Pain Management Pitfalls

Psychological research on intense provider-client interactions yields insight into the doctor-chronic pain patient relationship and provides lessons in improving interactions.
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Much has been written about the controversy surrounding prescription of appropriate pain medications, the issues involved in prescribing, and effective risk-management prescribing procedures that help physicians implement an effective approach in working with chronic pain patients. However, little has been said about how this approach can complicate the provider-patient relationship to a degree that everyone involved in the process, including the patient, feel frustrated and misunderstood. There is, however, clear research in psychology that can help in the difficult and complex situations of professional interactions with pain patients. These studies have implications for physicians, psychologists, psychiatrists, clinical social workers, physical and occupational therapists, and other providers of care who offer treatment or independent evaluations for chronic pain patients.

Impediments to Patient-Doctor Interactions

The management of chronic pain patients has been the subject of much debate over the years. The public has been concerned about inadequate pain medication prescribing for those suffering from chronic pain conditions or those who have terminal conditions and are struggling with adequate pain control during their last days. Medical licensing boards, physicians, and the Federal Drug Enforcement Administration (DEA) are concerned about inappropriate or over-prescribing, addictions to opioids, and drug diversion. This has resulted in physicians losing their license to prescribe, some physicians being jailed for prescribing opioid pain medication,[1] and many physicians who are, as a result, extremely reluctant to prescribe any type of pain medication beyond the use of NSAIDs. Tensions and concerns are high among the DEA, physicians, and licensing boards. Patients respond to these tensions in negative ways by withholding information, trying to manipulate patient-physician interactions, or by being tense and angry in interactions with providers.

The American Pain Society, the International Society for the Study of Pain, and the American Academy of Pain Management, have all worked hard to change the environment and to present realistic approaches to prescribing for chronic pain patients. Pain medication prescribing is now seen as a basic patient right, but many physicians are still concerned about what this means for them as professionals and their practice. There are those who continue to have lingering suspicions that patients who are seeking pain medications are ‘drug seekers’ who only want to obtain legal prescriptions to satisfy their drug habits. To combat this, specific guidelines have been established to assist the prescribing professional working with chronic pain patients. These guidelines include a pain contract, specific documentation, follow-up, and monitoring for diversion or overuse of medications.[2]

Complication of Managed Care

The managed care model in which the physician is the ‘gatekeeper’ of medical care has further complicated the relationship between doctors and pain patients since this model is based on limiting services, watching for ‘over-utilizers,’ and keeping the costs of care down as much as possible. As a result, physicians involved in treating chronic pain patients now feel that they must be constantly on guard for patients who will misuse services in some manner — even though only a small percentage of patients fall into this category. Even psychologists are being recruited by Independent Medical Examiner (IME) panels to detect deception and malingering rather than focusing on assisting patients in finding the most appropriate focus for care. Patients often report that they feel ‘talked down to’ and have

assumptions being made about them without an attempt to understand them as individuals. These pain patients feel that medical appointments are more like interrogation sessions where they are under investigation and are dictated to about how to live and function, rather than being 'listened too.'

This charged environment, especially in the pain patient's case, often transforms the character of health care relationship from a relaxed atmosphere where one can feel safe in expressing fears and struggles, into a one-way dictation. Humor has often gone out of these interactions and the 'curative factors in the professional relationship' — central to psychological care and improvement — have been lost. This has fostered a professional relationship filled with misunderstanding, distance in relationship, and has left some physicians and patients, alike, feeling like criminals.

Social Situational Blocks

Psychological researchers have identified blocks to effective provider-client (i.e. doctor-patient) relationships and shed light on the struggles pain physicians face in providing services. Though many positive changes have happened in the field of pain management, including the importance of a multi-disciplinary approach to care, there are still blocks that often complicate the health care relationship.[2-7] Psychological research has repeatedly demonstrated that people tend to underestimate how the influence of social situations can dramatically impact their behaviors. Studies — conducted in the 1960's and 1970's — tested the social functioning of roles in situations with outside controlling authority and great power differential, respectively. The insight from these studies is directly applicable to pain management physicians in that similar social forces are at work, namely DEA, licensing boards, and the legal system, on the one hand; and the great power differential existing between doctor and patient, on the other.

What both studies have demonstrated is that powerful situations can cause anyone to perpetuate cruel acts — all the while justifying their behaviors and viewing the clients as 'the enemy' and therefore deserving of punishment. It particularly becomes a problem when the situation is focused on specific 'situational myths' that identify the clients in a negative manner. This can be aggravated when one is functioning in an environment of mistrust, frustration, stress, suspicion, anxiety, fear, or concern about complying with authority. Following are brief synopses of each situational study.

Impact of Outside Authority

A series of studies by Stanley Milgram, PhD, at Yale University in the 1960's showed the impact that outside authority can have on human behavior, in particular where it relates to a relationship of power over others. This series involved 1,000 individuals participatinge in role playing as either a "teacher" or "learner." The teachers were to administer increasing electric shocks to learners (actually hired actors) for any mistakes. The teachers could hear the screams of the learners (actors) in a separate room. Dr. Milgram wanted to see if the teachers would continue to administer increasingly lethal shocks to learners when told to do so by an authority figure in a 'white coat.' The result was that two thirds of the teachers continued to administer shocks with increasing voltage levels — up to 480 volts — despite screams and then total silence from the other room. In all, 100 percent of the teachers — although to varying degree — were obedient to the authority figures in administering shocks to the hapless learners.[8-19]

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The following guidelines may be useful for focusing treatment efforts in the best in the best interests of both the patient and physician:[1]

1. The recommendations about doing an adequate history, documentation, assessment, and treatment plan, along with a medication contract, should in no way reflect an assumption that all pain patients are 'drug seekers' who will misuse their medications. It is important to have adequate documentation with a treatment plan that also has a focus on a multi-disciplinary approach to care. The vast majority of chronic pain patients feel they have been abandoned by the medical system and do not believe that anyone will work with them to address their needs. Their initial distrust needs to be overcome with the development of a positive relationship where the patient can feel free to express their concerns along with receiving education about how to care for themselves.[2,6,21,22]
2. It is critical to understand that psychological research has repeatedly demonstrated that people tend to underestimate how the influence of social situations can dramatically impact behavior. While everyone likes to think that they have full control over their own actions, certain aspects of social situations can exert powerful influences and precipitate an unwanted reaction. Most importantly, one tends to underestimate the impact of obedience to authority on one's own behavior. In fact, even professional experts tend to underestimate how much human obedience to authority will affect an individual's behaviors. It is critical that providers prepare themselves with preemptive guidelines and training to avoid negative behavioral patterns — due to societal and professional authority interactions with pain patients — that would otherwise have negative impacts on the doctor-patient relationship.[20]
3. Third, the tragic situation of prisoner abuse that happened in the Iraq war at the Abu Ghraib Prison underscores how inadequate training, undefined ethical guidelines, lack of clear lines of leadership command, poor staffing patterns, and a focus on 'the ends being more important than the means,' all lead to negative consequences for all concerned. Following the prison abuse scandal at Abu Ghraib, new techniques were instituted focused on 'incentive based interrogation' based on the development of trust, respect, rapport building. These techniques are designed to insure the dignity of suspects as an integral part of relationship building with the goal of attaining more reliable information. Such lessons in relationship building in difficult circumstances should guide health care professionals' interactions with pain patients.[4,7,22,23]
4. Psychological research has shown that personality style and attitudes are basically stable over an individual's life-span. Those who tend to be more compliant to authority will have a more difficult time making independent decisions even when they violate ethical standards. Others who are more independent thinkers tend to avoid group conformity and are less prone to blind obedience to authority. However, since there is a complex interplay between personality and social situational influence, it is difficult to fully predict future human behavior based on personality style alone. This is further complicated by the fact that humans are very quick to justify their behaviors. When there are negative consequences for behaviors resulting from peer pressure, unquestioning obedience to authority, or situational influence, most are quick to project blame on to victims and others; it is easy to shift responsibility from oneself. All of this suggests that leadership, oversight, and training all play an important role in allowing, or avoiding, abusive behaviors to happen within any setting. It is important to be aware that such behaviors can happen in any work setting/organization, and points to the need to carefully select and train supervisors because of their unique position of authority in a work setting which can cause abuse of power toward employees and customers. It also points to the need to be aware of one's own struggles with counter-transference interactions with patients that can be influenced by the situation, peer pressure, and the patient's transferred fears, concerns and anxieties.[2,22,24,25]

Impact of Power Differential

In 1971, Philip Zimbardo, PhD, professor of psychology at Stanford University studied the social functioning of roles where there is an enormous power differential in interactions with others. His study focused on two dozen college students who were randomly assigned to be either prison guards or prisoners in a simulated two week jail/prison setting. Dr. Zimbardo found that he had to stop the study after only six days because the prison guards became extremely abusive and angry — basing their actions on their perception of prisoners as being manipulative, trying to get away with things, and not

acquiescing to their fate/role as inmates. Prisoners were isolated, stripped of clothing, bags put over their heads — among other abusive tactics — in concerted attempts to humiliate and over-control the prisoners. Anger at the prisoners was extremely high. Prisoners, responding to their treatment, became protectively manipulative and engaged in negative behaviors that was then noted by the guards and further justified retaliation.[7-19]

Dr. Zimbardo concluded that when the balance of power is so unequal, even normal people with no past history of psychological problems will become abusive and brutal unless extreme measures are taken to control hostile impulses. None of the students in the study had any previous pathology or problems noted prior to the study. Dr. Zimbardo further noted that when individuals are placed in alien settings, the situation itself will likely produce classic cases of abuse of power and control.

Implications for Pain Professionals

What both Zimbardo and Milgram noted is that interactional problems first start with a failure of leadership. This can include a diffusion of responsibility, dehumanization of clients, secrecy, lack of accountability, re-labeling controlling behaviors as necessary, developing justifications for controlling behaviors, social-peer modeling of negative behaviors, group pressures to conform, issues related to obedience of authority, and self-protection.[11]

These studies have clear implications for pain management professionals who are treated as suspect by their peers, licensing boards, the DEA, and legal professionals. The fear of pain patients becoming addicted, or being perceived as ‘drug seeking,’ often heightens a sense of concern for how to best work with patients who present with complex health care problems. It requires that patient management programs be constructed to facilitate better interactions with the patients. Discussing potential social situational blocks openly with staff is critical to helping to reduce negative consequences in patient-provider interactions.[20]

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Conclusion

Basic patient interactions require:

1. an understanding of information on how to work with patients presenting with chronic pain
2. ‘starting where the patient is at’ rather than where the provider feels things should be focused
3. starting interactions with patients using uncritical listening
4. knowing the importance of a ‘non-judgmental attitude’ in interactions with patients
5. remembering that the most important curative factor in all therapeutic interactions is "the relationship"

Without a positive, and trusting, relationship with mutual respect, little can be accomplished therapeutically, while a positive relationship can help deal with even ‘problem behaviors’ in a more open and helpful manner. This can even facilitate work with patients who present noncompliance, abuse, or other problems, since it allows the professional to work within the professional relationship to assist in resolving such dysfunctional behaviors.

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