GUIDELINES FOR ASSESSMENT OF PAIN DISORDER

Drs Michael Epstein, Diane Neill and Sandra Hacker

The concept of pain and its relationship to psychiatric diagnosis is not always clear cut

- pathological findings sometimes cannot explain the pain.
- Each specialty has developed its own nomenclature
    - myofascial pain syndrome
    - fibromyalgia
    - myalgic encephalopathy
    - complex regional pain syndrome
- Some specialist groups regard unexplained pain as indicating a psychiatric disorder.

QUESTIONS

- When should a diagnosis of a pain disorder be made?
- When should the diagnosis of a pain disorder not be made?
- Does this diagnosis mean any more than that there is widespread unexplained pain?
- Does it indicate that there is a psychiatric condition?
- How is the diagnosis made, and how can any impairment from a pain disorder be quantified?

DEFINITIONS

The **DSM IV** defines the essential feature of a pain disorder as the pain being the predominant focus of the clinical presentation which is of sufficient severity to warrant clinical attention; and

- The pain causes significant distress or impairment in a social, occupational or in other important areas of functioning.

- Psychological factors are judged to play a significant role in the onset, severity, exacerbation or maintenance of the pain.

- The pain is not intentionally produced or feigned.

There are three sub groups related to pain disorders.

- pain disorder associated with psychological factors alone.

- pain disorder associated with both psychological factors and a generalised
- medical condition.

- pain disorder associated with a general medical condition, where
- psychological factors are not considered to be significant.

These conditions are defined as acute if they last for less than six months and chronic if they last for greater than six months.

When should a Pain Disorder not be diagnosed

If the pain:

- is better accounted for by mood, anxiety or a psychotic disorder
- occurs exclusively during the course of somatization disorder
- is part of a conversion disorder
- is intentionally produced or feigned in factitious disorder or malingering
- definitely or feasibly explained by a medical condition
- appears superficial without corollary distress, impairment or treatment
- meets the criteria for dyspareunia (an alternative diagnosis)

Is Pain Disorder more than widespread unexplained pain?

In addition to widespread unexplained pain this diagnosis requires observable distress, psychological dysfunction and functional impairment.

Does the Diagnosis of Pain Disorder mean that there is a psychiatric condition?

- The diagnosis of Pain Disorder does mean that there is a psychiatric condition using DSMIV-TR terminology.
- Chronic pain and chronic pain disorder may additionally both be associated with comorbid psychiatric diagnoses-such as major depressive disorder, personality disorder, substance-abuse disorder, somatisation disorder and a generalised anxiety disorder.
- Chronic pain as a symptom may alternatively be better subsumed into a different diagnosis e.g. major depressive disorder, delusional disorder or conversion disorder.

ISSUES IN PAIN

- Psychological based pain is a complex/multi-factorial
    - process, about which there is only limited understanding.
- Psychological pain is "real" and involves suffering.
- Pain is not imaginary or hallucinated
- Psychological pain is a major signal of distress.
- Pain is the most common reason for visits to a healthcare provider
- Pain is the major cause of disability for injured people.

CHRONIC PAIN AND DEPRESSION

Chronic pain and depression are usually linked.

- Chronic pain leads to depression
- Depression exacerbates chronic pain

Chronic pain is frequently associated with:

- an inability to function effectively in relationships and work
- lack of pleasure in recreational activities.
- feeling miserable.

Depression arising from chronic pain is associated with:

- reduced family support
- referrals to psychiatrist or psychologist implying it is "all in my head"
- an increased focus on pain leading to a negative feedback loop, more pain equals more depression equals more pain

RESEARCH FINDINGS - PSYCHOLOGICAL ASPECTS OF CHRONIC PAIN RESEARCH ON CHRONIC PAIN

Early adverse life events can contribute to the development of psychologically based pain.

A link has been found between childhood abuse, childhood illness and/or emotional deprivation and the development or persistence of chronic pain.

Some people are pain prone and lack resilience in dealing with pain and have:

- continuous or frequent (unexplained) pain
- spreading pain in a non-anatomical distribution.
- frequent use of analgesic medication and sometimes analgesic medication abuse.
- frequent requests for surgery with lack of resolution of pain.

- denial of emotional and interpersonal difficulties, denial of conflict, dependent traits, and/or an inability to cope with hostility.
- chronic lowered mood.
- a family history of chronic pain, chronic invalidism or other abnormal illness behaviour, depression or substance abuse.

Assessment of these elements requires a developmental history especially regarding the person's history of pain – onset, triggers, etc

Concerns about these and other issues have led to the development of the following guidelines.

THE USE OF THE GEPIC IN ASSESSING PAIN DISORDERS.

Psychologically based pain disorders follow patterns in mental status assessments and hence impairment assessments. There are significant exceptions to what follows.

Intelligence

Usually normal.

Thinking

There may be a slight deficit in thinking unless (rarely) there is some form of psychotic process and hence the presence of psychotically related pain which may have a specific delusional cause. If this is not the case and the person has a pain disorder which is psychologically based the person's thoughts about the pain, their preoccupation with the

pain, or impaired attention and concentration because of the pain and/or its treatment may lead to an impairment of thinking in class 2.

Perception

Perception relates specifically to the five senses of sight, hearing, smell, taste and touch. A pain disorder may involve an impairment of touch, and hence an impairment of perception, usually in class 2 at the most. The corollaries of pain, depression and anxiety, may contribute to some changes in perception but at most in class 2.

Judgement

A worker with psychologically based pain may not understand that the pain is psychologically based and may tend to believe that it is organically based. Under these circumstances it could be argued that the person has lack of insight or a slight deficit in judgement leading to a score in class two.

A common impairment of judgment in people with chronic pain arises when their dysfunctional pain /illness beliefs override other decision making processes and repeatedly adversely effect their social /relationship /work /financial arenas.

Mood

Dysphoric moods are often associated with chronic pain and its treatment. Where there are significant symptoms of depression, anxiety, anger, this should be scored in the appropriate class with regard to the severity of the symptom.

Behaviour

People with a chronic pain disorder may have significant alterations in their behaviour (avoidant, dependent, hostile) because of their chronic pain and this can be scored accordingly.

Secondary/non-secondary

Usually pain disorders are secondary to physical injury
If the physical injury has resolved and pain is still present any impairment is still secondary to physical injury.
Pain conditions such as fibromyalgia can develop without prior physical injury or psychological stress.

SUMMARY

Pain can be either physically or psychologically based or both.
Pain may be an expression of emotional distress.

A person with pain may have an unconscious exaggerated response to physical pain.

Medical practitioners commonly see people complaining of significant pain where organic factors cannot fully explain the pain presentation.

The psychiatrist is required to assess the presence or absence of a genuine pain disorder. Measurement of the psychiatric impairment related to a pain disorder is often done by using proxies of pain such as impairment of thinking, judgement, mood and behaviour.

COMBINED PYCHIATRIC AND PHYSICAL ASSESSMENTS

It would be helpful if non-psychiatrists adopted some conventions in relation to **individuals with pain who have suffered a physical injury but where the objective signs are not in accordance with the with the level of the pain**.

a. If a physical specialist finds **no physical signs or injury** after an initial physical injury then stating that:

   "the physical injury has entirely resolved" or

   "it is not possible to explain the extent of the complaint of physical symptoms (and reported limitation of physical activities) in the absence of objective clinical evidence"

   would allow the psychiatrist to indicate if appropriate the presence of "a pain disorder related to psychological factors and a generalised medical condition (namely a resolved xxx)".

b. If there is **a persistence of physical signs** after an initial physical injury and in the opinion of the physical specialist there is only partial resolution of the physical injury, but the symptoms and signs are greater than the physical evidence would suggest then an statement such as:

   "the physical injury has partially resolved but the extent of the pain cannot be explained in its entirely by the physical medical condition", or

   "it is not possible to entirely explain the extent of the complaint of physical symptoms and reported limitation of physical activities based upon the objective clinical evidence",

   would enable the psychiatrist to indicate if appropriate the presence of a "pain disorder associated with both psychological factors and a generalised medical condition (namely a partially resolved xxx)".

With thanks to Dr Nigel Strauss for excerpts from 'Occupational Psychiatry'