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Connecting Pain and Mental Illness

In the United States and around the world, there is a heightened awareness of mental illness, unlike anything seen in the past. Mental illnesses (MI) are conditions that affect emotions, behavior, and thinking along with negatively impacting daily functioning. Examples are post-traumatic stress disorder (PTSD), major depressive disorder, and schizophrenia National Alliance on Mental Illness (NAMI, n.d.). According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2021), in 2020 one in five adults, or nearly 53 million people in the United States, had a MI. The statistics among youth are equally startling, as 17% of ages 12-17 had an episode of major depression. In addition, just over 14% of people aged 12 and older had a substance use disorder.

It is well known that comorbid pain and MI can covary, particularly with certain disorders. As an example, Tang et al. (2022) found a causal factor between pain and depression. They also found a genetic predisposition to depression associated with a risk for headaches, shoulder/neck pain, back pain, and shoulder/stomach pain. These researchers further discovered a risk for depression in people genetically predisposed to those types of pain. In addition, Kleycamp et al., 2021, identified over half of persons with fibromyalgia tended to have a lifetime prevalence of depression along with one third of them having a greater prevalence of bipolar disorder, PTSD, and anxiety disorders. Moreover, with migraine headaches, it is well established that these are strongly linked to affective disorders, including depression, anxiety, and bipolar disorders (Dindo et al., 2017; Giri et al., 2022; Stubbs, Eggermont, et al., 2015).

People with MI are also more likely to abuse opioids compared to those without a MI (Mason et al., 2016). At the other end of the spectrum, people with schizophrenia may be less likely to report pain, which could delay treatment of an underlying condition. Stubbs, Thompson, et al. (2015) found that schizophrenia patients have a higher pain tolerance and decreased pain sensitivity, whether on antipsychotics or not.

Assessing for Mental Illness

Assessing for MI in pain patients is important for several reasons and should become a routine part of care. One reason is that bodily aches and pains may be the primary presentation of depression (Dreher et al., 2017), increasing the risk of inappropriate analgesic management. Pain may worsen psychiatric symptoms (Stubbs, Gardner-Sood, et al., 2015) or make MI treatment less effective (Fishbain et al., 2014). The opposite is also true. In a study by O'Connor and da Silva (2019), depression predicted functional limitations after physiotherapy.

Uncovering common MI can be accomplished with screening tools such as the PHQ-9 for depression and the GAD-7 for generalized anxiety disorder (Sapra et al., 2020). Both are short, self-report questionnaires that patients can fill out in the waiting or examining room. For patients with literacy problems, clinicians may instead ask the screening questions. The National HIV Curriculum (2022) provides a quick, online resource that contains several mental health and substance use screening tools, including the PHQ-9 and GAD-7 (https://www.hiv.uw.edu/page/mental-health-screening/gad-7).

A formal diagnosis of MI is assigned by mental health specialists such as psychiatrists, psychologists, and psychiatric-mental health nurse practitioners. However, nurses in any setting should be able to recognize common signs of depression, anxiety, mania, and psychosis. Information on signs and symptoms of MI is available from organizations such as the National Institute of Mental Health (https://www.nimh.nih.gov/health/topics), National Alliance on Mental Illness (NAMI) (https://www.nami.org/Home), and Mental Health America (https://mhanational.org/MentalHealthInfo).

Reviewing Medications

Reviewing all patients' medications is another strategy for identifying MIs. The five categories of psychotropics are antidepressants, antipsychotics, anxiolytics, hypnotics, and mood stabilizers (Caraci et al., 2017). Selective-serotonin reuptake inhibitors (SSRIs) such as sertraline and escitalopram, are a class of antidepressants used for both depression and anxiety disorders. It is important, not to assume that your patients are taking psychotropic drugs for MI. Lamotrigine and divalproex sodium, for example, which are used as mood stabilizers, are anti-epileptic drugs (AEDs). Reference materials on psychotropic medications should be on hand for any practice managing pain patients. These could be textbooks, websites, apps, or commercially available "cheat sheets."

Multidisciplinary Approach

Patients with comorbid pain and MI often present with complex treatment needs that require a multidisciplinary approach. Mental health professionals may include psychiatrists or psychiatric-mental health nurse practitioners for psychotropic medication management and/or psychologists, licensed social workers, or counselors for therapy. In some instances, your patients may have case managers who help them with housing, transportation to appointments, and accessing other community resources.

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Need for Compassion and Listening

When working with patients who have MI, an important point is to remember their humanity and individuality. They have children, hobbies, and like to talk about sports, just like anyone else. A person with schizophrenia, for instance, is not a "schizophrenic," or diagnosis, but a human being who has lived experience of a MI called schizophrenia.

Communicating to engage people with MI in treatment is a matter of conveying empathy and respect, and above all, listening. Patients with MI in a study by Hemmings and Soundy (2020) didn't feel like they were listened to or understood. It is not possible to understand if you are not actively listening. This entails paying attention to nonverbal cues, reflecting back to them that you have heard (not just parroting the exact words), and using appropriate periods of silence to allow them time to answer your questions. People with severe depression or thought disorders, such as schizophrenia, may process their thoughts at a slower pace and need more time to respond. Try replacing yes/no questions with "tell me about…" statements whenever possible. Too many yes/no questions asked in rapid succession, especially when you fail to look away from your computer, comes across as indifference.

Symptoms of MI may make understanding your patients more challenging. People who are depressed may speak in a soft voice, making it difficult to hear. They need gentle reminders to talk more loudly. Mania or anxiety can cause people to talk very rapidly. If your patient is anxious, take a slow, deep breath with them to relax. Someone with schizophrenia or a person experiencing mania often displays thought disturbances. In mania, a "flight of ideas" manifests itself as a rapid-fire succession of topics. Thoughts can be disorganized in schizophrenia as well as mania, where topics and ideas are unrelated. It is often helpful, when you aren't following the flow of a conversation, to listen for themes. Don't pretend to understand if you do not. Repeat back what you think you heard and ask for confirmation. Even if you are not correct, your patient will likely appreciate that you made the effort.

These strategies may sound like they consume valuable time, but the expenditure is well worth it. They result in obtaining a more comprehensive, accurate picture of your patients and establishing a therapeutic alliance, which promote better treatment outcomes.

It is vital to remember that MI is prevalent and commonly co-occurs in patients with pain. Healthcare providers, including nurses, often feel underprepared to work with these patients. In collaborating across disciplines, accessing educational resources, and communicating respect and sensitivity, we can provide our patients with skilled, compassionate, and holistic care.

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