Psychiatric and Psychological Perspectives on Chronic Pain

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KEYWORDS

• Major depressive disorder • Dysthymia • Panic disorder
• Posttraumatic stress disorder • Substance use disorders • Illness beliefs
• Coping strategies • Fear avoidance

KEY POINTS

- Several psychiatric disorders are so common among chronic pain patients that physiatrists should be alert to them. They include major depressive disorder, dysthymia, panic disorder, posttraumatic stress disorder, and various substance use disorders.
- A high proportion of chronic pain patients have dysfunctional belief systems about their conditions and/or dysfunctional coping strategies to deal with their conditions. These beliefs and coping strategies can occur in the absence of a diagnosable psychiatric condition and can have significant negative impacts on the patients' response to treatment.
- Physiatrists should consider several factors when they decide whether to refer a pain patient to a psychiatrist or a psychologist. In general, though, an initial referral to a psychiatrist is usually the best strategy.

INTRODUCTION

Physiatrists who treat patients with chronic pain frequently request assistance from mental health practitioners. The 2 types of professionals who typically evaluate these patients are psychiatrists and clinical psychologists. The present article describes the perspectives taken by these 2 professional groups and offers recommendations about when to refer to a psychiatrist versus a psychologist.

THE PSYCHIATRIC PERSPECTIVE

Any discussion of psychiatric disorders in patients with chronic pain is haunted by the concept of psychogenic pain. One is drawn to this concept because it fills the gaps left

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when the attempts fail to explain clinical pain exclusively in terms of tissue pathologic abnormality. In fact, psychogenic pain was codified into the pain disorder diagnosis in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The diagnosis presumes that some pain conditions are solely or predominantly explained by psychological factors rather than medical conditions. Psychogenic pain, however, is an empty concept. Positive criteria for the identification of psychogenic pain, mechanisms for the production of psychogenic pain, and specific therapies for psychogenic pain are lacking. Psychiatric diagnosis of many disorders, such as depression, can be helpful to the clinician and the patient by pointing to specific effective therapies. However, the diagnosis of psychogenic pain too often only serves to stigmatize further the patient who experiences chronic pain.

A notable and welcome change from DSM-IV to DSM-5 is the elimination of the pain disorder diagnosis. The rationale for its removal was given in the introductory section to the chapter, "Somatic Symptoms and Related Disorder," in DSM-5: "The reliability of determining that a somatic symptom is medially unexplained is limited, and grounding a diagnosis on the absence of an explanation is problematic and reinforces mind-body dualism" (American Psychiatric Association, 2013, p. 309).

Epidemiologic evidence supports the use of inclusive rather than exclusive models of psychiatric diagnoses in medical settings that allows for the presence of both medical disease and mental disorders. Medical illness in no way excludes the possibility of a clinically important psychiatric illness. Medically ill patients are, in fact, much more likely to have psychiatric illness than patients without medical illness. Psychiatric illness in no way precludes the possibility of a clinically important medical illness. Psychiatric illness is, in fact, associated with health behaviors and physiologic changes known to promote medical illness.

In the discussion that follows, psychiatric disorders as defined in DSM-5 are used as an organizing strategy. It is important to note, however, that the categorical model of mental disorder favored by psychiatrists and used in DSM-5 can imply more discontinuity between those with and those without a mental disorder than is actually the case. For example, it is common for patients with chronic pain to partially meet criteria for several mental disorders. Therefore, it is sometimes useful to think of these disorders as dimensions rather than categories. The DSM-5 nevertheless provides a well-recognized and systematic template for the discussion of psychiatric disorders in patients with chronic pain.

When asked to evaluate patients at the authors' Center for Pain Relief, they typically consider the following issues: depression, anxiety, trauma and abuse history, posttraumatic stress disorder (PTSD), and substance use disorders. The authors do not usually use a structured interview for psychiatric diagnosis, but some brief, self-administered questionnaires are routinely given to the patients at every visit to screen for major psychiatric symptoms and for outcome tracking in a nonresearch clinical setting. These evaluations include the 9-item Patient Health Questionnaire,[1] the Generalized Anxiety Disorder 7-item scale,[2] and a 4-item Primary Care PTSD Screen.[3]

Depression

One must begin by distinguishing between depressed mood and the clinical syndrome of major depression. It is important to note, especially when working with chronic pain patients, that depressed mood or dysphoria is not necessary for the diagnosis of major depression. Anhedonia, the inability to enjoy activities or experience pleasure, is an adequate substitute. It is common for patients with chronic pain to deny dysphoria but to acknowledge that enjoyment of all activities has ceased, even those without