

07 - 13.7 Pain Disorder

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13.7 Pain Disorder In the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), pain disorder warranted its own diagnostic category; but in the current fifth edition (DSM-5), it is diagnosed as a variant of somatic symptom disorder. Its importance is such, however, that it warrants a separate discussion in this textbook. A pain disorder is characterized by the presence of, and focus on, pain in one or more body sites and is sufficiently severe to come to clinical attention. Psychological factors are necessary in the genesis, severity, or maintenance of the pain, which causes significant distress, impairment, or both. The physician does not have to judge the pain to be “inappropriate” or “in excess of what would be expected.” Rather, the phenomenological and diagnostic focus is on the importance of psychological factors and the degree of impairment caused by the pain. The disorder has been called somatoform pain disorder, psychogenic pain disorder, idiopathic pain disorder, and atypical pain disorder. Pain disorder is diagnosed as “Unspecified Somatic Symptom Disorder” in DSM-5 or it may be designated as a “specifier” under that heading.

EPIDEMIOLOGY The prevalence of pain disorder appears to be common. Recent work indicates that the 6-month and lifetime prevalence is approximately 5 and 12 percent, respectively. It has been estimated that 10 to 15 percent of adults in the United States have some form of work disability because of back pain alone in any year. Approximately 3 percent of people in a general practice have persistent pain, with at least 1 day per month of activity restriction because of the pain. Pain disorder can begin at any age. The gender ratio is unknown. Pain disorder is associated with other psychiatric disorders, especially affective and anxiety disorders. Chronic pain appears to be most frequently associated with depressive disorders, and acute pain appears to be more commonly associated with anxiety disorders. The associated psychiatric disorders may precede the pain disorder, may co-occur with it, or may result from it. Depressive disorders, alcohol dependence, and chronic pain may be more common in relatives of individuals with chronic pain disorder. Individuals whose pain is associated with severe depression and those whose pain is related to a terminal illness, such as cancer, are at increased risk for suicide. Differences may exist in how various ethnic and cultural groups respond to pain, but the usefulness of cultural factors for the clinician remains obscure to the treatment of individuals with pain disorder because of a lack of good data and because of high individual variability.

ETIOLOGY **Psychodynamic Factors** Patients who experience bodily aches and pains without identifiable and adequate physical causes may be symbolically expressing an intrapsychic conflict through the

body. Patients suffering from alexithymia, who are unable to articulate their internal feeling states in words, express their feelings with their bodies. Other patients may unconsciously regard emotional pain as weak and somehow lacking legitimacy. By displacing the problem to the body, they may feel they have a legitimate claim to the fulfillment of their dependency needs. The

symbolic meaning of body disturbances may also relate to atonement for perceived sin, to expiation of guilt, or to suppressed aggression. Many patients have intractable and unresponsive pain because they are convinced they deserve to suffer. Pain can function as a method of obtaining love, a punishment for wrongdoing, and a way of expiating guilt and atoning for an innate sense of badness. Among the defense mechanisms used by patients with pain disorder are displacement, substitution, and repression. Identification plays a part when a patient takes on the role of an ambivalent love object who also has pain, such as a parent. Behavioral Factors Pain behaviors are reinforced when rewarded and are inhibited when ignored or punished. For example, moderate pain symptoms may become intense when followed by the solicitous and attentive behavior of others, by monetary gain, or by the successful avoidance of distasteful activities. Interpersonal Factors Intractable pain has been conceptualized as a means for manipulation and gaining advantage in interpersonal relationships, for example, to ensure the devotion of a family member or to stabilize a fragile marriage. Such secondary gain is most important to patients with pain disorder. Biological Factors The cerebral cortex can inhibit the firing of afferent pain fibers. Serotonin is probably the main neurotransmitter in the descending inhibitory pathways, and endorphins also play a role in the central nervous system modulation of pain. Endorphin deficiency seems to correlate with augmentation of incoming sensory stimuli. Some patients may have pain disorder, rather than another mental disorder, because of sensory and limbic structural or chemical abnormalities that predispose them to experience pain. **DIAGNOSIS AND CLINICAL FEATURES** Patients with pain disorder are not a uniform group, but a heterogeneous collection of persons with low back pain, headache, atypical facial pain, chronic pelvic pain, and other kinds of pain. A patient's pain may be posttraumatic, neuropathic, neurological, iatrogenic, or musculoskeletal; to meet a diagnosis of pain disorder, however, the disorder must have a psychological factor judged to be significantly involved in the pain symptoms and their ramifications.

Patients with pain disorder often have long histories of medical and surgical care. They visit many physicians, request many medications, and may be especially insistent in their desire for surgery. Indeed, they can be completely preoccupied with their pain and cite it as the source of all their misery. Such patients often deny any other sources of emotional dysphoria and insist that their lives are blissful except for their pain. Their clinical picture can be complicated by substance-related disorders, because these patients attempt to reduce the pain through the use of alcohol and other substances. At least one study has correlated the number of pain symptoms to the likelihood and severity of symptoms of somatic symptom disorder, depressive disorder, and anxiety disorder. Major depressive disorder is present in about 25 to 50 percent of patients with pain disorder, and dysthymic disorder or depressive disorder symptoms are reported in 60 to 100 percent of the patients. Some investigators believe that chronic pain is almost always a variant of a depressive disorder, a masked or somatized form of depression. The most prominent depressive symptoms in patients with pain disorder are anergia, anhedonia, decreased libido, insomnia, and irritability; diurnal variation, weight loss, and psychomotor retardation appear to be less common. A 54-year-old accountant sought out his family physician with complaints of severe back pain that came on suddenly while trying to lift a piece of heavy furniture at home. On examination he showed no focal neurological signs but was unable to straighten up into an upright position. The patient was referred for magnetic resonance imaging (MRI), which revealed no structural abnormalities. He was advised to have several sessions with a physical therapist to treat what was diagnosed as "back strain," but as the therapy progressed, his pain became more severe, and he complained of muscle tension in his neck in addition to his back and spent most of his days sitting

in a chair or lying on a bedboard on his bed. He was eventually referred to a psychiatrist and talked about the stress he was experiencing at work since an assistant that he relied on was fired because of his firm's need to downsize. His work load had increased tremendously as a result. The formulation by the psychiatrist was that the patient was "somatizing" his anger, transforming the strong affect into pain that enabled him to escape from the stressful situation. A course of psychoeducation was begun in which these dynamics were explored. Equally important was his asserting himself at work, explaining that the load he was expected to carry was too much and that help was required. When this was accomplished, the patient's back pain disappeared within a matter of days.

DIFFERENTIAL DIAGNOSIS Purely physical pain can be difficult to distinguish from purely psychogenic pain, especially because the two are not mutually exclusive. Physical pain fluctuates in intensity and is highly sensitive to emotional, cognitive, attentional, and situational

influences. Pain that does not vary and is insensitive to any of these factors is likely to be psychogenic. When pain does not wax and wane and is not even temporarily relieved by distraction or analgesics, clinicians can suspect an important psychogenic component. Pain disorder must be distinguished from other somatic symptom disorders, although there may be overlap. Patients with hypochondriacal preoccupations may complain of pain, and aspects of the clinical presentation of hypochondriasis, such as bodily preoccupation and disease conviction, can also be present in patients with pain disorder. Patients with hypochondriasis tend to have many more symptoms than patients with pain disorder, and their symptoms tend to fluctuate more than those of patients with pain disorder. Conversion disorder is generally short-lived, whereas pain disorder is chronic. In addition, pain is, by definition, not a symptom in conversion disorder. Malingering patients consciously provide false reports, and their complaints are usually connected to clearly recognizable goals. The differential diagnosis can be difficult because patients with pain disorder often receive disability compensation or a litigation award. Muscle contraction (tension) headaches, for example, have a pathophysiological mechanism to account for the pain and so are not diagnosed as pain disorder. Patients with pain disorder are not pretending to be in pain, however. As in all of these disorders, symptoms are not imaginary.

COURSE AND PROGNOSIS The pain in pain disorder generally begins abruptly and increases in severity for a few weeks or months. The prognosis varies, although pain disorder can often be chronic, distressful, and completely disabling. Acute pain disorders have a more favorable prognosis than chronic pain disorders. A wide range of variability is seen in the onset and course of chronic pain disorder. In many cases, the pain has been present for many years by the time the individual comes to psychiatric care, owing to the reluctance of the patient and the physician's tendency to see pain as a psychiatric disorder. People with pain disorder who resume participation in regularly scheduled activities, despite the pain, have a more favorable prognosis than people who allow the pain to become the determining factor in their lifestyle.

TREATMENT Because it may not be possible to reduce the pain, the treatment approach must address rehabilitation. Clinicians should discuss the issue of psychological factors early in treatment and should frankly tell patients that such factors are important in the cause and consequences of both physical and psychogenic pain. Therapists should also explain how various brain circuits that are involved with emotions (e.g., the limbic system) can influence the sensory pain pathways. For example, persons who hit their head while happy at a party can seem to experience less pain than when they hit their head while angry and at work. Nevertheless, therapists must fully understand that the patient's

experiences of pain are real. **Pharmacotherapy** Analgesic medications do not generally benefit most patients with pain disorder. In addition, substance abuse and dependence are often major

problems for such patients who receive long-term analgesic treatment. Sedatives and antianxiety agents are not especially beneficial and are also subject to abuse, misuse, and adverse effects. Antidepressants, such as tricyclics and selective serotonin reuptake inhibitors (SSRIs), are the most effective pharmacological agents. Whether antidepressants reduce pain through their antidepressant action or exert an independent, direct analgesic effect (possibly by stimulating efferent inhibitory pain pathways) remains controversial. The success of SSRIs supports the hypothesis that serotonin is important in the pathophysiology of the disorder. Amphetamines, which have analgesic effects, may benefit some patients, especially when used as an adjunct to SSRIs, but dosages must be monitored carefully. Psychotherapy Some outcome data indicate that psychodynamic psychotherapy can benefit patients with pain disorder. The first step in psychotherapy is to develop a solid therapeutic alliance by empathizing with the patient's suffering. Clinicians should not confront somatizing patients with comments such as "This is all in your head." For the patient, the pain is real, and clinicians must acknowledge the reality of the pain, even as they understand that it is largely intrapsychic in origin. A useful entry point into the emotional aspects of the pain is to examine its interpersonal ramifications in the patient's life. In marital therapy, for example, the psychotherapist may soon get to the source of the patient's psychological pain and the function of the physical complaints in significant relationships. Cognitive therapy has been used to alter negative thoughts and to foster a positive attitude. Other Therapies Biofeedback can be helpful in the treatment of pain disorder, particularly with migraine pain, myofascial pain, and muscle tension states, such as tension headaches. Hypnosis, transcutaneous nerve stimulation, and dorsal column stimulation have also been used. Nerve blocks and surgical ablative procedures are effective for some patients with pain disorder; but these procedures must be repeated, because the pain returns after 6 to 18 months. Pain Control Programs Sometimes it may be necessary to remove patients from their usual settings and place them in a comprehensive inpatient or outpatient pain control program or clinic. Multidisciplinary pain units use many modalities, such as cognitive, behavior, and group

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