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Observational study

# Comparison of patients diagnosed with “complex pain” and “somatoform pain”



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## HIGHLIGHTS

- Comparisons between patients with “somatoform” and “complex” pain were made.
- Very little differences were found between the groups.
- Both patient groups were seriously impaired both physically and mentally.
- The diagnostic groups might be considered as one and the same group.
- Multidisciplinary centers with both pain and psychiatric specialists are suggested.

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## ABSTRACT

**Background and aim:** Chronic pain conditions can be diagnosed and treated in both somatic and psychiatric settings. It is still a discussed and unanswered question whether the two groups of patients differ. The purpose of this short article is to inform further reflections concerning the classifications of somatoform pain and complex pain.

**Method:** Sociodemographic and questionnaire data concerning anxiety and depression, perceived injustice, well-being, and levels of psycho-physiological functioning were compared for patients diagnosed with complex pain (somatic diagnosis) at a pain clinic and somatoform pain (psychiatric diagnosis) at a Liaison-psychiatric clinic.

**Results:** Very little differences were found between patients with complex pain (N = 162) and somatoform conditions (N = 89). Both patient groups were seriously impaired both physically and mentally.

**Conclusion:** These comparisons lend support to the viewpoint of non-segregation of somatoform and complex pain.

**Implications:** Pain treatment might be better-managed in common multidisciplinary centers with specialists in both pain treatment and psychiatric aid.

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## 1. Introduction

According to ICD10, patients with persistent pain conditions can be diagnosed in two ways, linking the pain to either a somatic or a psychiatric understanding. The idea of two distinct pain types – one somatic, complex (viewed as medically explainable) and one psychogenic, idiopathic (viewed as medically unexplained) – has historical roots [1], but the idea of pain being of different types is no longer a part of modern pain theory and clinical

understanding [2,3]. Still, the ICD10 diagnostic system and the present organizational structures in health management concerning chronic pain maintain the idea of the two pain types, and patients with chronic/long lasting pain conditions can be referred to either a somatic or a psychiatric unit. The diagnostic labels are further exported into diagnostic databases, and they may play a major role in patient rehabilitation and social security management.

The purpose of this short report is to shed light on these inconsistencies in understanding and clinical management by empirically comparing the two groups involved: (1) patients with a diagnosis of complex pain treated in a (somatic) outpatient pain clinic. (2) Patients diagnosed with somatoform pain and treated in an outpatient liaison clinic (“unexplained pain”).

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## 2. Methods

### 2.1. Participants

All participants had been referred for assessment and treatment at either the Cross-disciplinary Pain Center, Rigshospitalet ( $N = 89$ ) or the Liaison Clinic, Mental Health Center ( $N = 89$ ). Both are multi-disciplinary clinics in Copenhagen, Denmark. Data were collected between January 1 and December 31, 2014, by consecutively collecting data from the patients referred at the clinics. They were all diagnosed by specialist physicians at the units.

From a total participant sample of 358 individuals, two subgroups were made. One subgroup with the diagnosis of “complex nonmalignant pain” (Pain Center sample,  $N = 162$ ; ICD10 code R522E); one group with the diagnosis of “persistent somatoform pain disorder” (Liaison Clinic,  $N = 89$ ; ICD10 code F45.4).

### 2.2. Questionnaires

The data collected comprised *sociodemographic information* (age, gender, marital status, number of children, educational level, relation to job market, and duration of pain symptoms).

*Hospital Anxiety and Depression Scale* (HADS), which is a 14-item anxiety and depression screening instrument for use in non-psychiatric patients [4]. HADS has been validated and found reliable for use in the Danish general population [5], as well as in patients with chronic pain [6,7]. Scores on the HADS range from 0 to 21 for both measures, with higher scores indicating greater anxiety and depression. The average Cronbach's alphas are reported as 0.83 for anxiety and 0.82 for depression [5].

The *Injustice Experience Questionnaire* (IEQ) assesses the degree to which individuals perceive their present condition as being characterized by injustice. Respondents rate their experiences of 12 different thoughts/emotions/attitudes using a 5-point Likert scale [8]. The final score is the sum of all items, with high values indicating high perceived injustice levels. In the original study, the IEQ had a Cronbach's alpha of 0.92 and a test–retest reliability of 0.90 [8]. The Danish validated version showed Cronbach's alpha = 0.90 [9].

The *WHO-five well-being scale* (WHO-5) is a well-being index that includes five items concerning feelings of positive mood, vitality, and general interest. It is answered using a 5-point Likert scale, with higher scores indicating higher well-being. The scores are added and multiplied by 4, giving a final score ranging from 0 to 100. The Danish language version of this scale has been found valid [10].

The *SF-36* is a standardized, well-validated, multi-dimensional questionnaire that measures health, level of function, and well-being in eight dimensions [11]. The Danish language version has been validated and found to be reliable [12]. The dimension *Physical function* is measured using 10 items concerning physical disabilities. *Role physical* is addressed by 4 items regarding present physical limitations. *Bodily pain* is evaluated based on 2 items about pain and impact of pain. *General health* is assessed using 5 items concerning self-rated health perception. The scores on these first four dimensions are used to calculate an overall *Physical health component*. The dimension *Vitality* is measured with 4 items concerning feelings of energy and tiredness. *Social functioning* is assessed using 2 items about social limitations. *Role emotional* is measured using 3 items about daily limitations for emotional reasons. Finally, *Mental health* is addressed in 5 items concerning present mood and nervousness. The scores for these last four dimensions are used to compute an overall *Mental health component*. All SF-36 scores range from 0 to 100, with higher scores indicating better function on the specific dimension. Population studies usually show norms of around 50 for the two-component sum scores [13].

**Table 1**

Sociographic data of the diagnostic groups of somatoform pain and complex pain.

Treatment setting Diagnosis	Pain clinic ( $N = 162$ ) Complex pain	Liaison clinic, pain ( $N = 89$ ) Somatoform pain
Age	50.8**	41.9
Female gender	59%	64%
Years with pain	12.4(*)	9.2
Married or with partner	52%	50%
Children at home ( $N$ )	1.0	0.9
Formal education, yes	76%	69%
Currently employed	19%*	30%
If employed, working hours/week	25.8	29.5

\* = significance  $<.05$ ; \*\* = significance  $p <.01$ ; (\*) non-significant after control for age.

**Table 2**

Questionnaire scores from the diagnostic groups of somatoform pain and complex pain.

Treatment setting Main diagnosis	Pain clinic ( $N = 162$ ) Complex pain	Liaison clinic ( $N = 89$ ) Somatoform pain
Anxiety, HADS	9.3	10.3
Depression, HADS	8.1	8.6
Perceived Injustice Scale	27.3	28.4
WHO-5 total	33.8	28.5
SF36 physical function	42.0 (*)	50.6
SF36 role physical	13.0	13.1
SF36 bodily pain	21.7	24.2
SF36 general health perception	33.9	33.2
SF36 vitality	27.6	23.6
SF36 social functioning	42.6	40.0
SF36 role emotional	42.4	32.2
SF36 mental health	54.6	49.7
SF 36 physical sum score	27.2**	30.6
SF 36 mental sum score	39.9**	35.1

\*\* = significance from somatoform pain group  $<.01$ ; (\*) significance  $<.05$ , non-significant after control for age and gender.

Statistical analyses were performed using SPSS 22 Chi Square methods for showing significant differences in the binary (sociodemographic) variables, while independent t-test comparisons were used for the continuous variables. Controlling differences for age, gender and years with pain was done by using a univariate general linear model.

## 3. Results

### 3.1. Sociodemographics

Mean age for the “somatic” pain sample was 50.8 (SD12.5, range 21–81); and for the “psychiatric” pain sample was 41.9 (SD 12.0, range 23–72) (Table 1). The age difference was nearly 9 years, and the “somatic” pain sample has had the pain condition more than three years longer, which was depending on the age: When controlled for age, years with pain was no longer significantly different ( $p = .66$ ).

The “somatic” pain sample was employed less frequently, and age played a role here too: only one patient was over official retirement age (65 years) in the “psychiatric” sample, while 18 patients were over 65 years in the “somatic” pain sample. However, when these age-retired patients were removed from analysis, the difference was still significant (Pearson chi-square  $p = .04$ ).

### 3.2. Questionnaire data

The calculated SF-scores of the questionnaires are shown in Table 2. Only three of the 14 variables show initial significant differences. The “somatic” pain sample functions worse on the SF36 physical function subscale (items concerning physical disability in

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