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Patient's Perspective on Management of Chronic Pain Associated With Frequent Emergency Attendances and Psychiatric Diagnoses

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Abstract

This case presents a patient's perspective of clinical care and management of chronic pain with a psychiatric component, the latter of which was not initially apparent to both patient and services. It aims to understand patient's experience of illness (part A), its effects on patient's family (part B), experience of care from liaison psychiatry (part C), service provision for persons with chronic pain and its often-neglected mental health aspect (part D), and patient's hopes for the future (part E). Early involvement of liaison psychiatry may target the interaction between physical and psychological factors and provide appropriate interventions across the health-care system.

Keywords

pain management, patient/relationship-centered skills, clinician–patient relationship, communication, emergency medicine, patient perspectives/narratives, relationships in health care, patient satisfaction

Introduction

Chronic pain is associated with significant clinical, social, and economic impact. It is evident that common pain conditions give rise to loss of productivity. The estimated annual cost of loss of productivity in the United States due to common pain conditions is US$61 billion (£32.34 billion) (1). The majority of this is due to reduced performance, but absenteeism from work is also important. Similarly, chronic pain causes people to leave the labor market, resulting in long-term morbidity. A Danish study concluded that chronic pain leads to a 7-fold increase in the odds of leaving regular employment (2). For many patients, pain can become a profound feature in their lives, resulting in fatigue, sleep disturbance, impaired social function, and a reduction in physical and cognitive functioning (3). It is difficult to quantify the suffering and deleterious effects on quality of life as a result of chronic pain, but these figures demonstrate the enormity of the issue.

Patients suffering from chronic pain have widespread needs. As well as experiencing the physical discomfort, they also must contend with other stressors that can impinge on their lives (4). Chronic pain services should therefore take a holistic approach. Such a multidisciplinary service should involve liaison between rehabilitation, physiotherapy, neurology, surgery, and psychiatry, together with clinical psychology. Furthermore, it must be realized that the health-care needs for chronic pain patients extend from the hospital to the community (ranging from over-the-counter medications to prescription medications as well as more specialized interventions).

Liaison (or consultation-liaison) psychiatry delivers mental health care to patients attending physical health-care settings. Due to the overlap of mental and physical illnesses, and the nature of comorbidity, liaison psychiatry does not exist in a vacuum. It is usually delivered to patients attending other services who have been identified as needing further support for their mental health (5).

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Table 1. Case Formulation of Biopsychosocial Factors.

	Predisposing	Precipitating	Maintaining	Protective
Biological	Birth of an extramarital relationship; biological father not known to her; biological mother had postnatal depression; adopted by grandaunt; frequent constipation		Repeated rectal and other physical examinations at accident and emergency (A&E); ongoing depressive illness; poor sleep	
Psychological	Idealized adoptive mum (grandaunt)	Anger at death of adoptive mother at 33 years old and death of biological mother's husband	Sense of hostility toward second marriage; attitudes of A&E staff	Relationship with mental health professionals; review appointments; A&E as rescue center
Social	Death of biological mother; death of adoptive father	Physically and emotionally abusive first marriage, ended at 30 years	Second marriage ended in separation; looming divorce	Relationship with children and best friend

This article attempts to capture the unique experience of a particular patient, accessing different services, in different locations for various aspects of a complex illness. In the first instance, this illness manifested only as chronic pain. It is the opinion of the authors that the involvement of liaison psychiatry in the patient's care improved her overall experience. This article advocates, in tandem with health policies, that mental health services should be available for patients experiencing chronic debilitating physical problems and that they should be easily accessible (6,7).

Description

In this case report, patient and clinician's details are anonymized. The unedited interview is included in Supplemental Appendix and is narratively presented below, with her consent. This was based on a semistructured format. Questions were predetermined by the authors and sent to the patient ahead of the interview. The patient was interviewed at home, a year after discharge from liaison psychiatry, on October 6, 2014.

The patient was a 44-year-old single mother who was referred to liaison psychiatry for low mood and suicidal ideation. At the time, she was an inpatient on an acute surgical ward, having been admitted with abdominal pain. She was reviewed on the ward where she was assessed as being "moderately depressed." She was on an antidepressant, fluoxetine, which had been commenced in primary care. She was offered a liaison psychiatry outpatient appointment.

The background of the presentation was one of chronic abdominal pain, with recurrent admissions to hospital wards, and frequent presentation to emergency services, usually out of hours. She had exploratory laparoscopic surgery for the pain, but no obvious physical cause was found. She continued to require high-dose analgesics, including opioids. Over the year of the referral to liaison psychiatry, she had 47 hospital admissions, 35 abdominal films, 29 chest X-rays, 4 abdominal ultrasound scans, and numerous blood tests. She had numerous investigations for her pain, yet no further identifiable physical cause was found. The input of liaison psychiatry involved the assessment of her mental health which led to a diagnosis of post-traumatic stress disorder (PTSD), with superimposing recurrent depressive disorder.

Pharmacological Treatment

Following consultation, her fluoxetine was tapered off due to inefficacy. She agreed to a trial of mirtazapine, which was titrated up to the optimal effective dose (45 mg nocte) for her. This was subsequently combined with duloxetine, which was gradually increased to 120 mg daily to augment the mirtazapine. She was also started on low-dose zopiclone for a limited period for insomnia.

Psychological Treatment

Psychological interventions comprised of psychological formulation (psychological understanding and hypotheses of one's problems and pain), sleep hygiene measures for insomnia (8), eye movement desensitization and reprocessing (EMDR) for PTSD and pain (9), and self-hypnosis for sleep management and chronic pain management (10). This combination of treatments was felt necessary due to the complex nature of her presentations.

A supportive patient–clinician relationship was an integral part of her management. This included collaborative communication to all those involved in her care: her general practitioner (GP), accident and emergency staff, and medical and surgical teams.

During subsequent outpatient clinic appointments, further history allowed formulation of her difficulties. A case formulation (see Table 1) was agreed with the patient and was presented as a letter addressed to the patient (and copied to her treating surgeon and GP).

Following the formulation (see Table 1) and treatment of her comorbid PTSD and depression, she recovered from chronic pain and had remained pain-free for at least 20 months as at the time of the interview. With liaison psychiatry input, she went from being housebound for at least a year, to being able to go on outings with her family and

embarking on part-time voluntary work. This leads to attendances at job interviews and eventually recommencing full-time work. In the 7 months prior to her discharge from liaison psychiatry, no hospital admission was recorded. She reported coping better with the pain.

In the transcript in Appendix, "Q" denotes interview questions and "P" denotes the patient's responses. In part A, a negative feeling of being dominated by illness is described. This was associated with an emotional state of continually being on guard. In part B, the traumatic effects of illness on her family are described. Part C describes how liaison psychiatry helped in addressing both chronic pain and the patient's comorbid mental health problems. In part D, the needs to identify and provide mental health needs for persons experiencing chronic pain are stated. Part E demonstrates that recovery is possible and that a fulfilling life can be forged from a traumatic past.

Results

Very often patients presenting with chronic pain have comorbid mental health problems (4). The exact causality of this comorbidity remains unclear. Goldenberg's literature review provides strong evidence that depression and chronic pain share a genetic and phenotypic basis, which may help explain this overlapping interface (11). As seen in our case, such patients can recurrently present to various services, typically physical health services, hoping to receive definitive treatment for their pain. However, they often do not feel validated by professionals, and instead some can feel judged and disregarded (12). This understandably can lead to feelings of rejection. We have demonstrated the importance of bridging the body–mind divide by involving liaison psychiatry, preferably at the earliest possibility, so that the right resources may be deployed to address any underlying mental health issues for people suffering from chronic pain.

To improve patients' experience and to provide a holistic approach to treating chronic pain, it has been suggested that the role of psychiatry should be strengthened (13). This may be in the form of improving compliance, reducing stigma, as well as attending to mental health concerns while optimizing appropriate pain management. The American Psychiatry Association has issued a position statement which aims to reduce the disparities of mental health management of pain and several chronic conditions (14).

Many theories have been proposed to formulate the experience of these patients. From a psychodynamic viewpoint, chronic pain may be conceptualized as physical manifestations of unconscious conflicts or disturbances, of which the pain serves to defend the person from the adverse experience or awareness of these conflicts (15). In our case, the patient, as stated in the formulation letter, agreed that her chronic pain served a previously unconscious role of absorbing all the hostilities in her home environment from various difficult relationships, in order to create a peaceful place for her children. Nevertheless, the consequence of this repressed emotion was that she felt "a strong sense of pain." Although the focus of this article is on a patient's experience of how her chronic pain was managed, rather than her mental health diagnoses, it is worth mentioning that past trauma and abuse, physical, psychological, or a combination of both, can contribute to the development of a somatoform disorder, including chronic pain. However, not every patient with pain disorder has a history of abuse (16).

Another theory that explains the role of chronic pain in our patient's life was that her experience of serial bereavements, loss of relationships, and physical and psychological abuse associated with these losses became a source of her post-traumatic stress (see Table 1). In these circumstances, pain sensation has been conceptualized as a somatic "flashback" of intrusive traumatic experiences (17). This formed the rationale for the application of a trauma therapy (EMDR) as her treatment.

It is possible that the patient in our case (part A) expressed attentional engagement to pain, as she described constantly thinking about the pain even when it was felt not unduly severe. Previous experimental research has found that catastrophic thinking can affect attentional disengagement from pain in clinical populations (18). There may be a role within the remit of psychiatry to challenge these negative cognitions.

Patients with chronic pain often feel judged, not listened to and of not being taken seriously. This is demonstrated in our case (part D) where she spoke about the need to have someone on her side to help coordinate her complex needs. As a result, achieving a shared understanding of her difficulties ensured her ongoing engagement. To do this, a case formulation (see Table 1) was agreed with the patient. This set out what the patient–clinician collaboration made of her difficulties regarding the presenting problems, associated predisposing, precipitating, and maintaining factors, as well as protective or mitigating factors, in a manner and language that was acceptable and understandable to her.

At initial assessments, considerable amount of time may be spent to assuage patients who may be upset by the referral to mental health services when they perceive their problems to be purely physical in origin. Upon presenting to various other services, patients may have been told that their problems are "in their head" (19). Without addressing these concerns satisfactorily, such patients are likely to disengage or at best engage half-heartedly with mental health services. Some may attend with emotions such as anger, rage, shock, shame, disappointment, mistrust, despair, desperation, or even disdain. These emotions may be projected onto treating professionals and could potentially interfere with their overall pain management.

Dutch guidelines have suggested ways to tackle this initial resistance to mental health services (20). Liaison psychiatrists should explain that they might help them reduce the distress and perceive their difficulties in a more helpful way. The ability to do this may vary according to the

motivation of the patients and the skills of the clinicians in generating a therapeutic engagement.

Due to the complex nature of her past, serial assessments were required to arrive at a formulation that made her feel heard and understood. We believe that agreement on a formulation with patients is crucial as, by nature, chronic pain runs an enduring course and its treatment may also take time. Having an agreed formulation can severe as an anchor for both patients and clinicians. Patients may refer to it from time to time, share it with family and friends, and base future directions or changes in treatment on it. This agreement may also serve as a turning point in facilitating trust and cooperation.

Lessons Learned

- Chronic pain can dominate one's life enormously—the constant anticipation of pain and the limitations of its treatments—and can leave people who suffer from chronic pain with a sense of isolation and loneliness.
- Chronic pain can impact on one's relationships. This may generate an enduring sense of guilt, as patients may feel responsible for breakdown in relationships.
- The psychological aspects of chronic physical health issues should not be ignored. Referral to and/or involvement of appropriate mental health services (eg Liaison psychiatry) should always be considered.
- Patients who had chronic pain can easily feel judged, misunderstood, or even abandoned by various services. There is a need to identify and provide health needs for people experiencing chronic pain in a compassionate and nonjudgmental way.
- Control of pain symptoms can bring hope to patients, enabling them to restore their functionality.

Conclusion

Chronic pain can be very debilitating to sufferers on various levels. Physically, it is a difficult and enduring sensation that can greatly undermine one's quality of life and productivity. The implications of this can be wide ranging—hopelessness, social isolation, impaired self-esteem and confidence, self-blame, guilt, damaged relationships, just to name a few.

For those who have a pain disorder that does not have an apparent physical justification, they can feel judged, neglected, abandoned, disregarded, and undervalued by services. The comorbidity with mental health illnesses may not be initially apparent which can further hinder one's experience on accessing appropriate health-care services.

Our case study demonstrates the huge issue of invalidation that patients may experience when they perceive that their symptoms are "not taken seriously." The provision of liaison psychiatry within physical health services could help to bridge the gap between mind and body, promoting the consideration of psychosocial factors in the causation and maintenance and treatment of complex physical health conditions. Early involvement of liaison psychiatry can also target the interaction between physical and psychological factors and provide appropriate interventions across the health-care system at an earlier stage, reducing repeated admission to emergency services.

Appendix A

Interview Transcript

Part A:

Q: How were things with you when your pain was at its worst?

P: I didn't really focus on anything apart from the pain. My concentration was totally gone because all my energies were focused on the pain. My pain was off the scale at its worst. Normally, accident and emergency (A&E) would ask what is your pain level between 1 and 10 (10 being the highest), when it was really, really bad I would have put the pain at 15+. The most distressing part of it for me was the impact it had on my family. And also I felt as though nobody was listening to me—I was straight in A&E, given the morphine and back out again and although, yes it did help with the pain. I would stay at home until the pain was off the scale because I didn't like going into A&E. When I look back on it now, I can see what it actually did to my children, it must have been terrible for them seeing me rolling around the bed in pain; they also had to come with me; it was a viscous circle really.

Q: How did it affect or interfere your life?

P: It took over my life completely. Even if the pain wasn't bad I would be constantly thinking about when it is going to get worse. I was like waiting for the pain to get worse and 9 times out of 10 it did. Looking back now, I got myself into such a state that I was making it worse. Cos I think part of the pain came from my focus on the pain and that is what it affected my life. It definitely disrupted my life. I wouldn't go out. I wouldn't eat in case it brought on an attack. Obviously the depression is linked to the pain as well, so yes for 18 month to 2 years it did take over my life completely. I know it sounds selfish, it felt as though it was all about me and the pain, nothing else mattered.

Part B:

Q: How was the family affected?

P: It was awful what I put my kids through. I would be upstairs rolling around the bed in agony; the kids would have to phone an ambulance. I'm their mother and they don't want to see that. I did put my kids through hell because I was frightened to go to A&E.

Q: How else was your life affected?

P: As I said, even if the pain wasn't so bad I couldn't feel happy about things because I was always thinking it's going to get worse.

Q: What give you the hope to hang on to?
P: I'll be perfectly honest with you the exercises I did with Dr [xxxx] really helped and when I was taken on to a ward in the early days I actually said something to a nurse which she had to report. The exact words I said to her were "I don't want to be here anymore." The nurse obviously said that this was something that she had to report and that is how I got in touch with Dr [xxxx]. Obviously the hope—things did start to get better, I was doing hypnosis with Dr [xxxx] and I was also doing 7 to 11, where you breathe in for 7 and out for 11. That was good as well. It was just having someone to talk to that wouldn't judge you, which Dr [xxxx] didn't and he was on my side. So it was nice to have somebody to listen to me. Receiving care in A&E, well, the nurses in there were absolutely fantastic and they do run around like headless chickens. The nurses got to the stage where they knew who I was and 9 times out of 10 the nurses would give me the IV morphine prior to a doctor coming because they knew what was wrong, they knew what would fix it so that by the time the doctor came to see me, sometimes it can be up to 4 hours in there, I was okay and I was sent home. I had a really traumatic experience one time in A&E with a particular doctor, he tried to give me alternative suppositories and things like that and I actually refused them because I know they don't work and in the end, and it's not me cos I'm not a violent person at all, I actually lost my temper with him. There was one nurse in charge who actually calmed the situation down, told the doctor to leave me alone and he went and got what he needed off another doctor to give me. That particular doctor, I said to [nurse] take him away; I don't want him near me. But that particular doctor actually came back and threatened me, when there was nobody was about. But I've moved on, it's fine. However, I did speak to somebody about it and I think Dr [xxxx] did speak to A&E about it. The next times I had gone in he wasn't allowed to treat me at all.

Part C:

Q: The help you got from Liaison?
P: Well Dr [xxxx] was liaising with A&E to tell them my fears, I didn't want to come in and I know Dr [xxxx] had some meetings with A&E saying that this is the best way forward for me. They agree to initially just carry on with the IV and the antisickness and everything else that went with it, so the answer there is in the question because Dr [xxxx] took a lot of the talking to A&E for me. He was listening to me and he liaised with A&E. Definitely the hypnosis was the best part for me. It was as if, I know it sounds weird, but it was like an out of body thing. Sometimes I would go and see Dr [xxxx] and I would be in pain and it was as if he was giving me something else to focus on with the hypnosis. But as soon as I came away from there, 9 times out of 10, I still had to go to A&E. But at that particular time it was to me giving me something to focus on that wasn't affected with the pain. It was like, the only way I can describe it, is that the pain was a big red ball and when I was under the hypnosis it kind of like a small yellow ball toward the end. So that definitely, definitely helped. I don't think my GP understood the extent of it to be honest. My GP would ring me up and tell me that I've had too many admissions to A&E and I said what do you want me to do because 9 times out of 10 it used to be on a night when the pain got worse, and to be honest when I did ring the GP's help line 9 times out of 10 they would say we know what you are suffering from then just go to A&E there is nothing we can do for you. But to be fair my GP's surgery I do thank the world of them. I've got a fantastic doctor but I don't think he understood just how bad this was.

Part D:

Q: How can people who have chronic pain be best helped?
P: I think pain is definitely there cos you do feel it. Hypnosis Dr [xxxx] did with me helped immensely. But it wasn't just the pain; it was the mental health issue as well. There was chronic depression and there was the pain so there were actually 2 things wrong with me. I think anybody with chronic pain and especially if it affects their mental health should definitely try the alternative route, which I took. The reason why I think it is important is that when you are suffering from chronic pain and depression, you need somebody who listens to you, that doesn't judge you and is on your side because I found that 9 times out of 10 there was only Dr [xxxx] was concerned for my mental health. I would go on to A&E and I would say to the nurses "I'm really sorry," and they would say "don't be so stupid this is what we are here for," but the doctors would say "I really think you should get in touch with your Consultant, this is ridiculous." So for me it was important to speak to somebody that was on your side, which obviously Dr [xxxx] was.

Part E:

Q: "What is the future like for you?
P: Absolutely brilliant. We have combated the pain. I am actually working full time now, Monday to Friday. I was working as a transport clerk at [xxxx] but we got given our notices in August. As luck would have it, I found another job within 2 weeks. I've been there for about a month now and yes the future is really good. Definitely I have come out of the other side now.
Q: Other comments?
P: Well Dr [xxxx] is worth his weight in gold. He really is. Obviously because I had such a good patient–doctor relationship with Dr [xxxx], when he got another job he didn't actually tell me. So he was actually going to [the hospital] just for my sessions only. I was making progress so he didn't want to say. It got to the stage that he couldn't

do it anymore and he had to say "look I need to pass you on to [xxxx]." But by that time I was getting better anyway. So yes, definitely the future is a lot brighter now.

Q: That's good to hear.

P: But I think part of it as well when I was really suffering with depression the slightest thing would upset me, Dr [xxxx] would tell me. I wouldn't tackle things like putting the house on the market because I couldn't tackle it. But obviously now I'm facing things head on.

Q: That's good isn't it?

P: It is. It's brilliant. I think that's it for now.

Q: Thank you very much for talking to me.

Ends.

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