THE PSYCHIATRIST'S TOOLBOX

Psychiatry and Chronic Pain Patterns

As a psychiatrist known for using behavioral techniques as well as a variety of relaxation therapies, I was not surprised when, a number of years ago, orthopedic surgeons and neurosurgeons started referring their chronic pain patients to me. These surgeons had been consulted for chronic pain problems and were unable, in many cases, to offer either a surgical or medical approach to treatment.

BY ROBERT T. LONDON, M.D.

My observations led me to write a paper for an orthopedic journal addressing some of the chronic pain problems experienced by our patients (Foot Ankle 1986;7:133-7).

Many of the patients referred to me had chronic pain patterns that were musculoskeletal—the pain apparently stemmed from soft tissue and muscle fibers. Today, we refer to these pain patterns as fibromyalgia.

Current research relates fibromyalgia more to stress dysregulation within the central nervous system, involving the hypothalamic-pituitary-adrenal axis as it affects autonomic regulation. The American College of Rheumatology (ACR) is actively involved in understanding and treating this disorder. Plus, it developed diagnostic criteria for fibromyalgia in 1990 (Arthritis Rheum. 1990;33:160-72).

In my 1986 paper, I divided patients suffering from chronic pain patterns into three categories:

► Those patients whose complaints were psychological, and their musculoskeletal system was responding to some emotional stress.

► Those whose complaints were psychological/physiological and had an injury or illness providing a focus for an emotional stressor to localize a pain pattern as an Achilles heel phenomenon.

► Those whose complaints were physiological, and the pain pattern was injury/illness related with no intervening emotional factors.

This construct still provides a valid way of thinking about musculoskeletal pain patients who appear to be in search of relief from their suffering. Years ago, orthopedic surgeons and neurosurgeons said that these patients had some form or other of fibromyositis—which often tended to be linked to some emotional stress, as they put it. Some would say that "it's all in the head."

I don't know if that's the case or not, but there did seem to be an emotional overlay in many of these patients. Does that suggest that these syndromes are psychogenic in origin and need psychological intervention?

Whether there is an emotional connection and a possible need for psychological intervention are good questions. Certainly, the use of antidepressants, especially the tricyclics, have a beneficial effect on the chronic pain patterns. Anticonvulsants have been used off label to achieve the same results, and last year, the Food and Drug Administration approved pregabalin (Lyrica) as the first drug for treating fibromyalgia. Lyrica is a medication not too different from gabapentin (Neurontin), an anticonvulsant often used to control mood, anxiety, and pain.

Should these patients undergo Freudian analysis to control their pain, or would cognitive-behavioral therapy do the trick?

Although fibromyalgia is not a psychiatric illness, it does not preclude using psychiatric/psychological techniques to alleviate some of the pain and suffering these patients experience. Numerous approaches exist to treating patients with mind/body problems, including chronic pain. For me, the two that worked best after medicinal therapy failed or was only partly effective were the use of relaxation/desensitization and rapid learning based interpretive psychotherapy to help connect the dots in the genesis of the stress-related physical problem.

The relaxation technique usually involved allowing the patient to gain control of the symptoms that caused the most distress by empowering her with treatment methods such as glove anesthesia, warm/cold imagery, and some projection techniques using a split screen. After teaching a simple relaxation/hypnotic technique, I usually offered the patient several strategies for pain control.

With the glove anesthesia strategy, the point was to find a way for a person to numb her hand and then transfer that numbness to a part of the body that was in pain. The goal was to have the numbness from the hand move to the painful part of the body, creating numbness in that area and removing some of the pain.

I helped the patient's hand become numb by having her make a tight fist and then imagine that she was carrying a heavy suitcase in a very busy airport and that she could not put it down because of crowds in the airport and a spate of recent thefts that had occurred recently. I would weave a good story about the imagery that is created, so that the patient became more and more removed from the chronic pain pattern. As the suitcase felt heavier and heavier, the patient's hand began to feel almost completely numb. With the numb hand, she then touched the painful area or areas and felt the numbness spread to the affected area—relieving the pain. This was taught repeatedly over three visits.

After relaxation/hypnosis methods were taught, I would try the cold/warm technique. I instructed the patient to see herself in pain on a movie screen and to envision cold or warm packs being applied to the affected painful areas. As the patient imagined this application of warmth or cold to the affected area, some of the pain subsided. These physiologic pain relief methods, warmth and cold, using imagery proved helpful, and the ongoing practice effect helped to further reduce the pain and offered the patient a mastery technique.

Another interesting technique I developed was the red balloon method, in which a patient could metaphorically pack her pain in a wicker gondola attached to a big red balloon. As that big, big red balloon floated away into a blue, blue sky, the actual pain in her muscles became less and less intense as the gondola and red balloon got smaller into the blue sky.

My view is that many approaches to pain control—acupuncture, hypnosis, relaxation, behavioral models, and biofeedback—are fairly similar in terms of successes and failures. They just represent different kinds of ceremonies that different people and their personalities find more or less appealing.

Modern psychiatry should be part of the treatment approach, including knowledge and use of certain complementary/alternative medical therapies. We should teach certain complementary/alternative treatments so that these techniques become part of our toolbox.

Let me know your thoughts on this important emerging medical/psychiatric problem in pain control, and I'll try to pass them along to my readers. ■

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Workplace Program Lowers Headache Frequency, Analgesic Use

BY JONATHAN GARDNER
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A workplace exercise and relaxation program can significantly reduce the frequency of headaches and shoulder pain as well as employees' use of analgesics, according to an Italian study of 384 workers.

Researchers from the University of Turin (Italy) and A.S.O. San Giovanni Battista di Torino said their findings suggest that educating workers on how to prevent headaches can be a noninvasive approach to reducing the burden of headaches, even among those with migraines and depression (Cephalalgia 2008;28:541-52).

"We observed a significant reduction of about 40% of the monthly frequency of headache and neck and shoulder pain in the study group subjects compared with controls," wrote the researchers, led by Dr. Franco Mongini of the headache and pain unit at the university. Workers with frequent and more intense episodes benefited even more, the researchers found.

Researchers asked all of the participants to keep a diary of headaches, neck and shoulder pain, and analgesic use during a baseline period in March and April 2005. About 80% of the subjects enrolled were female; subjects in the control group were significantly younger than in the intervention group (median age 44 years vs. 48 years, respectively.)

One group of workers was then given instruction on exercises to relax face, neck, and shoulder muscles. Reminders to avoid excessive contraction of those muscles were posted in their offices. The control group was not given the instruction or the reminders.

The researchers then followed up with subjects in both groups in months 7 and 8.

They found significant reductions in the primary end points—reduction of monthly frequency of headaches, neck and shoulder aches, and analgesic consumption, and reduction among those with four or more episodes per month—and the secondary end point of a frequency and intensity index among those with four or more per month.

At follow-up, the adjusted change in the mean days per month with headaches for the intervention group was –2.72, compared with the control group; for neck and shoulder pain it was –3.2; and for analgesic use it was –0.83.

For patients with four or more episodes per month, the adjusted change in the mean days per month with headaches was –4.53, compared with the control group; for neck and shoulder pain it was –5.13; and for analgesic use it was –3.55, the researchers said. Among that patient group, the frequency and intensity index underwent a greater adjusted change in the intervention group: –0.33 for headaches, compared with the control group and –0.41 for neck and shoulder pain.

Patients with frequent pain episodes were also more likely to improve if they took part in the intervention program. Compared with the control group, those in the intervention group had 6.59 higher adjusted odds of decreasing headache frequency, 3.94 higher adjusted odds of decreasing neck and shoulder pain frequency, and 4.47 higher adjusted odds of decreasing analgesic use.

The researchers found it "particularly interesting" that subjects with anxiety or depression had even stronger responses: Those with depression or generalized anxiety disorder (GAD) had an adjusted change of –6.46 from baseline in headache frequency, compared with –1.50 for those with neither condition. "This result is in line with the observation in other studies that the placebo response was stronger in patients with GAD and major depression," they wrote. ■

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