THE RELATIONSHIP AND IMPORTANCE OF PAIN AND DEPRESSION IN ASSESSMENT OF THE ELDERLY IN PRIMARY CARE

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Pain and Depression

THE RELATIONSHIP AND IMPORTANCE OF PAIN AND DEPRESSION IN ASSESSMENT OF THE ELDERLY IN PRIMARY CARE

Abstract

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Chronic pain syndromes and depression are major medical problems. As the population of elders in the United States continues to increase in proportion to the general population, both depression and chronic pain are likely to become ever more problematic. People over 85 are the fastest growing segment of the population in the United States. It is estimated that by the year 2020 this population will include 7.5 million persons and by 2040 this population group will double to 14 million (U.S. Census Bureau, 2004). It is incumbent that providers understand the close relationship between depression and pain and exercise due diligence in making certain that both depression and pain have been accurately assessed so that the appropriate and adequate treatment can be prescribed. This paper explores the prevalence and relationship of depression and pain. The importance of assessing both in the primary care setting is described.
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Introduction

There is a growing body of literature that addresses a close relationship between depression and chronic pain. The view that there is a close relationship arises from research which investigates the mutual influences of depression and chronic pain. Depression appears to predispose an individual to increased vulnerability to pain problems and the manner in which an individual deals with pain. Conversely chronic pain is often accompanied by depressive symptoms. In a study assessing depression in outpatients who completed a self-rating questionnaire, 80% of the respondents reported painful somatic symptoms that included stomach pain, neck and back pain, headache and nonspecific generalized pain (Jann, & Slade, 2007).

The relationship between pain and depressive symptoms has been well established in community dwelling seniors (Chou & Chi, 2005). In this population the prevalence of pain ranges from 25% to 50%. People living in long term care centers have rates of pain from 45-83% (Ferrell, Ferrell, & Osterweil, 1990). Data from the Epidemiological Catchment Area (ECA) study of more than 18,000 adults collected from site catchment sites found that the lifetime rates of depression for men and women over the age of 65 to be 2% of men and 3% of women. Of the geriatric respondents 15% had current depressive symptoms (Fombonne, 1994). The prevalence rate of depression of geriatrics in primary care settings is estimated to be 5% (Consensus panel, 1992).

Chronic pain syndromes and depression are major medical problems. As the population of elders in the United States continues to increase in proportion to the general population, both depression and chronic pain are likely to become ever more problematic. People over 85 are the fastest growing segment of the population in the United States. It is estimated that by the year 2020 this population group will include 7.5 million persons and by 2040 this population will double to 14 million (U.S. Census
Bureau, 2004). It is incumbent that providers understand the close relationship between depression and pain and exercise due diligence in making certain that both depression and pain have been accurately assessed so that appropriate and adequate treatment can be prescribed.

This paper explores the prevalence and relationship of depression and pain. The importance of assessing both in the primary care setting is described.

The general public assumes that nurses and physicians possess comprehensive knowledge about pain and pain management and that such knowledge is being readily used in practice. However there are many studies that indicate that this is not the case (Coyne, Reinert, Cater, Dubuisson, Smith, Parker, et al., 1999). Healthcare professionals, including nurses often hinder adequate treatment of both pain and depression due to a lack of understanding of the physiology of pain, pharmacology, lack of understanding about the differences between dependence and addiction and long held misconceptions about elderly patients in relation to pain and depression (Siciliano, 2006).

The Prevalence of Depression and Pain

The Prevalence of Depression

In 1990 depressive disorders were estimated by the World Health Organization to be the world’s leading cause of disability (non-fatal), accounting for 10.7% of the total years lived with disability (YLD). Correspondingly depressive disorders were the fourth leading cause of the total global burden of disease, accounting for 3.7% of the total disability adjusted life-years (DALYS) (Ustun, Mateos-Ayuso, Chatterji, Mathers, & Murray, 2004). Depression is the most prevalent of all mental disorders. Depression affects approximately 10% of primary care patients (Kessler, Bergland, Demler, Jin, Koretz, Merikangas, et al., 2003). In the elder population accessing primary care the prevalence of depression affects roughly 5-10% of this population (Blazer, 2003). According to Beekman (1999) the
prevalence of clinically significant depression among older persons living in a community setting is 13.5%.

Two-thirds of older people with serious depression do not have symptoms that clearly fit into the current DSM-IV classifications of mood disorders that have been generated to describe and reflect symptoms in younger people. Older people, while experiencing depression may not have sufficient symptoms to meet the diagnostic threshold for major depressive disorder. Older people may present differently from younger people because of aging, physical illness or a combination of both (Graham-Chew, Baldwin, & Burns, 2004). Depression in older medically ill presents a significant public health problem because of the high prevalence rate of depression in the elderly who also have pain related to disorders such as diabetes, arthritis, renal disease and cardiovascular disease (Drayer, Mulsant, Lenze, Rollman, Dew, Kelleher, et al., 2005).

Depressive illness is related to significantly increased morbidity and mortality (Wells, Stewart, & Hays, 1989). Depressed patients make more office visits, make more calls to their physicians, have more medical tests done and are more likely to be hospitalized for medical disorders than non-depressed patients. Depression is particularly prevalent among “high utilizers” of medical care resources of whom as many as 40% may have a current depressive disorder (Katon, Berg, Robins, & Risse, 1986).

*The Prevalence of Pain*

Pain is an unpleasant experience and it is reasonable that its symptoms are closely linked to depression (Jann, & Slade, 2007). In the general population chronic pain affects over 80 million persons in the United States. Pain of the acute and chronic type is the primary presenting symptom in more than 80% of all primary care physician visits. The prevalence of persistent pain has been reported to be present in 20% of primary care patients. In a report by the American Academy of Pain
Management greater than one-half of all Americans reported experiencing recurrent or chronic pain in 2002. Further it has been reported that 62% of the aforementioned patients have been in a pain state for more than a year and that 40% reported that they are in constant pain (Holmquist, 2007). Epidemiologic studies indicate that the lifetime prevalence of pain symptoms in various types of pain (i.e. joint pain, back pain, headache, chest pain, arm or leg pain, and abdominal pain) ranges from 24%-37% and that pain symptoms are the leading cause why people seek medical attention (Bair, Robinson, Katon, & Kroenke, 2003).

The Scope and Significance of the Relationship between Pain and Depression

Comorbid conditions such as pain and depression are the norm rather than the exception among patients who have a major depressive disorder. In a survey by Arnow, Hunkeler, Blasey, Lee, Constantino, Fineman, et al., (2006) of 5,808 respondents, 413 met the criteria for a major depressive disorder while 1,887 reported experiencing non-disabling chronic pain and 731 reported disabling chronic pain. Compared to those without chronic pain, respondents who reported chronic pain were more likely to report depression as a problem. Respondents with major depressive disorder and chronic disabling pain had significantly worse health related quality of life scores than other groups. Depression is a common experience among those with chronic pain. Upwards of 20% of respondents in a survey by McWilliams, Cox, & Ems (2003) who reported suffering from chronic pain also reported that they experienced depression as well. Comorbid pain and depression are associated with serious effects on normal functioning and economic burden that persists and often increases in severity over time. This is particularly true in the aged and in those who are reaching retirement years. Compared to groups who did not experience persistent pain or depression, all groups of individuals who
experienced depression and pain experienced greater decrements in outcomes related to general health and function. Depression with persistent pain and pain states alone were associated with greater decrements in outcomes than depression alone even when the pain was reported to be mild or moderate (Emptage, Sturm, & Robinson, 2005).

Patients with depressive disorders often complain of a constellation of emotional and physical complaints. Physical complaints such as fatigue, insomnia, and pain are more numerous in depressed patients than in nondepressed patients. The presenting symptoms are frequently nonspecific and unrelated to a known organic process (Kirkmayer, & Robbins, 1991). According to Ohayon, & Schatzberg (2003) who polled 18,980 subjects in the United Kingdom, Germany, Italy, Portugal, and Spain, the association between chronic pain and depressive symptoms increased with the number of depressive symptoms reported by study subjects. More than a quarter of subjects reporting only two symptoms of depression (28.5%) also had a painful chronic condition. This rate increased to 37.9% when subjects had five depressive symptoms and jumped to 61.9% when at least eight depression symptoms were reported.

Implications for Practice

One of the difficulties in treating pain or depression as a singular condition is that the presenting symptoms of each can overlap. It can be difficult to differentiate which condition is the core problem. Because of this there is a risk that either condition or both conditions will not be treated properly. Despite the high prevalence and substantial impact of depression, detection and treatment in the primary care setting have been suboptimal. In usual care by primary care physicians 30-50% of depressed patients go unrecognized (Pignone, Gaynes, Rustan, Mills, Burchell, Burchell, et al., 2002). Despite the prevalence of depression in the elderly there has been widespread neglect of detection and treatment in patients who have medical diseases (MacHale, 2002). Conversely physical problems are
underdiagnosed in psychiatric patients. Patients with physical illnesses and depression have poorer levels of functioning and higher levels of mortality and morbidity compared to non-depressed patients with similar illnesses (Wulsin, Vaillant, & Wells, 1999).

Depression in the elderly medical patient is also frequently missed. Fewer than 10% of a series of depressed medical in-patients were correctly recognized by house physicians (Rapp, Walsh, Parisi, & Wallace, 1988). Why does this situation exist? Is there a focus on somatic complaints in primary care to the exclusion of psychological issues and vice versa?

Major depression is under diagnosed in approximately half of all elderly people. Since most elderly persons do not see a specialist but rather their primary care provider, the diagnosis of depression is often overlooked. In addition to the half of all elders who are underdiagnosed, 2% of community dwelling seniors have underdiagnosed depression and 3.4% of those seen in primary care settings have been underdiagnosed as well. (Attupurath, Menon, Nair, Muralee, & Tampi, 2008).

In a study by Saver, Nguyen-Van, Keppel, & Doescher (2007) participants frequently reported incidents of missed diagnoses during visits to their primary care provider. Reasons for missed diagnoses appeared to fall into two categories. The first category involved patients who expressed that they were unwilling or unable to raise their true concerns with their practitioner. The second category was practitioner related. For example, practitioners missed the correct diagnosis because they were unsuspecting; focusing on the patient’s somatic complaints which may be depression related or the practitioners seemed uninterested in the possibility of non-physical issues or was dismissive of the diagnosis when the subject was raised with them. This view would tend to support the notion that talking about depression or other psychological issues may be unsettling to primary care providers either because of lack of knowledge about mood disorders and psychoactive medications, lack of
interest, or both. Focusing only somatic complaints such as chronic pain may miss the bigger clinical issue. Continuation of pain medications or other types of medications may not be successful because the core issue of depression may not be receiving the attention that it needs.

The burden of depression on society is sizable. Innate to the burden of depression is the under diagnosis and under treatment of unipolar and bi-polar depressive disorders that exists in all parts of health care systems and is the result of under recognition of the physical symptoms that are commonly associated with a major depressive disorder. Many patients, particularly the elderly de-emphasize psychological symptoms while emphasizing pain as their primary presenting complaint (Greden, 2003). Despite the seriousness of late-life depression and the availability of efficacious treatments many older adults do not receive such treatments (Swartz, Wagner, Swanson, Burns, George, & Padget, 1998).

There are many barriers to the diagnosis and treatment of depression in the elderly. Many older adults believe that depressive symptoms are a natural part of aging. Many primary care providers may also believe that depressive symptoms are a part of the aging process or that what a patient is presenting in a primary care setting is not depression but “failure to thrive” (Sarkisian, & Lachs, 1996).

Depression may present in less obvious ways in older people. This may be due to cultural factors, the shame of having a psychological illness or the pathological effects that come with aging (Katona, 1996). Older people may be unaware of their own depression because it is sublimated in somatic complaints, particularly pain. Depression is also more difficult to diagnose in people with physical illnesses. The biological symptoms of depression which includes anorexia, weight loss, sleep disturbance, lethargy and psychomotor retardation can also be symptoms of physical illnesses in the absence of a depressive disorder (MacHale, 2002). The reporting of somatic symptoms may not reflect so much an unwillingness or inability to acknowledge psychological distress but rather patients may believe that reporting physical
symptoms is a more appropriate route when seeking help from a primary care provider (Simon, Von Korff, Piccinelli, Fullerton, & Ormel, 1999). This approach has been termed “facilitative somatization” and has characterized the initial reporting of somatic symptoms as a ticket of admission to primary care. If there is not direct questioning regarding possible psychological distress, depression and other psychological disorders may not be recognized (Goldberg, & Bridges, 1988).

Given the time demands and number of patients needing to be seen in primary care the differentiation of whether pain or depression is the primary problem can be daunting. Another factor making adequate diagnosis and treatment difficult is the notion of “criterion contamination.” This refers to the overlapping symptomology of pain and depression. For example, symptoms such as sleep disturbance, motor retardation, loss of energy and poor appetite are symptoms of both depression and pain. This is precisely why depression and chronic pain should be assessed together (Dersh, Polatin, & Gatchel, 2002). Recognition of depression in primary care settings is difficult as depressive symptoms are often comingled with vague somatic complaints and persistent pain complaints. This places a special burden on primary care providers as the vast majority of chronic pain sufferers are treated in primary care settings (Arnow, et al., 2006). The common co-occurrence of depression and pain is one reason that depression is frequently unrecognized and therefore untreated in primary care. The somatic symptoms that often predominate may distract attention away from depressive symptoms. (Bair, Robinson, Katon, & Kroenke, 2003).

A key phenomenon that often occurs that should raise suspicion for depression are medically unexplained symptoms. Unexplained medical symptoms are often associated with potentially treatable depressive and anxiety disorders when such symptoms are persistent, are multiple in nature and disabling. Twenty-percent of general practice patients present with physical symptoms without
pathological explanation (Peveler, Kilkenny, & Kinmonth, 1997). Rather than being a diagnosis of exclusion depressive disorders should be considered before embarking on expensive and costly searches for unlikely diseases. An evaluation of symptoms will often reveal more than one cause but will also help focus on those causes that can be specifically treated (Kroenke, 2001).

Symptoms such as chronic pain, abnormal behavior, non-compliance with treatment or the refusal of treatment are often clues to an underlying depression. Identifying the depressive symptoms in the medically ill may permit the appropriate interventions that can relieve distress and improve the quality of life for many individuals (Rodin, & Voshart, 1986). The number of somatic complaints has been found to be directly proportional to the likelihood of a depressive illness in medical patients. These patients may present with abnormal or exaggerated illness behavior, unexplained pain or other somatic complaints rather than presenting or admitting to a low mood (MacHale, 2002).

There are other conditions that can raise the index of suspicion that there is either depression present, that pain alone is present or that both are present. Somatic symptoms are directly related to depressive disorders. For example, 22% - 45% of depressed patients also suffer from fibromyalgia. Depressed patients are four times more likely to suffer from chronic headaches and five times more likely to suffer from chronic backaches compared to non-depressed patients (Greenberg, Kessler, & Birbaum, 2003). Persons with chronic medical conditions such as diabetes mellitus, asthma, and chronic pain are at higher risk for comorbid depression (Aina, & Susman, 2006).

In addition to the social and physical costs of depression and pain there is a financial cost. Pain related events and treatment exceeds 90 billion dollars on an annual basis. 50 million work-days are lost due to sick days as a direct consequence of uncontrolled pain (Holmquist, 2007). The human costs and
the financial costs of both depression and pain are considerable. So it is incumbent that providers understand the close relationship between depression and pain and exercise due diligence in making certain both depression and pain have been assessed so that the appropriate and adequate treatment can be prescribed.

**Assessment Tools**

Appropriate treatment begins with a thorough assessment. One arm of assessment is the use of standardized assessment tools. There are many tools for assessing depression. Therefore two of the best known depression scales will be singled out for discussion because they have been extensively studied and used. Two well known scales for pain assessment will be described as well.

**Depression Scales**

The first scale is the Geriatric Depression Scale. This scale is probably the most recognizable scale for assessing depression in the elderly. It is versatile in that it can be used with healthy individuals, medically compromised individuals and individuals with mild to moderate cognitive impairment. It has been found to have 92% sensitivity and 89% specificity when evaluated against diagnostic criteria found in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders 4th ed.) for depression (Sheikh, & Yesavage, 1986). This scale is either self-administered or administered by a clinician. The scoring is straightforward with a graduated scale indicating mild to severe depression (Kurlowitz, & Greenberg, 2007). A score of 0 to 4 indicates no depression. A score of 5 to 8 indicates a mild depression. A score between 9 and 11 indicates a moderate depression. A score of between 12 and 15 indicates a severe depression.

The second depression scale is the Patient Health Questionnaire (PHQ). There is a short form which is the two questions PHQ-2 and a longer version called the PHQ-9. The PHQ-2 is an easy and useful tool
that can identify patients at high risk for depression. The PHQ-2 questionnaire has two sub-questions. The patient is asked if he/she has been bothered by two problems over the preceding two weeks. The first problem is framed by the first sub-question which asks if the patient is bothered by experiencing little or no interest in doing things. The intensity of feeling bothered is scored between 0, meaning not at all bothered, to 3 which is being bothered every day. The second sub-question asks about feeling down, depressed or hopeless. The scoring is also on a 0 to 3 scale with 0 meaning not feeling down, depressed or hopeless at all and 3 meaning feeling down, depressed, or hopeless every day. The lowest score is 0. The highest score is a 6. If a 6 is scored the probability of the presence of a major depressive disorder is 78.6%. The probability of any depressive disorder is 92.9% (Thibault, & Steiner, 2004). The PHQ-2 has a sensitivity of 100%, a specificity of 77%, and a positive predictive value of 14%. In studies the PHQ-2 has been found to be a valid tool despite the fact it asks only two questions which is a consideration if there is some suspicion of depression being present but there is inadequate time or patient cooperation for a full work-up. If a patient responds affirmatively to the two questions then the PHQ-9 can be administered (Unutzer, 2007). The PHQ-9 provides a thorough assessment because it includes all nine symptom criteria necessary to establish a DSM-IV depressive diagnosis (Kroenke, Spitzer, & Williams, 2003). The PHQ-9 is a self-administered depression scale that is a subset of the PRIME-MD diagnostic instrument for common mental disorders. In one study by Kroenke, Spitzer, & Williams (2001), the PDQ-9 was found to have a sensitivity of 88% and specificity 88% for major depression. Once again one of the main advantages of the PHQ-2 is that it has been shown to be valid and reliable but also brief. It may be used more consistently in primary care practices which tend to be very busy for those very reasons.
There are a multitude of pain scales that can be used in the assessment of pain. According to Horgas (2003)), the most important components of pain assessment in older adults are regular evaluations of pain in terms of worsening pain or improving pain and the use of standardized tools that are used consistently with careful documentation of the patient–provider encounter.

Because older adults have a constellation of factors that might affect their ability to use a particular scale secondary to hearing, visual and/or cognitive deficits the choice of a scale may be determined by the aforementioned factors. The more simple assessment tool can be the more effective tool because of ease of use, physical or cognitive deficits in the patient being assessed that may make using a more complicated test too difficult for the patient to complete. Of the literature reviewed there are two scales that are prominently mentioned.

The Visual Analog Scale (VAS) is a simple yet effective tool. It consists of a straight line that is 100mm in length anchored on one end with a no pain heading on the left end of the scale and a worst possible pain or pain as bad as one could imagine on the right end of the scale. The response is simply to choose a point on the line that best represents the patient’s pain level. The systematic use of the VAS increased the detection of pain in two different long term care facilities from 15% to 30%, p=<0.001 (Kamel, Phlavan, Malekgoudarzi, Gogel, & Morley, 2001).

The Numeric Rating Scale (NRS) is commonly used and well recognized. The scale consists of a line with a 0, indicating no pain, which is generally on the left end of the line and 10, which indicates the worst pain one can remember or imagine, on the right end of the line. The person being assessed then chooses a number that best describes their pain level (Bruckenthal, & D’Arcy, 2007). The sensitivity of
the VAS and the NRS have been found to be approximately equal (Breivik, Bjornsson, & Skovlund, 2000).

Regardless of the assessment tool chosen it is important to use some kind of a tool on a consistent basis because valid and reliable assessment of pain is essential for effective pain management. Managing pain and depression requires a systematic approach that uses tools to establish baselines then ongoing use of assessment tools to judge the efficacy of treatment modalities (Breivik, Borchgrevink, Allen, Rosseland, Hals-Breivik, Kvarstein, et al., 2008).

Implications for Research

According to Brown (1990) the difficulty in researching pain and depression is the lack of testable hypotheses concerning the relationship between pain and depression. Brown (1990) goes on to say that there needs to be a more integrative, explanatory model of chronic pain and depression. At present patients with chronic pain are not separated out into discrete groups in terms of response to different treatment modalities. For instance, persons who suffer from chronic low back pain may have a different experience of pain and depression than say, persons who suffer from chronic gastrointestinal pain. At present it seems as though most of the research does not differentiate between the different kinds of suffering that occurs secondary to a particular type of pain and comorbid depression.

Recommendations that might yield better data from research as elucidated by Banks & Kerns (1996) are that the DSM-IV criteria always be used to assess depression and that standardized measures of symptoms be used so that the data collected are as standardized as possible. This would facilitate comparisons between studies, as outcomes could be evaluated. Further, there is a need for studies regarding depression rates and pain that compares different types of chronic pain patient groups (i.e. heart disease patients and AIDS patients). There needs to be more longitudinal research.
In addition to better data collection and standardized screening and assessments, research into the neuroanatomy and physiology of pain and depression responses may also lead to hypotheses that can be tested. Functional resonance imaging is now being done and is showing what structures in the brain appear to be involved in the detection and processing of stimuli involving pain and depression (Strigo, Simmons, Matthews, Craig, & Paulus, 2008). Recent neurological research has shown evidence of a central pain modulation system that can dampen or amplify nociceptive signals from the peripheral nervous system and the effect on that system by serotonin and norepinephrine. Since the neural pathways that modulate pain and depression are often shared, understanding the mechanisms of how these neural pathways function may lead to a greater understanding of the neurological response to pain and depression which could lead to more effective treatment thus alleviating much of the current suffering (Bair, et al., 2003).

Implications for the Psychiatric Mental Health Nurse Practitioner

What is the role of the Psychiatric Mental Health Nurse Practitioner (PMHNP) in regards to the relationship between depression and chronic pain? Since most of the treatment of both pain and depression are done in primary care there are opportunities for the PMHNP to collaborate in the detection of depression and in treatment recommendations involving the use of antidepressant therapy for depression and chronic pain. Psychiatric Mental Health Nurse Practitioners are in a unique position to be of assistance to primary providers by virtue of the fact that Psychiatric Mental Health Nurse Practitioners are educated in advanced physiology, pathophysiology, pharmacology, psychopharmacology, advanced physical assessment, and advanced studies in human psychology which promotes understanding of both the physical causes and psychological aspects of pain and depression. In group practice settings the Psychiatric Nurse Practitioner can provide ongoing education about the criteria for and diagnosis of depression. Psychiatric Mental Health Nurse Practitioners have
advanced knowledge of antidepressants which have been shown to be effective in the treatment of chronic pain (Fishbain, 2000). By working in a collaborative fashion Psychiatric Nurse Practitioners have the opportunity to share their specialist knowledge with other medical providers through communicating about why certain medications are prescribed for depression and pain (Stenner, & Courtenay, 2008). Psychiatric Nurse Practitioners are often well versed in non-pharmacological techniques to deal with both depression and chronic pain. They can be of assistance in developing a comprehensive interdisciplinary treatment plan for patients.

This type of interdisciplinary care can be seen in the area of medication management. Adjunctive medications in the management of chronic pain include tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors (SNRIs), and antiepileptic medications (Guay, 2001). These medications are known and frequently prescribed by Psychiatric Mental Health Nurse Practitioners. As their use in the management of chronic pain becomes more common the Psychiatric Mental Health Nurse Practitioner may find that their expertise with these medications may be tapped into by primary care providers who are confronted with patients who have complex pain problems. In a Danish multidisciplinary study looking at chronic pain it was found that those patients with chronic pain were five times more likely to use health care services than those without chronic pain. As such it is critical that primary care providers determine if they alone can provide the appropriate level of care or is the help of one or more additional clinicians needed, particularly if there is a comorbid psychiatric condition ((Becker, Bodegaard, Olsen, Sjogren, Beck, & Erikson, 1997). In a complex case with comorbid psychiatric issues the Psychiatric Nurse Practitioner would be a key co-provider.

There are many studies that have investigated the use of antidepressants in the treatment of pain. It would appear that the use of antidepressants is becoming more accepted as a front line treatment in many cases. This trend suggests that Psychiatric Mental Health Nurse Practitioners need to know the
latest in traditional pain modalities of treatment as well as what the latest research shows about the use of antidepressant therapy. There are now mandates about the treatment of acute and chronic pain. Pain assessment is now considered the fifth vital sign by the Joint Commission on the Accreditation of Health Care Organizations which mandates that a pain assessment be done just like blood pressure, temperature, heart rate and counting respirations that are part of a general assessment. As more information becomes available about the relationship between pain and depression the paradigm of pain management that now exists is likely to be reworked with perhaps the wider use of antidepressants as the first line treatment modality instead of an adjunctive role as is now the case. This will likely mean that Psychiatric Mental Health Nurse Practitioners may practice in realms that they did not practice in before. There may be more of a blending between mental health care and medical care as related to the management of depression and chronic pain. Attitudes that pain management lies within the realm of medical care and not psychiatric care may not suffice in the future as the comorbidity of chronic pain and depression continues to be revealed through research that is ongoing.

Collaborative care very important role given the research that shows that depression in the elderly is under diagnosed by primary care providers as they may not recognize the early symptoms of depression and may attribute the symptoms to the normal course of aging (Hoek, & Ho, 2008). Collaborative care takes on even more importance when realizing that the single biggest population group in the future will be the elderly. Treatment for depression and pain does work but mood disorders in the elderly remain a significant public health issue because of the disability, diminished quality of life, stress on caregivers and care-giving families, and lack of proactive governmental and reimbursement in providing adequate funding for research and direct care (Reynolds, & Charney, 2002). Mood disorders in the elderly remain a serious problem because of historical misconceptions about the elder experience with pain and depression which leads to under treatment. One of the most
significant barriers is the lack of education (Duquette, 2009). Historically nursing has been at the forefront of education and it is in the education of professional staffs, patients, and families that the Psychiatric Mental Health Nurse Practitioner can have a major impact.

There is a role on research teams for the Psychiatric Mental Health Nurse Practitioner. Psychiatric Mental Health Nurse Practitioners can be involved in clinical trials by collecting data, testing research medications, and administering assessments which may be part of a group research project or an individual researcher such as a Doctor of Nursing Practice (DNP) who is conducting a research project involving the relationship between depression and pain.

Summary

The prevalence of pain in depressed individuals is greater than in non-depressed individuals. The prevalence of depression in persons with chronic pain is greater than the prevalence rates of either condition alone when examined singularly. When chronic pain is present it is more difficult to detect depression because the somatic complaints are often the focus. Numerous studies have shown that relating pain to an underlying depression and vice versa by primary care providers is not done as usual care. This is particularly true in the elderly population. In the elderly population it is often more acceptable to present with somatic complaints instead of psychological discomfort (Bair, et al., 2003). Because of this depression is often missed. Primary care providers should recognize that pain is a common symptom of depression. It should be recognized that pain and depression often coexist and that detection and treatment of both needs to occur in order to put both pain and depression into remission. The only way to do this is to screen for both conditions particularly when pain becomes chronic, when presenting symptoms do not seem to have any clinical explanation and when the person's daily functioning is adversely affected.
The reciprocal nature of the pain and depression relationship does make treatment difficult and more complicated. Depressed persons with pain have worse outcomes in terms of the intensity of pain, the duration of pain and the very likely possibility that recovery from the pain is not possible (Bair, et al., 2003). Much work remains to establish a more causal relationship between depression and pain. Further research is needed as to the effectiveness of antidepressants in the treatment of chronic pain compared to the usual pain treatment using non-narcotic and narcotic based pain medications.

In both practice and research the psychiatric nurse practitioner can fulfill a vital role in improving the assessment of chronic pain and depression in the elder.
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