

Debate & Analysis

Persistent pain:

the need for a cooperative approach

ADDRESS FOR CORRESPONDENCE

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INTRODUCTION

Williams and Johnson present a strong argument against seeing chronic pain as an example of somatisation or as a medically unexplained symptom.¹ They are concerned that such perspectives encourage undue psychologisation of physical complaints, and might be prejudicial to good patient care. They are particularly critical of documents produced by the Increasing Access to Psychological Therapies (IAPT) programme and Commissioning Support for London (CSL), as examples of initiatives which may lead to chronic pain sufferers being managed by practitioners without adequate grounding in the types of pain management strategies supported by NICE guidelines or by the Cochrane Pain, Palliative, and Supportive Care Group.

I have considerable sympathy with their position, especially their idea that the general practice consultation is the 'art of unravelling the medically unexplained'. I strongly agree about the dangers inherent in assuming that all complex symptom presentations indicate an underlying psychological problem. However, their arguments in favour of chronic pain as a disease entity and against MUS perspectives are both overstated.

OVERSTATING THE CASE

I am not convinced by their argument that chronic pain should be seen as a disease entity in its own right, for nosological and epidemiological reasons. First, at the level of nosology, evidence of changes in brain structure may be better seen as associative rather than causative. Notionally, a similar argument could be made that pyrexia of unknown origin should be awarded disease status, on the grounds that a persistent rise in temperature is associated with widespread physiological and functional changes: but a more reasonable view would be that pyrexia of unknown origin (like chronic pain) is not a disease state per se, but is rather a final common pathway

for a heterogeneous set of possible causative factors. Second, at the level of epidemiology, there is good long-term evidence against chronic pain syndromes all being the same problem with a common mechanism of persistence, and in favour of regional pain complaints tracking distinctively over time.²

Williams and Johnson's critique of the IAPT and CSL documents is too swingeing. Although simplistic in places, these documents do acknowledge that anxiety, depression, and psychological distress can be a consequence of physical symptoms such as pain, and that unexplained physical symptoms should not be assumed to be mental health problems. The CSL document does not advocate interrogating databases as a method of detecting clinical cases of MUS, but rather as a guide for commissioners seeking to establish the likely extent of persistent unexplained symptoms; and it does support pharmacological and neurological approaches for moderate and severe cases.

ALLEVIATING SUFFERING

We are still in a position where there is a great deal of work to be done, in understanding the complex inter-relationships between chronic pain and psychological distress, and in finding effective interventions. Our goal of alleviating suffering remains problematic whether we pursue physiological or psychological approaches. Williams and Johnson acknowledge that even in the pain management field, better understanding of underlying mechanisms has not yet led to the introduction of an array of effective treatments.

There is a need for further research into possible common antecedents of pain syndromes and psychological problems. Pain and depressive symptoms may share common pathogenic pathways, perhaps accounting for the effects of some antidepressants on both affective and

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painful symptoms.³ They are associated with similar predisposing social factors and childhood experiences,⁴ which may be mediated through long-term changes in hypothalamic-pituitary-adrenocortical activity,⁵ participation in risky behaviours that undermine health, or cognitions and beliefs that amplify health problems.⁶

New guidance from the British Pain Society, as promised by Williams and Johnson, is to be welcomed. When considering how best to manage chronic pain problems in primary care, we should seek to avoid exacerbating the symptoms that our patients present.⁷ While we are generally agreed on the value and importance of continuity of care, we cannot assume that the doctor–patient relationship is the key to success, especially with problems such as chronic pain where that relationship is often characterised by a mutual incapacity to take effective action. The key question for the patient can easily become: how can I make sure that my suffering and concerns are taken seriously?⁸ The key question for the doctor becomes: how can I contain this patient? This can all too readily develop into a spiral of confusion, conflict, and even hostility. With no exit point in sight, the doctor–patient relationship itself risks becoming a chronic problem.⁹

In seeking to help people living with persistent pain, it may be more productive to focus on cooperation rather than conflict: not just between doctors and patients, but also between practitioners with differing perspectives and professional agendas.

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