Psychiatric assessment of chronic pain

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Most of the times, when a patient has chronic pain, he/she may see a family doctor or a specialist who is responsible for the site of the pain. The doctor normally performs a full pain assessment in order to locate the culprit of the pain. This is usually done by history taking, physical examination and investigations. Sometimes, it is not easy to locate the exact pathology of the pain. The difficulty might be due to the vague nature of the complaint and the possibility of pain radiation. Moreover, psychological cause of pain should not be overlooked in the difficult cases. That is why referral of a patient with pain to a psychiatrist happens at times. The referring clinician may be concerned about the patient's psychological issues that might be contributing or perpetuating the pain. In some cases, the pain remains unexplained by any clear etiology and psychological origin is therefore suspected.

When a psychiatrist sees a referred patient, he/she needs to obtain a detailed pain history. This helps the psychiatrist to understand the pain features which are amenable to treatment. In cases of chronic pain, a psychiatrist usually pays extra attention to the impact of pain on a person's psychological wellbeing, adaptive functioning and social life. Apart from the somatic component, a psychiatrist will focus on the psychological component of the pain. Psychiatric disorders in which pain might be a feature or focus should be carefully inquired. Examples of these including depressive disorder, anxiety disorders, sleep disorders, substance abuse and sexual dysfunction should be considered. Assessment for the possibility of somatoform disorders is necessary and the differentials include dissociative disorder, hypochondriacal disorder, somatization disorder and pain disorder.[1] Malingering and factitious disorder are two other rare conditions.

A psychiatrist starts by examining the mood state and inquired about any change from the baseline mood. The relationship between the affective state and the pain levels might be discerned. In some cases, mood changes may exacerbate pain. In other situations, pain predisposes to mood changes.

[1] Annagur BB, Uguz F, Apiliogullari S, Kara I, Gunduz S: Psychiatric disorders and association with quality of sleep and quality of life in patients with chronic pain: a SCID-based study. Pain Medicine 15: 772-781, 2014.

The relationship between the two can have implications for interventions. Other emotional states which have correlation with pain severity, such as anxiety and anger should be assessed.[23]

Next, the patient's cognitive appraisal about pain should be examined. This includes patient's meaning of the pain, interpretation of the impact of pain on different aspects of life and the expectation about future experience of pain. Some patients manifest maladaptive cognitive thoughts under emotional disturbance. Examples of the distorted cognitive thoughts include catastrophizing (expecting the worst), magnification (exaggeration of negative event), overgeneralization (extending to all aspects of life), helplessness (belief that nothing can help), selective abstraction (focusing on negative aspect of life), personalization (ascribing pain event to oneself) etc. These distorted thoughts can affect mood state. The pervasiveness and rigidity of these distorted thoughts can decrease self-efficacy, support systems and effective coping strategies, and have implications on the need of psychotherapeutic interventions.

The risk of suicide is increased in people having chronic pain.[456] Therefore, assessment of suicidal risk is imperative. It is important to inquire the patient about any despair, hopelessness, suicidal idea, suicidal attempt, suicidal plan and suicidal note. Once the patient develops suicidal thoughts, patient's safety is of paramount importance.

In the presence of chronic pain, people have different coping strategies. Active coping strategy involves enlisting support of others, following doctor's interventions or self-medicating with analgesics or other substances. Passive coping includes sleeping or hoping for improvement. Some adopts the way of withdrawing from their usual life. It is necessary to know the availability of resources and support systems. The coping strategies should be considered in the plan for interventions.

Chronic pain affects different aspects of life to different extent. These include the patient's activities of daily living, study or work, interpersonal relationship, recreational life, adaptive functioning and quality of life. Patient's disease conviction and assumption of sick role should be thoroughly assessed. These help in determining the most suitable treatment approaches for the patient.

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[2] Fernandez E, Milburn TW: Sensory and affective predictors of overall pain and emotions associated with affective pain. Clin J Pain 10: 3-9, 1994

[3] Wade JB, Price DD, Hamer RM, et al: An emotional component analysis of chronic pain. Pain 40: 303-310, 1990

[4] Chochinov HM, Wilson KG, Enns M, et al: Desire for death in the terminally ill. Am J Psychiatry 152: 1185-1191, 1995.

[5] Fishbain DA: The association of chronic pain and suicide. Semin Clin Neuropsychiatry 4: 221-227, 1999.

[6] Fishbain DA, Goldberg M, Rosomoff RS, et al: Completed suicide in chronic pain. Clin J Pain 7: 29-36, 1991.

In many occasions, patients are reluctant to be interviewed by psychiatrists when they present with pain symptoms. They might become defensive when they are inquired about their psychological state. They might feel that the organic cause of the pain is overlooked and their pain complaint has been dismissed. Therefore, psychiatrists should be sensitive and better adopt a comprehensive approach in the assessment.

In conclusion, psychiatric assessment of chronic pain should be comprehensive and individualized. Emotional, cognitive and social factors in relation to pain should be evaluated. Psychiatrists can make use of pain assessment scales (such as Visual analog scale or pain diary) or psychometric scales (such as Minnesota Multiphasic Personality Inventory)[7] in the assessment. All these information contributes to the formation of a suitable treatment plan.

[7] Butcher JN, et al: Minnesota Multiphasic Personality Inventory-2: Manual for Administration. Minneapolis, University of Minnesota Press, 2009.