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Forensic, Child, Adolescent, and Adult Psychiatry

INDIVIDUAL & FAMILY PSYCHOPHARMACOLOGIC TREATMENT OF:

- MOOD AND ANXIETY DISORDERS • OBSESSIVE-COMPULSIVE DISORDER
- PERVASIVE DEVELOPMENTAL DISORDERS/AUTISM
- ATTENTION DEFICIT DISORDER • MENTAL RETARDATION • TOURETTE'S DISORDER
- TRAUMATIC PSYCHIATRY • TRAUMATIC BRAIN INJURY
- POST-TRAUMATIC STRESS DISORDER • CHRONIC PAIN MANAGEMENT

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REVIEW OF CHRONIC PAIN ASSOCIATED WITH DEPRESSION

Chronic Pain Syndrome has been associated with depressive symptoms in patients, including the diagnosis of Major Depression, as well as symptoms of anxiety with each person perceiving anxiety in their own unique way.

In the Handbook of General Hospital Psychiatry[1], Drs, Bouckoms and Hacket have noted that 60%-100% of pain patients have symptoms of a depressive disorder and that Major Depressive Disorder is found in 25% of chronic pain patients.

Some pain patients may have Alexithymia, that is, they have difficulty expressing their emotions into words, may deny emotions and/or deny depressive symptoms. They may have a form of depression which is manifested by anger, irritability, sleep and/or appetite disturbance, lack of enjoyment in activities, diminished sexual desire, as well as a wish to be dead rather than be in their present state. This clinical presentation is different than the classic textbook picture of the depressed person with a sad face and crying- spells. Furthermore, patients with chronic depression who have had orthopaedic injuries over one year prior to being evaluated, have an atypical presentation different than a patient with acute depression. In fact, many patients who do not want others to think that they are mentally disturbed may deny being depressed. The acute clinician Hacket noted that asking questions about vegetative depressive symptoms (e.g., sleep and appetite disturbance, fatigue) and cognitive depressive symptoms (e.g., difficulty thinking, concentrating, making decisions) that depressive symptoms could be elicited from the patient. Thus, a diagnosis of depression could be made. As noted by Bouckoms and Hacket, the *Minnesota Multiphasic Personality Inventory (MMPI)* may be of particular use in differential diagnosis in pain patients where denial is operative.

Other patients may have what is called "Pain Disorder" which is a disorder listed in the Diagnostic Statistical Manual-IV (*DSM-IV*) published by The American Psychiatric Association. Patients with Pain Disorder have preoccupation with pain for at least six months and have a perceived pain and/or impairment that is in excess of what would be expected from their physical findings. These patients are not malingering, but truly believe they have a significant problem causing their pain and disability.

Furthermore, patients with significant pain may become anxious due to a multitude of

reasons, such as worry that their condition will not get better and/or fear of being in pain for the rest of their life. In most cases significant anxiety coexists with depression.

The individual expression of pain is variable. While some patients are stoic, others may develop various types of Somatoform Disorders (listed in the *DSM-IV*). One example is Hypochondriacal Disorder, in which the patient has persistent fears of having a serious illness, despite reassurances that minimal physical findings are present.

In the textbook Neuropsychiatry[2], one of the most definitive texts in the world, Drs. Mayberg, Mahurin, & Brannan have noted that chronic pain is associated with depression and significant changes in cerebral metabolism occur with depression. Functional neuroimaging studies consistently demonstrate involvement of frontal and subcortical structures in both primary and neurologic-induced depression. Monty Buschbaum, M.D. noted decreased activity in the frontal lobe (amotivation and apathy) and decreased activity in the temporal lobe (decreased memory).

The relationship of chronic pain and depression is also discussed in The Textbook of Neuropsychiatry[3] in the chapter entitled *Pain and Psychopathology* by Vogel. In depression, The vast majority (approximately 55%) of chronic pain patients are depressed. The lifetime prevalence of Major Depression among patients with chronic pain varies between 21% to 71%. Using *The Millon Clinical Multiaxial Inventory-II* (*MCMI-II*), more than 50% of chronic pain patients have elevated depression scores, and most studies show well over 55% of these patients have mood disorders. Chronic pain patients have higher lifetime rates of depression, alcohol abuse, and anxiety disorders, and the first episode of major depression often follows the onset of pain.

Other Effects of Depression due to Chronic Pain

1. **Weight Gain:** Many patients with chronic pain develop increased weight, and this can further decrease self-esteem and aggravate depression. This may increase already-present feelings of disability and impact one's actual and perceived level of disability.
    1. **Decreased Immunologic Competence:** Depression itself decreases a person's immune response and, when chronic pain is an additive, a person's immune response can be even more compromised. This may account for the fact that, in persons who suffer with chronic pain (with or without depression) -- and especially accompanied with sleep disturbance, which also decreases immune response -- there is a greater risk of developing fibromyalgi, a potentially lifelong, incapacitating pain/fatigue disorder. (*Reference:* UCLA Third Annual Review of Psychiatry, Margaret Kemeny, Ph.D.)

Psychopharmacologic Treatment of Chronic Pain

1. **Antidepressants:** Almost all antidepressants have been used. Elavil is considered preferable for headaches by Martin Samuels, M.D., Professor of Psychiatry, Harvard Medical School since it is the most anticholinergic drug.[4]
2. **SSRI's:** A paucity of studies, but may be effective.[5]
3. **Tricyclic Antidepressants:** Multiple studies using Tricyclic antidepressants. For headaches, Elavil is considered preferable by Martin Samuels, M.D. because it is the

most anticholinergic drug.

4. **Carbamazepine *(Tegretol)*:** For specific pain syndromes.[6]

Psychological Treatment

1. **Group Therapy**
   1. **Individual Therapy**: Patient is told they may have to live with the pain, but not the misery.
   3. **Family Therapy**

In summary, the clinical presentation of depression -- with symptoms of apathy, lack of motivation, decreased thinking, and impaired cognition -- is associated with decreased metabolism in the frontal and temporal lobes which accounts for the patient's significantly decreased functioning and ability to perform cognitive aspects of work/life activities. In the same way, the majority of patients with chronic pain develop significant depression with this same symptomatology and resulting work/life-disabling cognitive impairment.

References:

1. The Handbook of General Hospital Psychiatry, Edited by Ned H. Cassem, M.D., Chapter: *The Pain Patient: Evaluation and Treatment* by Anthony Bouckoms, M.D. and Thomas P. Hacket, M.D., Massachusetts General Hospital, 1991.

2. Neuropsychiatry, Edited by Barry S. Fogel, M.D., Randolph B. Schiffer, M.D., and Stephen M. Rao, Ph.D., Chapter: *Pain and Psychopathology* by David Fishbain.

3. Textbook of Neuropsychiatry, Edited by Stuart Yudofsky and Robert E. Hales, M.D., American Psychiatric Association Press, June 1997. Chapter: *Neuropsychiatric Aspects of Mood and Affective Disorders* by Helen S. Mayberg, M.D., Roderick K. Mahurin, Ph.D., Steven K. Brannan, M.D., Williams & Wilkins, May 1997.

4. Lecture Series: *Continuing Medical Education in Psychiatry* by Martin Samuels, M.D., Harvard Medical School, 1998. *See also:* Harvard Review of Neurology by Martin Samuels, M.D., Boston, Massachusetts, 1996, and Chapter: *Pain Management* in the textbook Neuropsychiatry.

5. Seminars: *Continuing Medical Education in Psychiatry, Subject:* Psychopharmacologic Treatment of Chronic Pain by Steven King, M.D., Professor of Psychiatry, Temple Medical School, 1998.

6. The Textbook of Psychopharmacology, Chapter: *Carbamazepine*. American Psychiatric Association Press, 1995