Understanding the Basics of Pain Management: FACTS AND MYTHS

Pain is an unpleasant sensory or emotional experience associated with actual or potential tissue damage, occurring in varying degrees of severity. According to Margo McCaffery, RN, FAAN, pain is “whatever the person says it is, occurring whenever the person says it does.”

There are some disturbing mindsets that people carry about pain and its management. This brief overview attempts to provide some basic up-to-date concepts and information, sorting facts and fiction, and promoting a better understanding of the complex issues surrounding good pain management.

Certainly, no one wants to be in constant pain....but many will endure it...for fear of something worse. Research suggests that patients fail to report pain for several reasons:
- Being thought of as a “weakling,” “complainer,” or “bad” patient
- Not wanting to distract the physician’s attention away from the primary disease
- Unwillingness to acknowledge worsening disease (which they think pain signals)
- Fear of the drugs used to treat pain, or the side effects of medication

Here are some FACTS about some common myths surrounding pain management:

**MYTH:** “*If the patient takes narcotic medications, he/she will become addicted*”
**FACT:** Addiction is characterized by the compulsive use of drugs for their psychological effects; the drugs are causing harm to the person, but are still taken. It is rare for pain patients with no history of substance abuse to become addicted to pain medication—including opioid drugs, such as morphine. Many people confuse physical dependence, which is the occurrence of withdrawal when the drug is stopped, with addiction.

**MYTH:** “*If the patient no longer needs the medication, he/she will go through severe withdrawal when trying to stop it*”. **FACT:** Withdrawal is a physical phenomenon that means that the body has adapted to the drug is such a way that a “rebound” occurs when the drug is suddenly stopped. All people who take opioids for a period of time can have this withdrawal syndrome if the drug is stopped or the dose is suddenly lowered. This can sometimes be lessened by slowly tapering use of a drug over time or with a short course of medication during withdrawal.

**MYTH:** “*The patient will develop a tolerance to his/her medication and will have a keep taking more and more until he/she is immune to it and it doesn’t work anymore*”.
**FACT:** Tolerance to opioid drugs occurs but is common and to some degree, expected. Tolerance means that taking the drug changes the body in such a way that the drug loses its effect over time. Initially, patients’ doses are gradually increased until pain relief is obtained, and then they stabilize at this dose for a long period of time. If doses need to be increased because pain returns, it is more commonly due to disease factors than to tolerance, particularly if the pain is due to cancer.
**MYTH:** “Pain medication should be saved and used only when pain is severe.”

**FACT:** Pain medication should be given on a regular schedule so that there is a stable amount of medicine in the body to keep the pain away. By taking medication before the pain becomes unbearable, the patient can get better relief with lower doses and fewer side effects.

**MYTH:** “The patient will not be him/herself on the medication and will become a zombie.” **FACT:** Although opioids can make people sleepy and cloud their thinking, this side effect is usually temporary. Long-term therapy is generally associated with normal thinking. Most patients can take opioid drugs for a long period of time and be mentally very normal. Patients who have been stabilized on opioid therapy and are clear-headed can drive, work, and do whatever else their health allows.

Generally we think of pain as being either **acute** (describing a condition with a rapid onset and short but relatively severe course) or **chronic** (a condition six months or longer), and in one of three categories: **Somatogenic pain:** having a physiological cause, **Psychogenic pain:** having a psychological cause (this is quite rare), or **Idiopathic pain:** pain with no apparent cause.

Acute pain causes a stress response, and we may see anxiety, sweating, increased heart rate, blood pressure, or respiratory rate. We may see problems such as exhaustion, sleep problems, lowered immunity or decreased appetite with either acute or chronic pain, while depression, progressive disability and loss of strength or more likely with chronic pain.

There are numerous treatment modalities and medications available that include non-opioids, as well as medications that combine opioids with other analgesics or anti-inflammatory medications. Virtually every authoritative body from the World Health Organization (WHO) to the Agency for Health Care Policy and Research (AHCPR) agrees that opioids are central to the treatment of moderate to severe pain. Treating pain does not just relieve suffering; it can lead to shorter hospital stays, fewer readmissions, and better quality of life.

**For Care-givers: “What you can do to help”**

*Encourage the patient to take pain medications exactly as prescribed, help them keep a record of medications, side effects, and questions for the doctor.*

*Involve the patient in other activities to distract them, such as watching a movie, using the computer, reading, or playing games.*

**For Clinicians: “What you can do to help”**

*Respect the person’s report of pain. Provide assessment before and after interventions, document accurately the person’s report of pain, your assessment, and interventions. Anticipate problems; work with the physician, pharmacy, patient and their family to provide education, empathy, and appropriate medication and therapies. Make certain your patient understands instructions, offer explanations, teach and guide through relaxation strategies. Simple actions such as touch, listening and encouragement can have a powerful effect. Ask for help, if you are unable to reduce suffering, request a consult from the pharmacy or pain team.*