

# Pitfalls and Pearls of Persistent Pain

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## Introduction

Persistent pain is a burden to those who suffer from it—and a behemoth to those who treat it. One hundred million adults in the United States suffer from pain that has persisted longer than six months, presenting significant costs for society.<sup>1</sup> Pain costs 600 billion dollars per year in America, including healthcare expenses and lost wages, which surpasses the entire Medicare budget for 2018.<sup>2-3</sup>

Persistent pain is as expensive as it is daunting for some healthcare providers. Sixty-eight percent of internal medicine residents reported that persistent nonmalignant pain experienced by their patients had a negative impact on their clinic experience.<sup>4</sup> Many physical therapists perceived that neither their training nor available continuing education opportunities provide the skills or confidence required to treat persistent pain.<sup>5</sup>

Healthcare providers' frustrations may be rooted in a biomedical understanding of pain, by both providers and patients.<sup>5</sup> But research disproves the notion that pain is a purely biomedical phenomenon; modern guidelines recommend a biopsychosocial approach to treating persistent pain.<sup>6-7</sup>

Healthcare providers' stigmatization of persistent pain may stem from a lack of empathy with patients when pain fails to fit a biomedical definition of illness.<sup>8</sup> Promoting empathy and a biopsychosocial approach to persistent pain may pave a path toward richer patient-provider relationships, more effective pain management, and more invigorated healthcare providers.<sup>5,9-10</sup>

## Clinical Stories

The following three clinical examples highlight the challenges that healthcare providers face in treating chronic pain—and offer a few lessons for our development as clinicians in caring for patients with pain.

### ZACH'S STORY

My first evaluation as a licensed physical therapist was

with a woman who was in a traumatic motor vehicle accident. Both of her children were in the car. The other driver ran a red light, clipping the patient's car. She and her children suffered no immediate injuries. The next day the patient noticed pains in her chest and abdomen that would jump from one place to another without a specific pattern. Her legs started to hurt as well, with pain jumping from leg to leg; she was afraid she damaged something in the car accident without realizing it. She went to the Emergency Department at her local hospital; radiographs taken there showed no evidence of injury or disease.

After two weeks of persistent pain, and a referral for physical therapy from her primary care physician, she met me. She was too afraid to drive, and she had stopped playing with her kids. She did not understand her pain, and felt that her healthcare providers did not understand it either. After a number of tests that all came back negative, I told her I saw no tissue damage that could be causing her pain. She asked a question that many others have since asked me: "If nothing is wrong, then why do I hurt?"

At first, I asked her to trust that even though we don't know exactly what is wrong, it's important to remain active. Her pain persisted, and she became more confused about it. Still, she gradually returned to her normal activities, and within three months she reported occasional pain, but that her symptoms no longer interfered with her daily life.

## LESSONS LEARNED

I regret having fed her fear that we had no idea about what was causing her pain, which implied that we didn't know what would alleviate it. After thinking that the Emergency Department performed a cursory evaluation, I tried to find a clearer answer despite feeling that the symptoms didn't fit any common

pathoanatomical diagnoses. In hindsight, I believe that a more effective evaluation would have investigated her fear of activities, her ability to cope with pain, and her goals. I was so focused on identifying a physical diagnosis that I didn't allow time for education or an exploration of the barriers she faced to improving her quality of life.

## MARISSA'S STORY

As I interviewed my new patient, she was adamant that her pain was caused by a pinched nerve. She had significantly limited her mobility and all spine movements for fear of making her pain worse. After reviewing her medical record, examining the patient, and discussing the case with the patient's referring provider, I found no physical or radiographic evidence of neurological compromise. I concluded that I needed to help change her perception of her symptoms and experience; otherwise, we would not get anywhere.

I delved into what I thought was an effective explanation of her pain based on pain neuroscience. As I started to discuss the difference between tissue pathology and pain, common findings on imaging, and the reassuring results of her physical exam, the patient's body language demonstrated that she was not interested in my explanation. I attempted to elicit her thoughts regarding the education and her pain experience, but she no longer wanted to talk or participate in physical therapy. She told me that she felt I was missing something and because of this, working with me would do more harm than good. From that moment forward, I was unable to regain trust with the patient and she did not return to the clinic.

## LESSONS LEARNED

In this case, when determining what intervention to provide, I automatically assumed what was best for my

patient rather than involve her in the decision-making process. By not involving her in this process, my realization that she was not interested in discussing pain physiology came too late. This led to a lack of trust and a poor therapeutic alliance. I learned some crucial lessons with this interaction: a foundation of trust is essential and it is important to tailor interventions to an individual's readiness for change. If I had fostered a collaborative environment with shared decision-making, it may have led to the development of a positive therapeutic alliance, which could have facilitated behavioral change.

### MORVEN'S STORY

A thorough chart review of my patient revealed multiple surgeries, comorbidities including anxiety and depression, and extensive pain management interventions. I envisioned an individual with central sensitization, an amplification of neural signaling within the central nervous system that elicits pain hypersensitivity.<sup>11</sup> I speculated that he had received a biomedical explanation for his pain and was searching for answers to "fix it." Consequently, I knew that I would need to focus my treatment on pain education and the role of the nervous system in persistent pain. The patient's subjective and objective assessment confirmed my suspicions of central sensitization.

I asked the patient if anyone had ever talked to him about how we experience pain. When he said "no" and was willing to discuss pain, I remember thinking, "Oh, I got this. This is going to be great!" When I finished my typical pain education, he just looked at me and stated, "OK, but I have arthritis, so there is something wrong with me. I have real pain."

### LESSONS LEARNED

The error that I made in this case was jumping to

conclusions too quickly, providing too narrow of an explanation for this patient's pain, and failing to acknowledge the patient's underlying concerns about osteoarthritis. This led to decreased trust and buy-in from the patient. In my explanation of his pain I should have acknowledged his osteoarthritis, explained how it can cause nociceptive pain, but also how it related to his current central sensitization symptoms in order to give him a more thorough and personal explanation of his pain. This case reminded me of the importance of understanding the patient's perspective and acknowledging it to lead to improved therapeutic alliance and a more successful outcome for the patient.

## Conclusion

These patient stories reflect the complexity of pain and some pitfalls in clinical decision-making. Persistent pain is a condition with many potential contributing factors; its multifaceted nature can intimidate individuals experiencing it as well as their healthcare providers.<sup>12</sup> Providers across multiple disciplines express concern about patients' motivation, attention-seeking behavior, and the existence of actual pain.<sup>4-5,13</sup> However, it is important to consider that these individuals are just like all patients we see. They have limitations in their daily lives and our job is to help them achieve their goals.

While all individuals have a combination of biological, psychological, and social factors impacting their pain experience, the extent to which each of these factors plays a role is unique to each person.<sup>14</sup> For some, the biological factors will play a larger role; for others, the psychological factors will dominate.

Physical therapists are often viewed as healthcare providers who address biological factors, but we are in an excellent position to address certain psychosocial

factors as well.<sup>14-15</sup> Lack of familiarity can lead to discomfort when addressing psychosocial factors, but we can use our skills to identify modifiable impairments, and through shared decision-making, we can develop a plan of care to improve overall health and quality of life. Despite the complexity, we can make a significant impact in the lives of individuals with persistent pain. As Joshua J. Marine writes, "Challenges are what make life interesting and overcoming them is what makes life meaningful."<sup>16</sup> Marine's words illustrate for us why we value working with individuals who have persistent pain, despite the challenges along the way.

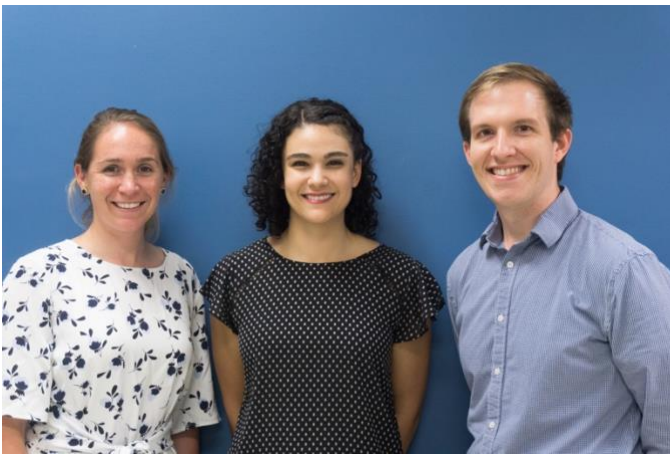


Figure 1: From left to right, Morven Ross, PT, DPT, OCS, FAAOMPT, Marissa Carvalho, PT, DPT, and Zachary Stearns, PT, DPT

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## *About the Authors*



Zach Stearns, PT, DPT, is an outpatient physical therapist practicing in Duke University Health System. He earned his Doctor of Physical Therapy in 2017 from the University of Florida. He primarily treats patients with persistent spinal pain and osteoarthritis. His previous career experience includes working in psychiatric hospitals and clinical psychology laboratories. Zach is passionate about applying psychological skills and principles to physical therapy practice, and he is currently completing a pain coping skills certification program based on cognitive-behavioral theory.



Marissa Carvalho, PT, DPT is a practicing physical therapist in the Duke University Health System. She practices at the Duke Pain Medicine clinic where she primarily works with patients who have persistent pain. Marissa graduated from the Duke Doctor of Physical Therapy program in 2012 and is board certified in Orthopaedic Physical Therapy. She received her Therapeutic Pain Specialist certification through the International Spine and Pain Institute in 2016 and completed the Duke University Health System Orthopaedic Manual Physical Therapy Fellowship in 2018. Marissa is also currently completing a pain coping skills certification program based on cognitive-behavioral theory. While at Duke, Marissa has been involved as a course assistant in the Duke DPT program, has participated in research, and has given several talks at the state and national level.



Morven Ross, PT, DPT, OCS, FAAOMPT, is a physical therapist at Duke University and is board certified in Orthopedic Physical Therapy and a Fellow in the American Academy of Orthopedic Manual Physical Therapists. Morven graduated in 2014 from the Doctor of Physical Therapy Program at University of North Carolina-Chapel Hill. She completed an orthopedic residency program in 2015 and a fellowship program in Orthopedic Manual Physical Therapy in 2017 all at Duke University. Morven is currently the Program Practice Leader of the Duke Joint Health Program (JHP), a program that provides comprehensive conservative management for individuals with hip and knee osteoarthritis utilizing a biopsychosocial approach.