

The concept of chronic pain nursing essay

[Health & Medicine](#), [Nursing](#)



10301787Stakelum Aine11315526Stenson Aine10314999Stroiescu

Stefania10100031Suresh Malavika11360836Talty Marie11270019Tan Shu

Jun10307279Thompson Elein11000761Ab. Ghapar Siti

Nurzulaikha11000671Abdillah Mohammad Azzahari11000676Abdul Haris

Aima Farhana

WORD COUNT: 3, 879

INTRODUCTION

A fundamental challenge in medicine is the concept of chronic pain (Smith et al., 1999). The International Association for the Study of Pain (IASP) defines pain as " an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described by the patient in terms of such damage" (H., 1979). This is a very broad definition, which doesn't provide enough guidelines for medical practitioner in terms of the management of chronic pain. The absence of links between the experience of chronic pain and the detectable or visible pathology or even the objective evidence of pain and intensity often causes many drawbacks in the chronic pain management. (Smith et al., 1999). Chronic pain challenges the distinction between mind and body, as it is essentially a subjective experience (Sullivan et al., 1991). The concepts of cure as the goal in medical practice are also challenged (Smith et al., 1999). The case study we will discuss in this essay involves a thirty-five year old woman, Emily Scott and her GP. Emily was involved in a car crash in 2009, which resulted in her becoming a sufferer of chronic pain, which she says has ' consumed' her and ' affected every facet of her life'. Since the accident Emily has experienced pain everywhere in her body, 24 hours a day. Despite this her GP has not

offered or discussed with her any comprehensive pain management plan. As a result of this, Emily changed her GP in 2011. This essay will discuss the biopsychosocial implications, the ethics and the law related to chronic pain. We will also briefly discuss the methods of measuring pain. This will be outlined in a way that mirrors the approach to the need of management of chronic pain required in primary care.

HEALTH PROMOTION

Suffering from a chronic pain condition impacts all functional domains. Patients are individuals with a life history, beliefs, standards and expectations (Bender 1999) and this is why the acknowledgment of psychological and social factors, not just the physical, is important in their treatment. The biopsychosocial model can help the doctor focus on the problems caused by the pain in the context of the patient's life and thus come up with a more effective and well-rounded treatment plan. In Emily's case, the physical impact of her pain may include symptoms of pain, fatigue, stiffness and increased immobility. Sometimes, the wish to decrease pain can lead to the "disuse syndrome", which is when patients limit the amount of things they do daily in order to avoid the pain. This search for a way to function with the least amount of effort can be very detrimental to all bodily systems. It can cause loss of muscle bulk, weakness and muscle atrophy, which encourages even less activity and a dangerous cycle is formed (Bortz II, 1984). Psychological effects can include feelings of frustration, low mood and concern about the future. Depression and anxiety are common factors in the affected and these can have a greater debilitating effect on the patient as they can lower the pain threshold and further potentiate the pain. Chronic

pain sufferers have three times the risk of developing psychiatric disorders, usually mood or anxiety disorders, while depressed patients have three times the average risk of developing chronic pain (Turk DC June 2002). Social implications can include concerns about work, role within the family and whether the patient can continue to engage in valued leisure activities. Nearly half of chronic pain sufferers have to give up work due to their excess pain, despite wanting to work and contribute to society. Research has shown that nearly a third are worried about losing their jobs as a result of their pain, while 44% worry that it will stop them from progressing in their career (Collett 2010). Meanwhile, the patient's role within the family can change drastically too. The sufferer can become dependent both physically and emotionally on family members. As the sources of support decline with the development and maintenance of a chronic pain problem (e. g. loss of work, recreational and other social activities) the importance of perceived marital support increases (Kerns and Turk, 1984). A significant amount of pressure is placed on the spouse to help and if the patient feels they are not being supported properly, depression may ensue. It has also been shown that spouses can have positive or negative effects on the patient's pain. If the spouse is unsolicitous, the patient exhibited fewer pain behaviours in their presence than when they were not there (Kerns and Turk, 1984). The physical and psychological impact of chronic pain may hinder both the desire and ability to partake in leisure activities. Inability to take part in old hobbies can have a detrimental effect on the individual's quality of life and severity of pain. Inaccessible facilities, lack of transport, absence of support or negative attitudes from others may all impact negatively on leisure (Specht

et al., 2002). This can all lead to further potentiation of the individual's leaning on family for support. In Ireland, there are still no sufficient treatment care structures for conditions such as chronic pain. A common complaint is the time taken to receive effective treatment. For example, a study shows that " the waiting time to be assessed in clinic was beyond the acceptable time which is an average of 12 weeks"(Fullen et al., 2006). The study also found out that " There are no multidisciplinary pain clinics or pain clinics that meet the IASP recommended guidelines for the management of chronic pain patients" (Fullen et al., 2006). In the CSAG study, they found " that the number of consultant sessions was too low, and only half of the services had a specialist chronic pain nurse" ((CSAG), 2000). However, if the correct measures are taken, the possibility to improve the quality of life of the patient is there. The study also recommended to " improve GP access to investigations and to prompt opinion from specialists." It is recommended that guidelines should be provided centrally to all clinics and hospitals. The Pain Proposal, developed by European health care professionals to examine how treatment of pain can be improved, identifies potential savings in welfare and workforce costs by changes in organization of pain management services. Future demands on healthcare resources are also looked at (Proposal, 2010). Another key approach is to establish fine treatment management pathways for people with chronic pain. For example, improve timeframes for diagnosing patients and to ensure primary care professionals know their treatment options and therefore refer them to the right specialists. Therefore, a national strategy is paramount to increase education in management of pain, increase treatment services and facilities and indeed

maximize patient treatment. In the clinical setting the ability of the General Practitioner to uphold his responsibility reflects his competency. The first duty of the GP is to be able to recognize chronic pain when it occurs and provide effective treatment. If he is unable to provide effective treatment, his responsibility then lies in making a referral to a chronic pain specialist who should be trained in all aspects of pain management and care. The Irish Pain Society believes it is the right of the chronic pain sufferer to have easy access to appropriate information to further their understanding of their condition. Patients with chronic pain present a multidimensional challenge for GPs, with medical, social, psychological and ethical considerations to be taken into account when planning appropriate investigations and treatment. Pain is considered to have both a physiological and psychological component, and in dealing with his chronic pain patient, the GP should realize that despite there being minimal soft tissue damage in his patient, it does not prevent her from experiencing pain. As a gesture of empathy, he should have expressed concern for her condition, validating her experience and thus allowing a more honest, trusting and productive relationship between them. Amongst Chronic pain suffers, at least 4/10 believe that others doubt the existence of their pain so it is imperative that the GP demonstrates belief and trust to his patient. The Pain Proposal noted that in Ireland, most people will consult their GP first in regards to their Chronic Pain. GPs often prescribe a number of ineffective medications, before finally referring their patient onto a specialist. This can be a long and arduous process, taking anywhere between months and years between diagnosis and effective treatment. This process can be further lengthened due to the lack

of medical specialty in chronic pain in Ireland, which means that the initial referral of the GP may not be to a pain specialist but to another discipline. The patient is passed through the medical system with no satisfactory treatment. The GPs approach, management, and competency when dealing with Chronic Pain is largely based on their education and training in this area of specialty. The current state of GP training in chronic pain management, and GP's general knowledge and expertise when it comes to dealing with Chronic pain patients, is greatly underwhelming. The Irish Health conducted a survey where 52% of GPs stated that they would be unsure of how to proceed if their patient complained of continuing and persistent pain after their treatment. The survey also revealed that 81% felt that their patient received suboptimal pain management, and that a striking 89% would be interested in receiving more training in this area. Currently there are an underwhelming number of courses in Ireland providing training in chronic pain. There is a strong need for the target audience of these courses to be vastly widened and made available and attractive for all clinicians in all disciplines of medicine. Currently, undertaking training in pain management is a form of self-motivated education. GPs must take a personal interest in pursuing further education on pain related therapies, and dig deep in order to find them. A greater emphasis must be placed on providing more undergraduate and post graduate education in pain management. The Irish Pain Society is one of the leading representative bodies of medical specialists with an interest in the treatment and management of chronic pain. They work in collaboration with <https://www.anaesthesia.ie/> as Anesthesia is one of the few disciplines of medicine with a foundational and

relevant interest in the pain management. Accessible through Irish training. ie is a training pain management consultancy and educates students on how to provide relief from both intermittent and chronic pain. Here they use both conventional and alternative methods to construct a strategy to help alleviate pain, taking into account nutritional, physical, medicinal, spiritual and mental health programs as part of the process. They also focus on the studying of specialized pains such as back pain, arthritis pains, etc. If the GP is unable to provide treatment, he must make a referral to the pain clinics in Ireland for treatments, and to the chronic pain support groups such as Chronic Pain Ireland . Currently there are 5 pain clinics located within public hospitals in Dublin (only 2 of which provide educational pain management programs), and 2 clinics in Cork, along with a few additional facilities. Ultimately, it is evident that change by reorienting the health service, is absolutely necessary to avoid unnecessary societal, personal and financial costs to not only to patients but also to the Health Care Structures.

ETHICAL ISSUES

There are many ethical issues involved in the treatment of chronic pain, and some of these can be seen in the case of Emily Scott. Patients often describe the stigma attached to the condition, with many sufferers saying they fear others think it is " all in their head" (Lechnyr and Lechnyr, 2003). This occurs because of the difficulty in defining and measuring chronic pain. Because many chronic pain patients do exhibit typical pain behaviours, family members, physicians or friends of the patient may be sceptical about its intensity and even reality and this can be very distressing for patients suffering from chronic pain. Of those that do exhibit pain behaviours, often

the sympathy from others only lasts a very short time, after which sufferers are expected to "suffer with dignity" (Jackson, 2005). Physicians have "the duty not to inflict pain and suffering beyond what is necessary for effective diagnosis" and "the duty to do all that can be done to relieve all the pain and suffering which can be alleviated." (Edwards, 1984). In Emily's case, her GP did not fulfil these duties. The under-treatment of any type of pain will impact on patients, both physically and psychologically, often leaving them untrusting of medical professionals if they feel their physician has not taken their concerns seriously. Chronic pain, if poorly managed, can result in an array of problems and can leave the patient with lower energy levels, decreased mobility and increased susceptibility to disease (Brennan et al., 2007). A study by the World Health Organisation found that patients suffering from chronic pain were at a significantly higher risk of suffering from anxiety and depressive disorders than those not suffering from chronic pain (Gureje O, 1998). Emily's GP should have displayed a greater level of empathy towards Emily, and should have referred her to a pain specialist if he/she felt that Emily's condition was outside his/her area of expertise. However, the lack of pain specialists in Ireland is also an issue, with only one pain centre in the west of Ireland and the majority of the rest located in Dublin (Ireland, 2009). Another ethical issue that may arise is the treatment of chronic pain using opioids. Emily's GP did not offer to discuss any comprehensive pain management with Emily, so it will be the responsibility of her new GP to come up with a treatment plan to try and relieve the pain from which she suffers. Physicians who choose opioid analgesics as a means of treatment face a number of considerations. In the past, sanctioning by

medical regulatory bodies for overprescribing was common, and even though opioids have been proven to have legitimate, therapeutic effects on chronic pain, many physicians are still reluctant to prescribe them (Martino, 1998). Because of this, patients sometimes feel that caregivers are more concerned with the rules and regulations governing opioid treatment than they are with the patient's pain (Jackman et al., 2008). The majority of primary caregivers in an American survey believed that long term opioid prescription for chronic pain would lead to addiction (Nwokeji et al., 2007). These beliefs are primarily due to a lack of education on chronic pain as a disease entity in medical schools and it is suggested that more lecture hours are provided for the subject (McGee et al., 2011). If the GP in this case does decide to prescribe opioids for Emily, he/she must use caution, as opioid addiction and misuse is not uncommon among chronic pain patients. Emily will need an initial physical and psychological assessment and will need to be monitored and assessed regularly. She and her GP will need to comprehensively discuss long-term treatment goals and side-effects of the medications before embarking on a treatment plan. Studies have shown that where physicians have displayed good prescribing practise, the risk of patients becoming addicted to opioids is significantly reduced (Tordoff and Ganty, 2010). The new GP in this case will have a number of responsibilities towards Emily's care. Building rapport with Emily and re-establishing her trust in healthcare professionals will be crucial in the development of the doctor-patient relationship. In her article, Jean E. Jackson defines pain as " an aversive feeling experienced by the body that cannot be measured directly" (Jackson, 2005), so it is important that this GP maintains an open mind and

accepts Emily's pain, even in the absence of physical symptoms. Physicians also must be aware of the boundaries of their knowledge and expertise, and know when to refer a patient onto a specialist who can provide a better standard of treatment to that patient. Many pain specialists have stated that in general, primary physicians tend to have "limited education on the proper diagnosis and treatment of pain" (Chapman et al.) so referral is often the best option for the patient's recovery. Psychological therapies like cognitive behavioural therapy and behavioural therapy can be introduced to the patient as a means of treatment, and it will be the role of the new GP to do so. These therapies help people to change their behaviour that maintains or worsens pain, disability or distress. Therapies such as these have proven to be very useful in the management of chronic pain(Williams et al.).

Health Informatics

There are many measurement devices or instruments used to measure pain and quality of life. In 1992, Von Korff developed and evaluated a straightforward method of grading the severity of pain (Von Korff et al., 1992), known as the Chronic Pain Grade. Based on Von Korff's three dimensions; the pain intensity, the impact and the duration of the pain, it has become one of the most successful instruments used to date (Smith et al., 1999). Some measurement devices, such as the Oswestry Low Back Pain Disability Questionnaire are specific to the exact cause of the chronic pain (Smith et al., 1999). This questionnaire is used to determine a patient's functional disability due to low back pain (Fairbank et al., 1980). It involves assessing a patient's pain intensity and to what degree their pain affects different areas of everyday life (Fairbank and Pynsent, 2000). Another

recently developed device is the pictorial representation of illness and self measure (PRISM) which is used to measure the burden of suffering due to illness or chronic pain in a patient. In 2008, a study by Kassarian found that the PRISM tool is competent at measuring quality of life and pain intensity of patients with chronic non-cancer pain (Kassardjian et al., 2008). This study also found that those questionnaires such as the Pain Disability Questionnaire or the Short-Form 36 (sf-36v2) are lengthy and time-consuming for both the patient and the clinician. However, the PRISM method is fast and simple and can be completed in less than five minutes (Kassardjian et al., 2008). Overall the most frequently used and known device is the dolorimeter. This is a quantitative and objective measure of a patient's pain tolerance level. It allows chronic pain diagnosis, diagnosis of subtle abnormalities and pain measurement quality assurance (Lipman, 1999). Finally, there are simple uni-dimensional pain scales, such as the verbal rating scale, which classifies the pain as mild, moderate or severe. The numeric pain scale classes the pain between 0 and 10 with 0 being no pain and finally the FACES pain scale, which is a pictorial representation of both the numerical and visual analogue scale. The range varies from "happy" to "severe pain" in six to eight different pictures of faces. This scale is exceptionally useful for children, or for patients with whom the language barrier may be an issue (Kock, 2012).

Medical Law

Legal issues are one of the most significant aspects of a case involving patients suffering from chronic pain. The legal matters surrounding the case in question include medical negligence and opioid prescriptions. In Ireland, a

medical negligence claim may arise if one has suffered an injury as a direct result of medical mistreatment or lack of care. Medical malpractice or negligence law is a portion of tort law. To succeed in a tort lawsuit, it must be ascertained that the defendant owed a duty of care to the plaintiff, the defendant breached this duty by failing to comply with the standard of care expected, and this breach of duty caused the plaintiff discomfort or further injury. (Management, 1997)The standard method used to evaluate whether the practitioners actions equated to the level of negligence is medical custom. This involves comparing the quality of care given by the defendant to the plaintiff to that of the quality of care that would be expected of a reasonable practitioner in similar circumstances. Custom is determined principally via the testimony of specialists in the same field as the defendant, although other utensils such as practise guidelines may be used. (Law, 2009)In looking at this case we see that the practitioner in question may be liable of medical negligence. In the immediate aftermath of the accident Emily Scott, the patient in this case, presented to her GP in ‘ excruciating pain’ and was referred for X-Rays. She was told that she only has soft tissue damage and would be better in approximately six weeks. However, Emily continued to experience pain everywhere in her body, 24 hours a day, yet the practitioner did not prescribe Emily pain relief, or send for further tests to identify the cause of Emily’s pain, or indeed offer any aid to Emily. Instead, Emily was left to suffer with the pain, a pain which she described as having ‘ consumed’ her and ‘ affected every facet of her life’. In the medical profession it is acknowledged that comprehensive and continued remission of most chronic pain is rarely achieved (Chou R, 2007), but much could have

been done on the practitioners behalf to reduce the patients pain and improve quality of life, such as the employment of pain management therapies (Paul A. Hardy, 1997) or the prescribing of medication to alleviate Emily's suffering. However, the case is question may not be so clear cut. It is easy to view the practitioner as negligent here, but other factors should also be observed. It is difficult for practitioners to prescribe pain relief in chronic pain cases. Reports of the " under-treatment" of pain by doctors are widespread (DE, 2002), while many physicians are also fearful to advocate some therapeutic options , mostly chronic narcotics, because of the regulatory and legal concerns inherent to prescribing these medications, and also due to their addictive properties. The use of opioids as a treatment of chronic pain patients is increasing significantly as a result of combined efforts of clinical needs, recommendations from pain clinicians and also impressive sales promotion activities from pharmaceutical companies. Although the use of opioids is very effective in alleviating pain, excessive consumption may pose significant harm to the patient. Eriksen et al stated that opioid drugs should not be dispensed or administered in an outpatient setting as physicians do not have the automatic permission from the Drug Enforcement Agency(DEA) (Jørgen Eriksen a, 2006). Furthermore, Clark et al explained that patients who use incorrect prescription of opioids are at a higher risk of becoming drug abusers and the prescribers (physicians) themselves will be held as guilty (H. Westley Clark, July 1993). The laws and regulations have promoted the use of standard guidelins in prescribing psychoactive substances in response to the growing concern about the wrong prescription (H. Westley Clark, July 1993). However, the

implementation of guidelines, strict laws and other factors such as fear of causing addiction and drug abuse encourage many clinicians to avoid prescribing these medications.

CONCLUSION

In conclusion, the issue of chronic pain, especially in primary care, is a very challenging and serious issue for Irish medical professionals. Chronic pain is an illness which even though it is without very visible signs, which often makes it difficult to categorise or grade (Gendreau, Hufford et al. 2003), causes distress and hurt to sufferers in all aspects of their lives. It is clear more education of health professionals is needed on chronic pain as an illness, and also perhaps on the obligations and duties of care of the doctor to a chronic pain patient, as well as the legal responsibilities and requirements (Upshur, Luckmann et al. 2006), which are clearly very important. As chronic pain has prevalence in the community of about 35% (Raftery, Sarma et al. 2011), doctors clearly need to recognise it as an important health issue which requires proper patient-centred treatment. Unfortunately Emily's doctor failed to do so in this case which only added to her distress. Her new doctor must recognise and address it as a serious concern, impacting on not only her physical and psychological health but also her family, work and social life (Breivik, Collett et al. 2006). Overall chronic pain needs to be accepted as a " valid" illness, as it may not have been in the past, and was the case with Emily's previous GP. Thereby sufferers can obtain most effective treatment to maximise their everyday abilities.

Bibliography

(CSAG), C. S. A. G. 2000. Services for Patients with Pain. BORTZ II, W. M. 1984. The disuse syndrome. *Western Journal of Medicine*, 141, 691.

BRENNAN, F., CARR, D. B. & COUSINS, M. 2007. Pain management: a fundamental human right. *Anesthesia & Analgesia*, 105, 205-221. CHAPMAN, C. R., LIPSCHITZ, D. L., ANGST, M. S., CHOU, R., DENISCO, R. C., DONALDSON, G. W., FINE, P. G., FOLEY, K. M., GALLAGHER, R. M., GILSON, A. M., HADDOX, J. D., HORN, S. D., INTURRISI, C. E., JICK, S. S., LIPMAN, A. G., LOESER, J. D., NOBLE, M., PORTER, L., ROWBOTHAM, M. C., SCHOELLES, K. M., TURK, D. C., VOLINN, E., VON KORFF, M. R., WEBSTER, L. R. & WEISNER, C. M. Opioid pharmacotherapy for chronic non-cancer pain in the United States: a research guideline for developing an evidence-base. 20100428.

EDWARDS, R. B. 1984. Pain and the ethics of pain management. *Social Science and Medicine*, 18, 515-523. FAIRBANK, J., COUPER, J., DAVIES, J. & O'BRIEN, J. 1980. The Oswestry low back pain disability questionnaire. *Physiotherapy*, 66, 271-273. FAIRBANK, J. C. & PYNSENT, P. B. 2000. The Oswestry Disability Index. *Spine*, 25, 2940-52; discussion 2952. FULLEN, B., HURLEY, D., POWER, C., CANAVAN, D. & KEEFFE, D. O. 2006. The need for a national strategy for chronic pain management in Ireland. GUREJE O, V. K. M. S. G. E. G. R. 1998. Persistent pain and well-being: A world health organization study in primary care. *JAMA*, 280, 147-151. H., M. 1979. Pain. Pain terms: a list with definitions and notes on usage recommended by the IASP subcommittee on taxonomy. H. WESTLEY CLARK, J., AND KAREN LEA SEES, DO July 1993. Opioids, Chronic pain, and the Law. *Journal of Pain and Symptom Management*, Vol. 8. IRELAND, C. P. 2009. Pain Specialists and

Pain Clinics [Online]. Chronic Pain Ireland. Available: <http://www.chronicpain.ie/index.php?q=Pain-Specialists-and-Pain-Clinics> [Accessed 14th March 2013]. JACKMAN, R. P., PURVIS, J. M. & MALLETT, B. S. 2008. Chronic nonmalignant pain in primary care. *American Family Physician*, 78, 1155-1162+1164. JACKSON, J. E. 2005. Stigma, liminality, and chronic pain - Mind-body borderlands. *American Ethnologist*, 32, 332-353. JØRGEN ERIKSEN A, P. S. A., *, EDUARDO BRUERA B, OLA EKHOLM C, NIELS K. RASMUSSEN C 2006. Critical issues on opioids in chronic non-cancer pain: An epidemiological study. *Journal of Pain*, 125. KASSARDJIAN, C. D., GARDNER-NIX, J., DUPAK, K., BARBATI, J. & LAM-MCCULLOCK, J. 2008. Validating PRISM (Pictorial Representation of Illness and Self Measure) as a Measure of Suffering in Chronic Non-Cancer Pain Patients. *The Journal of Pain*, 9, 1135-1143. KERNS, R. D. & TURK, D. C. 1984. Depression and chronic pain: The mediating role of the spouse. *Journal of Marriage and the Family*, 845-852. KOCK, K. 2012. Assessing pain in primary care. *South African Family Practice*, 54, 21-24. LECHNYR, R. & LECHNYR, T. 2003. Psychological Dimensions of Pain Management. *Prac Pain Mgmt*, 3, 10-18. LIPMAN, J. J. 1999. Heatbeam dolorimeter for pain and sensory evaluation. Google Patents. MARTINO, A. M. 1998. In Search of a New Ethic for Treating Patients with Chronic Pain: What Can Medical Boards Do? *Journal of Law, Medicine and Ethics*, 26, 332-349. MCGEE, S. J., KAYLOR, B. D., EMMOTT, H. & CHRISTOPHER, M. J. 2011. Defining chronic pain ethics. 20110802. NWOKEJI, E. D., RASCATI, K. L., BROWN, C. M. & EISENBERG, A. 2007. Influences of attitudes on family physicians' willingness to prescribe long-acting opioid analgesics for patients with chronic nonmalignant pain. *Clinical Therapeutics*, 29, 2589-2602.

PROPOSAL, P. 2010. Improving the Current and Future Management of Chronic Pain. SMITH, B. H., HOPTON, J. L. & CHAMBERS, W. A. 1999. Chronic pain in primary care. *Family Practice*, 16, 475-482. SPECHT, J., KING, G., BROWN, E. & FORIS, C. 2002. The importance of leisure in the lives of persons with congenital physical disabilities. *American Journal of Occupational Therapy*, 56, 436-45. SULLIVAN, M. D., TURNER, J. A. & ROMANO, J. 1991. Chronic pain in primary care. Identification and management of psychosocial factors. *J Fam Pract*, 32, 193-9. TORDOFF, S. G. & GANTY, P. 2010. Chronic pain and prescription opioid misuse. *Continuing Education in Anaesthesia, Critical Care & Pain*, 10, 158-161. VON KORFF, M., ORMEL, J., KEEFE, F. J. & DWORKIN, S. F. 1992. Grading the severity of chronic pain. *Pain*, 50, 133-49. WILLIAMS, A. C., ECCLESTON, C. & MORLEY, S. Psychological therapies for the management of chronic pain (excluding headache) in adults. [Review][Update of Cochrane Database Syst Rev. 2009; (2): CD007407; PMID: 19370688]. 20121114.