

# *Psychological Aspects of Chronic, Nonmalignant Pain: Moving from “Reality Vertigo” to Hope*

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*“My life wasn’t supposed to be like this. I used to have a great job and a wonderful marriage. Since the pain started, everything has gone downhill. I am teed off a lot of the time, I lost my job, my wife and I argue and never have sex anymore. . . . I can’t even play ball with my kid. Doc, this wasn’t the plan—what did I do to deserve this?”*

Pain affects all aspects of the individual: physical, cognitive, emotional, social, occupational, sexual and spiritual. The patient in pain often experiences a significant decrease in perceived control over one’s life and circumstances. In fact, patients may experience a kind of “reality vertigo,” intense perceptual shifts and emotional turmoil, following the realization that one will likely have to live with pain for an indeterminate period of time. During this turbulent period, it appears that the individual’s entire world-view, as well as their plans and hopes for the future, are suddenly thrown into question. Depression, anxiety, and somatizing of emotional distress may be strongly related to this overall belief that one has completely lost control over their lives as the result of their pain.<sup>1</sup> This article will focus on elucidating the psychological aspects of chronic, nonmalignant pain. Additionally, this article will illustrate several brief, targeted, strategies that the physician can utilize to assist pain patients in countering this downward affective spiral of psychological distress, or “reality vertigo,” and to assist in the restoration of hope.

## **Background**

*“You can’t help me, nobody can help me. I wish I could just die.”*

One of the most difficult patients seen in the medical setting is the chronic pain patient.<sup>2,3</sup> A patient with pain, who also has a myriad of psychological symptoms, is even more vexing for most physicians. Unfortunately, it appears that the majority of patients with chronic pain fit into this category. Psychopathology affects between 30% and 50% of patients seen in academic and community pain centers<sup>4,5,6,7</sup>, with depression, anxiety, personality disorders and substance abuse being the primary diagnoses. Furthermore, it appears that psychological distress is a consequence, rather than an antecedent, of pain in most cases.<sup>8</sup> A comorbid psychiatric diagnosis appears to be associated with significant functional limitations<sup>9</sup>, a negative

change in pain threshold and tolerance<sup>10</sup>, and greater sensitivity to acute pain stimuli.<sup>11</sup> Chronic pain patients frequently have feelings of loneliness, worthlessness, and fear of abandonment<sup>2</sup>, and may, additionally, experience a strong sense of shame<sup>12</sup> and guilt, especially if the patient is in a parenting role.<sup>12,13</sup>

## **Recognizing Depression and Anxiety in Chronic Pain Patients**

*“I’m tired all the time, yet I can’t sleep. Why even bother? I am going to be in pain the rest of my life and nothing can be done about it.”*

Pain patients who present with fatigue and sleep disturbance<sup>14</sup>, low mood, increased worry and irritability should be screened further for mood and/or anxiety disorders.<sup>2</sup> Depression and anxiety may also manifest as “lashing out” by the patient towards the physician, poor motivation to remain active in one’s treatment plan, or in perceived intensification of pain in the absence of changes in pain pathology.<sup>2</sup> The Beck Depression Inventory<sup>15</sup> and the Beck Anxiety Inventory<sup>16</sup> are two brief (i.e. 21 items each) questionnaires which may be useful to the physician for assessing depression and anxiety, respectively, in this patient population. Certain “red flags” evident in the patient’s spoken words are also cues for the physician to perform a more thorough assessment of depression and anxiety. These red flags include negative statements focused on the future, “What if I never get better?” or the past, “I never should have driven to work that day; now I can’t do anything anymore.” Cognitive-behavioral theory posits, “We feel what we think.” Patients who are exhibiting this kind of negative thinking may meet criteria for a mood and/or anxiety disorder. Other symptoms of underlying psychopathology most commonly seen in pain patients, such as personality disorders and substance abuse, should also be assessed.

Patients who have a long-standing history of impaired interpersonal relationships and who exhibit patterns of inconsistent, exaggerated behaviors (i.e. alternating between anger towards, and idealization of, their doctor or overly dramatic, grandiose, irritable or dependent behaviors) may have a diagnosis of a personality disorder and should be referred to a psychiatrist for further evaluation. It is important to note that the presence of comorbid personality disorders with depression has been linked to an increased risk of suicide<sup>17</sup>, and suicidal ideation and attempts are common among chronic pain patients overall.<sup>7</sup> It is extremely important to ask patients in

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pain about suicide: not addressing suicidal ideation in this population is “clinically unfeasible and ethically inappropriate.”<sup>2</sup> (pg 190) Physicians are strongly encouraged to carefully document all obtained information, both objective and subjective, in the patient’s medical record. Substance abuse may be suspect if the patient exhibits a strong focus on opioid issues in combination with problematic behaviors, such as early refills, lost prescriptions, and illicit substance use.<sup>2</sup> The CAGE questionnaire (alcohol) or the SOAPP inventory (narcotics) are useful for identifying pain patients with substance use disorders.<sup>18,19</sup> A narcotic contract is also highly recommended for patients who are on opioid medications. Research indicates that untreated or undertreated psychopathology is the single most important factor in poor pain-treatment outcomes, regardless of the treatment modality.<sup>2,20</sup> Hence, a psychiatric evaluation, and referral to a psychologist or other mental health professional for ongoing counseling, is strongly recommended for pain patients with comorbid psychiatric illness. In sum, screening and adequately treating pain patients for underlying psychopathology can improve outcomes and thus aid in assisting both the patient and the physician in feeling more in control.


## Nonpharmacologic Treatment Strategies for the Physician

*“I finally feel like there is hope. I finally feel like I have some degree of control over my pain and my life. For the first time since all of this happened, I am finally starting to believe that things will get better.”*

When patients begin to feel that they are controlling their pain, versus their pain controlling them, their mental and emotional health is improved. The dizzying downward spiral of “reality vertigo,” as discussed earlier, appears to level off and the patient begins to see “light at the end of the tunnel.” The physician can act as a catalyst for this change by acting in an empathic manner towards the pain patient, helping the patient to feel heard and understood, involving the patient in her/his treatment plan, and seeing the patient for regularly scheduled visits.<sup>2,3,21,22</sup> Past research indicates that pain patients rate “listening” and “being believed” as the most important qualities in their physician, regardless of whether or not the doctor can actually help them with their pain.<sup>23</sup> However, for the physician, this may be easier said than done. As stated earlier, pain patients can be very difficult. Hence, the challenge for the physician is to develop an empathic, caring style with a patient who may “hateful” in some respects.<sup>3</sup> Some communication strategies for increasing empathy include asking questions such as, “Is there anything else?” and “Let me see if I understood you correctly?”<sup>24</sup> In addition, validating the patient’s experience with statements such as, “It is very difficult to live with pain, and I know it affects all areas of your life” may be very useful in helping the patient feel understood. There is a relationship between thoughts, feelings and pain perceptions.

Cognitive behavioral strategies, such as reframing negative self-talk and diaphragmatic breathing, have been proven

to be beneficial in helping the pain patient regain a sense of perceived control.<sup>25,26</sup> The physician may assist the pain patient by encouraging him/her to become more aware of how thoughts create feelings and by teaching the patient that distressful emotions, such as depression and anxiety, exacerbate perceptions of pain. The physician may ask the patient, “What can you tell yourself to make you feel less (sad, scared, angry)?” and then give the patient “homework” to practice reframing, or replacing, negative thoughts with more balanced, hopeful cognitions. In addition, to assist in increasing feelings of well-being, the patient can be taught to breathe deeply from their lower diaphragm, rather than from their upper thorax. The patient is directed to place one hand on the chest and another on the stomach. The physician then encourages the patient to focus on “moving” their lower hand by breathing in deeply.

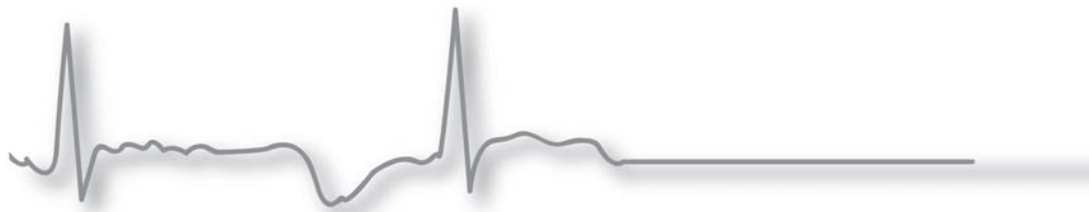
Finally, it is of utmost importance that the physicians practice their own “self-care” to avoid becoming “burned out” from caring for such a difficult patient population. Engaging in pleasurable activities outside of medicine, getting adequate time alone as well as time spent with loved ones, and discussing feelings of frustration about patients with trusted colleagues are a few of the strategies suggested. By putting oneself first, the physician is better able to care for his/her patients, and to help them move from reality vertigo into hope. 

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