INTRODUCTION
Williams and Johnson present a strong argument against seeing chronic pain as an example of somatization or as a medically unexplained symptom. 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.

OVERSTATE ING 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 (like chronic pain) is not a disease state per se, but is rather a final common pathway accounting for the effects of some other factor. The need for further research into possible common antecedents of pain syndromes 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

“In seeking to help people living with persistent pain, it may be more productive to focus on cooperation rather than conflict...”

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

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. 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 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.

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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