



## Chronic Pain and Etiology of Psychological Disturbances

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### Abstract

**Objective:** The aim of this study was to review the impact of a possible association between self-efficacy, symptom severity, pain intensity, depression, anxiety and catastrophizing on health-related quality of life among chronic pain patients.

**Background:** A large number of people experience and live with various types of physiological-oriented chronic pain (CP) diseases. Lives of individuals who suffer from CP may alter in various ways. Particularly, in terms of health-related quality of life after diagnosis. Even though, there has been significant increase in chronic pain research, this area of research continues to offer patients significant health repercussions.

**Findings:** This research has discovered that, there still, is an urgent need for improvements in regard to treatment and quality of chronic pain management care. A range of literatures assessed several aspects in which CP alters the patients' lives, as well as its potential repercussions in the workplace, on the dynamic of patients' families, and their social environments.

**Methods:** An exploratory review of literature alongside the implementation of a small exemplary pilot study that was solely undertaken to help further validate the results that were acquired via review of literature. The data presented in the pilot study were drawn from purposive sampling and structured survey questionnaires.

**Participants of the pilot study:** Thirty adults (>18 years) diagnosed and currently living with various kinds of chronic physical non-cancer pain.

**Keywords:** Pain, Depressiveness, Unpredictability, Management, Catastrophizing

### Introduction

This study intended to investigate the experiences of individuals with chronic physical non-cancer pain diseases. Pain is distressing and irritating and is often referred to as an emotional experience connected to potential or actual tissue damage (Magni et al., 1994). Pain is the

most frequently complained about somatic symptom in medical interviews and doctor visits (Krishnan et al., 1985). Chronic pain [CP] significantly interferes with the normal functioning of an individual's life (Cunha et al., 2008). Universality of CP makes this disease the foremost physical as well as mental health care predicament (Gatchel et al., 2007). Annual cost of CP is reported to



be \$635 billion which is significantly higher than the annual costs for Cancer, Heart Disease, and Diabetes (Institute of Medicine, 2018).

CP is a potential source of emotional distress and often causes depression, burn out, anxiety, fatigue and catastrophizing (Vlaeyen & Linton, 2000). Traumatic injury, surgery, and arthritis are the most common causes that may develop chronic nonmalignant pain (Langley et. al., 2010; Schopflocher et. al., 2011; Johansen et. al., 2012). For considerable number of patients, available treatment techniques seem to be inadequate and disappointing (Blyth et. al., 2001; Catala et. al., 2002; Eriksen et. al., 2003; Breivik et. al., 2006; McDermott et. al., 2006; Eriksen et. al., 2006; Jensen et. al., 2006).

More importantly, this life incapacitating condition is very often comorbid with psychiatric disorders particularly, major depression and anxiety disorder (Merskey & Bogduk, 1994; Bair et. al., 2008). Both conditions are usually not sufficiently treated, which can potentially lead to the development of significant disability, diminished health-related quality of life (HRQoL) and a substantial escalate of the health care costs (Stahl & Briley, 2004; Kessler & Ustun, 2004). For the specific motives of this research, all chronic pain disorders outside of emotional pain, cancer pain and, or pain at end of life are all together titled “chronic physical non-cancer pain” (CPNCP).

### ***Mechanisms of emotional distress in chronic pain***

Taking into account that there appears to be a consistent relationship between chronic pain and experience of emotional distress particularly, major depression and anxiety

disorder, it is prudent to examine the elements of this relationship in more details. Numerous interpretative and mental processes appear to have modified or controlling influences on the dynamic of the relationship between chronic pain and emotional distress (Walker, 2005). Some of the most striking examples consist of self-efficacy, somatisation, catastrophizing, and fear-avoidance. Each of these constituents adds a particular trait to the demonstration of pain associated with emotional distress. What is more, part of patients’ emotional instabilities was an outcome of one of these constituents (Walker, 2005). Robinson and Riley (1999) explained somatisation as being prone to experience a greater extent of physiological sensations or a person’s susceptibility to wrong categorization of symptoms related to emotional arousal (Robinson and Riley, 1999).

It is proposed that, chronic pain patients often suffer from an intensified extent of physiological consciousness and reactivity. As a result, they are more susceptible to struggle with emotional turbulence in regard to physical or pain-related circumstances. In cases such as chronic pain in which pain co-occurs frequently with emotional distress, these patients are likely to concentrate on the somatic constituent of their situation to the point that they may not be aware of the co-occurring perceptions and sensations (Dworkin, Wilson & Masson, 1994). CP patients who tend to misinterpret psychological sufferings as physical pathology may be perceived as patients who are predisposed to respond to negative life circumstances and potential social stressors with exacerbated experiences of pain. Catastrophizing persists to gain considerable recognition related to the associations between negative perception and the



experience of chronic pain (Geisse et al., 1994; Jensen, Turner & Romano, 2001; Cano, 2004; Sullivan, Lynch & Clark, 2005).

Pain associated with catastrophizing is explained as an overestimated adverse evaluation of pain and its significance (Peters, Vlaeyen & Weber, 2005). It is not uncommon for some of the CP patients to have a tendency in depicting a catastrophic picture of their current existing pain situation, and the potential next stage in terms of the unknown future of their condition. These patients are generally likely to exaggerate the enfeebling impact that pain has on their productivity and therefore, are much more susceptible to become considerably less active or identify themselves as incapacitated (Walker, 2005). Additionally, a catastrophic way of thinking can also adversely impact the patient's interpretations and evaluations of received social and emotional support from loved ones. Furthermore, in many cases the wrong evaluation of the degree of ongoing sufferings and potential debility are likely to amplify the extent and likelihood of depression due to catastrophizing among chronic pain patients (Geisser et al., 1994).

### ***Potential Co-morbidity between Chronic Pain, Depression and Anxiety***

Chronic pain is often co-morbid with anxiety and depression. Castro et. al. (2010) examined the widespread presence of correlation between depressive or anxiety symptoms and chronic pain and have illustrated the clinical outcomes. They have found that the co-occurrence of depression or anxiety was considerably prevalent. Additionally, they confirmed that the clinical burdens linked with depression and anxiety and chronic pain is notably more

substantial than for those with chronic pain alone (Castro et al., 2010). Participants with depression and anxiety had remarkably lower HRQoL than the group of participants that did not experience these symptoms.

The widespread presence of depressive symptoms in their sample was remarkably greater and almost identical to what they had found in other clinical samples ranged from 30% to 60% (Gallagher & Verma, 1999). Similar correspondence was found for anxiety symptoms (Gallagher & Verma, 1999). The collected data supported several studies in which depressive and anxiety symptoms very often coincided in patients with chronic pain (Judd et al., 2008; Leimkühler, 2002). Clearly, chronic pain and mental health illnesses are prevalent worldwide, the generality of chronic pain ranged between 2% to 40% (Henschke et al., 2015). Moreover, the widespread presence of mental health illnesses ranged between 17% to 29% (Kessler et al., 2005).

### ***CP and Depression***

Pain appears to be a frequently prevailing symptom in depression and anxiety. Numerous studies had examined this relationship for particular pain symptoms, such as back pain and neck pain (Croft et al., 2001; Gilkey et al., 2010; Kindler et al., 2010). A bidirectional relationship was found between chronic pain and clinical depression, in which depression indicated as CP whereas pain indicated as progression of depression (Ohayon & Schatzberg, 2003; Bair et. al., 2003; Gureje et. al., 2008).

A practical description would be that incapacitated functioning due to persistent pain can potentially cause social isolation, while feelings of isolation may have additional negative impact on depressive symptoms, and vice versa (Jang et. al., 2002;



Saito, Kai & Takizawa, 2012). Moreover, different parts of the brain, such as the amygdala and hypothalamus, appear to be associated with depression as well as pain (Millan, 2002; Ossipov et al., 2010). In circumstances that depression and chronic pain happen to be co-morbid, the diagnosis and treatment of depression is likely to be less successful than usual, as patients mainly discuss and seek treatment for their physical problems (Bair et al., 2003).

Depressed patients regularly complain of particular pain associated problems, for instance headache, abdominal pain, joint pain and chest pain (Mathew et al., 1981; Kroenke et al., 1994). Also, depressed patients appear to be two times more likely to experience low back pain (Croft et al., 1995). Correspondingly, various studies support the amplified likelihood of progressing depressive symptoms among CP patients. It is reported that, patients who struggle with more than one pain-related issue are at three to five times more likely to experience depression than those patients who have pain problem in one area only (Von Korff et al., 1988).

### ***CP and Anxiety***

Anxiety is a word that is applied to explain extreme feelings of fear or worry experienced by an individual, and it can be detected via one of the many currently available screening questionnaires (Bjelland et al., 2002; Leyfer et al., 2006; Kroenke et al., 2010; Julian, 2011). Anxiety disorder is a type of disorder that is related to the experience of extreme fear and perception or expectation of future danger. For example, generalised anxiety disorder (GAD), panic disorder, agoraphobia, and post-traumatic stress disorder (PTSD) are some of the most frequently diagnosed anxiety disorders. It

has been reported that, present or existing one-year prevalence of abnormal levels of anxiety or the occurrence of any type of anxiety disorder appeared to be greater than 50% in sufferers with temporomandibular joint disorder, fibromyalgia, and chronic abdominal pain (McWilliams et. al., 2003; McWilliams et. al., 2004; Clemens et. al., 2008; Van Oudenhove et. al., 2016).

In addition, studies reported patients with migraine headache, pelvic pain, and arthritis tend to have a greater tendency of 35% to 40% in developing anxiety (McWilliams et. al., 2003; McWilliams et. al., 2004; Arnold et. al., 2006; Clemens et. al., 2008; Burris et. al., 2009; Van Oudenhove et. al., 2016). The widespread prevalence of anxiety appears to be the lowest among patients diagnosed with spinal pain or neuropathic pain (McWilliams et. al., 2004; Demyttenaere et. al., 2006; Gore et. al., 2007; Yawn et. al., 2009; Reme et. al., 2011). Several population-based studies propose that, people who struggle with migraine headache are at least two to three times more likely to be diagnosed with PTSD, GAD, panic disorder, or agoraphobia when compared with individuals who did not suffer from migraine (Saunders et. al., 2008). Interestingly, people who suffer from an anxiety disorder are expected to experience migraine headache two times more than people who do not have any type of anxiety disorders (Bruffaerts et. al., 2015).

### **The exemplary pilot study**

#### **Aim**

The aims of this small exemplary pilot study were to investigate an in-depth understanding of the essence of chronic physical non-



cancer pain disorder, and to explore the potential impact of chronic physical non-cancer pain disorder on the sufferers to further elucidate the ramifications of the association between self-efficacy, symptom severity, pain intensity, depression, anxiety, and catastrophizing on disability and health related quality of life among chronic pain patients. Additionally, this study integrated the views, concerns and experiences of the participants to further examine the theoretical findings that were collected via the review of literature.

## **Methodology**

### ***Participants***

The data were drawn from in-depth structured survey questionnaires that were conducted with 30 people who currently live with chronic physical non-cancer pain in various parts of the world. To be included in the research, participants must be over the age of 18 and currently receiving medical treatment for any type of chronic pain not related to cancer or terminal illness.

### ***Procedure***

Data was collected through structured surveys. The questionnaires were of approximately 10–15 minutes duration. Participants were asked to explain as extensive as possible about all the potential outcomes, challenges, and limitations that their chronic pain has led to. Surveys were mostly consisted of questions which aimed to understand and interpret various consequences of chronic physical non-cancer pain on the individual. A link survey was created via Google Docs and was sent to the participants. The survey results were recorded for analysis.

## **Findings**

Participants (n = 30) were diagnosed for the period of time ranging from two years to forty years. Participants' age ranged between 18 years old to 68 years old, and 10 of 30 respondents were men.

### ***Participants' diagnosis***

- Juvenile rheumatoid Arthritis
- Rheumatoid arthritis (RA)
- Failed back syndrome (Post laminectomy)
- Penile pain prostatitis (Urogenital pain)
- Herniated disc in the back, neck and knee
- Fibromyalgia
- Chronic fatigue syndrome
- Chronic bronchitis
- Shoulder bursitis
- Dysmenorrhoea
- Endometriosis cyst
- Sciatica pain
- Migraine
- Pain in the Scapular, leg, muscles, arm, elbow, lower back, entire back, chest, heel, and wrist

### ***Ineffectiveness of treatment techniques***

Majority of patients hoped and expected to feel better after obtaining a proper and correct diagnosis. However, that did not seem to be the case with CP ailments. Several participants talked about experiencing disappointment after diagnosis. Patients stated that, the only solution and management method suggested to them was taking pain killers, which made them feel unwell and dizzy. Additionally, pain killers had adverse effects on their productivity and energy level throughout the day.



### ***GPs lack of training in diagnosing CP diseases***

Obtaining the correct diagnosis has been discussed as a major challenge. Some participants reported experiencing uncertainty and confusion throughout their long journey of being misdiagnosed till they finally obtained a correct diagnosis. Patients also discussed that, it was not unlikely for patients to seek diagnosis from several doctors and spend several years just so they could obtain a correct and definite diagnosis.

### ***Self-awareness and self-acquired knowledge are key factors***

Self-awareness is reported to be perceived as an essential factor and is associated with earlier diagnosis. The change in self-awareness appears to provide patients with greater ability to understand their bodies' signs, how they feel about themselves and their wellbeing. Self-education, familiarity and being well-informed appear to be crucial components in obtaining early diagnosis, experiencing less psychological distress, and having much better treatment outcomes.

### ***Accepting one's limited capacity***

Acceptance of the new body and understanding the new limits are beneficial for patients in terms of helping them with incorporation and adjustment. Some participants discussed that at the early stages of their diagnosis, they had experienced a lot of stress, fatigue, physical pain, emotional discomfort, resentment, and severe lack of ability to cope with their illnesses and illness-related symptoms. However, throughout the course of the time, patients

have managed to come into peace and acceptance with their new changes.

### ***Making priorities and setting boundaries***

Some participants, particularly those who have lived with their illnesses for longer period of time have talked about setting boundaries and making priorities. Evidently, the progressive nature of chronic ailments will not allow the patients to be the same person and live the same lifestyle that they used to live prior to their diagnosis. Consequently, it is essential for patients to come into understating with their new identities after diagnosis, and possibly try to redesign their lives around their "new changes".

### ***Importance of emotional and social support***

Receiving love and support and feeling well understood by family and partner are discussed as positive, beneficial and very much helpful. Being emotionally balanced seems to be an important factor, as balance of the psyche is very much connected with the experience of health-related quality of life after diagnosis with a chronic pain disease. Participants discussed that having supportive family members who are understanding and nonjudgmental toward their needs, and are willing to step up and take over some of the responsibilities and duties of the patients is comforting and also has great significance for the patients.

### **Discussion**

This study aimed to draw attention to the intricate characteristics of chronic pain, as well as the subjective nature of individuals' experiences of chronic pain and the associated disability. CP offers its sufferers



multitudinous long term physical and psychological repercussions. CP is inclined to grow and develop throughout the course of the time, and its progressive nature will additionally increase the possibility of advancements of various fundamental pathologies and associated complications. When left undetermined, under-assessed and unmanaged, the neuroplastic alterations that appear to subscribe to the advancement of pain may become irreversible, and in the long run became recalcitrant and unresponsive to treatment.

For these reasons, it is crucial for the health care providers as well as the chronic pain sufferers to be well concerned about the urgency and importance of the early diagnosis and potential beneficial methods of treatment. Evidently, as discussed by several of the participants, it is common for chronic pain patients to come up with a possible diagnosis on their own, and specifically consult a GP to confirm their diagnosis. This act seems to be quite beneficial considering all the sufferings, challenges, difficulties, and uncertainties that CP patients normally struggle with from their very first symptoms until they finally obtain a correct diagnosis. It appears that for many patients, it takes quite some time to finally have an accurate and precise diagnosis, as patients are often at the risk of being misdiagnosed. Many chronic ailments have similar symptoms and indications. Therefore, it is not difficult for practitioners to misread the signs and misinterpret the situations. This study would like to offer three notions that are likely to be beneficial for the treatment of chronic pain disorders. Three notions related and regarding to:

- Health care professionals: Medical doctors
- Health care professionals: Psychotherapists
- Family and partner: Possible training aspects

### ***Health care professionals: Medical doctors***

An estimated 20% of world population are impacted by chronic pain yet, not that many physicians are specialised in the field of pain medicine world-wide (International association for the study of pain [IASP], 2018). Typically, CP patients refer to primary care providers in an attempt to search for treatment for their pain and pain-related symptoms. The first concern that comes to mind is the fact that, primary care physicians are not required or obliged to obtain formal training related to the management and treatment of chronic pain disorders. Not to mention that primary care services are in accordance to the standards of the biomedical model of pain and are certainly not based on the merits of biopsychosocial model of pain which is also known as the only model that is suitable and appropriate for the treatment and handling of chronic pain due to its multidimensional characteristics (Guzman, 2001; Scascighini et. al., 2008).

In fact, a considerable number of PCPs are very much aware of the fact that they do not have the necessary preparations and education to treat and manage chronic pain diseases. As a matter of fact, in a research that was conducted with 500 primary care physicians, it was reported that as little as 34% of the respondents perceived themselves as competent in treating CP patients (Institute of Medicine, 2011). On top of that, PCPs constantly scored low on evaluative items such as "I am confident in my ability to manage chronic pain" (Anderson et. al., 2012). In addition, they confess knowing that their medical training has not sufficiently coached them for treating chronic pain diseases, and more than half of them reported a lack of



contentment with their pain related training (Upshur et. al., 2006). Yet, ironically and for whatever reasons CP patients continue to seek pain related treatment from PCPs. A report presented by the Institute of Medicine (2011) is another indication of how crucial it truly is for those primary care physicians who intend to treat chronic pain diseases to consider cooperating and teaming up with pain specialists.

### ***Health care professionals: Psychotherapists***

Now that we looked at the importance of obtaining pain treatment from specialized pain doctors, we should also look into whys and wherefores surrounding the importance of our next suggested notion. Chronic pain patients are often quite familiar with psychiatric and psychotherapeutic practices. In fact, it has been estimated that 38% of psychiatric inpatients and 18% of psychiatric outpatients mainly seek treatment as a result of their pain (Yutzy & Parish, 2008). Various psychotherapeutic studies indicated that, it is possible for chronic pain patients to receive positive outcomes from psychotherapy, particularly from psychotherapists who have acquired additional training to treat pain patients. A psychotherapist that does not have expertise and familiarity with the field of chronic pain is unlikely to be equally effective and even possibly be problematic in the long run. Majority of chronic pain patients' sufferings revolve around the topic of physical pain, medications, disability, loss of employment, loss of partner, and most importantly loss of identity. Hence, a psychotherapist who is not skilled in the field of pain psychology is highly unlikely to be productive and successful. This study would like to suggest to those psychotherapists who are interested

in accommodating and working with CP patients, to possibly consider acquiring additional training related to the treatment of pain. CP patients are likely to benefit from psychotherapy specially, patients who do not have great social support, or someone that they could openly talk about their feelings, concerns, and thoughts without fear of judgement. Hence, it might be helpful and positive for them to seek psychotherapy from psychotherapists who are trained in the field of pain management.

In circumstances that a mental health practitioner is unfamiliar with pain diseases and pain-related symptoms, the therapeutic relationship is likely to become frustrating with minimum likelihood that the patient will experience positive outcomes or benefit in any ways from therapy. Mainly to the fact that, the CP patients solely seek therapy to obtain help in handling their pain and pain-related limitations in order to cope better with their "new changes" and manage their personal and professional lives post diagnosis to some extent. Additionally, the fact that the psychotherapist may lack the necessary education and training to specifically deal with and treat pain patients could be a major deal-breaker. Their pain-related sufferings and anguish need to be constantly acknowledged and addressed. Consequently, this research suggested that a psychotherapist who lacks training in chronic pain is unlikely to be able to maintain therapeutic relationship with a major CP sufferer, as patients will at some point drop out from the treatment.

A psychotherapist with additional training and specialized in pain management has that extra tool that is very much essential for the treatment of chronic pain patients. They can work with the patient toward "acceptance" and "becoming" two very crucial elements surrounding the





challenging topic of chronic pain. Due to the permanent nature of a chronic disease there really is a need for a certain degree of knowledge and expertise to help accommodate these long-suffering patients to reclaim their identities, to manage to incorporate their “new self” into their characters without too much adversity. Pain patients with more advanced pain diseases are particularly at risk for self-harm and suicide consequently, they really need to be precisely monitored. A psychotherapist that does not have familiarity with the nature and circumstances of the chronic pain diseases may not be able to detect these patients and accommodate them in a way that is necessary. CP patients can be difficult patients as they often have lost a lot of themselves. For instance, patients that have become disabled, lost their spouse or/and their job due to their pain disorders, are quite severe and not a case that can be treated by a general psychotherapist. In fact, what makes the work of a pain expert so crucial is that, they apply and practice a multidisciplinary approach - an approach that this study suggested to be the most beneficial and very much essential for the treatment of chronic pain diseases. Multidisciplinary treatment approach appears to be a quite effective technique in lessening patient’s pain and pain-related sufferings as it combined several components of treatment as one unique treatment approach. Taking into account the unique and destructive nature of chronic pain diseases and all the potential ways in which a person’s life can be altered by it, it is only effectual if all the elements of a patient’s life are taken into account throughout the course of the therapeutic treatment.

### ***Family and partner: Possible training aspects***

This study has assessed that, family and partner are major constituents of a chronic pain patient’s life. CP diseases are overwhelming and complicated. Hence, having to live with a chronic condition and having to face all the adverse repercussions surrounding the chronic ailment is likely to create profound emotional distress and turbulence not only for the sufferers but also their partner and family. Consequently, this study suggested that attending community-based training workshops and self-help groups that are typically offered at no cost or at a small cost are crucial for both the patients and their spouses or their children. CP diseases have adverse effects on the quality of the relationship between patients and their spouses, and this impact is likely to have a reciprocal impact on the pain-related outcomes of the patients (Leonard & Cano, 2006).

While looking into various studies that involved patients’ spouses and families, this study has noticed that attending community-based workshops or chronic pain functional restoration programs are rarely discussed or emphasized on. And, it was definitely disappointing. Evidently, chronic pain is complicated to be managed by patients and their families, hence, seeking for a proper treatment is more effective compared with self-management. Clearly, there are no doubts that the experience of chronic pain has major impact on the dynamic of patients’ social relationships as it limits their competency in terms of leisure activities and social relationships (Gatchel et. al., 2007). Moreover, patient’s experience of adverse emotions, frequent mood swings, and feelings of resentment is likely to negatively influence patient’s interpersonal



relationships and ultimately, this will increase the magnitude of distress within the structure of their family (Leonard & Cano, 2006).

CP patients are likely to have less communication with the members of their families. Misunderstandings and miscommunications are major problems for many chronic pain patients. The challenges related to adequate understanding and effective communication is another indication of the importance of participation in community-based programs and workshops that can provide patients and their families with necessary education and training to help them gain in-depth understanding regarding alterations that has been placed on their lives as an outcome of the fact that one member of the family has been diagnosed with a chronic life-changing illness.

Specially, in circumstances that a patient has experienced loss of employment due to the severity of the chronic disease or in cases that the other spouse had to take time off from work or even possibly let go of their daily routine to manage and supervise the family member who is sick. Most importantly, in circumstances that young children are involved, lack of proper education, explanation, and training could possibly result in children experiencing trauma. Not to mention, in many cases, the experience of role reversals which is also known as role tensions within the structure of the family following a person's diagnosis with a severe chronic ailment are so severe, agonising, and excruciating that are unlikely to not be experienced as a shock for the children.

In addition, children's involuntary experience of social learning via watching their parents plays a major part in regard to the formation of their recognition and understanding of the pain and pain-related

behaviors (Flor & Turk, 2011). For instance, children's propensity to understate or over evaluate a potential pain-related symptom, and the coping mechanisms of their choice is usually influenced by their parents (Flor & Turk, 2011). Not to mention, there are severe damages that children may experience due to dysfunctional parenting practices that is likely to be provided for children by an unwell parent (Semrud-Clikeman, 2007). Without any doubts, diminished attention and emotional presence of the caregivers have direct impact on the character of the children, their perceptions of themselves, their environment, and most importantly on their sense of self-worth and self-esteem. Additionally, there appeared to be a possible connection between maternal and paternal chronic pain and occurrence of anxiety and depression-related symptoms among girls and boys, smoking and alcohol misuse among adolescent boys (Kaasbøll et al., 2012). All facts and aspects taken into account the current research is certain that, these issues are strong demonstrations that are redolent of an urgent necessity for enrolment in training workshops and informative programs. Without ambivalence, the current research believes all members of a CP patient's family are likely to benefit from these types of programs in one way or another.

Furthermore, and most importantly, active participation in chronic pain training programs can also help the patients, their partner and family to become resilient. As via learning to understand each other empathetically, they are more likely to be able to maintain a cohesive dynamic within their family and consequently, they can manage to develop more strength that can help them to go through the evidently challenging and complicated transition of chronic illness. Resilience is explained as



the circumstance in which individuals who are involved in a particular adverse situation will not only manage to effectively cope with their circumstances, but they will also manage to successfully overcome such experience with greater ability to cope with future occurrences (McCubbin & McCubbin, 1988; McCubbin et. al., 1997; Walsh, 1996). The current study aimed to demonstrate the importance of active participation in patient-focused training program and chronic pain continuing education programs. Programs that are likely to provide patients and their loved ones with tools that can help them to acquire correct knowledge and in-depth understanding of the phenomenon of pain, and consequently guide them in the direction of achieving and maintaining some extent of health-related quality of life after diagnosis.

### Conclusion

This study aimed to reinforce and expand current knowledge regarding the impact of chronic pain on patients. CP is evidently a major health problem impacting not only the suffering individuals but also their partners and families. Despite its evidently concerning widespread prevalence, longevity, potential co-morbidity with mental health disorders and destructive nature, the current available treatment methods are insufficient. The current study suggested an in-depth understanding of anxiety symptoms and depression can definitely help in terms of improving the health-related quality of life after diagnosis among CP patients. Furthermore, this study also suggested that the application of an interdisciplinary approach for the treatment and management of chronic physical non-cancer pain is essential.

### Limitations

The small sample size has been at the cost of practicality of the extent of the scientific scope to which these findings can be generalised to the chronic pain population at large.

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