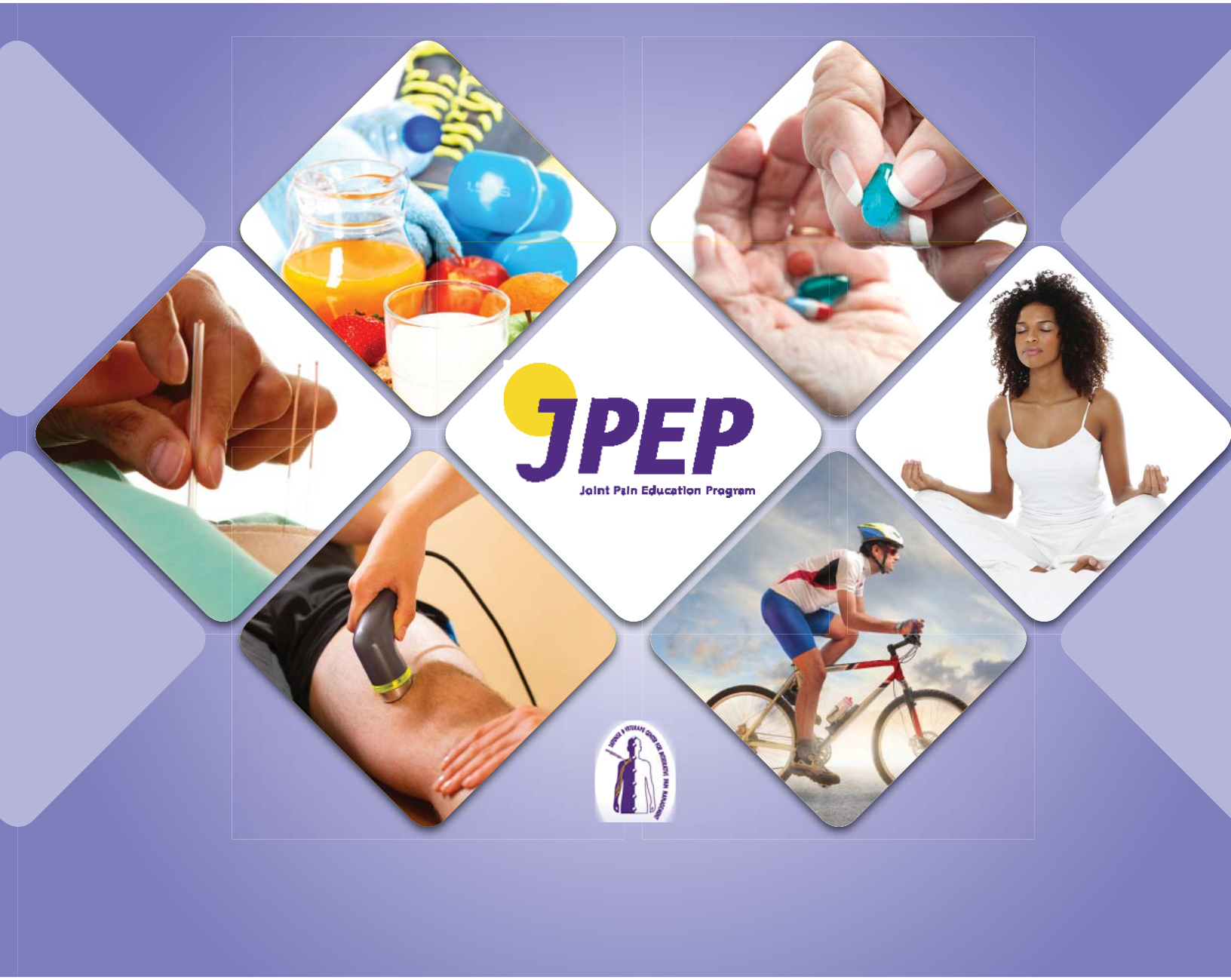
Pain Management for Primary Care



Series: Sixteen
Pain Common Comorbid Conditions

Module 16-1
Psychiatric Comorbidities and Pain

Module 16-1

Psychiatric comorbidities and Pain

By the end of the module, you will be able to:

- Describe comorbid pain and affective disorders.
- Discuss suicide risk in comorbidities.
- Review psychodynamic concepts in the provider-patient relationship.
- Differentiate psychotherapeutic interventions.
- Demonstrate the importance of pharmacology interactions.

We will review:

Topic One: Comorbid Psychiatric Disorders and Pain

Topic Two: Treatment Approaches

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Topic One

There are a few psychiatric comorbidities common with chronic pain.

The 2011 Institute of Medicine report says that:

- Post Traumatic Stress Disorder
- Depression
- Anxiety
- Substance Use Disorder
- Less commonly associated with Chronic Pain are Somatic Symptom and Illness Anxiety Disorder.
- Malingering and Factitious Disorder are uncommonly associated with Chronic Pain.

Notes

Emphasize that contrary to common belief, pretending, faking, malingering and other factitious disorders are very rare with chronic pain.

Patients with psychiatric comorbidities have poorer outcomes.

- Higher pain intensity and increased disability.
- Higher healthcare costs through increased utilization.
- Increased negative thoughts about pain, catastrophization and symptom amplification.
- Increased risk of chronicity/refractory illness.
- Increased risk of suicide.

Notes

Facilitator may add:

It is important to note here that Chronic pain increases comorbid psychiatric conditions

As the risk of suicide increases with comorbid psychiatric conditions, it is important to consider the assessment and management of patients with suicide.

Pain causes Psychological stress

Common cause of pain treatment failure

Associated with poorer outcomes

Predictive of increased health care utilization

Poorer adherence to treatment

Increased likelihood of future episodes of pain
- Bidirectional relationship
- Unrecognized psychological disorder worsens pain

Pain worsens underlying psychological disorders

Features Include
- Magnification
- Sense of Helplessness
- Rumination

Predictive of poorer pain management outcomes

Cognitive behavioral therapy effective in recognition and improvement of these unhealthy thought patterns

Refer to a Behavioral Health provider if the patient is at risk for suicide.

- If there is suicidal ideation.
- Patient suffers from:
  - A psychotic episode
  - Bipolar Disorder
  - Past Attempts
  - Family History
  - Concurrent Substance Abuse
- Recognizes a loss of impulse control.

Notes

Facilitator may add:

Most state laws mandate that any treating clinician must take action to ensure

safety/psychiatric evaluation (need references for this information)

VA/DoD clinical practice guidelines exist

The risk of suicide in primary care can become volatile when treating patients

Physical Disease is an independent suicide risk factor, present in 25-75% of people who commit suicide

Medical surgical patients who commit suicide may have experienced a recent loss of emotional support

Most general hospital patients who commit suicide have chronic, painful, or disfiguring illnesses.

High frequency of psychiatric illness, particularly mood and alcohol use disorders

Wrist slashing and drug overdose are the most common non-lethal suicide attempts methods in hospitals

Be very cautious if prescribing Tricyclic Antidepressants in impulsive patients; high risk of fatal overdose

Identify the risk level – difficult due to ambiguity about suicide reported by patients
SAMHSA suicide prevention mobile app helps providers assess suicidal risk
SAMHSA 5-Step Suicide Assessment Evaluation

SAMHSA 5-Step Suicide Assessment Evaluation
Identify Risk Factors
Identify Protective Factors
Conduct Suicide Inquiry
Determine Risk Level/Intervention
Document

Depression or depressive mood is found in up to 75% of patients with chronic pain.

- Depression worsens pain and pain worsens depression.
- Depression interferes with daily sleep activities thereby reducing quality of life.
- Diagnosis requires the presence of symptoms 1 or 2; and at least 5 or more symptoms for a 2 week period:
  - Depressed mood nearly everyday
  - Marked reduction or loss of interest or pleasure in all or nearly all activities
  - Significant non-dieting weight loss or weight gain or change in appetite
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation
  - Fatigue/ loss of energy
  - Feelings of worthlessness or guilt
  - Reduced ability to think, concentrate, or decide
  - Recurrent thoughts of death and/or suicide, suicide planning, or a suicide attempt

Notes

Facilitator may add:

Studies show that people with more severe depression feel more intense pain.

Like depression, chronic pain can cause problems with sleep and daily activities, reducing your quality of life.

Chronic pain can worsen depression symptoms and is a risk factor for suicide in people who are depressed.

May have medically unexplained symptoms which don't meet criteria for a psychiatric disorder

Depression and Pain often coexist and share common biological pathways and Neurotransmitters

Depression and Pain exacerbate one-another, cycle of pain/psych may respond to similar treatments

Chronic Pain causes depression, chronic pain worsens depression, depression can activate chronic pain. Family studies document that without any prior history you are still at risk for depression after 6 month

Pain medicine will not necessarily cause a patient's depression to go away. It is important to treat the depression in itself (move away from opioids). Treat pain effectively early on

It is important to Re-emphasize biopsychosocial model here

Collaboration between Mental Health providers, primary care providers and pain specialists is crucial

It is very important to appropriately assess depression with pain. You have to screen for depression. If there are red flags, then you need to take the next steps

Important to distinguish between clinical depression versus bereavement or normal Sadness

Use Beck Depression Inventory or Hamilton Rating Scale for Depression (HAM-D)

Collateral information often informative

According to the DSM V for Major Mental Disorder:

symptoms are not due to the direct physiological effects of a substance (e.g., medication or drug) or a medical condition

symptoms cause clinically significant distress or impairment in social, occupational or other areas of functioning

Use a tool to screen (PHQ2) and monitor (PHQ9) depressive patients.

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Notes

Facilitator may add:

Models of depression focus on concepts of cognitive, learned helplessness, reinforcement, biogenic amine, neurophysiologic, and final common pathway

It is important to screen patients for depression

- Patient Health Questionnaire PHQ-2
  - 2 item self report which inquires about the frequency of depressed mood over the last 2 weeks)
  - "First Step" approach . All who screen positive should be further evaluated with the PHQ-9
  - Screening should be completed annually by all patients seen in primary care settings
- Patient Health Questionnaire PHQ-9
  - 9 item report which screens for and diagnoses depression based on DSM criteria
  - Can help track a patient's depression severity as well as specific symptoms

Beck's Cognitive Triad characterization

- The self is seen in a negative light
- The current situation is viewed negatively
- The future is viewed negatively

"Learned Helplessness" – the depressed person views his/her responses as ineffective and that others (i.e. clinicians) WILL NOT bring relief

Screening: If a patient screens positive, then you do the PHQ-9 depression screening and get the behavioral health person involved to diagnose.

Further information can be found in the VA/DoD Clinical Practice Guidelines

Many patients with chronic pain report anxiety, loss of control and vulnerability, which can be:

- Generalized Anxiety Disorder
  - Difficulty to control worry for at least 6 months
  - Fatigue, restlessness,
  - Social and occupational dysfunction
- Separation Anxiety Disorder
  - Anxiety lasting 6 months or more
  - Clinging to loved ones or attachment figures
  - Inability or fear of being alone/separate from loved ones/attachment figures
- Agoraphobia
  - Severe fear or anxiety when in public places/social situations lasting 6 months or more
  - Fear or anxiety that is out of proportion to the actual danger

Notes

Facilitator may add:

Anxiety disorders are characterized by sense of fear and signs of autonomic arousal.

Fear is out of proportion or inappropriate in the context.

Arousal symptoms heighten perception (fight or flight), including perception of pain.

Predisposing vulnerability combined with feeling that situations are outside one's control.

Often a response manifestation of the pain

May amplify and distort a patient's pain

- Pain can be a common symptom — and sometimes a good indicator — of an anxiety disorder, particularly generalized anxiety disorder (GAD)7
- Many chronic pain disorders are common in people with anxiety disorders.7

May manifest as somatic complaints which compounds difficulty of evaluation of underlying medical complains and/or medication side effects.

Frequent co-morbid diagnosis include

Generalized Anxiety Disorder

Panic Disorder

Post Traumatic Stress Disorder

Other anxiety disorders include:

- Social Anxiety Disorder
  - Persistence fear or intense anxiety (6 months or more) about situations which person feels he/she may be scrutinized or act in a way that is embarrassing or humiliating
  - Avoidance of anxiety - producing social situations
  - Anxiety or distress that interferes with daily living
- Panic Disorder
  - One month or more of ongoing worry following a panic attack
  - Frequent, unexpected panic attacks
  - Maladaptive changes in behavior to avoid attacks

Notes

Obsessive Compulsive Disorders and PTSD are now within their own category of the DSM V (previously these fell under anxiety disorders)

Chronic pain may cause PTSD, which in turn, increases pain.

- PTSD is diagnosed when there is:
  - Criterion A: Stressor
  - Criterion B: Intrusion Symptoms
  - Criterion C: Avoidance
  - Criterion D: Negative changes in Cognitions and Mood
  - Criterion E: Changes in arousal and reactivity
  - Criterion F: Duration
    - Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.
  - Criterion G: Functional Significance
    - Significant symptom-related distress or functional impairment (e.g., social, occupational).
  - Criterion H: Exclusion
    - Disturbance is not due to medication, substance use, or other illness

Notes

Read through the slide

When PTSD is diagnosed, follow the DoD/VA guidelines:

- All new patients should be screened for symptoms of PTSD using paper-and-pencil or computer-based screening tools
- The following screening tools considered for use should be:
  - PCL: PTSD Checklist
  - PC- PTSD: Primary Care PTSD Screen
  - PTSD Brief Screen
  - Short Screening Scale for DSM IV PTSD
- Other validated screening tools can be considered

Notes

Substance use disorder (SUD) needs to be recognized and addressed when treating pain.

- Substance use disorder is diagnosed when 2 (or more) of the following occurs within a 12-month period:
  - Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home
  - Recurrent use in situations in which it is physically hazardous
  - Continued use despite persistent or recurrent social or interpersonal problems by the effects of the substance
  - Tolerance (1. Need for increased amount to achieve desired effect, 2. Markedly diminished effect with continued use of the same amount of the substance)
  - Withdrawal
  - The substance is often taken in larger amounts or over a longer period than was intended
  - There is a persistent desire or unsuccessful effort to cut down or control substance use
  - A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
  - Important social, occupational, or recreational activities are given up or reduced
  - Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem
  - Craving or a strong desire or urge to use a specific substance

Notes

Go over slide.

Note tolerance and withdrawal are part of the diagnosis.

Addiction refers to the negative, self destructive social behaviors related to procuring substances (drugs, medications and alcohol).

Very rarely pain patients will present with:

- Somatic symptom disorder
- Conversion Disorder
- Psychological factors affecting a medical condition
- Fictitious Disorder (Munchausen)
- Illness Anxiety Disorder

Notes

Contrary to common belief.

Facilitator may add:

These are not individual diagnoses that stand alone. These are complicated factors not isolated diagnosis that stand alone (intertwined) .

The DSM V has the category of factitious disorder however this is rare. People have pain related to other psychological symptoms. This is a very uncommon condition

Munchausen's, pseudologica fantastica, peregrination

Fictitious Disorder

A common type of somatic symptom disorder

Very colorful, dramatic personal and medical history

Multiple Hospitalizations, malpractice, and insurance claims, disability

Common to all:

- Preoccupation with somatic symptoms (with or without clear tissue diagnosis) resulting in significant distress and functional impairment
- Distinguished from malingering in that secondary gain is not a motivator for symptoms, though secondary gains may ensue over time
- Somatic Symptom Disorder "with predominant pain" is common with or without a diagnosis of a painful condition.
- Symptom magnification may occur due to multiple conflicting messages by providers as to the etiology of the pain or feel patients are not being heard

Patient may report transient improvements but "relapse" with social reinforcement of complaints by family members or seeking comfort of being in care of health care providers

Knowledge Check

The clinical management of somatization is best accomplished along several domains, including psychotherapeutic or psychopharmacologic approaches. Which of the following statements are true?

a. Psychotherapeutic approaches focus on the patient as main perpetrator and causation of pain.

b. Those patient's openly hostile to the exploration of their pain through a psychotherapeutic manner should be forced to see a Behavioral Health Provider.

c. A helpful framing of the patient's experience in a psychotherapeutic approach is to validate the patient's suffering, emphasize the limitations of medical options, and educate about the importance in addressing problems, other than pain, that are contributing to suffering and disability.

Knowledge Check – Answer

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Topic Two

Treatment Approaches

Motivational interviewing is the foundation of talk therapy with pain patients.

- Approach challenging situations with a 'what is best for the patient' mindset.
- Be aware of transference (the unconscious redirection of feelings from patient to provider) and countertransference (transfer of feelings from provider to patient).
- Have a nonjudgmental "conversation" with your patient aimed to clarifying patient's needs and values, and identify goals of care that are consistent with the patient's functional goals (e.g. "being able to play with my children" rather than "making my pain go away").

Notes

Cognitive Behavioral Therapy (CBT) is the most successful approach to help patients with chronic pain.

- Education – focus on unlearning negative perceptions regarding abilities to manage pain
  - Skills acquisition – learn new behaviors
  - Skills consolidation – practices new behaviors
  - Solidifies skills preventing relapse
- Cognitive Restructuring:
  - Identifies maladaptive thoughts
  - Introduces and practices coping thoughts
  - Shifts from self-defeating to coping thoughts
  - Introduces and practices positive thoughts
  - Home practice and follow up
- CBT helps patients understand the relationship between thoughts, emotions and behaviors and sets appropriate expectations helping patients to function as well as they can.

Notes

Most common form of therapy offered and heavily studied to help in many comorbid conditions

Based on the idea that people hold beliefs that they are unable to function because of their pain

Techniques include cognitive restructuring, assertiveness, stress management, relaxation training, goal setting, and pacing of activities

Hurt versus Harm

Patients should not feel coerced or forced into therapy

Computer based CBT may be an effective alternative option to traditional individual or group psychotherapy (reference major depressive disorder CPG)

Acceptance Commitment Therapy (ACT) is a good alternative approach to CBT.

- Accept: Inner thoughts/experiences and stay present.
  - Thoughts and feelings are accepted, particularly the unwanted ones (e.g., pain, anxiety, guilt). End the struggle with unwanted thoughts by not attempting to eliminate or change them.
- Choose & Commit: To living with personal values
  - Helping patients choose directions by focusing on what really matters to them.
- Take Action: In areas that matter
  - Committing to action, using steps toward realizing valued life goals.

Notes

Facilitator may add:

ACT focuses on nonjudgmental acceptance of what is being experienced, negative or positive, versus an attempt to makes changes as in CBT.

For those patients who may have tried unsuccessfully to challenge and change their thoughts, ACT is an ideal alternative as it allows for letting thoughts or experiences "be" and getting more comfortable with their existence. As one Veteran put it, "I thought I needed to feel better and then I realized I needed to get better at feeling."

Biofeedback can be integrated.

- A technique which measures blood pressure, heart rate, galvanic skin response and teaches patients to relax and control them.
- Connected by electrodes to equipment with physiological parameters recorded:
  - Heart rate
  - Respiratory rate
  - Skin conductance and temperature
  - Muscle tension
- More successful in headaches and lower back pain.
- Relaxation techniques often used in concordance with biofeedback, have mixed results.

Notes

Facilitator may add:

Example of self care : Fit Bit

Discuss Relaxation responses that you can teach (examples of tools that patients can use)

Antipsychotic medication is better deferred to a Psychiatrist, however you may start with:

- Low dose Tricyclic antidepressant at bedtime.
- Use with caution for patients over 60 years old, cardiac disease and suicide risk.
- Beware of using Tramadol – interacts with many medications. Risk of seizure low, unless combined with Buproprion and may cause a life threatening Serotonin Syndrome.
- Avoid Opioids and/or Benzodiazepine that may worsen anxiety and depression, and are prone to misuse.

Notes

Tramadol – Opiate effects and inhibits both NE and 5-HT
Risk of seizure low, unless combined with Buproprion
Serotonin Syndrome may result with SSRI/TCA/SNRIs

- Higher dose Tramadol
- For Patients with depression and anxiety as comorbidities , antidepressants may be okay
- Patients at highest risk (Tricylic antidepressants)
- Opioids can worsen anxiety and depression. Important to outline these effects explicitly
- Use and impact of medications. Misprescribing is a big problem (especially as doses increase)
- Opioids can worsen anxiety and depression

Tricyclic Antidepressants – may be very good, but
SSRIs- in older patient population, consider effects on platelets (bleeding) as well as hyponatremia

Knowledge Check

Biofeedback equipment records a patient's _____ and _____ to treat headache and low acute back pain.

a. Speech rate; Muscle flexion

b. Respiratory rate; Muscle tension

c. Tactile response rate; Muscle tension

d. Muscle tension; Speech rate

Knowledge Check – Answer

Biofeedback equipment records a patient's _____ and _____ to treat headache and low acute back pain.

a. Speech rate; Muscle flexion

b. Respiratory rate; Muscle tension

c. Tactile response rate; Muscle tension

d. Muscle tension; Speech rate

Notes

Read question aloud

Summary

Recall that depression, anxiety, PTSD and Substance Use Disorder (SUD) are common among chronic pain patients, factitious disorder and malingering is not.

Feel confident in screening and monitoring patients with tools like PHQ2, PHQ4, PHQ9.

Follow the DoD/VA guidelines when you suspect PTSD or suicidal ideation. Motivational interviewing is the best way to communicate.

Use adjuvant medications carefully and avoid sedatives, and opioids altogether. Cognitive behavioral approaches combined with patient activation, sleep hygiene, nutrition are best.

Resources

Assessment and Management of Patients At risk for Suicide (VA/DoD Clinical Practice Guidelines) pocket guide (2013): http://www.healthquality.va.gov/guidelines/MH/srb/

SAMHSA suicide prevention mobile app: http://www.samhsa.gov/newsroom/press-announcements/201504020400

SAMHSA 5-step Evaluation and Triage Pocket Guide: http://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-Pocket-Card-for-Clinicians/SMA09-4432

PHQ 9 depression screening: https://www.myhealth.va.gov/mhv-portal-web/anonymous.portal?_nfpb=true&_pageLabel=mental Health&contentPage=mh_screening_tools/PHQ_SCREENING.HTML

Anxiety and Depression Association of America List of Anxiety Disorders - http://www.adaa.org/understanding-anxiety/DSM-5-changes

DSM V PTSD criteria: http://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp

VA/DoD Clinical Practice Guidelines http://www.healthquality.va.gov/guidelines/

DSM-V Substance Use Disorder and Addictive Disorders Fact Sheet - http://www.dsm5.org/Documents/Substance%20Use%20Disorder%20Fact%20Sheet.pdf

SAMHSA List if Substance Use Disorders : http://www.samhsa.gov/disorders/substance-use

VA and DoD CPG depression screening: http://www.healthquality.va.gov/guidelines/MH/mdd/MDDTool1VADoDEssentialsQuadFoldFinalHiRes.pdf

VA/DoD Clinical Practice Guidelines for the Management of Post-Traumatic Stress (annotation c, page 18-19) : http://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSD-FULL-201011612.pdf

Transference and countertransference in cognitive behavioral therapy: http://mefanet.upol.cz/BP/2010/3/189.pdf

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JPEP

Joint Pain Education Program