

PRACTICE BRIEFS



Chronic Pain Counseling

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ABSTRACT: Chronic pain significantly impairs an individual's physical and psychological quality of life, affecting daily activities, work, and overall well-being. Effective management requires a holistic approach, beginning with comprehensive assessment strategies and including evidence-based counseling treatment aimed at helping patients manage pain and improve their quality of life.

Introduction

Acute pain manifests abruptly as an alert to a potential disease or threat to the body, often beginning with a sharp or intense sensation (International Association for the Study of Pain [IASP], n.d.-a). It can be induced by injury, surgical intervention, illness, trauma, or distressing medical procedures, and typically endures for a duration ranging from several minutes to less than six months. Acute pain generally subsides upon the appropriate treatment or healing of the underlying cause. Chronic pain lasts for more than 6 months and extends beyond the typical recovery period associated with an injury or illness (IASP, n.d.-b). Chronic pain may be persistent or intermittent, disrupts daily activities, and adversely impacts a person's physical and emotional health.

When chronic pain causes at least one major activity restriction, it is called high impact chronic pain (Pitcher et al., 2019). In 2019, approximately 20.4% of adults in the U.S. experienced chronic pain, and 7.4% experienced high-impact chronic pain (Zelaya et al., 2020). Long-term chronic pain often results in a lower physical and psychological quality of life that can include depression, anxiety, suicidal ideation, and earlier mortality (Weissman et al., 2022). It can negatively impact work and family roles, lower earnings, increase the risk of unemployment, and increase health-care costs (Weissman et al., 2022). In 2021, a person experiencing chronic pain in the U.S. spent \$8,068 more on average on medical expenditures and lost \$2,923 in work productivity as compared to those without chronic pain (Guy et al., 2025). That same year, the economic costs of chronic pain were estimated to be \$722.8 billion, with \$530.6 billion in medical care costs and \$192.2 billion in lost work productivity.

Research has found that biological changes in the body, the mind, and a person's social environment all contribute to an individual's experience of pain (National Institute of Neurological Disorders and Stroke [NINDS], n.d.). As such, pain is a biopsychosocial experience, and chronic pain management usually requires a holistic approach that includes medical intervention, lifestyle modifications, and psychological support. Biological factors associated with pain include body injury, genetics, epigenetics, the brain, the immune system, and the endocrine system (NINDS, n.d.). Routine life stresses, lifestyle patterns, and medical diagnoses influence which genes turn on or off over a person's lifetime. Therefore, genetics and epigenetics influence how a person experiences pain, their risk of chronic pain, and their response to pain treatments. For example, research has demonstrated that epigenetic changes following regular physical activity can lower a person's experience of pain, and that chronic emotional stress can cause epigenetic changes that can increase levels of pain.

Additionally, areas of the brain responsible for the experience of pain overlap with areas responsible for the experience of emotions, sensation, motivation, attention, and memory (NINDS, n.d.). The immune system helps heal the body through inflammation processes that, when chronic, can become problematic and contribute to greater, longer-lasting pain. Stress-related hormones can increase or decrease the feeling of pain, which is why some treatment options focus on finding helpful ways of coping with stress. Psychological factors that contribute to pain include fear and avoidance; emotions, mood, and mental health; resilience; beliefs and thoughts; and social factors. Fear and avoidance can negatively contribute to pain when a person is afraid to use an injured area or engage in physical therapy after it has healed because they are worried about reinjury. This contributes to weaker muscles, poorer mood, and increased stress levels.

Chronic pain and emotions, mood, and mental health bidirectionally influence each other and can lead to people feeling anger, worry, sadness, guilt, grief, defeat, hopelessness, and frustration. Research has suggested depression, anxiety, trauma, and sleep disorders commonly co-occur with chronic pain (NINDS, n.d.). A person's level of resilience will influence their ability to use personal strengths to adapt productively to chronic pain. Further, their automatic beliefs and thoughts about pain will affect a person's experience of pain. Lastly, a person's social world including relationships, socioeconomic status, community, safety, education, and access to health care influences their experience of pain (NINDS, n.d.).

Assessment Strategies

When working with a client in chronic pain, it is important to assess the client's pain history, including the pain's impact on social, occupational, physical, and psychological functioning. There are several questionnaires and inventories that can be used to gauge a client's level of pain. This section details some of the questionnaires that are currently available.

The Brief Pain Inventory–Short Form (BPI-SF; Cleeland, 1991) is a self-administered questionnaire that assesses the severity of pain at its worst, least, average, and current levels over a specified period. The nine items are rated on a 0-10 scale. It also measures pain interference with general activity, walking, work, mood, relations with others, sleep, and enjoyment of life. It takes approximately five minutes to complete and has demonstrated reliability and validity across various populations and languages (American Academy of Family Physicians, 2021).

The McGill Pain Questionnaire (MPQ; Melzack, 1975) is a self-administered questionnaire comprising 78 words organized into 20 categories that represent different aspects of pain. The 20 categories are grouped into four main dimensions: pain, affective, evaluative, and miscellaneous. Scores are derived from the pain rating index, the number of words chosen, and the present pain intensity. The pain rating index is calculated based on the intensity values assigned to each selected word descriptor, with a possible total score ranging from 0 to 78, wherein higher scores indicate more severe pain. The number of words chosen reflects the complexity or variety of the patient's pain descriptors and influences the score on this dimension. The present pain intensity score is derived from rating pain on a scale, with 0 indicating no pain and 5 indicating the worst possible pain. The MPQ is sensitive to differences in pain relief methods and treatment effectiveness. A short-form version, the short-form McGill Pain Questionnaire (SF-MPQ; Melzack, 1987), includes 15 descriptors (11 sensory and four affective) rated on a 0 to 3 intensity scale, along with present pain intensity and a visual analogue scale (American Academy of Family Physicians, 2021).

The Multidimensional Pain Readiness to Change Questionnaire 2 (MPRCQ2, Nielson et al., 2003) measures a client's willingness to implement various pain management and coping strategies commonly used by chronic pain patients, which can help reduce treatment dropout rates. The assessment comprises 69 items organized into nine subscales: exercise participation, task persistence, relaxation, cognitive control, pacing, avoiding pain-contingent rest, avoiding regularly asking for assistance, assertive communication, and proper body mechanics (Shawcross et al., 2021). Understanding clients through

these nine constructs can help the counselor quickly identify factors that may help or hinder treatment outcomes.

The Pain Catastrophizing Scale (PCS; Sullivan et al., 1995) is a self-report questionnaire that measures catastrophic thinking about chronic pain across three subscales: rumination, magnification, and helplessness. Clients rate the frequency of 13 thoughts or feelings on a Likert scale from 0 (never) to 4 (always), with total scores ranging from 0 to 52; higher scores indicate greater levels of catastrophizing. This assessment can identify individuals at risk for maladaptive pain-related thoughts along with increased pain intensity, disability, and psychological distress, such as depression and anxiety.

The Pain Disability Index (PDI; Tait et al., 1987) measures the degree to which aspects of the client's life are disrupted by chronic pain across seven areas: family/home responsibilities, recreation, social activity, occupation, sexual behavior, self-care, and basic life-supporting behaviors (Fidler, 2022). A total score results in four levels, ranging from minimal to severe disability, to help interpret the functional impact of pain and monitor changes over time or in response to treatment.

The Pain, Enjoyment of Life and General Activity (PEG; Krebs et al., 2009) Scale is a three-item self-administered questionnaire that was derived from the Brief Pain Inventory (BPI) to assess and monitor chronic pain. It evaluates pain intensity, enjoyment of life, and general activity. It is most often used to evaluate functional outcomes and treatment effectiveness.

The West Haven-Yale Multidimensional Pain Inventory (WHYMPI; Kerns et al., 1985) is a 61-item comprehensive self-report questionnaire that assesses the multidimensional impact of chronic pain on an individual's life in three parts. Part I measures the five key domains of interference of pain in daily functioning, perceived support from a significant other, pain severity, perceived life control, and affective distress (Murphy et al., 2022). Part II evaluates the patient's perception of how significant others respond to their pain, including solicitous, distracting, and negative responses. Part III assesses the frequency of participation in everyday activities across four domains: household chores, outdoor work, activities away from home, and social activities, with a general activity score derived from these subscales. Altogether, this assessment shows the counselor how pain affects the client's daily activities, mood, and interpersonal relationships.

The World Health Organization Quality of Life-BREF (WHOQOL-BREF; WHO, 2012) is a 26-item assessment that measures self-perceived quality of life in four areas: physical health, psychological health, social relationships, and environment (Murphy et al., 2022). It is a shortened version of the WHOQOL (a 100-item assessment) that is brief, reliable, and cross-culturally applicable. It assesses an individual's perception of their life within the context of their culture, values, goals, expectations, standards, and concerns. Each of the four areas is scored on a 0–100 scale, and two additional questions measure overall quality of life and general health.

Treatment Approaches

Although counselors do not prescribe medications, they do play a large role in pain management as part of an interdisciplinary team with the chronic pain patient's prescribing medical providers (Andrews et al., 2025; Patidar et al., 2025). For example, medical providers face significant challenges in obtaining weekly patient monitoring, including current risk and psychological assessments, medication compliance, quality-of-life indicators, and providing psychoeducation to clients (Andrews et al., 2025; Patidar et al., 2025). Counselors can work with prescribing medical providers in all of these areas to better assist clients experiencing chronic pain achieve holistic treatment.

Cognitive behavioral therapy for chronic pain (CBT-CP, Murphy et al., 2014) is a time-limited, structured intervention that teaches patients to manage chronic pain and improve their quality of life by modifying thoughts and behaviors related to pain. The manual is divided into two main parts. Part I provides foundational information on chronic pain, including definitions, types, locations, treatment options,

an evidence review, case examples, and critical elements for CBT-CP implementation. Part II outlines an 11-session core protocol, with an optional 12th booster session. Each session is structured to include agenda-setting, subject-matter review, patient materials for learning and home practice, and examples of therapist scripting. The sessions cover key components such as pain education, relaxation training, activity pacing, cognitive coping strategies, pleasant activities scheduling, sleep improvement, and discharge planning. As a national initiative to promote effective mental and behavioral health interventions, the VA notes that the program has demonstrated significant clinical effectiveness (Murphy et al., 2014). Large effect sizes have been observed for people within and outside of the VA with reductions in pain catastrophizing, pain intensity, and pain interference, and in improvements in physical quality of life and depression.

Pain reprocessing therapy (PRT) recalibrates signals between the brain and body to break chronic pain cycles (Ashar et al., 2022). PRT suggests that a brain-generated false pain alarm occurs and that reexamining the causes and threat value of pain can lower or extinguish it. PRT has five main components: a) psychoeducation about the roots and reversibility of pain in the brain, b) identifying and strengthening personal evidence about the roots and reversibility of pain in the client's brain, c) using a lens of safety to identify and judge pain sensations, d) identifying additional emotional threats, and e) leaning into positive feelings and sensations. A randomized controlled trial at the University of Colorado Boulder suggested PRT was the most effective treatment for chronic pain. Ninety-eight percent of PRT patients improved, and 66% were pain-free or nearly pain-free at the end of the study (Ashar et al., 2022). PRT significantly lowered pain intensity and fear avoidance behaviors in participants.

There are times when, despite best efforts, chronic pain will be part of a person's life. Counselors can help these clients to embrace a willingness to experience pain and associated negative emotions without unnecessary struggle or avoidance while also developing present-moment awareness of what is truly important to the client beyond pain management. Acceptance and commitment therapy (ACT) focuses on managing chronic pain by increasing psychological flexibility through acceptance, cognitive defusion, being present, self-as-context, values, and committed action (Lai et al., 2023). ACT helps the individual reduce the emotional struggle associated with chronic pain by having the person be open to pain experiences without attempting to control or eliminate them. It encourages patients to accept pain as a part of life rather than viewing it as an enemy to be defeated. The committed action element of ACT involves identifying personal values and helps the person take purposeful steps toward living a meaningful life despite pain. ACT has demonstrated improvements in pain-related functioning, psychological flexibility, and quality of life observed at three-, six-, and twelve-month follow-ups (Lai et al., 2023).

Cultural and Ethical Considerations

During a 3-month period in 2019, women in the U.S. experienced more chronic pain (21.7%) and high-impact chronic pain (8.5%) than men (19% and 6.3%, respectively; Zelaya et al., 2020). The chances of experiencing chronic pain increased with age, from 8.5% for those 18–29 to 30.8% for those 65 and older. The same trend was found with high-impact chronic pain, from 2.2% for those 18–29 to 11.8% for those 65 and older. Further, chronic pain tends to be more common in populations characterized by limited economic resources, limited education level, and females, older adults, and people from historically marginalized identities (Rikard et al., 2023). Disparities in treatment options for chronic pain management are starkly evident. McDermott et al. (2023) highlighted that older adults from limited socioeconomic communities often do not receive essential psychosocial treatments for pain management, despite their heightened risk for adverse pain outcomes. The study underscored the multidimensional nature of these disparities, which span patient-provider communication, decision-making variability, and access to effective treatments.

Conclusion

Chronic pain significantly impairs an individual's physical and psychological quality of life, affecting daily activities, work, and overall well-being. It is a complex biopsychosocial phenomenon influenced by biological factors such as genetics and the immune system, psychological factors such as fear and mood, and social determinants such as socioeconomic status. Effective management requires a holistic approach, beginning with comprehensive assessment strategies that lead to evidence-based counseling treatment aimed at helping patients manage pain and improve their quality of life. Addressing chronic pain also requires considering females, older adults, and people from historically marginalized identities, as disparities in prevalence and treatment access exist across different demographic groups.

Resources

- **Cognitive Behavioral Therapy for Chronic Pain Manual:** https://www.va.gov/painmanagement/docs/cbt-cp_therapist_manual.pdf
- **Pain Reprocessing Therapy Center:** Information about PRT, as well as trainings, courses, and a practitioner directory, can be found at the Pain Reprocessing Therapy Center. <https://www.painreprocessingtherapy.com>
- **Acceptance and Commitment Therapy for Chronic Pain:** McCracken (2015) created a manual for ACT to treat chronic pain. <https://societyofclinicalpsychology.org/wp-content/uploads/2025/09/ACT-for-Chronic-Pain-manual-McCracken.pdf>

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