

## **CHRONIC PAIN MANAGEMENT: PAIN VS. SUFFERING**

**by William K. Dixon, Psy.D.**

One reasonable definition of “chronic pain” is the report of pain and limitation persisting beyond expected healing times and without evidence of any further damage. The designation of “chronic” has less to do with the severity of the reported pain than with its impact on a patient’s life. Similarly, time considerations are only one element in defining chronicity. Disability and distress are nearly always the major foci of attention for the patient, the health care provider and others concerned, when the term “chronic” is employed.

Most injured patients understandably view their overall experience of discomfort as pain caused by the incident or activity which initiated the distressing sensations. This understanding is usually sufficient for the acute stages of recovery from an injury. But when pain problems continue to the point of chronicity, as defined above, a new set of understandings and new management strategies become necessary.

In his 1988 article “Pain and Suffering: A Reappraisal” (American Psychologist), Wilbert Fordyce, Ph.D. emphasized important distinctions between acute and chronic pain management strategies, between nociception and pain behavior, and between pain and suffering. Some simplifications and modifications of Fordyce’s concepts are reflected in the definitions below.

Both research and clinical experience reveal that a myriad of factors influence the individual’s experience of pain and response to it. George Engle’s “Biopsychosocial Model” (Science, 1977) is generally well understood by health care providers working with patients with complicated pain problems. Many patients, although not usually using the same vocabulary, also understand this. For example, patients are quick to notice that tests and laboratory results are not identical with their experience of their illness, and that the interpersonal relationship between health care providers and patients powerfully influences outcome. There can be little doubt that the meaning an individual attaches to an injury, illness or disorder partly shapes the experience. In providing care to patients with complicated, ongoing pain it is helpful to establish some common language; in particular these four terms:

Hurt: The personal experience of uncomfortable physical sensation. The pain we feel (a personal, subjective and authentic experience). Patients are the experts in identifying their own perceptions.

Harm: Tissue or structural damage to the body, generally associated with nociception (i.e. mechanical, chemical or thermal energy impinging on specialized nerve endings). Harm is almost always accompanied by hurt, but not all hurt means that there is harm.

Pain: The sensation arising from perceived nociception. While this term is frequently used in a general way, it serves better to limit its use to the sensory description of hurt and harm.

Suffering: Affective (emotional), behavioral and cognitive responses to pain and to the problems/experiences associated with pain and injury. Emotional reactions, meanings, thoughts, and existential and psychosocial issues all fall into the domain of suffering.

With complex pain problems, it is essential that patients be advised of the most precise possible diagnosis and practical, functional descriptions of their disorder. When no further damage is taking place, patients require assistance in understanding that the hurt they experience is not the same as harm. Focusing on pain is appropriate during acute stages of illness or injury, but the exact opposite is best when the problem approaches chronicity. Without education, most individuals fail to distinguish between hurt and harm.

During rehabilitation, injured individuals are encouraged to exercise, stay active and ignore or “work through” their familiar pain – all useful recommendations. But this is counter-intuitive and threatening to patients if they do not understand and believe that their hurt is not a signal of further damage. It is essential that safe limits for activities be outlined as objectively as possible (e.g. “Walking is fine up to three miles” or “No lifting more than 20#” or “Build up to 30 minutes on the treadmill at 4 mph.”). Unless there is a specific medical reason, individuals with chronic pain conditions should not be advised to participate in activities “to tolerance.” This encourages vigilance for pain levels, and makes pain itself a determining factor for activity. Again, this is often appropriate for acute injury but it’s unnecessarily limiting with chronic pain. Difficult as it may be, individuals with chronic pain must be helped to not let hurting run their lives.

Emotionally, a similar approach can be used with pain versus suffering. Apprehension, discouragement and resentment are not dimensions of pain; they reflect suffering. The uncertainty patients feel about returning to work, anger about the injury, unexpected depressed moods, family distress and various similar concerns are just as important and genuine as the hurt, and typically need to be addressed psychotherapeutically. It should be emphasized that these reactions, while significant, are not synonymous with pain. While it is unfortunately true in many cases that the hurt may not be very controllable, the suffering virtually always can be changed. Moreover, in an encouraging recent meta-analytic study of chronic low back pain, Hoffman, Chatkoff, Kerns and Papas (Health Psychology, 2007) found that studies show that cognitive behavioral therapy and self regulatory therapies (biofeedback, hypnosis and relaxation training) may not only help with coping, but also lead to reduced reports of pain intensity.

A collaborative team approach is needed. Family consultation or counseling is generally worth careful consideration. Most patients accept psychological interventions and a full rehabilitation approach best when the multidimensional nature of their problem is acknowledged. Keeping distinctions clear between hurt and harm and pain and suffering facilitates individuals taking responsibility for their own recovery. Fordyce offers a simple yet sagacious concept he calls “Fordyce’s Law”: “People who have something better to do don’t suffer as much.” Resumption of meaningful and productive activity is vital. Individuals with chronic pain can better engage in activity when they don’t confuse these concepts. Compassionate psychotherapeutic interventions are likely to be the most efficacious method for addressing the challenge of resuming maximum levels of functioning.

Much of rehabilitation is understanding. Assisting patients/clients to manage hurt and suffering and not let these experiences become excessively important or limiting in their valuable lives is a pursuit of extreme significance for all of us.

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