

Psychological Distress and Help-Seeking in Patients with Chronic Pain

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Background: High prevalence of psychiatric morbidity has been reported among patients with chronic pain. However, there were no such investigations in Taiwan as well as help-seeking behavior in chronic pain patients.

Methods: One hundred patients with chronic nonmalignant pain over a period of six or more months were assessed systemically by a research psychiatrist and an anesthesiologist using structured interviews. Self-reported pain in patients was measured with the McGill Pain Questionnaire. Their help-seeking behavior was analyzed and compared with the psychiatric diagnoses.

Results: Ninety-four percent of the subjects had at least one psychiatric diagnosis, and nearly three-quarters had depressive disorders. Pain was multifocal, mostly involving the head and neck areas. More than one-third of the patients attributed the cause of pain to both psychological distress and physical problems.

Conclusions: Significantly high psychiatric morbidity was found in patients with chronic pain, predominantly depression, but very few had sought psychiatric consultation. Psychiatric intervention is therefore necessary for effective chronic pain management.

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Key words: chronic pain, psychiatric morbidity, help-seeking behavior.

Pain is a common and debilitating symptom often presented to a physician. It is embodied in various forms and subsequently infringes on the full spectrum of a person's physical and emotional functioning. Chronic pain is defined as pain that persists for more than six months and results in the need for long-term treatment.⁽¹⁾ The term 'chronic pain patient' is used when doctors are unable to detect a clear physical pathology that accounts for the patient's symptoms. It is believed that psychological factors are playing a part in the production of the symptoms and that the physical disease is either non-existent or not sufficient to produce the level of pain.⁽²⁾

The scope of negative effects caused by chronic pain are notably high frequency of health service utilization, reduced quality of life and increased economic cost. The general social disability indicated by sick leave, work loss or early retirement results in a greater fiscal cost than medical expenditures. In the United States, more than \$10 billion was spent on disability payments for chronic pain problems.⁽³⁾ The annual absenteeism from work resulting from pain exceeded 50 million days per year and approximately 170 million people-days of pain-related, short term work loss.⁽⁴⁾

The degrees of distress and dysfunction produced by chronic pain are extensive. Besides ortho-

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dox medical treatment, many patients seek alternative treatments such as herbal remedies, homeopathy or acupuncture. In addition, it has long been recognized that chronic pain patients also suffer from depression, anxiety and other psychiatric symptoms, unfortunately reports using systemic psychiatric evaluation are lacking.⁽⁵⁾ Therefore reports about psychiatric morbidity among the chronic pain patients vary widely, depressive disorders, for example, ranging from 10%⁽⁶⁾ to 87%.⁽⁷⁾ To date, however, there are no reports of psychiatric morbidity in chronic pain patients in Taiwan.

In view of the above discrepancy, this study aims to estimate psychiatric morbidity in patients with chronic pain, furthermore it aims to investigate their help-seeking behavior in terms of their level of distress.

METHODS

Subjects were drawn from pain clinic of the department of psychiatry at a medical center (KCGMH) from August 2000 to October 2001. We recruited from consecutive patients with aged eighteen years or older and having nonmalignant pain that had lasted over six months. Pain was diagnosed according to the ninth revision of the International Classification of Disease (ICD-9).⁽¹²⁾ Informed consent was obtained before the study began. The attending psychiatrist and the anesthesiologist made independent assessments. Socio-demographic characteristics of the subjects were also collected along with their help-seeking behavior.

The assessments

The subjects were first examined and assessed by an anesthesiologist. Besides the examination they were asked to complete the Chinese version of the McGill Pain Questionnaire,⁽¹³⁾ a questionnaire in which the subject rates his or her subjective experiences with the character, intensity and changes of the perceived pain. This questionnaire has been validated and used in a published study of cancer patients in Taiwan.⁽¹⁴⁾ Psychiatric assessments were conducted by a senior psychiatrist Dr. Yu Lee (YL) using the Chinese version of Structured Clinical Interview (SCID),⁽¹⁵⁾ and the Explanatory Model Interview Catalogue (EMIC),⁽¹⁶⁾ an anthropologically based semi-structured interview schedule that systematical-

ly examines patients' help-seeking behavior for quantitative and qualitative data information.⁽¹⁸⁾ Psychiatric diagnosis were made based on the Fourth Edition of the Diagnostic and Statistical Manual system (DSM-IV).⁽¹⁷⁾ Help-seeking behavior data were collected using the EMIC.

Statistical analysis

Descriptive and inferential statistics were computed with the use of statistical software, SPSS for Window 8.0. Comparisons of measures between two groups were made using either the student's *t* test or chi-square test, depending on the nature of the data with statistical significance defined at p-value less than 0.05. Their help-seeking behavior was categorized for further analysis into a professional sector that comprised of legally sectional medical professions and a folk sector with the medicine sacred or secular healings and traditional medicine.

RESULTS

Altogether, one hundred subjects (sixty-eight females and thirty two males), with the mean age of 44.6 ± 12.8 years (range 20-77; female 43.8 ± 12.0 , male 46.2 ± 14.4) completed the study. Sixty-four were married, of which forty-seven percent were housewives; and more than half (fifty-two percent) had seven to twelve years of education.

Temporal features of pain

Pain presented by the subjects was predominantly multifocal and lasted an average of 99.4 (median=60) months. Three quarters reported a moderate to severe level of pain. The most distressing pain subjectively perceived were headaches (60%), backaches (27%) and limb pains (27%). They were relatively consistent with the main diagnostic categories of pain assessed by the anesthesiologist among the 212 disorders of pain with organic origin, the most common group being pain involving head and neck (58%), other and unspecified disorders of back (17%), joints and soft tissue (7%).

Psychological distress and help-seeking

Despite being distressed by the chronic pain, thirteen percent of the patients with chronic pain reported problems in social relationships and eight percent complained of sleep disturbances. Many

labeled themselves as having sciatica, frozen shoulder, muscle tension, degenerative arthritis, central nervous system degeneration, vertebral disorders and the common cold all with regard to the location of their pain. About one-tenth acknowledged that they had a depressive illness that manifests in the form of vague pain without any specific focus. The psychiatrist diagnosed approximately three quarters of the subjects as having depressive disorders (more major depressive disorders -thirty-two percent- than dysthymia -twenty-nine percent) or other conditions, and only approximately one tenth of the patients as having anxiety disorders. It is noteworthy that fifteen percent of the subjects had substance abuse, especially with analgesics (Table 1). The concurrent psychiatric morbidity in this sample estimated at 94%. Table 2 summarizes the patients' perceptions of the cause of their pain and their help-seeking behavior. An equal number of subjects (thirty percent) thought that their pain originated either from physical or psychological problems, while thirty-seven percent thought their pain was caused by both physical and psychological problems. Most patients sought a plu-

realistic model of treatment, with the additional use of professional treatments and folk healings, including the use of the traditional Chinese remedies, acupuncture, chiropractor, praying and even religious practices. Nevertheless, about sixty-four percent of the subjects were dubious about the most effective model of treatment.

DISCUSSION

This study demonstrates that patients with chronic pain have significantly high psychiatric morbidity, a finding consistent with other studies.⁽⁵⁻¹¹⁾ Three quarters of the subjects had depressive disorders. The rate of depression in this sample was higher than that of the general population,⁽¹⁹⁾ primary care,⁽²⁰⁾ and other medically ill patients.⁽²¹⁾ There is also an inconsistency in the estimation of depressive disorders when comparisons are made among patients with chronic pain syndrome⁽⁶⁻⁹⁾ (Table 3). The difference in rates of psychiatric morbidity among chronic pain patients might be due to differences in the definition of chronic pain, patient selec-

Table 1. Concurrent Psychiatric Diagnosis Using the DSM-IV Criteria

Category and diagnosis	Male (N=32) (%)	Female (N=68)(%)	p
Depressive disorder			
Major depression	6 (18.8)	26 (38.2)	0.051
Dysthymia	10 (31.3)	19 (27.9)	0.734
Depressive disorder NOS	4 (12.5)	6 (8.8)	0.568
Depressive disorder due to general medical condition	0	1 (1.5)	0.491
Adjustment disorder with depressive mood	0	1 (1.5)	0.491
Substance abuse			
Analgesia abuse	5 (15.6)	5 (7.4)	0.198
Benzodiazepine abuse	3 (9.4)	0	0.010
Alcohol abuse	0	2 (2.9)	0.327
Anxiety disorders			
Generalized anxiety disorder	3 (9.4)	4 (5.9)	0.523
Obsessive compulsive disorder	1 (3.1)	1 (1.5)	0.581
Somatoform disorder			
Pain disorder	2 (6.3)	7 (10.3)	0.510
Undifferentiated somatoform disorder	0	1 (1.5)	0.491
Schizophrenia	3 (9.4)	1 (1.5)	0.60
Primary insomnia	2 (6.3)	3 (4.4)	0.694
Personality disorder			
Borderline personality disorder	1 (3.1)	4 (5.9)	0.555
Histrionic personality disorder	0	1 (1.5)	0.491
No diagnosis	2 (6.3)	4 (5.9)	0.942

Abbreviation: Depressive disorder NOS: depressive disorder not otherwise specified.

Table 2. Help-seeking Behavior of Patients with Chronic Pain

		Depressive N = 73 (%)	Non-Depressive N = 27 (%)	<i>p</i>
Perceived causes	Physical	18 (24.7)	12 (44.4)	0.055
	Psychological	25 (34.2)	5 (18.5)	0.128
	Both	29 (39.7)	8 (29.6)	0.353
	Others	1 (1.4)	2 (7.4)	0.116
Past help-seeking	Professionals	11 (15.1)	5 (18.5)	0.676
	Folk	1 (1.4)	0 (0)	0.541
	Pluralistic	59 (80.2)	22 (81.5)	0.940
Most effective help-seeking	Not yet met	46 (63.0)	16 (59.3)	0.640
	Professionals	19 (26.0)	8 (29.6)	0.755
	Folk	4 (5.5)	2 (7.4)	0.735

Table 3. Comparison of Comorbid Depression in Chronic Pain Patients

Author (year)	Setting	Case No	Assessment / Diagnosis	Rates
Piloswky et al ⁽⁶⁾ (1977)	Pain clinic	100	LPDQ	Dep: 10%
Lindsay et al ⁽⁷⁾ (1981)	Pain clinic	44	RDC	Dep: 87%
Reich et al ⁽⁸⁾ (1983)	Pain clinic	43	MMPI/DSMIII	MD: 23%
Fishbain et al ⁽⁹⁾ (1985)	Pain center	283	DSM III	Dep: 56.2%
Katon et al ⁽¹⁰⁾ (1985)	Inpatient	37	DIS	MD: 32.4%
Wilson et al ⁽¹¹⁾ (2002)	Pain clinic	150	DSM IV	MD: 30%
Huang et al (2005)*	Pain clinic	100	SCID/ DSMIV	Dep: 73%; MD: 32%

Abbreviations: LPDQ: Levine-Pilowsky Depression Questionnaire; RDC: Research Diagnostic Criteria; MMPI: Minnesota Multiphasic Personality Inventory; DIS: Diagnostic Interview Schedule; Dep: depressive disorder; MD: major depression.

*This study

tion, measurement of depression, and the diagnostic criteria used. The definition of chronic pain encompasses pain that extends for a long period of time, represents low levels of underlying pathology, and prompts patients to frequently seek health care, often it is rarely effectively treated. Because of persisting pain, it is likely that environmental and affective factors eventually interact with the tissue damage, contributing to the persistence of pain and illness behaviors.⁽²²⁾ Some studies defined chronic pain solely by a temporal criterion of duration of over a month. In addition, most studies which assess depressed states or depressive symptoms are based on checklists or screening instruments that are sensitive to standard criteria for diagnosis of depression. However, patients with chronic pain are affected by physical illness and disability, and it is not unusual for the over-inclusion of somatic symptoms if these screening instruments are applied. In this study, a trained experienced psychiatrist conducted all assessments and measurements, hence reducing the rate of false

positives.

Pain is a common complaint of many psychiatric disorders, particularly in depressive and anxiety disorders. Nearly sixty percent of depressed patients report pain as part of their disorder.⁽²³⁾ Pain thresholds are lower in depression, and depressive disorders may be associated with the altered endorphin levels and the regulation of neurotransmitter especially serotonin and norepinephrine in the brain.⁽²⁴⁾ Pain is often in the head, face, chest or abdomen regions, and usually ill-defined. Nevertheless, some investigators have regarded chronic pain as somatization of depressive disorders⁽²⁵⁾ while others considered it as the somatic equivalent of depression that is, as a variant of depression⁽²⁶⁾ or a synchronous expression of an underlying or 'mute' depression.⁽²⁷⁾

The reported rates for anxiety disorders in the chronic pain patients have also differed widely from 7%⁽⁸⁾ to 62.5%.⁽⁹⁾ Methodological problems similar to those mentioned for studies on depression probably account for these differences. The pain in anxiety

patients however, is often muscular tension and is usually experienced as headache, chest pain, back pain and occasionally limb pain.⁽³³⁾ Two thirds of patients diagnosed as having an anxiety disorder in this study had headaches. They had a higher frequency of headaches than those with depressive disorders. Pains associated with anxiety often become chronic, as in this study, and this may be because the stress that has initiated the anxiety is chronic by nature. As with depression the tension related pains are just symptom of psychiatric illness, and the diagnosis is made from the presence of other classical symptoms suggestive of autonomic over-activity and the associated state of anxiety.

Most of the subjects in this study presented somatic complaints as a form of distress, including pain. It has been documented that somatization has been found to play an important role in the process of communicating and coping with social and personal distress, especially in the Chinese patients.^(28,29) The expression and meaning of pain in Chinese people are influenced by the traditional Chinese medical concept of psychosomatic functioning where it is both referred to the psychological as well as physical symptoms.⁽³⁰⁾ Hence, it could be seen that over one third of the subjects perceived that the pain was caused by both physical and psychological factors, while only less than one third thought that psychological factors were the cause of the chronic pain symptoms. It is thus apparent that perception and belief of one's illness affected psychological functioning and help-seeking behavior.

Before visiting the pain clinic, over half of the subjects did not receive any satisfactory treatment, while the pluralistic model of help seeking with the combination of professional treatment and folk healings was undertaken. The latter was more frequently seen in subjects with depression, and it has been shown that chronic pain patients with depression are more likely to either drop out of the professional treatment or respond poorly to intervention.⁽³¹⁾ The medical or psychological symptoms may be a cause in most cases but taken alone are not a sufficient cause for the use of the health care services.⁽³²⁾ The patients' understanding of their pain symptoms and their expectations for treatment determines much of their interactions with health care providers. Although we have new models for conceptualizing pain and increasing numbers of effective treatment

approaches, pain however, remains poorly treated. With such high rate of psychiatric morbidity among the patients with chronic pain, it seems necessary that psychiatric intervention be indispensable for the effective management of chronic pain syndrome.

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慢性疼痛患者之心理困擾及求助行爲

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背景：慢性疼痛是臨床上常見的症狀，過去研究顯示合併各種精神疾病的罹病率甚高。台灣缺乏本土研究資料，因此本研究的目的探討慢性疼痛患者精神疾病罹病率與求助行為。

方法：共 100 位慢性非癌症疼痛病患，其病程至少達六個月以上，經精神科及麻醉科專科醫師利用結構性訪談及國際診斷標準完整評估，並分析其求助行為。

結果：發現 94 位個案罹患至少一種精神疾病。憂鬱疾患佔四分之三。最常見的疼痛診斷為頭頸部疼痛。超過三分之一自覺病因以合併生理因素及心理因素，以多元求助模式為主。

結論：本研究顯示，綜合醫院慢性疼痛患者精神疾病罹患率頗高，特別是憂鬱症。精神科的介入對慢性疼痛的處理是不可或缺的。

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