INTRODUCTION

Chronic non-malignant pain differs from acute pain problems by its recurrent disabling nature. Chronicity suggests that traditional pain relief modalities have failed and a different treatment approach is required. Chronic pain syndrome can be simply characterized as a "3-D problem": the individual is disabled, usually depressed, and addicted or habituated to drugs. The focus of treatment must necessarily move from curative modalities associated with an acute, time-limited illness, to management strategies for the special problems presented by chronicity. In order to achieve an optimal outcome, the anesthesiologist specializing in pain management must develop an understanding of the chronic pain treatment process as essentially an interdisciplinary activity involving medical, rehabilitative, and behavior change components.

The primary purpose of this presentation will be to explore an interdisciplinary approach to the management of chronic pain syndrome and, in particular, offer guidelines to identify and treat psychological or behavioral aspects. I will review the special character of interdisciplinary activity, discuss its application to chronic pain management, and outline psychological and behavioral aspects of chronic pain syndrome. It is hoped that greater awareness of the psychological components will promote a more interdisciplinary approach to the unique problems associated with chronic non-malignant pain.
INTERDISCIPLINARY PAIN PEERS

In his presidential address to the 1980 American Congress of Rehabilitation Medicine, Fordyce called for an interdisciplinary health care delivery system that could more effectively and efficiently address the problems of chronic illness and disability (1). He called attention to the distinction between multidisciplinary and interdisciplinary activity that may be best summarized by a direct quote:

"Both (activities) involve efforts by people from several disciplines and both require that these people have at least passing familiarity with the knowledge and methods of the other disciplines. But interdisciplinary differs from multidisciplinary in that the end product of the effort—the outcome—can only be accomplished by a truly interactive effort and contribution from the disciplines involved. In a multidisciplinary exercise, two or more professions may make their respective contributions, but each contribution stands on its own and could emerge without the input of another. In an interdisciplinary effort, life is not so simple. The end product requires that there be an interactive and symbiotic interplay of the contributions from different disciplines. Without that interaction the outcome will fall short of the need... The essence of the matter is that each of the participating professions needs the others to accomplish what, collectively, they have agreed are their objectives" (1).

A colleague of mine in the chronic pain management field, Dr. Michael Corley, captures the distinction by describing multidisciplinary care as basically, "the Detroit, assembly-line model" (Corley, personal communication, 1989). The patient with chronic pain may see a physician, physical therapist, and psychologist in the same clinic area on the same morning, traveling the “assembly line” to receive different system checks much the same way a Buick is treated at General Motors. While the patient may benefit from the individual expertise of the treatment providers, unless there exists overlapping knowledge about chronic pain, an understanding of how your particular treatment may impact the patient at another systems level, an agreement on overall treatment goals, and routine staff communication on these points, the patient could easily become a chronic pain treatment patient forever on the health care “assembly line”. Fordyce (2) emphasized in his president’s