

Pain and Comorbid Psychosocial Factors

Psychosocial comorbidities are commonly seen in patients with chronic pain. Comorbidities range from depression, anxiety, maladaptive personality styles, maladaptive coping mechanisms (fear-avoidance, catastrophizing, etc.), and family dynamics. Cultural factors and personal belief systems may also manifest in maladaptive behaviors that increase pain. The incidence of depression and anxiety ranges from 40 to 80% in the chronic pain population.

Depression is associated with lowered pain tolerances and decreases a patient's willingness or ability to comply with medical advice. Anxiety interferes with a patient's ability to concentrate and comprehend information. Anxiety may lead to activity avoidance and pain hypervigilance. Hypervigilance and pain related activity avoidance can lead to anatomical disuse, perception of disability, depression, and low self-esteem. Depression and pain related anxiety are potent predictors of observable physical performance deficits and increased self-reported functional disability levels.

Fear-avoidance beliefs are strongly related to functional disability in daily living and work. In fact, fear-avoidance issues correlate with functional disability in daily living and work to a greater degree than pain variables. Because avoidance occurs in anticipation of pain, not just in response to pain, avoidance may easily persist and become dissociated from the actual pain experience. This challenges the notion that lower performance and ability to accomplish tasks of daily living is merely the consequence of pain severity.

Catastrophizing is the tendency for a patient to ruminate about the pain condition, magnify or exaggerate the meaning of the pain for daily function, and feel helpless to manage the pain (Butler 1989, Rosenthal 1983, Sullivan 1995, Schaeffer 2009). Numerous studies have demonstrated that pain catastrophizing is associated with increased pain sensitization and emotional distress. When controlling for variables such as pain severity, depression, anxiety, and fear of pain, catastrophizing remains an important variable which correlates with a perception of disability out of proportion to the injury. Catastrophizing is considered one of the most maladaptive coping mechanisms.

Personality styles interact with personal belief systems, coping strategies, family dynamics, and cultural expectations to produce a complex reaction to the perception of pain. Comorbid psychosocial issues distort the perception of pain and disability leading to feelings of helplessness which can be reinforced by family and cultural beliefs. Families that are not supportive can be as counterproductive for the patient as can families that enable maladaptive beliefs and behaviors.

Comorbid psychosocial factors are known risk factors for developing chronic pain syndromes after an acute injury, increase probability to pursue disability benefits because of pain, poor coping strategies, aberrant use of controlled substances, and failure to benefit from interventional strategies.

Therefore, in order to achieve effective control of pain, identification and effective treatment of comorbid psychosocial depression, anxiety, fear-avoidance, and maladaptive coping strategies is required as a companion strategy to restoration of physical function. Failure to adequately treat comorbid conditions is likely to compromise the quality and success of pain management. While pain is inevitable, suffering is optional. Effective pain management is suffering management combined with functional restoration. Pain treatments are unlikely to produce durable benefits without exploring why the patient suffers from pain.

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