



THE ROLE OF THE FAMILY IN THE TREATMENT OF CHRONIC PAIN

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The experience of chronic pain can abruptly change lives. Feelings of frustration, bitterness, and anxiety are common for both the individual experiencing the condition and his or her family. The uncertainties of the future often appear overwhelming. While relatively acute illnesses such as pneumonia, gastritis, bone fractures, etc., affect the family for short periods of time, when a person suffers from chronic pain it has a much more profound and long lasting effect and can, consequently, influence family dynamics significantly.

For the purposes of this paper, the term family encompasses both the traditional meaning of the word and the broader interpretation that reflects many contemporary situations. With chronic pain, psychiatric problems may arise as a result of the pain (e.g., reactive depression), problems may re-emerge because of the pain, or problems may be exacerbated by the pain (of which Post Traumatic Stress Disorder is a good example). The latter two scenarios are especially likely to lead to significant domestic conflicts. Patients and their families frequently experience difficulty adjusting to changes in roles and limitations of function, mobility, and socializing brought on by chronic pain. There are shifts in family income, emotional support, time spent together and sexuality.

Before we proceed specifically with families, let's take a look at the co-morbidity of psychiatric problems with the chronic pain patient because it can exacerbate the impact on the family. Studies on co-morbidity vary widely in terms of demographic groups studied, variables examined, and specific co-morbid psychiatric conditions considered, consequently the prevalence of co-morbid psychiatric illness is difficult to determine with any accuracy. Broadly speaking, you may find that in approximately 30% of chronic pain cases no psychological intervention is necessary, no problems exist. But approximately 30% of the cases show signs of workable limitations such as, anger, depression, frustration, histories of co-dependencies, chemical and process addiction, passive-dependency, aggression, violence and so forth. In another 30% of chronic pain cases there are signs of more complex limitations such as Post Traumatic Stress Disorder, dissociative problems, severe personality problems, and hyper-aggression. Further, in approximately 10% there are catastrophic limitations/problems such as severe suicidal ideation/attempts, or even psychosis.

In the first category mentioned, the group with no preexisting co-morbid psychiatric condition, basic supportive counseling will

most likely suffice; the support of a social worker to help the family negotiate the shifts in the family, coordinating services, applications, and the like. However, in the latter three categories more intensive systems/family oriented therapy would probably be indicated and prove more helpful.

How the Family Can Help

The primary role for loved ones is to offer support, coaching, encouragement and patience. In addition, one of the key roles a family can play is assisting the patient in getting the professional care that is needed. It may mean helping them make contact and support them in interacting with the many professionals that are part of the treatment team. Further, the family may also assist in the interface with insurance companies, managed care organizations, hospital administrations, and other interested parties.

Assisting in the Care of Your Loved One

Positive interaction between the family and the relative with chronic pain is crucial. It can be difficult and frustrating, especially when pain level is high and dependency is great. However, it is well worth the effort to establish a positive environment for all.

Clear, open communication is very important to help prevent mounting resentments and other

counter-productive emotions. Strive to make communication as clear as possible. It is important for family members to practice good basic communication skills: make eye contact, speak in short, clear sentences, not wander from point to point, avoid yelling, and take time to really listen, repeat or clarify what is heard, and validate the experience of their loved one.

Establishing routines and setting goals are important for chronic pain patients, as well as, their family. Setting realistic expectations for all involved is very important. When assisting with any care, questions that should be pondered are: Is this something that the individual could accomplish for themselves?; What is likely to be expected of me?; Do I have the time to assist with the task?; Am I beginning to build resentment now, and should someone else do it for now? One should be realistic about one's limits. It will be necessary to line up assistance from time to time before one feels overwhelmed.

Nurturing the Care Giver

The idea of family care and assistance of the chronic pain member should not mean that the needs of the other family members must be ignored. The focus of the family should include more than providing for the individual. It is important that care givers have time and energy for their other family roles – that of parent, child or

spouse. If not, resentments will surely mount up and relationships will suffer.

Care givers and families need to manage their stress and learn to take time out when pressure is mounting. They need to learn to make time to pursue their own social, educational, and recreational interests. Having some balance in their lives helps reduce the stress of care giving.

Summary

If you are not looking at the underlying psycho-social dimensions of a patient's life, you will not uncover and diagnose problems that may exist there, and sooner or later they may interfere with the patient's ability to get better.

Nearly one third of the 80 million Americans who suffer

from chronic pain get little or no relief from "conventional" approaches to pain management. This is, in part, because of a failure to appreciate the emotional and psychological problems a patient (and by default, their family) may be encountering, and the role those problems play in the overall picture. Treating a complex chronic pain patient separately from his or her immediate social network, the family, may doom the treatment at worse and slow down the process at best. Family involvement in treatment assists in the understanding of the dynamics of the patient's social network and how it all fits together in the chronic pain syndrome. The involvement of family in the establishment of goals can be

instrumental in helping the patient achieve better pain management.

Bibliography

- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders, (4th ed.). Washington, D.C.: Author.
- Enel, G. (1959). Psychogenic pain and the pain-prone disorder. American Journal of Psychiatry, 26, 899-918.
- Fishbain, D., Goldberg, M., Meagher, R., Steele, R., & Romanoff, H. (1986). Male and female chronic pain patients categorized by DSM III diagnostic criteria. Pain, 26, 187-197.

- France, R. & Krishnan, K.R.R. (1988). Chronic pain. Washington, D.C.: APA.
- Hoffman, L. (1981). Foundations of family therapy. New York: Basic Books.
- Moris, D. (1991). The culture of pain. Berkeley: University of California Press.
- Voon, A. (1990). The process involved in becoming a chronic pain patient. In E. Tunks, A. Bellissimo, & R. Roy, (Eds.), Chronic pain: Psychosocial factors in rehabilitation, (2nd ed.). Melbourne, FL: Krieger.

DIFFERENTIAL DIAGNOSIS OF RSD (CRPS I) VERSUS OTHER DISORDERS

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Severe burning pain, with extreme sensitivity to touch, was first reported by Weir-Mitchel et al. (1864) in the 1860's based on his experience with soldiers who had received "high velocity missile" wounds during the Civil War. Ghostine et al. (1984) reported similar findings in combatants during the wars in Lebanon in the 1970's. However, most reports in the literature indicate that Reflex Sympathetic Dystrophy (RSD) or Complex Regional Pain Syndrome Type I (CRPS I), can be caused by minor injuries to susceptible individuals. These injuries range from twisting an ankle to striking the back of the hand, to wearing a new pair of shoes (Hendler & Uematsu, 1983). Obviously, the development of a disorder that affects an

entire limb, based on minor trauma, is disproportionate to the trauma, very often resulting in accusations of psychosomatic disease, as espoused by Ochoa (1985).

The pathophysiology of RSD (CRPS I) suggests that there is sensitization of the wide dynamic range neurons in the spinal cord by altering the activity of NMDA receptors (Ren & Dubner, 1993). This produces the clinical feature of allodynia. Allodynia is defined as a painful response to a normally non-painful stimulus (Kim & Chung, 1995). There are three types of allodynia: a) thermal, b) chemical, and c) mechanical. These can easily be tested by the Hendler Alcohol Drop and Swipe Test (Hendler, 1995). In this test, a physician squeezes an alcohol swab so that a drop

of alcohol lands on the patient's affected area. If the patient immediately withdraws the limb and complains of a burning pain, the physician has demonstrated thermal allodynia, i.e. a painful response to the cooling effects of a drop of alcohol on a limb. After two minutes, if there has been no response to the thermal test, a patient may begin to experience burning pain in the affected limb. This occurs as the fat soluble alcohol permeates the skin and begins to chemically irritate the hypersensitive C fibers, which conduct the message of pain. If the patient then experiences pain, this demonstrates chemical allodynia. Then, with the leftover alcohol swab, the physician gently strokes the affected area. If

this produces pain, this clearly demonstrates mechanical allodynia. In order to establish the diagnosis of RSD (CRPS I), Raja and Campbell (1996) have reported that thermal allodynia is an essential criteria. Hendler has reported chemical allodynia (Hendler & Raja, 1994). However, mechanical allodynia can be found in many types of neuropathic pain, such as post-herpetic neuralgia, trigeminal neuralgia due to vascular compression, nerve entrapment syndromes, and radiculopathies (Hendler, Bergson & Morrison, 1996).

The clinical manifestations of RSD (CRPS I) are varied. Wu (1983) has called this the chameleon disease, since the symptoms change over time. Schwartzman (1987) has