Psychiatric Aspects of Chronic Pain Conditions

Dr Prem Chopra
Epworth Camberwell
Outline

- Psychiatry and Chronic pain
- History
- Examination
- Formulation
- Diagnostic challenges
- Management challenges
- Case study
Psychiatry and Chronic Pain

- Definition of Chronic Pain: pain that persists for longer than 3 months, that accompanies a disease process, or that is associated with a bodily injury that has not resolved over time
- Psychiatric comorbidity is high
- Impaired occupational, social level of functioning
- Inability to engage in activities may contribute to increased isolation, feelings of worthlessness, and depressed mood
- 27% of patients with pain in primary care clinics meet criteria for major depression (Otis and Hughes 2010)
- Is it physical or psychosomatic?
  - Dualistic thinking about chronic pain is unhelpful
  - No longer conceptualized according to a dichotomy where pain is thought to be due to either physical or psychological causes
History

- HOPI: pain, anxiety, depression
- Context: triggers for worsening of pain / mood
- Past psychiatric history
- Drug and alcohol history: prescribed substance use disorder
- Family history: chronic pain (significant parental role models)
- Personal history: prior trauma
Examination

- General appearance: level of apparent discomfort, avoidance behaviours
- Affect: depression, irritability
- Thoughts: guilt, helplessness, hopelessness, suicidal ideation
- Perception
- Cognition: impact of sedative medications
- Insight / judgment: locus of control (internal vs external)
Formulation

BIOPSYCHOSOCIAL APPROACH TO UNDERSTANDING HEALTH

BIOLOGY
- Gender
- Physical illness
- Disability
- Genetic vulnerability
- Immune function
- Neurochemistry
- Stress reactivity
- Medication effects

PSYCHOLOGY
- Learning/memory
- Attitudes/beliefs
- Personality
- Behaviours
- Emotions
- Coping skills
- Past trauma

HEALTH
- Social supports
- Family background
- Cultural traditions
- Social/economic status
- Education

SOCIAL CONTEXT
The Pain Cycle

**PAIN**
- Muscle atrophy, weakness

**DISTRESS**
- Negative self-talk
- Poor sleep
- Missing work

**DISABILITY**
- Reduced activity
- Amotivation
- Isolation
Fear Avoidance Model (Lethem et al 1983)

- Injury
  - Disuse
  - Depression
  - Disability

- Avoidance
  - Hypervigilance

- Pain-related fear

- Pain experience
  - Pain catastrophizing
  - Negative affectivity
  - Threatening illness information

- Confrontation
  - Recovery

- No fear
Psychological issues

- Pain proneness
  - George Engel – the ‘pain prone patient’
  - Suggested that many patients with chronic pain had a pattern of defeat, punishment, and emotional deprivation in early life, that continued on into unsatisfactory relationships in adult life, often with continuing abuse and fear
  - Engel implicated guilt as a central feature

- Individuals with certain personality structures may be more vulnerable to chronic pain disorders especially those with dependent, anxious or avoidant personality traits

- Defence mechanisms: coping strategies; some individuals may be more vulnerable to psychiatric comorbidity

- Conversion reaction (Functional Neurological Symptom Disorder) is rare
  - Unconscious repression or conscious suppression commonly of anger

- Secondary gain: unplanned, fortuitous advantages of being in the 'sick' role and which may maintain the status-quo
  - Has been misused to label patients
Diagnostic Challenges

- Physical condition with comorbid psychiatric disorder
- Comorbidity with substance use disorders
- Personality dysfunction
Abnormal Illness Behaviour

- Issy Pilowsky (1969)
- Defined abnormal illness behaviour according to the norms of the ‘sick role’
  - Illness denying
  - Illness affirming
Management Challenges

- Rehabilitation approach
  - Dealing with patients’ expectations
  - Collaborative approach to management

- Biopsychosocial management
  - Psychotropic medications
  - Psychotherapy
  - Social interventions
Multidisciplinary Approach

- Patients with chronic pain may benefit from a multidisciplinary team approach that focuses on a chronic illness model
  - encouraging patients to move away from the acute illness model
  - adjusting expectations – living a life despite pain
- Therapeutic alliance is vital (patients are often angry, suspicious, defensive)
Role of psychotropics in the management of chronic pain alone

- PATHWAY FOR CHOOSING ANTIDEPRESSANTS IS REVERSED
  - MOST EVIDENCE IS FOR TCAS
  - CONSIDER SNRI EG VENLAFAXINE
  - SSRIS IF DEPRESSED AND NOT ABLE TO TOLERATE SNRIS/TCAS (less likely to be of benefit as analgesics)
- Tricyclic antidepressants
  - Doses less than those used for depression generally have been used in analgesic regimens
  - Use with caution in patients with a history of cardiovascular disease, glaucoma, urinary retention and autonomic neuropathy, and in elderly patients
  - Contraindications: significant cardiac arrhythmias, prostatic hypertrophy and narrow angle glaucoma
- SNRIs
  - Venlafaxine
  - Desvenlafaxine
  - Duloxetine
- Other psychotropics of interest
  - Pregabalin
    - Useful for the management of comorbid anxiety
  - Antiepileptics:
    - Carbamazepine
    - Lamotrigine
    - Sodium valproate
Key components of CBT for chronic pain include:

- cognitive restructuring (ie, teaching patients how to change maladaptive thoughts)
- relaxation training (eg, diaphragmatic breathing, imagery)
- time-based activity pacing (ie, teaching patients how to be more active without overdoing it)
- graded homework assignments designed to decrease patients’ avoidance of activity and to reintroduce a healthy, more active lifestyle.
ACT

- Acceptance and Commitment Therapy
- Three key components
  - Cognitive defusion: distancing from and letting go of unhelpful thoughts and beliefs
  - Acceptance: making room for painful feelings
  - Contact with the present moment and committed action (goals based on the person’s values)
Case Discussion