

# A Pain Management Primer for Behavioral Health Providers

Behavioral health does not pay enough attention to pain because pain is not viewed as a community mental health problem. Pain is seen as associated with physical illness or injuries and therefore regarded as “somebody else’s problem.” When pain comes up at all it is often regarded, correctly or incorrectly, as a manifestation of drug-seeking behavior.

Pain is a daily reality in the consumer community, and a mental health issue. It affects how consumers respond to treatment, how they follow-through with treatment as well as the effectiveness of treatment. It may

trigger relapse, crisis, suicidality, and hospitalization. It is a factor in self-medication and other substance misuse and abuse. It impedes recovery and wellness.

Over the past few years, MCES has added pain assessment and pain management to its clinical focus. We have found that both acute and chronic pain are routinely present among many whom we serve. Here we share some of what we have learned about the nature of pain and pain management, and dealing with opioid use and misuse among those with and without chronic pain.

## Pain Management Fundamentals

### ***A Pain Typology***

From a behavioral health perspective, pain can most readily be understood in terms of the following classification:

Physical Pain - “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” International Association for the Study of Pain (IASP)

Psychological Pain - Severe pain, with no specific physical complaints, that originates in cognitive and emotional processes caused by emotional trauma, such as loss, and by depression and other psychiatric disorders. This differs from “psychogenic pain,” physical pain rooted in psychological problems. It is not the same as pain disorder.

Acute Pain - An unrelieved non-pathological condition comprising normal neural functioning signifying actual or potential physical or psychological trauma, lasting less than three months. This type of pain typically indicates the presence of physical injury or trauma. It may accompany healing and is often present in post-operative situations. It usually can be readily managed and passes as the source is resolved.

Chronic Pain - An unrelieved pathological, dysfunctional, physically and psychologically debilitating condition lasting longer than 3 months. This type of pain affects quality of life on a day-to-day basis. It can occur anywhere in the body, and can range from being mildly annoying to unbearable. It may originate with an identifiable condition, but it often persists to the point where it becomes the main problem. This form of pain may also be further divided in terms of being malignant and nonmalignant (i.e., caused by cancer).

### ***Common Causes of Pain***

The most common causes of acute physical pain include: an injury (such as a fracture, puncture, or laceration); pressure by a growth (e.g., tumor) on organs, nerves, or bone; side effects from procedures such as chemotherapy, radiation, or surgery; blockage within the body; the dysfunction of an organ, such as an infection or inflammation; and, muscle aches from physical inactivity or overuse.

Various disorders in major bodily systems may cause or contribute to chronic pain. Some common musculoskeletal disorders related to chronic pain include Osteoarthritis/

## Common Causes of Pain (continued from pg. 1)

degenerative joint disease (DJD)/spondylosis, Rheumatoid arthritis, Lyme disease, disk herniation, and Fibromyalgia. Neurological disorders involving chronic pain include neuralgia, postherpetic neuralgia (shingles), reflex sympathetic dystrophy (RSD), spinal stenosis, and temporomandibular joint (TMJ) dysfunction. Urologic disorders include chronic urinary tract infection, cystitis, and prostatitis. Gastrointestinal disorders such as gastroesophageal reflux, peptic ulcer disease, pancreatitis, chronic intermittent bowel obstruction, colitis, diverticular disease, inflammatory bowel disease, and irritable bowel syndrome are often accompanied by long-term pain. Other chronic pain-related conditions are cardiovascular disease (e.g., angina) and peripheral vascular disease. Chronic pain is also a characteristic of Sickle Cell Anemia.

## Basic Pain Management Principles

The World Health Organization (WHO)  
Three-Step Analgesic Ladder

Use, as appropriate, aspirin, acetaminophen, or non-steroidal anti-inflammatory (NSAID) drug with mild to moderate pain (Step 1).

Use an opioid when pain persists or increases (Step 2).

Use increased opioid potency or dose if pain continues or becomes moderate to severe (Step 3).

- Use the least invasive routes, simplest modalities, and the most basic dosages initially.
- Use a regular dosing schedule (i.e., “by the clock” not PRN) to maintain a drug level to prevent recurrence of pain. (Can be done with acetaminophen, NSAID, etc or narcotics.)

The following represent techniques that providers may most likely come across among consumers.

## Pain Management Methods Encountered in Behavioral Health

### Pharmacological Modalities

- Oral Administration – Analgesics in tablets and liquids taken by mouth.
- Transdermal Administration – Analgesic patches applied to the skin
- Intramuscular Administration - Intermittent analgesic injection

### Physical Modalities

- Heat and Cold Applications
- Massage, pressure, vibration
- Exercise, stretching, repositioning, and immobilization

### Psychological and Psychosocial Modalities

- Relaxation and imagery; yoga
- Cognitive distraction (e.g., watching a movie, playing a video game, or reading) and reframing
- Patient education about pain management
- Psychotherapy and structured support addressing the emotional facets of pain
- Mutual self-help pain management support groups

## Mental Wellness, Pain, and Recovery

By Mary Ellen O'Donnell, RN, MSN, MEd

Severe pain is a characteristic of depression and other disorders. Pain and depression are linked. Pain causes depression and depression causes pain. Many patients with chronic pain also suffer from clinical depression related to their pain, and most experience some mood changes. Depression makes the effects of pain much worse. The overwhelming majority of individuals with clinical depression initially see their primary care physician with complaints of physical symptoms, including pain.

In addition, many consumers may contend with chronic pain arising from the co-morbidity of having both physical and psychiatric illnesses. Poor overall health care is all too commonplace among the seriously mentally ill. Undiagnosed or undertreated physical health problems may lead to the onset of chronic pain syndromes that in turn aggravate

their psychiatric problems. Misuse of alcohol and other substances can often be self-medication for untreated or poorly controlled pain.

Severe pain fosters anxiety, sleeplessness, fatigue, depression, and anger. These factors modify and aggravate the pain. They elicit changes that increase stress, which further drives pain. Severe pain is disruptive of any therapeutic regimen and destructive to mental wellness. Optimal individual functioning, effective coping, self-sufficiency, and taking responsibility for one’s care are the essence of mental wellness, but chronic pain keeps them from taking hold.

Worsening pain attacks self-control and self-esteem. It generates fear, panic, and powerlessness. It creates a sense of profound isolation. Untreated chronic pain may overwhelm coping and leave helplessness and hopelessness in its wake. These may lead to suicidality.

Pain is not only an obstacle to recovery, it is actually antithetical to recovery. Chronic pain directly undermines every component essential to recovery (see figure). Chronic pain nurtures the negative mindset known as “stinkin’ thinkin’.” This is an attitude that facilitates relapse by provoking self-pity and the inability to meaningfully solve problems. Its most insidious consequence is what’s called the “catastrophization” of the pain or coming to see it and feel it as more hurtful and more debilitating than it would be without the influence of a dark and dismal outlook.

Requirements for Recovery	Impact of Chronic Pain
Hope, adaptability, and positiveness	<ul style="list-style-type: none"> <li>- Pain fosters hopelessness</li> <li>- Pain encourages resignation</li> <li>- Pain engenders negativity</li> </ul>
Self-management as well as self-respect	<ul style="list-style-type: none"> <li>- Pain diminishes self-control</li> <li>- Pain compromises self-respect</li> <li>- Pain crushes self-esteem/self-worth</li> </ul>
Wellness and self-awareness	<ul style="list-style-type: none"> <li>- Pain exacerbates illness and symptoms</li> <li>- Pain weakens selfhood</li> </ul>
Peer support and community living	<ul style="list-style-type: none"> <li>- Pain promotes social isolation</li> <li>- Pain leads to relapse, crisis, and hospitalization</li> </ul>

If providers want to promote recovery they must recognize the role that pain plays in countering recovery. They must recognize the impact of pain on the effectiveness of the services that they offer. They must increase their understanding of chronic pain as a problem prevalent among consumers and they must help consumers to mobilize pain management as part of their recovery strategies, where applicable.

*A Note on the Neurophysiology of Pain: In the brain, the same neurotransmitters, serotonin and norepinephrine govern pain and mood. Substance P, another important neurotransmitter also plays a role in pain transmission and mood. In light of the physiological links between pain and mood we might expect that treating one might affect the other. This has been found to be the case. Antidepressants are often of value in relieving pain and analgesics have sometimes reduced depression.*

## Consumer Misconceptions About Reporting Pain

By Tony Salvatore, MA

Here are some reasons for not seeking pain relief that may apply to mental health consumers:

**“Taking pain meds can make you an ‘addict.’”**

Narcotics are just one of many ways to manage pain. When they are prescribed for genuine pain relief this is not drug seeking. Drug addiction in pain management is rare, and almost never occurs in people who do not have a history of drug abuse prior to illness. (See next article for more on this misconception.)

**“Pain meds can make you feel worse.”** Some pain medication may cause sedation and other problems. Not everyone has such side effects, and if they occur, they can usually be treated successfully.

**“You need to take more and more of the meds for them to work.”** Tolerance should not occur in the course of good pain management. Dosing should be increased gradually until relief is achieved and then be maintained. Worsening of pain (and increasing need for medication) may be due to disease progression or aggravation of the underlying trauma.

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## Consumer Misconceptions (continued from pg. 3)

**“You go into withdrawal when you stop the meds.”** Consumers treated with opioid analgesics over a period of time can experience withdrawal if the drug is significantly decreased or suddenly stopped. However, good pain management practice involves the tapering down of a drug, which will avoid the withdrawal syndrome.

**“Hurting is sometimes part of being sick or injured.”** Pain is common with some conditions but it can be safely and effectively relieved to some degree in most cases.

**“Pain is something that you have to put up with.”** Religious, moral, or cultural factors can lead consumers to think that getting help for pain makes them seem “weak.” It is actually pain that is debilitating to both body and the spirit.

**“Providers just don’t get it.”** Consumers with pain may feel that providers will think they are exaggerating, malingering, or are being manipulative. Consumers have a right to pain management.

**“If I say anything about pain they’ll think that I’m a ‘bad patient.’”** Consumers may be afraid of being labeled a pest if they talk about pain. Consumers know best when it comes to their pain, and the better they describe it, the more helpful for all concerned. Consumers may feel stigma with pain.

**“Messing around with pain will keep me from being helped with my illness.”** Managing the pain will actually help improve overall quality of life. Chronic unrelieved pain can interfere with other treatment programs.

These misconceptions may be widely shared by both consumers and providers, as well as the general public. Misinformation and myths are major barriers to the availability and accessibility of effective pain management.

## Pain Management in Drug/Alcohol Patients By Susan Costello, RN

On average 80% of consumers treated on an inpatient basis at MCES have a dual diagnosis with substance abuse secondary to a primary mental illness. Accordingly we immediately confront the problem of meeting the pain management needs of consumers with substance abuse issues. This article is adapted from a staff in-service on this area of concern.

Pain may be difficult to evaluate. It can be masked by stoicism, exaggerated by hysterics, or disguised by psychological problems. Most patients who take narcotics by prescription do so responsibly, but because of DEA scrutiny, physicians are often concerned about sanctions related to controlled substances. This contributes to under-treatment of pain in many cases and, in general, presents more of a problem than the management of drug seeking patients. Failure to provide adequate treatment for pain and somatic manifestations of anxiety result in needless suffering.

Physicians encountering consumers in pain face a two-horned dilemma: the desire to relieve pain and anxiety must be weighed against the fear of creating addiction, being investigated by authorities, and being “scammed” by the occasional patient who abuses medication. Let’s start by clarifying our terminology.

“Abuse” refers to taking the drug in a way other than as prescribed. It could refer to taking it “recreationally,” more frequently, in higher doses, or by different route. “Addiction” is a greater loss of control with patterns that take on a life of their own. Acquiring the medication becomes a major preoccupation. “Dependence” is physical adaptation to a particular substance that results in withdrawal with abrupt cessation, rapid dose reduction, or decreasing blood level of the substance. It is a predictable process in the prescription of opioids and benzodiazepines. It is dose, time, and potency related and often results in tolerance to both side effects and therapeutic effects. This is not, however, the same as addiction.

“Pseudoaddiction” is a behavioral manifestation due to inadequate pain relief. It causes much anxiety and may cause some addictive type behaviors that may be difficult to differentiate. One difference with a drug seeking, addicted patient is that a stated lack of improvement or worsening of social or vocational functioning despite pain control may occur. A pseudo-addicted patient who gets the appropriate

pain control will display an improvement in social and job functioning. Another marker for a true pain patient is the lack of concurrent substance abuse. Prescription drug abuse ALONE is unusual. There is almost always concurrent abuse of alcohol with frequent abuse of cocaine.

Treatment of pain in known substance abusers requires careful assessment. Until recently most physicians felt that controlled substances should not be prescribed for patients with current or past addiction histories. There are, however, basic principles in pain management and the first is to provide effective relief. Those with a substance abuse history may be at a serious disadvantage when requiring pain management.

Controlled release opioids (used appropriately) are less likely to cause abuse. "Round the clock" analgesia does not produce euphoria leading to craving. If the need for a narcotic is clearly indicated and documented, the physician has nothing to fear from regulatory or law enforcement agencies. Using a few simple safeguards can optimize risk management. One way is to maintain a contract with the consumer. This will establish boundaries and provide informed consent. Stipulate, in writing, any specific behaviors that will not be tolerated ("I lost my prescription," or "My dog ate it."). It is wise to have a one doctor, one pharmacy policy. Providers may consider random drug screens (obviously opiates will be positive, but since true addiction rarely exists in a vacuum, you can assess other drug use) or verification of AA/NA attendance. Provisions should be made for violations as well as the possibility of modifying the agreement as the patient shows increased dependability.

Faced with a manipulative patient, there may be a fine line between compassion and enabling. Some doctors may find it difficult to say "no" or set limits; many people are just uncomfortable with confrontation. (Time constraints may also lead to just writing a prescription.). In a situation where a physician's initial inclination is to say "no" but is changed to a "yes" by a patient's pressure and insistence, there was, to some extent, a "scam." Once this works, it will likely resurface periodically until it stops being reinforced. Dealing with scams consists of recognizing the common ones and not giving in, and having communication, with consumer consent, among caregivers, and, as possible, families.

Use these signs as suggestive, not indicative. Do not make judgements solely on the findings of one technique. Various alternative techniques have been proven to work (in patients who want them to work.). Document all refusals.

### **Common Indications of Drug Seeking Behavior**

- Consumer states symptoms that greatly deviate from objective evidence
- Consumer's implication that the only possible solution is "X" – a particular medication; the patient may even know the manufacturer, etc.
- Consumers who present after hours and claim to be from out of town, requesting pain medications. ("I accidentally left mine at home.")
- Consumer's insistence that non-opiates "don't work" and/or they are allergic to all of them; refusal to try alternative techniques (e.g., TENS, relaxation, biofeedback)
- Consumer pressure in the face of a doctor's initial hesitancy, usually in an escalating manner ("I guess I'll have to go to a more caring – or smarter, whatever – doctor.") This may lead to offers of money or sex and then to outright threats of violence.
- Consumer will not allow contact with her/his other physician.
- Insistence on name brand pills rather than generic. (This may indicate someone illegally selling drugs since name brands are easily recognized and therefore, much more profitable.)
- Consumer's overwhelming concern about the immediate availability of a particular medication.
- A consumer who is incredibly informed about pain meds. He/she is able to list colors of different doses, appearances, manufacturers, etc. He/she uses medical jargon and "buzzwords" which get the patient what he wants. ("My migraine is intense but has my usual pattern" means no testing needed – just give me meds.)

### **Physical Indication of Drug Seeking**

- Superficial tenderness of the skin (saying "ouch" when barely touched). Physical pain does not make the skin hurt and is very rare in those with demonstrated pathology.
- Non-reproducible localization of pain (i.e., it moves during test).
- Simulated rotation. Standing the consumer, with shoulders and hips rotated in unison, should NOT produce pain as back is not being stressed.
- Distracted straight leg raises (hip flexed, knee straight). True pain will produce the same results with standard and distracted straight leg raises.
- Plantar flexion (in same position as above) will not cause pain and generally relieves sciatic pain.
- Regional weakness.

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## Pain Management (continued from pg. 5)

- Over-reaction. Any exaggerated reaction to light touch or inappropriate sighing, grimacing, or collapse.
- If the consumer is limping, check shoes for pattern of wear.
- Look for callous patterns in laborers. (If unable to work for 3 weeks, they should be gone.)
- Palpation of the painful area should raise pulse by 5%.
- True pain sufferers will display greater passive range of motion (ROM) than active. Suspect behavioral origins if reversed.
- Very determined consumers may actually taint test results. (blood in urine, for instance)
- Most common complaints specifically requesting narcotics: dental pain, back pain, colitis, cancer (especially in an “out of town” patient), migraines, painful herpes, sciatica, and sickle cell pain.

A drug-seeker may be very effective at manipulation and making the doctor feel uncomfortable. If this happens, shift this discomfort onto the consumer: “I’m really feeling pressured by you to write for something that is not medically needed. I’m concerned about you and we need to talk about your use of [whatever].”

Patients with end stage cancer or any end of life pain should be provided with whatever comfort is needed regardless of past or current addiction. Keep in mind that active addicts may well require higher doses to achieve that relief.

## Implementing Pain Management at MCES

By Lina Atkinson, RN, MSN

About four years ago, we determined that we needed to institute formal pain management in our inpatient unit at MCES. Our decision was a result of our quality improvement (QI) process and an interest in complying with JCAHO hospital accreditation guidelines.

We sought to benchmark what was being done in other psychiatric facilities. We formed an interdisciplinary and interdepartmental team to carry out this task and guide program development. At the time we could not locate settings similar to ours to serve as possible models. So we looked at how community hospitals and other specialty facilities went about introducing pain management to their practice.

We found that we had already taken the first step with our interdisciplinary work group. It is obviously critical that every discipline involved with patient care be represented in the planning of any new clinical program. We included our pharmacy consultant. It is essential that the group be empowered by management to see the job through to completion. This gives the group status as a formal task force pursuing work pertinent to the hospital’s mission.

However, as important as this group is, it is also key that there be a “pain management champion.” This is someone who serves as the focal point for the effort and is identified as the “go to” resource person to staff and management. This individual has to be a clinician with strong credibility among all patient care staff. He or she must be a good communicator and educator. Above all, the person must have a high frustration tolerance. Our champion was Susan Costello, RN, our Nurse Educator.

Step two is identifying both the current pain management needs among patients, and the effectiveness of current treatment of these needs. Frankly, in most psychiatric hospitals this step will not be very long or involved. In our case, our former range of pain assessment and interventions were fairly nominal. Pain was underassessed because it was not a significant part of our overall patient evaluation procedure. Nonetheless our inquiries indicated that pain was a patient care issue. Accordingly, work quickly began on developing an appropriate assessment process.

As we explored pain assessment approaches we reached out to members of our clinical staff not involved with our work group. Some had knowledge of pain treatment in other settings, and others had a strong interest in what we were trying to set in place at MCES. However, there was no common baseline of information or understanding about contemporary pain management and its applicability to our hospital. So step three focused on amassing information and sharing it with staff through handouts and inservices.

As work on assessment tools and staff education proceeded, we naturally arrived at step four, defining a standard of practice for pain management. This involves the practical side of who is charged with responsibility for initially assessing pain, how they should do it, and when should it occur. It also demanded consideration of the role of our Medical Consultants and Physician Assistants who are responsible for medically screening our new admissions.

Step five was pulling it altogether and rolling it out to the floor, so to speak. This step may have a clear starting point but its end is nowhere in sight. Pain management is a rap-

## A Pain Care Bill of Rights

As a person with pain, you have the right to:

- Have your report of pain taken seriously and to be treated with dignity and respect by doctors, nurses, pharmacists, and other healthcare professionals.
- Have your pain thoroughly assessed and promptly treated.
- Be informed by your healthcare provider about what may be causing your pain, possible treatments, and the benefits, risks and costs of each.
- Participate actively in decisions about how to manage your pain.
- Have your pain reassessed regularly and your treatment adjusted if your pain has not been eased.
- Be referred to a pain specialist if your pain persists.
- Get clear and prompt answers to your questions, take time to make decisions, and refuse a particular type of treatment if you choose.

The American Pain Foundation  
[www.painfoundation.org](http://www.painfoundation.org)

idly evolving area and we are still learning, re-evaluating, and reconfiguring how we do it at MCEs. There are always new staff to orient to the program. There are also new disciplines, as when we introduced psychiatric nurse practitioners as members of our Interdisciplinary Teams.

In some respects, we have ended up back where we started, with our QI process, because that is where the ongoing accountability happens. Over time our new pain management program was positively cited in patient satisfaction measures. Pain management has become part of our inpatient culture and is strongly supported in our philosophy of care. Pain management is beginning to “fit” more naturally into our clinical rhythms and regimens. Staff are more aware of the needs of those in pain and more sensitive to how pain affects who we serve and how we serve them.

### **What Consumers Can Do About Pain** **By Cindy Gross**

As indicated above, chronic pain is a demoralizing experience that depletes personal energy and initiative. Pain sufferers may become resigned to their condition and passive in regard to doing anything about it. To make things worse, most pain sufferers, especially consumers, often find themselves in a provider environment marked by apathy, mistrust, and misunderstanding.

Ideally, consumers should be able to get care for all of their health problems, including pain. However, the health care system is still far from ideal and seeking help and advocating for themselves are the first steps that consumers must take to getting treatment for their pain.

Just as consumers need a support system for their illness, a comparable resource, call it a personal pain management team, is needed to help with chronic pain issues. There may be some overlap, but a pain team must include a primary care provider (PCP) to help with the medical aspects of pain. This may be a physician, a nurse practitioner, or a health clinic. For various reasons, consumers with a serious mental illness may not have a relationship with a PCP. Providers can help consumers make this connection. We can identify possible sources of medical care and assist with insurance coverage.

Once they have put a personal pain management team together, consumers can turn to how they can help themselves in coping with their chronic pain. Self-help strategies for dealing with chronic pain are basically similar to those used for mental illness and other health care problems. The key elements are information, education, support, and involvement. The recovery model can readily be applied to chronic pain, which like chronic mental illness may always be there but doesn't have to dominate a consumer's life. Consumers must take charge of their pain as part of their health. It is their pain and it is going to be they who must assure that it is treated and managed.

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## What Consumers Can Do (continued from pg. 7)

Here are some tactics for a self-help chronic pain management strategy:

**Set realistic pain management goals.** Learn to accept where you are in your pain recovery process and remain open-minded regarding the possibility of improvement. Pace yourself appropriately. It is important to keep moving forward but not push too hard and cause a relapse. Try to see pain as a part of life, and don't let pain become life. Try to keep pain from affecting things that you enjoy.

**Remember to manage emotions.** Feelings and emotions directly impact pain. Anger, frustration, fear, and sadness usually accompany chronic pain. If they get the upper hand they make things much, much worse. Negative emotions must be held in check. This is easier said than done as everything about chronic pain is conducive to negativity. Allow yourself to laugh. Keep your sense of humor.

**Try stress management techniques.** Stress makes pain worse. Stress management can improve pain control. Learning relaxation skills can usually help. Muscle tension plays a big role in pain. Using relaxation skills helps to relax muscles, which reduces tension.

**Keep a diary and record changes in your pain and emotions.** Chronic pain management is a long-term process. Appropriate treatment requires accurate information that comes from the consumer, who can help providers to decide on treatment, then monitor and report on how treatments are working. Start a pain diary or journal and log when, where, and how you feel better or worse. This helps to specifically identify what things make the pain hurt more or less.

**Set up a personal pain support network.** As mentioned above, this can include a primary care provider, family members, friends, support groups, and providers. Contact other chronic pain sufferers. Talking with a pain peer can be a form of mutual self-help that gives both parties a chance to help each other. If available, join a chronic pain support group, which are sometimes offered by local hospitals. This is a way to learn what others have tried and what works.

**Educate yourself.** Learn more about chronic pain, treatment, and coping approaches through books, tapes, the Internet, and organizations.

**Develop a regular exercise program.** First, talk to your physician about exercise and follow her or his advice. If exercise is appropriate, you begin with a stretching routine or yoga and then move on to activities that strengthen muscles and increase endurance. Go for a daily walk. Stay active. Build exercise into your daily schedule

**Don't use alcohol or drugs.** Many consumers think that these help with pain, but they do not. Drinking and using non-prescribed drugs interfere with pain management in any form. They increase depression, which is one thing that no chronic pain sufferer needs. They are also detrimental and dangerous when used with pain medications.

Please keep in mind that chronic pain is a medical condition that requires medical intervention and management. Self-help can supplement the medical treatment of pain. It is not meant to replace it. Devising a plan for your pain in consultation with your doctor will assure that your self-help efforts are compatible with your medical care.

## About Psychological Pain

Tony Salvatore, MA

It is known that pain has a psychological dimension, and that it can be psychological in origin. What is less well known is that pain can be intrinsically and exclusively psychological. A recent review of psychological journals over the last 15 years found few references to this concept (I. Orbach et al., 2003, "Mental Pain: A Multidimensional Operationalization and Definition" *Suicide and Life-Threatening Behavior* 33).

Psychological pain has come up in the mental health literature over the years. In *Mourning and Melancholia* (1917), Freud links it to the aftermath of what we now call traumatic loss. In *Man's Search for Meaning* (1963), Victor Frankel saw this form of pain as arising from the sense of emptiness that comes from a loss of meaning in life.

Over the past two decades, however, psychological pain has become part of the conceptual parlance of the emerging discipline of suicidology. This is due to the work of Edwin Shneidman the field's acknowledged father, who singles out "intolerable psychological pain" as the "common stimulus" to suicide. Shneidman terms psychological pain that can produce suicidality, "psychache."

In *The Suicidal Mind* (1996) and other writings, Shneidman theorized that psychache arises from an individual's complete inability to satisfy strongly felt personal needs, such as

control over her or his life or retaining self-esteem. This abject frustration may lead to a state of hopelessness that brings about a generalized sense of severe psychological suffering. When this grows in intensity to a level felt intolerable, the cessation of consciousness through suicide may be seen as the only means of relief.

There are a number of psychiatric disorders and adverse life events that may be associated with psychological pain. These can include a chronic and/or potentially terminal illness, a physical disability or a disabling illness, depression, Bipolar Disorder, Schizophrenia, severe psychological trauma, loss of an interpersonal relationship, economic or job loss, and loss of status.

Psychological pain may account for the pervasive allusions to severe pain often expressed by consumers with serious mental illness who do not show any physical basis for their suffering. It is hard to conceive of anything more singularly disruptive and destructive to satisfying personal needs, to personal growth, or to maintaining a positive sense of self than serious mental illness.

Moreover, the severe psychological pain that may be brought about by serious mental illness is not passive or benign in its relationship to the illness. Psychological pain may directly affect how the consumer deals with the illness. It can be a major factor, perhaps often the sole factor, in critical issues like noncompliance, self-medication, relapse, and crisis. As such, it may be the single highest hurdle in achieving recovery.

Lastly, understanding psychological pain, as conceptualized by Shneidman as psychache, can give us significant insight into the connection between serious mental illness and suicidal behavior among consumers. Psychological pain may be, in some cases, the principal driver underlying parasuicidality and suicidal gestures, suicide attempts, and suicide completions.

## What About Pain Disorder? By Tony Salvatore, MA

Pain disorder is a condition in which severe pain is experienced at one or more locations on the body, but is basically or exclusively brought on by psychological factors, such as stress. Pain disorder differs from psychological pain, which is a purely psychological phenomenon, and is literally felt psychologically.

Consumer pain complaints related to this problem may involve any part of the body, but typically the back, head, abdomen, and chest are the most common sites. The pain may be acute or chronic. It is usually suspected in cases of physical pain that seem to have no physiological or neurological source. In some cases, physical illness or injury may be present, but is not determined to produce the pain. Likewise, pain disorder may co-occur with other psychiatric disorders.

Some additional clues to the presence of pain disorder include:

- Presence at multiple sites around the body
- The absence of any evidence of “faking” or feigning of signs or symptoms
- The individual’s social and/or occupational functioning are impacted

With pain disorder, assessment indicates that psychological factors play a role in the onset, severity, worsening, or persistence of the pain. Also, it should be noted that while diffuse pain sites may be cited by drug-seekers, the body locations involved with pain disorder are generally fixed.

Pain disorder appears to be comparatively common, but this has not helped its sufferers be seen as having a “real” pain problem. Both the lay and professional communities still most often view pain of a “psychological” nature with skepticism and suspicion. Stigma and under-treatment are frequent consequences. However, pain disorder is a clinical reality and must be considered in cases of consumers whose pain doesn’t seem to have any other explanation.

Even when identified correctly, pain disorder may go untreated. As a psychiatric condition, pain disorder requires treatment by a mental health provider, which is another source of stigma. Some sufferers also cannot accept that their pain is not amenable to medical intervention. Nonetheless, pain disorder is treatable. It usually abates when the psychological factors underlying it are addressed.

Prescription and over-the-counter pain medications usually provide no relief whatsoever for consumers with pain disorder. Indeed such remedies may make matters much worse because of potentially serious side effects and other complications. On the other hand, hot and cold packs, distraction and imaging techniques, massage and other non-pharmacological treatment may be very helpful in terms of providing relief.

## Pain Clinics 101

### Tony Salvatore, MA

Chronic pain may be treated by primary care physicians and other practitioners, by other physicians who are not pain specialists, by physicians specializing in pain management, or increasingly by a new provider entity, the pain clinic. These facilities have emerged in recent decades, partly as the community-based (or hospital-based outpatient) counterparts of the inpatient pain teams found in many hospitals. Behavioral health providers should have some basic understanding about the role that these resources can play in aiding consumers with chronic pain.

The term pain clinic may sometimes describe a physician practice specializing in the treatment of pain or a provider organization with extensive diagnostic, therapeutic, and, sometimes, rehabilitative capabilities. We will be taking a look at the latter in this section. Pain clinics generally take one of three forms: multidisciplinary, modality-oriented, or syndrome-focused. Each of these pain clinic models has unique advantages and disadvantages depending on the patient's pain management needs. Matching pain patients to pain providers remains problematic given all of the complicating factors involved. Many chronic pain patients only arrive at the "right" provider after a frustrating trial and error process involving any number and combination of medical referrals, peer referrals, and self-referrals.

A multidisciplinary pain clinic can best be thought of as a "full-service" or "one-stop shop" pain clinic. It can usually address all forms of chronic pain and consists of an interdisciplinary team of physician and non-physician specialists, and a broad array of evaluative and clinical technologies under one roof. In addition to treating patients on an ongoing basis, these facilities are often used to sort out some of the more elusive aspects of chronic pain cases and to give consultations on interventions and care plans. Such comprehensive pain services are the least common provider type and are usually affiliated with teaching hospitals or regional medical centers (which may also be the sites of the other types of pain clinics outlined below).

A modality-oriented pain clinic offers a single type of pain management treatment or a limited number of treatment options. Examples of this type of facility include pain clinics operated by anesthesiologists specializing in nerve blocks or interspinal procedures, physiatry-based clinics utilizing physical therapy, clinics staffed by psychologists that rely on behavioral and cognitive techniques, and chiropractic clinics devoted exclusively to pain management. These types of

pain services are obviously most useful when the etiology of the pain is well understood and an appropriate accepted treatment mode has been defined. Modality-oriented facilities are the most common pain clinic format. However, accessibility is only one factor to consider in choosing a provider.

A syndrome-focused pain clinic is an entity that specializes in treating a particular type of pain problem. Some of the most common examples include cancer pain centers, back pain clinics, clinics treating migraines and other chronic headaches, facial pain clinics, and those dealing with pain associated with arthritis. While some clinics of this nature may center on a specific discipline (e.g., oncology, orthopedics, rehabilitation medicine, neurology, oral surgery, rheumatology, etc.) most are multidisciplinary and bring a wide range of clinical skills and perspectives to bear on a specific problem. The scope of services offered will vary by the nature of the pain targeted by the clinic. Syndrome-focused clinics clearly offer advantages when the source of the pain is recognized or strongly suspected. In terms of availability, this type of clinic falls between multidisciplinary and modality-oriented pain services.

Regardless of their mission or structure, true pain clinics share a common clinical philosophy and culture. They see themselves a "the experts" in understanding and managing pain as a medical condition in its own right whatever its cause. They are by nature pain-focused. They treat pain, which is viewed as the primary problem of patients who come to their attention. Subject to the best determinations that they can make in situations that may not be clinically explicit, they "believe" what their patients say about their pain. They are typically aggressive, often extremely so, in their approach to dealing with pain. Behavioral health providers are frequently skeptical of consumer accounts of the nature of the care that they may have received at pain clinics for chronic pain.

In regard to mental health consumers, when a chronic pain diagnosis has been validated or accepted, any issues about past or present substance abuse or misuse are not permitted to stand in the way of the treatment that promises the greatest palliative outcome. This includes the use of opioid analgesics in whatever form, strength, or dosage indicated as appropriate to relieve the pain at hand. While there may always be exceptions, pain clinics "see" a consumer with a history of substance use as a chronic pain sufferer, period. They will employ all appropriate precautions, most notably contracts obligating the patient to adhere to the pain management regimen and avoid behaviors that will compromise its integrity or effectiveness. Most pain clinics have a "once and done" policy for patients that breach such agreements.

## What Is Intractable Pain?

“Intractable pain is a pain state in which the cause of the pain cannot be removed or otherwise treated and which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physicians and surgeon and one or more physicians and surgeons specializing in the treatment of the area, system, or organ of the body perceived as the source of pain.”

The National Foundation for the Treatment of Pain  
[www.paincare.org](http://www.paincare.org)

## For More Information About Pain Management

American Academy of Pain Medicine  
[www.painmed.org](http://www.painmed.org) 847-375-4731

American Academy of Pain Management  
[www.aapainmanage.org](http://www.aapainmanage.org) 209-533-9744

American Chronic Pain Association  
[www.theacpa.org](http://www.theacpa.org) 800-533-3231

American Pain Foundation  
[www.painfoundation.org](http://www.painfoundation.org) 888-615-7246

American Pain Society  
[www.ampainsoc.org](http://www.ampainsoc.org) 847-375-4715

International Association for the Study of Pain (IASP)  
[www.iasp-pain.org](http://www.iasp-pain.org) 206-547-6409

National Foundation for the Treatment of Pain  
[www.paincare.org](http://www.paincare.org) 713-862-9332

National Hospice and Palliative Care Organization  
[www.nhpco.org](http://www.nhpco.org) 703-837-1500

Pain.com  
[www.pain.com/painclinics/default.cfm](http://www.pain.com/painclinics/default.cfm)

Partners Against Pain  
[www.partnersagainstpain.com](http://www.partnersagainstpain.com)

## Toward a “Balanced” Pain Management Policy

As this issue is being completed, pain management is national news. The US Supreme Court is weighing in on the medicinal use of marijuana and the US Drug Enforcement Agency (DEA) is backing off a recent statement that pain management advocates felt would ease physician fears of federal prosecution for prescribing opioid analgesics.

From physicians’ offices through state medical boards to the US Congress, the needs of chronic pain patients and the needs of society to be protected from opioid abuse seem to always conflict, with chronic pain sufferers being the usual losers. Do policies regulating opioid analgesics always have to be an “either/or” proposition? Is there a way that policy can serve pain relief and drug control ends?

The Pain & Policies Study Group (P&PSG) at the University of Wisconsin promotes the “central principle of balance” as the basis for sound public policy on the opioid analgesic use. The principle acknowledges “a dual obligation of government to establish a system of controls to prevent abuse, trafficking, and diversion of narcotic drugs while, at the same time, ensuring their medical availability” (P&PSG, Achieving Balance in Federal and State Pain Policy: A Guide to Evaluation, 2003).

“Medical availability” is the recognition that “opioid analgesics should be accessible to all patients who need them for the relief of pain.” “Drug control” is the recognition that restrictions are necessary to prevent abuse but that they should not “diminish the medical usefulness of opioids, nor interfere in their legitimate medical uses and patient care.”

On the one hand, public policies governing opioid analgesics should not preclude effective pain management. On the other hand, reasonable accessibility of effective pain management should not put the community a greater risk of substance abuse. Hopefully, the balance principle will gain acceptance among policy makers.

- Almost 15,000,000 in the US suffer chronic and intractable pain that is severe enough to be disabling.
- As many as 75% of cancer pain patients receive grossly inadequate pain relief.
- The suicide rate among pain patients is almost 20 times that of other patients.

From The National Foundation for the Treatment of Pain - [www.paincare.org](http://www.paincare.org)

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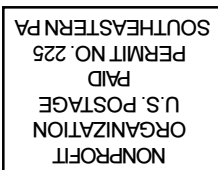
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