For the Office-based Teacher of Family Medicine

William Huang, MD
Feature Editor

Editor’s Note: Caring for patients with chronic pain can be difficult for learners and even the most experienced physicians. In this month’s column, Heidi Pomm, PhD, of the St Vincent’s Medical Center Family Medicine Residency in Jacksonville, Fla, explains important diagnostic and management issues that the office-based teacher should discuss with learners caring for patients with chronic pain. Dr Pomm has written an article of similar content that was published in the Summer 2005 edition of Northeast Florida Medicine, the journal of the Duval, Clay, Nassau, St. John’s, and Putnam Medical Societies in Florida. This month’s column is published with the written permission of the Duval Medical Society, the copyright holder of Northeast Florida Medicine.

I welcome your comments about this feature, which is also published on the STFM Web site at www.stfm.org. I also encourage all predoctoral directors to make copies of this feature and distribute it to their preceptors (with the appropriate Family Medicine citation). Send your submissions to williamh@bcm.tmc.edu. William Huang, MD, Baylor College of Medicine, Department of Family and Community Medicine, 3701 Kirby, Suite 600, Houston, TX 77098-3915. 713-798-6271. Fax: 713-798-7789. Submissions should be no longer than 3–4 double-spaced pages. References can be used but are not required. Count each table or figure as one page of text.

Regaining Balance After “Reality Vertigo:” Teaching Learners to Attend to the Psychological Aspects of Patients With Chronic, Nonmalignant Pain

Heidi A. Pomm, PhD

One of the most frequent complaints of patients seen in primary care settings is pain. However, most physicians have received little training in how to manage all aspects of chronic, nonmalignant pain that affects some patients, particularly the psychological sequelae. Therefore, many physicians feel overwhelmed, frustrated, and/or powerless when dealing with patients from this difficult population.

Since my pain started, everything has been different. My wife and kids don’t understand me, and I had to quit working. Doc, I had my life all planned out, but now, because of my pain, I have no idea of where I’m headed.

Pain affects all aspects of the individual: physical, cognitive, emotional, social, occupational, sexual, and spiritual. The patient in pain often experiences a significant decrease in perceived control over one’s life and circumstances. In fact, patients may experience a phenomenon, which might be termed “reality vertigo,” that includes intense perceptual shifts and emotional turmoil following the realization that one will likely have to live with pain for an indeterminate period of time. During this turbulent period, it appears that the individual’s entire world view, as well as his or her plans and hopes for the future, are suddenly thrown into question. Depression, anxiety, and somatizing of emotional distress may be strongly related to this overall belief that one has completely lost control over his/her life as the result of his/her pain.

Recognizing Comorbid Psychopathology in Patients With Chronic Pain

You HAVE to do something about my pain—no one else has been able to help me.

One of the most difficult patients seen in the medical setting is the patient with chronic pain. If this patient also has a myriad of psychological symptoms, it is
even more vexing for most physicians. Unfortunately, it appears that a large percentage of patients with chronic pain fit into this category. Psychopathology affects between 30% and 50% of patients seen in academic and community pain centers, with depression, anxiety, personality disorders, and substance abuse being the primary diagnoses. Further, it appears that psychological distress is a consequence, rather than an antecedent, of pain in most cases. A comorbid psychiatric diagnosis appears to be associated with significant functional limitations, a negative change in pain threshold and tolerance, and greater sensitivity to acute pain stimuli. Patients with chronic pain frequently have feelings of loneliness, worthlessness, and fear of abandonment, and may additionally experience a strong sense of shame and guilt, especially if the patient is in a parent role.

This is all hopeless . . . I know that I’ll have to live with this pain for the rest of my life so why even bother? I’m so tired, but I can’t even get to sleep. I keep thinking about the future and also about all the things in the past that I should have done differently . . . I wish I could just go to sleep and never wake up . . .

Office-based teachers should help residents and students learn to recognize depression and anxiety in patients presenting with chronic pain. Patients with pain who present with fatigue and sleep disturbance, low mood, increased worry, and irritability should be screened further for mood and/or anxiety disorders. Depression and anxiety may also manifest as “lashing out” by the patient toward the physician, poor motivation to remain active in one’s treatment plan, or in perceived intensification of pain in the absence of changes in pain pathology. The Beck Depression Inventory and the Beck Anxiety Inventory are two brief (21 items each) questionnaires that may be useful to the physician for assessing depression and anxiety, respectively, in this patient population. Certain “red flags” evident in the patient’s spoken words are also cues for the physician to perform a more thorough assessment of depression and anxiety. These red flags include negative statements focused on the future: “What if I never get better?” or on the past: “I never should have driven to work that day; now I can’t do anything anymore.” Cognitive-behavioral theory posits that “We feel what we think.” Patients who are exhibiting this kind of negative thinking may meet criteria for a mood and/or anxiety disorder.

Preceptors should also help learners understand the need to assess for other symptoms of underlying psychopathology most commonly seen in pain patients, such as personality disorders. Patients who have a longstanding history of impaired interpersonal relationships and who exhibit patterns of inconsistent, exaggerated behaviors (ie, alternating between anger toward, and idealization of, their doctor or overly dramatic, grandiose, irritable, or dependent behaviors) may have a diagnosis of a personality disorder and should be referred to a psychiatrist for further evaluation.

It is important to note that the presence of comorbid personality disorders with depression has been linked to suicide, and suicidal ideation and attempts are common among patients with chronic pain overall. It is extremely important to direct learners to ask patients in pain about suicide since not addressing suicidality in this population is “clinically unfeasible and ethically inappropriate.” Learners should also be encouraged to carefully document all obtained information, both objective and subjective, in the patient’s medical record.

Finally, clinical teachers should make the effort to help learners suspect substance abuse if the patient exhibits a strong focus on opioid issues in combination with problematic behaviors, such as early refills, lost prescriptions, and illicit substance use. The CAGE questionnaire (alcohol) or the SOAPP inventory (narcotics) are useful for identifying patients with chronic pain who may have substance use disorders. A narcotic contract is also highly recommended for patients who are on opioid medications.

Research indicates that untreated or undertreated psychopathology is the single most important factor in poor pain-treatment outcomes, regardless of the treatment modality. Hence, a psychiatric evaluation, and referral to a psychologist or other mental health professional for ongoing counseling, is strongly recommended for patients with pain and comorbid psychiatric illness. In sum, screening and adequately treating patients with pain for underlying psychopathology can improve outcomes and thus aid in assisting both the patient and the physician in feeling more in control.

Nonpharmacologic Treatment Strategies for the Physician and Learner

When my pain started, I felt as if I had completely lost control over my life. Now, for the first time, I am beginning to believe that there may be hope.

When patients begin to feel that they are controlling their pain, rather than their pain is controlling them, their mental and emotional health improves. The dizzying downward spiral of reality vertigo, as discussed earlier, appears to level off, and the patient begins to regain balance and see “light at the end of the tunnel.” Office-based teachers and learners have an opportunity
to act as catalysts for this change by acting in an empathic manner toward the patient with pain, helping the patient to feel heard and understood, involving the patient in her/his treatment plan, and seeing the patient for regularly scheduled visits. Past research indicates that patients with pain rate “listening” and “being believed” as the most important qualities in their physician, regardless of whether or not the doctor can actually help them with their pain. However, for the learner, this may be easier said than done. The challenge for the physician or learner is to develop an empathic, caring style with a patient who may seem “hateful” in some respects. Some communication strategies for increasing empathy include asking questions such as, “Is there anything else?” and “Let me see if I understood you correctly.” In addition, validating the patient’s experience with a statement such as, “It must be very difficult to live with pain, and I know it affects all areas of your life” may be useful in helping the patient feel understood. The learner may also be encouraged to explore the underlying reasons for the patient’s behavior, such as fear, loneliness, and poor self-worth, as well as the possibility of a traumatic life history and/or past abuse. By changing one’s perspective, the learner may become better able to feel empathy, instead of frustration or anxiety, about their difficult patients with chronic pain.

Preceptors must also help students and residents understand the relationship between thoughts, feelings, and pain perceptions. Cognitive behavioral strategies, such as reframing negative self talk and diaphragmatic breathing, have been proven to be beneficial in helping the patient with pain regain a sense of perceived control. The learner may assist the patient with pain by encouraging him/her to become more aware of how thoughts create feelings and by teaching the patient that distressful emotions such as depression and anxiety exacerbate perceptions of pain. The physician or learner may ask the patient, “What can you tell yourself to make you feel less (sad, scared, angry)?” and then give the patient “homework” to practice reframing, or replacing, negative thoughts with more-balanced, hopeful cognitions. In addition, to assist in increasing feelings of well-being, the physician or learner can teach the patient to breathe deeply from his/her lower diaphragm rather than from the upper thorax. The patient is directed to place one hand on the chest and another on the stomach. The physician or learner then encourages the patient to focus on “moving” their lower hand, by breathing in deeply.

Summary
Caring for patients with chronic pain is often challenging, even for experienced clinicians. In encounters with patients with chronic pain, office-based teachers have an opportunity to teach learners to recognize comorbid conditions that must be addressed to best help the patient. During these encounters, office-based teachers can also demonstrate patient-centered care, empathic responding, and useful cognitive-behavioral strategies, such as reframing negative thoughts and enhancing one’s well-being through diaphragmatic breathing. Learning to care for patients with chronic pain cannot be adequately learned through textbooks, and when the office-based teacher takes the time to teach and demonstrate how to care for these patients, it can be extremely useful for learners.

Finally, it is of utmost importance that physicians and learners are supported and encouraged to practice their own “self care” to avoid becoming “burned out” from caring for such a difficult patient population. Engaging in pleasurable activities outside of medicine, getting adequate sleep and time alone, as well as time spent with loved ones, and discussing feelings of frustration about patients with trusted colleagues are a few of the strategies suggested. By putting oneself first, physicians and learners are better able to care for their patients and to help them move from the chaos and turmoil of reality vertigo toward regaining balance, perceived control, and hope.

Correspondence: Address correspondence to Dr Pommarum St Vincent’s Medical Center, Family Medicine Residency Program, 2527 Riverside Avenue, Jacksonville, FL 32204. 904-308-8482. Fax: 904-308-2998. pommarum01@stvincentshshealth.com.

REFERENCES