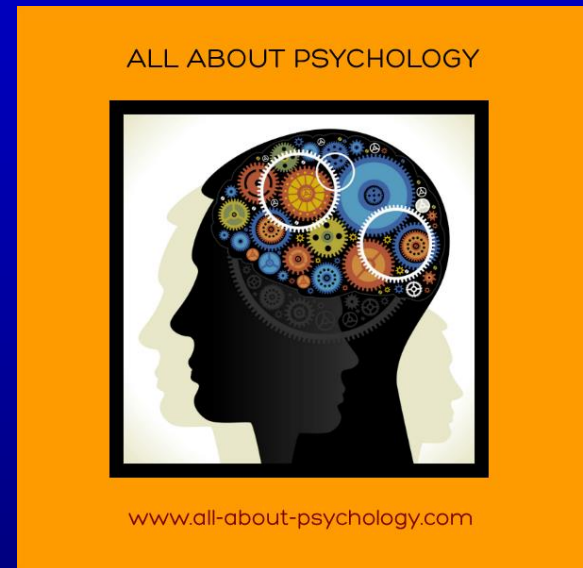


# Psychology of Pain

**DR. ARNEL BANAGA SALGADO,**

Doctor of Psychology (USA)  
FPM (Ph.D.) Psychology (India)  
Doctor of Education (Phl)  
Master of Arts in Nursing (Phl)  
Master of Arts in Teaching Psychology (PNU)  
Registered Nurse (Phl, Mal, UAE)  
Licensed/Registered Teacher (Phl)  
Certificate in Teaching,  
Bachelor of Science in Nursing



Dr. Arnel Salgado 2018

# Learning Outcomes

After the lecture discussion, the students will be able to:

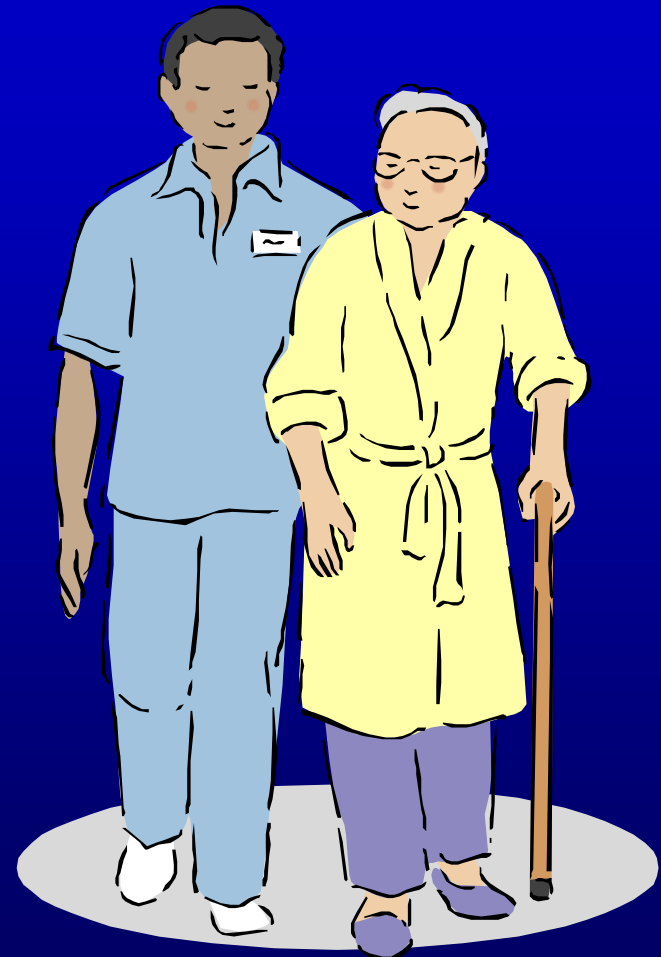
1. Define pain
2. Identify pain standards
3. Apply pain scale
4. Determine the different causes of pain
5. Identify the different barriers for pain management

# Definition

- Persistent or recurrent pain lasting more than 48 hours and not alleviated by simple comfort measures.
- It can be just flashes of pain, burning, or tingling; or unremitting, sharp, aching, or dull.

# Highlights Pain Standards

- Assess all patients routinely for pain
- Record assessment data in a way that facilitates reassessment and follow-up.
- Educate patients and families on the importance of pain management as part of care.
- Do not permit pain to interfere with optimal level of function or rehabilitation.
- Include pain and symptom management in discharge planning.



# When should I assess a patient's pain?

- On admission to the inpatient setting
- At patient's report of pain
- Post-procedure or post-operative
- With each nursing assessment
- One hour after a pain intervention
- At the time of discharge planning

# How should I assess for pain?

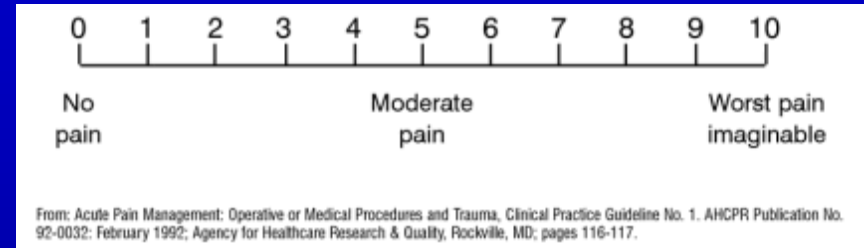
- A complete pain assessment will include the following factors
  - Location
  - Intensity—at present, at worst and at best using **pain scale**
  - Duration—include onset, variation, continuous or intermittent
  - Frequency
  - Character—throbbing, shooting, stabbing, sharp, ache, etc.
  - Comfort goal—this is determined by the patient

# Pain Rating Scales

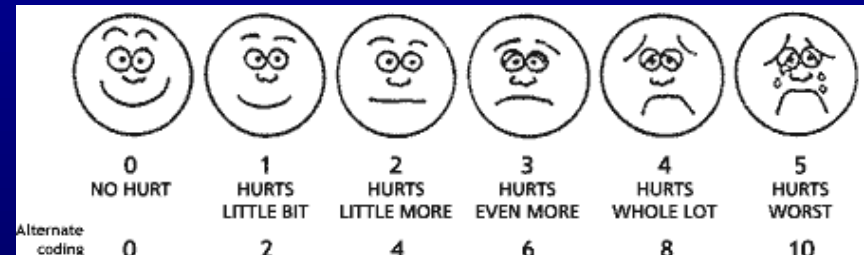
- The most commonly used Pain assessment scale is the **Numeric Pain Rating scale**.
- You ask the patient to rate their pain on a scale from 0 to 10 with “0” being no pain and “10” being the worst pain they have ever had.
- Be sure and let patients rate their own pain, do not be influenced by family members rating the pain.

# Pain Rating Scales

- The **Visual Analogue Scale** may be easier for some patients to use. Show them the scale and ask them to rate their pain.



- The **Face Scale** may be used for some adults who are unable to use the number scales. Ask the patient to pick a face that matches how they feel and record that # as their pain level.





# Pain Rating Scales

- The **FLACC scale** should be used with patients who are nonverbal or noncommunicative

<b>FLACC Scale</b>			
<b>Category</b>	<b>Scoring</b>		
	<b>0</b>	<b>1</b>	<b>2</b>
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Crying	No crying (awake or asleep)	Moores or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Crying; (C) Consolability is scored from 0-2, resulting in a total score range of 0 to 10.  
source: Merkel, 1997.

# Pain Documentation

- Be sure to document a complete pain assessment with each nursing assessment on the Assessment tool.
- Record a pain rating on the Clinical Data Flowsheet and include interventions if made and the reassessment after an intervention.



# Assessment of Pain

Take a detailed history of the pain

- Site and radiation (where is it; is it localized or radiating)
- Nature (sharp, pulsating, dull, burning, stabbing, aching, squeezing)
- Duration (continuous or intermittent; how long and how frequent)
- Factors: Aggravating,relieving
- Effect on patient's mobility, activities of daily living, sleep
- Intensity and severity (mild, moderate, or severe)
- Assess the intensity using a numeric pain scale (or a "faces" pain scale for children)
- Associated symptoms

- Do a psychosocial assessment
  - Assess patient's mood—this affects his/her perception of pain
  - Take a detailed social history: social aspects (family problems, lack of care) can affect pain
- Do a full physical and neurological examination
- Carry out investigations and follow-up:
  - ✓ start with simple, available, affordable tests
  - ✓ monitor control of pain and adjust treatment as necessary

# Types and Common Causes of Pain

## Headache:

Toxoplasmosis

TB meningitis

malaria

muscle tension headache

dehydration

Herpes zoster

Cryptococcal Meningitis

viral meningitis (HIV, CMV)

neurosyphilis

side effect of some medications

lymphoma of the brain

## Peripheral neuropathy:

HIV

Cytomegalovirus

due to medication

Diabetes

avitaminosis

post-herpetic neuralgia

## Types and Common Causes of Pain, continued

Abdominal pain:	peptic ulcer	PID
	gastroenteritis	abdominal abscesses
	abdominal tumors	acute abdomen
	worm infestations	retroperitoneal adenopathy
Oropharyngeal and esophageal pain:	reflux esophagitis	Kaposi's sarcoma
	Candidiasis tonsillitis/pharyngitis	
	Herpes simplex	aphthous ulcers

## Types and Common Causes of Pain, continued

Skin pain:

Herpes zoster  
skin sepsis

Chest pain:

lung infections  
esophageal candidiasis  
mediastinal lesions

Generalized pain:

fever  
rheumatism  
bed ridden status  
non-specific etiology

# Barriers to Pain Management

## Problems related to health care providers

- Inadequate knowledge of pain management
- Poor assessment of pain
- Concern about regulation of controlled substances
- Fear of patient addiction
- Concern about side effects of analgesics
- Concern about patients becoming tolerant of analgesics



### Problems related to patients

- Reluctance to report pain
- Reluctance to take pain medications

### Problems related to health care system

- Low priority given to AIDS pain treatment
- Most appropriate treatment may be too costly
- Restrictive regulation of controlled substances
- Problems of availability or access to it

# Therapeutic Approaches

## Principles of pain management

- For most patients, physical pain is only one of several symptoms. Relief of pain should be seen as part of a comprehensive pattern of care
- While the cause of pain is often susceptible to specific treatment, symptomatic treatment should not be delayed
- Oral medication is recommended to encourage patient autonomy
- Aggressive treatment of pain is needed in the later stages and terminal phase of illness

## Therapeutic Approaches, continued

- Regular medication is preferred over PRN medication: the goal is to prevent pain round-the-clock; addiction should not be a consideration
- Anticipate and prevent side effects of nausea/vomiting with an antiemetic
- Opiates can cause constipation: this may actually be a positive effect in patients who have chronic diarrhea; if not, give laxatives or appropriate dietary advice
- Inform the patient that sedation usually decreases after 3-5 days
- Initially pain relief may simply allow the exhausted patient to sleep

# WHO 3-Step Treatment Model for Pain

Drug	Dosage
<b>Step 1: Mild pain—Give non opioids</b>	
<ul style="list-style-type: none"><li>Aspirin</li><li>Paracetamol</li><li>NSAIDs: Ibuprofen, Naproxen</li></ul>	600 mg q4-6 hrs 1gm q6-8 hrs 200-400 mg qid, 250-500 mg qid
<b>Step 2: Moderate pain—when the above drugs fail, give a weak opiod in addition to the nonopioid</b>	
<ul style="list-style-type: none"><li>Codeine</li></ul>	32-65 mg po q 4 hrs

# WHO 3 Step Treatment Model for Pain

Drug	Dosage
<p>Step 3: Severe pain—when the above combination is no longer effective, give a strong opioid, preferably with a non opioid</p>	
<ul style="list-style-type: none"><li>▪ Morphine (oral or Injectable)</li></ul>	<p>Minimum 5mg q4 hrs.</p> <p>In severe pain there is no maximum dosage (sometimes 500mg q4 hrs is needed)</p>
<p>Adjuvant therapies may be used at each step for specific pain treatment</p>	
<ul style="list-style-type: none"><li>▪ Anticonvulsants: for pain of a nervous origin such as herpes zoster</li></ul>	<p>Carbamazepine 200mg tid</p>

# WHO 3 Step Treatment Model for Pain

Drug	Dosage
<ul style="list-style-type: none"> <li>▪ Antidepressants for tingling or burning pains of peripheral neuropathy and nerve compression</li> </ul>	<p style="text-align: center;">Amitriptyline 10-25mg at bedtime</p>
<ul style="list-style-type: none"> <li>▪ NSAIDs for pain of inflammatory origin such as rheumatic conditions and hepatomegaly or bone pain</li> </ul>	<p style="text-align: center;">Ibuprofen 200-400mg tid Indomethacin 25mg tid</p>
<ul style="list-style-type: none"> <li>▪ Anxiolytics, hypnotics</li> </ul>	<p style="text-align: center;">Lorazepam 1mg at bedtime Hydroxyzine (Atarax) 25mg tid</p>
<ul style="list-style-type: none"> <li>▪ Antihistamines</li> </ul>	<p style="text-align: center;">Promethazine 10mg at bedtime</p>
<ul style="list-style-type: none"> <li>▪ Neuroleptic to reduce side effects of Morphine (i.e., nausea and agitation)</li> </ul>	<p style="text-align: center;">Haloperidol 1.5mg at bedtime or bid Chlorpromazine 10 mg tid-qid Hydroxyzine 50-100 mg qid</p>

# The Use of Steroids

- Steroids can be used, provided that any concurrent infection is treated at the same time and nystatin or Ketaconazole are given to prevent/treat thrush
- Side effects are seen with prolonged use; use lowest effective dose
- If no benefit is seen, withdraw steroids after 1-2 weeks

# Steroid Recommendations

Indication	Recommended steroid
Raised intracranial pressure Spinal cord compression	Dexamethasone 24mg daily in divided doses. Reduce by 2mg on alternative days for maintenance dose
Nerve compression	Dexamethasone 8-16mg qd ---then reduce as above to 2mg bid
Anorexia      Severe itching Stevens Johnson syndrome	Dexamethasone 4-6mg qd then reduce to 2mg qd