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What are the Most Effective Coping Strategies for Managing Chronic Pain?

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Chronic pain conditions such as rheumatoid arthritis, low back pain and fibromyalgia affect about two out of every seven Americans [1]. The responses to these conditions vary greatly between individuals, with some persons able to function relatively well and others faring more poorly. One important element determining how well a person adapts to chronic pain seems to be *coping*. The degree to which a person copes well with his/her pain helps determine adjustment and quality of life. The problem begins, however, with deciding what *coping well* means.

Coping: the Good and the Bad

It is a popularly held belief that there are demonstrably “good” ways to cope with pain and “bad ways,” or ineffective ways, to cope with chronic pain. It is common to hear some authority or other declare that some types of coping are better than others, and that patients should be doing it “this way.” We argue that not only is this not true, but that this view of coping is misleading and ultimately counterproductive.

First, we should discuss what coping is and what it is not. We prefer to use a definition like that proposed by Lazarus and Folkman [2]: coping is a person’s cognitive and behavioral efforts in response to stressors that determine how those stressors will affect physical and emotional well-being. That is, coping entails intentional efforts to mitigate the effects of stressors, and not simply any miscellaneous response that occurs. Thus catastrophizing, for example, which is an exaggerated negative cognitive appraisal in response to a stressor, while an important construct, is *not* an example of coping.

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Types of Coping

In order to better understand the range of coping efforts used by persons facing stressors, including chronic pain, a number of authors over the years have tried to categorize coping strategies. Among the coping dimensions that have been explored are: Problem-focused v. Emotion-focused [2]; Active v. Passive [3]; Cognitive v. Behavioral [4] and Approach v. Avoidant [5]. The number of dimensions seems bounded only by the imaginations of the various researchers involved. Skinner and colleagues [6] noted that they uncovered over 100 category systems of coping, and that no two of them contained the same set of categories.

The proliferation of categories, and the lack of consensus among theorists, has not stopped researchers and clinicians alike from declaring that certain types of coping are better than others. A general audience webpage article discussing problem-focused versus emotion focused coping [7], for example, concludes that “In general problem-focused coping is best, as it removes the stressor, so deals with the root cause of the problem, providing a long term solution” (p. 1). Similarly, several reviews have concluded that responding to chronic pain with “passive” strategies has been associated with poor overall adjustment [8, 9]. And Zeidner and Saklofske [10] unequivocally refer to avoidance coping as “maladaptive.” Self-help websites and magazine articles are replete with similar conclusions and recommendations. An obvious take-away is that if you are still having trouble adapting to your chronic pain “you are not doing it right.”

Assessment of Coping: The Mismeasure of a Construct?

But what is the basis for these conclusions? The assessments of coping that have formed these theories and coping categories are in fact deeply flawed. The coping instruments that have yielded the results discussed above are incredibly broad, relatively insensitive to change, often conflate coping action items with items assessing cognitive errors, appraisals (such as catastrophizing), and adjustment [8], and are psychometrically suspect. In fact, it is these flaws that probably account for any significant relationships in the literature between coping types and outcomes. For example, a passive coping item like “restricting social activities” is confounded with performance outcomes. And the general, retrospective nature of these coping assessments make it likely that some of the relationships between coping and adaptation are accounted for by third variables like depression.

A serious problem is that all of these coping instruments are retrospective in nature. Invariably, these questionnaires require the respondent to imagine or recall a stressful encounter during some period of time, such as the last few days, the last month or the last year. Retrospective reports of coping are subject to numerous biases when people are asked to reconstruct memories and to explain their actions [11]. Thus memories of stressors and associated coping actions are “biased narratives” rather than true recollections of events [12], and are influenced by the person's need to explain his or her actions, or to simply make coherent a set of poorly connected memories [13, 14]. Related to this phenomenon is the concept of retrospective bias, or “effort after meaning” [15]. That is, reports of coping with events that have already taken place may be distorted by knowledge of the resolution of the event (i.e., coping success or failure). Finally, recollections of events and one's coping

efforts are often influenced by both intervening events and contemporary moods and cognitions [e.g., 16].

It is this limited assessment methodology that has shaped our understanding of coping (rather than the other way around). Because coping instruments typically yield only a single measure at a single moment they encourage the view that coping behavior is static and trait-like. But coping is a dynamic process, changing with changing circumstances, and varying from day to day or moment to moment. Coping is also transactional; the occurrence of a coping strategy at one point in time is in part dependent on its success at a previous point in time. This dynamism is not captured by traditional coping instruments.

Coping from Another Perspective: Assessment in Near-Real Time

So what can we recommend to chronic pain patients as a way to cope effectively? Right now the best we can do is provide general suggestions, such as those provided by the American Psychological Association [17], which advises people to manage their stress, talk to themselves constructively, become active and engaged, find support, and consult a professional.

But we no longer need to be bound by the limitations of traditional coping assessment methodology. The development of daily and momentary assessment procedures, along with hierarchical statistical models to analyze the data, has provided researchers with new ways to look at coping. In particular, we can now use these methods to get a better approximation of what people are actually doing *in near real time* when faced with pain crises or stressful situations. These methodologies minimize retrospective bias and give us a more accurate picture of how people cope in context. That is, some people may experience less or more pain and may cope differently when there are other people around, or when they are at work instead of at home. We can further refine our measurements by taking into account people's dispositions, or traits [18]. This model implies that a full understanding of a phenomenon like coping with variable pain can best be understood by taking into account trait, or dispositional, variables such as neuroticism, as well as state, or situational, variables, such as coping strategies used in specific circumstances.

Preliminary studies using a momentary assessment approach were conducted by our group [19]. Patients suffering from chronic temporomandibular joint dysfunction pain were treated non-surgically, administered measures of dispositional traits (e.g., tendency to catastrophize), and then assessed four times per day using a cellphone that prompted them to respond to questions about their pain levels, their thoughts and feelings, and their pain coping efforts. We found that that momentary pain was a function of momentary catastrophization, self-efficacy, mood states, and both behavioral and cognitive coping efforts. Examination of individual records indicated that patients' pain was highly variable, and that pain coping efforts were context-dependent, with some "maladaptive" strategies (e.g., avoidant, passive strategies such as distraction) being quite useful for some people in some situations.

Similarly, Conner, Tennen, Zautra, Affleck, Armeli, and Fifield [20] examined whether a stable characteristic, in this case history of depression, influenced the effects of coping strategies on daily pain in individuals with rheumatoid arthritis (RA). They found that on higher pain days, RA patients with a past depressive episode were more likely to cope by venting their emotions and to show steeper declines in mood. In fact, venting emotions as a coping strategy and negative mood were twice as strongly associated with daily pain for formerly depressed individuals than for patients with no such history.

Concluding Thoughts

What can we conclude from this history? First, there is no “best” way to cope with chronic pain. The effectiveness of a given coping strategy is context-dependent and subject to stable traits and circumstances. So what can we do? One thing we can do is to adopt the coping assessment technology we have been using in the past several years to devise optimal strategies to actually help people cope. That is, daily and momentary assessment of pain and coping can identify what coping efforts work and don’t work for people in particular circumstances, and then coping-based treatment can be tailored to each individual in context, with those coping efforts that work strengthened and those that don’t work deemphasized. Our response, then to the question, “What are the most effective coping strategies for managing chronic pain?” should be, “Let’s follow you around for a while and find out!”

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