Although acute pain typically resolves on its own with little need for intervention, for some persons pain persists past the point where it is considered an adaptive reaction to injury. Pain that persists for longer than 3 months, that accompanies a disease process, or that is associated with a bodily injury that has not resolved over time may be referred to as chronic pain.\(^1\)

Pain affects nearly 100 million people and is one of the most common complaints made to primary care physicians (PCPs) by their patients.\(^2,3\) More than 20% of all medical visits and 10% of all drug sales are pain-related.\(^4\) Overall, the total direct and indirect costs of chronic pain in the United States are estimated to be between $150 billion and $260 billion annually.\(^2\)

There are a number of provider and patient factors that contribute to the challenge of effectively managing pain in the primary care setting. These factors include appointment time limitations, a relative lack of clinician education and expertise in managing pain, and the extensive use of medical diagnostic tests and interventions that contribute to patients’ belief that a medical cure for their pain exists. These types of beliefs can make it less likely that patients will take steps to manage pain on their own, and they may cause patients to feel more dependent on their PCP for pain relief. When a patient’s expectations for a cure are not met, anger, frustration, and depression often follow. These obstacles represent real challenges in managing this complex medical condition.

Individuals with chronic pain often report that pain interferes with their ability to engage in occupational, social, romantic, or recreational activities, which is consistent with a biopsychosocial model of illness. Their inability to engage in these reinforcing activities may contribute to increased isolation, feelings of worthlessness, and depressed mood. In fact, research indicates that approximately 27% of patients with pain in primary care clinics meet criteria for major depression.\(^5\)

In addition, conditions such as anxiety, substance abuse, and personality disorders occur at a greater rate in individuals who have a chronic pain condition than in individuals who do not. Realizing that patients with chronic pain may be experiencing a variety of psychosocial issues that are maintaining and exacerbating the experience of pain, PCPs are making greater use of mental health services in order to address these issues and improve patient outcomes.

A variety of disciplines have increasingly become involved in pain management, yet psychiatrists...
Psychiatrists who have received specialized training in pain play a key role in the care of patients with chronic pain. The purpose of this article is to describe and illustrate how psychiatrists can integrate and coordinate pain management efforts with PCPs.

**Working collaboratively with primary care**

Psychiatrists who are interested in collaborating with PCPs may consider several strategies to maximize the productivity of the relationship. An important first step is to ask all patients to sign a release of information consent form that permits active communication and coordination of care among the various health care providers involved in their treatment. In the mental health and organizational literatures, the terms “integration” and “coordination” are frequently used inconsistently and interchangeably.

There are 2 concepts implied by the term “integration.” The first concept is structural integration, which refers to the manner in which physical space has been allocated within primary care offices; this facilitates collaboration, purposefully or not, between mental health and primary care. This can vary considerably, with some psychiatry offices located within primary care space (complete structural integration) and others located on a separate floor or in a separate building from primary care (no structural integration). Space limitations for complete structural integration may be overcome by having the mental health clinician attend primary care meetings, by case presentations, and by other efforts to promote the accessibility of psychiatry. Although structural integration is desirable, it may be more important for providers to coordinate and communicate with one another effectively.

The second concept is coordination, which refers to standardized approaches that are used to assign activities and responsibilities in advance of the performance of services, to specify the types of services being provided and the skills required to perform the services, and to facilitate the transfer of information from one person to another. Coordination can be increased by changing management structures and staff resource funding pathways; however, these strategies are often challenging to implement, especially in the private sector. Fortunately, coordination may also be enhanced by establishing regular and timely communications with PCPs (ie, face-to-face discussion about patients), soliciting the PCP’s opinion regarding the specific needs of patients, inviting PCPs to participate in the planning and execution of treatment, and clearly showing patients the value of mental health care.

Many studies support the benefits of increased integration and/or coordination between mental health and primary care. Integration/coordination of mental health and primary care enhances patient and provider satisfaction, improves patient outcomes, and decreases health care costs. It also increases adherence to medications and decreases medical utilization among “high utilizers.” Mental health interventions delivered in primary care are also likely to have crosscutting medical beneficial effects on unhealthy behaviors and health-related issues, such as smoking, high cholesterol levels, alcohol use, and obesity. Thus, integration and coordination of services between psychiatry and primary care offers an opportunity to identify and intervene with many problems before they develop into significant pathology.

**CHECKPOINTS**

- Coordination between psychiatrists and primary care physicians may be enhanced by establishing regular and timely communications, soliciting the primary care physician’s (PCP) opinion regarding the specific needs of patients, inviting PCPs to participate in the planning and execution of treatment, and clearly showing patients the value of mental health care.

- Using the stepped-care approach, the level of care is guided by a patient’s response to treatment and his or her readiness to engage in self-care.

- Cognitive-behavioral therapy is an effective psychological treatment for chronic pain that is aimed at changing maladaptive thoughts and behaviors that serve to maintain and exacerbate the experience of pain.

**Developing a stepped-care approach**

Given the number of patients who have chronic pain, psychiatrists should consider the most efficient and effective way to provide services. One model of care that has been used for pain management is...
called stepped care. Using this approach, the level of care is guided by a patient’s response to treatment and his or her readiness to engage in self-care. This approach has been successfully implemented for a variety of medical conditions and health behaviors, including alcohol and cigarette use and reducing cholesterol levels.

Three basic steps are involved in this model.

- **Step 1** is appropriate for all patients seeking treatment for pain. The psychiatrist teaches the PCP how to identify and address specific patient concerns about pain and how to enhance patient readiness for self-care. For example, a common patient fear is that exertion, exercise, or sexual activity will result in further injury. This fear can be addressed by explaining the benefits of remaining active and by creating a plan for gradually returning to a safe level of activity. Psychiatrists can teach PCPs to use motivational interviewing to address a patient’s unrealistic expectations of a cure for pain, reinforce the use of self-care strategies, and develop a plan for managing pain flare-ups.

- **Step 2** is appropriate for patients who continue to experience pain and disability several weeks after the initial primary care visit. These patients require a more active approach to pain management that may include identifying the specific difficulties they are experiencing (eg, pain when lifting heavy objects), developing and implementing an individually tailored treatment plan, and providing support and follow-up. Following a brief evaluation, the psychiatrist determines whether the patient’s goals are likely to be best achieved through brief individual or group therapy, medication, or a more comprehensive program.

- **Step 3** is appropriate for patients who continue to experience a significant level of disability and distress despite the efforts of the PCP or the availability of brief therapy or psychoeducational programs. Patients may present with complex medical and social histories, and they are often seen as “challenging” and hard to manage within the limitations of the primary care setting. For these patients, more extensive involvement of the psychiatrist and other members of the pain management team may be indicated.

**Organizing a pain management team**

One way that psychiatrists can facilitate care related to pain is to organize a group of providers with specific expertise in pain management and rehabilitation into a multidisciplinary pain management team. Multidisciplinary pain programs consist of a group of providers with specific expertise in pain management and rehabilitation. The goal of the team is to provide a comprehensive pain assessment and deliver an integrated and coordinated plan for treatment that emphasizes medical, psychological, and rehabilitation approaches as needed. This type of approach is appropriate for patients with chronic pain that has been unresponsive to less intensive interventions.

**Evidence-based treatments for pain**

One of the most effective psychological approaches for pain management is based on a cognitive-behavioral therapy (CBT) approach. CBT is an effective psychological treatment for chronic pain that is aimed at changing maladaptive thoughts and behaviors that serve to maintain and exacerbate the experience of pain.

Key components of CBT for chronic pain include cognitive restructuring (ie, teaching patients how to change maladaptive thoughts); relaxation training (eg, diaphragmatic breathing, imagery); time-based activity pacing (ie, teaching patients how to be more active without overdoing it); and graded homework assignments designed to decrease patients’ avoidance of activity and to reintroduce a healthy, more active lifestyle. CBT also focuses on promoting patients’ increased activity and functioning using techniques such as exercise homework, activity scheduling, and graded task assignments. A substantial literature exists documenting the efficacy of CBT for chronic pain conditions.

While pain is the most common presenting somatic symptom in medical outpatients, depression is the most common mental disorder in patients who present to primary care, and it is found in 10% to 15% of all of these patients. Kroenke and colleagues recently conducted a randomized controlled trial of a Stepped Care for Affective Disorders and Musculoskeletal Pain (SCAMP) protocol that combined pharmacological and self-management interventions for patients with comorbid depression and chronic pain.

Their findings indicate that participants who received the treatment demonstrated substantial improvements in depression and moderate reductions in pain severity and disability when compared with usual-care participants. These data further support the contribution psychiatrists can make to the management of pain in the primary care setting.

**Group or individual treatment modalities**

CBT for pain can be facilitated in individual and group formats; both have potential benefits and
challenges that need to be considered. While individual therapy may be requested by patients, there are several advantages to group treatment.

First, group treatment allows the therapist to provide services to several participants at the same time. Second, group treatment provides an opportunity for participants to learn from other group members who have had to overcome hurdles in coping with pain. Third, attending group therapy may enable patients to see that they are not alone in dealing with the distress and disability that often accompany pain. Furthermore, a group format allows participants to gain valuable social support.

On the other hand, there are times when individual therapy is the treatment approach of choice. Individual therapy provides greater opportunity for patient-specific problem solving and goal setting. For example, in an individual format, a psychiatrist can spend more time addressing the issues most relevant to a patient. There is more flexibility in timing of sessions when providing individual therapy, because sessions can be scheduled to meet the needs of one person rather than a group. In addition, some patients may report feeling uncomfortable sharing information with a group.

Addressing PCP concerns and questions

Psychiatrists are often consulted when PCPs become frustrated with their chronic pain patient’s poor response to medical interventions. These patients may be given labels such as malingerer, nonadherent, or a challenge. Psychiatrists who have training in the biopsychosocial approach to treating illness are well suited to investigate and determine the relative influences of these domains of functioning on the experience of pain.

Psychiatrists may also be asked to assist PCPs in differentiating patients with somatogenic pain from those with psychogenic pain. Examples of psychogenic pain include several of the somatoform disorders, such as somatization disorder, hypochondriasis, and pain disorder. The pain in these disorders is real and not consciously produced by the patient, although the pain origins are psychological.

In addition to the somatoform disorders, there are medically unexplained illnesses that lack consistent pathognomonic findings, such as fibromyalgia and chronic fatigue syndrome. These disorders are accepted by some PCPs as legitimate medical conditions, but they can be viewed with suspicion by other PCPs who see these conditions as primarily psychological in origin. Finally, there are the rare but potentially confounding conditions of factitious disorder and malingering. In these disorders, as opposed to previously mentioned disorders, patients consciously produce the pain symptoms themselves or in children (by proxy) for attention or other secondary gain.

Addressing patient concerns

Patients are often referred to a mental health provider after they have failed to benefit from more conservative approaches for pain management. The psychiatrist needs to consider 3 things:

• The etiology of the pain may not have been correctly diagnosed
• The context of pain in the patient’s culture
• The patient’s risk of suicide

Diagnosing the etiology of pain can be challenging, especially in atypical presentations of rarer diseases, such as multiple sclerosis. Psychiatrists must remain vigilant while treating their patients for the delayed emergence of a diagnosable and possibly treatable medical disease.

It is also important to understand patients within the context of their own culture. For example, is it more acceptable for the patient to report physical pain than emotional pain to his family and friends? Many cultures view depression and anxiety as signs of personal weakness or serious mental illness, while they view the suffering from a medical illness with more compassion. If, in fact, the patient has major depression or anxiety, then the mental health provider should treat the illness and educate the patient and his family about how real the suffering and pain is to the individual who has either of these conditions.

Remaining mindful of the depth of despair a patient with chronic pain may experience will lead to routine assessment of patients for suicidal ideation. While chronic pain itself is not a risk factor for suicide, it may exacerbate other known risk factors for suicide, such as major depression, substance abuse, and feelings of hopelessness.17

Ensuring that patients are not medication seeking

When performing an initial assessment, ask patients to list all their medications, including pain, anxiety, and sleep medications; indicate where the medications were prescribed; describe how they are using each pain medication; and give information about the use of other substances to manage pain.

When a patient reports a deviation from the prescribed plan for the use of medication (eg, selling or trading medication, taking all at one time, hoarding medication), advise him of the risks of harm and
discuss the options, particularly the option that he inform his PCP. If a release of confidential information agreement was signed by the patient before that psychological assessment—a step that is highly recommended—then this information can be shared with the PCP and other members of the pain management team. In the Veterans Affairs health care system, the psychiatrist should advise the patient that the information will become part of the electronic medical record and that the PCP will be notified. This is done so that PCPs can clarify instructions for optimal pain relief and consider whether to alter the prescription. Often, when patients reveal this type of information, they are sending a message to the psychiatrist that they need help.

While some patients will admit to mental health providers when they have used substances to manage their pain, others will not and may be seeking pain medication for diversion or other inappropriate uses. Warning signs include reports that only 1 particular opiate medication will reduce the pain, requests for assistance to obtain pain medication, reports of lost or stolen medications, and frequent visits to the emergency room. Assessment measures have been developed to help the clinicians identify patients who are at high risk for abusing medications. Collecting treatment outcome data. Pretreatment, posttreatment, and follow-up data can help pain patients recognize the changes they have made over the course of treatment. The data help evaluate the effectiveness of treatment, and demonstrate to PCPs the benefits of services provided. There are a number of brief and standardized self-report pain questionnaires that are commonly used that assess domains such as pain intensity, mood, interference due to pain, and coping (Table).

Summary

Chronic pain can have a significant impact on how individuals think and feel about themselves and the world in which they live. In turn, a person’s mood, personality characteristics, and social environment can influence his overall experience of pain. Given the high prevalence of chronic pain in the primary care setting and the known psychological influences on patients’ perception of pain, there is a growing demand for psychiatrists with specialized training in pain management to assist PCPs in the care of patients with chronic pain.

Psychiatrists with an interest in working with persons who have chronic pain conditions should consider ways of integrating and coordinating services within the primary care setting, delivering services in an effective manner, and providing services as part of a pain management team. Psychiatrists with expertise in conducting comprehensive pain assessments and delivering evidence-based interventions for pain have an opportunity to make a unique and significant contribution to improving the quality of life for patients with pain.

References:


Links:
[1] [http://www.psychiatrictimes.com/special-reports](http://www.psychiatrictimes.com/special-reports)
[7] [http://www.psychiatrictimes.com/authors/john-d-otis-phd](http://www.psychiatrictimes.com/authors/john-d-otis-phd)
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