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Clinical Study of the Interrelationship Between Complaint of Pain and Depressive Illnesses

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ABSTRACT

30 females suffering from pain associated with depressive symptoms were studied in detail from the general medical and psychiatric aspects and compared with two control groups one was suffering from depressive illnesses without pain, and the other was suffering from organic pain. Results revealed a background of depressive illness in the study group of patients, characterized by atypical depressive state in which pain, work affection, retardation, loss of energy, sleep disturbances, depersonalisation and loss of interest were the main features. Pain was gradual in onset, persistent in course, long in duration with vague or dull aching nature.

INTRODUCTION :

Depression has claimed the attention of psychiatrists, who have duly studied and described the psychiatric symptomatology characterising depressive modes of expression; and, as a cause of purely subjective somatic symptoms which lack the deepness of frankly depressive experience. Among these somatic symptoms, a psychic conflict may sail under a pain flag in the sea of depression. In these cases, pain may constitute the 'mask' concealing the underlying depression.

The belief in the existence of a relationship between depressive illness and somatic disturbances, which may be the main complaint and a diagnostically puzzling presenting symptom of depression, has

been handed down to us since ancient times, and was described by Ancient Egyptians in the books of the heart in Eber's papyres (Okasha, 1978). The causal relationship between the two syndromes (pain and depression) remains controversial. The anatomical, psychophysiological, biochemical, psychological, and the psychopharmacological studies all have contributed to knowledge of the mode of pain production in such cases.

Clinical relationship between pain and depression :

Chapman (1977) denoted that a dual relationship between pain and depression, that makes it possible to report; a chronic painful illness producing secondary depressive changes and a depressive illness that makes a primary contribution to the pain. Depression secondary to chronic painful illness was emphasized by Stengel (1965). Joffe and Sandler (1967), Swab et al. (1967), Woodforde and Fielding (1970), Lepes (1973), Mumenthaler (1975), Pildwsky and Spence (1975), Rayon (1978), Boyer and Guelfi (1979), and Peteet (1979). On the other side, depression as a prime cause of pain was reported by Bradely (1963), Dowling and Knox (1964), Stengel (1965), Merskey (1963), Lascelles (1966), Joffe and Sandler (1967), Lopez-Ibor (1972). Sternbach (1974), Pilowsky and Spear (1975), Chapman (1976). Merskey (1978) and Bond (1978). Neurophysiologically based contradictory opinions of Von Knorring (1974), and Ben-Tovin and Schwartz (1981), who described reduced pain sensibility in affective illnesses.

Description of pain as depressive symptom :

Pain as a presenting symptom of depression was described by various authors and investigators. Bradely (1963), Lascelles (1966) and Chapman (1976) reported that patients could not relate an ascertainable precipitating factor to any of their pains. Bradely (1963), Lascelles (1966), Spear (1967), Lessé (1968), Serry and Serry (1969), White and Sweet (1969) and Pilowsky (1976) agreed that this pain is constant or currently present and endures for long periods of weeks to years. Engel (1959) described it as vague complex complaint, Bradely

(1963) stated adjectives as stabbing, burning, aching or gnawing, and noted that head pain was distinguished by the patients from headache. Devine and Merskey (1965) reported bizarre descriptions of psychologically determined pains. Lascelles (1966) referred that the most typical descriptive phrase of the atypical facial pain that coexists with depression was "a deep dull severe ache-unbearable at times". Bond (1978) showed that headache with depression has an indefinte nature. Walter (1961). Gittleson (1962), Bradely (1963) and Bond (1978) found that depressive pain is most common in the head, face or abdomen, affecting one or more area, but lacking the generalisation or shifting character of tension pain. Halliday (1937) showed it to be left sided, while Spear (1967) reported that the possibility of its occurrence on the left or right is equal. Spear (1967) noticed that radiation of this type of pain is not common, but, Lascelles (1966) and Bond (1978) showed that it does not conform to the peripheral distribution of near by nerves. Depressive pain may change or fluctuate in relation to mood variation (Bond, 1978), but it does not wake the patient from sleep (Spear 1967; Bond 1978). In some cases, there was tenderness over the area involved that disappears at the level of anesthesia where the eye lash reflex ceases (Bradely, 1963). Spear (1967), Bond (1978), Khatami and Rush (1978), Kielholz (1979) and many others justified that pain with depression is relieved by rest, antidepressants and tranquilizers but is not reduced by analgesics. This improvement is best reached, the higher the site of pain (Walter, 1961) or the shorter the clinical history (Lascelles, 1966; Pilowsky, 1976; Bond, 1978). Bradely (1963), Spear (1967) and Pinsky (1975) credited that emotional strain and exertion are the most common precipitating factors. Kassel and Coppen (1963), Spear (1964) and Merskey (1965) left doubt that some association does exist between painful experiences and depression. But, Engel (1959) showed that some patients have had previous episodes of depression without pain. Positive family depression or in the first degree relatives may be detected in those patients (Lascelles, 1966). Lascelles (1966), Lopez – Lbor (1972), Bianchi (1973), Bond (1978) and Chowdhurg (1979) indicated that with pain, the depressive

features were not typical; lethargy, fatigue, insomnia, decreased libido, diurnal mood variation were frequent. A high proportion of patients with pain and depression were females (Bradely, 1963; Lascelles, 1966; Notermans and Zophoff, 1967; Blumenthal, 1967) at the age of menopause (Bradely, 1963), or at younger ages (Lascelles, 1966), of the lower socioeconomic status and of rural domicile (Baker and Merskey 1967; Spear, 1967; Pilowsky, 1970), and less educated (Pilowsky, 1970).

No significant abnormalities were found either on examination or in the investigations carried out for such patients (Lascelles, 1966). Clinicians and researchers have noted that patients referred with intractable pain tend to show evidence of other psychiatric disorders, as; anxiety, hysteria, phobic reaction, O.C.N., hypochondriasis, compensation neurosis, psychopathic personality or malingering, mental subnormality, organic confusion states or schizophrenia.

MATERIAL AND METHODS

The material of this work consisted of 90 female subjects. 30 patients suffering from any type of depressive illness associated with pain as the most salient clinical presentation, 30 cases suffering from any type of depressive illness not associated with pain, and 30 females reporting long lasting pain of organic origin diagnosed by general and regional physical examination and complete neurological evaluation and investigation as each case required as a prominent symptom. In choice of cases, those suffering from other associated psychiatric illnesses or where there was any doubt about an organic lesion to account for the pain, were excluded. With the exception of sex, any other criteria for selection or exclusion were not considered. A complete detailed information about the patient's family, social, and financial relations was asked for. All cases were subjected to full physcial, and psychiatric examinations, with the necessary investigations to exclude or confirm presence of organic disease. Diagnosis of depression was based on the Egyptian Diagnostic manual of psychiatric diseases.

RESULTS AND DISCUSSION:

Distribution of patients of the group of pain and depression according to their ages showed that their ages ranged between 12–65 years, with a mean age of 37.8 years. 90 % of them were between the ages of 20 – 40 years (Table 1). Statistically insignificant differences were detected between patients of the three groups according to age, residence (Table 2) , occupation (Table 3) , social or marital status (Table 4), birth – order (Table 5), relevant illness in past history of the patients or their families (Table 6), past history of drug treatment (Table 7)and events preceding the present illness (Table 8). Unsatisfactory marital relationship differed significantly between the group of pain and depression or depression only and the other group of organic pain. The educational level differed significantly between patients with pain and depression and those with depression only, being more illiterate in the first one, a factor that may be considered in classifying patients of this group among depressives.

Analysis of the complaint of pain in those of the first group and the third group of organic pain cleared that, the mode of onset of depressive pain was gradual in 86.7 % of cases in relation to 56.7 % of patients of the organic pain, with a statistically significant difference between each. In case of patients of the organic pain, depression reported was almost always secondary to the onset of pain, while, in depressive pain, 80 % of cases showed that both were found to occur together, in the remaining 20 % onset of depression preceded that of pain showing that the link between both is rather a direct causal association. Duration of depressive pain ranged from 6 months to 22 years, with a mean duration of 4.52 years. A weak positive statistical relationship was found between ages of patients and duration of pain ($r = + 0.24$), i. e. age may be a factor in the chronicity of illness in cases of depressive pain but it is not the only factor. 73.3 % of cases of depressive pain reported that once the pain started it continued without relief, i.e., had a persistent course. This type of pain was found to be of variable nature, but commonly of dull aching (33.3 %),

TABLE I

Distribution of Patients of the Three Groups According to Their Ages

(in years)

	Range		— 20		20 —		30 —		40 —		50 —		60 — 70		Total	Mean	SD
	Min	Max	No	%	No	%	No	%	No	%	No	%	No	%			
GP A.	21	65	—	0	4	13.3	13	43.3	10	33.3	1	3.3	2	6.7	30	37.8	9.67
GP B.	21	57	—	0	10	33.3	13	43.3	3	10	4	13.3	—	0	30	35.2	9.12
GP C.	13	60	2	6.7	6	20	7	23.3	8	26.7	6	20	1	3.3	30	38.4	12.29
Total	13	65	2	2.2	20	22.2	33	36.7	21	23.4	11	19.2	3	3.3	90	37.1	10.39

"t" value for the mean ages of groups A&C : $t = 0.24$, $P > 0.05$

A&B : $t = 1.05$, $P > 0.05$

B&C : $t = 1.13$, $P > 0.05$

TABLE II

Distribution of Patients

According to Their Residence

	Urban		Rural		Total
	No	%	No	%	
GP A.	21	70	9	30	30
GP B.	26	86.7	4	13.3	30
GP C.	24	80	6	20	30
Total	71	78.9	19	21.1	90

For Gps. A, B&C : $X^2 = 2.51$, $P > 0.05$

A&B : $X^2 = 1.51$, $P > 0.05$

TABLE III A

Distribution of Patients According to Their Occupation

	House Wife		Employee		Labourer		Merc hant		Student		Profess.		Unemployed		
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	Total
GP A.	25	83.3	1	3.3	1	3.3	1	3.3	1	3.3	—	0	1	3.3	30
GP B.	17	56.7	7	23.3	1	3.3	—	0	2	6.7	3	10	—	0	30
GP C.	21	70	3	10	1	3,3	1	3.3	2	6.7	1	3.3	1	3.3	30
Total	63	70	11	12.2	3	3.3	2	2.2	5	5.6	4	4.5	2	2.2	90

TABLE III B

Classification of Patients into House Wives & Working Outside the House

	House Wife		Working Outside the House		
	No	%	No	%	Total
GP.A	25	83.3	5	16.7	30
GP.B	17	56.7	13	43.3	30
GP.C	21	70	9	30	30
Total	63	70	27	30	90

For Gps. A&C : $X^2 = 1.49$, $P > 0.05$

For Gps. A&B : $X^2 = 5.00$, $P > 0.05$

For Gps. B&C : $X^2 = 1.14$, $P > 0.05$

TABLE IV

Distribution of Patients According to Marital Status

	Single		Married		Separated		Divorced		Widow		Total
	No	%	No	%	No	%	No	%	No	%	
GP A.	2	6.7	21	70	3	10	1	3.3	3	10	30
GP B.	4	13.3	23	76.7	—	0	—	0	3	10	30
GP C.	7	23.3	19	63.3	—	0	1	3.3	9	10	30
Total	13	14.4	63	70	3	3.3	2	2.2	9	10	90

For the three groups : $X^2 = 10.56$, $P > 0.05$

TABLE V

Birth – Order of Patients

	1		2		3		4		5 or more		
	No	%	No	%	No	%	No	%	No	%	Total
GP A.	7	23.3	11	36.7	4	13.3	5	16.7	3	10	30
Gp B.	8	26.7	4	13.3	7	23.3	4	13.3	7	23.3	30
Gp C.	7	23.3	8	26.7	7	23.3	3	10	5	16.7	30
Total	22	24.4	23	25.6	18	20	12	13.3	15	16.7	90

For A&C : $X^2 = 10.18$, $P < 0.05$

TABLE VI

Past History of Relevant Illnesses

	Affective		Physical		Free		Total
	No.	%	No.	%	No.	%	
GP A.	3	10	2	6.6	25	83.4	30
GP B.	4	13.3	1	3.3	25	83.4	30
GP C.	1	3.3	6	20	23	76.7	30
Total	8	8.9	9	10	73	81.1	90

A&C : $X^2 = 3.08$, $P > 0.05$

TABLE VII

Past History of Drug Intake for Treating the Present Illness

	None		Occasionally		Took many		Total
	No	%	No	%	No	%	
GP. A	—	0	9	30	21	70	30
GP. B	8	26.7	17	56.6	5	16.7	30
GP .C	—	0	11	36.7	19	63.3	30
Total	8	8.9	37	41.1	45	50	90

A&C : $X^2 = 0.3$, $P > 0.05$

A&B : $X^2 = 20.3$, $P < 0.05$

TABLE VIII

Relationship of the Present Illness to a Precipitating Factor

	No		Social troubles		Unhappy marital relationship		Financial		Total
	No	%	No	%	No	%	No	%	
GP A	10	33.3	6	20	12	40	2	6.7	30
GP B	11	36.7	7	23.3	11	36.7	1	3.3	30
GP C	28	93.4	—	0	1	3.3	1	3.3	30
Total	49	54.4	13	14.4	24	26.7	4	4.4	90

A&B : $Z = 0.38$, $P > 0.05$

and vague characters (26.7 ٪). The head as the site of complaint of pain was the most commonly encountered site of this type of pain (56.7 ٪ of cases), followed by the abdomen (20٪), chest (6.7 ٪), upper limbs, back, lower limbs (6.7 ٪ each), and lastly the face (3.3٪). 76.7 ٪ of patients of the first group had multiple sites of complaint of pain, but no cases were complaining of pains allover. In both groups there was no pattern of lateralisation or sidedness of the site of pain complaints whether among the patients of the first or third groups. In the group of depressive pain 73.3 ٪ of patients reported that as soon as the pain started, it propagated to different regions but manifested this radiation in a non–specific pattern. Those showing radiation of pain in the third group (80 ٪) manifested this propagation in a specific manner.

Worsening or increased awareness of pain was noted by 93.3٪ of patients of depressive pain compared to 43.3٪ of those of organic pain. They reported that pain was continuous throughout the day but with its maximum intensity occurring in the morning after awaking (50٪). or was markedly augmented at the end of the day (36.7٪), or attacks of increased intensity were variable in its time of occurrence as well as its duration. This rhythmic change was related to emotional stresses in most of cases. But, in patients of the first group,pain was found to interfere with sleep in 30٪ of cases only, that differed statistically from the organic group (76.7٪,$x^2 = 11.31$, $P < 0.05$). (**N.B.** Insomnia was a symptom of depressive illness in 83.3 ٪ of patients of the first group, 95٪ of patients of the third group).

In all cases of the third group, pain was found to be associated with other relevant complaints (e.g. dysuria, unilateral rhinorrhea, ect.), while this character was lacking in 86.7٪ of cases of group of depressive pain, in the remaining cases (13.3٪) of this group, the major complaint (pain) and the relevant complaints were originating from the emotional stress. This emotional stress e.g. mental worry, and exhaustion, beside or without other specific or non–specific factors, was found to be an aggravating factor of pain in 96.7٪ of cases of the first group, while, specific factors related to the type of the disease

e.g. exercise in cardiac pain, stooping or straining in headache of increased I.C.T. etc. were encountered to aggravate the pain in 76 % of cases of the third group.

Pain was reported to be relieved by antidepressants in 30% of cases of the first group and none of the patients of the third group, by analgesics in 56.7% of patients of the third group and 26.6% of patients of the first group, who indicated that pain was relieved temporarily by mild analgesics. Non–specific factors e.g. rubbing and manipulation, tight bandage, heat, or admission to hospital were effective in relieving pain in 13.3 % of patients of the first group and 6.7 % in the third group. A statistically significant difference was detected on comparing the effect of antidepressants and analgesics as relieving factors (X^2 = 9.67, P < 0.05) denoting that antidepressants were more effective in relieving depressive pain and the use of analgesics proved to be of little value in this group of patients. Prescription of antidepressants for relief of pain in cases of organic group was not encountered. The presence of history of excessive use and abuse of drugs was positive in 78% of cases of the first group and 63.3% of patients of the third group with no statistically significant difference between both (χ^2 = 0.3, P > 0.05).

Diagnosis of depressive illness among the patients of the three groups according to Neurotic–Psychotic continuum showed that distribution of N. and P illnesses was more or less homogenous among the first and second groups while patients of the third group were suffering more from neurotic depression. In cases of patients with depressive pain, psychological and behavioural changes were more frequently encountered (37.6 % ,34.6 % respectively) compared to the physiological changes (21%) and the least were the mood changes (6.8%). So, work affection, retardation, loss of energy, sleep disturbances, depersonalisation and loss of interest were the main symptoms colouring the background of the complaint of pain.

None of the patients of the first group was found with a lesion which might seem likely to cause pain on the general, or local physical examination. In 53.3% of cases, there was tenderness over the area involved. Negative result of investigations was a characteristic of those patients complaining of pain as a depressive symptom.

CONCLUSION :

The complaint of pain that was probably the most ancient reason for the development of the physician, was reported to conceal the depressive symptomatology and to modify its presentation. The study of these patients who present complaining of pain and depression revealed the main features of that type of pain. Although it is difficult to draw a pen picture for those patients, but it could be possible, on a statistical basis, to recapitulate the common features that characterise this type of pain.

Depressive pain may occur at any age, but generally in the middle aged group. There was no association between depressive pain and the other demographic data except that it was reported to be more common in less educated and illiterate groups; this may be due to the fact that they have got no other means to express their depression. Events preceding the onset of depressive pain could clarify the causation of depressive illness in these cases, and characterizing them between those with organic pain. The onset of depressive pain is most frequently gradual, in most of cases pain and depression were found to occur together. Depressive pain is a chronic one, currently present, its nature is characterized by its great variability but most commonly dull aching or vague. The head and abdomen were the commonest sites encountered, but this type of pain usually affects more than one area. It radiates but in a non-specific pattern. It usually changes in relation to mood variation, does not interfere with sleep and never wakes the patient at night, is always not associated with relevant manifestations, aggravated by emotional stress or anticipation of emotionally charged events. Drug abuse is a significant problem in those patients and antidepressants

were reported as the most effective relieving factor, while analgesics exert a temporary relief. Careful interviewing revealed a back-ground of depressive illness in the study group of patients, which was atypical in that the classical features of a depressive state were replaced by pain, work affection, retardation, loss of energy, sleep disturbances, depersonalisation, and loss of interest.

Lastly, one needs hardly to be reminded that pain is a symptom and not a disease. The holistic view is favourable in dealing with pain complaints not as a symptom, but as a patient complaining of pain. It would be a good rule to bear the possibility of depression in mind in all cases where the patient presents with a peculiar syndrome that is inexplicable on organic grounds. Non-psychiatrists too should observe this rule in mind to save the patient's time and money and it is unavoidable that the specialists in internal medicine as well as the general practitioners should have to treat these cases. So, informational and educational measures, with post-graduate psychiatric training are needed.

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الموجـــــــــز

دراسة اكلينيكية فى العلاقة بين الالم ومرض الاكتئاب

قام الباحثون بدراســـــة حالات ثلاثين مريضـــة من المصابات بالالم المصاحب لاعراض الاكتئاب النفسى . وقد قاموا بدراسة شـــاملة للنواحى العضوية وكذلك النفسية مستخدمين مجموعتين ضابطتين ، يشـــكو افراد احداهما من الاكتئاب ، والاخرى من اعراض الم عضوى ، ولقد اظهر البحث وجود خلفية من الاكتئاب فى تلك الحالات ، تتميز نوعيا عن الانواع الاخرى للاكتئاب ، اذ انه يتميز بوجود الالم ، وافتقاد الطاقة ، وفقد الاهتمام ، اما الالم فيحدث تدريجيا ويستمر لفترة طويلة .

ABSTRAIT

Une Etude clinique des relations

Entre Les Plaintes de douleur Et La Maladie Dépressive

Trente malades (femelles) souffrantes de douleurs associés avec des symptômes dépressifs ont été examinées en détail suivant les aspects médicaux généraux et les aspects psychiatriques. Ceux-ci ont été comparés avec deux groupes contrôles l'un souffrant d'une maladie dépressive sans douleurs et l'autre souffrant de maux organiques. Les résultats ont révélé un fond de maladie dépressive chez les patientes essentielles de l'étude, celle-ci est charactérisée par le fait d'être un état dépressif atypique où les douleurs, les répercussions sur le travail, l'inhibition, l'aboulie, les troubles du sommeil, la dépersonalisation et le désintérêt étaient ses principaux charactéristiques.

Les douleurs apparaissent graduellement au début avec une progression continue et une longue durée avec des maux sourds et ennuyeux.