Prevention in Action

Cast a Wide Net With Chronic Pain

Perspective

People who have chronic pain are extraordinarily clear about the devastating impact this problem has on their psychological balance. The resulting sense of helplessness often generates a great deal of grief, depression, stress, pessimism, and loneliness.

People who have never experienced severe, chronic pain, however, have no idea how disruptive it can be. Because of this, they may erroneously assume (and even suggest) that the pain is purely psychological or a sign of weakness of character or will—sentiments that further isolate and alienate the sufferers.

BY CARL C. BELL, M.D.

This isolation is exacerbated by the current health care culture. Although some understanding exists of the medical conundrum of pain, the psychiatric ramifications are very much an afterthought. The proactive approach of considering mind and body takes a back seat to the mechanistic approach of trying to heal the physical body while ignoring the mind.

This approach is rather typical of Western medicine and has its origins as far back as the Descartes doctrine of the distinction between the mind and body.

Because Western medicine focuses so intently on the mechanistic view of life and well-being, we don't have evidence of the efficacy of other, more esoteric forms of healing, such as acupuncture, meditation, prayer, and support group activities. We won't be able to collect such evidence until Western health care providers routinely begin to embrace non-Western approaches to health care that address issues of both the mind and the body.

Fortunately, science may be taking us in that direction. The mechanism of pain has been connected to the serotoninergic neurotransmitter system in the brain and body, which is also linked to depression. This connection suggests a potential route for therapeutic benefit of antidepressant medications for chronic pain.

Bridging the mind/body gap in our management of chronic pain is not impossible, but doing so does require a critical culture shift in which neither element takes a backseat to the other.

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Chronic pain cuts wide. One out of every five people lives with some sort of chronic pain. Of that 20%, one-third are not able or are only minimally able to maintain an independent lifestyle because of it, according to the International Association for the Study of Pain.

And chronic pain cuts deep. Beneath the veneer of the physical symptoms lies the social, emotional, and psychological havoc caused by the associated disability, isolation, fear, and helplessness, which leads to a substantially diminished quality of life.

Unfortunately, chronic pain is also invisible. There's no gash to suture, no broken leg to set. Instead, there exists an amorphous condition that is difficult to measure and even more difficult to manage, particularly in a health care culture that values cut-and-dry diagnoses and magic pills. Adding to the complexity is the fact that chronic pain often coexists with a range of psychological disorders, including depression, anxiety, personality disorders, cognitive problems, and substance abuse.

In one study designed to assess the prevalence of chronic pain conditions and their relationship with major depressive disorder (MDD), investigators from Stanford (Calif.) University conducted a cross-sectional telephone survey of a random sample of nearly 19,000 subjects from the general population.

About 4% of the survey participants met the diagnostic criteria for MDD, and of those, 43.5% reported having at least one chronic pain condition—a number four times greater than reported by individuals in the study who did not have depression (Arch. Gen. Psychiatry 2003;60:39-47).

More recently, another Stanford study sought to evaluate the strength of the association between major depression and chronic pain and to examine the clinical burden associated with the two conditions. Of nearly 6,000 randomly sampled primary care patients who responded to a questionnaire, about 7% met criteria for MDD, and two-thirds of those with depression reported chronic pain. Among all of the subjects in the sample who reported chronic pain, the prevalence of MDD was significantly higher than in those without pain (Psychosom. Med. 2006;68:262-8).

The direction of the pain/depression connection has yet to be fully understood, but the degree of disability appears to play an important role, according to lead investigator Bruce A. Arnow, Ph.D. Among those respondents with chronic pain, the prevalence of MDD was 23% in people with disabling pain, compared with 5% in those who were not disabled by their pain. "It's possible that those who are disabled by pain become depressed, and it is possible that those who are depressed are more likely to become disabled," he said.

Regardless of initial direction, the likelihood that one will coexist with the other warrants that both be addressed. Numerous studies have shown that depressed chronic pain patients report greater pain intensity, more malignant disease course, and poorer response to pain treatments. Additionally, depression can impede rehabilitation efforts because of low motivation, poor morale, low energy, and hopelessness.

In contrast, considering the physical and mental health components of chronic pain as symptoms of a single pain syndrome can improve patient outcome. A large, multisite investigation of depression care from the University of Washington, Seattle, showed that older adults with chronic arthritis pain who were screened and treated for depression had significant improvements in pain severity and functioning, compared with those patients who received standard arthritis care. The treatment group benefited from a multidisciplinary program that included medication, psychotherapy, and in-person and telephone follow-up (JAMA 2003;290:2428-9).

The multidisciplinary intervention "not only helped patients with arthritis feel less depressed but also helped them cope better with their pain, to be more active, and to have a higher quality of life," according to lead investigator Dr. Elizabeth H.B. Lin of the Group Health Cooperative in Seattle. Treating patients' depression isn't going to take the pain away, she said, but treatment can change the experience of pain, which can lead to improved outcomes.

In addition to antidepressant medications when warranted, various nonpharmacologic strategies, including patient psychoeducation, and cognitive-behavioral interventions, can give chronic pain patients a sense of control over their pain and the tools needed to modify behaviors that contribute to emotional and physical distress.

The bottom line, according to chronic pain expert Robert D. Kerns, Ph.D., associate professor in the departments of psychiatry, neurology, and psychology at Yale University, New Haven, Conn., is that patients with chronic pain have to be viewed from a broad biopsychosocial perspective.

"For greatest effectiveness [in managing chronic pain], we should be treating the whole person, not fixing a 'broken' body part," Dr. Kerns said. ■

By Diana Mahoney, New England bureau. Share your thoughts and suggestions at clinicalpsychiatrynews@elsevier.com.

Pain Relief Is a Phone Call Away

Patients suffering from chronic, nonmalignant pain generally have to come to terms with the fact that finding a cure for their symptoms is an elusive goal. A more reasonable treatment target is pain management, often through some combination of analgesic medication and behavior modification.

In fact, numerous studies have shown that behavioral interventions—particularly cognitive-behavioral therapy (CBT) and self-regulatory techniques such as biofeedback and hypnosis—can significantly reduce pain intensity and improve emotional and physical functioning.

Ideally, after participating in a behavioral intervention, patients will regularly access and employ the various coping strategies they've acquired. Realistically, the likelihood that they will do so diminishes over time.

Although it may not be feasible to conduct open-ended behavioral intervention groups, pain specialists at the University of Vermont in Burlington may have developed the next best thing. Therapeutic Interactive Voice Response (TIVR) was developed to enhance the therapeutic outcome of patients who have completed a course of group CBT for chronic pain and to minimize their reliance on pharmacologic painkillers.

The first component of the TIVR enhancement is a daily self-monitoring questionnaire. Patients access the computerized interactive telephone system and respond by touch-pad to a series of questions that measure coping, perceived pain control, mood, medication, and stress. The objective is to improve self-monitoring of pain behavior, coping skills, and medication use, said TIVR principal investigator Dr. Magdalena R. Naylor, director of the university's MindBody Medicine Clinic.

If patients desire a coping skills "refresher," they can access a didactic review that provides a verbal review of the various pain management skills learned during the CBT intervention, such as relaxation response, positive self-talk, cognitive restructuring, and distraction techniques.

The final component is a monthly feedback message: A therapist analyzes computer-collated, patient-specific data from the telephone response system and records a personalized message for participants summarizing the daily reports and offering insight into potential problem areas. This element is critical to the efficacy of the system, according to Dr. Naylor, as it is a vehicle for valuable feedback and an ongoing positive connection with the therapist.

In a pilot test of TIVR in a group of 10 middle-aged patients with severe, chronic musculoskeletal pain, regular use of the TIVR both maintained and strengthened the therapeutic gains associated with the CBT intervention (J. Pain 2002;3:429-38).

The Vermont investigators are currently replicating the TIVR study in a randomized, controlled trial.