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11

Psychosocial and Cultural Aspects of Pain

I. Definition and measurement of pain

A. Know the definition of pain as a biopsychosocial experience. Understand that pain is a subjective experience with important affective, cognitive, and behavioral as well as sensory components. Appreciate what is known and not known about the influences of development, environment, and genetics on pain components (Merskey and Bogduk 1994; Turk and Gatchel 1999; Edwards et al. 2001a; Flores et al. 2002; Sufka and Price 2002; Flor and Hermann 2004; Mogil and Devor 2004; Price and Bushnell 2004; Riley and Wade 2004).

B. Know that pain measurement is fundamentally inferential. Thus, the objective is to evaluate and relieve the subjective experience. This can be accomplished only through the interpretation of a variety of verbal (self-report) and nonverbal behaviors, including treatment-related behaviors. These must be considered in a context of communication influences as well as physiological differences (Melzack and Katz 1999; Jensen and Karoly 2001; Turk and Melzack 2001; Hadjistavropoulos and Craig 2002).

C. Distinguish between pain as a subjective experience; pain behavior as a pattern of audible or observable actions (e.g., posture, facial expression, verbalizations); and physical, emotional, and disability functioning (Keefe and Block 1982; Hadjistavropoulos and Craig 1994; Melzack and Katz 1999; Turk and Melzack 2001; Gatchel 2004).

D. Describe the major psychological and behavioral consequences of acute pain, progressive disease-related pain, chronic nonprogressive pain, and end-of-life care (Abresch et al. 2002; Breitbart and Payne 2004; A.C. Williams 2004; D.A. Williams 2004).

E. Understand the potential shifts in goals, approaches, and legal issues for pain associated with terminal illness (Meisel et al. 2000; Steinhauser et al. 2000; Breitbart and Payne 2004).

F. Identify psychosocial developmental issues that must be considered in evaluating and treating pain (Turk and Melzack 2001; Turner and Romano 2001; Farrell and Gibson 2004; McGrath 2004; von Baeyer and Spagrun 2005).

G. Recognize that verbal reports provide unique access to subjective experiences but have limitations, including response biases, and are complemented by observed nonverbal behaviors and self-reported or observed functional activities. Also, recognize that inferences of the observer can be erroneous or biased (Turk and Flor 1987; Labus et al. 2003).

H. Understand measurement methods and their strengths and weaknesses for assessing these multiple dimensions of pain (Jensen and Karoly 2001; Turner and Romano 2001; Jensen 2003a,b; see also Chapter 43).

I. Be familiar with the psychometric concepts of reliability, validity, sensitivity, specificity, usability, standardization, and norms (Jensen 2003a,b; Bolton 2004; Herr et al. 2004).

J. Understand which self-report and psychological tests have been validated and standardized on chronic pain populations and thus can be utilized with appropriate conclusions (Turk and Melzack 2001; Turner and Romano 2001; Dworkin et al. 2005).

II. Individual differences

A. Recognize fundamental individual differences in affective, cognitive, and behavioral responses to pain and understand their interactions with physiology (Turk and Monarch 2002).

1. Affective processes

a. Understand the various emotional reactions to actual or potential tissue damage, including anxiety, fear, depression, and anger (Romano and Turner 1985; Vlaeyen and Linton 2000; Rainville 2004; Symreng and Fishman 2004).

b. Distinguish affective states associated with acute, recurrent, progressive, and chronic pain (Gallagher and Verma 2004; Holder-Perkins and Wise 2004).

c. Know that anticipatory anxiety, distress, and fear may exacerbate pain or predict pain severity (Syrjala and Chapko 1995; Linton 2004).

2. Cognitive processes

a. Be able to describe basic cognitive processes that determine the nature of painful experience, including beliefs, meaning, appraisal, expectancy, attention, distraction, somatic preoccupation, labeling/reinterpretation, and observational learning (Kotarba 1983; Barkwell 1991; Moerman and Jonas 2002; Bushnell et al. 2004; Hadjistavropoulos and Craig 2004; Holder-Perkins and Wise 2004).

b. Describe the major interactions between cognitive appraisals and affective reactions (e.g., the role of catastrophizing, helplessness, and other maladaptive patterns of thinking, or the consequences of self-efficacy and personal control) (Rosenstiel and Keefe 1983; Turner et al. 2000; Sullivan et al. 2001; Tan et al. 2002).

3. Behavioral processes

a. Understand the principles of operant theory as they relate to the acquisition and maintenance of pain behavior and their role in devising intervention strategies (i.e., primary and secondary reinforcement, punishment, extinction, schedules of reinforcement, shaping, avoidance learning, stimulus control, modeling, and observational learning) (Fordyce 1976; Sanders 2002).

b. Know the distinction between operant and respondent conditioning (Fordyce 1976; Sanders 2002).

c. Understand that function, activity level, and disability are associated with, but are not the same as, pain (Robinson 2001).

4. Integrated psychophysiological model

a. Recognize the substantial variability in response to actual tissue damage or potential tissue damage as reflected in the modest correlations among physical damage, pain, and disability for acute, progressive, and chronic pain (Syrjala and Chapko 1995; Flor and Hermann 2004; Manning 2004).

b. Understand the basic neurochemical and neurologic mechanisms through which emotion, cognition, and behavior influence each other and are influenced by physiology (Geden et al. 1984; Rainville et al. 1997; Turk and Flor 1999; Wolfe 1999; Price 2000; Bushnell et al. 2004; Chapman and Okifuji 2004).

III. Coping

A. Know the basic coping styles and how they influence pain experience and responses to treatment (e.g., problem solving/active coping, information seeking, support seeking, reappraisal or reframing, distraction, praying/hoping, catastrophizing, avoidance or escape) (Fernandez and Turk 1989; Jordon et al. 1998; Keefe et al. 2000; Jensen et al. 2001; Skinner et al. 2003; Spinhoven et al. 2004).

B. Understand theoretical frameworks for coping that have demonstrated relevance to outcomes for pain and pain treatment.

1. Describe the transtheoretical model and current research on applicability of this model to pain treatment (Prochaska and DiClemente 1998; Kerns and Rosenberg 1999; Jensen et al. 2000; Dijkstra 2005).
2. Describe the concepts of catastrophizing and avoidance in relation to pain (Sullivan et al. 2001; Turner and Aaron 2001; Rosenberger et al. 2004; Severeijns et al. 2004).
3. Explain the concept of self-efficacy and its relationship to coping with pain (Jensen et al. 1991; Allegrante and Marks 2003).
4. Explain how motivation, coping style, social support, and social environment responses to pain can influence pain and treatment outcome (Jensen et al. 2001; Jensen et al. 2002; Hanly et al. 2004; Montoya et al. 2004; Nielson and Jensen 2004).

IV. Psychosocial and cultural factors in expectations and in access and adherence to treatment

A. Recognize the internal and exogenous barriers that impact access to and implementation of pain evaluation and treatment (e.g., individual motivation, beliefs, side effects, availability of opioids or other prescribed treatment) (Ward et al. 1993; Breitbart et al. 1998; Miaskowski et al. 2001; Jensen 2002).

B. Be familiar with how individual differences in both patients and health professionals affect adherence to treatment recommendations (DiMatteo et al. 2000; DiMatteo 2004).

C. Understand how expectations, coping, cultural factors, and environmental factors influence disability, treatment outcome, and maintenance of treatment effects (Gatchel and Epker 1999; Severeijns et al. 2001; Goossens et al. 2005).

V. Sociocultural, economic, and racial variation

A. Know that there are cultural, environmental, and racial variations in pain experience and expression and in health care seeking and treatment (Bonham 2001; Edwards et al. 2001b; LeResche 2001; Green et al. 2003; Linton 2004; Sullivan 2004).

B. Understand the contributions and limitations of race, ethnicity, economics, and genetics to pain experience, pain expression, and treatment access (Morrison et al. 2000; Edwards et al. 2001a; McCracken et al. 2001; Carey and Garrett 2003; Green et al. 2003; Fillingim 2004).

C. Recognize that racial, cultural, and gender differences in pain expression and treatment may reflect differences in health care professionals' responses (Todd et al. 2000; Bonham 2001; Hahn 2001; Carey and Garrett 2003; Green et al. 2003).

D. Describe some aspects of communication related to cultural and religious variation that health care professionals should consider when assessing and managing pain (Morris 1999; Flores et al. 2002; Davidhizar and Giger 2004).

E. Know that pain behaviors and complaints are best understood in the context of social transactions among the individual, spouse, employers, and health professionals and in the context of community, governmental, or legal procedures (Romano et al. 1995, 2000; Gatchel and Epker 1999; Main 1999; Robinson 2001; Linton 2004).

F. Recognize that social environment factors, including beliefs about the origins and nature of pain and how one should access health care, influence both experiential and expressive features of pain (Green et al. 2004; Linton 2004).

G. Understand that the workplace and the employee's appraisal of the work environment are potential sources of variation in pain, illness behavior, and disability (Feuerstein et al. 1999; Garofalo and Polatin 1999; Gatchel and Epker 1999; Robinson 2001).

VI. The family and pain

A. Describe the potential role of the family in promoting illness or well behavior (Romano et al. 1995; Kerns 1999; Otis et al. 2004).

1. Describe the role of familial models of pain complaint and disability as predisposing factors for maladaptive responses and disability (Romano et al. 1995).

B. Be aware of the significance of stress, trauma (e.g., family violence, sexual abuse), and marital discord as predisposing, exacerbating, or maintaining factors in pain complaints and disability (Kerns 1999; McGrath and Dade 2004).

C. Appreciate that communications of pain, distress, and suffering by patients elicit responses from health care providers and significant others, particularly family caregivers (Romano et al. 1995, 2000; Giardino et al. 2003; Smith et al. 2004).

VII. Emotional problems and psychiatric disorders associated with pain (Gatchel 2005).

A. With regard to pain and depression:

1. Be aware that pain and depression, as well as anxiety, are associated with each other. Know that chronic pain is not masked depression, nor is there evidence for the concept of a pain-prone personality disorder (Keefe et al. 1986; Averill et al. 1996; Gureje et al. 1998).
2. Be aware that depression in chronic pain patients is more likely to be a consequence than a cause of chronic pain; but that psychosocial factors, may increase risk for the development of chronic pain, particularly anxiety, catastrophizing, alcohol or other use substance disorders, and occupational impairment (Atkinson et al. 1991; Polatin et al. 1993; Gatchel and Dersh 2002; Main 2002; Picavet et al. 2002; Boersma and Linton 2005).
3. Understand that depression may be a predictor of pain severity, pain behavior, disability or adherence to pain treatment, and that the presence of pain may be a predictor of depression severity. However, be aware that these are associations not causal statements (Averill et al. 1996; DiMatteo et al. 2000; Lin et al. 2003).
4. Recognize that early intervention is increasingly seen as central to the prevention of long term disability. Be able to evaluate psychosocial risk factors that influence the onset and maintenance of disability and understand interventions for their management (Picavet et al. 2002; Boersma and Linton 2005).

B. Understand the complex interaction of pain expression with the following psychological factors:

1. Recognize that personality disorders and maladaptive coping styles are frequently found in chronic pain patients, but it is uncertain whether the prevalence of personality disorders or of subtypes of personality disorders is greater in chronic pain patients than in the general population (Polatin et al. 1993; Weisberg and Keefe 1999; Geisser 2004).
2. Describe the DSM-IV diagnostic concepts of somatoform disorders (e.g., somatization, conversion, pain hypochondriasis, body dysmorphic disorders, factitious disorders, and malingering). Understand the contradictions between this classification and the scientific research described in this chapter, particularly in section A above (American Psychiatric Association 2000).
3. Be aware that chronic pain patients can present with signs and symptoms that are incongruent with medical expectations based upon anatomical and physiological knowledge. Appreciate that these cases cannot be considered malingering. While they may predict limited success with conventional medical treatment, they cannot be used to make a reliable psychiatric diagnosis (Craig and Badali 2004).
4. Recognize that malingering and deception are possible, and identify factors that increase this likelihood as well as the limitations in our capacities to accurately assess malingering (Craig and Badali 2004).

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