

ARTICLES

In Conversation With Chronic Pain: An Integrative Framework for Understanding and Treating Chronic Pain

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Chronic pain as an entity presents a challenge across many domains of life. It fails to serve adaptive or physiological functions. Beyond the exorbitant economic burden and strain on our healthcare system, chronic pain takes a heavy toll on the psychosocial and emotional wellbeing of sufferers and their relationships. As a complex biopsychosocial condition, routine treatments can ignore important variables, rendering them insufficient in relieving patient suffering. Research examining psychological management strategies for chronic pain is largely dominated by cognitive-behavioural models of therapy. Psychodynamic psychotherapeutic models have been substantially less explored. Through a relational lens, this theoretical essay explores aetiological influences of chronic pain. Consideration of the intersection of trauma, attachment, and pain then grounds an argument for a psychodynamic approach to chronic pain management.

Chronic pain as an entity presents a challenge across many domains of life. It is distinct from acute pain, ultimately failing to serve adaptive or physiological functions (Katz et al., 2015). Beyond the exorbitant economic burden and strain on our healthcare system, chronic pain takes a heavy toll on the psychosocial and emotional wellbeing of sufferers and their relationships. As a complex biopsychosocial condition, routine treatments can ignore important variables, rendering them insufficient in relieving client suffering. Research examining psychological management strategies for chronic pain is largely dominated by cognitive-behavioural models of therapy. Psychodynamic psychotherapeutic models have been substantially less explored (Williams et al., 2012). Through a relational lens, this paper will explore aetiological influences of chronic pain. Consideration of the intersection of trauma, attachment, and pain will support an argument for a contemporary psychodynamic approach to chronic pain management, specifically, using the conversational model (CM). The CM is a trauma-informed relational model of therapy (Guthrie & Moorey, 2018) grounded in neuroscience and attachment theory and is well positioned to enhance the efficacy of psychological management for chronic pain sufferers.

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Carrying the Burden

The problem of chronic pain is enormous. A global burden of disease project specified that pain and pain-related diseases are the leading cause of disability and disease globally (Vos et al., 2017). At home, 1 in 5 Australians are suffering. Placing undue strain on our economy at large, estimates suggest that chronic pain incurs losses of over \$130 billion annually (Australian Institute of Health and Welfare, 2020). Economics aside, the psychosocial and functional impact of chronic pain is arguably more costly. The physical limitations of suffering with chronic pain can be readily imagined, but the impact on one's relationships and social engagement may be more salient (Sturgeon et al., 2015). Often the functional impairments caused by chronic pain have cascading impacts, deleteriously affecting a person's cognition, behaviours, social wellbeing, and emotional life. This often distorts both intrapersonal and interpersonal aspects of one's world. One's sense of self (Morley, 2010) and the deeper intrapsychic costs of pain (Osborn & Rodham, 2010) need to be additionally recognised and considered if management standards and outcomes are to improve.

Formulating Chronic Pain: Biopsychosocial Considerations and Psychodynamic Insights

Throughout the 19th and 20th centuries, a reductionistic view informed by Cartesian dualism dominated conceptualisations of pain, whereby pain was seen as synonymous with nociception. The discovery of descending modulation (Wall, 1967) and early biopsychosocial models of pain (Engel, 1977; Loeser, 1982; Waddell et al., 1984) triggered a shift from a biomedical conceptualisation of pain, beyond consideration of mere tissue damage, to one which respects the role that cognition, emotions, attention, and meaning can play (Turk & Flor, 1999). These top-down processes interact dynamically with incoming sensory information to inform one's pain experience. Sociocultural and developmental contexts equally influence nociceptive circuitry through both cognitive appraisal and biological mechanisms (Gatchel et al., 2007). Although present in acute pain, these physiological, psychological, and sociocultural variables are of greater importance in chronic pain phenomena, impacting both vulnerability to the development of chronic pain and treatment outcomes (Kleinman et al., 1992; Meints & Edwards, 2018; Turk, 2003).

Despite contemporary biopsychosocial definitions of pain, psychodynamic determinants and mediators of the pain experience are often not considered. Interpersonal trauma is profoundly associated with biological dysregulation and allostatic overload leading to compromised autonomic, immune, and neuroendocrine responses (Danese & McEwen, 2012; Gerbner & Gerbner, 2019). Ordinarily, these biological systems function to restore homeostasis in the face of pain-inducing experiences. Equally, chronic stress and hyperarousal fostered in the context of early trauma impede somatic, cognitive, and affective responses (Adshead & Guthrie, 2015). Management frameworks need to

consider different biopsychosocial processes, including often neglected early developmental and environmental experiences which exert their modulatory influences on nociceptive circuitry.

If chronic pain does not linearly reflect the state of our tissues and is not solely (or at all) driven or maintained by our biology, then what is a chronic pain experience reflecting? At the turn of the 20th century, psychoanalysts began to link psychological conflicts with physical experiences, where physical symptoms were considered as a possible form of neurotic conversion attributed to the psyche (Bräutigam & von Rad, 1977). The understanding of psychosomatic disorders has since evolved from this work. The notion of somatisation refers to the process by which unexpressed or unprocessed emotional conflicts manifest as somatic difficulties, with chronic pain being a common presentation. It would be inaccurate to assume that chronic pain is synonymous with somatisation, but there is a high correlation between the two entities. More broadly, the psychodynamic literature reveals many possible formulations for psychologically grounded chronic pain. Among others, chronic pain has been suggested to reflect a latent expression of attachment needs (Meares et al., 2008), driven by unassimilated stored traumatic memories (Mazzola et al., 2009) or reflective of somatoform dissociative processes (Van der Hart et al., 2004). Some have argued that chronic pain may present as a confusion of one's internal psychic and somatic worlds (Bob, 2008), a form of communication, or reflective of a person's self-concept (Smith & Osborn, 2007).

Ultimately, psychodynamic insights value a multitude of interpersonal and intrapersonal forces shaping the dynamic state of an individual's *bodymind* and their pain experience. A person's unique relational experiences, their environment, intrapsychic processes, and attachment behaviours informed by their trauma history may be at play. As with many psychosocial variables, relational experiences mediate vulnerability to the development of chronic pain and largely inform coping mechanisms and consequent impairment. For many, these are the primary interactive determinants of the aetiology, course, and management of pain (Basler et al., 2014). Contemporary clinical approaches commonly do not reflect these psychodynamic understandings. This may be due to residual mind-body dualism processes in our healthcare systems, and practitioners being uneducated about the distinction between chronic and acute pain (Jimenez, 2019). Treatment has become overly simplistic, falling short of addressing these psychodynamic dimensions and the idiosyncratic meaning of chronic pain. With a psychodynamic lens, a deeper and truly biopsychosocial understanding can emerge for both client and therapist.

A Protective System Gone Awry: Linking Pain and Trauma

Butler and Moseley (2014), leaders in the pain field, advocated for a paradigm shift in the communal psyche about the true meaning of a pain experience. Since then, a move away from conceptualising pain as a pure reflection of tissue damage has gained momentum, and a scientifically

grounded understanding of pain as a protective signal is permeating the clinical community. Chronic pain does not serve a protective function but is the result of a miscalculation in our system, which perceives that we are not safe. We know that trauma disrupts one's felt sense of safety, and the correlation between trauma history and chronic pain has been well established (Häuser et al., 2011). Psychopathology develops in the face of a person's inability to inhibit their defence system despite the presence of safety (Porges, 2011). It is possible that this same process is at play in the development of chronic pain.

Kolacz and Porges (2018) propose a pathophysiological mechanism to explain this relationship. Polyvagal theory explains our evolutionary responses to safety and perceived threat through autonomic functions, ultimately serving to try to restore and maintain homeostasis (Porges, 2011). These neuroceptive functions are highly integrated with nociceptive signalling via feedback loops (Cortelli et al., 2013; Hohenschurz-Schmidt et al., 2020) and anatomical overlap of brain centres which process pain, fear, and anxiety (Elman & Borsook, 2018). Ultimately, trauma causes a chronically compromised state in which one's system continues to perceive threat even after it is gone. This could make a system vulnerable to the development of chronic pain (Hill, 2019) and maintain it through disinhibited or facilitatory modulatory responses to environmental and psychosocial stressors and/or the pain symptoms themselves.

A Relational Perspective: Attachment Theory and Pain

The importance of an affective maternal-infant bond is recognised by Bowlby's attachment theory (Bowlby, 1988). This bond provides a secure base from which a capacity for trusting relationships, exploration, and emotional regulation develops (Haliburn, 2017). It can be argued that the development and maintenance of pain states is closely related to the reciprocal influence of pain and attachment style (Porter et al., 2007). A substantial body of literature explores attachment styles and their mediating impact on psychological appraisals and reactions to pain specifically (Pfeifer et al., 2018; Romeo et al., 2017). Built on the work of Kolb (1982), Mikail et al. (1994), and Anderson and Hines (1994), the attachment diathesis model of chronic pain (Meredith et al., 2008) lays the foundation for recognition of the interpersonal dimensions of chronic pain. Cognitive processes such as hypervigilance, anxiety, depression, and catastrophising can occur alongside an insecure attachment style (Wong et al., 2014).

Additionally, lower self-efficacy common to those with insecure attachment styles is a strong predictor of pain intensity and pain-related disability (Meredith et al., 2006). Avoidant attachment styles can impact health-seeking behaviours, rendering those impacted unable to benefit from the buffering potential of social support (Maunder & Hunter, 2001). In contrast, secure attachments can serve as a buffer for pain-related distress, self-efficacy, and resilience (Porter et al., 2007), reflecting the socioemotional regulatory capacity afforded by this relational style. This is achieved through the mesocorticolimbic dopaminergic reward system having positive impacts on

both biological and behavioural levels, through effects on the hypothalamic-pituitary-adrenal (HPA) axis and the sympathetic nervous system (Luyten & Fonagy, 2020). Research centred around the impact of attachment style on pain coping has lent itself to cognitive-behavioural treatments, which aim to change coping mechanisms and behavioural responses through cognitive learning.

The attachment system impacts more than cognitive appraisals and behaviours relating to pain and serves as a vulnerability factor (Luyten & Fonagy, 2020). It determines our regulatory strategies. A secure attachment style, developed through experiencing an appropriately nurturing, empathic, and sensitive relational environment (Bowlby, 1988), will enable the maintenance of one's psychophysiological equilibrium (Schore & Schore, 2008). In turn, a lack of attuned nurturing in the attachment environment leads to insufficient regulatory capacities (Chauhan et al., 2014; Karr-Morse, 2012). Maunder & Hunter (2001) suggest that a preoccupied attachment may lend itself to a sense of vulnerability and vigilance, such that normal physiological interoceptive processes are perceived as threatening. One's capacity for self-regulation likely contributes aetiologically to chronic pain phenomena and can largely influence the intensity of one's pain experience (Solberg Nes et al., 2009). Social and environmental stressors which shape an insecure or disorganised attachment system can trigger parallel adverse neurophysiological mechanisms seen in chronic pain states. Dysfunction of the HPA axis (Guilliams & Edwards, 2010; Heim et al., 1998), opioidergic signalling, and dysfunction of the immune system (Sachs-Ericsson et al., 2009) are neurophysiological changes which impact nociceptive circuitry and are changes seen in response to early life stress, trauma (Burke et al., 2017), and poor attachment experiences (Diamond & Hicks, 2004). Additionally, certain attachment states can impede threat processing by the amygdala (Opendak et al., 2017). As a key part of the limbic brain, the amygdala plays similar roles in response to chronic stress and chronic pain (Abdallah & Geha, 2017), tending toward hyperactivity and playing a part in disinhibition of nociceptive signals.

Common Therapeutic Paradigms

Cognitive behavioural therapy (CBT) is the most widely utilised psychological treatment for clients experiencing chronic pain, despite research suggesting weak to modest evidence for its positive effect (Morley et al., 2013; Niknejad et al., 2018; Williams et al., 2012). Although the term CBT is applied to a variety of treatments used in chronic pain management, they are not historically relationally orientated (Safran & Kraus, 2015). Many are largely dependent on top-down higher order processes to change arousal-driven, cognitive-behavioural responses such as hypervigilance, catastrophising, fear-avoidance, and anxiety. As a number of these variables can also be understood in physiological terms and relate to one's fundamental sense of safety and pain experience, it is worth considering some contemporary trauma-informed models of care. Emotional awareness and expression therapy (EAET) has shown encouraging results in those with chronic pain (Burger et al., 2016;

Lumley & Schubiner, 2019; Maroti et al., 2021), having demonstrated greater reductions in pain severity than CBT (Yarns et al., 2020). Mindfulness-based stress-reduction (MBSR) programs have been shown to positively impact physiological activity (Ditto et al., 2006) and may reduce pain intensity and improve physical functioning in clients with chronic pain (Anheyer et al., 2017). Eye movement desensitisation and reprocessing (EMDR) therapy has also been shown to support physiological regulation (Sack et al., 2008) and has been successfully applied for clients experiencing chronic pain (Gerhardt et al., 2016; Marcus, 2008). Considering the substantial proportion of chronic pain clients with concomitant trauma histories, traditional models of CBT seemingly fall short compared to other approaches in addressing the autonomic processes active in chronic pain populations.

Theories espoused by the likes of Hughlings Jackson suggest that traumatic insults lead to a dissolution of higher order functions reflected in disrupted streams of consciousness (Meares, 1999). These theories have been affirmed by contemporary neuroscientific understandings of the hierarchical organisation of the brain (Bassett et al., 2008) and the observed disruption to cortical function in those who have experienced trauma (Bidzan, 2017; Krause-Utz et al., 2017; Paret et al., 2016). Many of these corticolimbic circuitry changes parallel findings seen in clients suffering from chronic pain (Ong et al., 2018; Vachon-Preseu et al., 2016). Chronic pain, trauma, and dissociative experiences are highly correlated (Duckworth et al., 2000), with a high incidence of post-traumatic stress disorder (PTSD) co-occurring with chronic pain (Seng et al., 2006). It is worth questioning whether engagement of cortical areas with CBT to modify reactivity and cognitive coping skills is the most logical technique for chronic pain sufferers experiencing dissociative phenomena.

Trauma-focused CBT (TF-CBT), on the other hand, is considered the gold standard treatment for PTSD sufferers (Lee et al., 2016). TF-CBT treatments often include prolonged exposure to traumatic memories, psychoeducation, and cognitive restructuring of trauma-related dysfunctional beliefs (Fischer et al., 2021). TF-CBT can improve PTSD symptoms, dissociation, and behavioural problems, and may improve affect regulation, self-concept, and interpersonal relationships—all variables which likely compound chronic pain challenges (Hébert & Amédée, 2020). Unfortunately, no current studies have examined the application of TF-CBT in chronic pain populations specifically.

A Proposal for a Relational Model

CBT can improve quality of life, decrease disability, and psychological distress, but it is worth questioning whether this is due to theory-specific mechanisms (Burns et al., 2012, 2022) or common factors (Burns et al., 2015). As described above, poor relational patterns developed in the early caregiving environment can lead to dysfunctional coping mechanisms and limited regulatory strategies. Ultimately, these perpetuate the intrapersonal and interpersonal challenges associated with chronic pain. It is both the relationally mediated vulnerability to chronic pain and the relational consequences of

chronic pain that can benefit from a psychodynamic model of care (Basler et al., 2014). Further, insecure and disorganised attachment styles are over-represented in chronic pain populations (Meredith et al., 2006), which warrants the consideration of attachment-informed treatments (Meredith et al., 2008; Pfeifer et al., 2018; Porter et al., 2007). Basler et al. (2014) contended that “relational variables have been underused as a resource that can be harnessed to maximise treatment response and the alleviation of suffering [in a chronic pain population].” (p. 95). A relational approach may be able to restore more effective social support, decrease sufferer’s identification and reliance on the “sick role”, improve healthcare interactions, and ultimately mitigate the interpersonal stressors which compound the pain sufferer’s experience (Basler et al., 2014). Importantly, a relational therapy which capitalises on interpersonal physiological phenomena through a focus on empathy, affect regulation, and synchrony may be able to better regulate autonomic dysfunctions (Kleinbub, 2017) in this client population.

An Overview of the Conversational Model

The CM, as coined by Hobson (1985), is a wholly relational model of psychodynamic psychotherapy. Its relational emphasis reflects a more contemporary psychodynamic model of therapy having evolved away from traditional psychoanalytic thought. It is an integrative theory, incorporating the likes of Kohut and self-psychology, neuroscience, trauma theory, as well as Bowlby’s attachment theory. Initially formulated to treat clients with borderline personality disorder (Stevenson & Meares, 1992), the model has a more general application (Meares, 2004), validated for treatment of depression, functional disorders (Guthrie et al., 1991; Shapiro et al., 1994), and self-harm (Guthrie et al., 2001). Winnicott emphasised Freud’s notion that the therapeutic relationship is both a basis and a means of treatment (Courtois & Ford, 2013), which has been absorbed by the CM. The creation of an authentic, reciprocal relationship is pursued through the therapist’s attuned application of the CM principles including empathic listening, representing, amplifying, and resonating (Haliburn, 2017). The CM aims to utilise essential relational elements of human connectedness to explore and transform maladaptive coping patterns and behaviours, unexpressed affect, and emotional experiences. Particular attention is paid to the nonverbal and verbal forms of communication, encouraging the use of symbolic language to expand reflective self-awareness and explore the client’s internal world. The goal is to allow a dualistic form of self, one with the capacity for reflective awareness, to emerge and then traumatic memory systems can be integrated (Meares, 2005).

The Conversational Model, Self, and Pain

The CM has adopted a Jamesian notion of *self* to reflect a stream of consciousness (Barkham et al., 2017) that contains an affective core of value (Stevenson & Meares, 1992). The *self* is a property that emerges in relationships, and pathologies of self may be seen alongside pathology or disease. One’s sense of self may be the pathway connecting the physical and

psychological dimensions of chronic pain (Smith & Osborn, 2007). Interestingly, the medial pain system, which is responsible for affective and motivational aspects of a pain experience, is inextricably linked with processing systems involved in feelings, meaning making, and, in turn, self (Meares et al., 2008). Development of self is impeded when our sociocultural and environmental contexts do not provide adequate nurturing and attunement from our early caregiving relationships. As described above, these experiences are common in chronic pain sufferers. A self-system lacking the dualism, vitality, and agency espoused by the CM may contribute a certain vulnerability to the development of chronic pain. Additionally, the experience of chronic pain has the potential to impact all intrapsychic and interpersonal qualities of one's self-concept through the relentless challenges posed to one's identity and self-worth (Smith & Osborn, 2007). For these reasons, application of a contemporary psychodynamic psychotherapy such as the CM, designed to foster growth and the integration of self, is warranted in a chronic pain population.

Safety and Regulation

Remembering Porge's theory of neuroception (2011) and how this relates to pain phenomena, a primary goal of any pain management model would be to seek the establishment of safety, particularly in the therapeutic space. Psychodynamic interpersonal therapies can trigger neurophysiological safety responses and remove threat cues that have perpetuated chronic allostatic overload (Kolacz & Porges, 2018). A CM therapy, grounded in attachment theory, aims to recreate a therapeutic dyad reflective of the protoconversation in which the therapist's attunement, empathic resonance, and affective focus actively seek to create a secure base for the patient (Meares et al., 2012). It is attunement to both verbal and nonverbal aspects of the exchange and the "minute" particulars (Barkham et al., 2017) that can allow for the therapist to help support the patient's psychobiological regulatory strategies (Gill, 2009). Through harnessing the forces of interpersonal neurobiology, CM techniques encourage activation of the social engagement system which inhibits sympathetic activation (Porges, 2006; Riess, 2011), in turn positively impacting nociceptive circuitry. Scaer (2001) argued that chronic pain treatments should aim to address conditioned autonomic responses driven by trauma histories. A trauma-informed model of care such as the CM works to create an embodiment of a felt sense of safety and with this, homeostasis could be found in previously dysregulated autonomic systems in pain.

A Brief Vignette

Working primarily as a physiotherapist for the last 10 years, I have treated people from many different demographics and have consulted on a wide variety of acute and chronic pain presentations. Learning about the CM has undoubtedly changed my clinical practice. My attention has shifted from enquiring about symptoms to trying to understand each person in front of me. With this changed perspective, I have experienced a profound change in

the way I connect with my patients and the way they connect with me. As a result, I am involved in interactions which go much deeper than a traditional somatic therapy ordinarily would. Below is a brief vignette. To highlight my observations of the application of CM techniques in my work and for purposes of confidentiality, this is a composite case. Names and other identifying information have been changed.

Kay, a 53-year-old Canadian woman, booked in to see me on a Tuesday afternoon. My receptionist informed me that Kay had been reluctant to see yet another practitioner as she had consulted multiple specialists, physiotherapists, chiropractors, and alternative medicine practitioners over the years, yet no one had been able to provide any relief. Kay had experienced 25 years of relentless pain, which had moved around her neck and back, but was consistently in her pelvis and left hip. The pain had rendered her unable to hold down a job or socialise to any fulfilling degree.

Conscious of demonstrating my commitment and respect, I went to greet Kay in the waiting room promptly at 2pm. She was sitting stooped, looking blankly at a nonspecific spot on the floor. I introduced myself and welcomed her into my room. She was slow to respond, but picked up her bag which was tucked in tight next to her, pushed through her thighs to stand, and walked gingerly toward the treatment room. Her body and movement were already trying to tell me something. Once we were both seated, I opened our conversation with my usual line, “I wonder how I can help”. She glanced up at me with a doubtful and almost judgemental expression, suggesting that my offer felt meaningless.

Actively trying to meet her feeling state I acknowledged that I’d been told she had had a long road and must be exhausted from seeking treatment. She mustered a sarcastic laugh, and said, “You have no idea, and I don’t know why I’m even bothering”. I responded tentatively, sensing that I was wrong to presume. “You’re right, I don’t know what you’ve been through, but I would love to try and understand”. She reluctantly began describing her story. Her descriptions were filled with bitterness and a sense of defeat, as she listed the ways in which her pain had restricted her. There were hints of a trauma history with her offhand commentary around needing to take an extended sabbatical from work, and fleeting reference to a tumultuous teenage life. But more than this, Kay seldom made eye contact and held her limbs stiffly, close to her torso, as if she was half-frozen. I did not believe this was only because of our interaction but wondered if this was the way in which Kay always existed. I was conscious of my body language, trying to sit back and exude a sense of calm, but being careful to ensure I demonstrated my engagement and interest. I interjected where I could, aiming to reflect on the emotional core of what Kay was sharing with me. It had been hard. She felt it was hopeless. And she was totally and utterly consumed by her pain, so much so that I had no sense of who Kay was without it.

I empathically expressed that I wanted to work with her to see what we could do. I had helped many people like Kay, but I could feel myself internalising the doubt and weariness that she was projecting into the space between us. Was I capable of helping her? As always, after the subjective assessment I offered an objective assessment, the process through which my hands felt the tone of her muscles, observed her movement patterns, and gained a sense of how her body coordinated itself. It was easy at this point for me to succumb to an automatic process, but I was acutely aware of trying not to leave her feeling as though I was simply going through the motions. I needed to stay connected and support the rhythm of a conversation, but this was challenging as she was not offering much. As my hands examined various parts of her body, she appeared bored, or perhaps dazed, I wasn't quite sure. As her pain on presentation centred around her pelvis, I proceeded to gently place my top hand along her left iliac crest and simultaneously cupped my hand around the femoral head of her left hip joint. She instantly recoiled, her respiration increased, and she started to perspire. Her autonomic nervous system had been aroused. I removed my hands albeit with slightly too much urgency, as I noticed my system responding to the change in energy in the room. I was mindful to stay regulated and offered an observation: "It seems as though this part of your body is trying to protect you." She briefly looked straight at me with a blank expression on her face, but this was the first time since our session began that our eyes had met. It did not last long, but I tried to capitalise on the moment and said, "I don't presume to understand what you've been through, but pain is often our body and mind just trying to keep us safe". She glanced at me again briefly, covered her face with her hands and broke down. As she sobbed, we sat quietly on the plinth together and allowed space for her to express her feelings.

With a focus on empathy, affect, and the "minute particulars", noting the detail of more than the content of our conversation, but also the "how", I was able to meet Kay in a way she had seldom experienced. Our first session became a foundation on which a particular form of intimate human relatedness could emerge, where emotional moments, moments of "aliveness" were shared and experienced between us. Our work together continued for many months and, as is the nature of a therapeutic relationship, it constantly evolved and traversed the full spectrum of relational dynamics. I learnt more about Kay, her body, and intimate details of horrific childhood experiences, broken relationships, and ongoing struggles with addiction. Kay learnt that her pain had a purpose. She connected with the idea that her body and mind were trying to protect her, and this changed its meaning. She slowly began to reframe the experience. Her pain lessened. She was better able to cope with flare-ups and was less reliant on pain medication. Alongside this, Kay's bitterness and tendency to withdraw became less frequent. I believe this was reflective of a more dynamic and vital self, one that could still exist alongside the pain.

Conclusion

Pain, in common with our relational matrix, is a deeply personal and unique experience, and any model of psychological management needs to reflect this. This treatise has posited an additional conceptual layer to the traditional biopsychosocial conceptualisation of chronic pain phenomena. Through both the behavioural and regulatory implications of insecure attachment and traumatic experiences, relational dimensions are powerful aetiological influences on chronic pain. The relative absence of psychodynamic models of care in this client population has meant that often these key variables are ill-considered and are not maximised to support a return to homeostasis and the downregulation of nociceptive circuitry. Through actively creating and building a secure therapeutic space and the power of a positive attuned relationship, the CM is well positioned to tackle the intrapersonal and interpersonal forces which perpetuate and compound chronic pain experiences. This theoretical paper offers sound support for the application of the CM for clients experiencing chronic pain. Equally, the application of a psychodynamic framework and CM techniques could significantly support traditional manual and somatic therapies in this space. Despite some methodological challenges due to the nature of psychodynamic models of care (Aveline, 2006), future research should aim to evaluate the effectiveness of this model for chronic pain management.

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