The importance of the psychiatrist as a member of the multidisciplinary pain team

A importância do médico psiquiatra como integrante da equipe multidisciplinar em dor

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ABSTRACT

Introducion: In Brazil, pain is a relatively new specialty, as the largest entity responsible for distributing content related to the area, the Brazilian Society for the Study of Pain (SBED) started its activities in 2006. However, psychiatrists can't act as a pain specialist under the Specialist Qualification Registry (RQE), since psychiatry is not a specialty listed as pre-requirement for applying in the pain specialization selection process. Objective: This article aims to present skills of the psychiatrist in relation to the study of pain, so that effective inclusion in the multidisciplinary pain team as specialist and not just as a supporting mediator. Methods: For the construction of this original article, the bibliographic databases PubMed and Google Scholar were used, The MeSH terms used in this research were diverse, among the main ones: "pain residency", "pain education", "psychiatry pain residency" and "psychiatry pain education". Results: Many of psychiatric disorders such as depression, borderline personality disorder, post-traumatic stress disorder, among others, are commonly prevalent in patients with chronic pain. Mental health can be affected as a consequence of chronic pain, in the same way

that a history of psychiatric disorder can be a risk factor for the development of chronic pain. Patients with pain and depressive disorder have a worse experience, because they report greater intensity, worse functioning and greater disability, compared to patients with pain without depression. Added to that, drugs considered pillars of pain treatment, such as antidepressants, gabapentinoids and antipsychotics, are frequently used by psychiatrists in their clinical practice. Conclusion: The relation between psychiatry and pain must be re-evaluated, this article aims to express the relevance of the psychiatrist in such a diverse and skillful team, in addition to unravel skills and competences for their incorporation in an important area of activity that tends to grow extraordinarily in Brazil and in the world.

Keywords: psychiatry, education, specialization, pain, multidisciplinar.

RESUMO

Introdução: No Brasil, a dor é uma especialidade relativamente nova, visto que a maior entidade responsável pela distribuição de conteúdos relacionados à área, a Sociedade Brasileira para o Estudo da Dor (SBED) iniciou suas atividades em 2006. No entanto, os psiquiatras não podem atuar como um especialista em dor sob o Registro de Qualificação de Especialista (RQE), uma vez que a psiquiatria não é uma especialidade listada como pré-requisito para inscrição no processo seletivo de especialização em dor. Objetivo: Este artigo tem como objetivo apresentar competências do psiquiatra em relação ao estudo da dor, para sua efetiva inserção na equipe multidisciplinar da dor como especialista e não apenas como mediador coadjuvante. Métodos: Para a construção deste artigo original foram utilizadas as bases de dados bibliográficas PubMed e Google Acadêmico, Os termos MeSH utilizados nesta pesquisa foram diversos, dentre os principais: "residência em dor", "educação em dor", "residência em dor em psiquiatria" e "educação psiquiátrica da dor". Resultados: Muitos dos transtornos psiquiátricos como depressão, transtorno de personalidade borderline, transtorno de estresse pós-traumático, entre outros, são comumente prevalentes em pacientes com dor crônica. A saúde mental pode ser afetada como consequência da dor crônica, da mesma forma que a história de transtorno psiquiátrico pode ser um fator de risco para o desenvolvimento da dor crônica. Pacientes com dor e transtorno depressivo têm uma pior experiência, pois relatam maior intensidade, pior funcionalidade e maior incapacidade, em comparação com pacientes com dor sem depressão. Somado a isso, medicamentos considerados pilares do tratamento da dor, como antidepressivos, gabapentinoides e antipsicóticos, são frequentemente utilizados pelos psiquiatras em sua prática clínica. Conclusão: A relação entre psiquiatria e dor deve ser reavaliada, este artigo visa expressar a relevância do psiquiatra em uma equipe tão diversificada e habilidosa, além de desvendar habilidades e competências para sua incorporação em uma importante área de atuação que tende a crescer extraordinariamente no Brasil e no mundo.

Palavras-chave: psiquiatria, educação, especialização, dor, multidisciplinar.

1 INTRODUCION

According to the International Association for the Study of Pain, pain is configured as an unpleasant sensory and emotional experience associated with, or similar to that associated with, actual or potential tissue damage. This concept clarifies that the classification of a scenario as painful depends on circumstances related to the individual's own experiences, which include biological, psychological and social factors in a unique way[1.]

The complexity of the management and behavior of painful phenomena began to be unraveled from the origins of the human being, who perpetually sought to justify its emergence and find alternatives for its control [2]. Nowadays, the study of pain has become an abundant field for health professionals, who explore ways to improve the quality of life of patients who report pain as their main symptom[3].

Since then, the study of pain has become a basic need for students in health areas, especially in the undergraduate medical course, since the management of a patient with complaints of pain is essential at any level of health care, either it from primary care to the urgent and emergency service of tertiary units[2].

In the 1990s, the Pain Practice Area in Brazil was created for medical professionals, which configures the professional as a Pain Specialist, provided that said professional is approved in the agreed tender and completes the workload established under the selection process (two). Until 2020, the Brazilian Medical Association, provider of the title, allows access to specialization in pain, only to the following specialties: Acupuncture, Anesthesiology, Internal Medicine, Physical Medicine and Rehabilitation, Neurosurgery, Neurology, Orthopedics and Traumatology, Pediatrics and Rheumatology[4].

In this context, even if the psychiatrist specializes in pain or works in a multidisciplinary pain team, he/she would not be authorized to act as a specialist in pain under the Specialist Qualification Registry (RQE). Even though pain is configured as an institution with biopsychosocial components, which, the psychiatrist would have all the necessary attributes to perform the appropriate intervention [5].

This article aims to present bibliographical assumptions that expose the skills and competences of psychiatrists in relation to the study of pain, so that they can be effectively included in the multidisciplinary team of pain as a specialist and not just as a supporting mediator.

2 OBJECTIVE

This article aims to present skills of the psychiatrist in relation to the study of pain, so that effective inclusion in the multidisciplinary pain team as specialist and not just as a supporting mediator.

3 METHODS

For the construction of this original article, the bibliographic databases PubMed and Google Scholar were used, in which numerous articles were found, determined about their

relevance by the authors. The MeSH terms used in this research were diverse, among the main ones: “pain residency”, “pain education”, “psychiatry pain residency” and “psychiatry pain education”. Four main literary lines were selected, which became substrate for the gathering of argumentative ideas, namely Leo[5], Elman[6], Balon [30] and Belgrade[31]. In addition, bibliographies developed by the Brazilian Society for the Study of Pain (SBED) were used, such as the Pain Treaty and the documents of the National Campaign “Brasil sem Dor”.

4 RESULTS

4.1 PAIN: AN UNPLEASANT PHYSICAL AND EMOTIONAL EXPERIENCE

As previously mentioned, the International Association for the Study of Pain presents the concept of pain as an unpleasant experience associated or not with tissue damage, making the understanding of the painful mechanism an event that encompasses both the individual's physical and emotional spheres[1].

The Brazilian Society for the Study of Pain (SBED), presents in its latest edition of the Pain Treatise, a considerable relationship about the displeasure during the pain experience. A clinical situation with high-intensity abdominal pain in a cancer patient causes a series of negative feelings in face of possible metastases and complications. However, in a pregnant patient with pain in the face of labor contractions, they sound like a feeling of relieving pain, considering the affective scenario in question[2].

Emotions are closely linked to the pain process, especially negative emotions such as fear, anger, sadness, disgust and even disgust. This relationship is even more consolidated when talking about coping with pain, a circumstance in which the individual, his mind and his body need to adapt to the demands of this painful sensation and properly manage resources aiming at healing[2].

This process can be difficult to control when performed with a professional team that is not adequately prepared to deal with affective issues, especially when it sensitizes the patient to the point of resulting in treatment abandonment or withdrawal from the healing process[2]. The psychologist acts as a protagonist in this support, however, the psychiatrist can actively contribute in the process of psychotherapy and in the pharmacological management of psychiatric medications, which are often necessary and neglected[6].

4.2 PAINFUL STATES AND THEIR EVOLUTION TO PSYCHIATRIC DISORDERS

Pain is configured as the main symptom mentioned during medical care, often being the reason why the patient seeks the service to relieve the painful condition in which he/she is[2]..

This reality is ensured by numerous epidemiological studies that indicate the worldwide prevalence of chronic pain around 10 to 55%[2,7]. In Brazil, although there are no complete studies, analyzes carried out in specialized pain treatment services have identified a 42% prevalence of chronic pain in residents of the city of São Paulo[2].

Despite the high prevalence and the large number of cases, the proper management of this pain is not performed, and it is often overlooked and forgotten by the medical team. This neglect of such an important factor for the patient's quality of life evolves with the need for assessment and management of the condition with a psychiatrist. The reasons are diverse: expectations about the disease and its course, concern about treatment failure, drug abuse and addiction, psychosocial factors that change the course of the disease and even possible symptom simulations[5].

The study by Leo[5] lists pain states that presumably will evolve with this need for evaluation and management by the psychiatrist, they are: headaches and their subtypes, facial pain, low back pain, central nervous system pain, conditions in which the pain acts as an important adjuvant (infections, multiple sclerosis, cancer), rheumatologic diseases and psychiatric disorders themselves[5].

Among the rheumatologic comorbidities, fibromyalgia is highlighted for being similar and based on the same three cardinal characteristics of chronic pain, pain, chronicity greater than three months and widespread location[8]. The disease manifests itself due to a decrease in the pain threshold in nociceptors, in addition to reaching receptors for heat, cold, electrical and auditory stimuli. In the opposite direction, elements such as substance P, glutamate and excitatory amino acids increase their basal levels, aiming at pain modulation, promoting a scenario of hyperalgesia and hyperstimulation[9].

This environment that is totally susceptible to pain at minimal stimuli becomes serious due to its direct relationship with the mental disorders that these patients develop before and during the course of the disease. Around 80% of patients diagnosed with fibromyalgia score positive on scales for depressive and anxiety disorder, during the anamnesis[10].

Diseases such as fibromyalgia, other rheumatologic and non-rheumatologic diseases, have a similar evolution, considerably impairing the patient's quality of life. The psychiatrist could help together with the multidisciplinary team to present skills that empower patients to develop strategies that help them to overcome barriers and psycho-affective issues in their comorbidity[5].

4.3 CHRONIC PAIN PATIENTS AND THEIR RELATIONSHIP WITH PSYCHIATRY

Psychiatric disorders such as depression, borderline personality disorder, post-traumatic stress disorder, among others, are commonly prevalent in patients with chronic pain[6]. Mental health can be affected as a consequence of chronic pain [12,13], in the same way that a history of psychiatric disorder can be a risk factor for the development of chronic pain[14,15]. Patients with pain and depressive disorder have a worse experience because they report greater intensity, worse functioning and greater disability, compared to patients with pain without depression[16].

Pain is influenced by biological and psychosocial factors. For a long time, the treatment of chronic pain focused on relieving physical symptoms. In recent decades, psychosocial factors have started to be recognized in pain management, promoting the role of psychology and psychiatry in this context[11]. Currently, optimal pain management includes a multidisciplinary team with specialist pain professionals, psychologists and psychiatrists[18,19].

Another adversity occurs in primary care environments, as usually when patients experience physical pain, mental health is often neglected by health professionals[11]. A study has shown that 60% of patients with a history of painful conditions would have been diagnosed with depression if they had been evaluated for this, through scales and a good anamnesis[20]. Therefore, the presence of pain negatively impacts the recognition and consequently the treatment of depression[11].

Primary care physicians and specialist pain physicians do not receive sufficient psychiatric training to act in the absence of the specialist, just as psychiatrists do not receive pain training to act alone. The work of these professionals must be done jointly, in which both participate in the management of physical and emotional pain in these patients. This partnership can effectively explore the medical skills of each specialty, complementing them and making the treatment much more effective[11].

4.4 PAIN MANAGEMENT WITH PSYCHIATRIC DRUGS

Antidepressants (ADs), anticonvulsants and antipsychotics are considered adjuvant drugs in the treatment of chronic pain and can be used in association with common analgesics, NSAIDs and opioids[2,6]. In the management of neuropathic pain, guidelines bring tricyclic antidepressants (TDAs), selective serotonin reuptake inhibitors (SSRIs) and gabapentinoids as first-line drugs, in front of tramadol and strong opioids[22].

Psychiatrists use these drugs frequently in their clinical practice, and therefore have control over them, their interactions and adverse effects, not only that the frequency of chronic pain in patients with depression and vice versa is increased, but there may also be, in patients

with chronic pain, the presence of other psychiatric symptoms, such as psychosomatic symptoms[6,11].

Although tricyclic antidepressants and selective serotonin and norepinephrine reuptake inhibitors appear to be more effective in treating chronic pain, patients who do not tolerate these two classes of antidepressants well may respond to other classes of antidepressants[21].

They offer an alternative to opioid analgesics as a first-line treatment for chronic pain, thus avoiding many of the adverse and lethal effects associated with long-term opioid use. In addition, antidepressants improve depression, anxiety, post-traumatic stress disorder, insomnia, and other concomitant psychosomatic disorders[21].

Antipsychotics can be used as adjunct therapy in the treatment of painful conditions, as a possibility for treatment-resistant pain. Its adverse effects must always be taken into account in decision making[23].

Not all mechanisms of action of psychotropic drugs in pain management are known. Antipsychotics act by inhibiting neurotransmitters[2]. Antidepressants increase the descending inhibitory action on the spinal cord by prolonging the synaptic activity of monoamines. They also block several other types of receptors involved in pain processing, including α-adrenergic, H1 histaminergic, and N-methyl-d-aspartate receptors. Antidepressants can also interact with μ opioid receptors or stimulate the release of endogenous opioid peptide[21].

4.5 THE IMPORTANCE OF THE PSYCHIATRIST IN THE STUDY OF PAIN

Gaps in the recognition and diagnosis of depression and other mental disorders demonstrate a clear problem: failure to address psychological comorbidities will likely impede progress in pain management. Psychiatrists may represent a solution to this problem as they have been trained using the biopsychosocial model to assess and treat patients and therefore recognize the importance of addressing not only the medical symptoms but also the psychological, behavioral and social dimensions of the illness. This is a very important factor, since differentiating disorders and optimizing treatment in general for mental health conditions can improve pain and, more importantly, the patient's general functioning and quality of life[11].

In general, pain management becomes a problem, due to the lack of specialized and adequate knowledge of most physicians, however, the psychiatrist has some extra domain skills, which can not only help him to perform this treatment but also add important themes[2,6]. Psychiatrists are specialists in psychopharmacology and may prescribe opioid drugs[24], and other analgesic alternatives such as antidepressants, anticonvulsants and neuroleptics[25], as mentioned in the previous topic.

Furthermore, psychiatrists can diagnose and treat suicidal tendencies[11], and mood, personality, anxiety and psychotic disorders, exerting essential effects on pain intensity and treatment outcomes[26]. The study of pain and the effectiveness of pain training in the psychiatric area and its sub-areas will contribute to a better recognition of chronic pain and psychiatric disorders, regardless of patients' pain status[6].

5 CONCLUSION

The Brazilian Medical Association (AMB), at the end of the 1990s, established the Area of Action in Pain in Brazil and, since then, the physician specialized in certain areas of medicine could act as a specialist in pain after a private educational process determined by responsible institutions[2]. These areas of medicine that are considered prerequisites for taking the AMB test are as follows: Acupuncture, Anesthesiology, Internal Medicine, Physical Medicine and Rehabilitation, Neurosurgery, Neurology, Orthopedics and Traumatology, Pediatrics and Rheumatology[4].

Unfortunately, Psychiatry is not yet considered a pre-requirement specialty for the tender of a specialist in pain, that is, so far there is no possibility for the psychiatrist to qualify for the Area of Expertise in Pain in Brazil. According to the Brazilian Psychiatric Association, the areas of practice in psychiatry validated in Brazil until the year 2021 are: Psychotherapy, Psychogeriatrics, Child and Adolescent Psychiatry and Forensic Psychiatry[27].

Also in the late 1990s, the American Council of Psychiatry and Neurology, in association with other councils, developed a subspecialty in pain, so that psychiatrists could improve their knowledge in the management of painful conditions. This deepening available to psychiatrists in the United States, allows greater interdisciplinarity in the administration of care to these patients who have chronic pain and difficult to treat[5].

In Brazil, pain is a relatively new specialty, as the largest entity responsible for distributing content related to the area, the Brazilian Society for the Study of Pain (SBED) started its activities in 2006[2]. Brazilian states still suffer from a shortage of doctors and teams specializing in pain, and for this reason, SBED has been instituting the “Brasil sem Dor” campaign, in which effective measures are proposed to address pain undertreatment, improve its assessment and monitor the quality of pain therapy in healthcare facilities. This project aims to improve services and train professionals to manage pain, especially chronic pain, which currently affects 10 to 55% of the world population[2,7,28].

Also, related to the scope of the campaign, the Clinical Protocol and Therapeutic Guidelines for Chronic Pain (PCDT) was established through ordinance number 1083, of

October 2, 2012. The regulation is composed of numerous clinical scenarios in which psychiatric medications, antidepressants and antiepileptics are considered pillars of pain treatment[29]. These and other relationships between psychiatry and chronic pain actively support the development of this article and the construction of a premise that justifies the inclusion of the psychiatrist as a specialist in this area of expertise.

The search for studies that corroborate the argumentation is based on the literature of four researchers: Leo[5], Elman[6], Balon [30] and Belgrade[31], which directly exemplify the relationship between psychiatry and the psychiatrist and the study of pain and its variants. This bibliography strengthens the importance of the possibility of in-depth pain education, whether through a subspecialization or the very introduction of the pain chair as one of the pillars of residency in psychiatry.

The results found, in these and in several literatures, provided some topics that were previously unraveled, the concept of pain as an unpleasant physical and emotional experience (a), painful states and its evolution to psychiatric disorders (b), patients with chronic pain and its relationship with psychiatry (c), pain management with psychiatric drugs (d) and the importance of the psychiatrist in the study of pain (e).

The detailing of these scenarios in which the psychiatrist presents himself with skills and acumen to assist in the management of the patient confirms and emphasizes the importance of his participation in the multidisciplinary team on pain, especially in the Brazilian reality, where access to specialized pain service is still little available[2,28].

This article aims to express the relevance of the psychiatrist in such a diverse and skillful team, in addition to transmitting skills and competences for their incorporation in an important area of activity that tends to grow extraordinarily in Brazil and in the world. The legitimacy of the psychiatrist as a specialist in pain is necessary for his participation to be relevant in the treatment of pain as a whole.

The possibility of acquiring the Specialist Qualification Registry (RQE) in Pain is an immense advantage for Brazilian psychiatry, which can broaden its horizons in the study and management of such a new and revolutionary area. Leo, Elman, Balon and Belgrade begin and structure this claim in an intelligent and brilliant way, which the authors of this paper consider essential to the consecration of the psychiatrist as a specialist in pain and part of his team.

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