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THE CHRONIC PAIN PATIENT: HOW CAN LOGOTHERAPY HELP?

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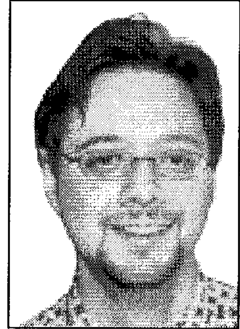

Viktor Frankl's insights into human suffering can be integrated into an interdisciplinary model used to treat chronic pain syndrome. These insights can be added to cognitive-behavioral therapy (CBT) to address existential issues related to a form of existential (spiritual) disorganization often found in these patients. Therapists are encouraged to pay attention to schemas (life traps), creative values, and iatrogenic neuroses that are often prevalent in the syndrome. The process of discovery and rational thinking, along with behavioral uses of dereflection and relaxation training, can have a substantial impact on this condition. Concepts like progressive existential disorganization (PED) and the two therapeutic processes mentioned beforehand will be explored further in this article. These combined logotherapy-CBT approaches can help clients possess a richer and cohesive "meaningful" narrative of their chronic condition.

Chronic Pain and the Iatrogenic Systemic Neurosis

Viktor Frankl's insights into human suffering provide a rich framework for the treatment of chronic pain. It is my contention that logotherapy concepts and cognitive-behavioral strategies will reduce both the physiological and psychological correlates of the syndrome. Chronic pain syndrome is a descriptive term for individuals who show persistent pain, poor coping strategies, functional limitations, significant life disruption, and dysfunctional pain behavior.[1] Symptoms frequently overlap with affective disorders, culminating in diffuse functional impairments (e.g., sleep disturbance, distraction, amotivation, inability to achieve goals, social isolation).[9]

Presently, an interdisciplinary approach that integrates CBT, physical rehabilitation, and pharmacological agents offer the best hope for reduction of chronic pain symptoms.[3,4] CBT techniques can include basic psychoeducation, cognitive restructuring, energy conservation strategies, relaxation, goal setting, communicating with significant others, and sleep hygiene techniques.[10,11] Even so, many patients make modest gains or relapse, perhaps due to unaddressed co-morbid Axis I and Axis II disorders.[1,8] In addition, many patients develop an "iatrogenic systemic neurosis". This is a psychogenic condition as a result of the constant frustration patients report when interacting with financial, health, and legal

systems. It is iatrogenic because the systems designed to help patients paradoxically multiply their stress, create mistrust and mild paranoia, and exacerbate depressive feelings. These patients tend to treat future interventions with suspicion.

The Unique Contribution of Logotherapy

Approaches designed to address existential questions in a brief setting can be integrated effectively into a biopsychosocial model of treatment for more treatment-refractory cases.[6] The synthesis of logotherapy modules and evidenced-based treatments (e.g., cognitive therapy) may compliment each other in significant ways.[2] The synthesis may enable therapists to engage the patient at multiple levels of abstraction, a macro perspective (existential) and a micro perspective (daily functioning). This flexibility between the two perspectives allows therapists to address appropriate concerns as needed.[7] This hybrid model may prove useful given that many chronic pain patients report a sense of existential meaninglessness following the onset of their symptoms. For example, they may wonder if they have been punished by God, or why life has been grossly unfair.

Course of the Syndrome

With many chronic pain patients, a form of progressive existential disorganization (PED) begins shortly after the onset of their chronic pain symptoms (see figure). I expanded PED from Frankl's ideas about the human being's struggles with meaninglessness. When life is experienced as having no meaning, it becomes empty. The PED captures this "becoming" process: it is the mechanism by which the existential vacuum slowly surfaces. It develops over time, until individuals finally realize that they feel worthless and feel like they have little sense of purpose. Part of this process involves the repetitive use of "meaningless" behaviors, e.g., compulsions, drugs, violence, food, sex, and, conversely, periods of inactivity that lead to apathy. From my experience, chronic pain patients mask their increasing feelings of meaninglessness by two extremes. Some fail to set goals that will challenge them in a healthy manner, and (because of their physical limitations) have pockets of idle time. Others are perpetually hyper-focused on their symptoms or the latest legal or medical iatrogenic event.

During this period, patients experience significant and frequent disruptions with their social support and medical treatments. It is my contention that the number, extent, and time between insults to physical, psychological, and social support dimensions (e.g., abandonment from loved ones) directly impact this disorganization by reactivating schemas (will be discussed below) and creating general confusion about life. From the onset of the symptoms, many patients receive some types of palliative treatments or passive modalities (e.g., massages, cold/ice packs, rehabilitative exercises, even supportive psychotherapy), but for some these treatments produce only modest results. By the time they see a psychotherapist as part

of an interdisciplinary model of treatment, patients may appear to be cynical, resistant, suspicious, and angry as a result of the failure of previous forms of treatment.

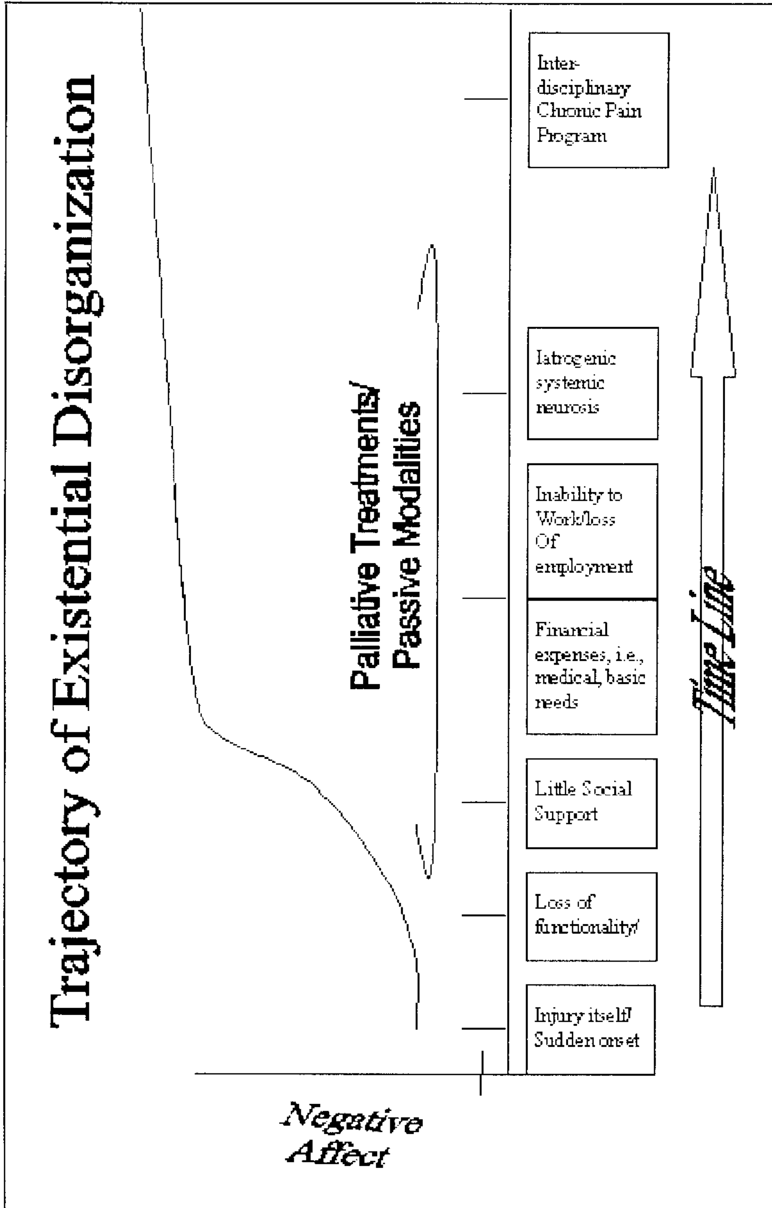

Figure 1

The trajectory shows that existential issues need to be addressed along with traditional cognitive-behavioral therapy. The intake process is a crucial first step for these patients. Many patients have memorized dates, facts, and figures related to their injuries and can easily hyper-reflect (i.e., over-analyze, be overly self-conscious about problems) if not directed properly. In addition to asking standard intake questions, applicable spiritual and religious coping information needs to be obtained. The clinician also needs to determine the level of the patient's social support, as this factor may have an impact on relapse prevention.

Therapy Sessions: Life Maps, Discovery, and Creative Values

During the initial stages of therapy, I have found it useful to assess life traps or schemas that have been re-triggered by the initial onset of chronic pain symptoms.[12] Some of these may include, but are not limited to, vulnerability ("I cannot cope with the future well"), powerlessness ("I have little control over my life"), avoidance ("I can't stand to deal with my problems"), and self-sacrifice ("Others' needs are more important than mine"). These themes can serve as powerful anchors that help bring consistency to treatment, given that many patients present with new crises each week. These elicited themes also help explain how patients exacerbate their symptoms with a negative, depressed, cognitive set. For example, one patient that I treated verbalized issues tied into the core belief that "After I had my injury, the world has become unsafe and unpredictable". More than likely, these schemas were simply activated, not birthed with the onset of the injury. These re-activated schemas also contribute to PED. The disorganization increases as lifelong coping styles are found to be ineffective in chronic pain management.

Therapists can use discovery processes and cognitive-behavioral techniques concurrently to address chronic pain issues. They can help their patients *discover* meaning in what appear to be chaotic life narratives. And yet at the same time, they can teach their patients to use *rational* (simply meaning more scientific, clear, and flexible) thinking to practice cognitive, affective, and behavioral coping techniques to deal with daily stressors.[7] One logotherapeutic/cognitive-behavioral technique that is successful here is dereflection. Patients hyper-focus significantly on their pain levels. One approach that I have found helpful is to validate the patient's pain complaint. I then address related psychological issues that are often tied to re-triggered schemas in an attempt to help patients dereflect from their pain. I also have patients elicit realistic, value-actualizing goals that they can fulfill *in spite* of their painful condition. For example, one patient agreed to spend more time with her granddaughter instead of being home alone and depressing herself. However, one warning about the use of dereflection is that it should never be used to distract both the patient and therapist from addressing issues related to practical survival (e.g., contacting charities to help pay for bills, home

health concerns, social work issues, making arrangements with psychiatrists for medications).

Frankl's emphasis on creative values is extremely important for these patients.[5] They can enrich their lives by simply doing or creating something new. Because chronic pain patients know they can no longer perform certain premorbid activities, therapists can use creativity to challenge them to meet parallel goals. For example, if patients can no longer go on a "ski jet", they can go to the lake and enjoy the surroundings. The actualization of creative values can serve as a strong protective factor against depression by helping patients realize that they can still achieve fulfilling goals.

The End of Therapy: Measuring Success

Successful therapy with chronic pain patients does not simply involve helping patients develop more adaptive behaviors, but empowering them to restore order to their PED. To aid this restorative process, patients become engaged in the discovery of meanings along with the adoption of healthier cognitions. Successful therapy can be measured by: (a) a reduction of the iatrogenic neurosis (the empathic therapist and pain program are introjected, i.e., positive attitudes or ideas towards healers are incorporated into one's personality unconsciously); (b) an increase in goal-setting activities; (c) better communication skills with their support group; (d) acceptance of the chronicity of their condition; (e) and an increase in the knowledge, sense of self-efficacy, and use of behavioral skills to lower pain symptoms. While successful therapy could be measured directly by self-reported lower pain levels, this does not have to occur always. Many times patients have a meaningful re-conceptualization of their chronic condition that allows them to face everyday with courage in spite of their pain. Some patients have shared that their condition has helped them mature spiritually as human beings.

Conclusions

Chronic pain syndrome is a debilitating condition that is responsive to a cognitive-behavioral approach often within an interdisciplinary pain program. The augmentation of this treatment with logotherapy ideas can help patients resolve their sense of existential meaninglessness. The course of therapy should not only include a restoration of the "progressive existential disorganization", but also a new skill set. Pain patients should learn effective behavioral techniques and better ways of attaining realistic goals. Dereflection is particularly important in this aspect, as pain patients are overly focused on pain symptoms. It is likely that a clear purpose in life may positively affect patients' sense of self-efficacy over their pain and act as a protective factor against depression. Future research may wish to examine the relationship between patients' perceived sense of pain control and their existential sense of meaninglessness.

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References

1. Aronoff, G., Feldman, J., & Campion, T. (2000). Management of chronic pain and control of long-term disability. *Occupational Medicine, 15*, 755-770.
2. Benware, J. (2003). On the compatibility of cognitive therapy and logotherapy. *International Forum for Logotherapy, 26*, 49-57.
3. Bradley, L. (1996). Cognitive behavioral therapy for chronic pain. In R. J. Gatchel & D. C. Turk (Eds.), *Psychological approaches to pain management: A practitioner's handbook* (pp. 131-147). NY: Guilford.
4. Fishbain, D., Rosomoff, H., Cutler, B., & Steele-Rosomoff, R. (1995). *Chronic pain treatment metaspecific predictors of response.* Proceedings: Integration of behavioral and relaxation approaches into the treatment of chronic pain and insomnia. NIH Technology Assessment Conference, Washington, DC.
5. Frankl, V. (1988). *The will to meaning: Foundations and application of logotherapy.* NY: Penguin Books.
6. Hutchinson, G. (2002). The medical ministry of a secular priest-in-training. *Clio's Psyche, 9*, 94-95.
7. Hutchinson, G., & Chapman, B. (2003, June 25). *Logotherapy and rational emotive behavior therapy: An integrative effort.* Paper presented at the 15th World Congress on Viktor Frankl's Logotherapy, Dallas, TX.
8. Kerns, R., & Haythornthwaite, J. (1988). Depression among chronic pain patients: Cognitive-behavioral analysis and effect on rehabilitation outcome. *Journal of Consulting and Clinical Psychology, 56*, 870-876.
9. Turk, D. (1996). Biopsychosocial perspective on chronic pain. In R. J. Gatchel & D. C. Turk (Eds.), *Psychological approaches to pain management: A practitioner's handbook* (pp. 3-32). NY: Guilford.
10. Turk, D., & Gatchel, R. (2002). *Psychological approaches to pain management: A practitioner's handbook* (2nd edition). NY: Guilford.
11. Turk, D., Meichenbaum, D., & Genest, M. (1983). *Pain and behavioral medicine: A cognitive behavioral perspective.* NY: Guilford.
12. Young, J., Weishaar, M., & Klosko, J. (2003). *Schema therapy: A practitioner's guide.* NY: Guilford.