Patient education is a critical component of shared decision making necessary for successful treatment of chronic non-cancer pain, yet is often overlooked. While patient education may seem like a time consuming task, the benefits gained will be numerous. Engaging patients in discussion to better understand their pain condition helps them make informed decisions about different treatment options. An informed patient is more likely to follow through on the treatment plan leading to better outcomes. Education can also reduce patient anxiety and uncertainty that often accompany treatment of chronic pain.

**General Components of Patient Education for Chronic Pain:**

1. **Nature of the patient’s specific pain problem.**
   - Ask patients to describe what they believe is causing their pain. Patients may have false beliefs about what is causing their pain, causing fear and anxiety which may prevent active participation in treatment.
   - Patients may feel their pain complaint is minimized by family and healthcare providers when the underlying cause of pain cannot be readily identified.
   - Explain to the patient their specific pain diagnosis but also explain pain in terms of the type of pain e.g., neuropathic, inflammatory, musculoskeletal, and visceral. Patients taking opioids chronically may have an element of opioid-induced pain.

2. **Acute versus persistent pain.** It is easy for patients to understand acute pain: an injury occurs, pain is treated with the usual medications and treatments, and it goes away as the body heals. It is not so easy to understand the complex nature of chronic pain. It often helps patients understand chronic pain if you explain the conditions that impact or prolong the pain experience, including:
   - Presence of a chronic, painful medical condition, particularly inflammatory conditions
   - Damage to the nerves that transmit pain; damage can arise from the disease (e.g., diabetic neuropathy), medical treatment (e.g., radiation neuritis), or from rewiring in the brain (neuroplasticity). A good analogy for neuroplasticity is a radio volume switch stuck on high; the body’s pain signals are stuck on high, firing long after the injury has healed. The pain nerves become irritable and may fire spontaneously causing greater intensity, duration, and location of pain over time.

3. **Pain as a multi-system experience.** The amount of pain experienced does not necessarily relate to the amount of tissue damage sustained.
   - Talk to the patient about the relationship between physical and mental health issues.
   - Help the patient understand that the pain experience is influenced by past experiences, social and cultural influences, spiritual beliefs and environmental factors.
   - Psychological factors, such as the situational and emotional factors that exist when we experience pain, can profoundly alter pain perceptions. Review [Psychosocial Complexities of Pain](#) for a more detailed discussion of the psychosocial variables that impact pain and pain treatment.
4. **Multimodal pain treatment**

- Patients must understand that multimodal treatment is more than just pharmacologic management. Successful management of chronic pain requires a multimodal approach that includes:
  - Medical management – medications, injections, or other medical interventions
  - Rehabilitation – exercise/activity to improve function
  - Psychological Management – active participation in care, improving self-management and gaining control over their pain or things that make their pain worse.

- All patients should be instructed to engage in wellness activities focused on good nutrition and weight management, improving sleep, and smoking cessation if applicable.

- Two patient handouts are available on the Opioid Guideline LibGuide: [A Guide to Managing Your Chronic Pain](#) and [Balancing Treatment to Improve Function: Chronic Noncancer Pain](#)

Patient education begins with the initial patient evaluation and continues with each patient encounter. Written materials can support your efforts to educate patients but are not a substitute for direct patient-to-provider discussion in the clinic.

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References and suggested further reading:
