Dear Sir,

We thank Drs Van Houdenhove and Luyten for emphasizing a biopsychosocial conceptualization of the experience of pain and agree that this is the correct theoretical model within which to conceptualize pain. There is no question that with development of fields such as psycho-neuro-immunology (Hillhouse et al., 1991) demonstrating the impact of stress on immune function and recent evidence supporting a significant contribution of immune dysfunction in the etiology of neuropathic pain (Watkins and Maier, 2004), that there is mounting evidence that physical and psychological aspects of pain are inseparable and in this we agree with Van Houdenhove and Luyten, from there we diverge. It is ironic that Dr Harold Merskey should be referred to as a dualistic thinker who ‘holds on to a rigid dichotomy between organic and psychological/psychiatric causes of pain’. It was Merskey who codified the biopsychosocial model in the IASP’s own definition of pain (Merskey and Bogduk, 1994). Indeed Merskey’s important observation that “It is conceptually important to recognize that all pain is a psychological experience” (Merskey, 1987) could be labeled monistic thinking, but those familiar with the breadth and scope of his significant contributions to the pain field know him as a multiplist. His work has served many in clarifying how to approach management in complicated cases of pain.

Over a decade ago, Merskey discouraged the use of the term ‘chronic pain syndrome’ identifying that this term encouraged the practitioner to neglect responsibility for establishing the precise contribution of physical and psychological components (Merskey, 1989). He identified that it is much better to include two diagnoses and estimate their importance, targeting both in the treatment of pain. This principle in pain management has been one that I have found very useful in educating the next generation of pain clinicians. More recently, Merskey has identified the dangers inherent in the use of the term somatization (Merskey, 2004), pointing out that this term is used in at least eight different ways and in addition notes that it is not useful to refer to patients “as somatizing, which automatically implies actively producing physical symptoms, whether indirectly or from some ‘unconscious’ motive”.

As clinicians treating patients who suffer from pain, we cannot extricate ourselves, or our patients from the sociopolitical context. The fact is we continue to live in a world that blames patients for their pain and history continues to generate terms with which to blame them. Whether we choose to call it a chronic pain syndrome, a personality problem or somatization, the end result is often the same. Patients are often abandoned to then go home and treat themselves, are denied just compensation and are denied access to pain relieving medications, which was exactly the point we intended to make and reiterate here.

References


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Distortion of the biopsychosocial approach

Dear Sir,


According to Grande et al., their patient with brain damage, epilepsy, back injury, post-traumatic stress disorder and depression probably had complex regional pain syndrome—type I. Changes occurred with progressive mainly unilateral painful vascular symptoms first in the left foot, and less and later on the right, following the