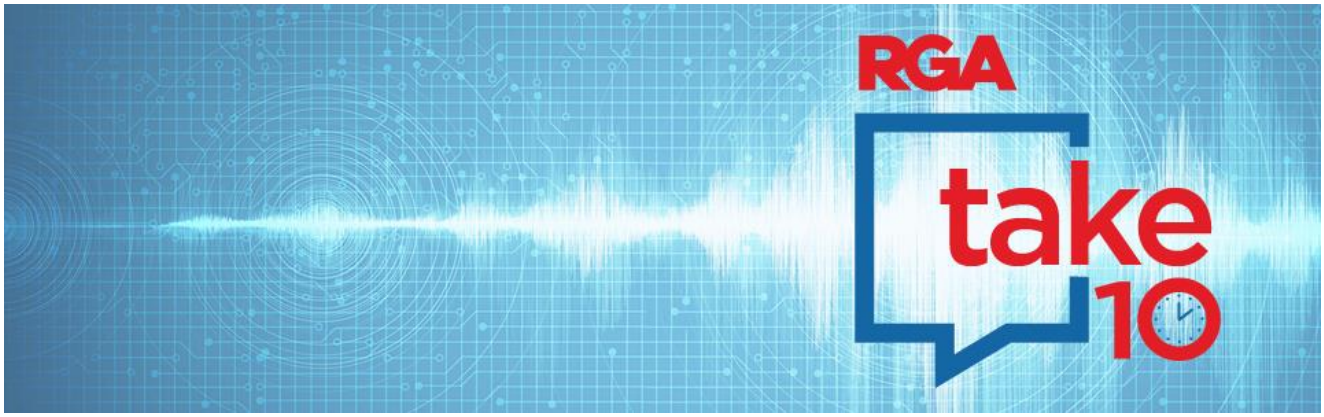

Chronic Pain – Body or Brain?

Take10 Podcast Transcript

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GK

Welcome back to RGA's Take10 podcast series, disability income claims in under 10 minutes.

From a claim's adjudicators perspective, some of the most complex cases are those where the disability is or is complicated by chronic pain?

I'm Gayle Kanchanapume and with me today is Consultant Psychiatrist, Specialist Pain Medicine Physician and Consultant CMO at RGA, Dr. Newman Harris.

Dr. Harris, thanks for joining me.

NH

Thank you, Gayle.

GK

Having managed claims for many years, I'd say that those suffering from a chronic pain disorder are often some of the most frustrated, not only because of their disability, but also due to repeated treatment failure and often actually the insurance claims process too.

Dr. Harris, can you help us understand a little bit more about the presentation of chronic pain and just how does this differ from regular pain?

NH

Well Gayle, by definition chronic pain is a pain which persists for longer than a three-month period. Anything less than that is considered acute or subacute and that sort of short-term pain usually indicates the threat of, or the real effect of tissue damage. A long-term unremitting pain on the other hand, provided its origin has been determined to be benign, doesn't signify any threatened or actual damage, although it activates many of the same parts of the brain as does acute pain and elicits therefore the same response of anxiety or distress.

Now, one in five people will suffer from chronic pain at some time in their life. Many factors will predispose to things becoming chronic, including a prejudicial development, the psychological or interpretive context of the injury and of course, a mental illness amongst many other factors.

It's important to note that there's a high co-morbidity between chronic pain patients, and mental illnesses, including personality disorder. The individual's interpretation of their pain is integral to the consequent response set, their attitudes and their behaviours, which follow. Distress and anxiety driven avoidance of activity is not usually appropriate and generate the secondary problems of bio-psycho-social deconditioning.

GK

So perhaps it's not just a simple case of taking a tablet and the pain going away. Can you talk to us about some of the treatments for chronic pain? What's best practice and why isn't it a simple case of just taking medication to kill the pain?

NH

Well, Gayle pain medications are just one of an array of so-called passive strategies. Strategies, where there's an emphasis on having somebody other than the patient improve their situation for them. Pain medications and complex interventional approaches like nerve blocks or insertion of spinal cord stimulators, oftentimes do not provide adequate and lasting benefit for the patient. They also come with the potential risk of greater adversity being generated through the reliance upon them. They serve to reinforce this attitude that someone's going to save me whilst it's actually me, who should be saving myself. The reality is that reactivation with a sensible, but prompt timeframe is crucial to the restoration of function and the mitigation of further damage to bio-psycho-social processes.

Now some medications are plainly harmful and whilst widely used the established scientific evidence for the long-term use is at best disappointing, if not lacking. Some of these drugs in common use can cause acute suicidality. We're well familiar with the concept of dependency to the opioid drugs, but you're probably not so fluid in the idea that those drugs used over the long period of time cause significant endocrine problems, and can even, we believe, turn up the volume of the pain to make wider spread pain more obvious, and that is the instance in a lot of people with conditions, such as fibromyalgia and unexplained abdominal pain. Where it's my experience that when you start removing those medications, their pain actually starts to get better.

We also look at things like hands-on treatments like long-term, hands-on physiotherapy and chiropractic. The evidence of which is poor in long-term chronic pain, but again, they serve to reinforce the attitude that somebody else will fix the situation and thus undermine the potential for patients to reactivate and reintegrate despite the presence of some residual pain.

GK

So, it could be quite common then to be managing a claim where the treatment for a chronic pain condition is not following what we would call a best practice approach. So, in a situation like that, what can claim's adjudicators do to help them?

NH

Well, I think the first thing we have to be really aware of is what actually is a best practice approach because oftentimes, unfortunately, the best practice approach is not necessarily the approach that's driven by healthcare professionals who are perhaps stuck in old fashioned beliefs about rest versus reactivation and avoidance rather than confrontation of the pain syndromes. Case managers, I think, should be encouraged to assess the claimant's orientation towards active self-driven approaches to rehabilitation and restoration and their focus on wellness behaviours. These things can be reinforced through pain management programs, if the patient has not yet been exposed to one, to an individual pain specific cognitive and or behavioural therapy, and of course the very important healthy lifestyle orientations. Ultimately of course, we must never forget the importance of the assessment of and the attention to any psychiatric co-morbidities because that can make a very substantial difference to the outcome, particularly if it's not noted and addressed in a timely fashion.

GK

Thanks Newman. Some great guidance there around understanding treatment. I'm really interested in hearing from you now about the role of employment in someone with a chronic pain disorder. Can an appropriate, gradual and medically supported return to some form of vocational activity actually aid in recovery.

NH

Well Gayle, I think that's a really important thing to ask and it's important for a number of reasons. We have plenty of scientific data, which shows us that if a person is happy, if they feel that they're being well occupied, they don't feel they're losing out on things, they will feel and report less pain. Whilst if they're depressed, bored, anxious, or worried, they will feel and report more pain, and with that more limitation.

Now of course, a lot of the reasons that we might feel underutilised, undervalued and in peril from a number of reasons would be because we're not at work. Now there is an immense amount of evidence now that's been done in the research literature, which talks about the health benefits, predominantly psychological, but not only, of being in work where you feel valued, where you feel that you're achieving and contributing well to a process that you yourself value. So yes, the health benefits of good work are myriad and with that in mind, being at work not only can promote recovery but it can also offset the likelihood of severity of mental illness which might develop otherwise. We do know that protracted unemployment carries a great risk to one's mental health, and we also know the longer one is not at work whilst with an injury or an illness, the less likely it is the person will ultimately return to work. So, an early return to work wherever possible with appropriate support and structure, I would suggest should be a priority within the treatment planning and an integral element.

Now, of course, many patients say I can't go back to work yet, I've still got a sore, whatever it is, and I ask my patients to consider past experience of say a twisted ankle and of course that's something with which we can all identify. We've all had a twisted ankle sometime in the past and we know that we have gotten ourselves walking again, even when the twisted ankle has still been a bit sore because the twisted ankle is normal, it doesn't scare us and we actually know that walking on it in a sensible way, not overdoing it, but gradually pushing our boundaries further and further is actually part of getting well and getting better again, and we also know that

if we spend too much time, not mobilising, waiting to get well that we will decondition in other ways more globally, and that will be unhelpful to our process. Obviously, sensible restrictions need to be applied and the work re-introduction needs to be carefully orchestrated, but if all of those things are done properly and appropriately, things will line up and it will be to the benefit of the patient, the patient's family and all concerned.

GK

So, one doesn't necessarily need to be better or pain-free to start thinking about or working towards a return to work, and this would likely in fact, help at least for some of the psychological aspects of the illness.

Finally, Dr. Harris, if you could offer just one piece of advice to claims adjudicators around how they can engage customers suffering with a chronic pain condition in the claim assessment process, what would that be?

NH

I think the most important thing of all, and the thing about which I've heard my patients complain most often is somebody's accusation that their pain is not real, that it's all in their head and that has been an accusation based upon the perception that the person's objective findings, their test results, their imaging studies, and so forth are not congruent with the amount of complaint and impairment being reported by the patient. Now unless the patient is lying, which of course is a matter for another podcast, the amount of pain the patient perceives, and reports is real. All pain is in the head, but we don't need to tell them that because that will offend them. The reality is that if the patient says this is what they feel, unless they're lying, it is real, as a product of a complex interaction between the subject of pathology, the broken foot, whatever it is, the spinal cord, the brain processing and the mood state, the society in which they live, it's a complex interaction. But the bottom line, when you add it all up is the pain which they really feel, and if they're being honest, the pain, which they really report. Without first acknowledging that you cannot move forward in a relationship with a person suffering chronic pain.

GK

Yeah. That makes sense and I really liked the way you put that, remember that the pain is real. I think that's the key takeaway for me, that pain can occur in the absence of external causes and it's no less real pain than if it were caused by a physical injury.

That's all we have time for today. Thank you for listening and a huge thank you to Dr. Harris for talking to us today about a very important topic.

Keep an eye out for our next instalment of Take10 and I hope you can join me.

Speakers

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