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Conversation with the Experts

Toward Optimal Health: Dawn A. Marcus, M.D., Discusses Comanagement of Depression and Chronic Pain in Women

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A HOST OF BIOPSYCHOSOCIAL FACTORS affect the confluence of chronic pain and depression, challenging the medical management of these concomitant conditions. It is well documented and clinically appreciated that chronic pain can trigger depressive symptoms and that depression manifests as both physical and emotional pain. An estimated 60% of individuals who suffer from a chronic pain condition will experience some level of depression or anxiety.[1] Despite the high prevalence of comorbidity, depression is consistently underdiagnosed and inadequately treated in women who have concomitant chronic pain. Similarly, chronic pain is too often disregarded as an overreaction and left to resolve on its own, leaving the individual to sufferer in silence or to look elsewhere for pain relief.

Mounting evidence supports the differences in the way pain, anxiety, and depression are experienced by women compared with men.[2] Researchers from the Pain Management Unit at the Royal National Hospital for Rheumatic Diseases in the U.K. report that anxiety and depression proved significant positive predictors of pain, and that although sex did not predict disability, it modulated the relationship between depression and disability such that when depression was high, women reported greater disability than men.[2] Their results suggest the need to consider the sex of the patient in clinical practice, given the differing experiences in depression and disability among women and men with chronic pain.

As women age, it is anticipated that both depression and chronic pain will increasingly challenge practitioners, necessitating a heightened awareness of the dynamic relationship between these two common conditions. More importantly, clinicians will want to consider instituting practices that address the simultaneous demands of caring for a person who is experiencing both depression and chronic pain. Dawn A. Marcus, M.D., responds to the complex clinical challenges involved in identifying and managing the woman who suffers from chronic pain and depression.

Do depression and chronic pain conditions arise concurrently more often in women than in men? Are there some sex-specific conditions, such as chronic fatigue syndrome (CFS), polycystic ovarian syndrome (PCOS), fibromyalgia, and arthritis, that make women more prone to depression?

Among women with chronic pain, there is a higher prevalence of depression and anxiety. Furthermore, there is a reciprocal relationship between pain and depression, which becomes more pronounced as women age. Anyone who develops chronic pain may then develop depression. Conversely, women with a prior diagnosis of depression are more likely to experience persistent pain that will be more disabling following an episode of acute pain and are at greater risk for developing new pain problems. The presence of depression in and of itself tends to raise the risk of having an acute pain episode devolve into chronic pain and to become more recalcitrant to therapy. These two conditions work in a negatively synergic manner, in that the depression reinforces the chronic pain and the pain promotes depressive symptoms.

Depression is quite widespread among women who have a chronic pain condition regardless of the type of condition. The prevalence of depression may not be as high in the primary care setting (vs. a pain center, for instance), but it is more likely than in the general population. The concurrence of depression and chronic pain warrants a more concerted effort to screen and treat women who experience these comorbidities; however, there are obstacles to achieving these goals that must be recognized. It is not unusual for the woman to avoid any discussion about depression or to acknowledge depressive symptoms out of concern that her pain will not be taken seriously. Among clinicians, there needs to be a greater recognition of the multidimensional challenges faced by women who experience chronic pain and depression. For example, chronic pain rarely occurs as a single condition; more often, it manifests as a constellation of pain symptoms, each requiring medical attention. In addition to depression, there is a strong likelihood that these women will experience additional comorbidities, such as sleep dysfunction, fatigue, and obesity.

Pain severity and persistence are commonly used measures for depression. What parameters offer the best predictors of depression?

The number of pain complaints provides a good predictor for depression and is a better indicator than pain severity or persistence.[3] When compared with women who have one pain complaint, individuals with multiple conditions have an increased prevalence of psychiatric disorders.[1] In effect, it is best to consider pain severity, persistence, and the number of pain complaints in evaluating the individual and developing a therapeutic plan. Every woman with a pain complaint fairs best when screened for psychological distress as part of the standard medical evaluation. Although they may or may not recognize their own depression, it is fairly common for these women to strongly deny any suggestion of a psychological component. Practitioners might anticipate that the women who are most resistant to screening for depression are more likely to have a positive assessment; the avoidance may be a reaction to the fear of being labeled as depressed or supplanting attention from the pain such that the pain condition is no longer taken seriously.

An across the board assessment that incorporates a psychiatric screen essentially removes any stigma or perception that the individual is being viewed differently or not being taken seriously. Assessment of psychological status in women with chronic pain can be achieved through interviews and self-report surveys. Good dual-screening tools include the Beck Depression Inventory (BDI) and the quality of life measures from the Medical Outcomes Survey short form (SF-36).[4,5] Another route is to use the newer Pain Patient Profile (P3), an assessment that provides an objective link between clinical observations and the need for a more through psychological evaluation.[6]

Because depression can only be managed once diagnosed, the precise screening tool is of less consequence than accomplishing the evaluation. The most efficient tools for assessing depression in the primary care setting, where time is precious, may be web-based resources, such as can be accessed at *mcrcr4.med.nyu.edu/psych/screens/index.html* and *www.stanford.edu/group/bipolar.clinic/what_is/primemd.htm*.[1] By instructing patients to complete the assessment prior to the appointment, the clinician's time can be spent focusing on the results and planning an appropriate therapeutic strategy rather than on the delimiting screening process. In addition, the questionnaire can be used in subsequent visits to evaluate treatment efficacy.

Individuals who have been diagnosed with diabetes or hypertension have a greater chance of receiving appropriate depression care than those with heart disease or arthritis.

How do you suggest that clinicians approach the management of depression and chronic pain to improve patients' treatment outcome?

The difficulty stems from a healthcare environment in which patients switch primary care doctors because of changes in insurance, and there is no objective test to validate the pain complaint from a patient who has no established relationship, creating a credibility gap that is further compounded by the knowledge that there may be a psychological component. It sets up a dismissive scenario supported by the data that most adults will be troubled by pain at some point in their lives. Thus, tension may arise between physician and patient based on the level of understanding and acceptance of the pain as presented by the patient and responded to by the clinician. A common feeling persists among general practitioners that most pain can be accepted.

Clinicians would do a great service to their patients to recognize that should depression be present, it is likely that the psychological problems are induced by the chemical changes resulting from a chronic pain condition. Fibromyalgia is a condition that highlights this relationship beautifully, as these patients appear as outwardly healthy and have an unremarkable physical examination other than looking for tender points They move up and down the hall, bend over, and appear very cooperative and well-spoken, yet they are more likely to have greater disability than women with only rheumatoid arthritis.[7] Too often, clinicians will discount how severely affected by pain a patient may be if she appears highly functioning in the office. This patient's complaints may be attributed to depression rather than an organic physiological condition. When the pain is not properly diagnosed, the pain does not improve, and the patient remains depressed and undermanaged.

On another note, excess body weight aggravates most chronic pain conditions and can have an adverse impact on mood. Therefore, it behooves clinicians to encourage women to adopt a healthy eating pattern and to establish a regular physical activity program, such as walking, to help manage body weight and improve both pain and mood.

Given the likelihood of multiple comorbidities in women with a chronic pain complaint, what should the management approach be in order to formulate an effective therapeutic plan that factors in depression?

Often, when women with mild depression get their pain under control, the depression may resolve on its own. Conversely, in individuals whose depression is severe, there generally is little improvement in their pain or depression if initial treatment focuses on pain management. For the vast majority who fall somewhere in between, the best course of action is treatment that addresses both the pain and depression simultaneously.

Individuals with both chronic pain and depression require extensive, even exhaustive, care, particularly in the initial assessment and management phases. Treatment plans should address not only symptoms of pain but also psychosocial issues, musculoskeletal dysfunction, and disability. Dividing care among several practitioners can improve efficacy and staff burnout. The establishment of a comprehensive treatment regimen that includes appropriate education, reassurance, and behavior modification techniques improves clinical outcomes and patient satisfaction.[1] As pain lessens, an improvement in depressive symptoms results.[3]

A professional barrier to delivering effective treatment has been attributed to a lack of understanding about the complexity of the mechanisms of action of both drugs and diseases in the brain, according to Stephen M. Stahl, M.D., professor of psychiatry at the University of California, San Diego (UCSD) School of Medicine. Gaining a basis in the neurosciences and psychopharmacology of psychiatry provides practitioners with an understanding of the mechanisms of actions rather than just the dose and side effects, enhancing the ability to prescribe drug therapies rationally.

Similarly, individuals who have a chronic pain condition and receive education that emphasizes self-management techniques as part of their treatment report less pain and disability than those who receive only standard treatment limited to prescription medication.[1] Handouts, commercially prepared pamphlets, websites, and discussions with a member of the pain management team promote maximum dissemination of information and an efficient sharing of responsibility for improved results. In older adults, a new approach to managing depression is based on the Improving Mood-Promoting Access to Collabo-

rative Treatment (IMPACT), a collaborative care model that relied on a depression care manager, supervised by a psychiatrist and a primary care expert, to provide education, monitoring, and support in addition to antidepressant therapy or brief psychotherapy (problem-solving treatment in primary care). The impact method was equally effective for depressed older adults with or without comorbid medical illnesses and appears to be feasible and significantly more effective than usual care of depression in primary care.[8]

Analgesics, antidepressants, and oral opioids are commonly prescribed to manage pain and depression. Which of these are right for women who are suffering with concomitant depression and chronic pain? Should neuropathic pain be treated differently from other types of pain?

Given that other morbidities, such as sleep disturbances, are likely to coexist, the best therapeutic approach will be selection of an antidepressant, such as the tricyclics (TCAs), rather than the newer antidepressants, which can alleviate pain and improve both mood and sleep problems. However, the downside is that the TCAs have more side effects, including sedation. This can be made to work to the patient's advantage when sleep disturbance is a primary complaint. Here, it is very important that the clinician take time to explain that the antidepressant medication is intended to provide pain relief as well as promote sleep in addition to its benefit in reducing depressive symptoms. By providing a context for the antidepressant, the clinician likely will be acknowledging many of the patient's fears and concerns, both spoken and internalized, thereby improving acceptance of the treatment as intended for the pain as much as for the other symptoms. Similarly, neuropathic pain with attendant comorbidities, such as depression and sleep dysfunction, responds well with select antidepressants, such as duloxetine (Cymbalta, Eli Lilly, Indianapolis, IN) or novel anticonvulsants.[9,10] Duloxetine is deemed an effective treatment for many of the symptoms associated with fibromyalgia with or without major depressive disorder, particularly in women.[11]

Above all, management strategies should be designed to treat the whole patient, not just the pain. Theoretically, therapies that not only reduce pain but also improve sleep and reduce anxiety and depression, can provide multiple benefits without the risk of increased side effects inherent in combination therapy.

In prescribing opioids—potentially addictive medications—practitioners should consider patients' personal and family histories of addiction, as well as the psychological and social stressors that may affect medication use.[12] Some patients may find that they are relying on their medication for its psychic brain effects. Therefore, it is important to be aware of this potential adverse effect and to educate patients and their families about appropriate use of addictive drugs. To better guide practitioners, the Federation of State Medical Boards has developed and updated guidelines for the use of controlled substances for pain treatment.

[**Editor's note:** The guidelines can be accessed at *www.fsmb.org/pdf/2004_grpol_Controlled_Substances.pdf*]

Other than or in addition to medications, will cognitive behavioral therapy or physical activity benefit women with these comorbid conditions? What is an advisable approach to monitoring patient progress?

In some cases, women will need to work with a therapist, a social worker, or a nurse practitioner—anyone who has had some training in stress management—so that the issues and hot buttons that may exacerbate symptoms can be anticipated and better managed. This can result in improved responsiveness to the therapeutic regimen. The one exception is profound depression, which negates the value of ancillary or adjunctive therapies because the patient is not capable of learning or motivated to learn new behaviors; here, the focus of therapy should be to improve depressive symptoms. Once the depression is controlled, the clinician can implement a more holistic approach. In other words, look at lifestyle behaviors, such as diet, physical activity, and sleep patterns. By addressing these factors, patients' lives become more structured and normalized, which goes a long way in helping the medications work better and achieving an improvement in quality of life measures.

Individuals who suffer from both chronic pain and depression may benefit from regular physical activity, which has been shown to improve mood and promote sleep as well as lessen pain associated with some conditions. Of note, it is

common for patients to consider physical rehabilitation as physical activity, which needs clarifying so patients appreciate the distinction and value of both of these necessary interventions. Although the efficacy of cognitive behavioral therapy is proven in patients with clinical depression and for chronic pain, its effectiveness in pain-associated depression has not been confirmed by published research.

Another useful application is the use of a diary—not limited to itemizing pain episodes but a more comprehensive logging of the amount and types of physical activity, relaxation techniques, sleep, diet, mood, and pain episodes experienced. This information lends itself both as a self-care tool, in which the patient can identify problem patterns and correct for unwanted behaviors, and as a useful dataset for the clinician to assess the effectiveness of the therapeutic plan, offer praise, and provide targeted counseling in areas that need adjustment. In most cases, women will benefit from 1–2-weekly follow-up sessions so the diary can be checked, symptoms can be monitored, and progress can be assured. This can be accomplished by a member of the office healthcare team, and the clinician need only be called in should a medical concern arise. The accountability created by requiring a return visit can be a strong motivator to keep patients on track until the management plan becomes routine and the medication is working effectively.

Case management seems to be a promising interventional route, offering the potential to bridge the gap in the usually time-limited and fragmented provision of care based on results of the Primary care Monitoring for depressive Patient's Trial (PRoMPT).[8,13]

In summary, practitioners are encouraged to consider the full range of therapeutic options in addressing the individual needs of patients who have concomitant depression and chronic pain, and this is best achieved with the support of a multidisciplinary healthcare team.

How might primary care practitioners approach the concern of women who may have medically unexplained, or psychogenic, pain?

It will be rare for a woman to have complaints of chronic pain that are not valid. For too long, women suffered with significant pain from such chronic conditions as chronic fatigue, fibromyalgia, and intersitial cystitis, which took years to gain acceptance within the medical community. When a woman has a chief complaint of pain that has no readily apparent medical cause, it behooves the clinician to remain open-minded and to be sensitive to the likelihood that she is experiencing some degree of depression or anxiety, given years of unrelieved pain. In this instance, when relying on the *Diagnostic and Statistical Manual of Mental Disorder*, 4th ed. (DSM-IV), somatoform disorders to make a proper diagnosis, for keeping in mind that a 2-fold-higher risk for persistent pain over time has been found in women.[14] In general, there are two types of patients in whom pain can be diversion: a patient with a true conversion disorder in whom complaints easily contradict the physical capability, making it clear that there is a psychiatric disorder, and a patient who is not forthcoming with answers to routine screening questions or cooperative with physical examinations (malingering).[15,16] The motivation for these patients is to get attention, unlike patients with a legitimate physiological abnormality and accompanying urgency to have their pain problem addressed. The prognosis for persistent pain is relatively good.

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RESOURCES

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