# Depression and Chronic Pain

by Mary French, RN, MSW, LCSW-C

Are you depressed? Depression is different from the occasionally sad mood all of us experience at times. Depression is not uncommon with chronic pain. Someone with symptoms of depression should be sure to seek help from a mental health provider. Depression has emotional and physical symptoms including fatigue, difficulty sleeping, and poor appetite. Other symptoms such as dizziness, upset stomach, shaking, and fluttering chest are common in people with depression.



## Signs and Symptoms of Depression

- Persistently sad, anxious, or "empty" mood.
- Feelings of hopelessness, pessimism.
- Feelings of guilt, worthlessness, helplessness.
- Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex.
- Decreased energy, fatigue, being "slowed down."
- Difficulty concentrating, remembering, making decisions.
- Insomnia, early-morning awakening, or oversleeping.
- Appetite and/or weight loss or overeating and weight change.
- Thoughts of death or suicide, suicide attempts.
- Restlessness, irritability.
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain.

Depression and chronic pain have a reciprocal relationship. A chronic pain condition can lead to depression and people with depression can subsequently develop pain. However, studies show that pain precedes depression in the majority of patients who have both. Therefore, when depression and chronic pain co-exist, it should be assumed that pain is causing the depression (Dr. Rollin Gallagher, Director of Pain Medicine and Professor of Psychiatry and Anesthesiology at the University of Pennsylvania in Boschert 2005).

The relationship between pain and depression is not completely understood. We know that both conditions involve neurotransmitters such as serotonin and norepinephrine, which help regulate mood. Low levels of these neurotransmitters in the brain may intensify pain. Brain studies show similar areas of the brain are affected in pain and depression. Specifically, the limbic area of the brain receives and regulates pain signals and is also the center for emotions.

On average, one out of three, and some studies suggest 50%, of people living with chronic pain experience depression, and at least 25% have anxiety. People with a history of depression are prone to relapse after the onset of pain. Although depression affects millions, it remains underreported. Treating depression may help reduce pain levels, so clients should be sure to seek treatment if they experience symptoms of depression.

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National Institute of Mental Health (NIMH), www.nimh.nih.gov.

## A Doctor for Judith?

*by Shelly Carlyon*

The first time I met Judith, she was covered in silly string. It was a Fourth of July celebration for my freshman class. Judith was the mother of my classmate, Natalie, and was supposed to be chaperoning the event. It seems, however, that she'd gotten involved in a silly string war with half of the baseball team. The picnic was intended to bring the scared freshmen closer together before the start of term, but many students (myself included) remained withdrawn. Judith wouldn't have that. Her buoyant personality was contagious.

I hadn't wanted to go the picnic. I was a new freshman in a new town, and I was terrified. My parents urged me to go and make new friends, but I had decided days before the event that I would just hover around the sidelines. I was toying with a blade of grass, determinedly not looking at anyone, when I heard Judith's loud, musical voice behind me. After introductions were made, she invited me to come over to her table. I was a little hesitant to spend the day around a woman with pink silly string in her hair, but I followed her. I didn't realize at the time that this woman would become one of the most influential people in my life.

Judith's daughter, Natalie, and I became fast friends. As the year progressed and Natalie and I grew closer, I learned more about Judith. She retired from the U.S. Navy after ten years of service. She loved animals of all kinds, but she was especially fond of horses. Judith was one of the most active people I ever met. That year, she and her husband took Natalie and me horseback riding, sailing, and on several long nature hikes. By the end of my freshman year, Natalie and I were best friends, and Judith had become my second mother.

But it couldn't last forever. A few days after her 45th birthday, Judith underwent surgery for a herniated spinal disc. She'd been in increasing amounts of pain for months before the diagnosis. Resigning to the truth, Judith realized that she might not be able to ride horses all day or hike to the top of a mountain anymore. But two months after surgery, when she was still in excruciating pain, Judith returned to her doctor. The doctor was either unable or unwilling to cite a specific cause, but he diagnosed Judith with Failed Back Syndrome (FBS).

Her life in the subsequent years was filled with pain. Judith could not straighten her spine; it was too painful. Because of her unnatural posture, she developed knee problems. Rising from her chair was too hard, so she spent nearly all day immobile in a recliner. A second surgery failed to help. Physical therapy seemed to make it worse. The pain medication turned my friend into a kind of zombie. But even in her pain, Judith remained the strong, brave woman I had always known. She

attended church when she could and spent her days knitting blankets as part of a volunteer program.

And then one day, about two years after the first surgery, Judith returned to her orthopedic surgeon for a re-evaluation. The doctor looked Judith in the eye and told her that she would never get better. She would be in pain for the rest of her life. In other words, the doctor had given up on her.

At first, Judith was understandably depressed. Natalie told me that after returning home from the doctor's office, her mother locked herself in her bedroom for nearly twelve hours. But when she emerged, Natalie thought Judith was happy, inappropriately happy. That night I was invited to dinner. Judith never mentioned the visit to the doctor or her pain. She chatted about frivolities. We all assumed this was her way of coping with what she had heard.

The last time I saw Judith she was covered by a handmade quilt in her recliner. The phone call came at dawn the next day. Natalie told me the news through frantic tears: Judith was found dead in her recliner.

Natalie's father declined an autopsy. Judith's body had been through enough medical procedures. The paramedics suggested she died of a heart attack. Suspiciously, none of us could find Judith's pain medication in the house, even though she had not been without it for two years. We were shocked, horrified, depressed. But if she did take her own life, none of us could blame her for wanting to escape.

It has been almost four years. Natalie and I remain as close as sisters, bonded by the tragedy of Judith's death. Natalie is engaged to be married. I am in college, bound for medical school.

No one can be blamed for the FBS. Perhaps that surgeon was uneasy about giving Judith false hope. But what is better: false hope or no hope at all? In truth, Judith may have never found relief for her pain. But maybe next year there will be a breakthrough for chronic pain sufferers. Maybe Judith could have been here to see her daughter get married, to see me become a doctor.

Judith taught me not to be afraid to come out of my shell. She had the most beautiful spirit of anyone I've ever met. And although Natalie blames the surgeon for Judith's untimely death, he taught me something as well. When I become a doctor, my first priority will be to inspire my patients as Judith inspired me. A doctor's job is to make her patients feel better, both physically and spiritually. I will become the kind of doctor that Judith deserved.

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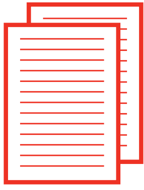

# Chronic Pain and Suicidal Thoughts

## *Handout Instructions*

Depression and chronic pain go hand in hand; if left untreated, serious consequences may occur. It is essential to talk to your clients about these thoughts, normalize the thoughts, and provide coping tools to help them through these dark stages. Use the following handout to discuss suicidal thoughts with clients.

**Notes:**

# Chronic Pain and Suicidal Thoughts

by Gwenn Herman, LCSW-C, DCSW

Many people with chronic pain think of suicide and/or death. However, it is the pain people want to end, not their lives. People in pain just want their old lives back. Pain causes multiple losses that can overwhelm and trigger thoughts of being trapped and hopeless. These experiences can trigger a major depressive episode and suicidal thoughts. These thoughts, while common for people with chronic pain, become dangerous when left untreated.

People with chronic pain are often afraid to tell others about these thoughts. They fear being labeled "crazy." Keeping these thoughts to oneself can amplify them, especially if someone already feels isolated, and suicide may be viewed as a reasonable option.

Talking about these thoughts with a family member, friend, clergy member, support group, doctor, or mental health professional is essential for safety and healing. If talking does not relieve these thoughts, then therapy and medications may be needed to help people cope with the changes in their lives. Acceptance of physical changes will change feelings and thoughts, especially hopelessness.

**There are always options. There is always hope of healing.**
**DON'T STAY ALONE IN YOUR PAIN!**

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1–800–273–TALK if you or someone you know exhibits any of the following signs (taken from U.S. Department of Health and Human Services):

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself.
- Looking for ways to kill oneself by seeking access to firearms, pills, or other means.
- Talking or writing about death, dying, or suicide.
- Feeling hopeless.
- Feeling rage or uncontrolled anger or seeking revenge.
- Acting reckless or engaging in risky activities—seemingly without thinking.
- Feeling trapped—like there's no way out.
- Increasing alcohol or drug use.
- Withdrawing from friends, family, and society.
- Feeling anxious, agitated, or unable to sleep, or sleeping all the time.
- Experiencing dramatic mood changes.
- Seeing no reason for living or having no sense of purpose in life.

**IF YOU OR SOMEONE YOU KNOW IS CONSIDERING SUICIDE:**
**CALL 1–800–SUICIDE (1–800–784–2433)**

Section 3

# Martha

*by Martha Leonard*

Trapped in this body

Cloistered from the world
my soul screams in silence
my muscles cramp, curled

into masses of knots
& rigid, taut bands
It's hard to believe
I'm still in your Hands

yet, I do +

Your word calms my spirit
Your Breath brings relief
from the torturous grip
of this merciless thief

who haunts me asleep
and hounds me awake
imprisoning my flesh
limiting what I partake

of Your very Life

yet, I do +

*Martha has been a Pain Connection member since 1999.*

# Chronic Pain and Trauma

by Mary French, RN, MSW, LCSW-C

Research related to traumatic stress is still a relatively new field of study. The International Society of Traumatic Stress Studies was formed in 1985. It is important to remember that many clients who cope with chronic pain may, in fact, have experienced physical and/or psychological trauma. For some clients, chronic pain is a direct result of injuries sustained from a traumatic event such as a motor vehicle accident or traumatic assault/abuse.

Section 3

The *Diagnostic and Statistical Manual of Mental Disorders* (2000) defines trauma as:

> *Direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior).*

John Briere and Catherine Scott (2006) state in their book, *Principles of Trauma Therapy*, that, "an event is traumatic if it is extremely upsetting and at least temporarily overwhelms the individual's internal resources." Under this broader definition, most people with chronic pain have experienced trauma. Family members may also be at risk for traumatic symptoms.

There is some evidence that traumatized individuals are at greater risk of developing medical illnesses. "Trauma survivors report more medical symptoms, use more medical services, have more medical illness detected during physical examination, and display higher mortality" (Foa, Keane, and Friedman 2000). Briere and Scott (2006) note that, "PTSD sufferers have been shown to have increased rates of back pain, hypertension, arthritis, lung disease, nervous system diseases, circulatory disease, cancer, stroke, digestive disorders, and endocrine disorders, among others. It has also been associated with lower overall health status, higher use of medical services, and higher health care costs." More studies are needed to understand the connection between trauma and the later development of chronic medical and pain conditions.

The clinician should assess clients for symptoms of chronic Post-traumatic Stress Disorder (PTSD) and other related psychological conditions such as depression, anxiety, and complicated grief. People with chronic pain should be evaluated for multiple traumas, as PTSD does not account for all trauma-related stress responses, particularly among non-Anglo/European cultures that may not present with symptoms of avoidance or numbing and may have more somatic and dissociative symptoms (Briere and Scott 2006).

Briere and Scott also outline victim variables associated with the likelihood of post-traumatic stress. These variables have been obtained from various research sources and are outlined below:

- Female gender.
- Age: younger or older individuals are at greater risk than those in mid-adulthood.
- Race: African-Americans and Hispanics are at higher risk than Caucasians.
- Lower socioeconomic status.
- Previous psychological dysfunction or disorder.
- Less functional coping styles.
- Family dysfunction and/or a history of psychopathology.
- Previous history of trauma exposure.
- A hyperactive or dysfunctional nervous system.
- Genetic predisposition.
- Greater distress at the time of trauma or immediately thereafter.

Somatoform responses are a wide variety of physical symptoms (pain, gastrointestinal, sexual, and neurological) that are strongly influenced by psychological factors—they cannot be explained based on medical phenomena alone. Somatoform disorders have been linked to a history of childhood abuse and other traumas. It is possible that this is a result of sustained autonomic arousal, increased sensitivity to bodily distress, and even underlying illness (Briere and Scott 2006). In the past, chronic pain clients have felt dismissed by this diagnosis, feeling their physical symptoms are minimized or "in their head." Fortunately, due to advances in the understanding of mind-body interaction and chronic pain, there is less minimizing or dismissing pain.

To evaluate the client for history of traumatic stress, you may want to consider a structured interview tool such as the *Acute Stress Disorders Interview* (ASDI) (Bryant et al. 1998) or the *Brief Interview for Posttraumatic Stress Disorders* (BIPD) (Briere 1998). With accurate diagnosis, treatment for trauma should be integrated into therapy. For information on various scales and how to obtain them, visit the National Center for PTSD website, www.ncptsd.va.gov/ncmain/assessment/adult_selfreport.jsp. For information regarding medical trauma and children visit the National Child Traumatic Stress Network website, www.NCTS.org.

A few of the treatment considerations include:

- Safety: a therapeutic relationship is key.
- Affect regulation skills and grounding skills.
- Form of trauma processing such as EMDR (Eye Movement Desensitization and Reprocessing).
- Cognitive intervention/restructuring.
- Transference/countertransference issues.
- Psychoeducation.

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