Chronic Pain, Comorbidity, and Treatment Complexity
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Chronic pain is typically defined as pain lasting longer than three months, resulting from either a disease process or bodily injury that has not resolved as expected. It is a major and complex public health reality for almost one-third of the US population. More than 116 million Americans have chronic pain conditions, contributing to healthcare costs amounting to more the $560 billion annually (http://bit.ly/lzlPcm).

Chronic pain is best understood with a biopsychosocial model, involving the interplay of physical limitations, psychosocial sequelae, personality predispositions, stress, medical uncertainty, and personal coping resources.

Most people with chronic pain want to do anything possible to get rid of it. They may come to you begging for a particular medication by name or simply asking for the strongest drug to ease their suffering. Treatment however should not be limited to getting rid of pain, but rather to reducing its influence, providing patients with realistic expectations, and teaching acceptance of pain itself.

Psychiatric Comorbidity
Psychiatry and clinical psychology can help patients with chronic pain, especially by addressing various comorbid states, such as depression, anxiety, and post-traumatic stress disorder. Chronic pain and depression, in particular, are intense bedfellows. It is thought that at least half of the chronic pain population meets criteria for dysthymic disorder or major depression (Banks S and Kerns R, Psychol Bull 1996;119:95–110).

The relationship between depression and chronic pain is complicated because the disorders share symptoms such as sleep disturbance, fatigue, poor memory and attention. But self-report of depressive symptoms in the chronic pain patient often exceeds what is found in standardized assessment. When depression coexists with chronic pain, negative emotions can magnify physical pain symptoms, the intensity of pain can magnify depression, and psychological distress and disability are much greater than in either condition alone (VonKorff M and Simon G, Br J Psychiatry 1996; 30:101–108). Furthermore, some pain patients, especially those uncomfortable with seeing themselves as psychiatrically ill, generalize their problems as somatic rather than psychological, intensifying their distress.

Suicidal thinking and intent are common among patients with depression and chronic pain. Research suggests a positive association between suicidal ideation and pain severity, and a family history of suicidal ideation compounds this risk. Interestingly, abdominal pain holds the strongest association with suicidal ideation while, statistically, neuropathic pain actually protects against suicidality (Sharp J, FOCUS 2006;4(4):573–580). This is likely because the idea of “nerve pain” has a more diffuse presentation which leads to a more hopeful consideration of varied medical options. Clinically significant depressive symptoms also combine with physical pain to contribute to suicidal thinking. Thus, psychiatry is well-suited to address...
the chronic pain patient’s struggle and treatment path when hopelessness and suicidal ideation take over.

Pharmacological Treatment of Chronic Pain
Chronic pain includes nociceptive and neuropathic pain. Nociceptive pain results from tissue damage; neuropathic pain is caused by nervous system lesions or dysfunction. Some patients with neuro-pathic pain exhibit heightened pain sensitivity with a lowered pain threshold or with reduced coping. These patients may be more responsive and vigilant to pain, which is known as “hyperalgesia.” Neuropathic pain conditions include but are not limited to fibromyalgia and chronic fatigue syndrome.

Since 1960, when non-opioid medications were first used and found to have analgesic properties, the benefits of tricyclic antidepressants (TCAs), particularly the tertiary-amine subtype, which includes amitriptyline (Elavil), doxepin, and imipramine (Tofranil), have been well established for the treatment of neuropathic pain. These agents affect serotonin and norepinephrine along the descending spinal pain pathway. Secondary amines like nortriptyline (Pamelor) (titrated to 100 mg/day to 150mg/day for at least two weeks) or desipramine (Norpramin) are more tolerable with fewer side effects than the tertiaryamine TCAs. TCAs, of course, have well known anticholinergic effects and should be used cautiously with patients with cardiac disease, seizure disorder, or glaucoma, or when other serotonergic drugs are being used, and are potentially lethal in overdose.

Lately, venlafaxine (Effexor) and other dual-action drugs such as duloxetine (Cymbalta) and milnacipran (Savella) have shown analgesic benefit. Duloxetine and milnacipran have gained Food and Drug Administration approval for fibromyalgia, while duloxetine has also been approved for chronic low back pain, osteoarthritis, and diabetic neuropathy. Duloxetine is better tolerated initially than milnacipran, although the two have similar efficacy when tolerated. Venlafaxine has been used off-label for the treatment of diabetic neuropathy with similar effects as duloxetine; in fact, these two agents appear to address neuro-pathic pain difficulties quite similarly, making them virtually interchangeable, a potential benefit when dealing with restrictive formularies. Both medications have been associated with discontinuation symptoms, so a gradual taper of each is recommended.

Opioids in Chronic Pain Treatment
Eliminating pain should not be the central focus when addressing chronic pain conditions, and most specialists in pain management believe that being “rid of pain” is not always an appropriate goal. Unfortunately, since 1996, when OxyContin was introduced, there has been a shift in pain treatment away from more rehabilitative and behavioral treatment models to reliance on opioid analgesia. So even though comprehensive interdisciplinary pain treatment centers are well documented as clinically effective, the pain treatment world now relies mostly on interventional pain procedures. The use of Chronic Opioid Therapy (COT), for instance, has become extensive, especially within the chronic non-cancer pain population. As opioids have been prescribed relatively freely, the increase in opioid analgesic overdose deaths, addiction, misuse, and diversion has led to a serious public health crisis.

Although short-term opioid analgesia may provide relief, long-term benefits have not been well established. In fact, the effectiveness of opioid analgesia has been estimated at 30% (Stannard C et al. Opioids in Non-Cancer Pain. Oxford University Press; 2008). As a result, in recent years, the pain medicine community has taken a more cautious and structured approach to evaluate clinical appropriateness for opioid therapy, with a focus on improved functioning instead of long-term opioid use. “Improved functioning” in this sense is not about feeling less pain; it is defined instead as improvement in physical movement and activity.

The organization Physicians for Responsible Opioid Prescribing (PROP) (www.supportprop.org) has published a number of helpful guidelines for professionals considering chronic opioid therapy (COT), including “Myths and Facts about COT,” “Do’s and Don’ts for Acute Pain Management,” and “Do’s and Don’ts for Chronic Pain Management” (http://bit.ly/SVcOok). They recommend not initiating COT before considering safer alternatives such as primary disease management, cognitive behavioral therapy (CBT), participation in pleasant and rewarding life activities, physical therapy, non-opioid analgesics, and exercise. Aberrant opioid use can be detected through objective sources like prescription-monitoring databases (available in many states) and drug screening tests.

It is also important to implement a stratification process to identify patients at high risk for complications with opioids. Opioid candidate screening measures include the Opioid Risk Tool (ORT), The Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R), The Current Opioid Misuse Measure (COMM) and the
Addiction Behavior Checklist (ABC). Links for more information regarding these measures can be found at www.opioidrisk.com.

Patients with a personal history of substance abuse or an untreated psychiatric disorder are at high risk for developing addiction and are often poor candidates for opioid analgesia. Saying “No” to these patients is a compassionate response because the treatment may cause further complications. Similarly, initiating COT with a patient with very limited or ineffective impulse control, as evidenced by poor life choices and corresponding negative consequences, typically does not improve impulse management.

Non-Pharmacological Treatment of Chronic Pain
In 2011, the American Psychological Association endorsed cognitive behavioral therapy (CBT) as an effective intervention in chronic pain, particularly a version called Acceptance and Commitment Therapy or ACT. ACT (pronounced as spelled) is one of the acceptance-based psychotherapies. It does not encourage chronic pain patients to invest in control strategies or struggle with the ineffective process of trying to be “rid of pain.” In fact, it challenges patients’ beliefs by introducing the concept of acceptance (see, for instance, http://bit.ly/WmRY2p). One pain theorist, Lance McCracken, notes that the acceptance of chronic pain predicts a patient’s pain level, depression, pain-related anxiety, and disability better than other measures of coping. He writes that “acceptance is an active process and requires that patients maintain functioning … even while continuing to experience sensations of pain. The assertion that patients cannot function while experiencing pain appears to be without merit in many circumstances” (McCracken LM et al, Pain 2004;107:159–166). He argues that patients should give up the struggle to control pain and, instead, pursue normal life activities as a more appropriate and ultimately successful approach to chronic pain.

Culture and medicine have focused on reducing or being rid of unwelcome symptoms. This is especially true when addressing chronic pain, and even more so when comorbid states join in. Pain procedures and chronic opioid therapy promise treatment outcomes that leave patient’s wanting, pleading, and demanding relief. Psychiatrists can play a key role by promoting our patient’s acceptance of pain rather than investing in ways to control, avoid or suppress them, while also managing complaints or depression, anxiety, and suicidal ideation. Acceptance is an essential skill that we should encourage our patients to learn and practice regularly.

Note
This is the final issue of Pain Release. The first issue was published 10 years ago, December 2002. The article that month was “Pain and Evaluation” and was written by Dr. Cal Robinson, the then Clinical Director, EHS Pain Management Center.

We thought it fitting that this final issue also would offer an article by Dr. Robinson.

Photo: Dr. Cal Robinson during a recent visit to the Pain Center at River’s Edge; with Bess Mosley.