EDITORIAL VIEW

Another dimension of pain

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ABSTRACT

Pain is usually regarded as of two types, pain caused by tissue damage, also called nociceptive pain, and pain caused by nerve damage, also called neuropathic pain. A less known third category is psychogenic pain, which becomes an integral part, in due course of time, of the first two types. It is pain that is affected by psychological factors. Pain physicians tens to focus usually on the first, less commonly on the second and very rarely on the last type of pain. This ignorance may be the prime factor in failure of otherwise more rational pain management regimen. It needs to be adequately addressed, and expert help from qualified psychologist and/or a psychiatrist may be required in selected patients to incorporate body-mind techniques in the pain management.

Key words: Pain; Nociceptive pain; Pain management; Imagery (Psychotherapy); Relaxation Therapy

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IASP was quick to understand that pain was not always associated with tissue damage or nervous system abnormalities, and that many a times you could fail to find out any demonstrable root cause of a pain, regardless of the recent advancement in diagnostic modalities. Hence the inclusion of phrases 'unpleasant …. and emotional experience' and '…. or potential tissue damage, or described in terms of such damage' in the definition. Only few years back pain was regarded as a symptom (of some underlying disease), but it soon became the only symptom which gave birth to a full specialty in its own right. Now pain is regarded as a disease and not only a symptom, and very rightly so.

Most of the pain physicians come across a patient in which pain has no physical correlation, or the physician fails to understand a correlation if one does exist. You treat this patient according to your full capabilities and employ all of the available ways and means of pain management, yet the pain will continue to wander from one site to the other. Is it only due to attention seeking behavior? Or is it just an indication of the second part of 'fight or flight' phenomenon?

Chronic pain, if left untreated, very frequently leads to depression and other psychological manifestations. It may lead to irrational or dysfunctional thinking with mismanaged feelings, the attitude of self-defeating, impulsive or compulsive behaviors to cope with depression. Their relationships with others is seriously compromised, leading to social isolation or their increasing dependence on others to take care of them. Lack of care by the near and dear ones may play catastrophic role, but on the other hand, continuous extra care may lead to dependence and a pain mimicking behavior. Thus, the pain physicians need to assess every patient every time to have an insight into psychological factors playing with the patient and perhaps with the physician as well.

Many social factors at home will lead to the complaint of pain. The treating physician has the responsibility to carefully take pertinent family and social history and try to identify predisposing and aggravating factors which might have been originated at home. A gentle and careful approach is of utmost importance, so as not to offend the patient or the attendants. In these patients the approach of management takes an entirely different direction. The merits and demerits of any interventional procedure proposed will have to be reconsidered and psychiatric evaluation and treatment will take precedence over pain directed therapy. The interactions between pain drugs and psychiatric drugs will have to be taken care of.

Patients suffering from chronic pain are bound to have this third dimension. Mind and body coexist in every human being and each one has profound influence on the other.[1,2] The psychological symptoms include both cognitive and emotional.

Most of the pain patients are not able to differentiate between the physical and psychological symptoms of their pain condition. To effectively manage their pain, we need to understand all aspects of their pain condition – physiological, psychological, and emotional. Often all of the dimensions of pain must be dealt with simultaneously to get maximum benefit. [1,2]

Pain management is often regarded as a multi-specialty approach. Complex pain conditions and the pain patients resistant to conventional treatment must be evaluated and co-managed by qualified psychologists and/or psychiatrists. Patients of chronic non-cancer pain (CNCP) suffer from a common and complex disorder associated with declines in physical health and functional status, emotional well-being, and quality of life.[1] Various non-conventional methods may be employed in these patients, including relaxation techniques, meditation, imagery and cognitive-behavioral therapy. Mind-body interaction has become an interesting subject of study during the recent past and the literature has been enriched with numerous randomized controlled trials and in many cases, systematic reviews. [3-6] These are enough to let us present the following recommendations: (1) multi-component mind-body approaches that include some combination of stress management, coping skills training, cognitive restructuring and relaxation therapy may be an appropriate adjunctive treatment for chronic low back pain; (2) multimodal mind-body approaches such as cognitive-behavioral therapy, particularly when combined with an educational/informational component, can be an effective adjunct in the management of rheumatoid and osteoarthritis; (3) relaxation and thermal biofeedback may be considered as a treatment for recurrent migraine while relaxation and muscle biofeedback can be an effective adjunct or standalone therapy for recurrent tension headache; (4) an array of mind-body therapies (e.g., imagery, hypnosis, relaxation) when employed pre-surgically, can improve recovery time and reduce pain following surgical procedures. [5,6]

In conclusion, the pain specialists must avoid a telescopic vision of pain in the patients consulting them; but must treat them as fully living human beings, having a body as well as a mind. Focusing only on an aching body part and ignoring the patients' mind will defeat your management, defeat you and defeat the patient.

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