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# What is the Subject-Matter and the Existing Gap in Pain Clinic Studies?

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ABSTRACT

The concepts of pain problems naturally require proper specialization to address subjects relevant to pain perception in all aspects. The purpose of this article is to highlight and critically evaluate current research on psychological aspects of persistent and acute pain and provides an overview of current research on theory and psychological aspects. Preeminent subject-matter in pain studies is established an accurate knowledge of psychological intervention and a course of psychological assistance for chronic pain control and it must be part of a comprehensive program. It is the purpose of this article to focus on the development of psychosocial indicators of success for pain adjustment and self-efficacy to investigation of coping and emotion in patients with persistent and acute pain. A body of evidence exists on pain mechanisms and pain management; however, patients continue to experience unrelieved pain. Referring to specialist literature author present a review of what is known, what is not known, and what remains controversial on the study of pain from psychological point of view. After reading this article we hope the reader will understand the importance of a psychological evaluation as part of the research and development of standards for identifying appropriate clinical approach in psychotherapy relating to the treatment of patients, it seems to be crucial for humanizing outcomes. The perspective of speculations that relies almost exclusively on theoretical and humanistic points of view which lead directly to the quality of people's lifestyle and their cognitions that are manifested from their outer world, inner world and beliefs, that may be less relevant as a result, but more relevant to the concepts of pain problems. In general, they almost derive from previous literature on the key issues of pain problems (theoretical, definition, methodology and assessment). This is a critical review of approaches that, therefore, have not been synthesized in a single published article.



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## INTRODUCTION

Sometimes clinicians may be entirely confident about their studies and explanations of the nature of pain, but they are often uncomfortably aware that they are making a choice without making sure, there is no convincing evidence and opinion to justify it and the difficulties that may arise when making these distinctions. Many diagnostic labels suggest a discrete entity and often identify a putative cause. Despite technical competence, patients and families are less satisfied with medical encounters when caring is lacking [4]. However, despite recent advances in the understanding of the complex nature of pain and the introduction of new technologies, such as patient controlled and epidural analgesia, there is evidence to suggest that pain management in the health service remains poor, with many patients suffering unacceptable levels of pain, leading to potential delays in recovery and psychological trauma [53]. Yet proponents of evidence-based practice have routinely ignored the root causes of many clinical psychologists' reservations concerning the use of scientific evidence to inform clinical practice [34]. However, these patients suffer from many non-specific symptoms, and identifying either pathognomonic features or distinguishing between diagnoses is frequently impossible. Patients, and sometimes their doctors, are convinced of causal relationships between either events or activities and the onset of symptoms, but there are often doubts. As a consequence, much of the resistance to evidence-based practice persists, potentially widening the already large scientist–practitioner gap. What is the

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only way to know the gap between theory and clinical practices? How to begin to understand what matters most to patient's behavior and what is the complex nature of individual's pain experience and the understanding of different clinician interpretation. At the same time, Psychological treatments emphasizing a self-management approach have become commonly accepted alternatives to medical interventions for chronic pain. Unfortunately, these approaches often fail to engage a significant portion of targeted individuals and are associated with high drop-out and relapse rates [30,31].

It is imperative that clinicians considered new ways to promote healthy behaviors from psychological interventions along with medical treatments. Therapeutic enhancement is intended to provide such a fresh view from multidisciplinary approaches. Traditional techniques focusing on education, contracts, social support and more frequent interaction with physicians appear not to be effective when used alone. Insight into the causes of motivation and the process of behavior change could increase the practitioners' effectiveness in stimulating patients to use self-management skills and seek internal motivation rather than other and external supports. The stages of change construct is new in that it stresses the process nature and the time dimension of behavior change. The stages of change construct is a psychological construct that maps the process of behavior change [8].

In point of fact, maybe we don't know or have forgotten what the evidence is, or perhaps there might not exist any knowledge in support our evidence. All clinicians have considerable amount of research is focused on informational needs, which are often unrecognized and unmet. Although chronic pain is increasingly recognized as a medical complex phenomenon with multifactorial etiology, the pathogenic mechanisms leading to the development of chronic pain in this state remain poorly understood the condition causing substantial disability, and clinical care costs. The effect of this unmet need for accurate information is a "knowledge gap" whereby many clinicians' decisions and approach studies are made with various opinion and uncertainty. Some of the difficulty in expanding this knowledge base undoubtedly is related to the lack of a solid conceptual foundation for exploration of human phenomenon. Although there have been attempts to provide needed conceptual clarity, these efforts typically have not been based on systematic inquiry [54].

We may emphasize on understanding the gap between theory and practice, and indicate whether such a gap exists and, if so, how we may address it. There is a great deal of contemporary theory concerning pain problems in various disciplines, but some of them have not been covered completely. Pain is a significant, yet elusive, phenomenon in practiced and health care. Despite the importance and prevalence of pain studies in psychological aspect, there is only a small body of substantive literature on this topic in unity point of view and sometimes these views are poles apart. Pain is defined as an individualized, subjective, and complex experience that involves the assignment of an intensely unconstructive meaning to come to an understanding or a perceived threat.

The experience of persistent pain can serve as a major turning point in patients' lives, affect patients' interpretations of other life events, and become a key component of patients' identities. These deficiencies indicate that centrality of event, a relatively new construct, could improve our understanding of persistent and acute pain [51]. This understanding aims to provide a broad overview of the literature on the effectiveness of knowledge in overcome to variety of sophisticated result on chronic pain studies.

On the other hand, it is unrealistic to expect anyone to locate, let alone keep up with the huge body of papers published in 20,000 biomedical journals every year, all at once [49] or not to identify gaps in the research and to inform and go ahead knowledge development movement and chairs theorizing in clinical trials, which are both scientifically sound and clinically important to psychology and often unknown. It has been a subject-matter in recent decades which is sterilized in any progress.

*Neuroplasticity in approaches:*

In recent years neurophysiologists and neuropharmacologists have generated a theory focused on neuroplasticity, which attempts to account for pain [57,58,63]. This unmanageable leads us to believe that chronic pain could be the consequence of undesirable neuroplastic changes, by which pathology becomes established and causes disability? Which responses are thought to play a role in the etiology of chronic pain syndromes? Animal studies generally examine the phenomenon of pain at the peripheral and central levels of processes present in pain transmission and perception and morph pathological changes [56,57]. The study of chronic pain in humans, however, needs to address much more complex issues of pain appraisal and response, which vary considerably from patient to patient, including the involvement of the emotional-affective system, cognitions, learning principles, pain behavior and societal and environmental factors [10,23,58,44,59,63,64]. Theory and concepts focused on neuroplasticity are far from the psychological structure of learning in the subjective nature of experience or to stand pain. Disabling pain is a significant problem for many patients, and sufferers often complain that they are dismissed by doctors and prescribed ineffective medications [20]. For most complaints of pain there is no demonstrable physical pathology, although their complaint were not grounded and exceptions.

*Human experience in chronic pain:*

There are many literatures on varieties of models on how chronic or acute pain develops and resists interventions, but these varieties are not the dominant approaches and an integrated perspective in pain studies. Variability in the outcome measures used in clinical trials hinders evaluations of the efficacy and effectiveness of treatments [11,12]. However, the construct validity of these psychometric approaches among pain patients has been called into question. In reality, it is a question of taste rather than a question of science in such studies. It would foster the use of a common language among pain researchers and clinicians from various disciplines [29]. The emergence of the cognitive-behavioral model of chronic pain ignited a proliferation of research, but because it rejected psychodynamic pain theory, investigation of emotion was largely suspended. These results may call for a shift in our approaches to chronic in line with knowledge development movement taking place in boarder areas of behavioral and cognitive therapy. As it relates to the human experiencing chronic pain, the conceptual meaning of pain management has not been clarified previously. Analysis will contribute to instrument development, theory testing, and an understanding that should positively impact the self-management of persons experiencing chronic pain [7,33]. From a practical perspective, we frequently must decide whether to re-identify and add more information in pain perception to fill gaps after some modifications, yet less clinically relevant or complete. These decisions are not easy, and yet they are rarely unforgiving. It is also modified by the degree of attention and emotional state to beat a path [17,40,41].

Evidence-based practice consists of using research evidence to validate patient care. A body of evidence exists on pain mechanisms and pain management; however, patients continue to experience unrelieved pain [62] and implementation of evidence-based practice in the allied health professions may be reduced with the publishing of relevant clinically directed research. Of particular concern in allied health research are the methodological flaws, which may seriously affect the capacity of the allied health therapist to use the evidence in their clinical practice [19]. At the first blush, this may belong to accurate knowledge movements which recognize the subject matter. This matter is concerned with the phenomenon of human in advancement degree of reaction to the pain and will be an attempt to the situation justified further investigation in theoretical development of this phenomenon for the research specialists.

*Playing of environment in influence of the pain experience:*

In the past decade, the concept of pain has paid attention to the multidimensional perspective. This perspective is usually based on the assumption of viewing pain as a purely sensory phenomenon which cannot completely understand and explain the nature of pain in helping of patient's needs. Based on the results of pain studies, it is necessary to carefully take into account the effects of personality, coping style, social support and pain if one is to fully understand the patient's psychological problems and trauma distress. One implication of this might be that psychological intervention may be more effective than the conventional "medical" treatments administered in the hospital [13].

Recent theories of pain [3,5,6,16,24,44,45,46] highlight the role that sensory stimuli from the environment can play in influencing the pain experience. Despite the awareness of the environment's influence on pain, patients with pain continue to be treated in settings that are devoid of distracting stimuli. The typical treatment room is painted white, lacking decoration, sparsely furnished, and windowless [36]. Creating an environment of compassion where patients feel that their emotional and spiritual needs are met is at the heart of holistic care. Patient satisfaction surveys address this powerful aspect of care and health care finds themselves in the position of making an impact. These mechanisms involve the patients' close social environment, often including doctors and hospitals. The described defence mechanisms are unconscious not only to patients but also to health care professionals, and are contributing to dysfunctional health care overuse. Therefore researches are faced with human's perception in psychological point of view, both physical and spiritual in health care circumstances. Superficial attention to matters of spirituality is no longer acceptable. Clinicians need to examine spirituality within themselves and be available when the patients give the invitation to join them in the struggle for peace. The critical care unit is most vulnerable because the intensity of illness is so great. Conscious or unconscious, the patient needs human touch and consolation, which transcends technology. Indifference to this is all but negligence on the part of the health care. Addressing this through careful care planning and joining the "fellowship of pain" brings the consulting room into the healing process. "Burnout" decreases as care increases, and therapist experience the healing process themselves as well.

*Cognitive theories and pain:*

Recent research shows that psychological factors predict adjustment to persistent pain. However, it has been highlighted the need to develop conceptual models that consider how these psychological factors are related [27,29]. Increasingly, treatment outcome studies incorporate methodological refinements including random assignment to treatment and control conditions, the use of psychometrically strong measures, and assessments across important domains of adjustment (e.g., pain, psychological distress, and physical disability), which are sophisticated data analysis methods [29,64,67]. In accordance to the psychological and cognitive theories and

the psychodynamic theoretical construct of introjections as an early process in the development of self-selecting and adjustment. These findings suggest that increased commitment to a self-management approach to chronic pain may serve as a mediator or moderator of successful treatment. These opinions underline the importance of establishing trusting therapeutic relations for unfolding the characteristics of early and later interpersonal relationships and their impact on adaptive and maladaptive behavior. Although an integrated model to address these important phenomena in dynamic path and to reinvigorate research may be premature, and it may difficult to analyze congruency with the conceptualization of uncertainty presented in the theory and definition of pain. Inquiries into hallucinatory wish fulfillment and the unconscious converge and, by distinguishing the concept of the unconscious in psychoanalysis from that of cognitive psychology, serve to bring out what is most essential to the psychoanalytic conception [18,37,50,52]. In Rosenblatt, [55], suggestion that the intuition represents an unconscious cognitive activity, the results of which become conscious at some point. Some recent nonpsychoanalytic explorations of cognition and consciousness are examined to illuminate our understanding of these processes and their relation to the psychoanalytic process. Our opinion is that intuition may be most usefully viewed as a form of unconscious pattern-matching cognition, which becomes conscious under certain conditions and which is only loosely related to primary process and self-adjustment. A clinical example is given of the analyst's intuition to illustrate the initial ostensibly theory-free nature of the raw intuition and the subsequent theory-bound explorations of the intuitive conclusion. Implications for teaching and learning psychoanalysis are well-known. It is argued that pain theory should receive renewed appreciation in such path way; it was never really absent, just forgotten. If we accept the knowledge of purpose of pain studies in theory and practice is out-of-the-way, then we should bring something out form ignorance into debate of subject matter. Therefore preeminent subject-matter in pain studies is established an accurate knowledge of psychological intervention and a course of psychological assistance for chronic pain control and it must be part of a comprehensive program in study of pain regarding to human traits. It seems to be crucial for humanizing outcomes.

*Calling for a "Master Key Theory":*

The mechanism of coping process and pain perception needs a "Master Theory" to support all the hypothetical aspects, and to develop new conceptual models that attempt to integrate findings from studies in this area into a more comprehensive theory of adjustment and self-efficacy to investigation of coping and emotion in patients with persistent or acute pain, and the dominant theory in this area may reasonably be psychodynamic in nature as well**.** When the study is designed with incomplete or inadequate theoretical models, the observed pattern among the latent emotional variables might be consistent with a variety of causal explanations, as a result the base any knowledge in this path way will be on copycatted. At the same time, views are cutoff from one concept to another or from one theory to another. In a given review or a given research study, which of these concepts and citations are likely to be novel or to be old? Which theory is preferred to others? Who has the vicarious authority in scientific approaches to determine the novelty? If this interesting and important field of research is to develop, we need to avoid the temptation to perform clinically-led free theory research into global unify. Then these huge of body of pain studies bring wisdom in scientific approaches for clinician and will free them from the mechanism of pain perceptional spontaneous discharges.

Methodology will be important in taking research forward, but sound theoretical direction, however flawed it may eventually appear to be, will be to its success [15]. It would to stand for global cooperation from different cultures and religious societies in order to understand the basic concepts and perception of pain in psychometric approaches, to produce the proper time to do a thing about the problem of clinical identification, and to determine the effectiveness of psychological attempts and (or) other means of investigation. What is novel about the approach is that it is not simply a new psychological variable but a description of a different set of processes of pain and suffering. This approach is fully situated within the broader empirical tradition of the behavioral and cognitive therapies. The examination of its potential merits is already underway [39,42].

*Evidence-based practice in communication disorders:*

Recent reports have increased debate about the psychometric approaches in the treatment of chronic and persistent pain associated with psychological variables which most of them have no any knowledge in supporting. It is unclear how these affected the results, and then is challenging and ambivalent. Interpret studies will increase the quality of evidence available to support clinical decision-making in communication disorders, and to the credibility of the studies field. Readers will be able to explain why rigorous scientific studies provide a stronger basis for clinical decision-making than do the opinions of authorities [9]**.**

Evidence-based practice and empirically supported treatment movements are potent forces that affect the practice of psychology today and have the potential to mandate the types of treatments psychologists conduct. The histories of these movements reveal that certain aspects of therapy valued by psychologists have been ignored. It is shown that the evidence-based movements (a) overemphasize treatments and treatment differences and (b) ignore aspects of psychotherapy that have been shown to be related to outcome, such as variation among

psychologists, the relationship, and other common factors. It is important that psychologists understand the development of these movements so that they can be critical consumers of research and can effectively influence the future course of events [66].

In the other hand, psychological approach and cognitive-behavior therapy may be more efficacious than unstructured neuropharmacological care for chronic pain. Current literature documents the use of many pharmacologic agents in the management of chronic pain. While numerous studies have been undertaken, there is no consensus on an algorithm for such treatment. Studies and reviews were excluded if they were not conducted in human beings. Chemical dependence constitutes a significant public health problem with immeasurable physical and psychological sequelae. Pain management is generally undertreated in this population because of the associated stigma and misconceptions about both pain and chemical dependence [22,60]. Moreover, in contrast to the cognitive conception, psychoanalysis holds that the processing of thought in the human mind is inseparable from the activity of desire [50]. Some had multiple reasons, including pain and anticipated pain, fear of indignity, loss of control, pain acceptance and cognitive impairment [42].

The divergences in the study of pain nature, either into the field of cognitive-behavior therapy or into that of emotional disorders, are closely linked to the psychometrical uncertainties that are still a source of debate in today's psychological research, and methodological limitations of the randomized trials prevent firm conclusions in practice. Qualitative and subjective research conducted on pain is an important addition compound to the international debate on psychological approach and assisted researchers. It would discuss a means of overcoming this limitation by considering the concept of the subject "Pain Nature," a conceptualization that corresponds to definition and theory. Thus, future research must focus on the complex interactions between personality variables, environmental factors, and the coping demands posed by the specific nature of pain problems [21].

*Concept of spirituality in pain perception:*

Previous pain studies strongly suggest a less thorough examination of human integration in pain perception and pain threshold shift, especially from inner properties. There is scientific evidence that the spiritual well-being of a person can affect quality of life and the response to illness, pain, suffering and even death [35]. It is probable that patients have differing thresholds for psychological pain as individuals do for physical pain, so what is felt as intolerable by one patient could differ in another [43]. The results of [35] were rich descriptions of the concept of spirituality. These concepts were described as a unique individual quest for establishing and, or, maintaining a dynamic transcendent relationship with self, others and with God/supernatural being as understood by the person. Faith, trust and religious belief were reported as antecedents of spirituality, while hope, inner peace and meaningful life were reported to be consequences of spirituality. Based on clinical observations, persistent pain is often described as a stressful life event that has significantly altered how patients view themselves and the world around them [51]. The subjective intensity of pain relates to different perceptions, meanings, attitudes, beliefs and emotional responses in different groups with different cultures and ideologies. Individual response to pain is influenced by a typical cultural pattern of beliefs about pain and how one should react to it. For example, in Eastern philosophy it is believed that those who suffer from pain and other difficult life events will derive spiritual value from the experience; In other words, for some religious devotees, the experience of pain is to be borne as a recognition of devotion and acceptance. Recognition of the spiritual dimension and its function as a vital component of human well-being has led to an increased interest in its effects upon perception of health and illness, yet very little progress has been made in identifying possible intervention methods for enhancing spirituality [14].

*Psychodynamic approach:*

Every pain management physician is familiar with the secondary gains that serve to keep the patient ill even after an array of cognitive, behavioral, pharmacologic, physical, and nutritional interventions have been used to alleviate their suffering [25,26]. In contemporary psychodynamic psychotherapy and psychoanalysis, lessons learned from previous human development research are now helping clinicians to appreciate more fully why interventions may have therapeutic power. Psychodynamic interventions can be further conceptualized as providing the space for these patients' primary reflective functions to grow and expand, thereby giving them the opportunity to make dramatic revisions to the internal working models of relationships [32]. Therefore the concept of "human integration" in understanding of pain perception is psychodynamic in its nature as well. It is a matter that never appears in the novel literature and requires definition for readership, because still many factors of self-adjustment and pain acceptance are ignored by researchers in their doctrines. They also suggest a desire for personal attachment and fulfillment that is insufficiently acknowledged. The review of the status of all of psychological factors that might be relevant to understanding nature pain is beyond the current on pain studies [28]. However, pain associated with no somatic pathology, where different psychological factors are viewed to play an important role, is still an unresolved problem [48]. Although a few poor studies have emphasized on the subjective aspect of pain, in reality, they also fall into the study of behavior physiological

reactions to the pain (indeed they have not been pay attention to study the subjective aspect of pain). These studies have yet to be fully translated into empirically testable (i.e. falsifiable) formulations and lack speculation and reasoning. Investigational pain studies with an empirical and descriptive approach may have some limitation in the nature of study purposes, but they should be accompanied by an analytic view of unconsciousness energy to the pain adjustment which is an important part of whole of human performance.

*Unconsciousness stimulation towards pain perception:*

It is unfortunate that so much pain, often lasting for years, has been unleashed. All this points to a failure to require the inner definition and understanding that may itself cause pain behavior manifested and other psychological problems. It is still questionable that which kind of psychological stimuli may initiate psychological stress, because the experience of stress is an individual response and is therefore influenced by several psychological factors and also how the personality is organized [48]. It truly graces an individual with the spark of the unconsciousness which is the stimulus towards consciousness. This is with the greatest potential that confers wholeness, balance, adaptation, a clear state of self-ability and greater satisfaction to pain adjustment. Its expression results in more motivation and positive coping strategies impact with most unpleasant situations. This function is known by many cultures. Psychology since Sigmund Freud's discovery of the unconscious function and its role in certain physical and behavioral reactions as well as self-destructive interpersonal behavior may be suggested more as a substitute for the spiritual dimension and more appropriate for inner characteristics.

Patients are initially ill emotionally or physically in coping with their pain because many factors in self-adjustment are ignored; by identifying these factors, it would be more efficient to support patients in coping with pain. In such pain studies, patients' acceptance attitude is so that they feel as a weak person that should trust others for help in adaptation. Regarding to McCracken [38] point of inspection that ‘Acceptance’ may be a limited word for all that it is supposed to imply. As it is currently conceptualized and measured it includes patients (a) seeing thoughts about pain as *just* thoughts about pain, that may be *unnecessarily* adding to their suffering, (b) being present with potentially disturbing thoughts and feelings without defense or struggling, and (c) choosing actions that move them toward things they most value in life, in the presence of these same thoughts and feelings. These processes appear to play a significant role in chronic pain and may be appropriate targets for continuing therapy development. The dilemma brought about by attending to patient's affects (which are initially unspoken and often unconsciously held) is primary in the treatment of persons with substance use disorders. The physician has, in a way, “absorbed” the mood or affective state (usually unconscious) of the patient. The therapeutic process allows hidden affects, emotions, and feelings that attach themselves to and worsen current problems such as chronic pain [47].

These beliefs are then passed on in everyday life and may become as a type of style and culture differences in coping with their problems. It manifests itself behaviorally in one's never being able to achieve emotional or psychological satisfaction and grace. Naturally, for recognizing the behavioral integration, psychoanalysis studies may provide the link between the world of unconsciousness and then outer world of consciousness and creates a reasonable perspective for the study of pain. The inner realm of individuals is taken into account by individual's attitude. Once the individual lost the ability to cope, he also loses contact with the unconsciousness and has no grace experience. The redefinition and re-explanation of unconsciousness (not as Freud suggests) and its powerful aspects is from spirituality which makes it possible to establish a model connection between the world of consciousness and the inner world within the unconsciousness (like Jung's point of view). It would describe some of the mechanisms through which interpretation aimed primarily at increasing conscious awareness can nonetheless produce unconscious changes, the latter being deemed the basic aim of psychoanalysis [2]. In Western psychologies have think that consciousness is changeless [1,65] and the occurrence of all changes in energy, time, space and the elements are witnessed by consciousness. This idea is true only for unconsciousness which reflected by central psychological actions and plays as gate control for pain perception in order to keep or free pain. If unconsciousness energy is suspended from the ego or consciousness some disability and psychological problems may happen [47], suggested that the Psychodynamic theory, developmental studies, and in-depth outcomes research are shaping the way that psychoanalytically informed treatments are performed. Although the topics selected here merely sketch how psychodynamic treatment may impact the practice of pain management, it is hoped that a more sustained inquiry and more frequent and earlier referrals to psychodynamically oriented practitioners will follow in its wake. In cognitive or dynamic psychology should emphasize on understanding the consciousness awareness through the unconscious performance, induced up to date the whole of the mind which is accessible to the conscious which affects behavior and emotions. Without regard to the unconsciousness effects in clinical pain studies, as it has been shown, accurate knowledge is sterilized, and we will involved with vicious circle in henceforward which is like that we had before.

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