COMMUNICATION AND CULTURE

By Paige Hector, LMSW

Integrating Psychosocial Elements for Comprehensive Pain Management

As you begin reading, I invite you to notice whether you are experiencing any pain. Where is it showing up in your body? How would you describe it? If you shift your body, is there relief or is the pain exacerbated? Does the pain make you think of something else going on in your life that isn't physical?

Universal and Multifaceted

As human beings, the experience of pain is universal, although how humans understand and address pain can vary across contexts and cultures (M.D. Good et al., eds., *Pain as a Human Experience*, University of California Press, 1992). In the United States, particularly in medical contexts, we tend to associate pain with physical manifestations, such as stemming from a wound; yet pain can also have psychological, social, and spiritual origins — such as grief or heartbreak. This is why many practitioners have come to understand pain as a multifaceted experience made up of biological, psychological, and social components. This is also known as the "biopsychosocial model" of pain, which considers the "'whole person,' with both the mind and the body together as interconnected entities" (*US Neurol* 2016;12[2]:98–104).

Just as pain can be caused by a variety of factors, experiencing pain — be it physical or emotional — can ripple into other areas of our lives, affecting our self-image, the essence of our personhood, and our livelihoods and relationships.

What Does Psychosocial Pain Stem From and Look Like?

One of the common aspects of psychosocial pain is underlying trauma. Individual trauma is defined by the Substance Abuse and Mental Health Services Administration as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" ("SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach," SAMHSA, 2014, http://bit.ly/3kvzFgk).

Experiencing shame in relation to trauma is one of the reasons people feel emotional pain. Shame following trauma can manifest in a number of ways, including (but not limited to) feelings of embarrassment, despair, or responsibility surrounding a traumatic event, no matter how long ago the event occurred (*Humanit Soc Sci Commun* 2022;9:214). For example, a person who divorced years ago and whose teen subsequently turned to life-long substance use may experience regret for what happened.

The concepts of somatization or embodiment, or the ways our bodies communicate psychological distress, are helpful here because psychosocial trauma or shame may manifest as physical pain or even disease. An individual's experience of their "heart hurting," or a "burning sensation" in their gut that results in a stomachache, may be a way for individuals to communicate pain around trauma, anxiety, or stress. Communicating these physical experiences may be a conscious attempt by an individual to make their invisible emotional pain visible, particularly in a medical setting. Physical pain can also be an unconscious manifestation of trauma. A classic and popular account of such embodied trauma is *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (Penguin, 2014) by Bessel van der Kolk, MD.

Medical trauma can also be associated with pain. As Scott Janssen, MSW, LCSW explains, "Medical traumas are psychological traumas that result from medical diagnosis and/or medical interventions" ("Medical Trauma," *Social Work Today e-Newsletter*, April 2016, http://bit.ly/3HelRQ1). He says, "We are socialized to endure medical treatment" and thus expected to "just deal with the emotional effects of care on the psyche."

Robert Rosenbaum, PhD, clinical neuropsychologist and psychotherapist, has noted that pain can also contribute to fear, which can in turn increase pain. For example, a person may believe that pain means they have a fatal disease or fear that they will be blamed for their pain or labeled a "drug-seeker."

Regardless of the cause or manifestation of psychosocial pain, enhanced communication between patient and practitioner is key. As Dr. van der Kolk writes, "The body keeps the score: If the memory of trauma is encoded in the viscera, in heartbreaking and gut-wrenching emotions, autoimmune disorders and skeletal/muscular problems, and if mind/brain/visceral communication is the royal road to emotional regulation, this demands a radical shift in our therapeutic assumptions."

Pain in Long-Term Care

In the context of post-acute and long-term care, effective pharmacological management of pain is one indicator of good resident care. Pain assessment is included in almost every resident interaction, and the staff use a variety of screening and assessment forms to inquire about pain location, intensity, quality, duration, pattern, treatment, and response.

In my review of numerous screening and assessment forms, I found they were missing exploration of the psychosocial contributors and impacts of pain. One form included a section for "Comments/Plans," and in parentheses it suggested areas for investigation that included pain barriers, family beliefs, and concerns, but questions or prompts were not included. On another form, the patient is asked to rate the amount of interference the pain causes in areas of general activity, mood, enjoyment of life, and relationships — but again, without additional context or information.

Although some physical pain does not have a psychosocial element, it is still important to consider an integrative-approach to pain to promote person-centered and trauma-informed care. As human beings, we need to know that being seen, heard, understood, and acknowledged for what is important to us matters. Having the experience that our needs matter supports a sense of well-being and healing.

Addressing Psychosocial Pain

What can facilities do to integrate a psychosocial component to create a comprehensive pain management program? One important step is to consider adding psychosocial *conversation prompts* to your pain assessment. The phrasing of conversation prompts is key: they should encourage a dialogue between patient and practitioner with an emphasis on listening to understand the person's experience, rather than a checklist approach.

I personally found a one-day training session with Dr. Rosenbaum in 2018 (through the company PESI) helpful in developing my own list of questions, and I recommend such training to readers. I've drawn on my own experience as a social worker and solicited the help of *Caring*'s managing editor to consider the recurrent themes that are reflected in his questions and in the ongoing work that we do in PALTC communities.

- Ask patients about what pain means to them or how they make sense of it to help uncover family, spiritual, or cultural beliefs that impact their perception of pain.
- Explore how the pain relates to other areas of their life with questions related to how the pain varies across time/space.
- Explore their life adjustments in relation to the pain (the most difficult adjustments or change in activity) to help identify struggles and possible alternative solutions.
- Ask patients what emotions or feelings emerge in relation to their pain to help them give voice to their invisible experiences of pain. (It may be helpful to have a few prompts: helpless, curious, ashamed, calm, puzzled, or alert.)
- Consider asking about their fear, anxieties, and worries surrounding the pain. These questions can be directive, such as in this example from Dr. Rosenberg: "When you wake in the middle of the night with pain, what do you fear?"
- Draw on questions asked in mental health questionnaires, such as "Have you ever thought about hurting yourself or taking your life because of the pain?"
- Help the patient create an action plan by exploring distractions, pleasures, and meaningful activities that can help alleviate the pain and identifying when and where these activities can take place.
- Explore the pain in a hopeful way. "If" and "when" questions are useful here: "If the pain goes away, what will you do?"

Perhaps you are thinking, "But Paige, I don't have time to have such in-depth conversations with my patients." I'd like to offer a different perspective. We are socialized with perceptions around time that emphasize scarcity thinking, as in "I don't have enough time" or "there isn't enough time." In her book *The Highest Common Denominator* (Bookbaby, 2021), Miki Kashtan says, "Instead of saving time up front and losing it later, the choice is to invest time up front and harvest the results later." By including psychosocial elements in pain assessments, we are investing our time in connecting with the individual, which can later help us better manage a patient's pain.

There is no magic wand or one-size-fits-all approach to a psychosocial pain assessment. As competent clinicians, we can continue to expand our role as healers and grow our capacity to hear a person's story in a new light by bringing a genuine sense of curiosity to the relationship and by asking about uncovered topics.

Ms. Hector is an author, speaker, and educator specializing in clinical operations for the interdisciplinary team. She is associate editor and a member of the Editorial Advisory Board for *Caring for the Ages*. The author's views are her own and do not represent those of the Society nor any other entity.