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Doubled Up with Pain: Applying a Relational Framework to the Primary Care Provider - Chronic Pain Patient Relationship

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BY
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Abstract

Treatment relationships between primary care providers (PCPs) and chronic pain patients are often rife with difficult interpersonal dynamics and experienced by both parties as being noncollaborative. It is important that PCPs are provided with recommendations to make these treatment relationships more collaborative. Relational psychological frameworks, such as intersubjectivity, can teach PCPs how to improve their relationships with chronic pain patients. This paper focuses on how to strengthen the working alliance between PCPs and chronic pain patients using intersubjective principles. Conceptualizing the working alliance from an intersubjective lens gives PCPs guidance about where to turn if their treatment relationships with chronic pain patients feel stuck and uncollaborative. Listening through the mindset of how to build collaborative treatment relationships rather than cure pain will allow chronic pain patients to feel tended to and their doctors to feel helpful even when their pain persists.

Keywords: Primary care, chronic pain, treatment relationship, intersubjectivity, working alliance

Doubled up with pain: Applying a relational framework to the primary care provider - chronic pain patient relationship

Chronic pain is a phrase that evokes strong feelings in people. Frustration is a particularly common feeling associated with chronic pain. It is one that is familiar for both chronic pain patients and their doctors. Relationships between chronic pain patients and their medical providers are characterized by difficult feelings, including frustration, helplessness, and resentment. Furthermore, both patients and medical providers often experience these relationships as being noncollaborative, meaning that there is not a shared sense of working together to meet treatment goals. Instead, it often feels as if the patient and provider are working at cross purposes, which perpetuates feelings of frustration, helplessness, and resentment, and leaves both the patient and provider feeling stuck in this treatment relationship. When the treatment relationship gets to the point of feeling stuck, primary care doctors, often the first point of contact for chronic pain patients, refer these patients to doctors specializing in chronic pain, only to have these patients eventually referred back to them for long-term management of chronic pain.

Given that chronic pain is mainly managed in a primary care context (Matthias et al., 2010) and the relationship between the primary care provider and chronic pain patient is one that is rife with difficult interpersonal dynamics, it is important for primary care doctors to be provided with recommendations for improving this treatment relationship. Furthermore, given the emphasis on collaborative treatment relationships in relational psychological frameworks, such as intersubjectivity, these relational frameworks can teach primary care doctors how to better understand what is getting in the way of having collaborative treatment relationships as well how to improve their relationships with chronic pain patients. This paper will specifically

focus on how to strengthen the working alliance between primary care doctors and chronic pain patients using intersubjective principles. A strong working alliance is characterized by the primary care doctor and chronic pain patient dyad having shared treatment goals, clear tasks that are perceived as related to achieving those goals, and an emotional bond built from trust and a mutual sense of purpose.

Description of Chronic Pain Patient

Although chronic pain patients have idiosyncratic experiences of their pain, there are common characteristics of people who have chronic pain. Chronic pain patients are defined as patients with pain that continues past the expected healing time with three months being the distinction between acute and chronic pain (Fordyce, 1986; International Association for the Study of Pain, Subcommittee on Taxonomy, 1986). An integral aspect of chronic pain is that it is ongoing rather than temporary (Turk & Monarch, 2002). Chronic pain is a prevalent medical condition with 57% of American adults reporting that they have experienced chronic or recurrent pain (Peter D. Hart Research Associates, 2003). Physicians report that they treat chronic pain frequently (Green, Wheeler, LaPorte, Marchant, & Guerrero, 2002) with many of these physicians being primary care doctors. Basler, Grzesiak, and Dworkin (2002) have identified a number of other common characteristics of chronic pain patients. These characteristics include a reduced ability to work and engage in social activities, isolation, lack of a sense of belonging, a fear of being misunderstood by others, relational conflict, loss of relational roles, and new roles and relationships. In terms of a loss of relational roles, Basler et al. (2002) speak to the importance of mutuality in relationships and how mutuality is often hindered by the presence of chronic pain.

Primary Care Providers' Experiences of Working with Chronic Pain Patients

As primary care providers are the foremost medical providers working with chronic pain patients, it is important to understand their experiences within this context. Primary care providers (PCPs) are defined as nonspecialized general practitioners who can treat a variety of physical health conditions across the life span. Often, PCPs recognize the importance of having strong relationships with chronic pain patients (Matthias et al., 2010) and are aware of feelings that arise within these relationships that get in the way of having positive and collaborative treatment relationships. These feelings include frustration, helplessness, resentment, dissatisfaction, guilt, and failure (Matthias et al., 2010).

Many factors contribute to these feelings, with one of the central ones being that there is a lack of effective chronic pain treatment (Frantsve & Kerns, 2007; May et al., 2004). Kenny (2004) states, "Chronic pain patients fail the test of the good patient. They do not get better" (p. 302). When their patients do not get better, doctors feel inept and often guilty about not being able to help their patients in the way they feel they should given their professional obligation. At the same time, they often feel resentful and frustrated toward their patients for evoking feelings of incompetence in them. Matthias et al. (2010) speak to these feelings of ineffectiveness: "PCPs described feeling ineffective and unsuccessful in their ability to treat many of their patients with pain" (p. 1692). Primary care doctors are keenly aware of the negative feelings they direct toward themselves and their chronic pain patients and how these feelings contribute to having difficult treatment relationships with this particular population of patients. May et al. (2007) describes the bind primary care doctors find themselves in: "they saw limited therapeutic benefits in such interactions for patients, but were profoundly aware that continuous relationships in which agreement was not reached about how to understand the patient's problem

themselves risked chronicity. They framed these accounts in terms of deep frustration; they could neither solve the patient's problem, nor escape responsibility for doing so" (p. 151). This impasse stems from doctors being oriented toward curing patients' chronic pain, which they often feel unsuccessful in doing. It is valuable to consider how this bind might be resolved by shifting doctors' orientation from curing chronic pain to helping patients live with and manage their pain if a cure is not in sight.

Chronic Pain Patients' Experiences of Working with PCPs

Similarly to primary care doctors, chronic pain patients often have a negative experience of their relationships with PCPs. They report feeling frustrated and misunderstood in this treatment relationship (Upshur, Bacigalupe, & Luckmann, 2010). They further report wanting yet lacking effective treatment of their pain as well as psychological care from their doctors (Kenny, 2004). By psychological care, they mean reassurance and tenderness from their doctors (Kenny, 2004). Upshur et al. (2010) speaks to how chronic pain patients feel disrespected and distrusted by their primary care doctors. Thus, not only do chronic pain patients feel as if they are not getting the treatment they need for their pain, but they also feel as if their doctors are not allied with them in treating their pain. As mentioned earlier, one of the reasons for this felt lack of collaboration may be that both patients and doctors are focused on curing rather than managing chronic pain and chronic pain is something that is often largely incurable from a medical lens. In addition, once primary care doctors frame patients' complaints as whining, their interest in a cure diminishes. This is akin to not putting effort into making dinner when you are sure that nothing will satisfy. The opioid scandal as it relates to treating chronic pain is a reflection of both parties' desperation: chronic pain patients are desperate to feel better and primary care doctors are desperate to get these patients off their back.

The following case study illustrates the experience of one chronic pain patient. For two years I engaged in relational psychoanalytic psychotherapy with a man “Steven” who had chronic pain that he experienced as dominating his life. Steven sought medical help from his primary care doctor as well as multiple chronic pain specialists. He felt as if something was medically wrong with him and engaged in multiple surgeries to try to cure his pain, none of which were successful. His pain persisted and he expressed feelings of great frustration and disappointment toward his doctors for not being able to help him in the way he wanted to be helped. Steven’s personality was organized around his perception that connection with others was shameful and he protected himself from this shame by disavowing his needs. When his chronic pain reemerged during our psychotherapy, he and I discussed how fixating on his pain served a function for him in terms of pushing people away whom he could disappoint, including his wife and me, yet it also had costs for him in terms of getting in the way of him living a meaningful life. I welcomed the part of him that needed connection to try to change his perception that he could not participate in emotionally interdependent relationships while he was sick.

Although all patients have an idiosyncratic narrative, this case study of Steven highlights the distress chronic pain patients often feel when they experience their doctors as not being able to help them. This distress is particularly perpetuated when all parties involved in chronic pain treatment are focused on curing rather than understanding and managing pain toward the goal of helping chronic pain patients live their lives to the fullest extent possible.

Ineffective Dynamics of the Primary Care Provider – Chronic Pain Patient Relationship

The complex that primary care providers and chronic pain patients find themselves in when they are both oriented toward curing chronic pain rather than managing it results in an uncollaborative and tense interpersonal dynamic. PCPs are often aware of interpersonal

difficulties in their relationships with chronic pain patients, but do not know how to address these difficulties, particularly when they have such limited time with patients (Matthias et al., 2010). Within the framework of being oriented toward curing chronic pain, the uncollaborative nature of the primary care provider – chronic pain patient relationship is largely due to patients and providers having competing goals and treatment preferences. Patients want their pain validated by doctors by understanding the biological etiology of their pain (a biogenic stance), whereas doctors want patients to understand the role of psychosocial factors in the etiology and perpetuation of their pain (a psychogenic stance) (Esquibel & Borkan, 2014; Frantsve & Kerns, 2007; Kenny, 2004; May et al., 2004). These differing etiological stances stem from the discrepancy between patients' subjective experiences of pain symptoms and doctors' diagnostic test results (May et al., 2004). Doctors focus on a psychogenic stance once they exhaust their medical tests and treatments, as is often the case with chronic pain, and patients focus on a biogenic stance because it validates them as patients with "legitimate" pain (Kenny, 2004). Holding opposing etiological stances results in both patients and doctors feeling frustrated, misunderstood, and stuck within the primary care provider – chronic pain patient relationship (Frantsve & Kerns, 2007). Dr. Mark Friedman, a PCP who served as a consultant for this paper, describes this dynamic: "Physicians become very dissatisfied because they can't cure patients' pain. They blame patients, send them for a number of consults and tests, and sometimes to the ER to get rid of them. The patient picks up on this and feels as if their doctor doesn't believe or like them. A recipe for disaster" (M. Friedman, personal communication, 2019).

Furthermore, chronic pain patients and their PCPs often hold differing views about treatment preferences. Patients typically are aligned with the most beneficial treatment that disrupts their daily functioning the least, whereas doctors are aligned with the most beneficial

treatment regardless of the extent to which it disrupts patients' day to day lives (Frantsve & Kerns, 2007). Another major area of contention among primary care providers and chronic pain patients regarding treatment preferences is the use of opioid pain medications. Primary care doctors are often cautious to prescribe opioids due to lack of training in opioid treatment for pain, concerns about addiction, and lack of research on the benefits of opioids for chronic pain (Barry et al., 2010; Esquibel & Borkan, 2014). Given the above factors, they often experience discomfort around prescribing and managing this kind of treatment (Barry et al., 2010). The differing etiological stances of PCPs and chronic pain patients also can affect whether or not doctors prescribe opioids (Esquibel & Borkan, 2014). On the other side, chronic pain patients are often aware that their PCPs may be concerned about them becoming addicted (Barry et al., 2010). They use opioid pain medications to cope with their pain and "make living more tolerable" (Esquibel & Borkan, 2014, p. 2578). When their doctors are cautious about prescribing opioids, patients tend to interpret this caution positively when they trust their doctors (Matthias, Krebs, Bergman, Coffing, & Bair, 2014). Patients also tend to be more "positive about their physicians' decisions about opioids [when they have] a long history with these physicians" (Matthias et al., 2014, p. 841).

When primary care provider – chronic pain patient relationships are less trusting or less long-term, conflict often arises around opioids. This conflict can manifest as a "patriarchal" primary care provider – chronic pain patient relationship that "depicts patients as being on trial and places the doctor in a detective, judge, or sheriff role that is detrimental to the relationship and in conflict with providing compassionate care" (Esquibel & Borkan, 2014, p. 2580). Patriarchal treatment relationships "hinder communication and collaboration between doctors and patients, disempowering both parties" (Esquibel & Borkan, 2014, p. 2581). Trust is

sometimes a function of race, sex, and ethnicity, and mismatches in these categories can make it harder to establish a collaborative versus patriarchal treatment relationship.

Ultimately, the differing viewpoints of chronic pain patients and their primary care providers manifest as tense, uncomfortable, and uncollaborative treatment relationships (Frantsve & Kerns, 2007). Patients and their doctors compete for control in these relationships in order to maintain their identities as valid patients and competent doctors (Egglely & Tzelepis, 2001). Kenny (2004) states, “Herein lies a possible explanation as to why doctors and patients alike continue to engage in exhausting rituals that leave both parties depleted. They are struggling to maintain their identity and integrity” (p. 303). Primary care doctors’ focus on getting their patients to agree to a psychological rather than physical explanation for their pain ultimately contributes to them feeling helpless as they feel unable to help their patients psychologically in the way that they need to be helped. Kenny (2004) describes this bind: “a paradox in the communication between doctors and patients. On the one hand, doctors attribute to psychological causes pain that has no visible manifestation, yet having communicated that they believed that the patient had psychological difficulties, they felt unable to offer the psychological care that such a diagnosis warrants” (p. 301).

The Importance of Focusing on the PCP – Chronic Pain Patient Relationship

In addition to working on improving the primary care provider – chronic pain patient relationship for the sake of nurturing a more effective and collaborative treatment relationship, it is also important to focus on improving this relationship as illness management behaviors occur within an interpersonal context. Mechanic (1977) defines illness behavior as “varying perceptions, thoughts, feelings, and acts affecting the personal and social meanings of symptoms, illness, disabilities and their consequences” (p. 79). To add onto this definition, Martire and

Helgeson (2017) define illness management as “concrete, discernable behaviors that are critical for survival or improving health” (p. 601). Both illness behavior and illness management are important to take into account when understanding and managing chronic pain. They are particularly important to consider when patients engage in maladaptive illness management. Maladaptive illness management can be defined as failing to engage in behaviors that are critical for survival or improving health as well as engaging in behaviors that are threatening to survival or improving health. This category could include maladaptive coping strategies in response to chronic pain as well as allowing chronic pain to dominate areas of one’s life that one could participate in, such as interpersonal relationships. In focusing on illness behavior, Mechanic (1977) implies that maladaptive illness behavior is just as important to treat as the medical illness itself. Maladaptive illness behavior includes a tendency not to complete the medical regimen, take the pills as prescribed, track one’s pain, and so on. Mechanic (1977) cautions treatment providers against reinforcing patients’ maladaptive response patterns and suggests that they focus on guiding patients to cope adaptively with illness. Thus, a critical aspect of the PCP - chronic pain patient treatment relationship is primary care doctors working with chronic pain patients to better manage their pain. In this vein, Martire and Helgeson (2017) argue that a dyadic approach to chronic illness management has the greatest effect on patient behavior as it acknowledges the influence of close relationships on illness management. These authors specifically recommend that dyadic approaches to illness management should focus on collaborative goal setting for illness management behaviors.

Given the importance of collaborative goal setting for illness management, primary care providers should focus on managing rather than primarily treating chronic pain in the context of an ongoing provider - patient relationship (Frantsve & Kerns, 2007). Frantsve and Kerns (2007)

found that improving the quality of the chronic pain patient - provider relationship was associated with improved patient care. They highlighted that in a more collaborative and comfortable treatment relationship, patients may feel more comfortable disclosing information about their pain that is important for treatment. Furthermore, chronic pain treatment is expensive and a more effective and collaborative primary care provider - chronic pain patient relationship may save treatment costs by effectively managing patients' pain in this relationship rather than referring patients to multiple pain specialists (Frantsve & Kerns, 2007; Matthias et al., 2010). Although it might be expected that patient satisfaction is most closely related to a decrease in pain scores, patient - provider relationships perceived as helpful are actually a better predictor of patient satisfaction (Frantsve & Kerns, 2007). Frantsve and Kerns (2007) state, "These factors highlight the particular importance of research designed to examine the nature of pain-relevant interactions between patients and providers and to develop effective strategies promoting improvements in these interactions" (p. 29).

A Preexisting Collaborative Treatment Model

One primary strategy that has been used to improve the relationship between primary care providers and chronic pain patients is utilizing a collaborative treatment model, which has had varied success. The collaborative treatment model is a type of Shared Medical Decision Making (SMD) (Frantsve & Kerns, 2007). Frantsve and Kerns (2007) describe it as "the patient and physician collaboratively identify and select a treatment plan that best matches the patient's preferences" (p. 26). Using a collaborative treatment model has been associated with increased patient satisfaction and better treatment outcomes (Frantsve & Kerns, 2007).

However, there are many factors that get in the way of implementing a collaborative treatment model. These factors include concern about adding to doctors' workloads and some

physicians' belief that they should have more input in treatment decisions than patients (Frantsve & Kerns, 2007). In addition, physicians are sometimes under the impression that they share an understanding of patients' health beliefs when often they do not, suggesting that they may think that they are collaborating with their patients when they are not (Street & Haidet, 2010).

Complicating all of these factors is specific patient relational patterns that get in the way of patients seeking or receiving support (Basler et al., 2002). These relational patterns include a distrust of vulnerability and intimacy, an exaggerated need for autonomy, a need to be in the caretaking role, deficits in using social support, and the function of being in a "sick role" (Basler et al., 2002, p. 104). These various relational patterns may manifest as patients having multiple relationships with treatment providers that end suddenly, being hyper competent and autonomous, experiencing guilt around receiving support, having difficulty identifying and conveying needs, and exhibiting a conflict between enjoying being in a sick role and wanting to be more productive (Basler et al., 2002). To add yet another level of nuance, the idiosyncratic relationally influenced meaning of pain also plays into how chronic pain patients experience their pain and relate to their treatment providers (Basler et al., 2002). For example, Basler et al. (2002) suggests that some patients may experience their pain as a deserved punishment, which understandably may hinder doctors' efforts to collaborate with these patients around managing their pain.

Despite the presence of these factors that may complicate and hinder efforts to engage in collaborative decision making, there are other factors that may increase the likelihood of engaging in shared medical decision making. One of these factors is patients having longer-term relationships with providers (Frantsve & Kerns, 2007). Having more of an ongoing treatment relationship allows patients and doctors to nurture a collaborative relationship over time as well

as understand what gets in the way of their relationship being more collaborative. Primary care providers are in an optimal position to have an ongoing relationship with their patients and the ongoing nature of the PCP - chronic pain patient relationship should be leveraged to improve interpersonal dynamics within this relationship. Longer office visits are also a factor that could improve collaboration but implementing this practice may not be possible given the brief nature of primary care visits within the managed care context (Frantsve & Kerns, 2007). A third factor that is in line with improving collaboration is encouraging patients to be more active participants in the patient - provider relationship. Street and Haidet (2010) found that physicians had a more accurate understanding of patients' health beliefs when patients were more involved in the treatment relationship. Patient - provider relationships were experienced more positively when chronic pain patients felt part of the decision-making process (Upshur et al., 2010). Thus, it is important for primary care providers to foster treatment relationships in which chronic pain patients feel comfortable being more active participants as the more involved patients are, the greater likelihood of these relationships being collaborative.

Communication Training

Valuing collaborative treatment models has led to the development of communication training for primary care physicians. Eggly and Tzelepis (2001) state that the purpose of communication skills training should be to “train physicians to adopt strategies to improve the quality of their patient encounters through sharing control and adjusting their communication style in response to the needs of each encounter” (p. 332). Furthermore, Frantsve and Kerns (2007) suggest that “physicians may benefit from communication training that focuses not only on delivering patient-centered care, but also on assessing patient desire for involvement in treatment decision-making as well as eliciting patient preferences when discussing treatment

options” (p. 29). Communication skills training has been associated with improved patient-provider relationships and more effective chronic pain management (Frantsve & Kerns, 2007). Patient - provider relationships were experienced as more positive when chronic pain patients felt listened to and understood by their primary care providers (Upshur et al., 2010). An important aspect of communication skills training is that it increases physicians’ self-awareness, which allows physicians to better recognize ineffective interpersonal dynamics in treatment relationships and examine their part in contributing to these dynamics (Eggly & Tzelepis, 2001).

Although communication skills training shows promise in helping primary care providers relate to chronic pain patients in a more collaborative way, there are limitations to this type of training, particularly the overemphasis on skills. Communication skills training often overemphasizes behavioral skills and, in doing so, neglects doctors’ and patients’ subjective experiences of the doctor - patient relationship (Zoppi & Epstein, 2002). As is true for any relationship, every patient - provider relationship is unique and thus, it is not effective to apply a standardized set of skills across different relationships. Within the context of the idiosyncratic nature of the patient - doctor relationship, it is important to understand how doctors and their patients experience each other and play a mutual part in constructing their relationship (Salmon & Young, 2009; Zoppi & Epstein, 2002). Zoppi and Epstein (2002) describe the concept of intersubjectivity as applied to the patient - provider relationship: “Intersubjectivity includes the creation of shared meaning. It is the process by which we understand others and are understood by them. The degree of intersubjectivity in communication can be marked by the degree to which both parties share the same goals, thoughts, and intentions concerning their work together” (p. 320). Thus, primary care providers collaborating with their chronic pain patients on specific goals to manage chronic pain is a critical part of their work together and of having an effective

treatment relationship. A focus on collaborative treatment goals would orient patients and their physicians toward trying to understand what gets in the way of their collaborating with each other in accomplishing joint treatment goals related to managing chronic pain. Ultimately, it would set the stage for working toward improved understanding of each other.

Teaching communication as a way of relating. As alluded to above, an intersubjective approach to improving the primary care provider - chronic pain patient relationship might be more effective than a purely behavioral skills approach in facilitating a collaborative treatment relationship. Zoppi and Epstein (2002) assert, communication is “both a skill and a way of being” (p. 319). An intersubjective approach would focus on helping a primary care provider adapt to working with each particular patient (Zoppi & Epstein, 2002). This type of approach would center on understanding and honoring the unique relational dynamics of each patient - provider dyad. Zoppi and Epstein (2002) state, “So, the ideal, patient-centered care may be more determined by idiosyncratic qualities of the relationship than by either the characteristics of the individual physician or patient” (p. 323). Thus, although the chronic pain patient is still the primary patient in the relationship between the primary care provider and chronic pain patient, the treatment relationship itself becomes a critical third party within this context and much attention should be directed toward making this relationship as effective and collaborative as possible. In this vein, Kenny (2004) states, “The practice implication of this research that moves beyond the suggestions made in previous research would be to train physicians in understanding and identifying the types of problematic relationships and processes within those relationships that can develop between doctors and patients and to make them explicit with their patients, thereby providing a unique opportunity for both doctor and patient to work through the antipathies and power struggles that are antipathetic to “good medicine”” (p. 305). Similarly,

Frantsve and Kerns (2007) assert, “the time is ripe for additional investigations to broadly explore a multitude of issues that can further describe and enhance the nature of patient-physician interactions within the context of managing chronic pain” (p. 33).

Applying a Relational Framework to the PCP - Chronic Pain Patient Relationship

Nurturing a collaborative relationship between a primary care provider and chronic pain patient in order to resolve binds within this treatment relationship lends itself to the application of relationship-based treatment models. In this vein, Dr. Mark Friedman suggests that the primary care provider - chronic pain patient relationship is a “therapeutic relationship” and the curative chronic pain model should be changed to being a “therapeutic relationship model” based on a “framework of a relationship between two people” and “understanding rather than treating chronic pain” (M. Friedman, personal communication, 2019). Central to relationship-based treatment models is the concept of the working alliance. Matthias et al. (2010) describe a working alliance as a relationship that “allows patients and providers to share both an emotional bond and instrumental goals, such as partnering with one another to identify treatment objectives, and deciding together how to realize these objectives” (p. 1693). These authors suggest that PCPs need training in patient-centered communication skills that “foster a trusting working alliance between patient and provider” (p. 1693). Conceptualizing the relationship between a patient and provider as a working alliance highlights the importance of the chronic pain patient and primary care doctor working together to meet shared treatment goals. In the case of chronic pain, these shared treatment goals may revolve around how to best manage a particular patient’s chronic pain so that the patient can live his or her life as fully as possible. Thus, a working alliance can be seen as the core of having a collaborative and effective treatment relationship.

The Working Alliance

Knowledge of the working alliance from other fields can be beneficial in understanding the importance of and how to develop this type of alliance. The idea of a working alliance is well-known in the field of psychology. Bordin (1979) defines the working alliance as consisting of three main parts: “an agreement on goals, an assignment of task or a series of tasks, and the development of bonds” (p. 253). I will describe each of these elements within the context of psychotherapy. “An agreement on goals” refers to the patient and therapist coming to a consensus on the aims of their work together (Bordin, 1979, p. 253). Having mutual goals helps facilitate treatment efforts and ensures that both parties are on the same page. “An assignment of tasks” refers to an “agreed-upon contract” of concrete aspects of the work that are assigned to the patient and therapist (Bordin, 1979, p. 253). There are individualized tasks for each party as well as shared tasks for the dyad. It is important that the tasks seem like they will lead to the goals. “The development of bonds” refers to the quality of the relationship between the patient and therapist and requires “deeper bonds of trust and attachment” (Bordin, 1979, p. 254). The key here is that both parties are more likely to engage in tasks that seem like they will produce the goals if the parties feel connected to each other. Horvath, Del Re, Fluckiger, and Symonds (2011) describe the alliance as an “emergent quality of partnership and mutual collaboration between therapist and client” (p. 11). As evidenced by the above definitions, the fundamental quality of the working alliance is that it is a “collaborative enterprise” (Horvath et al., 2011, p. 15).

Psychotherapy outcome research has consistently shown that the working alliance is a primary contributor to positive treatment outcomes (American Psychological Association, 2012). There is a robust and moderate relationship between the working alliance and therapeutic

outcomes (Horvath et al., 2011; Martin, Garske, & Davis, 2000). In their meta-analysis of the relationship between the therapeutic alliance and outcome, Martin et al. (2000) found that the “strength of the alliance is predictive of outcome” (p. 446). Given these empirical findings about the importance of the working alliance, Lambert and Barley (2001) suggest that the “development and maintenance of the therapeutic relationship is a primary curative component of therapy” (p. 359). Horvath et al. (2011) assert that “alliance development is a skill and/or capacity that therapists can and should be trained to develop” (p. 15). Thus, teaching primary care doctors how to improve working alliances with their chronic pain patients would go a long way in facilitating collaborative treatment relationships.

Intersubjective Framework

Given the emphasis on collaborative treatment relationships in relational psychological frameworks, such as intersubjectivity, these theories can provide guidelines around how to enhance the working alliance between primary care doctors and chronic pain patients. Intersubjectivity is a relational psychoanalytic theory that is particularly applicable to the problem at hand as it emphasizes the mutual influence the therapist and patient have on each other. This mutual influence happens within an “intersubjective field,” which is the psychological system that the therapist and patient constitute (Buirski & Haglund, 2001; Lessem, 2005, pp. 171). In focusing on the way in which the therapist and patient influence each other, intersubjectivity places a focus on the subjective experience of both the therapist and patient. The aim of intersubjectivity is to understand experiences that arise in the context where the patient’s and therapist’s unique subjectivities interact (Atwood & Stolorow, 2014). Money is a good illustration of intersubjectivity. Whether in cash or digits in a bank statement, it has value only

because many people subjectively value it, but no one would argue that money therefore does not “really” have value. The value and meaning of money are entirely intersubjective.

When seen from the lens of intersubjectivity, healing is understood as being nurtured within a therapeutic intersubjective context. Thus, the relationship between the therapist and patient is the main aspect of treatment. The therapist creates an environment in which the patient feels attuned to and understood. This type of environment then allows for the therapist and patient to “make sense together,” or understand together the patient’s difficulties (Atwood & Stolorow, 2014; Buirski & Haglund, 2001, pp. 26; Lessem, 2005; Orange, Atwood, & Stolorow, 2009). The therapist uses his or her subjective experience to understand that of the patient and uses this understanding to attune to the patient’s affect (Buirski & Haglund, 2001). The therapist attunes to a patient’s affect in several ways, including by identifying and articulating affect and tolerating and regulating negative affect (Buirski & Haglund, 2001). Affect attunement results in the patient feeling deeply understood, which allows for the opportunity of a new relational experience (Buirski & Haglund, 2001). It also forces reworking of the patient’s narrative which has excluded emotions and thoughts and memories that the feeling of being understood now includes.

Relationship Recommendations for Primary Care Doctors

In considering how an intersubjective lens can improve the working alliance between primary care doctors and chronic pain patients, I propose the following relationship recommendations for primary care doctors broken down into Bordin’s three elements of the working alliance.

Goals. From the outset of working with a chronic pain patient, the primary care doctor should focus on building a collaborative relationship with the patient. A strong working alliance will improve the chances of the patient engaging in a cure when it is in sight. Relational bonds will

improve the chances of engaging in prescribed exercises and taking medication as prescribed. It is important that treatment goals are made explicit. At first the goal is to find out what is wrong. The switch to helping the patient meaningfully living with pain should not be done when the diagnosis switches to psychogenic, but when the doctor's bag of interventions is empty. The patient often hears, "If medical science can't cure you, it must be psychogenic" instead of, "Medical science can't cure you, so let's talk about ways of living with pain while we keep hunting for a cure." Also, the social aspects of pain should be introduced early on. This can be done by asking the patient, "Are there moments when you forget or don't notice the pain?" The doctor should introduce the goal at the start of curing the pain but also managing it.

Tasks. Having a clear understanding of the individualized tasks of the PCP and the chronic pain patient as well as the shared tasks of the dyad will also help to facilitate a collaborative treatment relationship. The key element of tasks is that the tasks are seen by the patient as relevant to achieving the goals. The tasks of the PCP are to assess the patient's pain and make a determination about the likelihood of the pain being cured and to create an environment in which the patient feels attuned to and understood. The doctor can nurture this kind of environment by listening to the patient, paying attention to and identifying his or her feelings, and tolerating his or her negative affect. This negative affect includes negative affect toward the PCP, which is likely to arise once the PCP tells the patient that he or she is not able to cure his or her pain at this time. The patient's tasks are to describe his or her chronic pain and share how it affects him or her, trust his or her doctor to help him or her, and honestly share his or her frustrations with his or her doctor. The shared tasks of the chronic pain patient and primary care provider are to discuss treatment goals and come to a consensus about the aims of their work together as well try to collaborate with each other toward the goal of helping the patient. Tasks also include doing exercises and taking medicine as prescribed. Instead of just handing

the patient a sheet of paper showing the exercise, the doctor should explain how the exercise will strengthen this muscle or take the strain off that muscle.

Bonds. Underlying having clear tasks and shared goals is the importance of an emotional bond between the doctor and patient. Trust between the primary care provider and chronic pain patient is facilitated by having the framework of an ongoing relationship to fall back upon when things are going poorly and yet there is agreement on goals and tasks. Within this framework, the quality of the relationship between the doctor and patient becomes the main aspect of successful treatment. Thus, it is critical that the primary care provider monitors the quality of the relationship. The quality of the relationship is reflected in various ways, including whether the patient comes consistently to appointments, the extent to which the patient openly shares his or her thoughts and feelings with his or her primary care doctor, and how both the provider and patient experience the relationship. The provider can use his or her feelings about the relationship as helpful data for assessing how collaborative the relationship is. The doctor should especially pay attention to experiencing the treatment relationship as tense, uncomfortable, and hostile and feeling incompetent, frustrated, angry, and dissatisfied. The key insight is that feeling annoyed should be treated like a lump in a patient's elbow, a sign that needs curiosity and understanding about what is wrong.

Furthermore, an important lesson from intersubjectivity is that the PCP's and patient's experiences of each other interact in a meaningful way, resulting in an idiosyncratic relational context. One key aspect of this relational matrix that is specific to chronic pain is the PCP's level of comfort with not curing chronic pain and the patient's perception of the doctor's level of comfort. If there is not a high likelihood of the patient's pain going away, then it is important that the PCP becomes comfortable with the idea of not curing the patient. Medical doctors often see their role as fixing patients and feel uncomfortable when they are not able to fix patients in the way they think

they are supposed to. Much medical education emphasizes success over collaboration. Collaboration should be a focus even when the goal is still a cure. As it stands now, patients are easily blamed for less-than-full disclosure when what is needed is a doctor who makes patients feel like telling the doctor what is really going on. Focusing on building a collaborative relationship will facilitate increased comfort with not curing the patient. If the doctor is more comfortable with not curing the patient, the patient will likely perceive this increased level of comfort and acceptance and the patient himself or herself will feel more comfortable with not being fixed and instead, living meaningfully with his or her pain. Ultimately, if the patient is able to feel helped despite the pain persisting, then the PCP can feel competent and the patient can feel tended to.

As the relational bond, mutual goals, and relevant tasks all interact to form the working alliance, improving one of these components can strengthen another element of the working alliance. Agreeing on treatment goals can strengthen the bond between the primary care doctor and chronic pain patient and help to clarify tasks. Strengthening the bond facilitates an environment in which the primary care doctor and chronic pain patient are more likely to come up with collaborative goals and can negotiate tasks. Having defined tasks creates a clear structure that helps both the patient and doctor feel comfortable, which strengthens the bond between them and increases the likelihood that they will come to a consensus on treatment goals.

Therefore, conceptualizing the working alliance from an intersubjective lens gives primary care doctors guidance about where to turn if their treatment relationships with chronic pain patients feel stuck and uncollaborative. The four key aspects of the relational framework I am proposing to apply to the primary care provider - chronic pain patient relationship are 1) conceptualizing the primary care doctor – chronic pain patient relationship as an ongoing relationship that can be guided by psychotherapy principles, 2) recognizing the importance of having a collaborative treatment

relationship, 3) monitoring the quality of the treatment relationship and noticing whether it feels uncollaborative, and 4) actively working on fostering one of the three prongs of the working alliance between the primary care provider and chronic pain patient to improve collaboration. Nurturing a working alliance using the above relationship recommendations will allow the patient to feel helped and the doctor to feel helpful even when the patient continues to experience chronic pain.

Summary

Within the field of primary care, treatment relationships between primary care providers and chronic pain patients stand out as being particularly problematic. In many cases, relationships between primary care doctors and chronic pain patients continue on with doctors feeling inept, guilty, and resentful toward their patients for not being able to help them and patients feeling frustrated and disappointed with their doctors for not being helped in the way they want. These treatment relationships are often experienced by both parties as being ineffective and uncollaborative. Binds within these relationships are caused by a number of different factors, including a lack of effective chronic pain treatment and an orientation toward curing chronic pain rather than understanding and managing it. These relational binds take place within the broader context of the culture of medicine and the expectations and constraints that stem from this culture. This paper is limited to an interpersonal framework for understanding and addressing these binds, but it is likely that the medical system would benefit from top-down recommendations supporting improved collaboration between doctors and patients.

Given that strong treatment relationships are associated with positive treatment outcomes and better illness management, it is important to consider ways in which primary care provider – chronic pain patient relationships can be improved. It is particularly important to focus on how to make these treatment relationships more collaborative. Relational psychological frameworks,

such as intersubjectivity, can provide insight into how to strengthen the working alliance between primary care doctors and chronic pain patients. Focusing on how to build collaborative treatment relationships rather than primarily curing chronic pain will likely result in primary care doctors feeling helpful and chronic pain patients feeling nurtured and understood. Ultimately, this would allow both doctors and patients to feel empowered when chronic pain persists. Rather than being doubled up with pain metaphorically due to difficult interpersonal dynamics, doctors would be freed up to focus on helping chronic pain patients work toward meaningful life goals despite the pain.

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