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Pain and Patient's Behaviour

"Listen to the patient he is the one concerned
Listen to the patient he is telling you the diagnosis
No gain without pain, so there might be again behind the pain". -Hippocrates-

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Pain is one of the leading causes of doctor's consultation; probably it is the most common symptom seen in medical practice. Pain is usually considered by the patient as a very bad feeling, a real cause of suffering, and should be aborted very soon but from the other end; it is a mercy because it encourages early consultation, which usually leads to good outcome.

Pain consists of four components, which are;

1. Cognitive component:
   Perception, the patient become aware of the site, duration, and intensity of pain.
2. Affective components:
   Effect on emotional situation, impairment of well being.
3. Motor component:
   Movement of facial muscles, (expression of pain) rubbing and with drawl movements. (Protective function)
4. Autonomic component:
   a- Acute pain: increase in heart rate and blood pressure, deepening of respiration, dilatation of pupils, increased gland secretion & muscle tone.
   b- Chronic pain: sleep disorders, loss of appetite, irritability, loss of interest, loss of contact with surroundings and excessive egocentric preoccupation.

The reason behind pain is usually organic or physical disease, but pain may arise solely because of psychological reasons. A mix up is also possible; this is called psychological magnification, which means there is an organic disease, probably a minor pathology, but the patient response was exaggerated.

So it is vital to assess the patient response or behavior to pain, i.e. how he reacts to pain. The assessment should be based on the whole clinical picture and isolated symptoms should be ignored.

Pain sensation is a dual phenomena, it is not only a perception of painful stimulus, but an emotional reaction to it, which could be affected by so many factors like seeking compensation.

The influence of patient psychology on pain behavior should only be considered after all efforts are made to exclude an organic cause. This cause may be directly related or referred.

It is not always easy to find the associated or shared psychological reasons in the patients suffering. The patients usually dislike to admit this, and even tries his best to hide it, so the clever physician is one who is capable of detecting how real is the pain, and what is the reason or reasons behind pain.

Psychological distress can not be assessed accurately by clinical impression but is best measured by a specific questionnaire like Minnesota multiphasic personality inventory

test, the modified somatic perception questionnaire (Main 1993) and a depressive inventory such as that described by Back (1991) or Zung (1965).
So a good physician is the one who harbor some psychological standards in his Brain.
The reaction from the patient's side differs for the same painful stimulus arising from an identical pathology. A very good example is the labour pain. This is probably related to what is called pain threshold which is influenced by psychological and organic reasons like hyperglycemia as a cause of lowering pain threshold.
Another factor which plays a definite role is the personality of the patient.
A very vital point behind the response to pain is whether there is a gain behind it, like compensation.
So precise spotting of the reasons behind the response to pain is very important, particularly when surgical interference may be needed.
Identification of the reaction to pain and the differentiation between organic and non organic causes of pain is not always an easy job, but certainly it is eased by the clinical wisdom which is related to long and perfect clinical skills.
However certain clinical guidelines may help, like the dissociation between the anatomical distribution and the patient behaviour. So we can say the pain is physically inappropriate and much more related to the patient's distress.
The following findings may also help like if the patient tells, it is a whole leg pain, or numbness, whole leg giving way, absence of spells without pain, intolerance of and reactions to treatment and unnecessary emergency visit to the hospital.
Other helpful or guiding points in the physical examination are the non organic response to examination. Physical examination should not only detect objective physical abnormality but also provide information about the patient's response to pain. Superficial tenderness, non anatomical tenderness, simulation tests, axial loading, simulated rotation; distraction tests all are useful in the evaluation of the reality of pain and suffering claimed by the patient. Keefe and Block (1982) have developed a simple and reliable system of observing overt pain behaviour commonly displayed by patient with back pain, and that is guarding, bracing, rubbing, grimacing, and sighing.
These non-organic or behavioural signs are again clearly separable from the standard signs of physical disease and are closely related to emotional distress.
Realizing the patient's reaction to pain is very vital and should be considered before offering any sort of treatment, particularly if surgery is knocking the door.
To sum up, and acute is a cause of anxiety and chronic pain is a cause of depression; psychological trauma may lead to pain. Medicine is about people and about human illness, not about symptoms and disease. We all agree in principle with the need to treat people rather than pain.
One of the vital points, to put this into practice is to improve clinical assessment, and judgment, and how patients react to symptoms and disease.

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