There has been increased attention to pain as a factor in health care, well-being, and recovery (Arwood et al., 2015), as well as the cognitions that influence the pain experience (c.f., Yoshida et al., 2012). The standard way that pain is assessed in the medical field is by using a number from one (low) to ten (high). If you were to see a doctor about lower back pain, the doctor might ask “What number would you give it on a scale of one to ten?” Then there might be two pictures of a body, front and back, standing upright with arms a little ways from the sides. You would be asked to put an X on the spot(s) that have pain. Lastly, you might be asked to choose the words that best describe the pain, such as aching, burning, shooting, pins and needles, tingling, electric, itching, numbness, throbbing, or hot. The words help a doctor begin to understand if the pain is neuropathic (damage or dysfunction of the peripheral or central nervous system) or nociceptive (stimulation of pain receptors). These three methods – a number, Xs on a body image, and words, have become the standard in medicine. The ideal drug for pain would reduce pain that is five or above to below five, by at least two points, and have little to no side effects.

But should this be the standard way to describe and understand pain? First I will present two other ways of describing pain. Then I make recommendations for how psychologists might gain understanding of the pain experienced by some of their clients.

Let us return to our hypothetical person experiencing lower back pain. This person has been experiencing lower back pain that is new to her, and for about a week. She believes she might have strained it gardening ten days ago. She describes the pain as aching, sometimes sharp when she moves, and hot to the touch (probably indicating inflammation). She rates it a five in general, and eight briefly when she moves the wrong way and the pain shoots through her. She is told to put ice on the pain, then heat, and avoid lifting or strenuous activity until it subsides. She has every reason to expect the pain to subside within a few weeks.

First of all, what is a five, or an eight for that matter? Suppose this woman has experienced childbirth and active labor for three hours. If she would call that pain a ten, is pain that lasts for fewer than twenty seconds really an eight? Is pain that leads to the birth of a newborn experienced differently than intense pain that has no known purpose? Does duration of pain affect its rating? What is the effect of a level of pain that is five or above to below five...
rated as five over a brief period of time versus over a longer period of time? Imagine you have a mild toothache. It’s perfectly tolerable for a day or two but by day three the same level of pain becomes less tolerable. The absolute number on the one to ten scale hasn’t changed but the perception of tolerability has.

This idea of tolerability may be key to understanding perceptions of pain in those with chronic pain. In a study of 53 outpatients with persistent pain that was moderate to severe due to osteoarthritis, cancer, or lower back problems, participants did not use the one-to-ten scale, nor did they like the term acceptable pain (Zelman et al., 2001). Instead, they preferred the term manageable pain or tolerable pain. What emerged from this study is that a manageable level of pain allowed performing valued activities, relief from dysphoria and irritability, and socializing. Medication was described as taking the edge off, and was itself tolerable if the side effects of the medication did not interfere with manageability. Zelman et al. argue that a measure of a manageable day of pain control would be more useful, and more closely align with how persons with chronic pain think about their own pain experiences. The ideal of being pain free was not sought, as the reality of pain associated with the various conditions was acknowledged. Rather, participants wanted more days of manageable pain.

In my own experience as a person with polio and post-polio syndrome (new pain, fatigue, and weakness), I found that I developed a scale similar to the idea of Zelman’s manageable pain scale. But duration is key to my experience of pain. The meaningful periods for me would be under one day, several days, weeks, or longer (how much longer quickly becomes irrelevant). The second variable is constancy, whether the pain is at baseline level (i.e., rarely or never goes below that level), short bursts (of increased intensity), intermittent (unpredictable from day to day), or constant (becoming less tolerable over time). Keeping these factors in mind, I have a five-point scale. A level one means the pain is out of consciousness unless I focus on it. If I were to stop and inventory my body, I would notice and locate the pain, but I could then resume activities and the pain experience would again recede out of consciousness. Level two means that the pain is still out of my awareness, but it is affecting my mood and behavior. This is when my children would say “Mom, you’re crabby, go put your foot up.” They have made an association between pain and my mood that I only become aware of once it is pointed out to me, and then it seems obvious. At a level three I am conscious of the pain, and use it as information to change my behavior or plans. I might postpone an activity, or cease a task I know increases pain, or rest more, or put ice or heat on an affected spot. At a level four I am very conscious of the pain, and take steps to make immediate alterations in my day (e.g., cancelling events for later in the day, putting in a rest period, taking off shoes, elevating my feet, etc.). At level five pain is the primary event in my consciousness, and I halt whatever I am doing to

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take steps to ameliorate the pain. In this admittedly personal and untested scale, the critical factor is the effect of the pain on my awareness, mood, activities, plans, and sociability. To go back to the Zelman scale, I would label levels one and two manageable, level three tolerable, level four a fight for manageability, and level five unmanageable.

What do the above methods of pain assessment mean for psychologists, particularly clinicians who see clients experiencing pain? Using suggestions from Zelman et al. (2001), Linton and Shaw (2011), Arwood et al. (2015), and Olkin (in progress), I would recommend the following:

1. Ask clients about pain. Even if it is not part of the presenting problem, more people experience pain than we know, and it could be a relevant factor in treatment.
2. Understand the client’s way of explaining pain. Use the three methods discussed here as options, but allow for idiosyncratic ways of description.
3. Understand the pain history. Whether the person previously has experienced nothing more painful than a bee-sting, or serious injury in an accident, or torture, these prior encounters with pain will influence the current experience of pain.
4. Understand the context of the pain. This includes people’s beliefs about pain, their understanding of the causes and effects of the current pain, the role of the family in the pain management, and cultural beliefs about pain.
5. Assess multidimensions. Assess cognitions about pain, emotions and emotional regulation abilities, and overt pain behaviors or pain avoidance behaviors.
6. Assist with understanding. Help clients know about the multidimensional nature of pain; how pain is recognized, assessed, and measured; and the myriad avenues for pain management.
7. Discuss the goal. Although cessation of pain may be desired, it may not be possible. But a fulfilled life is possible, even with varying levels of pain. Increasing the number of manageable days is a viable goal.

REFERENCES