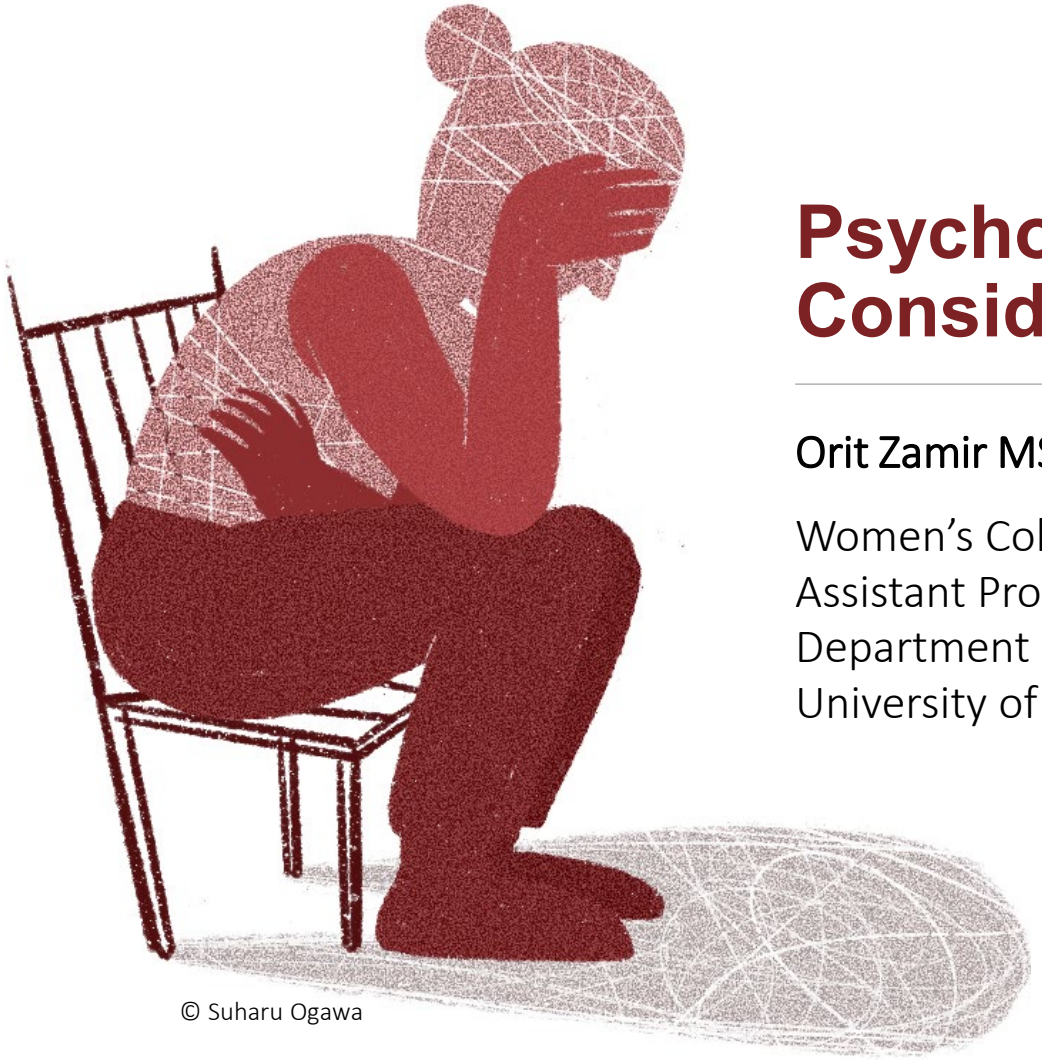

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Psychosocial and Mental Health Considerations of Chronic Pain

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LEARNING OBJECTIVES

1

Appreciate the impact of psychosocial factors and mental health comorbidities

2

Gain confidence engaging in a psychosocial and psychiatric screening

3

Develop management plan to target mental health comorbidities

TEMERTY FACULTY OF MEDICINE
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Continuing Professional Development

UHN Centre for Mental Health

Presenter Disclosure

- Faculty: Orit Zamir
- Relationships with financial sponsors:
  - Not Applicable

PSYCHIATRIC COMORBIDITIES ARE COMMON

2-3 x Increase in Major Depressive Disorder, Generalized Anxiety Disorder, Post Traumatic Stress Disorder (PTSD) and Alcohol Use Disorder (in a US community sample)

2 x Increased risk of suicide

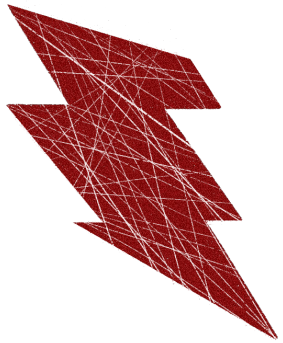
25-50% Significant emotional distress, mood and anxiety disorders, PTSD (in primary care or specialized pain clinic)

Demyttenaere et al., 2007. Pain;129:332–342
Tang and Crane. Psychol Med. 2006;36:575-86
Bair et al. Arch Intern Med. 2003;163:2433-45

TEMPORAL RELATIONSHIP BETWEEN CHRONIC PAIN AND PSYCHIATRIC CONDITIONS

77%

of anxiety disorders were present **before** pain onset



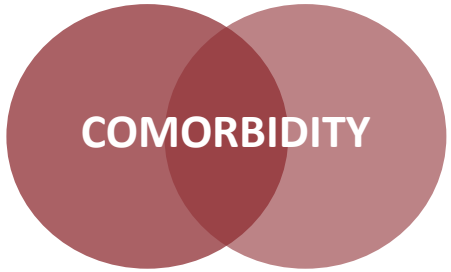
63%

of depressive disorders appeared **after** pain onset

(in tertiary pain clinic population)

Knaster et al. Gen Hosp Psych. 2012

THE PAIN-PSYCHIATRY LINK



VS

Psychosocial management helps *cope* with pain

- Emphasis on biological/structural generator of pain

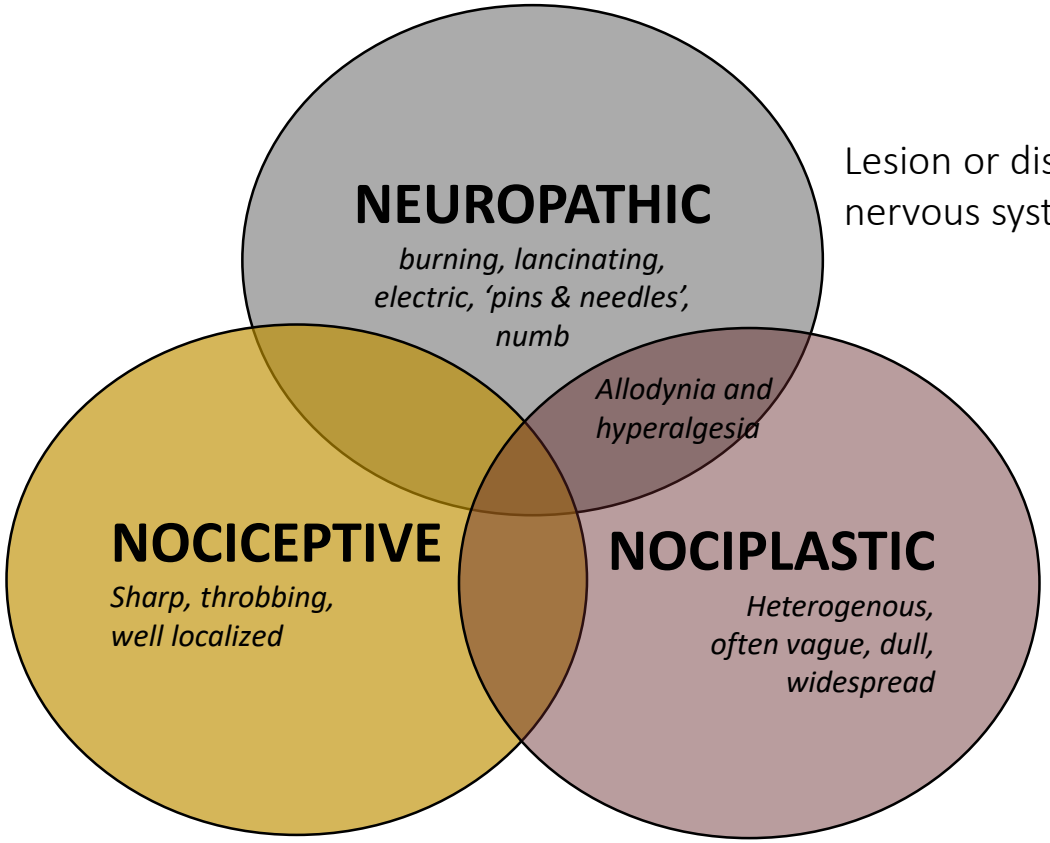
Psychosocial management *reduces or eliminates* pain

- Focusing psychological generators to reduce or eliminate some types of pain

SYMPTOM VS MECHANISM

Pain as an example:

IASP (International Association for the Study of Pain)



Lesion or disease of the nervous system

Noxious stimulation of nociceptors

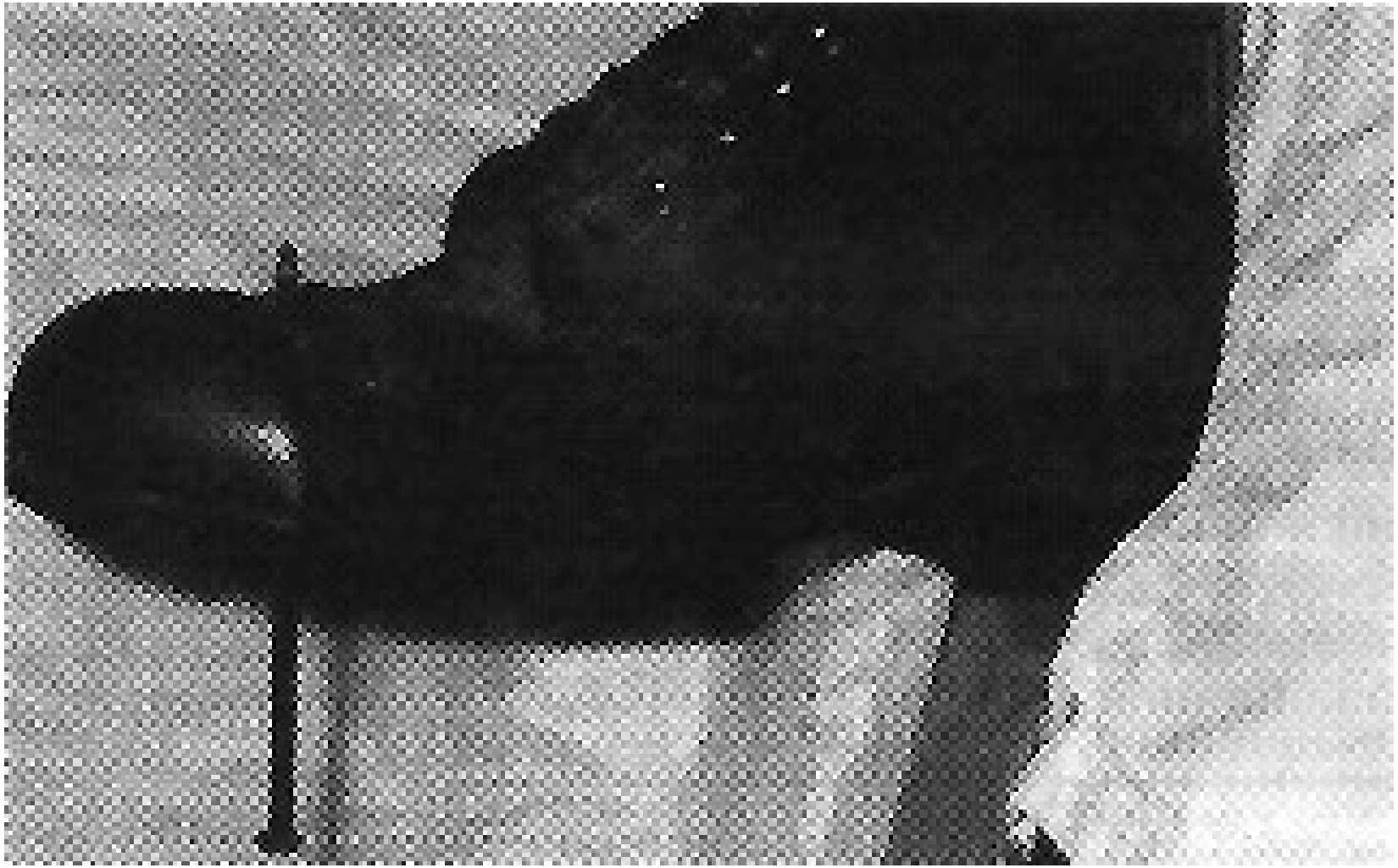
Sensitized nervous system, no lesion or clear etiology.

Varies in quality and location
Localized or widespread

Aggravated by activity, environmental stimuli or stress

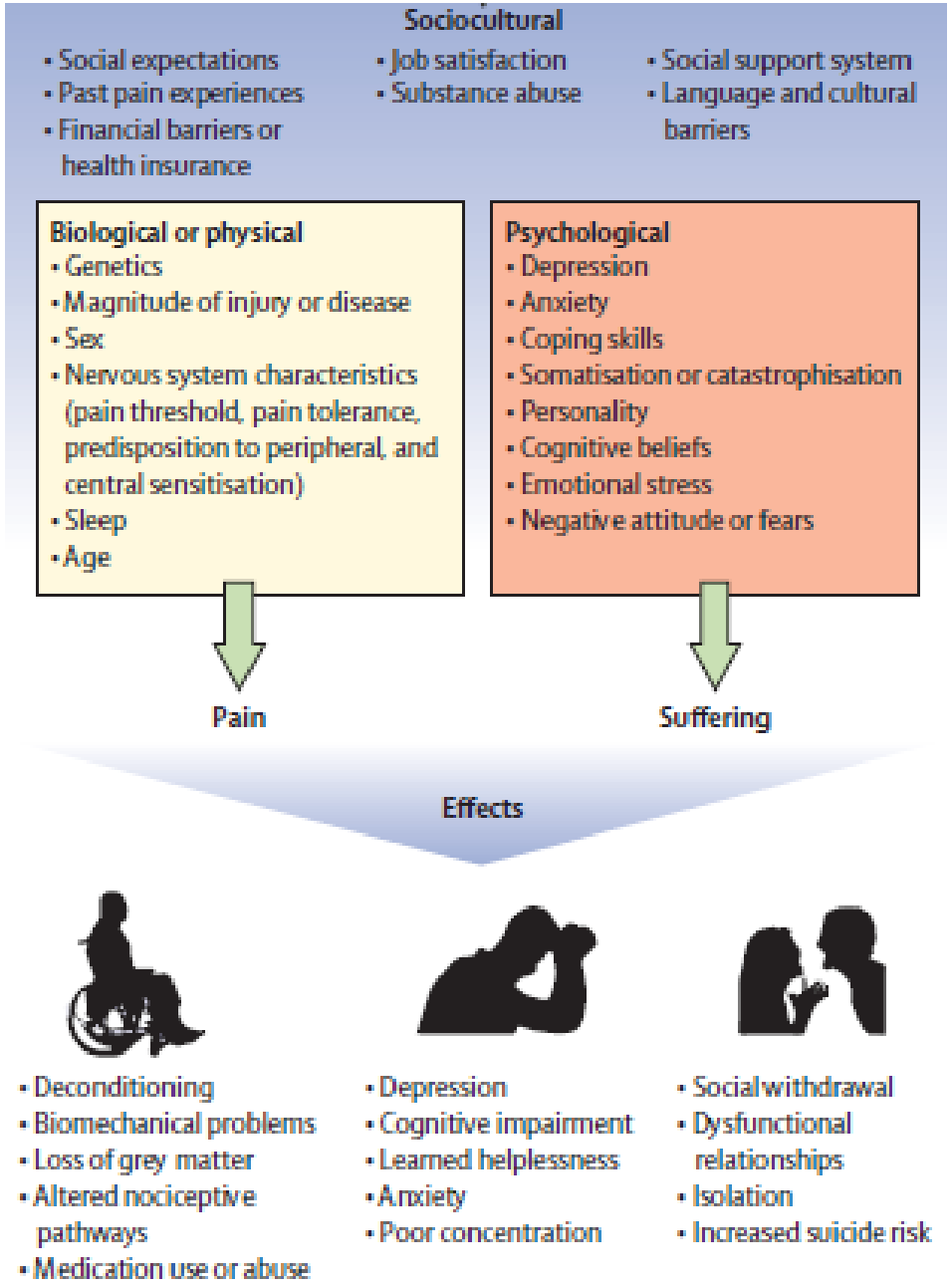
Afari et al. Psychosom Med 76, 2-11 (2014).
Fitzcharles et al. Lancet 397, 2098-110 (2021).

A builder aged 29 came to the emergency department having jumped down on to a 15 cm nail.



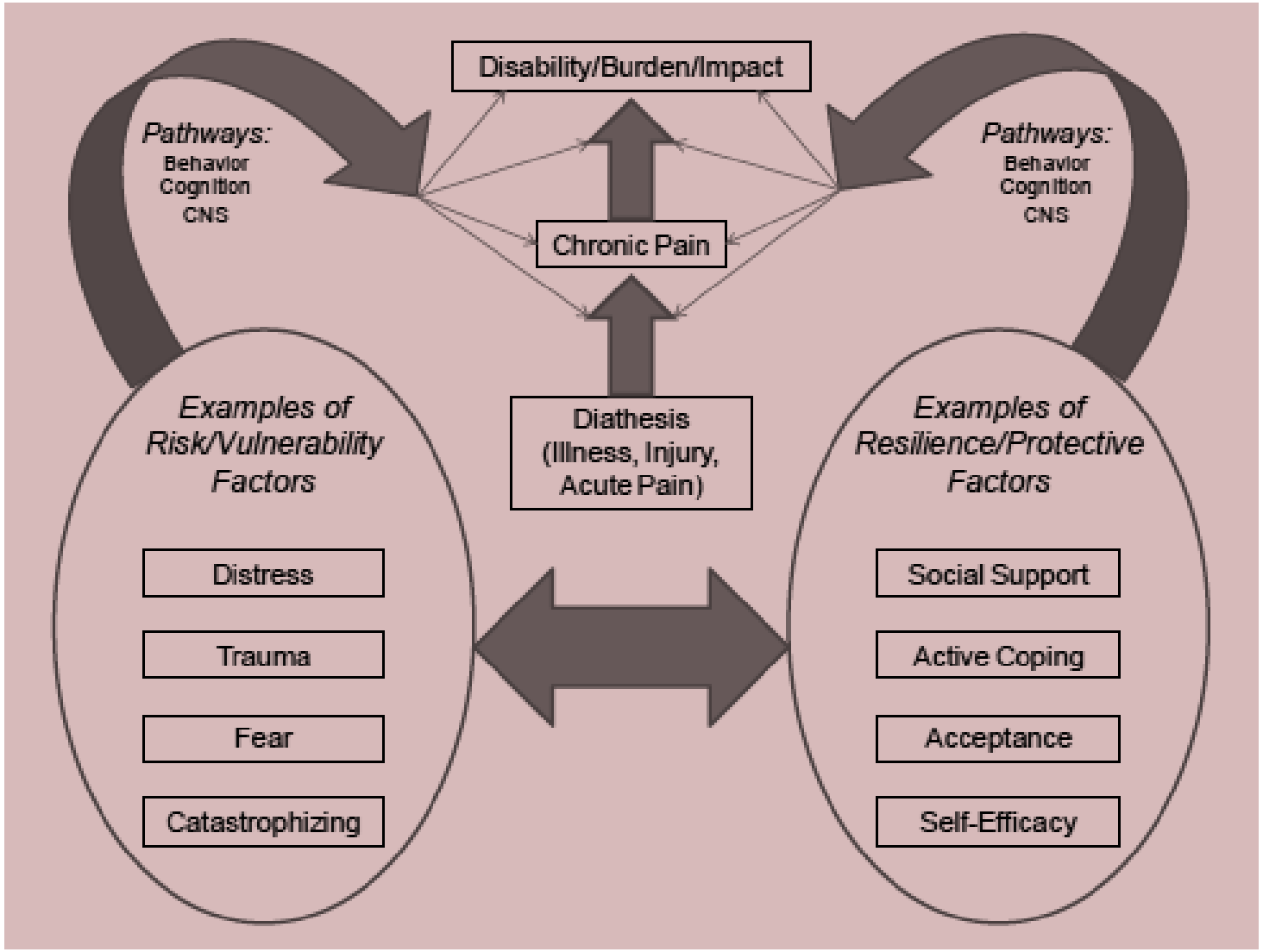
J P Fisher et al. BMJ 1995;310:70

Biopsychosocio-cultural model of pain



Cohen et al., 2021. Lancet 397:2082-2097

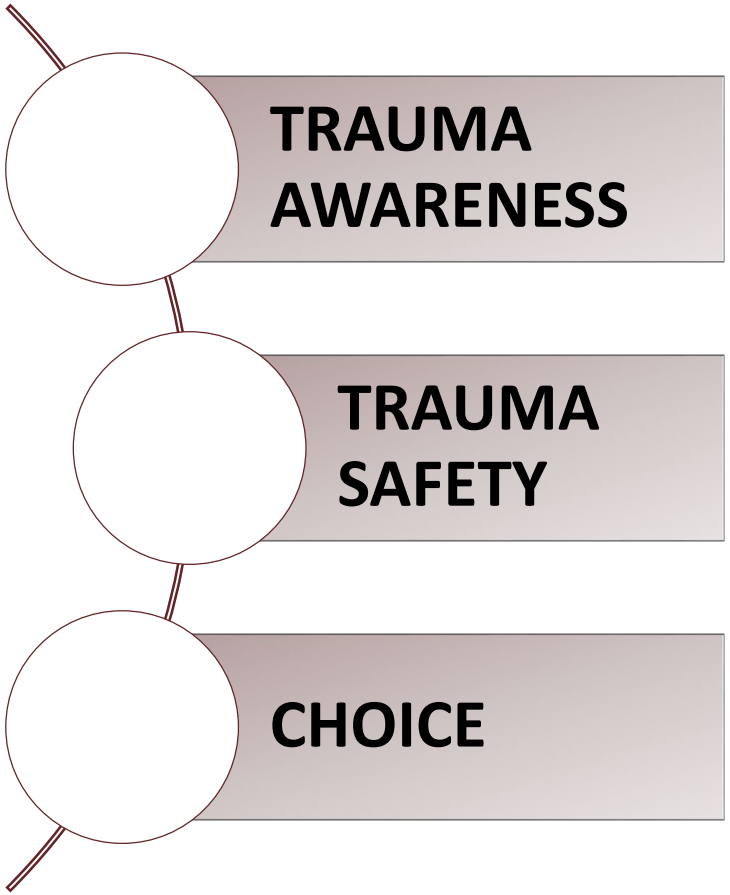
VULNERABILITY & PROTECTIVE FACTORS



Edwards et al. Pain. 2016

MENTAL HEALTH ASSESSMENT

TRAUMA-INFORMED CONSIDERATIONS



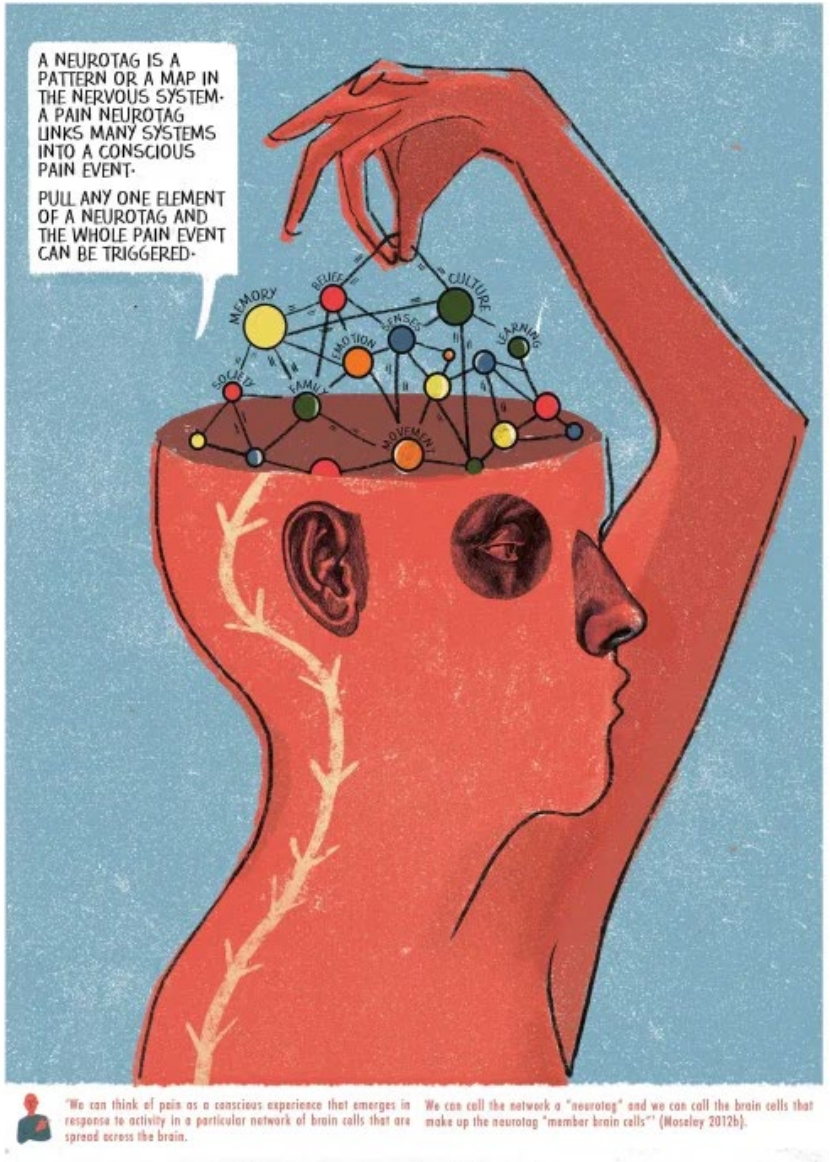
- ✓ Universal Precautions
- ✓ Involve full team
- ✓ Appreciate impact on health and behaviour
- ✓ Screen for adversity and trauma
- ✓ Summarize what you will do and rationale
- ✓ Invite questions, ask before examining
- ✓ Offer chaperone
- ✓ Consider tone and non-verbal cues
- ✓ Consider trauma triggers in your setting
- ✓ Ensure continuity of care

Purkey et al. 2018 CFP

The pain is not in your head &
it is processed in your brain

Once it is chronic, it doesn't matter how it started, various brain regions are affected that can worsen pain that we target to get you the best pain management.

This includes the emotional centers. What are your thoughts about that?



BRIDGE TO THE PSYCHOSOCIAL ASSESSMENT

Reframe in the context of pain so that it feels more acceptable:

“How does pain impact you emotionally?” or

“Stress or other lifestyle factors can contribute to pain, does that surprise you?”

STRESSORS, AGGRAVATING & ALLEVIATING FACTORS

Aggravating factors: stress, anxiety, or mood triggers
Alleviating factors: relaxation, enjoyable activities

Ask and look for connections between emotions and pain while discussing distressing content. Point it out to them so they can see the connection.

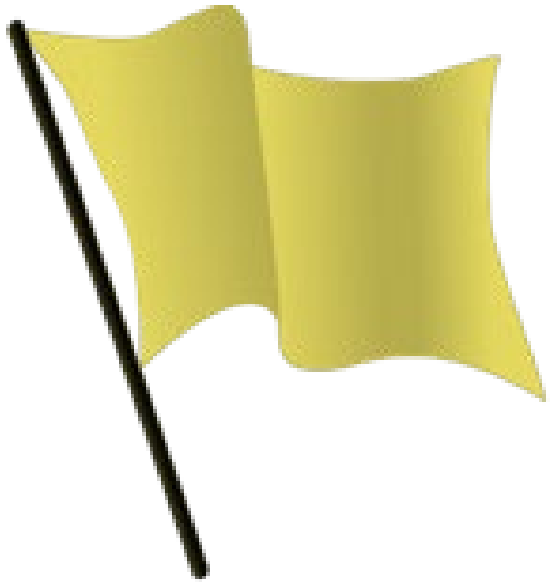
You may see clues during the assessment
Notice pain behaviour with distressing material, or ask about any shifts in pain symptoms

Use affective triggers to explain the emotion/mind contribution to pain and psychosocial management strategies

YELLOW FLAGS PREDICT BARRIERS TO RECOVERY

Belief that pain and activity are harmful
'Sickness behaviours' (like extended rest)
Low or negative mood, social withdrawal
Treatment expectations that do not fit best practice
Problems with claim and compensation
History of back pain, time off, other claims
Problems at work, poor job satisfaction
Heavy work, unsociable hours (shift work)
Overprotective family or lack of support

Canadian Lower Back Pain Guidelines 2017

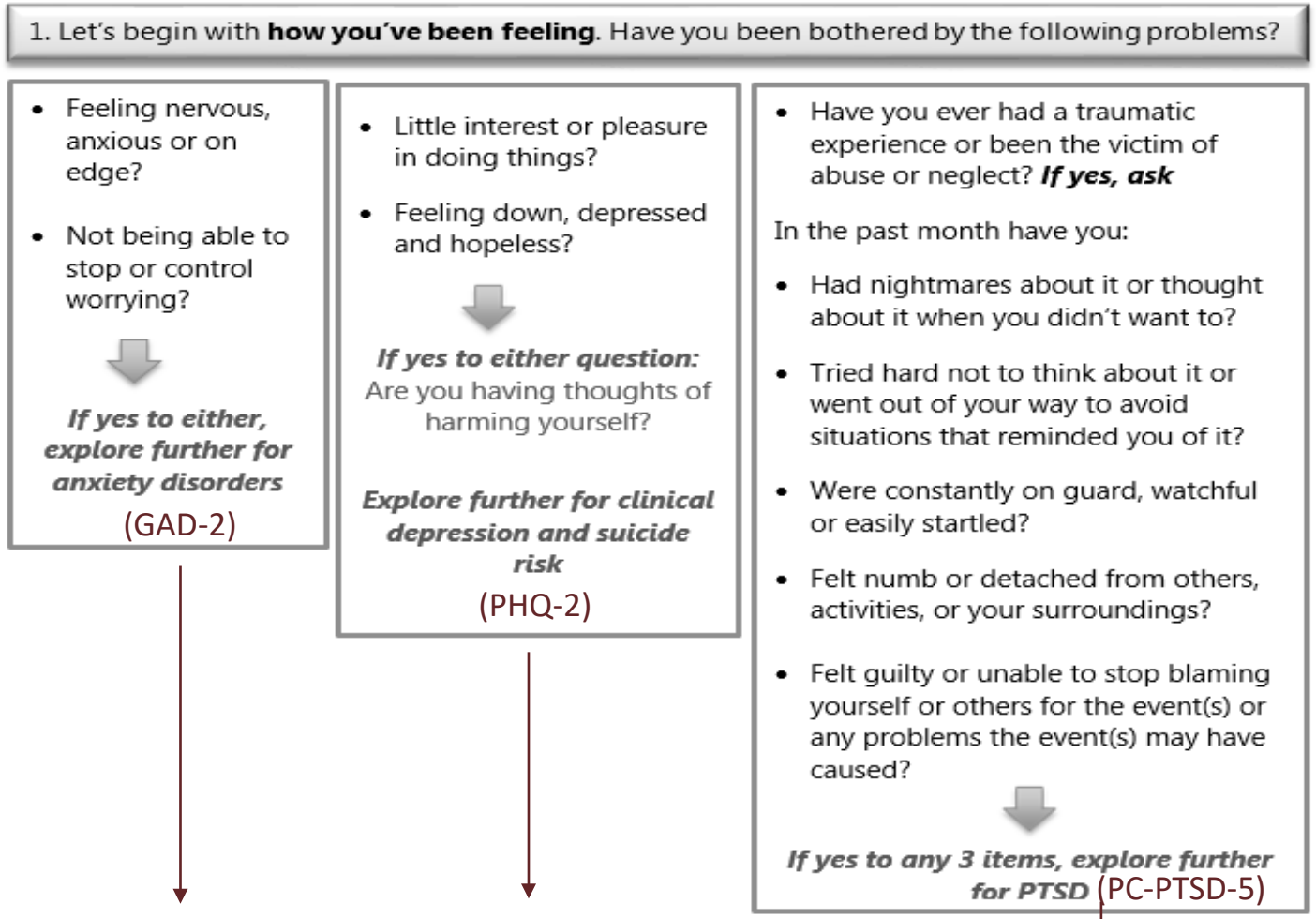


QUICK SCREEN FOR SOME COMMON PSYCHIATRIC COMORBIDITIES

Trauma-informed approach:

- Let them know what and why before you ask
- Give option not to answer

"Sometimes difficult life experiences can affect your health including pain. I would like to ask you a few general questions about trauma you may have had in your life. You only have to offer titles, and only if you feel comfortable. Is that ok that I ask?"



SUICIDE & PAIN

Chronic pain doubles the risk of all forms of suicidality, including death by suicide, even when common risk factors are controlled Tang & Crane. Psych Med. 2006

RISK FACTORS:

Sex (male)
Age (19< or >45)
Depression

Previous Attempt
Ethanol abuse
Rational-thinking loss (psychosis)
Social supports lacking
Organized plan
No Spouse
Sickness (chronic or severe illness)

PAIN-SPECIFIC:

Etiology (CRPS, fibromyalgia)
Location (low back, generalized)

High intensity, long duration

Premorbid depression, history of abuse

Cognitions (Catastrophizing, pain-related helplessness, feeling like a burden)

Martin Cheatle. J Family Practice. 2014

ASKING ABOUT CHILDHOOD ADVERSITY: THE CARE MODEL

CONSENT	"Some childhood experiences are pretty common, but difficult and can affect your health later in life. I'd like to ask you about things that may have happened to you when you were young. Is that okay?"
ASK	**"When you were young, did you have experiences that were frightening, or made you feel unsafe? Like being hit, touched or bullied?"**
REFLECT	Validate and ask "Sometimes experiences like that impact how you respond to stress later in life. Do you see any connections for your current situation?"
ENGAGE	"Is this something you would like to talk about?"

Hunter and Maunder, acechange.ca

ABERRANT DRUG-RELATED BEHAVIOUR (ADRB)

DEFINITION: Medication-related behaviours that depart from agreed-upon therapeutic plan

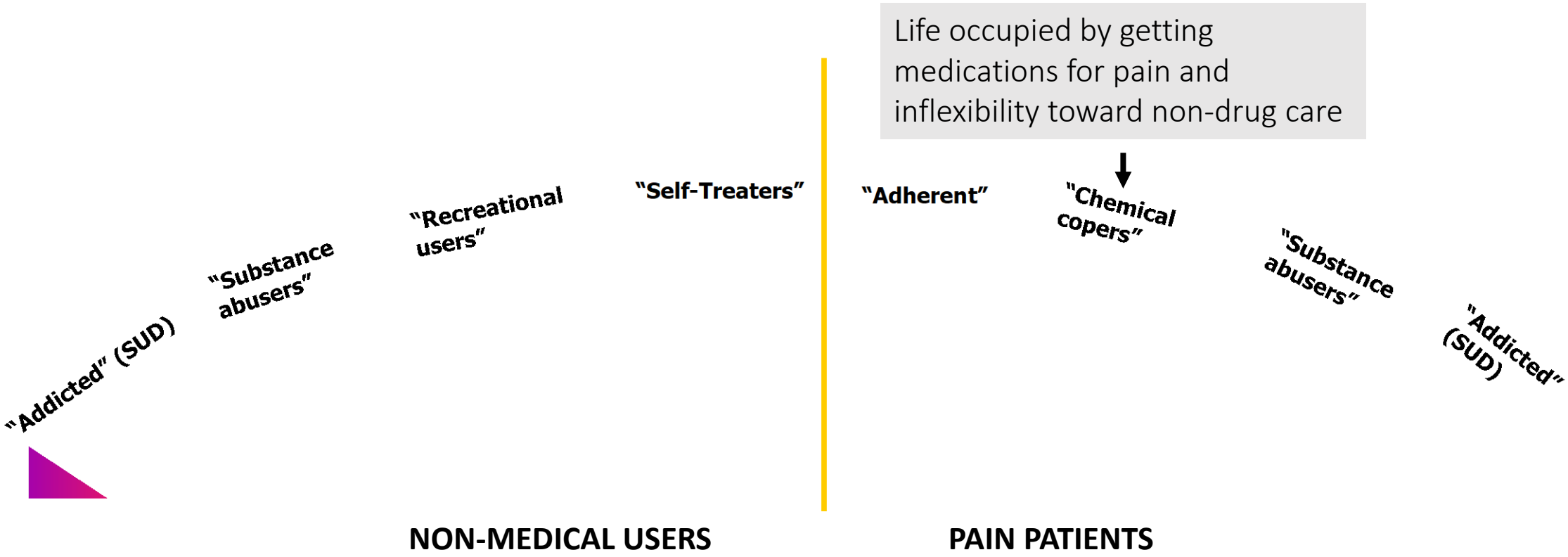
Data to be interpreted with a differential diagnosis of an SUD

EXAMPLES:

- ✓ selling
- ✓ forgery
- ✓ double doctoring
- ✓ street sourcing
- ✓ hoarding
- ✓ crushing
- ✓ snorting
- ✓ injecting
- ✓ multiple prescription loss or theft
- ✓ multiple dose escalation
- ✓ repeated resistance to changing medication despite clear evidence

White and Kelly. Alcoh Treat. 2011

SPECTRUM OF PRESCRIPTION OPIOID USE



Passik and Kirsh. Exp Clin Psych. 2008.

PAIN BELIEFS

Pain will harm:

Do you have any thoughts or worries about the causes, what keeps it going or worsens it?

What have you been told in the past?

What do you think might help?

Perceived Injustice:

Is there someone who is to blame for your pain?

Do you find yourself thinking about how unfair it is that you have pain?

Catastrophizing: *(next slide)*

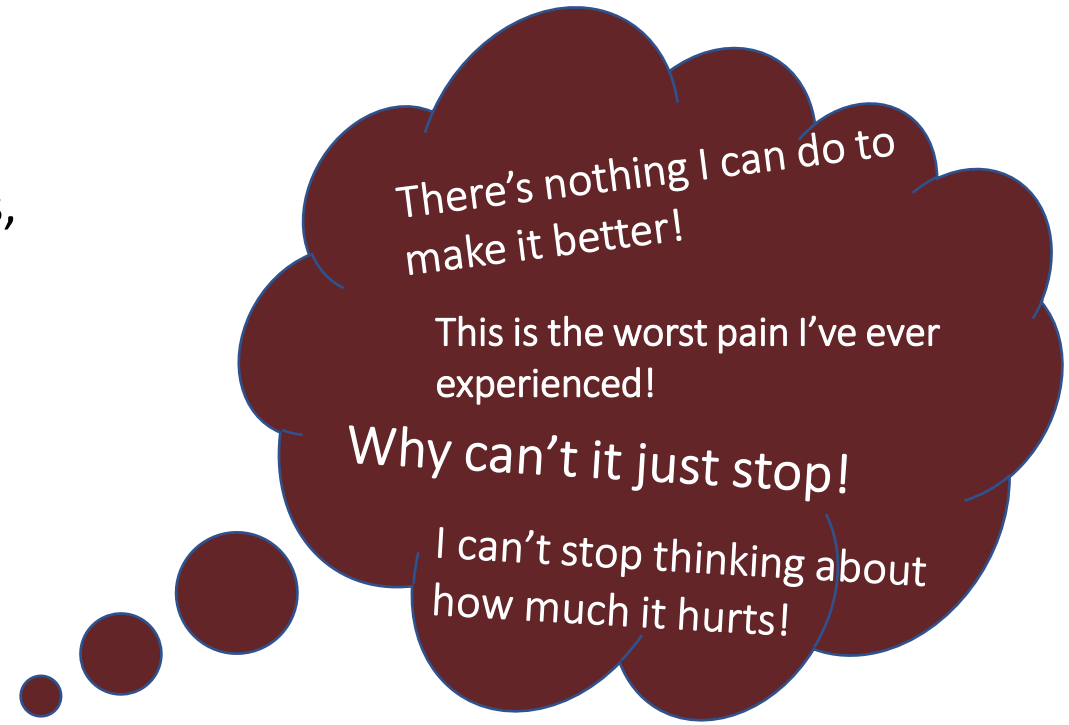
CATASTROPHIZING

Widely studied cognitive pain construct, that includes **3 factors:**

- Magnification
- Rumination
- Helplessness

Associated with more pain, emotional distress, disability and healthcare utilization. More predictive of onset of back pain and disability compared to physical measures

Commonly measured with the 13-item Pain Catastrophizing Scale



Turks et al. 2016 J Pain.

PAIN MANAGEMENT

OFFICE-BASED APPROACH

VALIDATE:

Build trust through listening and validation of the pain experience

COLLABORATE:

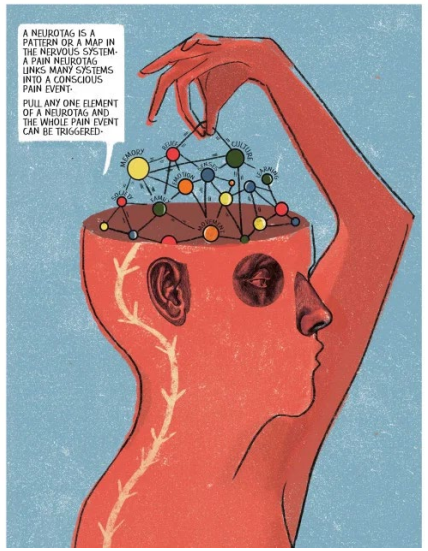
"I want to help you. We need to work together to find answers. What has been tried is clearly not working. Can we try a different way?"

EDUCATE:

Clear pain diagnosis and realistic expectations
Use biopsychosociocultural concept
Address concerns and misinformation
Hurt vs Harm, VIDEO: https://www.tamethebeast.org/#tame-the-beast

HOPE & MANAGE:

"I believe there is still hope to feel better. Why don't we test it out?"
Screen and treat comorbidities, self-management, psychotherapy
Schedule regular visits to monitor and reinforce progress



Haines & Standing. Pain Is Really Strange (2015)

CHRONIC PAIN EDUCATION

"Not all pain you have means danger. We are all born with an alarm system in our brain: the pain system. Imagine that your alarm system malfunctions so it goes off even when there is no fire or it does not go off when there is a fire. Pain and other symptoms can be caused by an over active nervous system. The pain is very real and can be severe. Both physical and emotional injuries activate this brain alarm. The brain's alarm system must be re-calibrated so that you can feel pain normally again. People exposed to chronic stress, possibly from an early age, are more likely to have an overactive alarm. There is good news that there are ways that have shown to change the system.."

Evidence: Education regarding the neurophysiology of pain has positive effects on pain, disability, catastrophizing, and physical performance.

Nijs et al. Man Ther. 2011

THANK YOU!
Questions?
Comments?

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