

Traditional health  
psychology versus  
critical health  
psychology nursing  
essay



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## **Introduction**

This paper will begin with a discussion of the prevalence of chronic low back pain. The physical and psychological precursors and effects of chronic low back pain will be reviewed. Traditional psychosocial interventions aimed at managing and treating chronic low back pain will be discussed. Finally, an alternative method for managing chronic low back pain using the framework of critical health psychology will be explored. With this alternative method, it is emphasized that effective management of chronic pain cannot be accomplished without consideration for the patient's unique pain experience.

## **Scope of the Problem**

Low back pain is a disorder with many possible etiologies, occurring in many groups in many populations and with many definitions. Low back pain is a common problem, with prevalence in the United States ranging from 8% to 56%. It is estimated that 28% of people experience disabling low back pain sometime during their lives, 14% experience episodes lasting at least 2 weeks, 8% of the entire working population will be disabled in any given year, and the lifetime prevalence of low back pain among all individuals is 65% to 80%. It is believed that most episodes of low back pain will be short-lived and that 80% to 90% of attacks of low back pain resolve in less than 6 weeks, irrespective of the administration or type of treatment. (Manchikanti, L., 2000). Although it is expected that the majority of patients seen for back pain in primary care will recover within a few weeks, a substantial amount of patients progress to chronic low back pain, or back pain persisting for longer than 6 months.

Although the mechanism by which acute (short-lived) back pain progresses into chronic (long-duration) back pain is individualized and largely unclear, several psychological risk factors for the progression to chronicity have been identified. These risk factors include prior episodes of pain, depression, family issues, work place issues such as stress and socioeconomic issues (Schmidt, et al., 2010). In addition, several schools of thought have emerged to try to explain the mechanism by which acute pain evolves into chronic pain, such as psychoanalytic models, behaviorist models, psychophysiological approaches and cognitive approaches (Innes, 2005). These models seek to explain the correlation of psychosocial factors to the onset and outcomes of acute pain episodes.

The role of psychology in chronic pain has been present since the advancement of behavioral psychology in the 1950's and 1960's, emphasizing the role of the environment on health behaviors and decision making (Eccleston, 2001). Because pain is not a disorder that can be validated by any external measure, it is often diagnosed and treated by patient behavior and report of their perception of the pain. (Gureje, et al., 1998).

This is similarly true in reports of an acute pain episode persisting, or evolving into a chronic pain situation. Typically, chronic low back pain is associated with a multitude of psychological factors. In this case, multiple facets of the patient's life are overwhelmed by the pain. Depression, one of the highest correlated psychological comorbidities of chronic pain, can develop rapidly. Work duties may become difficult. Family and home responsibilities may be challenged by the pain. (Eccleston, C., 2001). In <https://assignbuster.com/traditional-health-psychology-versus-critical-health-psychology-nursing-essay/>

addition, such patients have a chronically debilitating medical disorder that may precipitate a number of psychosocial factors, including psychiatric and substance use disorders, physical deconditioning, dependency upon the healthcare system, and perceived impairments that are out of proportion to objective medical findings. (McAllister, et al., 2005). Specific psychological factors that will be discussed further in this work include fear, worry, depression, self-denigration, loss of control and anger. (Eccleston, C., 2001).

Evidence emerging within the past several decades suggests that psychosocial factors from emotional states, such as depression, behavioral dispositions such as hostility, and psychosocial stress can directly influence both physiologic function and health outcomes, including chronic pain (Salovey, et al., 2000). There is also abundant research showing that psychosocial factors play a role in the high rates of healthcare utilization and disability exhibited by patients with complicated chronic pain syndromes. Because their pain disorders are complicated by psychosocial factors, their coping skills are also challenged and they tend to be overly reliant on opioid medications and the healthcare system in general. (McAllister, et al., 2005).

## **The Mind-Body Connection**

Mind-body medicine encompasses a wide range of practices and therapies designed to facilitate the mind's capacity to affect health (Sobel, 2000). Based on national survey data, relaxation techniques, guided imagery, hypnosis, and biofeedback are the most popular mind-body therapies in the United States (Wooten, et al., 2001). While use of many mind-body techniques predates modern biomedicine, they have received increased attention recently as biomedical research identifies mechanisms by which

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the mind and body influence each other. (Kiecolt-Glaser, 2002). Because mind-body medicine often involves inexpensive self-care-based activities, it also holds appeal as a cost-effective or cost-saving alternative in an age of spiraling medical expenditures (Sobel, 2000).

In 2005, Stanley Innes published a meta-analysis of the pain literature related to the role of psychosocial factors. Specifically, Innes describes how psychological research has focused on identifying those people with acute pain syndromes who are at risk for transitioning into chronic and debilitating pain, in the hope of producing better outcomes. To sum, he describes the historical evolution of treating chronic pain from a linear perspective to a more multi-causal one by describing different schools of thought regarding pain: historically the behaviorist and cognitive models followed by modern theoretical models psychosocial factors related to chronic pain.

From the behaviorist perspective, scientists have tried to show that all behavior can be shaped or modified by manipulations in the environment. According to the behavioral model of pain, it is thought that there are a simple causal connection between pain and its reinforcers. It proposes that pain persists from an acute to a chronic phase because the behavior of others (family, friends and health care providers) during the acute pain stage reinforces that pain returned secondary gains, such as permission to avoid chores, or obtain otherwise unobtainable attention and care. (Innes, 2005).

Cognitive theory examines intervening variables such as attributions, expectations, beliefs, self-efficacy, personal control, attention to pain stimuli, problem solving, coping self-statements and imagery. Pain studies from this

perspective have investigated the effects of these thought processes on the experience of pain and related problems. (Innes, 2005).

Using modern psychological thought on chronic pain, Innes describes how a substantial amount of people do not recover quickly from acute pain and transition into a chronic pain situation. From the lens of modern cognitive-behavioral approaches to chronic pain, Innes writes, “ The cognitive-behavioural researchers in the late 20th century noted that acute pain was associated with a pattern of physiologic responses seen in anxiety attacks, whilst chronic back pain was characterized more effectively by habituation of autonomic responses and by a pattern of performance of daily physical activities may lead more easily to pain and physical discomfort. As a result, the avoidance of activity becomes increasingly likely, as does the risk of chronicity”.

Additionally, when a person experiences pain they experience varying degrees of psychological distress as a consequence. A recent study suggests that as many as one third of people seeking care at physical therapists may have significant levels of distress (Eccleston, 2001). Conversely, people experiencing psychological distress may report more severe back pain. As much as 16% of low back pain in the general population may be attributable to or exacerbated by psychological distress (Strine & Hootman, 2007). Notably, a recent review article suggested that psychological factors are more important than most biomedical or biomechanical factors in the development of pain and disability (Linton, 2000).

## **Psychological Antecedents and Consequences of Chronic Pain**

According to Eccleston (2001), there exist specific psychological traits or specific states of experience that affect a person's perception, manifestation and treatment of pain.

Fear, for example, can be manifested as an individual's heightened attention to pain. In particular, when the threat of pain is constant or recurrent, a pattern of vigilance to pain can develop. Patients who report high levels of attention to pain also report higher pain intensity, increased use of healthcare resources and more emotional distress. Vigilance to pain was found to be a significant predictor of disability, distress and use of healthcare resources. (Eccleston, 2001).

More so, some authors have argued that the fear of pain is more disabling than the pain itself. In a study on this idea, Crombez and colleagues replicated the finding that pain-related fear is a better predictor of disability than the pain itself. In a study which asked pain patients to engage in a painful experience, called "musculoskeletal loading", patients either performed poorly on the test or avoided the activity altogether in fear of experiencing pain. The authors concluded that this fear-mediated response may be a normal mechanism of survival. (Crombez, et al., 1999).

Eccleston also describes depression as a major consequence of chronic low back pain, writing that the experience of chronic pain can lead to a low affect, and chronic low affect can lead to persistent feelings of frustration and anger or negative or destructive self-appraisal. Unsurprisingly, the

majority of adult chronic pain patients who present for treatment at pain clinics are also depressed to some degree (Eccleston, 2001). Depression related to chronic pain can be a consequence of disability/immobility, the inability to fulfill family and/or work obligations, and the inability to socialize normally.

Depression can also precipitate chronic pain. Depression, which is highly prevalent among persons with chronic pain, is a strong independent risk factor for the onset of disabling neck and low back pain (Carroll & Cassidy, 2004). Additionally, persons with depressive symptoms often have a lower threshold for pain and report greater functional impairment than those without depressive symptoms. In fact, the combination of chronic back pain and major depression is associated with greater disability than is either condition alone. (Strine & Hootman, 2007).

Anger (because of discomfort and disability) is also a common consequence of chronic pain and can be experienced by both the patient and the healthcare provider (Eccleston, 2001). Anger and hostility can have significant deleterious effects on both health and treatment outcomes, and it has been shown to negatively affect the patient-provider relationship. (Fernandez, et al., 2000). Anger can be a component of severe frustration, distress and possibly depression (Eccleston, 2001).

In addition to chronic pain, patients who present for treatment are often disabled and report other associated problems, such as difficulty sleeping and fatigue. Over time, they may become interpersonally isolated and have developed unsatisfactory family roles and responsibilities. It is also often



common that chronic pain patients develop an unhealthy reliance upon the health care system as they continue to seek relief and support. Moreover, chronic pain patients disproportionately experience a sense of loss of control over their lives. (Eccleston, 2001).

## **Psychosocial Interventions**

Evidence emerging within the past several decades suggests that psychosocial factors from emotional states, such as depression, behavioral dispositions such as hostility, and psychosocial stress can directly influence both physiologic function and health outcomes, including chronic pain.

Evidence from several converging lines of research, however, also suggests that despite seemingly widespread acknowledgment of and support for the importance of the biopsychosocial model, psychosocial factors continue to be overlooked or missed in many clinical encounters and are frequently underemphasized in medical education. (Salovey, et al., 2000).

Psychosocial interventions aimed at the management of chronic pain and its consequences (depression, loss of control, loss of self-esteem) are often termed “ Mind-Body Therapies”, or MBT’s. The National Institutes of Health (NIH) define MBTs as “ interventions that use a variety of techniques designed to facilitate the mind’s capacity to affect bodily function and symptoms” (Astin, et al., 2002).

Studies have examined the effects of MBT’s on chronic low back pain patients. These treatments typically include some combination of biofeedback therapy, relaxation, cognitive strategies and education.

In 2007, researchers Chou and Hoyt-Huffman reported on a synthesis of 17 randomized, controlled trials on psychological therapies for chronic low back pain and reviewed studies specific to cognitive-behavioral therapy and relaxation. Although no significant differences were found between the psychologically-treated patients and the pharmacologically-treated patients, the researchers were able to report that psychological therapies are beneficial in general. Chou and Hoyt-Huffman reported that they found good evidence that psychological interventions (cognitive-behavioral therapy and progressive relaxation), exercise, interdisciplinary rehabilitation, functional restoration, and spinal manipulation are effective for chronic or subacute (> 4 weeks' duration) low back pain. Compared with placebo or sham therapies, these interventions were associated with moderate effects, with differences for pain relief in the range of 10 to 20 points on a 100-point visual analogue pain scale. (Chou & Hoyt-Huffmann, 2007).

Biofeedback has also been used as a psychological treatment for chronic low back pain. Developed in the 1960s, biofeedback involves the use of devices that amplify physiological processes (for example, blood pressure, muscle activity) that are ordinarily difficult to perceive without some type of amplification (Astin, et al., 2002). Participants are typically guided through relaxation and imagery exercises and instructed to alter their physiological processes using as a guide the provided biofeedback (typically visual or auditory). Examples of prominent forms of this therapy are electromyographic biofeedback, in which patients with a condition, such as low back pain, are provided with feedback regarding the degree of tension in the back muscles; or temperature biofeedback, such as when patients with

migraine headache disorder are instructed to warm their hands using as their feedback cue sounds or tones indicating temperature changes in this region of the body. (Astin, et al., 2002).

Relaxation techniques, broadly defined, include those practices whose primary stated goal is elicitation of a psychophysiological state of relaxation or hypoarousal. In certain practices, the goal might be to reduce muscular tension (as in progressive muscle relaxation in which muscles are alternatively tensed and relaxed). In other cases, the primary goal is to achieve a “ hypometabolic state of reduced sympathetic arousal”. (Astin, et al., 2002).

A relaxation technique called “ mindfulness training” uses meditation and relaxation in the management of chronic pain. Meditation can include methods of “ distraction”. Distraction is a commonly used method of coping with pain, and typically refers to the voluntary or involuntary moving of attention away from pain (Morone, et al., 2008).

A study published by Morone and associates in 2008 explored the benefits of mindfulness meditation on older adults with chronic low back pain.

Participants in the study were asked to participate in mindfulness training and log a diary of their perceptions of their chronic pain severity. Many participants commented on the reduction of pain by indicating the methods and processes used to reduce it, such as distraction from pain, heightened awareness of pain sensation leading to behavior change, better coping with pain, and actual pain reduction using the meditation technique (Morone, et al., 2008). Interestingly, the process of learning meditation and becoming

more aware of the body also allowed some participants to be more introspective. Some realized that they had adopted maladaptive coping strategies such as repression in order to deal with their pain (Morone, et al., 2008). The study also found that learning mindfulness meditation resulted in positive affect and experiences of greater mental and physical well being which occurred immediately post meditation, but also remained long term. It was found that meditation also provided participants with a tool to positively handle stress.

Among more traditional psychological interventions, one of the more prominent MBTs is cognitive-behavioral therapy. It emphasizes the role of cognitive processes in shaping affective experience and argues that problematic emotions, such as anger, depression, and anxiety, that result from irrational or faulty thinking. (Astin, et al., 2002). Standard CBT pain protocols seek to: (1) teach patients specific cognitive and behavioral skills to better manage pain; (2) inform patients regarding the effects that specific cognitions (thoughts, beliefs, attitudes), emotions (fear of pain), and behaviors (activity avoidance due to fear of pain) can have on pain; and (3) emphasize the primary role that patients can play in controlling their own pain as well as adaptations to pain. Cognitive-behavioral therapy has proven efficacy for reducing pain and disability levels among middle-aged people with diverse chronic pain disorders (McCracken, et al., 2007).

## **The Critical Perspective**

The following discussion will explore the role of critical health psychology in the chronic low back pain experience, considering the patient's subjective

reality of the pain and their role as proactive participants in their own care.

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Traditional/mainstream health psychology will be compared to critical health psychology in the realm of chronic pain.

Traditional health psychology has focused its attention on reduction or alleviation of pain and supports management efforts aimed at cognitive-behavioral therapy, relaxation and biofeedback, as described above. These efforts are an attempt to objectify a very subjective experience of pain as it values individual perception of pain.

In terms of chronic low back pain and its antecedents and consequences, psychology in general plays a pivotal role in understanding its effects and its treatment. Because of the multi-faceted and complex nature of chronic pain, paired with its unique manifestation among individuals, chronic low back pain cannot be molded into an entirely biomedical model, nor can the experience of pain be standardized among groups of people. Because chronic low back pain can cause feelings of anger, loss of control, loss of function and loss of self-esteem, it is crucial to recognize the importance of the individual experiencing the pain in its management.

According to psychologist Michele Crossley in her work *Rethinking Health Psychology*, the critical psychology perspective promotes social justice, self-determination and participation in health care, an integrated approach to human experience and the tenet that human beings are not merely objects, but active and determined participants in their lives. (Crossley, 2000, pg. 5-7). In terms of chronic pain, Crossley writes, “ it will become apparent that when people give with experiences of pain, stress and disease in contemporary society, they do so in a far more complex and reflexive

fashion than mainstream health psychology has ever begun to depict” (Crossley, 2000, pg. 77).

The importance of critical health psychology in chronic low back pain is to “explore in depth the meanings and experiences of individuals...” (Crossley, 2000, pg 77). Critical Health Psychology focuses on the importance of the individual in their own care, which, in turn, should relieve the perception of loss of control/self-efficacy often experienced with chronic pain.

From the lens of critical health psychology, pain as an individualized disease can be best understood by the meaning patients assign to the experience. In an attempt to subjectify the experience of chronic low back pain, critical health psychology appreciates the patient’s individual perceptions and uses that subjectivity in developing a supportive management plan. According to Crossley, “from a critical health psychology perspective, a central aim is the development of understanding, not necessarily the attempt to predict, manage and control.” (Crossley, 2000, pg. 12).

### **Alternative Method of Management**

Rather than a focus on reducing the experience of pain to an objective, measurable disease, critical health psychology offers an integrated, individualized approach to its management. In order to best understand the unique experiences of chronic low back pain that patients experience, the health care provider must be receptive to reports of the pain experience by the patient. According to Smith and Osborn (2007), exploration of a patient’s sense of self in the pain experience can be an effective method for chronic pain management. As discussed previously, patients experiencing chronic

low back pain can feel a sense of loss of control, a loss of self-esteem, depression and even anger. These feelings can either precipitate the pain or be a consequence of the pain, but nonetheless, are important factors that reach far beyond basic physiological, reducible antecedents or consequences of pain. Methods of management involving the critical health psychology perspective can address these issues from an integrated perspective that respects the patient's unique experience.

An effective patient-provider relationship is crucial in the management of chronic low back pain. Providers managing chronic low back pain should become familiar with the methods of critical health psychology and its positive impact on integrated pain management. Providers should be aware that chronic low back pain is disabling not only physically but psychologically. Providers should recognize the patient's concept of "self" when managing their pain, as the sense of self is a result of one's collection of core beliefs, affects or cognitions that are utilized by the individual to define or represent themselves both privately and in their presentation in the outside world (Ashmore & Jussim, 1997, as cited in Smith & Osborn, 2007).

The writing of narrative accounts of their experience with chronic pain can be both empowering for the patient and informative for the provider. By being receptive to narrative accounts by patients, the provider will help to create a collaborative and trusting relationship with the patient. Taking the time to listen to individual accounts of the pain experience will aid in the tailoring of an individualized management plan for the chronic low back pain patient.

That's not to say that pharmacological and psychological management of chronic pain is ineffective. Management with medications and/or therapy is crucial to controlling the perception of pain and its detrimental consequences, but the added appreciation for the critical perspective can make the management plan more effective. By building a trusting patient-provider relationship based on understanding of the patient's individuality, the power imbalance often experienced in the patient-provider relationship can be reduced and can ultimately make the management plan more effective.

Research has shown that an effective patient-provider relationship can have positive effects on treatment outcomes. In critical health psychology, an "effective" patient-provider relationship exists when the power imbalance between provider and patient is minimized, and the patient and their perceptions and experience becomes central to the relationship. Patient-centeredness, originally defined as "understanding each patient as a unique human being," is now widely considered the standard for high-quality interpersonal care (Committee on Quality Health Care in America, 2001).

Furthermore, studies which have directly observed patient-provider communication have found that patient-centered communication is associated with patient satisfaction and positive health outcomes among patients with chronic diseases such as pain, diabetes and hypertension (Stewart, et al., 2000). In addition, Safran and associates have found that patient perception of their provider having "whole person knowledge" is one of the strongest predictors of adherence to therapy in the primary care setting (Safran, et al., 1998).

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Methods to keep the patient the center of chronic pain management might include assessing the patient's coping skills and assessing what they may know and what they fear about the cause and management of the pain. To build an effective relationship with the patient, the provider should match the management strategy to the needs of the patient. If the patient expresses that they need information, education is key. Finally, providers should involve the patient in making decisions about the management plan and be consistent with their approach to giving information, instruction and patient involvement with their care. What is important is that the education and management approach makes sense to the patient, not necessarily the provider, and what might make sense to one patient may not make sense to another. (Eccleston 2001).

## **Conclusion**

In sum, the experience of chronic low back pain cannot be fully understood or effectively managed without consideration for the patient's unique experience of the pain. Even the best psychosocial therapies, designed to alleviate pain, cannot be effective on an individual level if all that occurs is a reduction of the pain experience to objective measures. Without consideration of the patient's individuality and the many facets of their pain experience, further isolation, anger, depression and a sense of loss of control can occur, exacerbating a downward spiral of ineffective pain management. Without consideration for patient's stories of experience and perception, they may not adhere to prescribed treatment, further broadening the power differential between patient and provider. As McAllister and associates (2005) have discussed, chronic pain may lead to a patient's unhealthy

reliance on the health care system. If this system is ineffective in meeting the patient's needs, there is a continued risk of a downward spiral for the patient.