Two definitions of pain are widely accepted and emphasize the complexity and individuality of pain.

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (International Association for the Study of Pain).

- Indicates impact on both physical and psychosocial functioning
- Acknowledges the complexity of the pain experience
- Recognizes that the amount of pain experienced does not relate to the amount of tissue damage present

Pain is whatever the experiencing person say it is, existing whenever he/she says it does (Margo McCaffery).

- Refers to the subjectivity and individuality of the pain experience
- Recognizes that a person’s pain experience is influenced by past experiences, social and cultural influences, spiritual beliefs and environmental factors
- Places the patient at the center of the pain experience and establishes the patient’s self report as the gold standard for pain assessment

The Concept of “Total Pain”

- First used in Palliative Care to represent the physical, psychological, social, emotional, and spiritual components of the pain experience.
- Total pain is applicable to acute and chronic pain experiences as well.
- Acknowledging total pain helps understand the meaning of pain from the patient perspective, which leads to individualized patient care, improved clinical outcomes, and higher patient satisfaction.

Practice Implications:

- Pain is what the patient says it is. Only the person experiencing pain can truly measure the intensity and quality of pain that he or she is experiencing at any given moment.
- Staff have a responsibility to accept the patient’s report of pain.
- Pain assessment is more than a number; assessment should include all physical, social, psychological, and spiritual aspects related to the etiology and impact of pain.
- Consider multidisciplinary evaluation for complex pain issues including Social Worker, Psychiatry, Occupational and Physical Therapy, and Spiritual Services.
- Avoid judgement when behaviors are not consistent with report of pain; investigate why this is happening. Some examples to consider:
  - A patient with chronic pain reports significant pain without any identifiable injury. This might be due to actual change in the nervous system and how pain stimuli is processed (Meyr & Saffran, 2008).
  - A patient is laughing and talking on the phone yet reports severe pain. The patient may be using purposeful distraction techniques or the patient may have had bad experiences in the past that direct behavior to over-report or demonstrate higher level of pain to receive treatment.
  - The patient rates pain as a “20”. This likely represents “total pain” and suffering, not just the physical component of pain.

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References and additional suggested reading:


   See chapter 2, Basic Mechanisms Underlying the Causes and Effects of Pain.


