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Psychiatric Evaluation and Treatment

I. General principles

A. Be aware that chronic pain is associated with a large number of psychiatric and psychological comorbidities including depression, anxiety, drug dependence, somatoform disorders, and bipolar disorder (Fishbain et al. 1998)

B. Know that patients with diffuse complaints and widespread pain are at greater risk of psychiatric disorder and functional impairment than are patients with specific and/or localized complaints.

C. Be able to make a diagnosis of major depression and dysthymic disorder and to distinguish these forms of mental disorder from the depressive symptoms that often accompany chronic pain.

D. Be able to diagnose other psychiatric disorders that might present with pain as a symptom (such as a panic disorder presenting with nonorganic chest pain, post-traumatic stress disorder, or the rare presentation of psychotic disorders with delusional pain) as well as psychiatric disorders that might be comorbid with pain (e.g., obsessive-compulsive disorder).

E. Be alert to the possibility of comorbid alcohol or nonalcohol substance abuse disorders that might increase pain disability or impede response to rehabilitation. The diagnosis must be based on a clinical examination, including a detailed mental state evaluation, and not solely on questionnaire methods (Goli and Fozdar 2002).

II. Drug treatment

A. Know the indications for the use of antidepressants for both mood and anxiety disorders (Goli and Fozdar 2002).

B. Understand the indications, contraindications, efficacy, use, drug interactions, and side effects of classical and newer or alternative antidepressants for treating comorbid mood or anxiety disorders in patients with pain. This would include the use of first-generation agents (e.g., tricyclics, including nortriptyline and desipramine, and monoamine oxidase inhibitors, including phenelzine), as well as selective serotonin reuptake inhibitors (SSRIs, e.g., fluoxetine and paroxetine), serotonergic-noradrenergic reuptake inhibitors (e.g., venlafaxine and mirtazapine), and noradrenergic-dopaminergic reuptake inhibitors (e.g., bupropion).

C. Understand the use of other antidepressant/mood-stabilizing agents (e.g., lithium, valproate, and carbamazepine). Because mood disorders are often treatment resistant, use of augmentation and combination strategies should be understood.

D. Be familiar with the use and roles of antidepressants and anxiolytics (e.g., benzodiazepines) to treat generalized anxiety disorder, panic disorder, social phobias, and obsessive-compulsive disorder.

E. Be aware of the pharmacotherapy of psychotic disorders with first-generation and atypical neuroleptics (Breitbart 1998). Delirium can complicate the clinical picture of patients with pain due to diseases associated with pain and their therapy, as well as being a complication of opioid therapy, and thus it is important to be aware of the use of typical and atypical neuroleptics for delirium.

F. Understand the efficacy of psychopharmacological agents as analgesics, and their application for specific conditions.

G. Be aware that antidepressants do have an analgesic effect outside of their antidepressant effect (Fishbain 2000a) and that the SSRI antidepressants may have a greater analgesic effect than the non-SSRIs (Fishbain 2000b).

H. Be aware of the limitations of antidepressant medications and that data demonstrating their efficacy is strong only for selected neuropathic pain syndromes (e.g., Max et al. 1992), migraine and tension headache syndromes, and perhaps atypical facial pain (e.g., see Magni 1991; Onghena and Van Houdenhove 1992), although evidence is developing that chronic low back pain may be responsive (e.g., Atkinson et al. 1999).

I. Recognize that there is little evidence that antidepressants are effective for nonspecific or mixed pain states, and that their role as analgesics in rheumatoid disorders and fibromyalgia is not yet clear.

J. Understand the potential differential efficacy of noradrenergic antidepressants, compared to serotonergic antidepressants (Max et al. 1992), as well as the possibility that there may be concentration-response effects (Sindrup et al. 1985, 1991).

K. Recognize that the evidence is very limited on the efficacy of mood stabilizers, benzodiazepines, and neuroleptics (except methotrimeprazine) as analgesics (e.g., Atkinson et al. 1994).

L. Be aware of the use of anticonvulsants as an aid to analgesia (e.g., olanzapine, gabapentin, and tiagabine) (Covington 1998; Khojainova et al. 2002).

III. Psychotherapy

A. Be aware of the different forms of psychotherapy for depression including supportive, cognitive, behavioral, marital and family, interpretative, and group therapy (Pilowsky and Barrow 1990; Flor et al. 1992).

B. Understand that, of these forms of psychotherapy used in pain management, the evidence base is strongest for cognitive-behavioral treatment (Williams et al. 2002).

C. Be aware that psychotherapeutic intervention (specifically cognitive-behavioral treatment) may offer significant benefits to patients with painful illnesses such as rheumatoid arthritis (Sharpe et al. 2001), osteoarthritis (Keefe et al. 1990), or sickle cell disease (Gil et al. 1996).

IV. Anxiety

A. Be able to discriminate anxiety conditions (e.g., panic disorder or post-traumatic stress disorder) that may augment pain and suffering in patients with chronic pain (Sharp and Harvey 2001).

B. Understand the application of the different forms of psychotherapy for anxiety disorders, for example, supportive, cognitive, behavioral, marital and family, interpretative, and group therapy (Keefe et al. 1992). Note that high anxiety is associated with heightened pain and may disrupt the use of self control strategies in coping with pain (McCracken et al. 1993; Biedermann and Schefft 1994).

C. Be aware that the SSRI antidepressants are now utilized in treating a wide range of anxiety syndromes.

V. Anger

A. Be aware that anger is an emotion that is frequently seen in chronic pain patients (Fernandez and Turk 1995) and that anger intensity relates to perceived pain interference (Kerns et al. 1994).

B. Be aware that anger may be a specific affective component of pain along with fear and sadness (Fernandez and Milburn 1994) and may be an important concomitant of the depression seen in chronic pain (Wade et al. 1990).

C. Be aware that patients with persistent pain may be at risk for violent behaviors (Fishbain et al. 2000b). Those patients demonstrating significant anger should be evaluated for potential violent behaviors. The presence of anger in a chronic pain patient should alert the pain physician to a syndrome that may be treatable by psychopharmacology or cognitive-behavioral therapy.

VI. Opioids

A. Be familiar with the use of opioids for chronic noncancer pain in which there is objective nociceptive pathology that is related to and consistent with the pain syndrome.

B. Understand the difference among the concepts of addiction, tolerance and dependence.

C. Be familiar with the controversy over opioid medication in patients who have a history of substance abuse or do not have a demonstrable nociceptive source of pain (Ciccone et al. 2000; Robinson et al. 2001; Reid et al. 2002).

D. Understand substance-abuse-related issues including withdrawal symptoms. Be familiar with detoxification for the chronic pain patient (Chabal et al. 1992; Fishbain et al. 1992a; Sees and Clark 1992; Jamison et al. 1994) and be aware of the protocols for opioid and sedative detoxification (Fishbain et al. 1992b, 1993).

E. Understand the characteristics, different properties, and use of full agonist opioid agents, partial agonists, and mixed agonist-antagonist opioid drugs.

F. Understand the use of adjunctive agents to enhance opioid therapy and be aware of evidence that aspirin, acetaminophen, and selected nonsteroidal anti-inflammatory drugs augment analgesia at a given dose of opioid, whereas neuroleptics, hydroxyzine, benzodiazepines, and antidepressants do not.

G. Be aware of the importance of patient instruction and education regarding use of opioids, in order to minimize sense of stigmatization, lessen fears of addiction, and set the stage for appropriate use.

H. Understand the potential application of opioid treatment contracts to help guide expectations around the use of opioids, particularly when there are concerns about diversion of opioids.

I. Understand the medical-legal documentation relevant to patient instruction, selection, and follow-up of patients on opioid therapy.

VII. Somatization

A. Be aware that some patients with persistent pain may demonstrate somatic complaints or pain out of proportion to the alleged organic findings, indicating that they may be suffering from a conversion disorder or hypochondriasis (Fishbain 2000a).

B. In treating patients with somatoform disorders, including hypochondriasis, understand the importance of:

1. Developing a therapeutic relationship with the patient
2. Shifting the emphasis of intervention away from symptom alleviation and toward functional restoration
3. Avoiding reliance on invasive diagnostic or surgical interventions. Understand the application of the other techniques recommended for patients with somatization disorder and hypochondriasis, including cognitive, behavioral, marital, and family therapy (Smith et al. 1986; Tunks and Merskey 1990; Merskey 1994).

VIII. The interview

A. Know the value of interviewing a spouse or other relatives and evaluating information about the case obtained from a relative.

B. Be aware that interviewing a spouse or significant other can be useful in corroborating premorbid behavior, mood, personality, and functional status (Kerns et al. 2002).

C. Understand that discussions leading up to an appreciation by all parties of the implications of pain, and of other social or interpersonal problems exacerbated or ameliorated by chronic pain, are often of value in pain management (Kerns et al. 2002).

D. Understand that training both patient and spouse in pain control skills may be beneficial (Keefe et al. 1996).

IX. Beliefs and strategies

A. Understand the importance of coping strategies for the control of pain and the current status of this area of pain treatment research (Lester and Keefe 1997).

B. Understand that coping strategies may differ among individuals and may be affected by age and gender (Elton et al. 1994; Keefe et al. 2000).

C. Understand the important contribution that catastrophizing and fear-avoidance beliefs make to pain and disability (Sullivan et al. 2001; Vlaeyen et al. 2002).

D. Understand the importance of prior experiences with pain and illness in influencing how persons cope with pain. Be aware that persons who have suffered abuse may be at risk for chronic pain (Alexander et al. 1998).

E. Understand that in seeking medical care, chronic pain patients may have treatment goals that differ widely from those of the treating professional (Hazard et al. 1993; Leeman et al. 2000); a patient's satisfaction with care will be determined by whether his or her goals for treatment are met (Hazard et al. 1993).

F. Be familiar with the role of iatrogenic factors (inappropriate or excessive investigation or the use of spurious diagnosis) in contributing to chronic pain.

G. Be familiar with the importance of instructing the patient in risks associated with invasive medical procedures and passive modalities when performed on patients with unrealistic expectations.

H. Understand how to negotiate a balance of treatment goals (e.g., pain relief vs. functional improvement). Recognize the role of economic and social disincentives to rehabilitation, such as financial compensation (Rohling et al. 1995) or spousal relationships (Romano et al. 1992).

I. Be aware of the impact that current or future litigation may have on disability and pain (Main and Spanswick 1995).

X. Sleep

A. Be aware that many chronic pain patients complain of sleep disturbance (Menefee et al. 2000). Be familiar with the variety of sleep disorders experienced by persons having chronic pain.

B. Recognize that sleep laboratory analyses show that patients with persistent pain sleep less than do insomniacs and demonstrate nocturnal myoclonus and alpha intrusions (Atkinson et al. 1988a,b) and that patients with high pain intensities report significantly less sleep (Atkinson et al. 1988a).

C. Be aware that these chronic sleep disturbances are better treated with sedating antidepressants (e.g. amitriptyline, doxepin, trazodone, nefazodone, or mirtazapine) than with benzodiazepines or other sedatives (Menefee et al. 2000).

D. Be familiar with treatments available to treat sleep disorders including behavioral instruction on proper sleep "hygiene" (observing scheduled sleep times and avoiding caffeine-containing compounds) and antidepressants in low dose (e.g. trazodone, doxepin, or mirtazapine) (Morin et al. 1994; NIH Technology Assessment Panel 1996).

XI. Vocation and personality

A. Know the value of evaluation of the patient's past work level and educational attainment and be able to refer patients for appropriate psychological testing for both intellectual capacity and vocational preference.

B. Be able to identify patients for whom vocational guidance, further education, and retraining may lead to rehabilitation (Schade et al. 1999; Feuerstein et al. 2001).

C. Be able to advise on the effects of chronic pain upon personality, to provide insight and support for the patient, to interpret the situation to the family and other relatives and interested persons, and to advise on cognitive-behavioral treatments.

D. Be able to introduce suitable cognitive and behavioral pain management measures or recognize when it is appropriate to refer for the patient for special evaluation and therapy (Turk and Okifuji 2001; Turner and Romano 2001).

E. Know that personality disorders are common in chronic pain patients (Gatchel et al. 1996; Weisberg 2000).

F. Be aware of the role of personality in the patient's premorbid and current presentation.

G. Know that there does not appear to be strong empirical support for the notion of a "pain-prone personality" (Turk and Solovay 1984; Gatchel 1991).

H. Recognize that individuals without a history of personality disorders may appear personality disordered due to the exacerbation of premorbid personality characteristics resulting from pain and subsequent stressors (Weisberg and Keefe 1997).

I. Be aware that patients with chronic pain are at greater risk for suicidal behaviors and suicide completion and that those in greater pain may be at greatest risk (Fishbain 1999).

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