Psychological Treatment of Chronic Pain

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Disclosure

- I have no financial relationships to disclose.
- I will not discuss off-label uses or investigational uses of medications.

Objectives

- Identify the psychological aspects of chronic pain assessment
- Describe psychological treatment interventions for complex pain syndromes

Why Involve Psychologists in a Medical Problem?

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2016 CDC Guidelines for Opioid Prescribing

- Opioids should be prescribed at lowest dose possible, no more than 3 days for acute pain episodes
- Close monitoring of medications by MDs, with use of PMP
- Urine screens at start of treatment with at least annual retests
- Offer **alternatives**

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Alternatives

- Behavioral Health Treatment
- Physical Therapy
- Exercise
- Non-opioid medications
- Interventional Strategies

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Biopsychosocial Model of Pain

- Developed by Dennis Turk, PhD
- States patient is part of a nested set of factors:medical, psychological and psychosocial
- Essential to look at all three for comprehensive understanding of pain problems in patients

Biopsychosocial Model of Pain: [Turk and Rudy 1987; 1992; 1996]

- Chronic pain is viewed as a nested system, with following components:
  - Biological
  - Psychological
  - Psychosocial

Biopsychosocial Model of Pain [Turk et al]

- Pain is not EXCLUSIVELY sensory in nature
- System in which patient is embedded plays a large role in degree of disability
- **Behavior, emotions and attitudes** impact severity of pain experience as much or more than degree of tissue damage

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Medical/Biological

- What is the person's body type, genetic heritage, pre-existing medical conditions
- History of prior injuries
- Response to medications:allergies, sensitivities, no response

Psychological

- Personality Style
- History of prior conditions and treatment
- Energy level
- Pessimism/Optimism
- Locus of Control

Psychosocial

- Context in which injury occurred
- Environmental response to injury
- Beliefs about medical system, care received
- Family reactions to injury

Identifying Higher Risk Patients

- Have to address all three levels of nested influence
- Identify sources of support as well as sources of additional stress
- Employer/Employee relationship
- Level of fear/avoidance
- Pre-existing SEVERE psychiatric concerns

Appropriate Psychological Evaluation

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What is it made of?

- First:
  - Interview-Diagnostic Behavioral Health Plus
    - Mental status exam, prior medical and mental health history, psychosocial history, substance use history, current behavioral health factors e.g. smoking, alcohol intake, exercise and activity level
    - Knowledge of condition and treatment options, expectations for recovery, how it fits in the context of whole life, current coping strategies for pain control

In addition to standard psychological evaluation, the following are essential

- Current pain complaints
- Current medications
- Medical treatment history
- Degree of disability due to pain
- Payer source
- Expectations for recovery

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What is it made of?

- **Second**:
- Testing
  - Measures of depression/anxiety, expectations for recovery, opioid risk, prognosis for success
  - Commonly used tests of mood/personality
    - MMPI, MBMD, Beck Screens, SCL-90, PHQ-9, GAD-7
  - Pain Assessments
    - Oswestry, McGill, PDI, catastrophizing scales, sleep scales, substance abuse risk assessments, pain intensity rating scales, pain interference, PROMIS scales from NIH

Careful diagnosis is the KEY

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Diagnosis then Treatment

What to do with what you get

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Potential Psychological Treatment Goals

From Mark Jenson's "Hypnosis for Chronic Pain Management" 2011

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Pain Management Goals

- Decrease in perceived pain intensity
- Decrease in being bothered by pain
- Decrease in pain focus
- Increased ability to ignore pain
- Decrease in perceived fatigue severity
- Increase in belief that one has skills to cope
- Pain acceptance

Thought Management Goals

- Changing thoughts in positive direction
- Interrupting negative or catastrophic thinking about pain
- Increased belief that activity is safe
- Increased belief that one can manage well without pain-contingent analgesics
- Increased confidence in ability to function without pain-contingent help from others

Behavior Management Goals

- Engaging in some kind of enjoyable movement to stretch and strengthen
- No longer restricting use of affected body part
- Decreasing resting activity due to pain- lying down, resting in a dark room, etc.

Activity Management Goals

- Identify valued activities
- Increase participation in valued activities
- Maintain appropriate level of activity regardless of pain levels
- Not allowing pain to interfere with activities

Treatment Strategies to Meet Those Goals

Three Pillars Model

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Pillar One

- Goal is to allow patient to have the needed information to understand what is wrong and what the standard treatments and expectations are for both patient and provider.
- Heavy use of psychoeducation and behavior management strategies in this pillar

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Health Management

- Appropriate use of medications
- Increased exercise and activity
- Sleep hygiene
- Better eating/weight management
- Flare up strategies

Pillar Two

- Goal here is to develop more effective self talk and self regulation
- Heavy reliance on CBT strategies and self-regulation skill development

Self Regulation Strategies

- Abdominal Breathing
- Mindfulness
- Guided Imagery
- Autogenic Training
- Self-Hypnosis

Cognitive Strategies

- Self talk
  - Reframing
  - Thought challenging
- Realistic expectations
- Assertiveness
- Acceptance and Commitment Therapy
- Motivational Interviewing

Pillar Three

- The goal here is to help patients find new meaning after appropriate recognition and mourning of what has been lost
- This is the foundation of a “new normal”

Grief Work

- Letting go of “old self”
- Grieving loss of function
- Job/status changes
- Hope for future
- Creating new meaningful activities

Finding meaning

- Reasons to get out of bed
- Giving back to the community
- Feeling productive and useful

Hypnosis for Pain

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Hypnosis

- 2015 APA Monitor lead article stated that yoga and hypnosis are two of the best non-medication treatments for chronic pain management
- 2013 American Psychologist also cited hypnosis as one of the most effective treatments for chronic pain

Using Hypnosis

- Suggestions provided during a hypnotic trance are more likely to have clinical impact, and doubles the treatment effect in research trials(Jensen 2016)

Reviews of Randomized Trials

Findings are consistent with those of other clinical trials published in the past 20 years

All of the reviews of these trials have the same general conclusions

(Elkins et al., 2007; Montgomery et al., 2000; Jensen & Patterson, 2005; Patterson & Jensen, 2003)

- Hypnotic analgesia is more effective than no treatment and some biomedical treatments (PT, medications)
- Hypnotic analgesia has specific effects over and above placebo (expectancy) effects
- Response to hypnotic treatment is *variable*

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Imagine a Drug That…

- Produces a substantial ↓ in pain in 22% (SCI) to 47% (MS) of patients w/ chronic refractory pain
- Whose "side effects" are mostly positive, and include ↑'d sense of well-being and relaxation
- Whose worst side effects are: has no effect (3%), not as effective as hoped (3%), or benefits do not last as long as hoped (3%)
- That continues to be effective (no tolerance) and that most patients (80%) continue to use…

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Good practice involves providing realistic hope to pain patients

Jensen and Patterson, 2013

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QUESTIONS?

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