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Chronic Pain Patients in a Psychiatric Hospital

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Abstract

203 consecutive patients with presenting complaint of pain, non-organic in nature of more than 6 months duration have been evaluated, and diagnosis given according to D. S. M. III. Dysthymic disorder (43.3%), anxiety states (20.2%), psychogenic pain disorder (9.4%), conversion disorder (8.4%) and major depression (6.9%) were the commonest psychiatric illnesses in these patients. Pharmacotherapy was the commonest mode of therapy, especially use of anti-depressant drugs. Majority (56.7%) showed good response. Common reasons for non-compliance were found to be minimal relief, advice for psychological methods of treatment and continual complaint of pain.

Key words -
Chronic pain,
Psychiatric illness,
Treatment response,
Non-compliance

Chronic pain and psychiatric illness are intimately related, however, the exact relationship is not clear [1]. Also, chronic pain is currently recognised as a significant cause of morbidity and suffering as well as economic loss due to disability, unemployment and overutilisation of health care systems. Various biological, psychological and social factors have been identified as having a potential influence on patients perception of the pain or disability [2]. There is no single model for chronic pain management at present and predicting accurate prognosis is difficult in pain patients because of the complex and often obscure nature of the factors influencing outcome. However, predominance of psychiatric symptoms and identifiable psychiatric illness in non-organic chronic pain patients is well established [3], [4], [5], [6], [7], [8], [9], [10], [11], [12], [13], [14], [15]. The cause and effect relationship between chronic pain and psychiatric illness is unknown. Many chronic pain patients could be having secondary or reactive depression or anxiety feelings [7], [12]. On the contrary, pain and other somatic symptoms have been reported to be features of depressive illness [1], [4], [7], [9], [10], [15]. The management of chronic pain patients would significantly depend on these aspects. Poor compliance of psychiatric treatment is also well recognised. Treatment is either not well pursued or rejected by many patients [8]. In psychiatric clinics pain is found as a main presenting symptom in 45-60% of cases [12]. Pain has been reported from India in patients suffering from such psychiatric illnesses as depression, hypochondriasis and hysteria [1], [6], [7], [16], [17], [18]. However, the present knowledge is inadequate regarding the socio-demographic, diagnostic and therapeutic aspects of chronic pain. Such knowledge could be beneficial towards understanding of chronic pain and planning in effective management of such patients. The present study attempts to examine these aspects in a psychiatric hospital set-up, the management of non-organic chronic pain and their relative outcome. Also, attempts have been made to

identify clinical determinants of treatment non-compliance in these patients.

Material and Methods

Patients aged between 16-55 years presenting with chief voluntary complaint of pain, of more than 6 months duration, occurring daily or on alternate days without any related or unrelated physical illness were consecutively included into the study. Pain was considered intractable when the patients found no significant benefit with traditional therapies. Diagnosis was ascribed according to the diagnostic and statistical manual, DSM III [19] Axis 1. Details of demographic background and nature of treatment received and improvement were recorded on a proforma designed for this purpose, for which representative cases from the common diagnostic categories as major depression, dysthymic disorder, anxiety states, conversion disorder and psychogenic pain disorder were included by consecutive selection. Patients with epilepsy, mental retardation, alcoholism or any physical illness were excluded. Treatment and outcome details of 45 patients so selected were recorded. Nature of treatment given, duration, compliance and clinical outcome were recorded. Outcome was rated on a 5 point scale (recovered, moderate improvement, slight improvement, no improvement and worse). Reasons for drop out or discontinuing management were examined.

Results

203 patients fulfilled the criteria for chronic pain. Their demographic data and psychiatric diagnosis according to DSM III Axis 1 are given in Tables I and II respectively. Fourteen had a diagnosis of major depression, 88 dysthymic disorder, 41 anxiety states, 17 conversion disorder, and 19 had psychogenic pain disorder. Seven cases could not be classified and had no physical or psychological problems other than chronic pain. The nature of treatment of 45 representative cases is presented in Table III. 77.7 % of these cases were prescribed pharmacotherapy alone or in conjunction with other treatment. 22.2% were advised psychotherapy, 11.1 % behavior therapy and 15.6% were advised inpatient treatment. One patient required electroconvulsive therapy and one required occupational or day care treatment.

Table I - Socio-demographic breakdown of the sample of chronic pain patients (N=203)

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Table II - Diagnostic Breakdown

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Table III - Nature of Treatment

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Regarding clinical improvement, there is no information about 15 cases (33.3%) who dropped out after

initial evaluation. Of the 30 patients who continued treatment 40 % recovered completely, 16.7% showed moderate improvement and 43.3 % showed slight or no improvement. No case worsened (Table IV). In all 26 cases (57.8%) dropped out of treatment after 2-3 months and did not pursue further follow-up. The possible reasons for non-compliance and their possible relationship to the nature of treatment were examined. Nine (34.6%) dropped out cases had only partial or minimal relief, 30.7 % had been advised psychotherapy or behaviour therapy, 2 were advised admission. All 3 cases who were not given any treatment dropped out, reasons were unknown in 4 cases, 2 cases dropped out because of fluctuating course of pain problem. The average duration of treatment was 64 days and the range from 10 days to one year.

Table IV - Clinical Improvement

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Discussion

The criteria for selection were applied strictly in order to get a sample of non-organic chronic pain patients. Over-representation of females in pain patient population is well recognised [10], [12], [14]. There was no preponderance in any particular age group except that it was found less frequently in the elderly (8.4%) in contrast to 26.5% of cases in Large's series [10]. Low education and academic achievements were reported by Maruta et al. [19]. More urbanites and married patients having chronic pain has also been reported from India [1], [6]. Regarding diagnosis according to DSM III, relatively high frequency of affective disorders, somatoform disorders and low frequency of schizophrenia and other psychosis seem to be compatible with earlier studies [1], [6], [10], [12], though there are certain differences. Major depression diagnosed in 6.9% cases was reported in relatively small numbers by Merskey [12], 10.5% by Walters [20], 19% by Large [10] and 29 % by Tupin [14] and in none of low back patients by Maruta et al. [19].

Only 3 cases (7 %) in Tupin's study had dysthymic disorder. In most other reports neurotic depression has been found to be the commonest diagnosis [1], [6], [10], [12], [14], [19], [20]. Twenty percent cases had somato form disorders in contrast to 53 % in another report [14] using similar diagnostic system. Schizophrenia was diagnosed in very few cases, as by Walters [20] and others [1], [6], [10]. None of the cases had drug dependence. Certain differences recorded could partly be attributed to different selection criteria, diagnostic method and other methodological issues. Whether the differences in diagnostic distribution are due to cultural factors [6] would require closer examination. The likelihood of cultural differences gain importance since the results are reasonably different from another study using similar DSM III criteria [14]. This opens an interesting avenue for cross-cultural research. Another group of patients who have no organic or psychological etiology could be just idiopathic in origin, as in Varma's [1] report and would require further documentation of relevance. The results regarding treatment and outcome reveal partly the frustrations in managing chronic pain patients. The difficulties in effective management of chronic pain in patients is well recognised [2], [10], [11]. Pharmacotherapy is the commonest mode of treatment [10] as both psychoactive drugs [10] and non-psychoactive drugs [11] are commonly prescribed. The range of nature of treatment given in Table III shows how various modalities are used, depending on the condition. The need for increasing the

range of methods employed in the treatment of chronic pain and also dealing with personal reactions of patients to their disorder was stressed by Margolis and colleagues [11]. The personal reactions often interfere with the treatment regimen which could be an important cause of poor compliance. The rate of complete or moderate recovery in 56.7 % cases is comparable to Large's series [10] where he reported 51 % patients as improved or as recovered.

The disturbing feature is that 26 i.e. 58% of patients did not continue treatment as advised and most of them dropped out after initial evaluation. The reasons, some of them, appear quite understandable from the patient's point of view e.g. minimal relief, advised admission or psychotherapy or when no treatment is offered. The perception of pain patients is quite different and needs to be well understood and corrected whenever possible. The abnormal illness behaviour in pain patients characterises somatic preoccupation, considering pain to be organic in origin and denial of psychological problems [21], [22]. Reasons found by Margolis et al [11] were also similar. Patients often demand faster results, do not accept the diagnosis, ineffectiveness of treatment and continual complaining on patient's part were some common reasons, besides refusal of referral to mental health professional and reluctance to consider non-somatic causes or treatment [11]. Many chronic pain patients do not do well with psychotherapy especially those who are alexithymic [5], [23]. The results give a fair evaluation of rejection of most therapies and advices given to chronic pain patients.

The response rate to anti-depressants was 45 % and is comparable with other studies [10], [15]. Relatively low dosages of anti-depressants given at night are often effective and benefits in reducing pain appear rapidly when normal sleep is restored, fatigue is diminished and the patient is able to engage more energetically in rehabilitation [2]. The exact mechanism of anti-depressants effect in pain is not known. The current interest in chronic pain has yielded a variety of behavioural approaches designed for both in-patient and out-patient settings [24].

The emphasis of treatment plan, currently is rehabilitative rather than investigative. The focus is on coping with, rather than curing, the pain. The shift from a curative to a rehabilitative focus must also be accomplished without challenging the reality of the pain [2]. The common perception of psychiatric referral is misconstrued by the patient that his pain is being considered unreal or deliberate. admission of such cases should not be undertaken unless there are skilled staff and definitive programmes. Short term and long term follow-up studies of various treatment regimens should be conducted, and combinations or multi-disciplinary approaches are likely to be effective.

Brief Overview of Current Therapeutic Strategies

The pharmacology armamentorium basically involves use of antidepressants, preferably those that act selectively on serotonin metabolism should be chosen. Amitriptylline has been found to be reasonably effective. Minor tranquillisors, alone or with beta-blockers would be greatly helpful in those with predominant anxiety and tension. Placebos also has a definite role and should be given along with strong suggestions.

Psychotherapy should be used with caution, and in certain cases only. Supportive measures as reassurance, suggestions, family therapy etc., can be helpful in certain cases. Similarly, conflict identification and resolution can be attempted where there is doubt of underlying serious conflicts, especially about marital or sexual roles. Patients can also be provided with a variety of individually

selected coping strategies to reduce pain perception. These may include cognitive strategies, stress management techniques as relaxation training, biofeedback (EMG, alpha or G.S.R.). Oriental behaviour therapies such as yoganidra and shavasanas could also be beneficial. Other techniques to reduce pain include transcutaneous electrical nerve stimulation, acupuncture and autogenic training. For a majority of patients willing to accept a rehabilitative approach even though the contribution of specific variables to individual outcome remains unclear, multimodal comprehensive pain management programmes do offer effective treatment.

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