Chronic pain is a major public health problem that inflicts not only tremendous personal suffering but also huge economic loss to individuals and society. This article discusses the psychiatric aspects of chronic pain and disability. Topics covered include chronic pain and psychiatric illness (e.g., somatization disorder, conversion disorder, hypochondriasis, and so on), the interrelationship between pain and depression, and psychodynamics and psychotherapy.

The following quotation written by an unknown physician in the 1970s is as valid today as it was then. With the exception of malingering, all pain is real.

It is a burden for the physician to decide which pain is real and which imaginary. In fact, this decision can be arrived at quite simply. Pain occurring in unicorns, griffins and jabberwockies is always imaginary pain since these are imaginary animals. Patients, on the other hand, are real and so they always have real pain. Although the limitations of modern science are such that we are often unable to indicate the ultimate specific cause of a patient's pain, our own diagnostic inadequacies hardly justify downgrading even implicitly the reality of the patient.

In previous articles on chronic pain and disability [1, 2, 3, 4], I noted that if we define health not as the absence of disease but rather as a state of physical, psychologic, social, and spiritual well-being, then we are an extremely unhealthy society. Suicide among children and teenagers has risen dramatically. The divorce rate is soaring, and there is an increased incidence of depression in hospital admission and discharge summaries of individuals with physical pain.

Much more is known about the mechanisms and pathophysiology of acute than of chronic pain, and attempts to generalize from one to the other have resulted in dismal failures of pain control, frequent iatrogenic complications (including iatrogenic disability), and inappropriate usage of medication. Chronic pain is a major public health problem that inflicts not only tremendous personal suffering but also huge economic loss to individuals and society. If the pain remains intractable, the health care professional and the patient become increasingly uncertain about the appropriate course of treatment, and both develop a sense of impotence and helplessness. As each becomes frustrated and disappointed with the other, their interaction becomes more strained and less direct [4].

Clinically, physicians cannot prove or disprove the existence of pain in any given individual. A person complaining of pain may or may not have nociception, suffering, pain behavior, impairment, or disability. Pain behaviors often are conditioned, learned, and goal directed. As such, they are amenable to behavioral interventions and psychotherapies, and they can be modified and replaced by well behaviors that are more adaptive.

**Chronic Pain and Psychiatric Illness**

Pain is an extremely common complaint in patients with known emotional disorders, and it may be an associated symptom in virtually any psychiatric illness. Extensive clinical research has indicated the tendency for affective and personality disorders to occur with intractable chronic pain [5, 6, 7, 8, 9]. Table 1 lists emotional disorders that are associated with chronic pain syndromes.

**Table 1: Emotional Disorders Associated with Chronic Pain Syndromes**

- Somatoform disorders
- Somatization disorder
- Pain disorder
- Hypochondriasis
- Atypical somatoform disorder
- Affective disorder
- Personality disorders
- Psychologic factors affecting physical conditions
- Malingering
- Schizophrenia
- Substance use disorders
Somatization disorder
Those individuals with somatization disorder tend to consult many physicians to validate their symptoms, and they frequently have surgical procedures with basically negative pathologic findings. They are at high risk for iatrogenic complications and should be managed conservatively unless there are clear signs or objective pathology warranting more aggressive treatment.

Conversion disorder
Individuals who are said to have underlying hysterical personality patterns are prone to either exaggerate the magnitude of their complaints or to present these complaints in a melodramatic fashion. It should be emphasized, however, that these statements in no way imply that the patient's pain is not real or is not organically based. Patients with chronic pain frequently manifest nondermatomal sensory abnormalities. When working with these patients, it becomes apparent that their choice of words as descriptors for their pain usually involves emotionally laden and flamboyant language that often prejudices the clinician. When pain is the primary conversion symptom, the term pain disorder should be used.

Pain disorder
Clinically, the primary feature of pain disorder is the complaint of pain without adequate physical findings but associated with evidence for the etiologic role of psychologic factors. It is not, however, a diagnosis of exclusion. Patients with undiagnosed chronic pain or chronic pain of uncertain etiology should not be presumed to have psychogenic pain. It should be established that no other mental disorder is contributing to the disturbance. It has been my impression that the premorbid personalities of these individuals commonly reveal evidence of neurotic functioning and, less often, borderline personality organization preceding an injury or painful medical illness. Having said this, however, it must be emphasized that individuals who meet diagnostic criteria for pain disorder have "real" pain and "real" suffering, and they should be treated with the same empathy and compassion as those with organically based pain. The diagnosis of pain disorder must be made cautiously and periodically reexamined to rule out any possibility that the pain may be explained on an organic basis that earlier eluded clinical or laboratory diagnostic capabilities.

Pain itself may become the focal aspect within a neurotic conflict, as may financial compensation in a compensation neurosis. It then is called a pain neurosis. Sometimes, a core issue involves unmet dependency needs and both primary and secondary gain.

Hypochondriasis
Hypochondriasis is quite common among patients with pain. They fail to be reassured by clinical or laboratory evaluations, and they remain fixated in their belief of needing more diagnostic tests and evaluations. Arguing with these individuals or trying to dissuade them generally is futile. The degree of their concern often causes significant psychosocial dysfunction. Of course, one must exclude true organic disease; however, it should be emphasized that the presence of true organic disease does not rule out the possibility of coexisting hypochondriasis.

Psychologic factors affecting physical condition
According to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) [10], the category "Psychologic Factor Affecting Physical Condition" can be used to describe disorders once referred to as either psychosomatic or psychophysilogic. My experience indicates that a very common problem in patients with pain is a tendency to suppress emotional expression and internalize feelings. The physiologic expression of these tendencies manifests in autonomic hyperactivity and muscle tension, both of which directly contribute to the pain. Included in this category are tension and migraine headaches, angina pectoris, painful menstruation, sacroiliac pain, neurodermatitis, arthritis, peptic ulcers, and others. I find this category confusing at times, given the overlap with two previously described subcategories of pain disorder (ie, pain disorder associated with psychologic factors, pain disorder associated with both psychologic factors and a general medical condition).

Malingering
Malingering implies a conscious and voluntary fabrication of a physical or psychologic symptom for personal gain. This may involve financial compensation, drug-seeking, personal manipulation, vocational disability, or other attempts to manipulate the individual's environment through use of pain. To be classified as a malingering, the person must be consciously feigning illness. These individuals often are difficult to treat, because the obvious gain is so overwhelming. Frequently, they perceive themselves as having more to gain by retaining the symptom than by relinquishing it. There commonly is a great deal of underlying psychopathology, and the primary treatment of malingering, if it is amenable to treatment at all, must be psychiatric. Although malingerers often may have antisocial personality characteristics, this need not be the case.

Schizophrenia