

Patient action as means and end of chronic pain care: risks and routes to meaningful action

Sullivan and Vowles very effectively integrate research on understanding of pain, neuroscience, and chronic pain care in their topical review.¹⁴ In their paper they dismantle the models that focus primarily on sensory experience and instead target action – as their title so succinctly states – as means and end. They return to behavior as the focus, as it was for Fordyce and his contemporaries fifty years ago,⁸ but this time with an appreciation of cognitive processing of the experience in generating that behavior. Their discussion of patient action as the means to chronic pain rehabilitation draws substantially on the failure of analgesics, particularly opioids, to resolve chronic pain disability. This argument could be extended to a wider range of procedures in which sensory quality and quantity of pain are the main or only treatment targets, and that render the patient a passive recipient of treatment aimed at reducing pain intensity. The same examples underpin some of their arguments for patient action as the end, or goal, of chronic pain rehabilitation. In their review, Sullivan and Vowles elaborate some of the aims of self-management (a term with increasingly diverse meanings).

They also briefly review issues around the sense of threat, processed in the salience network (rather than the ‘pain matrix’), and avoidance of action. They summarize their position as “Pain intensity certainly helps determine pain salience, but pain salience also helps determine pain intensity.” Prescribing analgesics but increasing the patient’s anxiety about an undetected or undisclosed condition or its implications may have a net zero effect, not only on the patient’s activity but on his or her pain intensity. They conclude that “restoring the capacity for meaningful action” is key to effective rehabilitation, and few would disagree.

The length of a topical review does not allow them to develop many of their ideas. There is a risk of their models being simplified and traduced to fit moral positions that have no place in health care. It would be too easy to re-present self-management with a focus on action in terms of stoicism,

“resilience”, and even of the character-building effects of pain. Such discourses have been available throughout history and are most evident now in sports and exercise fields.² There is a substantial difference between pain endured voluntarily in pursuit of a valued (sports or exercise) goal, and expected to remit within days, and a pain endured because there is no option, but experienced as a threat to future goals and health, as in persistent pain. There is also an important difference between encouraging people with pain to be active in pursuit of a better quality of life, and blaming those with poor quality of life for being insufficiently active². Further, the notion of “meaningful action”, emotionally and intellectually satisfying activities that are available and accessible, is hard to apply to those whose efforts are almost entirely directed towards day to day survival, for themselves and their dependants. ~~Exercise routines are no substitute.~~ It is puzzling too to see no recognition of emotion, part of the basic definition of pain. Depressed mood is a serious obstacle to attempts to identify and pursue “meaningful action” in chronic pain, since depression tends to strip the meaning from action.

In addition to these difficulties applying patient action as primary goal, we need to define self-management. Although self-management is the name given to particular interventions delivered to patients, it is rather a cumulative change of habits, even of lifestyle. Intervention aims for an organically developed and unique combination of priorities, techniques, and experiments that build on patients’ strengths and values in their social and wider context.

The self-management model needs to engage and enthuse patients if they are genuinely to self-manage in the longer term. However, many programs described in recent reviews⁴ make little effort to engage the patient or to work with what he or she brings to treatment. Outcomes of self-management programs, particularly in terms of activity, are (unsurprisingly) very disappointing. If patients do not adopt the principles and practices of self-management, the strategies that they often choose, guided by anxieties about pain and injury, are largely focused on reducing activity.¹¹ The field also lacks good models of engaging patients so that they see the possibilities for improvement in the quality of their lives. The only current model, of energetic and personalized explanation of

pain,¹⁰ still lacks application in mainstream pain management, and we do not know whether pain explanation is necessary or sufficient to motivate people with pain to increase activity as part of pain management. We assume that increasing activity equals better quality of life, but some patients have unsatisfying or unpleasant jobs, lack social support, and have few disposable resources to enable the activities that they would value. Generating hope is a fundamental task in psychological treatment⁷ and Sullivan and Vowles provide admirably clear descriptions of what cognitive behavioral treatment, acceptance and commitment therapy, and behavioral activation offer the patient.

Thus threat - salience – is a key concept in Sullivan and Vowles' understanding of patient action. Learning not to react to pain, particularly persistent pain, by withdrawal and protective behaviors requires changing the salience of pain, changing the responses, or both. Cognitive interventions have focused mainly on trying to reduce the threat value of pain, with some good evidence that we are identifying relevant processes.^{1,12,13} Salience or threat value could perhaps be reformulated as changing the meaning of the chronic pain for the individual.⁶ Nearly forty years ago, Patrick Wall wrote that "Pain is better classified as an awareness of a need-state than as a sensation".¹⁵ Sullivan and Vowles chose to emphasize the motor element, whether inhibiting or initiating action, but with only a hint of cognitive, emotional or social modulation that makes sense of the action. In light of current advances in pain research, we now have a chance to try to identify cognitive and emotional processes, associations, and conditions for action, rather than to try to build a model of a network that produces "effective threat-defusing action" without any of these. Both cognitive regulation (rational self-talk) and emotional regulation (e.g. self-soothing) may also be important here,³ and their exclusion for a complete focus on motor activity weakens the model elaborated by Sullivan and Vowles.

Interestingly, much of the topical review by Sullivan and Vowles applies to pain care from the acute stage, not only chronic pain rehabilitation. In the acute pain setting too, there are advantages to encouraging the patient to understand his or her pain, and to self-manage distress and related

behavior alongside treatment attempts.⁹ In many chronic disabling disorders, a focus on valued activities and ways to continue them, despite restrictions from illness and treatment, characterizes better quality of life.⁵ Normal life, or some approximation to it, becomes the focus of therapeutic efforts, rather than symptom intensity. Making sense of the need to try to maintain some semblance or normal activities in the context of the salience network is a major contribution to developing better models of chronic pain care. Now we need to make sense of the focus on activity for the many people with chronic pain who are stuck in what they believe to be the safe option of careful and limited lifestyle. We need to guard against the message about activity and trying to maintain normal routines being traduced into refusal to offer analgesic methods, exhortations to self-manage without rationale, information or support, and dismissing those who struggle to self-manage.

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