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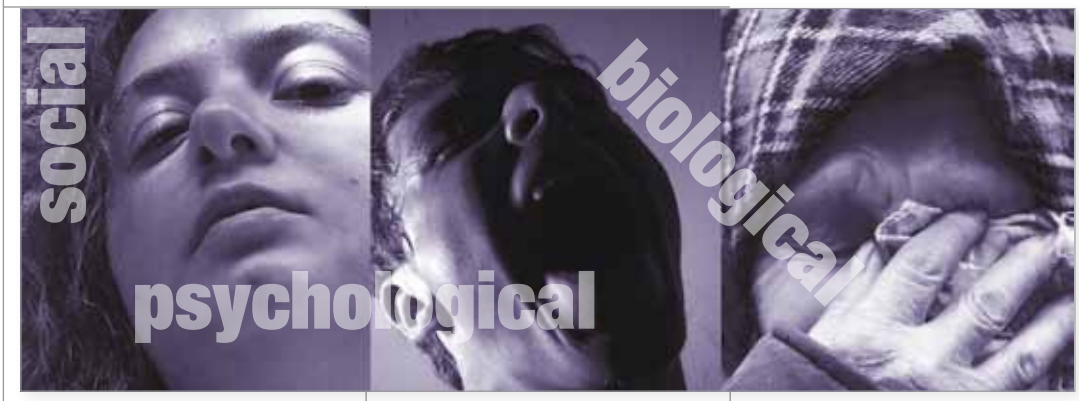
THE BRITISH PAIN SOCIETY

The different angles of pain



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No matter which way one looks at it, pain hurts. One way of viewing it is from a biopsychosocial perspective i.e. from a biological, psychological and social perspective. Such an approach looks to see how all three aspects may be influencing the experience of pain, its maintenance and its management. Biological and physiological factors such as hereditary conditions, nerve damage and physical illnesses is one area. The other is to consider the familial and social attitudes to illness and pain, such as the belief that we should seldom experience pain, pain is part of aging or that those in pain should simply accept their lot and suffer in silence. The third piece of this perspective refers to our individual personalities and psychological structure.

We are moving on from whether something is either in the mind or the body to a more cohesive view of mind and body. That in no way implies that the pain one feels in one's body simply comes from the mind but what it does suggests is that the one can influence the other. In addition, it allows for how our psychological structures and personalities as well as our social and familial environments and attitudes can impact on our wellbeing (Rezek, 2010).

The importance of this perspective is that it views an individual as being a combination of strands that are specific to that person. One person may have a high threshold for pain, a helpful family set up but poor mobility and is easily frustrated. Another may have a high pain threshold but have few social support systems and be more vulnerable to feelings of distress.

The biospsychosocial model is a conceptual one that advocates a shift when viewing pain from a singular biomedical perspective to a more inclusive one. It was initially given attention by George Engel in 1977 and the emphasis is not on which of the three factors has greater importance or significance (although they should be rated according to the condition and situation) but rather that all three should be taken into account as influencing or maintaining the condition. It does not prescribe a blanket cause-and-effect relationship or promote the idea that one automatically leads to any other. Its aim is to view the condition within the context of the person and not only as a medical condition with associated symptoms.

By acknowledging and addressing the condition from all angles, it can provide opportunities for barriers to be eased and facilitating factors to be encouraged and enhanced. For example, if a person has a poor body image or feels shame about his or her body due to previous experiences then this may prevent the person from engaging in physical interventions that could impact on recovery or pain management. This in turn may influence the person's ability to return to work, social or sexual relationships, financial stability and mood as well as increase the likelihood of, say, isolation, depression or anger. The example can have numerous variations and consequences, but the issue at hand is that the person's quality of life may be adversely affected.

The NICE guidelines (National Institute of Clinical Excellence [NICE], 2009) recently recommended screening for depression amongst patients with chronic physical health conditions due to their impact on mental health and wellbeing. People with chronic conditions are estimated to be two or three times more likely to be depressed than those who do not have such conditions. Many chronic conditions produce pain, such as cancer, multiple sclerosis, rheumatoid arthritis, fibromyalgia and the interaction of pain and depression can increase both morbidity and mortality (NICE, 2009).

These guidelines are a product of the growing body of evidence that supports the move towards both a biopsychosocial view of pain and pain management and how, for example, pain can increase the risk of depression as well as depression (and other emotional factors) being a risk factor in developing chronic physical health problems (Gatchel, Peng, Peters, Fuchs & Turk, 2007; NICE, 2009). In addition, emotional responses such as anxiety, fear, depression and anger can increase pain levels whereas better mood and happier mental states can assist in reducing them (Gatchel et al., 2007 provide an extensive overview of this concept; NICE, 2009).

This emphasises the mind/body connection and how a physical condition can influence a psychological one, and vice-versa. Inconsistent consideration is sometimes given to the psychological effects of pain and patients are not routinely asked about symptoms that may be pertinent to emotional distress (such as depression, anxiety, stress or even anger and hopelessness). Few questions are asked regarding the impact of chronic pain on relationships, whether sexual, familial or social, substance misuse or traumatic stress symptoms, and those referring to emotional or physical neglect or abuse of any kind are frequently avoided altogether. Considering how pain can impinge on all areas of one's life it seems limiting to view it from the physical angle alone.

If we can bring together the divide and view ourselves as mind **and** body, rather than mind or body, then we can respect the idea that people work as one system of integrated mechanisms. An illustration is the impact psychological stress has on the physical body. Our bodies are geared towards survival so when we are stressed it leads to the secretion of cortisol (and adrenaline) which prepares the body for the fight or flight response because it assumes we are in some form of danger. When our bodies perceive danger (so it doesn't have to be real) then the rest of the system shuts down in order for us to be able to run or fight. However, if cortisol is secreted when such a state is not required but is due to the likes of psychological stress, anxiety or

pain, then there is too much or too little of it in our systems as it is out of its regular/normal cycle of secretion. Stress, particularly severe or chronic stress, weakens the immune system, slows down healing and the ability of the body to repair itself, strains the heart, damages memory cells in the brain and deposits fat at the waist rather than the hips and buttocks (which can increase the risk factor for heart disease and cancer). It is implicated in IBS, aging, depression, chronic heart disease, hypertension, rheumatoid arthritis, diabetes and many other conditions (Gardner-Nix, 2009).

The ripple effect scenario regarding poor body image, or even stress for that matter, is not an uncommon one seen in clinical practice, albeit in multiple forms. The implications of chronic conditions can be far-reaching and pervasive. This can readily be seen in those who have suffered a personal injury, such as from a road traffic accident, work incident or in combat. The primary injury may have healed to some extent but there is frequently residual chronic pain and emotional distress that lingers, often for many years after the event, and it is this that can chip away at their quality of life, sense of control, resilience and wellbeing. It is not unusual to see individuals for psychological therapy two or three years after a traumatic incident and to uncover a life that is now fraught with ongoing physical pain, depression, hopelessness, anger and despair. Work lives and family relationships have been affected, substance abuse may be evident as a means of self-medication (more often for the emotional disruptions than the physical pain), explosive anger or increased isolation could be present and, in general, a number of unhelpful and even destructive features are noticeable. Not only have their lives changed but also their sense of identity, esteem and respect.

Younger individuals can sometimes turn to drugs, alcohol or harmful behaviours as they may not yet have developed sufficient coping mechanisms or had ongoing life experiences upon which to draw due to their age. However, adults too don't automatically have the skills to manage such life-changing and enveloping alterations in their lives. It becomes apparent how much distress people attempt to hide and how their long-established means of dealing with issues tend to be more entrenched under stress. Alternatively, their coping mechanisms for past matters may not be sufficiently robust or inclusive to allow them to deal with such a disruptive, chronic or intense situation and so they look for other means, some of which may not necessarily be in their best interests.

Personality factors may well influence how one deals with pain. They affect everything else in our lives so it is inevitable that they will have some bearing on how we react to health issues and pain. If one has a tendency to be abrupt and dismissive or to struggle in accepting assistance it is likely that these factors will impinge on any treatment interventions or social support needs.

Over my many years of clinical experience, predominantly in mental health settings but also in areas such as hospice and working with addictions, perhaps one of the most important things I have learnt is that we are all the same but inexplicably different. We are a combination of layers upon layers developed over the years with each experience. Each layer will contribute, in one form or another, to who we are today and how we manage our lives. The burgeoning of neuroscientific evidence is providing invaluable knowledge of how our physiological and psychological structures are intertwined and are determined by biological, emotional and experiential factors. This remarkable information can readily assist us in becoming more open, reasoned and inclusive in our approaches.

All interventions are important but perhaps at the heart of it is how these are combined. A cohesive and boundaried mix allows people to feel safe and cared for, from all angles. It is when discreet interventions are provided by disparate professionals that necessary and sometimes essential factors can be lost. It's the difference between being provided with separate items of eggs, flour, sugar and butter as opposed to a homemade cake made from those same ingredients.

Chronic conditions can shift and change over time, and whereas a psychological issue may have less impact at one time it may increase further down the line. What we think and feel (emotionally) will impact on what we feel physically. It's about learning to manage the pain with one's own internal resources and resilience, in addition to any medication or other intervention. The more tense and distressed/depressed one is the more pain one may feel and we know that pain can cause people to feel agitated, anxious, distressed, despairing, angry and many other things. It has a powerful and diffuse effect on our emotional and physical states, as well as on our quality of life, relationships, work and level of functioning. People in pain often lose faith in their bodies and feel emotionally worn down by it (Rezek, 2010). The less robust one feels to deal with this ongoing situation the more hopeless one may feel, and hopelessness is a strong predictor of suicide. The implications of pain shouldn't be dramatised or dismissed. However, the fact that every social or psychological effect is not overtly evident in each patient does not diminish their presence or importance.

The drive behind this article is to emphasise the advantages of viewing and addressing chronic health and pain conditions from a biopsychosocial perspective. It touches on some of the benefits of using an integrated approach of mind and body rather than a divisory one that splits people into camps that can only accommodate a mind or body view. The aim is to encourage an openness to the extent to which our physical and emotional mechanisms are entwined and to question the once rigid and inflexible precepts of the physical and emotional being entirely separate units. An emphasis has been placed on psychological factors which is not only due to my professional bias but because it is an area that is often complex and difficult to understand.

Pain, like people, is complex and multidimensional and this perspective is only one offering. The desire is to provide an opinion that may benefit our approach to pain and that may influence not only the quality of care we provide but also our attitude towards those who may be suffering in ways of which we have no knowledge. If keeping in mind one additional concept that could assist in reducing distress and increase quality of life, then something of value has been achieved.

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