychosocial comorbidities are most predictive of chronicity. It's the response to pain, more than pain itself, which precedes long-term health issues. When pain decreases a person's ability to work, play or otherwise engage, it adds additional stressors. This stress is important because of how the nerves try to interpret it.

When the pathways that produce pain are being activated and stressors reinforce their importance, they change by becoming more proficient at producing pain. The neurons will increase their sensitivity and can become active with less influence (sensitization). This process becomes impractical. Instead of the pain response trying to be protective, it's being activated by trivial sensations.

In this way, the system loses the ability to be particular in its interpretation of stimuli and instead pain grows, constantly changing its quality.

So, what do we do about it? While exposing any underlying tissue damage will be helpful (of course, treat that), to address the patient's perception of pain, we can develop a psychologically informed practice. Positive psychologists such as Albert Ellis describe the ABCs of pain interpretation. For those already somewhat familiar, this model comes from cognitive behavioral therapy (CBT). Targeting beliefs is a fundamental tenet of treatment. While many strategies exist, here are the ABCDEs and how they could relate to our patients.

Adversity

Adversity can be considered the onset or adverse event. It's what happened that started the pain. Even if the onset is insidious, it won't make much of a difference as long as the patient has a

starting point. We can't change adversity. What's done is done. However, discovering this point gives you a platform from which to work.

Belief

Beliefs are how the patient reacted to the adversity. It's what the patient thought at that moment in time, or how they believed it would impact their future. As they were first experiencing pain, did they experience a temporary or local thought (*Aww, shucks, I twisted my ankle*) or does it persist as permanent and pervasive (*My twisted ankle is sooo bad! I'll never be the same again*)?

Consequence

The consequence grows from the patient's initial belief and can be negative or positive – irrational or rational, respectively. Positive beliefs are good and not as commonly associated with long-term disability or dysfunction (think of a heart attack survivor who drastically changes their lifestyle for the better).

Negative consequences, however, can weigh on the patient and snowball into chronic symptoms. Ongoing beliefs continue to be reinforced by internal and external factors, important enough to the patient that they continue to validate their perceptions with them. These must be dealt with or disputed.

Disputation

If the consequence was irrational, disputation is now challenging the belief. Often, patients develop habits and ADLs that avoid situations assumed to elicit pain. The thought is typically: *If it hurts, I'm damaging myself.* This ideology becomes a slippery slope of helplessness, leading to a lifestyle of fear avoidance.

So, crucial among disputing the belief are approaches that consider another "D": Decatastrophizing. We must convince patients, either through thought or demonstration, that certain activities are not as deleterious as they'd imagine. Some helpful interview questions could be:

- What's the proof/evidence?
- Would we let a friend think this way?
- What are other interpretations of the belief?
- What other adoptive reactions are possible?
- What's another counterfactual?

Being forced to confront subjective experience through a different lens can be the necessary vantage point to begin healing.

Effects (New Effects)

With each new accomplishment or return to function, it's important to highlight these outcomes with patients. The effects of changing their perception should receive special attention to ensure continued success.

While full implementation of CBT into clinical practice would be best, there are a number of barriers to consider including initial training, time and reimbursement. Treatments, however, can become more effective when considering features of CBT by assessing and addressing psychosocial risk factors.

While this seems like a lot to consider, implementation can begin by asking a few additional questions. Address these during a report of findings, avoiding detrimental language. Let the patient choose their motivation. Soon, strategies to compose a patient interview will expose a narrative that will determine their perceptions and how best to move them forward.

Back to the Kettlebells

Back to the kettlebells. I use them to dispute the common symptomatic belief that a patient can't lift anything heavy. Since this complaint is frequently offered as a functional limitation, it seems only appropriate to develop strategies to break this mental barrier.

Within reason, most patients presenting to my office with low back pain and difficulty bending or lifting won't leave until they've picked up a sizable bell. Celebrating this step on the first day not only breaks a patient's mental barrier, but also encourages them to take a more active role in their rehabilitation.

Resources

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