Research

Living the "Vicious Circle" and "Deep Rut" of Pain and Depression: A Qualitative Comparative Case Study

Angela T. Ballew, DC, MS; Stacie Salsbury Lyons, PhD RN; Maria A. Hondras, DC, MPH*

Address: 1 Clinical Research Fellow, Palmer Center for Chiropractic Research, Davenport, IA, USA; 2 Clinical Project Manager, Palmer Center for Chiropractic Research, Davenport, IA, USA; 3 Associate Professor, Palmer Center for Chiropractic Research, Davenport, IA, USA

Email: Maria A. Hondras, DC, MPH* - maria.hondras@palmer.edu

* Corresponding Author

Topics in Integrative Health Care 2011, Vol. 2(1) | ID: 2.1004

Published on March 30, 2011 | Link to Document on the Web

Abstract

Purpose: The purpose of this study was to describe individuals’ perceptions, illness beliefs, and health seeking behaviors related to living with musculoskeletal pain and depression.

Methods: This qualitative study recruited adults ages 21 to 65 years with self-reported depression and musculoskeletal pain for an individual, semi-structured interview. Data were analyzed using thematic content analysis with themes compared across cases.

Results: Two individuals participated in these interviews. Although the participants appeared similar on 11-point numerical rating scales for pain and depression, their lived experiences of these conditions varied considerably. While Mr. B. described his pain and depression as a ‘deep rut’ characterized by physical limitation and the loss of desire, the metaphor of a ‘vicious circle’ typified the daily life of unpredictable pain and being hard on herself while in the grip of depression for Ms. S. Emergent themes across these cases included the overall experience of living with pain and depression, the mind-body interaction, impact on activities of daily living, and healthcare choices sought as treatment for these conditions.
Discussion: Individual interviews provided rich data that illustrated very different everyday experiences of two people living with co-occurring pain and depression. Clinicians should be sensitive to the words patients use when describing their unique pain and depression manifestations. This whole person approach to treatment may help guide the decision process related to referring or managing patients with co-occurring pain and depression.

Introduction

Many people live with musculoskeletal pain, depression, or both of these conditions concurrently. Musculoskeletal conditions are so prevalent that the World Health Organization (WHO) declared 2000-2010 the “Bone and Joint Decade,”¹ with momentum for this global movement continuing into the decade beyond 2010.² Back pain and knee pain are the most common complaints among people who suffer with musculoskeletal disorders.³ Similarly, the National Institute of Mental Health (NIMH) estimates that 20 million American adults, or about 9.5% of the U.S. population age 18 and older, have a depressive disorder.⁴ Depression and pain often co-occur, as people with depression have an increased risk for pain and those with pain are more likely to experience depression.⁵ A recent study on the psychosocial aspects of musculoskeletal pain⁶ reported depression as a correlate to pain, particularly for individuals who report low back pain. The same study reported that depression management may be one of the best targets for treatment of individuals with disabling musculoskeletal pain.

While the nature of the relationship between pain and depression is not clear, the two conditions negatively affect physical performance both alone and in combination.⁷ Researchers have proposed several different explanations for the association between musculoskeletal pain and depression. First, depressive symptoms may cause pain or are expressed as pain, a somatization of symptoms; second, pain may lead to depression; and third, mental health conditions such as depression share common biological pathways and neurotransmitters with pain.⁸⁹ Depletion of serotonin and norepinephrine which occurs with depression may decrease the pain modulation pathway in the central nervous system leading to a heightened awareness of pain signals from the body within the brain. This biochemical theory may explain why individuals with depression often report multiple pain symptoms.⁸

Middleton and Pollard encouraged healthcare providers, chiropractors in particular, to be attuned to the somatization of depression in people with back pain.¹⁰ Recently, Bair et al¹¹ used a qualitative approach to identify barriers to pain self-management among depressed patients. Likewise, we present a qualitative comparative case study¹² of the experience of chronic pain and depression in two people whose lives were changed by occupational injuries. The chiropractic profession has a long tradition of case reports that present uncommon musculoskeletal disorders or highlight unusual health outcomes among a single or small group of patients.¹³⁻¹⁵ As Sandelowski¹⁶ noted, a qualitative case-oriented approach within clinical disciplines is “especially useful for showing how the same set of factors, varying in the same way, can interact differently and have different consequences in different cases, or how different sets of varying factors in different cases can interact to produce common outcomes in these
cases” (p. 526). The purpose of this study was to describe individuals’ perceptions, illness beliefs, and health-seeking behaviors related to the experience of living with co-occurring musculoskeletal pain and depression.

**Methods**

The Palmer College of Chiropractic Institutional Review Board approved this study. We used one-time individual interviews to gather data and analyzed these data using thematic content analysis. We sought ‘information-rich participants’ or people who were willing and able to describe their everyday experience of living with co-occurring pain and depression. We recruited participants from two Palmer College of Chiropractic Outreach Clinics located in Iowa and Illinois, and one mental health advocacy group, the National Alliance on Mental Illness (NAMI), in Davenport, IA. We placed an advertisement in the NAMI monthly newsletter that is disseminated to local chapter members. We also placed flyers at the local NAMI office and Palmer Outreach Clinics during the five-week active recruitment phase of the study.

We conducted a telephone screen to ascertain the referral source and eligibility for study enrollment (Figure 1). Participants self-identified with the experience of living with both musculoskeletal pain and depression. We conceptually defined depression as self-reported feelings of sadness, lack of pleasure, loss of energy or interest in activities, and changes in sleeping or eating habits. Musculoskeletal pain was defined conceptually as the self-report of localized or widespread pain for a period of at least one month or recurring pain lasting for a short duration in any joint or tissue including bone, muscle, tendon, or ligament of the neck, back, or limb. Three people responded to the recruitment effort. We screened each person via telephone; all were eligible to participate and scheduled for an interview. Two people participated in an interview; one person did not attend the scheduled interview, thereby declining to participate.
Before the interview, participants read and signed an informed consent document which assured that all records would be kept private with identifying information only available to necessary personnel. Participants could refuse to answer any question during the interview. They completed a brief demographic and health status questionnaire that included items about age, gender, race, ethnicity, marital status, education, current employment status, self-reported overall health, current severity of pain and level of depression, and healthcare providers sought for pain and depression.

We scheduled the interviews for 60 minutes; each lasted approximately 40 minutes and was audio recorded with participants’ consent. One interview took place at the Palmer Center for Chiropractic.
Research and the second interview was conducted at the local NAMI office. Both interviews were conducted in a private room with a closed door to protect the privacy of the participant and to decrease interruptions and background noise. A pre-determined set of questions guided the interview (Figure 2). Beyond the core questions, follow-up questions uncovered the participants’ own meanings, which introduced new concepts that were unanticipated at the outset. The same person (ATB) conducted both interviews to ensure continuity across interviews. During the interview process ATB made an effort to be sensitive to the words and concepts used by the participant. Any relevant non-verbal communication was recorded in fieldnotes to provide the emotional context of the interview and to clarify sounds in the recording that could otherwise be misinterpreted. The digital audio recordings were transcribed verbatim by ATB into an electronic format for data analysis.

**Figure 2. Core Interview Questions**

- Why did you choose to talk with me today?
- When did your physical pain begin?
- What is your experience of living with pain?
- When did your depression begin?
- What is your experience of living with depression?
- Were these two experiences related in terms of when they began?
- How do these conditions either alone, or in combination affect your activities of daily living?
- How do you cope with living with these conditions?
- Has either your physical pain or your depression affected your participation in activities you enjoy?
- What types of care have you sought to address your depression?
- Why did you chose (insert type) of care?
- What types of care have you sought to address your physical pain?
- Why did you chose (insert type) of care?
- Are you or would you feel comfortable talking with a healthcare provider about your feelings of depression?

We conducted a five-phase thematic content analysis as described by Green and Thorogood to analyze the interview data (Figure 3) and used a paper-and-pencil approach to coding due to the small sample size. In phase 1, ATB listened to each recorded interview, transcribed it verbatim, and compared the audio recording with the written transcript to ensure accuracy of the data and correct transcription.
errors. In phase 2, the research team developed a codebook, which we refined throughout data analysis as new themes emerged. Predetermined codes included: ‘trigger for pain,’ ‘experience of depression,’ ‘experience of pain,’ ‘activities of daily living impact,’ ‘coping strategies,’ and ‘care sought.’ In phases 3 and 4, the investigators independently read and coded the transcripts and then compared their findings, came to consensus on disconfirming evidence, refined and revised codes as necessary, identified recurring themes, and sought additional insights about the ‘meaning’ of the data. In phase 5, all three investigators looked at the relationships between the themes and the context of particular codes to establish summaries and classifications of the accounts provided by the thematic analysis.

**Figure 3. Data Collection and Analysis**

[Diagram of data collection and analysis process]

- Telephone Screen Eligibility Questions (ATB) -> Exclude
- Informed Consent Questionnaires, One-on-One Interview (ATB) -> Interviews Transcribed (ATB) -> Phase 1
- Codebook Development (ATB, SSL, MAH) -> Phase 2
  - PI Codes Text (ATB) -> Code Identification Coding Consensus (ATB, SSL, MAH) -> Codebook Revision Recurring Theme Identification (ATB, SSL, MAH) -> Summarize and Interpret Findings (ATB, SSL, MAH) -> Phase 5
  - Co-I Codes Text (SSL, MAH)
Results

With the exceptions of gender and employment status, our case study participants, a man who called himself “Mr. B” and a woman who named herself “Ms. S,” appeared remarkably similar on demographic and clinical questionnaires. Both participants were 54 years of age, reported their race as white, and had completed some college. Each listed their marital status as separated or divorced, although both were involved in a relationship with a significant other. Mr. B reported full-time employment, while Ms. S was disabled and unemployed. Both participants rated their pain as a 7, on a scale of 0-10, where zero indicated “no pain” and 10 indicated the “worst pain possible.” On a similar 0-10 scale for depression where 0 indicated “none” and 10 indicated “greatest level of depression or sadness possible,” both participants rated their depression as a 7. Both participants reported living with musculoskeletal pain following occupational injuries that occurred over five years ago and stated their feelings of depression began at approximately the same time. These participants sought healthcare to address their pain from both allopathic and complementary healers, including medical doctors or surgeons, osteopathic physicians, physical therapists, chiropractors, massage therapists and acupuncturists. For depression care, they sought treatment from medical doctors, psychologists, and psychiatrists. Although Ms. S and Mr. B reported similar demographic and clinical characteristics, their everyday experiences of health and healing from pain and depression were unique. Using pseudonyms and their own words, we compare and contrast five themes that emerged during analysis: 1) the overall experience of living with musculoskeletal pain and depression; 2) impact on activities of daily living; 3) coping and pain minimization strategies; 4) healthcare sought; and 5) the mind-body interaction in pain and depression.

Living with pain and depression: the overall experience

When asked to describe her overall experience of living with pain, Ms. S said:

“It’s unpredictable as hell… I can get up one morning and feel 100%... be able to fold my own laundry and be able to put on my own shoes. And the next morning, no way... or help somebody clean their pool and then I’m down for a week. So I think that’s the main thing. It’s so unpredictable…”

Ms. S expressed concern that any plans she made for the future may not be possible, specifically referring to a fishing trip that was planned weeks in advance and which was to occur the day after the interview: “So today you don’t know if you’re going to be able to do that tomorrow and that’s part of the unpredictable.” Further, she described the unpredictable nature of her pain as affecting both her own and others’ perceptions of her reliability, particularly in relation to her ability to gain employment: “I can’t be relied on and I’ve been in positions of management... where that’s the main thing. If I can’t rely on somebody I’m not gonna give ’em a job... it’s unpredictable and it hurts like hell.”

In contrast, Mr. B expressed his overall experience of living with pain in terms of the limitations of the human form: “Well, it’s made me aware that we’re (sighs), we’re prone to injury as humans. We’re not... designed perfectly.” For Mr. B, pain placed limits on his activity and how he thought about his daily
life: “Trying to be aware of what I’m doing and just trying to limit what I do, or something I can’t do I won’t, or I’ll get help to do it.”

When asked about his overall experience of living with depression, Mr. B described the depression as negatively affecting his energy level and as a loss of interest and desire:

“Yeah, it’s a kind of malaise. Just an overall feeling of not having any real interest or desire. You lose interest and desire...I’m more tired. When you have a good day you try and enjoy it the best you can and hope that you can maybe string two or three of those days together and if you do, which I haven’t done, that would be really quite wonderful.”

Rather than offering details about its emotional qualities, Mr. B described living with depression as it affected his work activities. His full-time job required physical labor and this led to his taking frequent breaks to stretch, stand up, and walk when the “pain lets me know.” Mr. B highlighted how the physical pain of depression impacted his job:

“I’m not as mobile and I’m not as aggressive in my work...I’m not as apt to just go into it like I was before the injury, so I’m slower and guarded and try to be careful in how I approach my work and I have to take more frequent breaks.”

Conversely, Ms. S shared her experience of depression as one which impacted her feelings of self-worth: “...it comes around because I’m so hard on myself. Maybe if I wasn’t so hard on myself, I wouldn’t be depressed about it....” She continued:

“...just to wake up some morning and not be hard on myself would really be a miracle in itself...there are a lot of people who are a lot worse...maybe if I wasn’t so hard on myself I’d be able to handle it better.”

Together, pain and depression create a “vicious circle” in the life of Ms. S (Figure 4):

“...because I’m so angry at myself is when the depression comes in. And it’s this vicious circle, this vicious circle. I’m mad at myself ‘cause I can’t do things, I can’t do things because of the limits of the spine and how the legs are feeling...”

When Ms. S shared this insight with her mental health care provider who suggested that she not take this experience so personally, she replied, “Well, it is personal.”
Figure 4. Vicious Circle of Pain and Depression

Impact on activities of daily living

Individuals living with pain and depression may experience difficulty completing tasks of daily lives such as grooming, housework, and participating in recreational activities. For Ms. S, completing housework was affected “a hundred fold” by her pain and depression: “…there’s days when I can’t even stand long enough to do a load of dishes or try to fold a load of laundry….” In terms of personal grooming, she said, “The bad days are when I can’t get up, can’t put my underwear on, and can’t wash myself very good. And you know, lay in a bathtub? Forget it…”

Mr. B described limitations in his “mobility or flexibility” and being “guarded” in everyday tasks: “…you’re not as apt to do things, and you’re more careful about what you do.” As he did throughout the interview, Mr. B talked about his limitations before-and-after the injury: “And that’s not all bad, but you really are limited in things you can do and that includes anything for a prolonged period of time or anything I used to be able to do.”
Both participants expressed that pain and depression impacted their participation in recreational activities that were at one time important in their daily lives. Mr. B described being active in physical exercise before the onset of his pain and depression, but now he no longer participates in the sports he once enjoyed because “I’m afraid of perhaps exacerbating or perhaps making the pain greater.” Mr. B acknowledged that exercise might help his bodily pain. However, he was in a “deep rut” from the effects of the depression on his mind and has had a hard time initiating new activities (Figure 5):

“It’s a two-fold thing...your mind is on other things. I guess when you have chronic pain you’re thinking more about that as opposed to other things, but then, depression when you reach a certain point you’re there and it’s like getting into a deep rut. It’s hard to get out of that.”

Figure 5. Deep Rut of Pain and Depression

Ms. S, too, described herself as a former “jock” who used to “run three miles a day.” Her current life of pain and depression was epitomized by a loss of physical capacity, the aging process, and a poor self-image:
“You’re lucky if you can walk…I walk periodically with (her partner)... until we know we can’t anymore...I can’t play ball, I can’t even throw a ball anymore...so it’s done, it’s made me switch gears...made me realize I’m not 20 anymore...I had to realize there’s limitations, which is very hard for me to realize. Because I’ve never limited myself, I went gung-ho on everything I did.”

Ms. S went on to state that she is “one of those people that you’ve gotta be the best at all times. Well, I’m not that way now and that’s very hard for me to accept.”

Coping and pain minimization strategies

Ms. S and Mr. B both tried many different strategies to cope with and minimize the impact of pain and depression in their lives. Ms. S’s current approach combined social involvement with friends and family with avoidance of activities that triggered her pain and depression:

“Well, I get involved with things I know I can do. No, I don’t get involved with moving office furniture. But I get involved with my church...and the church community. I’m involved with my family.”

Ms. S relayed a scenario in which she and her partner attended a baseball game and she minimized the pain through movement: “...I can get up and down and go walk when I need to, I don’t have to sit there the whole time. I can get up and walk.” In contrast, Mr. B spent time alone and away from his family trying to “recuperate”:

“There’s times that your spouse might want to do something but you’re really not feeling like it. You’re really in pain, you really just want to try and recuperate and you may just want to recline or just, you know, lie down and try to cope with it, whether it be through just relaxing or stretching or lying down flat.”

Instead, Mr. B minimized the impact of pain with a long list of pain relief techniques:

“...I take, uh, ibuprofen and I ice and heat, ice packs, hot water bottle, heating pad and hot tub, when I can. Massage, when I can get a massage...that helps. The other thing is just to try and stretch my back and uh, anything that I feel will relieve the pain I’ve tried.”

Not satisfied with the degree of pain relief they had found in the past, each participant sought care from many different healthcare providers in the years since their injuries.

Healthcare choices for pain and depression

While Ms. S and Mr. B said they could talk with healthcare providers about their conditions, neither participant had an integrative approach to pain and depression management and both were on the lookout for the promise of sustained relief. Ms. S had visited many allopathic healthcare providers for
her pain, including a general practitioner, an orthopedist and a pain clinic during her journey towards healing. She also sought depression care from conventional healthcare professionals, including counseling from a mental health therapist and prescription medicine from a psychiatrist. While her 10-year relationship with her therapist was “very helpful,” Ms. S described the process of coming to terms with taking medication for her depression in this way:

“...it took me several years before I would let them prescribe me any medicine. I had already been taking enough crap that I didn’t want to add any more to it. Then I finally realized that there is no shame in taking the medicine, being taken care of, the shame is having the condition and not doing everything you can to help yourself....And then of course you go through all 10 or 15 different kinds of drugs to see which works better....”

Ms. S traced a timeline back more than a decade in her process of seeking care for her pain. After her first spinal surgery did not alleviate her pain, Ms. S tried modalities that included physical therapy, narcotic medications, and spinal injections. Finally, a neural stimulator implant for leg pain helped Ms. S reduce the amount of pain medication she took by more than half: “At least I get some relief from that...and this is a very good thing, because morphine and methadone are bad for your tummy ...”

Mr. B tried physical therapy for his pain and then used a combination of complementary and conventional modalities, including acupuncture, chiropractic care, massage therapy and, most recently, cortisone injections. Mr. B was scheduled for his third injection, but said a massage and a chiropractic adjustment “in the same day or concurrently, one after the other, seems to be the best approach to pain that I’ve found.” For treatment of his depression, Mr. B has seen his family doctor, a psychologist, and a counselor:

“One of the best professionals I’ve dealt with in regards to all of this was my family doctor who initially after receiving therapy knew that probably chiropractic would be a good thing...also with dealing with the depression and providing me with an anti-depressant, so those were two good things I got from my family doctor.”

Mind-Body Interaction in Pain-Depression

Both Ms. S and Mr. B described their experience of living with pain and depression in terms of a mind-body interaction. Each individual described connections between the bodily experience of pain and depression and their cognitive experience or emotional response to these conditions. Mr. B described the mind-body interaction of his pain-depression and its subsequent impact on his vitality this way:

“...the rest of your body is almost like it’s not completely in harmony or in line. Like say you had a, the front tie rod of your car gets bent and the tire wears differently...and it’s just not rolling right. I would draw the correlation between that and the body, because you’re not completely aligned and...somehow that energy isn’t being channeled right.”
In contrast to the disharmony evoked by Mr. B in his descriptions, Ms. S articulated an antagonistic mind-body interaction at play in her pain and depression. After visits to providers who labeled her ailments as a “failed spinal fusion” or a “diabetic stomach,” Ms. S experiences negative emotions and sleepless nights: “You just get mad at yourself, ‘I let myself get this horrible disease’ (laughs), you know…I don’t sleep because I’m mad at myself. Come on, you put fatigue with chronic pain then it starts back another circle, you know.” At the same time, she questioned the treatments her doctors have placed into her body. She also resisted how healthcare providers labeled her conditions, but tried to incorporate those metaphors into how she thinks about herself:

“I always thought that when you needed to have your spine fused, that they should’ve put something soft in there instead of metal. So I always told ‘em ‘can’t you put a marshmallow in there?’...Come to find out years later they actually do put soft stuff in there now, they do that....I have metal and you can’t reverse it. I have titanium, so I’m like a rocket ship.”

Discussion

For the clinician who is considering treatment options for patients with co-occurring pain and depression, quantitative measures of these conditions may present a cloudy clinical picture. In this study, both Mr. B and Ms. S had sustained occupational injuries more than five years ago, reported similar demographic information and scored identically on 11-point numerical rating scales for pain and depression. However, their overall experiences of pain and depression, and the impact on their activities of daily living, coping and pain minimization strategies and health care seeking behavior differed.

Both Mr. B and Ms. S have had to redefine what gives meaning to their lives. Ms. S relinquished her former role as “breadwinner” but felt “worthless” as she is no longer capable of working outside the home. She still was trying to accept these changes in her life. Further, Ms. S used negative emotional language about this process, such as being “hard on” and “mad at” herself when she cannot perform tasks, but softened her words when speaking about family and friends. In communicating her experience in this manner, Ms. S provided a glimpse into an internal dialogue that defines her “vicious circle” of pain and depression (Figure 4). In contrast, Mr. B’s descriptions of somatized depression centered on his physical limitations, loss of desire and lack of interest in activities he once enjoyed, and his decreased energy. He likened his experience to a “deep rut” from which it is difficult to escape (Figure 5). Just as having meaning in life is essential to happiness,21 loss of meaning therefore may lead to feelings of depression.

Mr. B and Ms. S both reported their activities of daily living were impacted by pain and depression. Here again, each individual engaged in a personal ‘redefinition’ as he or she negotiated the mundane work of daily life, such as grooming, household chores, job-related tasks and recreational activities, within the context of chronic pain and depression. Interestingly, both participants used the word “limited” to refer
to how they approached daily activities currently as opposed to how they would have performed them before living with pain and depression. In contrast, coping and pain minimization strategies are two areas where the participants differed. Mr. B used more palliative strategies to reduce pain and divert his thoughts, while Ms. S stayed involved socially and engaged in activities where she could move around and avoid prolonged positions.

Mr. B and Ms. S both felt comfortable talking with their healthcare providers about their pain and depression. While the participants sought different treatment modalities, both rejected active treatments involving exercise and physical therapy though each was once a physically active person. Ms. S described her journey for pain relief as “grasping at stones,” as though the right treatment is just beyond her grasp. Mr. B, though still dealing with both conditions and reluctantly continuing with cortisone injections for pain, described a greater overall satisfaction with his healthcare providers and treatment.

The mind-body interaction in pain and depression also was present in many dimensions for both Ms. S and Mr. B’s experience. Each participant depicted mechanistic metaphors (“rocket ship” and “tie rod of your car”) to describe their damaged physical bodies. Similarly, they used directional metaphors to demonstrate their changed mental and emotional status. Mr. B described feeling “not completely aligned” in his “deep rut,” while Ms. S spoke about how life circumstances caused her to “switch gears” and live in “the vicious circle” of pain and depression. Each participant was aware of an intimate connection between their physical and emotional experiences and identified reciprocal relationships between pain and depression.

Woolf\(^{22}\) wrote that among the most challenging barriers an ill person must overcome to regain wellness is “those great wars which the body wages with the mind...against the assault of fever or the oncome of melancholia” (p. 5). Sontag,\(^{23}\) too, suggested that an ill person must first recognize and then release the metaphors in his or her language to move towards health and healing. The insights provided by these participants may sensitize clinicians to the metaphoric language patients use to describe living with pain and depression, as well as to the clinician’s own use of metaphors when speaking to their patients. Where one patient may describe his depression using words related to emotions, another patient might focus on the physical symptoms of her sadness. The clinician and patient who “speak the same language” may engage in more patient-centered and nuanced whole-person approaches to pain and depression treatment.

There are several limitations from this study. Individual interviews were conducted only once. More time and multiple interviews may help build trust with participants, facilitate full and honest self-representation, and allow for follow-up or further probing related to unanticipated themes that emerge during analysis. For these interviews there was only one observer who conducted the interview and video recording was not used. Both of these situations allow for some details to be missed, therefore, in future studies using qualitative interviews, we aim to include video recording to enhance the detail gained from the interview. Also, a larger sample size is desirable to gain a wider range of experiences from more individuals. While comparing the experiences of two individuals allows us to attend to the
unique features of each case, a larger sample size would provide an opportunity to explore this phenomenon with greater depth and breadth. The five week recruitment period using passive methods (flyers, advertisements) is another study limitation. A longer recruitment period with active recruitment strategies, such as engaging clinicians from all of the Palmer College community clinics and speaking to local chapter groups associated with NAMI, may have increased the sample size.

Conclusion

Using a qualitative comparative case study approach, we obtained a rich description of the everyday experiences of two people living with concomitant pain and depression. Common themes included the overall experience of living with pain and depression, the impact on activities of daily living, coping strategies, healthcare seeking patterns and the mind-body interaction. Living with chronic conditions such as pain and depression may underscore certain facets of everyday life that many people experience at some point. For both participants, their pain and depression began almost simultaneously. These experiences significantly changed their work-lives, their physical stamina, and their ability to perform daily tasks related to self-care. They also became more involved with the healthcare system. Both participants described seeking care from a variety of healthcare providers to treat either their pain or depression separately and both continue to seek an intervention that will break the “vicious circle” or provide freedom from the “deep rut.” In considering treatment for these conditions clinicians may want to consider coordinating or collaborating treatment approaches between providers.

Acknowledgements

We thank Jennifer L. Kiebles, PhD, Northwestern University and Andrea G. Haan, DC, MS, Palmer College of Chiropractic for their valuable comments and insightful critiques of project development and earlier drafts of this manuscript. For support of our recruitment effort we thank the National Alliance on Mental Illness and the Palmer Outreach Clinics in Davenport, IA and Moline, IL. This project was conducted in a facility constructed with support from Research Facilities Improvement Program Grant Number C06 RR15433-01 from the National Center for Research Resources, National Institutes of Health. We especially thank the participants for sharing their experiences with us.

References


