

## Whole Person Pain

Pain is one of the most common and distressing symptoms of any disease process. However, it is not purely a physical experience but involves various other components of human functioning, including personality, mood, behaviour, and social relations. In an attempt to describe the all-encompassing nature of pain within a “whole-person” framework, Dame Cicely Saunders coined the concept of “total pain”(Saunders CM 1998). She suggested that pain has psychological, social, emotional, and spiritual components that make up the “total pain” experience. Yet the contribution of each component will be specific to each individual and his or her situation. The concept can be broadened to that of “total suffering” to include the many individual symptoms and the physical threat to the “intactness” of the whole person and their familiar world.



Physical pain may be caused by the effects of the underlying disease process, by treatment, by deconditioning, debility, and by unrelated problems. Spiritual distress is often overlooked in clinical assessments and will include existential questions, the search for meaning and purpose, and anger at “fate,” as well as specific faith issues in some patients. Social pain relates to the position the patient has within society and culture, financial issues, and the impact the pain has on the family and caregivers. Psychological pain causes and is affected by fear, anxiety, and depression.

Whole person pain is the combined effects of psychological, social, emotional, environmental, tissue (nociceptive) and neural (nerve) aspects of pain. This approach to pain management recognizes the role of idiosyncratic patient thoughts and beliefs in influencing the behavioural response to pain. Past experience of pain, family influences and contact with health care professionals play a role.

A biopsychosocial approach to assessment and management is needed taking into account all these areas of the pain experience. This approach calls for a multidisciplinary team including physicians from different disciplines (such as pain medicine, rehabilitation, orthopaedics, rheumatology, psychiatry, palliative care and oncology), nurses, medical social workers, physiotherapists, occupational therapists, pharmacists, psychologists, and chaplains.

The physical aspects of pain cannot be treated in isolation. The term “opioid-insensitive pain” is sometimes used to describe components of pain that are not amenable to analgesics, such as fear or financial distress, which need different management strategies. The various components must be addressed and treated simultaneously, and failure to do so will mean that pain is inadequately treated in many cases. In addition, recognition that some contributions to the pain may have roots in long-standing problems that are not easily solved and that patients may struggle to distinguish between the different components will allow the team to set realistic goals of treatment.

Adapted from:

Total Cancer Pain, IASP Global Year Against Cancer Pain October 2008-2009.

[http://www.iasp-pain.org/AM/Template.cfm?Section=Fact\\_Sheets1&Template=/CM/ContentDisplay.cfm&ContentID=8705](http://www.iasp-pain.org/AM/Template.cfm?Section=Fact_Sheets1&Template=/CM/ContentDisplay.cfm&ContentID=8705)