

Chronic Pain

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Definition

One way health care professionals describe pain is by how long it lasts: acute and chronic. Acute pain lasts a shorter time and is usually more specific. Chronic pain lasts more than three to six months. People with chronic pain may not be able to pinpoint exactly where the pain comes from, its location and description. Also often chronic pain affects a person emotionally, socially and even the ability to function in daily life. (American Academy of Family Physicians 2000; Wyngaarden 1992).

Introduction

In 2001, Rudin reported that more than 50 million Americans are affected by chronic pain. In fact, "...nearly one in four American adults [experience] chronic pain." (Engel 2002). The incidence of pain can be even higher with people with certain disabilities. As one example of that, in a sample of people with cerebral palsy studied by Engel in 2002, "...64% reported chronic pain."

Anyone can develop chronic pain. However, some people are at more risk for developing chronic pain, for example:

- People who sustain injuries, for example to their backs or joints, may experience chronic pain.
- As reported by Engel (2002) above, people with certain physical disabilities such as cerebral palsy may develop chronic pain.
- People who smoke "...have more pain than non-smokers." (American Academy of Family Physicians 2000). Nicotine can also "...make some medicines less effective." (American Academy of Family Physicians 2000).
- People who are elderly may have chronic medical conditions that cause chronic pain. For example, as many as 80% of people over 65 may have chronic pain caused by osteoarthritis. (Herr January 2002).
- People who have certain diseases may experience more pain (for example: atherosclerotic peripheral vascular disease, diabetic neuropathies, musculoskeletal disorders, trigeminal neuralgia, herpes zoster, cancer [Herr January 2002]).
- Women with a history of childhood and/or adult abuse may be more likely to develop chronic pain (Green 2001).
- People who develop pressure sores (decubitus ulcers) may experience pain. (Bergstrom 1994; Evans 1995)

Other problems are associated with chronic pain, for example:

- Chronic pain has also been linked to depression and anxiety (Herr January 2002; Wilson 2002) – "people seeking treatment for chronic pain also have high rates of clinical depressive disorders...the prevalence of major depression in pain clinic samples often exceeds 20%." (Wilson 2002). This means that one in five people who experience chronic pain are also depressed.
- Insomnia (inability to sleep through the night) is "...associated with increased pain and distress." (Wilson 2002)
- People who have all three, chronic pain, major depression and insomnia, report the highest levels of pain-related impairment. (Wilson 2002)

- Herr (January 2002) also reports that chronic pain contributes to people who are elderly falling, being malnourished, becoming deconditioned (out of shape), having problems with walking, slowing down rehabilitation and having a worsened quality of life.

Diagnosis

Health care clinicians rely on a variety of methods to diagnose pain:

- The first step in diagnosis is to ask the person about the pain experienced and what meaning it holds for the person (Wyngaarden 1992)
- The person is often asked to rate the pain using an assessment tool. These tools can use pictures, words or numbers. Herr (January 2002) describes four pain scales used with older adults:
 1. The "Faces Pain Scale" has drawings of 7 faces expressing progressively more pain;
 2. The "Verbal Descriptor Scale" uses 7 descriptors ranging from "no pain" to "the most intense pain imaginable";
 3. The "Pain Thermometer" includes 7 ranges from "no pain" to "pain as bad as it could be";
 4. The "Numeric Rating Scale" has 20 gradations with 1 being "no pain" and 20 being "the most intense pain imaginable".
- Support networks (family, friends, community members, support staff) may be asked to report their observations of changes possibility linked to pain for individuals with communication and/or cognitive challenges. Herr (January 2002) describes observation of:
 1. "...nonverbal pain behaviors (e.g., groaning, moaning, crying, sighing, verbal outbursts)"
 2. "...changes in behavior patterns (e.g., change in activity level, decreased social interaction, sudden cessation of common routines, new onset of confusion, refusal to eat, difficulty sleeping, resistance to care)"

Herr (January 2002) also notes the importance of observing the person when they are active, rather than at rest.

- A complete history is important to identifying the scope of the problem, contributing factors, and resources for healing (Rudin 2001). Examples of what a history might cover include:
 1. Health history including prior injuries as well as related conditions and/or diseases.
 2. Wellness activities (or lack of them, for example: Does the person smoke?).
 3. Related family history.
 4. Any pain or other medications taken.
 5. A detailed description of the pain's intensity, frequency, quality, location, and any factors that make it worse or better. (Herr January 2002)
 6. When and where the pain occurs. "For example, headache beginning early in the morning before arising suggests increased intracranial pressure, whereas headache occurring late in the day is more suggestive of tension. Back pain and sciatica made worse by sitting or walking suggest disc disease, whereas back pain and sciatica that are worse while the person is in bed indicate [other disease]..." (Wyngaarden 1992).
 7. Possible associated factors such as insomnia, major depression (Wilson 2002), and abuse (Green 2001)
 8. Ruling out conditions that need "...surgical or medical intervention such as tumors, infections, or lesions..." (Rudin 2001)
- In a physical examination, the physician examines the painful area for clues such as swelling, redness, temperature, range of motion (in affected joints), temperature, neurologic and other factors. (Wyngaarden 1992)
- Diagnostic examinations can give more information about the source of pain, such as CT scans (computed tomography), MRI (magnetic resonance imaging), x-rays, or nerve conduction studies. (Rudin 2001; Wyngaarden 1992)

- A functional exam; for example, observing the person's "posture and comfort during the exam...[and] sitting and standing tolerance" can give health care clinicians more useful information (Rudin 2001).
- Herr (January 2002) also suggests assessing how pain has impacted the person's quality of life.

Prevention and Treatment

Strategies for treating people with chronic pain can also be used to prevent some forms of chronic pain (such as back injury from developing):

- Learning "...safe techniques for working, lifting and bending". (Rudin 2001)
- Designing home and the workplace to be ergonomic. (Rudin 2001)
- Accommodations to prevent falls such as handrails on stairs.
- Meeting American's with Disabilities Act (ADA Title II – 28 CFR Part 35 – 28 CFR Part 35.150 & 35.151, ADA Accessibility Guidelines [ADAAG]) requirements (for example: Width of doors and hallways, ramps, carpet thickness). (Stevens, 2002)
- Exercising regularly, eating right and avoiding habits such as smoking.

Treatment for pain is often referred to as "pain management" (Herr February 2002). Clinicians suggest a variety of strategies to restore function, reduce pain, and to help the person develop coping skills (American Academy of Family Physicians 2000; Green 2001; Herr February 2002; Mettler 1992; Rudin 2001; Wilson 2002; Wyngaarden 1992):

- Catch the problem as early as possible, start treatment quickly, and treat the "underlying disorder". (Wyngaarden 1992)
- Identify and address any barriers to treatment such as:
 1. A person's fear that pain may mean (s)he is dying and thus should avoid seeking treatment (Herr January 2002):
 2. Thinking that if a person does not verbally communicate pain that that person is not experiencing pain. (Herr January 2002):
 3. A belief that a person should be strong and not complain about pain. (Herr January 2002).
 4. Fear of being prescribed addictive drugs if treatment is sought. (Herr January 2002).
 5. Unwillingness to seek treatment. (Engel 2001)
 6. Thinking that a person has a behavior problem when that person is actually trying to communicate about pain.
- Exercise is the most common treatment method and is thought to be the most important for long-term maintenance of function." (Rudin 2001)
- Use a team approach, involving multiple therapies, to treatment. (Rudin 2001; Wyngaarden 1992)
- Access therapies such as massage, psychology, "cognitive-behavioral" (Herr February 2002), and physical therapy as needed.
- Use "...relaxation and imagery techniques..." as appropriate. (Herr February 2002)
- Drug therapy if needed (for example: non-narcotic analgesics or narcotic analgesics [which should be "...used with discrimination..." because of the danger of developing physical dependence"] Wyngaarden 1992).
- Mettler (1992) lists some other ways people can deal with chronic pain, for example:
 1. "Experiment with heat, cold..."
 2. "Try to relax."
 3. "Do something distracting."
 4. "Expose yourself to humor."
 5. Practice positive self-talk."
 6. "Join a support group."

7. "Appeal to the Spirit."
 8. "Get educated."
- Monitor any treatment to see if it is effective. (Rudin 2001)

Emergency Situations – What can go wrong?

Undiagnosed pain may be related to a condition or a disease, which, if untreated, could become much worse and potentially life threatening.

Unmonitored effects of drugs and drug interactions could also endanger the person.

Conclusion

Anyone can develop chronic pain. Chronic pain lasts more than 3 to 6 months and may be difficult to pinpoint. People with certain conditions, diseases, disabilities, injuries, age and history are more at risk for developing chronic pain. Exercise, ergonomics, environmental adaptations, and education can assist a person to modify their habits to help prevent chronic pain. Treatment should start early and involve a team supporting the person by using many strategies – including identifying any barriers to treatment. Undiagnosed chronic pain may mask a life-threatening condition. Any medications, their affects and interactions, should be monitored to assure the person's safety. (American Academy of Family Physicians 2000; Engel 2002; Green 2001; Herr February 2002; Mettler 1992; Mior 2001; Rudin 2001; Stevens 2002; Wilson 2002; Wyngaarden 1992)

Direct Support Professionals can help by:

- Learning each individual's unique way of communicating and behaving and watch for changes that may be the individual's way of communicating that (s)he is in pain.
- Comparing the person's current quality of life as they are experiencing chronic pain to the person's desired quality of life - see the vision statement of the Individual Service Plan (ISP)/Plan of Care.
- Recognizing and reporting signs of abuse, neglect and exploitation.
- Educating the person about and encouraging wellness practices such as exercise, use of ergonomically correct equipment and furniture, getting enough sleep, correct lifting and bending techniques as well as avoiding smoking.

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