

# **Somatoform Disorders and other psychiatric aspects of chronic pain**

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# The Claim

- Minor injury causes Chronic Pain
- Can't work, can't clean, can't sleep
- Orthopaedic *“high degree of overlay and anxiety”*
- *“a large psychological component to her ongoing symptomatology.”*
- Pain Consultant *“significant and disabling pain syndrome”*
- *££££££££ ?????*

# **Pain disorder (syndrome) associated with a general medical condition**

This diagnosis is **not** considered a mental disorder. The pain results from a general medical condition and the psychological factors are judged to play either **no** role or a **minimal** role in the onset or maintenance of the pain.

This is not a psychiatric diagnosis.

# Mechanisms Contributing to the Reporting of Pain Symptoms

Pain symptoms due to organic damage.

Organic pain being augmented and magnified by anxiety and low mood.

Psychosomatic symptoms where pain is an expression of psychological distress e.g. anxiety.

# Mechanisms Contributing to the Reporting of Pain Symptoms

Pain symptoms being used to establish or reinforce a sick role. (mostly unconscious)

Pain symptoms being used to obtain financial reward through disability system or compensation.(mostly conscious)

An organic pain arising from psychiatric disorders e.g. consequences of drug and alcohol misuse such as falls, fractures. Assaults etc.

# The Claimants Psychiatric Report

- Depression which is caused by the pain
- No mention of pain as a psychiatric symptom
- Major Depressive Episode
- Adjustment disorder
- Post Traumatic Stress Disorder
- ?Following a minor injury

Psychogenic patients have a high score on the disease affirmation scale whether involved in a claim or not.

- *Do you think there is something seriously wrong with your body? (Yes)*
- *Does your illness interfere with your life a great deal? (Yes)*
- *If the doctor told you he could find nothing wrong with you, would you believe him? (No)*
- *Do you find you are often aware of various things happening in your body? (Yes)*
- *Are you sleeping well? (No)*

- *Do you find that you are bothered by many different symptoms? (Yes)*
- *Do you ever think of your illness as a punishment for something you have done wrong in the past? (No)*
- *Are you bothered by many aches and pains? (Yes)*
- *Is your bad health the biggest difficulty of your life? (Yes)*
- *Do you think your symptoms may be caused by worry? (No)*
- *Do you think there is something the matter with your mind? (No)*

# Medically Unexplained Symptoms

It is estimated that a quarter to a half of patients in medical clinics attend with symptoms that are medically unexplained. In the UK many thousands of patients go daily to their GP with physical complaints which with the passage of some brief period of time, gentle persuasion and perhaps a prescription, soon resolve.

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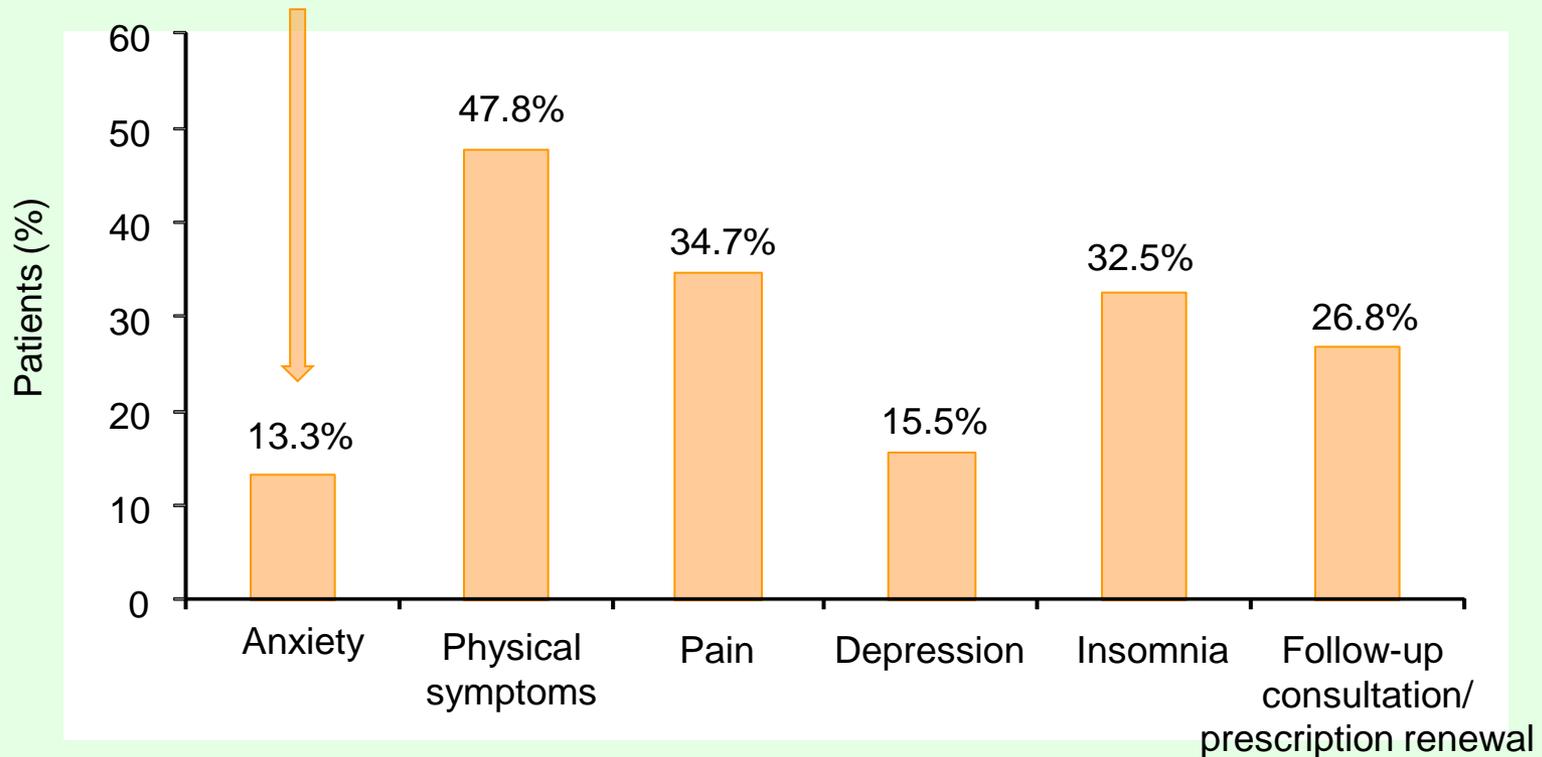
# Pain

A very common psychiatric complaint. Very difficult to measure and one whose significance is universally appreciated.

A cardinal symptom bringing patients and doctors into contact and one that is so often elusive to tie down.

# Anxiety is often not the primary complaint in generalised anxiety disorder

Few patients with generalised anxiety disorder seek help because anxiety is their primary complaint



# Somatization

The experience and communication of psychological distress as somatic symptoms.

“Illness as an (apparently) easier way of life ”

A process by which the body (the soma) is used for psychological purposes or for personal gain.

# Somatisation

- Psychological distress presenting through physical symptoms for which there is no organic cause.
- More frequent in unskilled manual workers.
- Responds poorly to antidepressants.
- Closely linked to anxiety and mood problems.
- Milder form very common and self limiting.

# Physical versus Psychiatric explanations

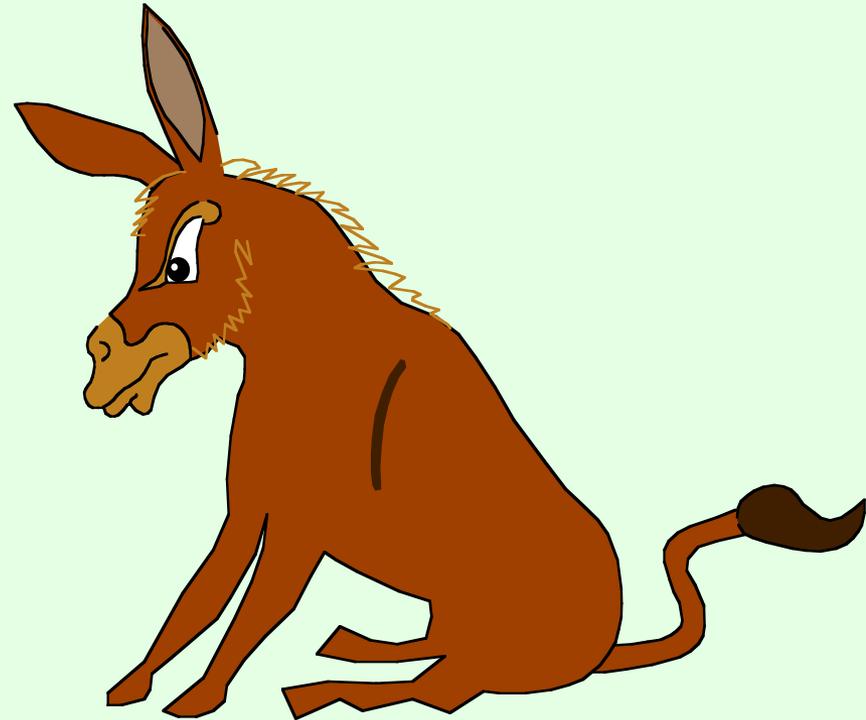
- Social acceptability
- Legitimising the sick role
- An apparent medical solution to psychosocial problems
- Opiates or antidepressants
- Advantages both conscious and unconscious of denying psycho-genesis
- Telling a good story
- Often easier to listen to e.g. at home

# Medically Unexplained Symptoms

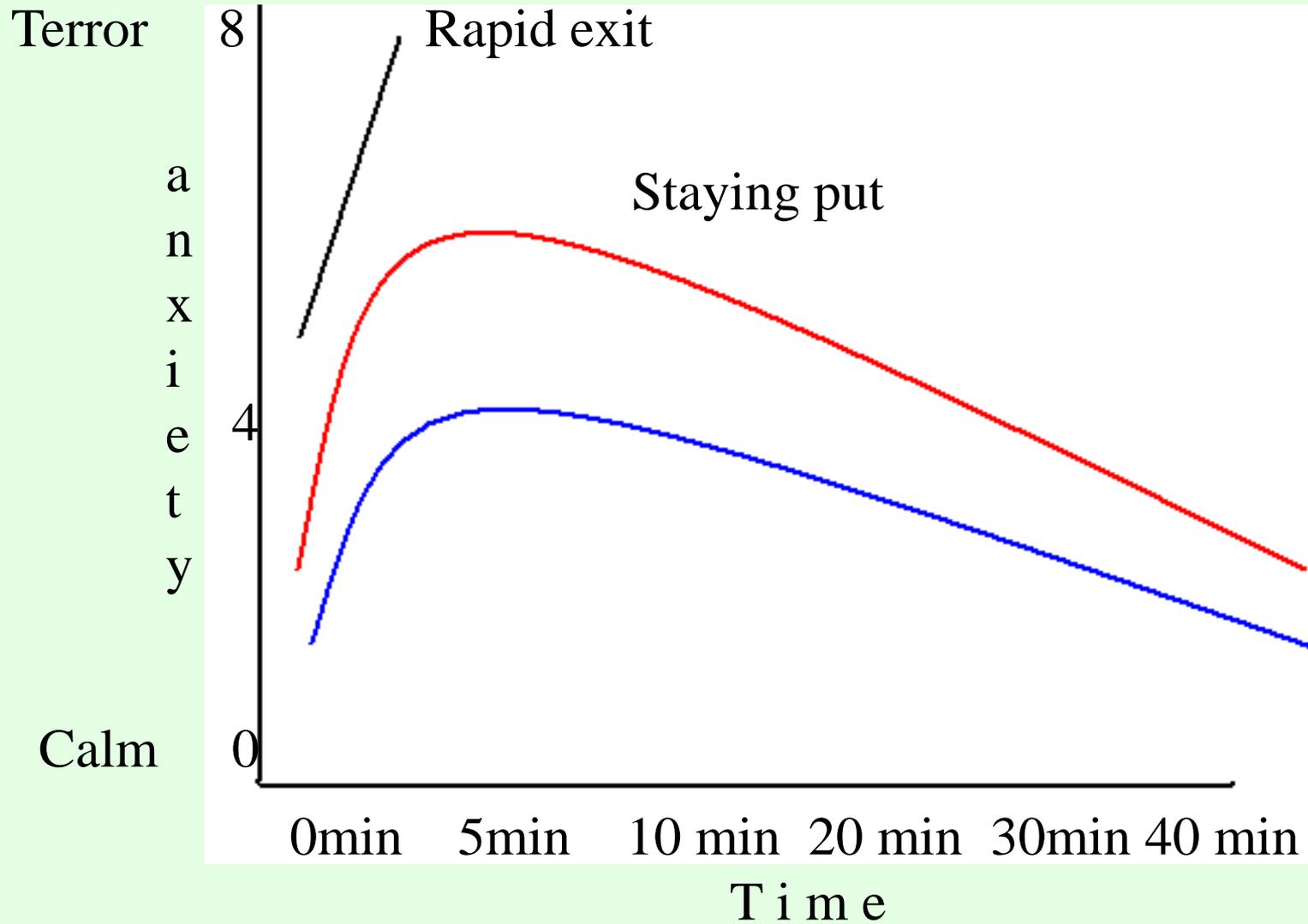
- Chronicity develops from a self-perpetuating cycle driven by high level attention to the symptom. Deliberate checking to see if the symptom is still present increases the resting activation level of the underlying symptoms representation.
- Observations and attitudes of carers are frequently important in the perpetuation of medically unexplained symptoms, especially motor conversion symptoms.

# Developing an inner caretaker

- Some patients are keen to take responsibility for their own health.
- Some have other ideas.



# The Effect of Avoidance on Habituation



# Anxiety

- Panic Disorder
- Generalised Anxiety
- Indirect
- Functional Symptoms (dissociative disorder, hysteria)
- Abdominal Pain (recurrent negative investigations)
- TMJ

# Deception

- Self deception .... *“I am not ...”*
- A failure
- Unlovable
- Anxious
- Comfort Eating
- An addict
- Angry
- Rewriting the story

# Compassionate Skepticism

- Psychosomatic pain is not imaginary
- The suffering is very real.
- The full story may be much sadder
- Loneliness
- Fear
- Unhappiness
- Failure
- Forensic Detachment and Respect for privacy

# Finding the pattern

- Pain always has psychological components.
- COMPLETE medical records
- Childhood abuse
- Depression
- Anxiety
- Domestic Violence 1 in 12 often denied
- Drugs & Alcohol often denied

# Pain Disorder 300.7

Disorder not Syndrome

The essential feature of pain disorder is pain that is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.

**Pain disorder associated with both psychological factors and a general medical condition. 307.89:**

Psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation or maintenance of the pain.

# **Pain disorder associated with psychological factors. 307.08:**

Psychological factors are judged to have the major role in the onset, severity, exacerbation or maintenance of the pain.

General medical conditions play either no role or a minimal role in the onset or maintenance of the pain.

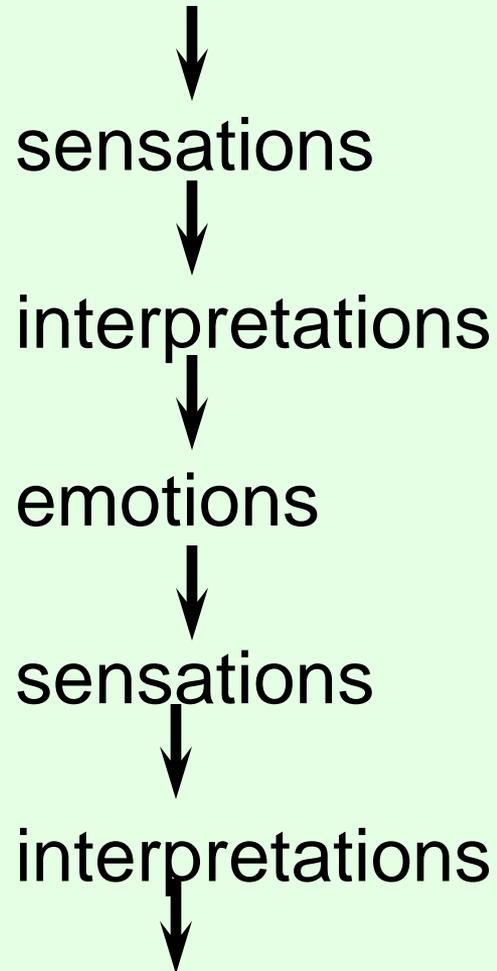
# The Missing Diagnosis

The pain results from a general medical condition and psychosocial factors are judged to play either **no** role or a minimal role in the **onset** of the pain but an increasingly **major** role in the **maintenance and exacerbation** of pain behaviour.

## Pain Prone Patient

- Pain can become a pathway for the expression of guilt and expiation.
- Greatly increased risk if there is a history of physical and sexual abuse in childhood or as an adult. E.g. domestic violence

# Deriving a vicious circle



# Outcome of Psychological and Psychiatric Treatment for Chronic Pain

- Results difficult to evaluate because reports differ with regard characteristics, patients and disorders.
- Many patients with chronic pain are unwilling to accept treatment, others are considered unsuitable. But psychological and rehab treatments can have a sustained effect.
- Patients involved in seeking compensation tend to have a poorer outcome.

# Transition from Acute to Chronic Pain

- Mood and anxiety disorders, negative life events, physical illness, trauma, dissatisfaction with work, problems in social support network.
- New episodes of chronic widespread pain were predicted by the number of previous non-pain somatic symptoms and by a measure of an illness behaviour which assessed the number of consultations, treatments and perceived disability and these two measures have an additive effect.

# Chronic Regional Pain and Chronic Pain Syndromes

“When there is a pre-existing psychological disorder, it is not merely a passive vulnerability worsened by the claimed injury but it can be an active factor causing symptoms that express a psychological conflict. In other words, whether conscious or unconscious, the patient needs the pain and may use it to solve a problem. A claimed injury is the opportunity for it to happen.

...Published medical definitions point to a primary psychological illness (see above), yet patients, lawyers and patients support groups commonly, strenuously deny psychogenesis with the sadly mistaken notion that this implies a bogus or spurious cause.

Patients fear of aggravation of further injury impedes activity and independence. This is often iatrogenic. The results and heightened state of arousal increases pain.

**JMS Pearce, Emeritus Consultant Neurologist**  
**Spinal Cord (2005 43, 263 – 268)**

# Key References

Chronic Regional Pain and Chronic Pain Syndromes –  
JMS Pearce  
Spinal Cord (2005) 43. 263-268.

Somatoform Disorders  
A Medico-legal Guide  
Michael Trimble  
Cambridge University Press, ISBN 0-521-81108-2.

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[www.southwestchambers.co.uk/expert/28/Dr-Paul-Aylard-FRCPsych.aspx](http://www.southwestchambers.co.uk/expert/28/Dr-Paul-Aylard-FRCPsych.aspx)

# DSM IV Somatoform Disorders

Somatisation Disorder (300.81)

Undifferentiated Somatoform Disorder (300.81)

Conversion Disorder (300.11)

Pain Disorder (300.07)

Hypochondriasis (300.07)

Body Dysmorphic Disorder (300.07)

# Somatisation

- “My problem is caused by physical illness”
- “Its not my fault” (I am not a failure)
- “I’m not responsible for my recovery”
- “I’m ill and frightened” (find me a doctor)
- “I am powerless” (???)

# Stress Modifiers

The majority of people exposed to all but the most stressful life events do not become depressed.

Factors such as social support ,cognitive flexibility ,good problem solving skills appear to be protective but these become insignificant once a history of depression is considered.

# Memory and Prediction

The effect of the “depression talking” .Long miserable, repetitive, self referent, negative ,paranoid etc.

Experiencing the recent past as failure and predicting more of the same .

# Perception of threat

Depression is associated with negative thinking  
e.g. lack of confidence, self criticism

- Depressed patients overestimate risk
- Magnification
- Catastrophisation
- Black and White thinking
- Self reference
- Selective abstraction

# Anxiety and threat

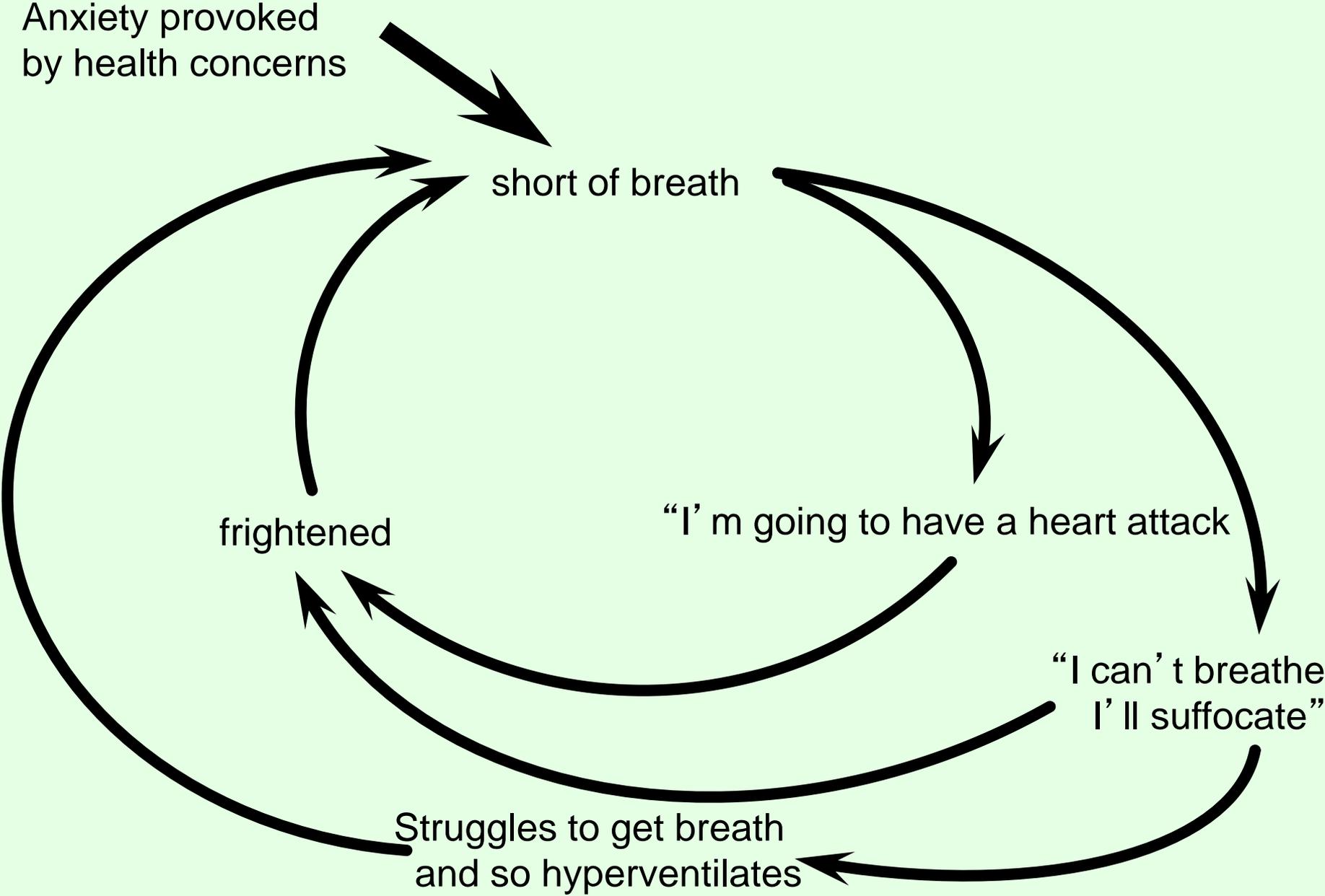
*Anxiety is proportional to the perception of threat factors:*

**perceived  
likelihood** × **perceived  
“awfulness”**

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**perceived  
coping** + **perceived  
rescue**

# Example of a panic-type vicious circle/spiral



# Meaning links bodily variations and misinterpretations

**Heart racing, pounding, palpitations**

**I'm having a heart attack, my heart will stop**

**Lumps under skin**

**I've got cancer**

**Loss of sensation and tingling in arms and legs.**

**I've got multiple sclerosis**

**Feeling dizzy, faint, weak legs.**

**I've got HIV, AIDS.**

**Feeling dizzy, heart pounding, chest tight and painful, palpitations.**

**I'm dying.**

**PRIORY**

# Safety seeking behaviours

- Behaviours intended to prevent harm
- e.g. work avoidance + litigation
  - Several effects on beliefs
    - prevent disconfirmation
    - can increase the stimuli which are misinterpreted
    - increase preoccupation and rumination
  - Are linked to the specific focus of threat by the internal logic of the person employing them
  - i.e. Escalating work avoidance which may be reinforced by “counselling” or by family members.

# Depression is a recurrent or chronic disease

- The majority of depressive episodes are recurrent episodes.
- Although stress may contribute to, the first episode with subsequent episodes the illness appears to evolve independent of significant life events . i.e. Loss of stress tolerance.
- This is relevant to Walker type claims