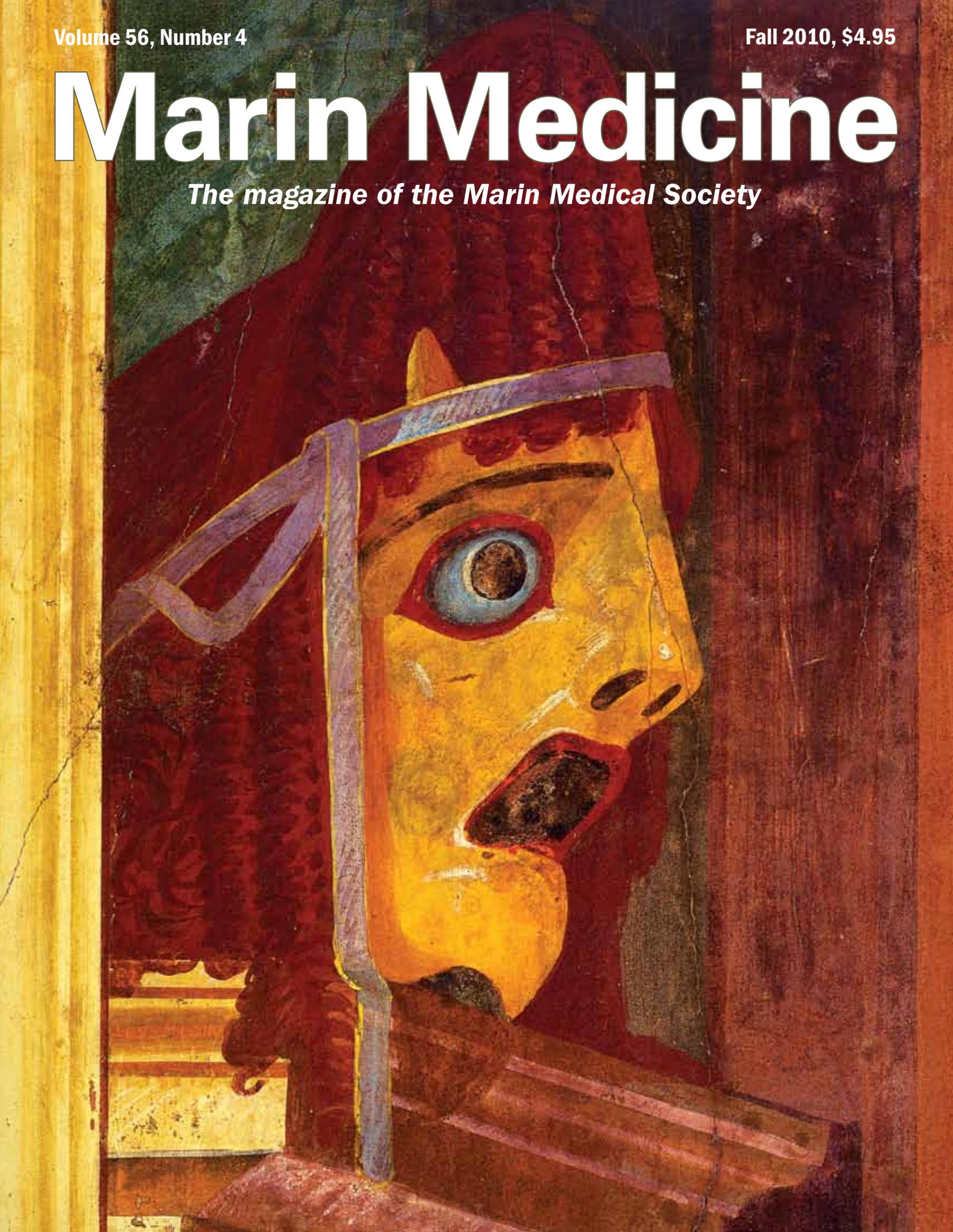


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Addressing the Complexities of Chronic Pain

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As a specialist in pain medicine since the 1970s (Dr. Gagné) and a clinical psychologist treating chemical dependency and personality and mood disorders since 1980 (Dr. Weedn), we are amazed by how far pain treatment has come, even though it remains mired in its central conundrum: the tendency to oversimplify. Simply stated, too many practitioners see only what they're trained to treat.

This problem is easy to caricature, as follows: Ignore the multifactorial underpinnings in many patients with chronic pain. Find a simple biological explanation for the patient's symptoms. If nothing turns up on a brief history or physical examination, do an MRI, which will reveal some sort of abnormality in almost everyone. If a simple treatment doesn't work—preferably a procedure that pays well—keep doing it over and over and prescribe lots of opiates and sedatives.

Chronic pain sometimes has a sim-

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ple biomedical cause. Spinal stenosis, hip or knee osteoarthritis, postherpetic neuralgia, and diabetic neuropathy are good examples. In a small percentage of cases, a purely emotional cause is found. One must also be diligent to rule out subtle metabolic causes of pain, such as osteomalacia, vitamin B12 deficiency, heavy metal poisoning and polymyalgia rheumatica.

More often, physicians and patients alike become frustrated because no cause is apparent. A recent clinical guideline found that “more than 85% of patients who present to primary care have low back pain that cannot reliably be attributed to a specific disease.”¹ What does one do when there is no clear diagnosis or identifiable treatment for chronic pain?

The answer to that question depends on our understanding of chronic pain. Instead of emanating from a single source, chronic pain often involves a complex interplay of injury, physical illness, emotions, behavioral style, pre-existing emotional trauma, lifestyle, deconditioning, and maladaptive coping responses. The following points illustrate some of chronic pain's multidimensional aspects:

- Workers' compensation claims representatives and nurse case managers will tell you that the worker who sustains an injury typically had been a marginal employee who struggled to function on the job long before the injury occurred.
- Best estimates place the incidence of borderline personality disorder (inability to cope with normal life stresses) at 50–60% among pain patients. Maladaptive coping responses create extreme emotional dysregulation, frequently to the point of the patient becoming overwhelmed.
- Estimates put the incidence of child physical or sexual abuse among chronic pain patients at 50–60%.
- Studies show that simple talk therapy is ineffective in most patients with chronic pain. But teaching patients effective coping strategies and self-soothing approaches has solid scientific support for efficacy.
- The most common maladaptive coping strategy is to retreat from the pain. Excessive rest due to fear of the inevitable flare-ups leads to deconditioning, which itself worsens pain.

- Loss of a productive role in the family and the sense that nobody takes them seriously further aggravates the suffering and social isolation of pain patients. Major depression is common and frequently overlooked.
- Although many pain practitioners agree that true addiction is uncommon, prescription opiate addicts brag about how easy it is to trick doctors into prescribing controlled drugs. Opiate misuse short of addiction is common.

Distinguishing a purely somatoform disorder (where behavioral factors are the sole cause of physical symptoms) from situations where emotions merely contribute to the development, expression or resolution of a physical illness can be difficult. Peptic ulcer, for instance, was once thought to be purely caused by stress, but later research revealed that *Helicobacter pylori* causes 80% of ulcers. However, four out of five people infected with *H. pylori* do not develop ulcers. An expert panel convened by the Academy of Behavioral Medicine Research concluded that ulcers are not merely an infectious disease and that mental health factors do play a significant role in ulcer development. One possible explanation is that stress diverts energy away from the immune system, thereby promoting *H. pylori*.

Codependency is common among those who present with physical symptoms combined with behavioral issues. Once thought to be limited to spouses and relatives of alcoholics and addicts, codependency can in fact follow many forms of psychological trauma. Particularly if childhood abuse or neglect continued over a long period of time, sequelae can manifest both physically and psychologically.

Codependents define themselves through others. Relatives, friends, and external events dictate their identity, self-esteem, feeling safe in the world, and ability to be soothed when emotionally distressed. Other characteristics of codependents include denial, low self-esteem, over-compliance, and trying to control everything in their

lives. Childhood traumas remain hidden from others due to the shame surrounding the traumatizing events or because the patient does not recognize the events as abnormal or extreme.

Because codependents have such a well-developed denial system and their focus is always outside themselves, they are often unaware of how their pain or illness relates to their emotional experience. The secondary gain of attention and nurturing in chronic pain or illness may be the only way in which these patients can get the emotional nourishment they want but have no means of requesting in a straightforward manner. In addition, codependents characteristically find it difficult to say no to others; their personal boundaries are poorly developed at best. Illness or chronic pain thus takes over, relieving them of their self-imposed burden by making it impossible to meet the needs of all the other people for whom the codependent feels responsible.

In addition, alexithymia (inability to find words to describe one's emotions) often plays a role in chronic pain. Alexithymia encompasses a cluster of cognitive and affective characteristics, including difficulty identifying and communicating feelings, trouble distinguishing between feelings and somatic sensations of emotional arousal, an impoverished and restrictive imaginative life, and a concrete and reality-oriented thinking style. A lack of introspection is typical in this population. As a result, such patients come to believe that any uncomfortable experience is always caused by an external force that must be identified and eliminated.

How can a physician take into account all these myriad perspectives? Why does Dr. Gagné arrive at a new diagnosis in two-thirds of his patients with chronic pain? A comprehensive evaluation is key to understanding the various systems involved. The evaluation outlined below is lengthy but can be scheduled in 2–3 sessions if needed.

- The history should start with how and when the symptoms began. What was the mechanism of injury,

if any? What sort of diagnostic and therapeutic endeavors ensued, and what were their results?

- What sort of physical therapy has the patient had? Was it largely passive (heat, massage, ultrasound) or active (strengthening, stretching, endurance and balance exercises)? Passive therapy is usually much less effective.
- What medications does the patient take now, and what have they tried in the past? What was the result of taking these medications?
- Regarding current symptoms, how many different kinds of pain can the patient distinguish? More than three different types and locations of pain suggest an emotional overlay.
- For each type of pain, what are its location (using surface anatomy), severity, quality, and aggravating or relieving factors? How does the pain vary by time of day?
- The Present Illness should include reviews of rheumatologic and neurologic symptoms, sleep pattern, and functional capacity.
- Psychiatric screening is critical, including questions about prior psychiatric hospitalization or serious illness, suicidality, self-injury (including cutting), mood, eating disorders, and childhood abuse.
- Addiction screening is more than "Have you ever had a problem with drugs or alcohol?" One should ask about the history of using each major category of drug and whether the patient has ever been treated for addiction or experienced consequences from using.
- Physical examination should include orthopedic and neurological function and muscle tenderness or "trigger points." Lab tests should be sufficient to rule out common metabolic causes of pain and should include a urine toxicology screen.

Many physicians aren't comfortable trying to assess psychological aspects of chronic pain. If a referral is made to a psychiatrist or psychologist, evaluation and testing may provide

essential information regarding the patient's overall psychological functioning and emotional or behavioral factors affecting physical symptoms.

If a patient is referred for psychiatric or psychological intervention, be aware that traditional "talk therapy" may not be helpful beyond the comfort of supportive therapy. More useful are interventions that empower the patient, thus moving the locus of control from a strictly external position (believing I have no power or authority in my life) to a more balanced view of internal vs. external loci of control. These interventions are mostly ways to train patients in needed coping skills. Examples include assertiveness training, boundary development, and cognitive behavioral therapy to counteract catastrophizing and generally negative self-talk. Especially with borderline personality disorders, dialectical behavioral therapy helps enhance emotional regulation and reduce self-injurious behaviors like cutting. In cases of prior abuse or neglect, trauma resolution therapy reduces dissociative episodes and symptoms of hyperarousal. Helpful education regarding the mind-body connection can be undertaken in therapy or by assigning appropriate reading.^{2,3}

One should also consider using antidepressant or other psychiatric medications. Though pure serotonin reuptake inhibitors offer no added pain relief, serotonin-norepinephrine reuptake inhibitors can reduce pain symptoms. Benzodiazepines characteristically worsen emotional dysregulation, whereas atypical neuroleptics may

help patients with personality disorders regain emotional control.

In patients on chronic opiates and sedatives who are not doing well, discontinuing controlled drugs is often helpful—and weeds out those seeking secondary gains from controlled drugs. Opiates and sedatives are problematic in patients with psychiatric disorders, because they can worsen psychiatric symptoms. Buprenorphine can be helpful in reducing opiate misuse, and sometimes it can eliminate opiate hyperalgesia and improve physical and psychiatric distress.

Inpatient chemical dependency programs that treat dual addiction and psychiatric disorders have proved helpful in patients with chronic pain. These programs combine a structured milieu, physical rehabilitation, medication management, and heavy emphasis on skills training. (By contrast, programs offering a strict 12-step approach usually have little to offer those whose primary concern is pain.)

If you're treating patients whose diagnosis is unclear, who have not responded to straightforward measures like switching to appropriate medications, and who have failed active physical therapy, what can you do? Several steps might be helpful:

1. A neurologist or rheumatologist can help rule out occult illness.
2. Consider psychiatric or psychological evaluation by a practitioner skilled in chronic pain.
3. A psychologist can teach effective coping skills as outlined above.

4. One of the more effective treatments is "functional restoration": aggressive physical therapy that ignores pain and addresses loss of function and physical fitness. The therapist works within the patient's limitations and helps them pace activities and minimize flare-ups.

5. If the patient is especially challenging and has sufficient financial resources, consider a comprehensive inpatient program for further evaluation and treatment of the pain syndrome.

A brief clinical vignette illustrates the benefit of a comprehensive approach. Frank (not his real name) was a police officer injured on the job. Despite equivocal evidence of lumbar disc bulging or herniation, he underwent multiple procedures without benefit and wound up on high-dose opiates. Pain migrated all over his back. Evaluation revealed myofascial pain without evidence of underlying pathology. Six weeks of treatment at an inpatient program addressed medication and emotional issues, and his pain completely resolved. ◇

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