Chronic Pain –
the psychiatric perspective

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Points to be addressed

- What is the psychiatric element of chronic pain?
- Diagnoses/Terminology
- What is the role of the psychiatrist
- The chronic pain patient and the chronic pain claimant - the role of litigation
- What can be done to determine if claim genuine?
- Predisposing factors/vulnerability/perpetuating factors
- Treatment
What is the psychiatric element of chronic pain?
What is the psychiatric element of chronic pain?

1. Somatisation
Mind-body dualism!

- Disease ‘organic’
- Illness ‘psychological’
All conditions have a psychological component (‘biopsychosocial medicine’)

Illness ‘psychological’

Disease ‘organic’

e.g. psychological effects of an acute slipped disk
Illness

Disease
e.g. person with disproportionate chronic disability following relatively minor back injury

A.k.a.
‘functional overlay’
or ‘somatoform disorder’
Illness

e.g. pure somatization disorder – no underlying organic pathology
Symptoms in US primary care

*Kroenke and Mangelsdorf, 1989*
What is somatisation?

Somatization as a process:
“...a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to a physical illness, and to seek medical help for them”

Liposwki, 1988

Several components
Not ‘all or nothing’ – a spectrum
**Terminology for Somatoform Disorders**

<table>
<thead>
<tr>
<th>Medical Speciality</th>
<th>Condition</th>
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<tbody>
<tr>
<td>Gastroenterologists:</td>
<td>Irritable bowel syndrome</td>
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<tr>
<td>Rheumatologists:</td>
<td>Fibromyalgia</td>
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<td>Infectious diseases:</td>
<td>Chronic fatigue syndrome</td>
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<tr>
<td>Neurologists:</td>
<td>Chronic headache</td>
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<tr>
<td>Hand surgeons:</td>
<td>Repetitive strain injury</td>
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<tr>
<td>Dentists:</td>
<td>Atypical facial pain</td>
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<tr>
<td>Cardiologists:</td>
<td>Atypical chest pain</td>
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<tr>
<td>Chest physicians:</td>
<td>Hyperventilation disorder</td>
</tr>
<tr>
<td>Gynaecologists:</td>
<td>Premenstrual syndrome</td>
</tr>
<tr>
<td>Pain physicians:</td>
<td>Chronic pain syndrome</td>
</tr>
<tr>
<td>Psychiatrists:</td>
<td>Conversion disorder/somatisation disorder/pain disorder</td>
</tr>
</tbody>
</table>
Anxiety and depression cluster together – patients often have elements of several.
Allergies: don’t they make you sick!

21st Century syndrome, social phobia, wheat intolerance... John Naish wonders if

Jennifer Mills’s allergy resulted in her being given planning permission to build a hilltop hideaway near Bristol. Even traces of detergent powder on a neighbour’s washing line make her ill.

Everything

Jenny Simpson, 46, from Aberdeenshire, lives on just four foods — cod, potatoes, spinach and cabbage — and has to take vaccinations for each. She drinks and washes in mineral water.
What is the psychiatric element of chronic pain?

2. Overt Psychiatric Disorder
One-in-five people across Britain is in pain every day, or most days, a survey suggests. This amounts to almost 10 million Britons for whom pain has a significant impact on quality of life. One-in-two of those in pain have taken days off work, an increase from one-in-three in 2002.

Half of those in pain (49%) said the burden had made them depressed and a quarter (26%) found their sex life had been affected. The results of the 2005 Pain Survey, in which the British Pain Society questioned 975 people, come despite an increased focus by the NHS on improving patient care.
Painful Symptoms: Correlated With Depression

Depressed patients are four times more likely to experience general aches and pains than people without depression.

Ohayon MM, Schatzberg AF. Arch Gen Psychiatry. 2003;60(1):39-47.
What is the psychiatric element of chronic pain?

3. Deliberate Exaggeration/Malingering (though this is not a psychiatric diagnosis)
Diagnostic Criteria for Chronic Pain
A. Pain is the predominant focus of the clinical presentation

B. The pain causes clinically significant distress or impairment in functioning.

C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.

D. The symptom or deficit is not intentionally produced.

E. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder.

Then specify whether:

- Pain Disorder Associated With Psychological Factors; or
- Pain Disorder Associated With Both Psychological Factors and a General Medical Condition:
What do psychiatrists do?
What do psychiatrists do?

1. Assess the pain
What suggests possibility of strong psychological element to pain?

- Widespread pain v localised
- Not conforming to usual anatomical patterns
- Excessive symptoms or disability over that expected
- Multiple symptoms
- Presence of diagnosable psychiatric disorder (e.g. Depression)
What do psychiatrists do?

2. Assess the person
Who develops chronic pain?

Multifactorial interaction of

- vulnerability
- the injury/trauma
- subsequent events

Both organic and psychological factors can operate at each point
Indicators of vulnerability

- Female gender
- Past psychiatric disorder
  - Clinical and subclinical levels
  - Most psych disorder seen by GPs (if at all)
- Prior history of pain or other somatoform complaints (e.g. chronic fatigue, IBS)
  - Frequent GP consulters/ “thick file patients”
- Genetic
- Childhood adversity, especially trauma/abuse
- Prior Stresses
## Childhood and Adult Abuse in Fibromyalgia

*Walker et al, 1997*

<table>
<thead>
<tr>
<th></th>
<th>Fibromyalgia (n=36)</th>
<th>Rheumatoid Arthritis (n=33)</th>
<th>P</th>
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</thead>
<tbody>
<tr>
<td><strong>Childhood abuse</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical assault</td>
<td>41.7%</td>
<td>16.7%</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Penetration</td>
<td>33.3%</td>
<td>13.3%</td>
<td>0.06</td>
</tr>
<tr>
<td><strong>Adult assault</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penetration</td>
<td>66.7%</td>
<td>23.3%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Physical assault</td>
<td>47.2%</td>
<td>16.7%</td>
<td>&lt;0.01</td>
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Development of Chronic Pain (McBeth *et al* 2001)

- Community sample of 825 pain free individuals and 833 with localised pain not widespread
- By 12 months - 2% and 8% respectively had developed widespread pain
- Features of somatisation highly predictive of those who developed widespread pain

i.e. high spontaneous rate of onset, related to psychological vulnerability

Persistence of Chronic Pain (McBeth *et al* 2001)

- 252 subjects with widespread pain at baseline
- 56% still had it 12 months later
- Factors associated with persistence were: psychological distress, fatigue and somatisation

i.e. persistence of widespread pain related to psychological factors
What do psychiatrists do?

3. Assess the perpetuating factors
Perpetuating factors

Organic Factors
- continuation of primary condition
- secondary physical changes e.g. disuse atrophy

Psychiatric Disorder
- depression – increased pain, increased disability
- anxiety – avoidance, increased disability

Pain Behaviours and Cognitions (‘illness behaviour’/illness beliefs)
- belief that exercise/use of affected areas is harmful
- fixed somatic attribution of cause
- symptom focussing
- use of avoidance
- ‘boom or bust’ patterns of activity
- loss of control

Social influences
- stress
- litigation
- reinforcement by spouse/family/work/doctor
- insurance/pension issues
- media
‘If you have to prove you are ill-you can’t get well’

(Dr. Nortin Hadler)
Effects of litigation

- An additional stress
- Some dispute it, but most accept litigation can be a perpetuating factor
- Can be subconscious or conscious
- But settling litigation doesn’t in itself lead to resolution of illness.
  - 760 claimants, 40 months litigation
  - 396 working, 363 not working at settlement
  - 2 y post settlement, 75% not working (other studies range from 35-75%) – Mendelson 1995
Psychiatric medicolegal assessment of chronic pain claimant

- **Current and past**
  - Pain
  - Other somatic syndromes
  - Depression and anxiety
- **Vulnerability**
- **Disability**
- **Treatments tried and attitude to future treatments**
ctd

- Helpful to have reports from other specialists regarding role of organic factors
- As much past medical documentation as possible – 9 times out of 10 patients will not report prior psychiatric history reported in the records
- Specific questions that need answering
Assessing if a claim is genuine

- **Patient background**
  - History of dishonesty
  - Antisocial personality

- **Patient presentation**
  - Avoids treatments without good explanation
  - Discrepant/changing history

- **Clinical examination**
  - Unco-operative/evasive
  - “malingering tests”
  - Inappropriate signs (NB don’t distinguish conscious v unconscious factors)

- **Surveillance**
  - Differs from description of disability to doctors
  - Appearance of signs differs e.g. gait
15 item Rey test

- Seen for 10 seconds
- <9 remembered suggests deliberate exaggeration (or lack of co-operation/effort)
Pain/depression subjective experiences that depend upon reliable patient report

Can’t “see” psychiatric disorder (unless very severe) – can see level of associated disability

If patient exaggerating one area – e.g. disability level – can’t rely on accurate description of psychiatric symptoms – likely to be exaggerating these too.
Treatment

- Somatoform pain/depression are potentially treatable
  - Medication
  - Specific psychological therapies
  - Rehabilitation/occupational therapy for more chronic conditions
  - Address perpetuating factors

- But…
Most people with depression are not treated adequately....

...but depression maintains pain and pain improves when depression is also treated....

.... (and often will not respond to other measures if depression is not treated)
Antidepressants can treat pain in depressed patients\(^1\)

Adverse events for Cymbalta vs placebo during controlled clinical trials for MDD included: back pain 3% vs 4%

Even chronic depression can be treated

- 681 patients with chronic depression
- All > 2 y, mean duration 8 years
- Treated with antidepressant, and psychological therapy for 12 weeks

Response Rate
(>50% reduction symptoms)
85%

Remission Rate
(symptoms all gone)
42%

Keller et al., 2000
Fatigue and pain
Unrefreshing sleep
Concentration and memory impairment

Specific psychological therapies
- cognitive therapy
- antidepressants
- Enlist social welfare agencies

Symptomatic treatments
- analgesics
- sleep strategies to stabilise sleep and reduce pain and other symptoms

Reduced
- intellectual activity
- physical activity
- work and social interaction

Increased
- depression
- anxiety
- social isolation
- physical illness

Graded activity plan
- graded exercise program
- workplace rehabilitation
- Assess patient's attitudes and knowledge base for fears/ideas that may hinder recovery

Loss of
- intellectual performance
- physical activity
- aerobic fitness
- enjoyable social contacts

Education and support
- provide information about CFS
- encourage return to work, social activities, physical activity
Pain Management Programmes

- Multidisciplinary – usually include clinical psychologist and cognitive behavioural therapy
- Effective against pain and disability
- Research studies of inpatient programmes show that despite taking the most disabled subjects there is:
  - 50% reduction disability
  - 30% return to employment
  - Results maintained 1 year follow up
  - Inpatient more effective than outpatient programme
Message re treatment

- It works!
- Sooner rather than later, but still potentially beneficial if occurs later
- Most people improve
- Benefits may occur after discharge