Pain and psychological dysfunction

Dr Peter Golus, Chief Forensic Neuropsychologist, Psych Quest. Researched by Susan Campbell

The client who presents seeking compensation following physical injury undeniably suffers from pain; for if pain and its effects were not impinging upon their life, there would be little need for such litigation.

Is compensation for physical suffering alone adequate? Clearly it is not, for physical and psychological suffering walk hand-in-hand in the daily life of the chronic pain client. One impacts upon the other in a vicious circle of discomfort and distress.

The role of the forensic psychologist, therefore, should now be as highly regarded as the role of the medical practitioner in the assessment, treatment and rehabilitation of such clients. This article shall examine chronic pain and psychological dysfunction, the relationship, causes and effects, as well as what rehabilitation is available.

Chronic pain is defined as persistent or regularly recurrent pain with a duration longer than the normally anticipated recovery time. Like many other symptoms, pain may be due to underlying disease, but it can also be a reflection of anxiety and other emotions; a reflection of psychological dysfunction.

Chronic pain can develop resultant of many different types of injury. Common causes are orthopaedic impairment, whiplash injury, closed head injury, soft tissue injuries and amputation.

Work-place accidents, motor vehicle accidents, chemical exposure, food poisoning, medical negligence and criminal assault are all repeat offenders who share the blame for the hundreds of thousands of men, women and children who suffer pain on a daily basis.

Once the "normal" period for recovery has passed and the pain comes to be known as chronic the psychological health of the client begins to suffer. Most clients appreciate that there will be a period of physical suffering following injury following which the body will heal and return to its pre-accident levels of health and fitness. However, when this readjustment does not come to pass, the client begins to feel frustrated and despondent. These feelings can quickly translate into anxiety and depression.

A Catch-22 scenario then occurs where one affects the other without relief. Anxiety and chronic pain can prove both difficult and exhausting for the client. The client feels frustrated at their inability to perform at their pre-injury physical capacities. Tasks of daily living, sexual activity, work and sports performance are all compromised by chronic pain. In turn, lifestyle and enjoyment are negatively affected.

Perhaps the key to the client's frustration is the lack of control they have over their situation. They have suffered injuries and endured pain and are now unable to do many of their previous tasks of work or enjoyment. Lack of control breeds frustration which in turns leads to anxiety.

Anxiety manifests in both psychological and physiological responses. It causes the mind and heart to race, the patience to shorten and the muscles to tighten. For the chronic pain sufferer the physiological responses of anxiety can intensify and prolong their pain considerably. Obviously, steps must be taken to alleviate both the cause of anxiety and its effects.

Chronic pain and depression share a similar relationship. Depression is an understandable, even expected reaction to living with chronic pain and on the flip-side, chronic pain is often exacerbated by and intensified by depressive feelings.

Depressed chronic pain clients consistently report lower levels of functioning and interference in a variety of common daily activities as compared to those who are not depressed. Chronic back pain sufferers in particular, exhibit significant associations with depressive symptoms. Steps must be taken to alleviate the cause of the depression as well as its effects.

Chronic pain affects much of the sufferer's waking day and wakeful night. Sleep is disturbed, leaving the client fatigued and lethargic. Physical activity is limited and fitness reduced. Housework and other tasks of daily living prove difficult and time consuming. Sexual intercourse becomes painful, less interesting and less enjoyable. Relationships grow cold and distant. Work is abandoned completely or redesigned to compensate for the restrictive effects of the injuries and pain. This leads to financial pressure and anxiety. In essence, the daily life of the chronic pain sufferer has changed completely.

Apart from anxiety and depression, chronic pain also elicits various cognitive responses, particularly following traumatic brain injury. Such responses are potential obstacles to effective rehabilitation and must be taken into account in the management of, and compensation for, the chronic pain sufferer. Deficits in memory and attention associated with traumatic brain injury (TBI) may be worsened by the presence of chronic pain.

Depression and anxiety commonly experienced by TBI clients may also be compounded by persistent pain. Functional limitations, especially in moderate to severe TBI clients, may be increased by limited mobility associated with chronic pain.

Effective pain management is vital for the alleviation of these limitations and effects. It is possible that inadequate pain management may compound the psychosocial stress that TBI clients experience and that rehabilitation efficacy may be consequently impeded.

Chronic pain clients have also been shown to experience significantly elevated rates of sleep disturbance. The chronic pain client does not sleep as well as they should and neither does the client in chronic pain who is also anxious and depressed. Common difficulties noted amongst chronic pain sufferers are difficulty falling asleep, diminished sleep qual-

ity, pain interference with sleep onset, awakening due to pain and early awakening.

Chronic pain can also precipitate the onset and development of psychological disorders. Most chronic pain clients referred for assessment present with classic symptoms of anxiety and depression including loss of interest, fatigue, sleep disturbance, irritability, frustration, nervousness, increased smoking or alcohol intake. Many of these clients have been living with chronic pain for twelve months or more and have seen the long-term effects of their injuries and suffering. The uninvited and unplanned for loss of or change in employment, social, familial, and physical lifestyles bring the also unwanted effects of loss of confidence, loss of stability and security, loss of happiness and loss of hope for any improvement in the future.

Psychometric assessment commonly reveals either one of or all three of the disorders of Generalised Anxiety, Dysthymia and Major Depression. Each disorder is significant enough in itself to warrant the client unable to function effectively in their pre-injury capacities. Coupled with chronic pain the client is made to feel isolated, helpless and punished.

Diagnosis of a Pain Disorder is also often warranted. Such disorder can be either wholly psychologically based (i.e. Pain Disorder Associated With Psychological Factors), wholly medically based (i.e. Pain Disorder Associated With A General Medical Condition) or a combination of the two (i.e. Pain Disorder Associated With Both Psychological Factors & A General Medical Condition).

Diagnosis of a pain disorder is the representation of a collection of symptoms, both psychological and physiological. Criteria for diagnosis include: pain in one or more anatomical sites of such severity to warrant clinical attention; distress or impairment in social, occupational or other areas of functioning caused by such pain; the presence of psychological factors that have a role in the onset, severity, exacerbation or maintenance of the pain; the absence of intentional malingering or feigning of symptomatology.

Effective Pain Management techniques employed by a suitably qualified professional can, over time, foster hope in the mind of the chronic pain sufferer. Anxiety and depression can be controlled; sleep improved: self-esteem increased; cognitive processes can resume much of their previous functioning; pain can be controlled.

The role of the forensic psychologist in the field of chronic pain rehabilitation is unmistakably important. For, as it has been shown time and time again, the mind affects the body, and the body affects the mind.

Techniques of positive imagery, self-hypnosis, progressive relaxation, deep breathing, and hypnoanaesthesia can all assist the chronic pain sufferer. Techniques of rational emotive therapy (RET), cognitive behavioural therapy and traditional psychotherapy can rebuild the client's self-worth, positivity and hope.

Even the simple act of the psychologist acknowledging the client and their pain as being *real* and of *real distress* is of great worth and comfort for many chronic pain sufferers experience rejection and ignoration of their symptoms by medical and other allied health professionals.

Results can be seen from as soon as the initial consultation wherein the client recognises that help is available, that their situation is not entirely hopeless nor are they completely isolated and misunderstood. Over a course of say, six sessions (all of one hour's duration) the client learns practices and employs techniques of stress management, pain control and mood elevation.

Often, the partner or companion of the chronic pain sufferer benefits greatly from a group therapy session and many compensation claims are now including in consortium claims. The reasons for this are clear. Just as the pain of the client affects their mood, so too does their mood impact upon the relationship between he or she and their spouse as well as their siblings, children, parents and whomever else they live with. Marital and sexual relations are affected, as are relations between parent and child.

Therapy wherein family members of the chronic pain sufferer come to better understand the psychological struggles of their loved one as well as learn techniques for stress management and relaxation themselves have proven time and time again to be of immeasurable benefit, and contributes a flow-on effect towards improving the quality of life for the chronic pain sufferer.

If we can help improve the client's psychological functioning, we can also affect some improvement in the quality of their physical functioning. Quality of life is the magic ingredient missing from the lives of the chronic pain patient. Effective rehabilitation can help restore this magic.

Referral to a psychologist and a pain management centre should not be considered merely as an option, but as a necessity. Here the client will be educated as to the nature, causes and effects of their pain and learn techniques for coping with, controlling and alleviating same. Awareness and education are the keys to solving the problems of chronic pain.

Such awareness and education must also extend to the legal fraternity for it is learned colleagues such as yourselves who assist the sufferer through the minefield-laden black tunnel of litigation, through to the other side where awaits justice and the ever helpful "pot of gold."

The role of the plaintiff solicitor is vital and one not to be taken lightly. To have awareness and knowledge is to be well-armed in this legal battle. To be able to recognise the effects chronic pain has upon the psyche of the client; to understand and empathise with their suffering: to appreciate the complexities of the symptoms; to know of the mind-body relationship.

To ensure comprehensive assessment and effective rehabilitation by a suitably qualified psychologist is to serve the chronic pain client the best way possible. It is to take that client a step closer to being fairly compensated and then to regaining their quality of life.

Dr. Golus is Chief Forensic Neuropsychologist at Psych Quest and an associate member of APLA. He has been in private practice for over 15 years. Psych Quest has offices in Sydney and on the Gold Coast and offer a Deferred Payment Scheme. For further information phone (02) 9818 3485 or (07) 5572 8850.