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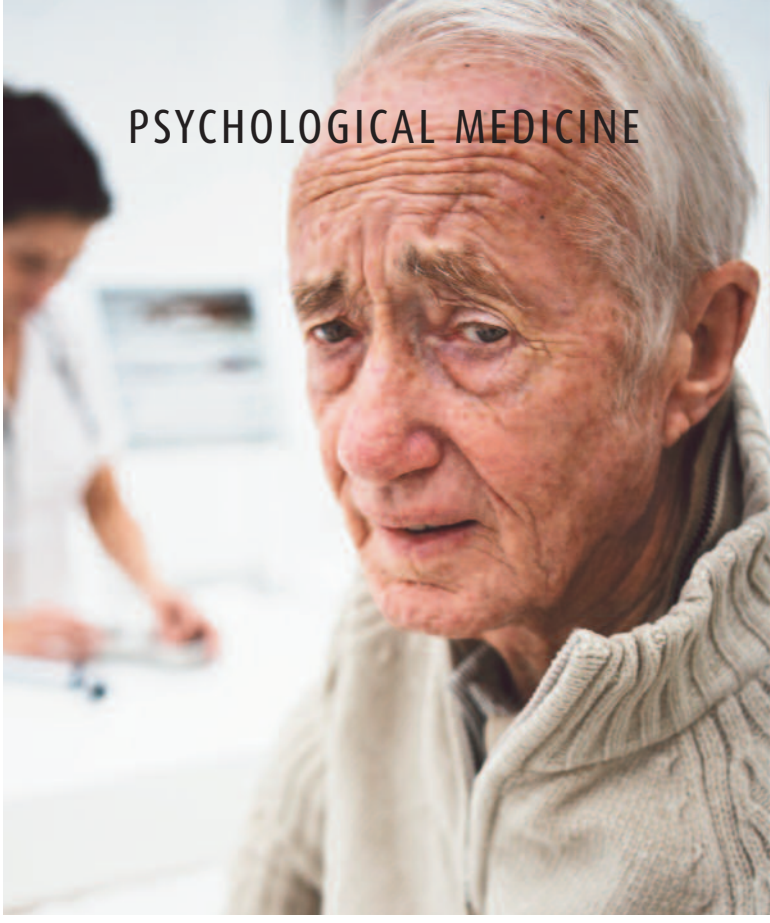

Common psychiatric issues in chronic pain

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Chronic pain is a major health problem, commonly accompanied and aggravated by emotional difficulties. If we look for, recognise and treat co-occurring psychiatric issues, we may improve outcomes for many patients.

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Nearly one in five Australians suffers from chronic or persisting pain, and the prevalence is expected to increase as our population ages. Whatever the original cause of an individual's pain, it is often a sensitised nervous system rather than structural tissue damage that is most strongly correlated with persistence of the pain. The concepts of neuroplasticity and central sensitisation are increasingly used to explain how such persistence develops.[1] Persistent pain is commonly linked to emotional distress and serious mental health problems.[2] Such comorbid psychiatric conditions, which are often unrecognised, may interfere with a patient's response to treatment and make successful pain management more difficult. If these psychiatric conditions are recognised and treated and function improves, it should make for a happier patient (and a happier doctor).

Much of the research on chronic pain and psychiatric problems has been focused on patients attending pain clinics. By the time patients are referred to a pain clinic, their pain is often highly disabling, complex and difficult to manage, and significant psychiatric comorbidity is commonly present. It is likely that they have already seen a range of clinicians. However, the persistent pain in patients attending their GP may be just as complex. Although many patients have milder emotional responses to their pain, these are still significant – and treatable.

It is important to recognise that patients with chronic pain are a heterogeneous group, not only in the physical origins of their pain but also in their psychological responses to it. Every patient is different, with his or her own coping styles, skills and vulnerabilities. Nonetheless, it is worth looking for groups within this population. From a psychiatric perspective, several

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TALKING WITH PATIENTS ABOUT CHRONIC PAIN: USEFUL CONCEPTS

- Chronic pain is very different to acute pain – it is much more complex. What works for acute pain may not work for chronic pain, and vice versa.
- In chronic pain, changes have developed in the nervous system (central sensitisation).
- 'Neuroplasticity' is not just part of explaining how chronic pain develops. It is also a reason for optimism to explain why behavioural, 'psychological' treatment can help.
- Mind and body are not separate disconnected entities; rather, they are aspects of the whole person. Both constructs include a range of factors that can aggravate or reduce pain levels.
- A rehabilitation approach is more likely to work than persisting in looking for 'the cure'.
- It's not just the level of pain that is important, it's also about how well the individual is functioning.

common comorbid conditions can be described, each of which may vary in severity from a minor presentation to a full-blown psychiatric disorder. The main issues to consider are depression, anxiety, somatisation, substance dependence and difficulties related to certain personality traits. These are not exclusive categories. For example, a patient with chronic pain may have an anxiety disorder plus a tendency to somatise and a dependency on opioids.

Patients with persistent pain who have straightforward depression or anxiety are usually open about describing their emotions and their symptoms, and they can be dealt with at a primary or secondary care level. It is when the picture becomes complicated by somatisation or substance dependence or when problems develop in the doctor–patient relationship that referral to a multidisciplinary pain centre is indicated.

A brief list of concepts that are often helpful when communicating with patients about their chronic pain is provided in the box on this page.

DEPRESSION

Research shows that 10% to 40% of patients with chronic pain have major depression.[3] In addition, many patients have chronic dysthymia, and many more just experience a lot of sadness. Depression is essentially about loss, and people with persisting pain have often experienced a cascade of losses: in their health, their self-image (reduced strength or competence), and their role in the family and their job, to name a few.

There is evidence that patients with coexisting chronic pain and depression have a poorer prognosis and response to treatment than patients with either condition alone.[4] Chronic pain and depression both require active treatment. We should not expect (as many patients do) that fixing the pain will make the depression go away.

GPs who are interested and comfortable in a counselling role are often best placed to treat such a patient – they have an existing relationship that can be continued over a long term. Patients with depression need support in talking about their feelings, especially about their losses and ways of coping with these.

There is a spectrum of intensity for depressed mood. The further that a patient's mood state is towards the major depression end of the spectrum, the more likely it is that antidepressants will be necessary. If the patient's pain is neuropathic and low-dose tricyclics (e.g. amitriptyline 20 mg) are already useful, increasing the dose into the usual antidepressant range (say, amitriptyline 100 mg or more) may be effective, assuming that the patient can tolerate any side effects and is not at risk of taking an overdose. SNRI antidepressants also appear to have analgesic properties that are distinct from their antidepressant effects. Two reviews have shown this for duloxetine and venlafaxine;[2,5] to date, there is little evidence about desvenlafaxine. So in the treatment of patients with both persistent pain and major depression SNRIs have an advantage over SSRIs, which do not appear to have these analgesic properties.

The decision to refer a patient to a psychiatrist, psychologist or counsellor will depend on where the depression sits on the major depression–sadness spectrum. Experience in helping patients with chronic pain is often more relevant than the clinician's label. Good communication between the GP and other health professionals is important because the GP will remain central to long-term management.

ANXIETY

Research indicates that between 15% and 30% of patients with chronic pain have an anxiety disorder, such as generalised anxiety disorder, panic disorder or post-traumatic stress disorder (PTSD).[2,6] Depression and anxiety often co-occur, together with chronic pain.

PTSD is increasingly recognised as accompanying chronic pain that originated in a physical injury that was emotionally traumatic, such as an assault or motor vehicle accident. In a study of patients who developed chronic pain following severe accidental injury, PTSD symptoms and other psychological factors were the strongest predictors of persisting pain three years later.[7]

Short of having an anxiety disorder, many patients with persistent pain experience some degree of anxiety. Both anxiety and pain can have physiological effects, such as increased muscle tension, that aggravate the pain. A person who worries that physical activities will increase the pain and also that pain means further damage may become very avoidant. Whereas depression is basically about losses that have already occurred, anxiety is more

apprehension about what might happen.

The GP is often the best person to deal with a combination of persisting pain and anxiety. Patients need to have their fears listened to and not have the conversation cut short with a prescription.

Cognitive behavioural therapy (CBT) encompasses a number of strategies to help people manage both anxiety and pain.[7] Such strategies include goal setting, problem-solving, pacing of activity, relaxation and the challenging of unhelpful beliefs.[8]

More recently, there has been interest in acceptance commitment therapy, which uses some elements of CBT but focuses more on encouraging the patient to accept their pain, usually via mindfulness meditation. Training in mindfulness often involves teaching patients to sit, relax and focus on their breath, and then being aware of and accepting their pain without reacting to it with distress.[9,10] In this context, acceptance means accepting that the pain is present right now, not accepting that it will never change.[8]

The usefulness of medications for mild to moderate anxiety is limited. Many drugs, such as benzodiazepines and analgesics, (and alcohol) are effective short-term anxiolytics, but they may do more harm than good in people with chronic conditions. Antidepressants may help to reduce anxiety, with less risk of tolerance, dose escalation and dependence.

Referral to a psychologist for CBT may be considered for a patient who has significant anxiety, especially if the anxiety is accompanied by avoidance of activities that threaten to increase pain or anxiety or by a high level of catastrophising. The treatment of PTSD, whether severe or subclinical, is under debate. There is little strong evidence that standard counselling or psychotherapy achieves much. It seems more likely that PTSD requires specific, focused treatment. This may include approaches such as exposure, relaxation and guided imagery by a practitioner with experience in the use of such techniques.[11]

SOMATISATION

Somatisation is more a process than a diagnosis. A somatising patient has medically unexplained somatic symptoms that may be driven or aggravated by underlying emotional distress, but the patient is not open to considering this possibility. Extreme somatising behaviour can result in somatisation disorder.

There may be cultural, language, educational or emotional reasons for somatisation. In addition, multiple visits to doctors who are much more attentive to physical complaints than emotional ones may reinforce somatising behaviour. There is also the stigma of 'mental illness'. Many people still believe that mind and body are separate entities, that only physical treatments can help 'real' pain and that psychological treatment is for 'imaginary' pain. But it is not 'either…or' in persistent pain, it is 'not only…but also'.

A patient who is very resistant to considering emotional factors or psychological approaches to helping cope with their pain is unlikely to agree to a referral to a psychologist, much less to a psychiatrist. In discussing referral, it helps to address the mind–body split, and a patient's fear that the GP disbelieves his or her symptoms. It may be helpful to explain that you wish to refer the patient to a practitioner who is an expert in helping people cope with and better manage their pain. A multidisciplinary pain centre is often more acceptable to the somatising patient. In the centre, the various personnel, from pain specialist to nurse practitioner, can work together with the patient, and it will be emphasised that the treatment package routinely addresses the whole range of physical and psychological factors.

SUBSTANCE DEPENDENCE

In terms of the potential for substance dependence, opioids are the obvious drugs of concern for patients with persistent pain. Expert opinions differ about the value of opioids in the long term and for whom they are suitable. Many people start taking opioids for acute pain but keep taking them after the pain has become persistent. In 2005, a large US study found that 3% of the population were taking prescribed opioids and that 45% of those had sufficient symptoms to be diagnosed with common mental health disorders (major depression, dysthymia and anxiety disorders), although very few of these disorders were being treated.[12] So when considering the use of opioids for a patient with chronic pain, first screening for and treating depression and anxiety is very important.

The subject of opioids in chronic pain is a topic in itself. One of the many ways in which acute pain and chronic pain are different is their response to opioid treatment: acute pain may often respond well to opioids but the evidence for long-term efficacy of opioids in chronic pain is much less convincing. The issues involved in prescribing opioids for chronic pain are discussed in a recent article in *Australian Prescriber* (and available online).[13]

Patients with chronic pain are at risk of developing dependence on other analgesics, benzodiazepines and alcohol, which initially relieve pain, insomnia and anxiety. However, once dependent, patients may be even less motivated or able to use psychological approaches to pain management.

There is also a group of patients who, while not physiologically dependent on a drug, have a fixed belief that the only real treatment for their pain must be medication (chemical coping) or surgery. For them, the pain is purely physical and will only respond to such 'real medicine' (see the section on somatisation above). This mind–body split may have been reinforced by their experiences with doctors. Such somatising patients are at high risk of developing a substance dependence.

In difficult cases, referral of the patient to a drug health clinician or pain clinic can be considered. At a tertiary level, pain clinics benefit greatly from close liaison with a drug health unit. Clear

communication between treating clinicians about treatment goals and dosage regimens is required, but it is essential that a single clinician be responsible for prescribing an individual's medication.

DIFFICULTIES RELATED TO PERSONALITY TRAITS

Personality traits are enduring patterns of relating to others and coping with the environment. Persisting pain can interfere with coping. For instance, the athlete for whom running is central becomes irritable and stressed without his regular exercise. As the pain goes on and on, with repeated experiences of frustration, disappointments, unhappy consultations and failed treatments, his range of coping strategies will narrow and his vulnerabilities will increase. The patient's interactions with doctors will become more difficult. This is an understandable development, rather than the result of a pre-existing personality disorder.

The diagnosis of personality disorder is occasionally useful but it is often arbitrary and unreliable. However, having an idea of a patient's personality traits, whether dependent or cynical, workaholic or avoidant, helps in developing an effective relationship in which the patient feels more heard and understood. It pays to focus on your patients' strengths, not just their weaknesses (they may well do that themselves).

Issues of personality style, or traits, and personality disorders relevant to general practice were discussed in a recent article in *Medicine Today*.[14] The author of that article noted that assessing the patient's personality style can help in predicting his or her response to the illness and compliance with treatment, and how the patient may relate to the doctor. In turn, this should help the doctor decide how to relate to the patient. To deal with the problem of imposing categories of personality disorders onto what are essentially dimensions, the author proposed a two-tier model: tier 1 describes the personality style, and tier 2 describes the degree of dysfunction along a spectrum (from minor trait to clear disorder).

Personality styles or personality disorders are mainly visible in an individual's manner of relating to the other people in his or her life. Patients with chronic illness who interact regularly with clinicians are more likely to become entrenched in patterns of transactions that may be uncomfortable for both.

A relationship is a two-person thing. The patient's relationship with healthcare workers is often crucial to successful management. Rather than just thinking 'difficult patient', the clinician can try to assess an individual's personality style and consider the kind of interaction that has developed between them. Increasing difficulty in the doctor–patient relationship is a strong indication for referral to a multidisciplinary pain centre, or perhaps to a psychiatrist if the patient will accept this.

FINAL POINTS

- Psychiatric conditions commonly accompany chronic pain and are often unrecognised.
- Comorbidity often worsens disability and reduces the likelihood of a good response to treatment.
- Depression is the best studied of the psychiatric conditions that commonly accompany chronic pain. The other main co-occurring issues are anxiety, somatisation, substance dependence and personality issues that contribute to difficulties in the doctor–patient relationship.
- Depression and anxiety are usually best treated at the primary care level.
- Chronic pain becomes harder to deal with when somatisation or substance dependence is present and when problems in the doctor–patient relationship develop. Management in these cases more often requires collaboration at a tertiary care level, such as a multidisciplinary pain centre. MT

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