

Cases of Low Back Pain in Psychiatry and Their Diagnostic Problems

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Abstract

The underlying cause behind prolonged low back pain may be depression. Patients suffering from depression have high risk of suicide, and there have been several reports on suicides linked to pain. Moreover, among people who had suffered unendurable low back pain, there have been reports of suicidal thoughts as well as cases of suicides just after their pain is alleviated. As such, the issue of suicide related to low back pain leaves much to discuss. Complaints of “heaviness” in the lower back and head, and even the entire body, are typical of patients with depression. As with the physical pain, the sensation of heaviness is a severe affliction for the patient, and should be treated with all due caution. When such patients are referred to psychiatrists by orthopedists or anesthesiologists, they are often diagnosed as psychogenic low back pain. Instead of using the umbrella term “psychogenic low back pain,” physicians should always consider the individual psychiatric problems that lie behind the low back pain. When referring a patient to psychiatric treatment, one preferred method is to inform the patient that he/she is not being completely turned over to psychiatrists and the original treating physicians will continue to monitor his/her health. Such approach will reassure the patients and help psychiatric treatment to proceed more smoothly.

Key words Low back pain, Depression, Functional somatic syndrome (FSS), Complaints of heaviness, Psychiatry

Introduction

After the common cold, low back pain is the second most common reason that people seek medical care,¹ meaning that many patients visit physicians with the chief complaint of low back pain.

Complaining of low back pain, patients often first visit orthopedists or anesthesiologists for treatment. By the time they come to see psychiatrists, they have suffered prolonged low back pain with poor treatment result, and frequently have been given a diagnosis of “psychogenic low back pain.” Deyo and others state that prolonged low back pain is related to failed treatment in the past, depression, and somatization.¹ We surmise that a significant number of patients suffering from prolonged low back pain have become fixated on

their pain and fall into a state of depression after being told that medical imaging revealed no physical problems.

This paper describes low back pain associated with depression and its treatment, as well as the validity of using the term “psychogenic low back pain.”

Low Back Pain and Depression

We would expect to find a considerable correlation between low back pain and the underlying physical lesions. However, according to Waddell’s studies on patients who are being treated by orthopedists for low back pain, the correlation coefficient r between the physical disorder and clinical presentation of low back pain was unexpectedly low,

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at 0.27.² This result suggest that factors other than physical impairment are involved in low back pain. We surmise that one factor behind low back pain is some kind of psychiatric problem.

Polatin et al. studied the frequency of mental disorders among 200 patients suffering from chronic low back pain who were undergoing treatment at a training facility for functional rehabilitation.³ This study found that 98% of these patients met the diagnostic criteria for at least 1 DSM-III-R Axis I disorder (American Psychiatric Association). Major depression was the most common diagnosis, accounting for 64% of the patients. This indicates that depression is associated with low back pain in many cases.⁴

Patients with depression have a high risk of suicide, and there are several reports of attempted suicides among them because of pain. On the other hand, there are also reports of patients who express suicidal thoughts and attempt to commit suicide after their unendurable low back pain is alleviated.⁵ There is no explanation for this contradiction, and further studies are needed to examine this issue.

Complaints of Low Back Pain and Physical Disorder

Among patients complaining of low back pain, some cases show signs of physical disorders affecting the lumbar vertebra, while some do not. The critical question here is whether these 2 types of low back pain should be treated all together. As such, we lay out the following points.

As described in the previous section, Polatin et al. suggest that there is a close relationship between chronic low back pain and psychiatric disorders.³ Addressing low back pain and mental problems, Kikuchi states that there are rather few cases of low back pain that does not have any psychological causes.⁶ He also argues that low back pain is often triggered by depression, a decline in physical condition, or excessive fear of illness, and these factors frequently act to exacerbate low back pain. Kikuchi further claims that, when determining whether an operation should be performed to correct disc herniation, the accuracy of the diagnosis improves to almost 90% by combining both imaging findings and psychosocial factors together.⁷

Morris states that all pain, and particularly chronic pain, is multidimensional, an interdepen-

dent and indivisible combination of human being's two most basic strengths, which the ancient Greeks called *psyche* (mind) and *soma* (the physical body).⁸ He continues to point out that many of the most advanced pain clinics adopt a definition of pain as perception, not sensation, and perception relies not only on the nervous system but also mind and emotions. According to Morris, the aspect of inner mind is immanent in the experience of chronic pain.⁸ Kikuchi concisely defines sensation as a simple process at the level of the receptor organs, while he defines perception as a complex process at the level of the cerebrum.⁹ Considering that perception occurs at the level of the cerebrum, mind and emotions as called by Morris can be regarded as components of perception (cerebrum).

Given these statements, it is reasonable to consider physical disorders and psychiatric problems in tandem when examining complaints of chronic low back pain. In other words, the potential of psychiatric problems cannot be ignored no matter how severe physical disorders are.

Validity of the Use of "Psychogenic Low Back Pain" as a Diagnostic Term

At academic conferences and other venues, people often ask psychiatrists about methods to distinguish between "psychogenic low back pain" and physical disorders of the lumbar vertebra. Is it really possible to make a clear distinction between the two?

We have received referrals stating that "The patient is believed to be suffering from psychogenic low back pain because no particular physical disorder can be found." The disease name "psychogenic low back pain" should only be used when the psychogenesis is apparent and clearly plays an important role as the cause of low back pain.

In recent years, the concept of functional somatic syndrome (FSS) has attracted more attention. Using the example of somatoform disorders, Kato explains that the technical term "somatoform disorder," which definition means "medically unexplained" conditions, implies that the disorder is ultimately psychogenic. This makes it unwilling for the patient to accept the diagnosis, and make it difficult to introduce psychiatric treatment. Given this, Kato states that the use of the term "somatoform disorder" should be

abolished. The patient should be informed that their disorder lies in physical functions, and not psychogenic disorders or physical disorders. Indeed, it is often easier for the patient to accept the explanation that he/she suffers functional symptoms. This is where the concept of FSS is proposed.¹⁰

Regarding the background of FSS, Fukunaga et al. state that testing methods to identify abnormalities in physical functions became more advanced since around 1990, which gradually clarified the relationship between functional abnormalities and symptoms.¹¹ Those new methods allowed to measure peripheral paresthesia of the internal organs and changes in motor and immune functions, which began to be referred to as FSS. The conditions that had been previously considered psychogenic were found to have functional abnormalities, and the term “psychogenic” became insufficient as an explanation. Noguchi states that, while psychological and mental aspects are involved in FSS, the psychogenic theory could not explain everything, and therefore saying that “it is believed to be psychogenic because no physical abnormality can be found” as often heard in referrals from general physicians is not correct.¹²

As described in the previous chapter, physical disorder and psychiatric problems are believed to coexist when it comes to low back pain. Thus, rather than trying to distinguish the two and labeling the condition as “psychogenic low back pain,” it is important to remain aware of psychiatric problems lying behind.

Below, we present 2 cases and describe the important aspects of diagnosis and treatment. For the anonymity of those involved, we modified the details while not compromising the point of argument.

Case Studies

Case 1 (male, age 67)

In January of year X, the patient became unable to sleep, lost his appetite, and felt restless. In May, he began to complain of low back pain. He said, “Using a poultice relieved the pain, but did not ease the heaviness in the lower back.” From early July, he felt that “The heaviness had become so severe that I was in such anguish, and I wanted to rather die if it didn’t go away.” In early August, he drank pesticides in his home in a suicide attempt,

and he was transported by an ambulance to the emergency medical center at our hospital. While he was in the emergency ward, he was examined by an orthopedist and was told that the pain in the lower back can be relieved but not the heaviness, which disappointed him. At that point, he was not given any tests or prescription.

A psychiatrist was called in for consultation. After he was diagnosed with depression, he was moved to the psychiatric ward and was prescribed a small dose of antidepressant. His symptoms improved quickly, and in late August he said that “The heaviness in my lower back is gone and I feel better now.” The patient was released from the hospital in late September.

Case 2 (male, age 66)

In March of year X, the patient retired from his company at the mandatory retirement age. In January of year X + 2, he found himself unable to enjoy anything, felt heavy in his entire body, and was unable to do anything. In year X + 5 in the summer, he still felt heavy in his body, but the heaviness in his lower back became particularly severe that he was in pain. He saw an orthopedist, who diagnosed him with lumbar canal stenosis. He underwent rehabilitation, but there was no effect. In June of year X + 6, he read in a newspaper article that epiduroscopy was effective as a treatment for low back pain, and went to see an anesthesiologist. During the examination, he complained that “I am extremely restless.” In July, he underwent epiduroscopy, but it had no effect. The low back pain was identified as psychogenic, and he was referred to a psychiatrist.

At the first visit, the patient complained that “My body feels like it is made of lead.” He was in depressed state, had thought inhibitions, insomnia, and decreased appetite, and felt extremely strong anxiety and irritability. “I read about this treatment in the newspaper, and I had hoped it would work,” he kept on repeating, claiming that he wanted to die. He was recommended to take antidepressant, which he refused, saying “it won’t cure me anyway, so I don’t want to take medicine.” Shortly after, he stopped coming to the hospital.

Complaints of “Heaviness” and Depression

When patients with depression receive medical

exams, they often complain about the “heaviness,” saying “my head feels heavy,” “I feel heavy in my lower back,” or “my entire body feels heavy.” The patient in Case 1 claimed that the heaviness in his lower back was causing him great misery, and the patient in Case 2 complained that “My body feels like it is made of lead,” “My entire body feel heavy,” and “My lower back particularly feels heavy and painful.” These symptoms can be thought of as a somatized phenomenon, in which the “heavy weight of emotional distress” — the fundamental clinical condition characterizing depression — is affecting the body.

Kato stated that it is very typical for patients with depression to use expressions such as “heavy” and “blocked up” to describe their physical sensations.¹³ The sensation of pain experienced in depression is essentially the same as the sensation of the physical (organic) heaviness in quality, and can be seen as extended form of physical heaviness.

In Case 1, the patient attempted suicide because of the heaviness in the lower back he was experiencing, and in Case 2 the patient complained that “My body feels like it is made of lead.” This sensation of heaviness is very distressing for patients just as the sensation of pain, and physicians should be wary of complaints of heaviness.

Important Aspects of Treatment

Trusting relationship between the patient and the physician

In Case 1, the patient was examined by a physician while he was hospitalized at an emergency medical center. At that time, he was told that the heaviness in his lower back could not be alleviated and was given no tests or prescription. Had the physician listed to the patient more at that point and said “I would like to make more observations, so I shall come back tomorrow to see you again,” it might have been possible to have formed a trusting relationship with the patient and possibly alleviated the patient’s anxiety to some degree.

Cognitive behavioral therapy is the most widely recognized psychological approach in pain management. Psychotherapy is also likely to be an effective approach for some patients as well. Regardless of which method is employed, the therapy will not be effective unless a relation-

ship of trust is formed between the physician and the patient to some extent. The physician’s usual manners toward patients, including at the very first examination, are important for successful results.

Building a good partnership with orthopedists and anesthesiologists

In Case 2, presumably the patient had already developed depression about 2 years after retirement. When he saw an orthopedist 3 years later and anesthesiologist 4 years later, he was likely in depressed state. After epiduroscopy, his depression worsened. The patient had hopes for this cutting-edge treatment, and the deep disappointment he felt when it was ineffective could not be lifted. In such situation, his depression should have been treated first.

The patient must be referred to a psychiatrist at the right time for appropriate treatment. If the patient is told that his/her condition is psychogenic, the patient may wonder “Why am I being sent to a psychiatrist when I am actually experiencing such severe pain?” and may feel abandoned. This would make it difficult for a psychiatrist to treat the patient. As one example, the physician could explain to the patient that “Sometimes a slight change in mood can make pain feel more unbearable, so I would like you to consider talking to a psychiatrist while I continue to see you as my patient.” Reassuring the patient that he/she will receive care from both physicians will relieve the sense of anxiety, which is helpful in building a relationship of trust between the patient and the psychiatrist.

Conclusion

In many cases of prolonged low back pain, depression may exist as the underlying cause. When a patient is referred by an orthopedist or anesthesiologist to a psychiatrist, he/she may have been diagnosed as “psychogenic low back pain.” It is important to always consider the individual psychiatric problems that lie behind the low back pain, rather than diagnosing the condition as “psychogenic low back pain.”

Complaints of “heaviness” in the lower back and head, and even the entire body, are typical of patients with depression. As with physical pain, the sensation of heaviness is a severe affliction for the patient, and should be treated with all due

caution. Needless to say, building a trusting relationship with patients is an important aspect of treatment. A good partnership between the referring physician and the psychiatrist will reassure

the patient and facilitate the development of a trusting relationship between the psychiatrist and the patient.

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