Assessing for Anxiety, Depression and Suicidality in our complex chronic pain patients

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Disclosures

• Nothing
Objectives

• Identify screening tools that can be used in chronic pain to assesses for
  • Anxiety
  • Depression
  • Suicide Risk
• Identify what is considered the gold standard for identifying depression in patients
• Identify one limitation of the currently available screening tools
Mood and Anxiety in the setting of chronic pain
McWilliams, et al. Pain, 2003;106:127-133

Mood/Anxiety in Pain

- N = 5877, US civilian population, survey
- OR of having chronic pain, adjusted for sociodemographics (1) and medical dx (2)
Background

- American Indians and Alaska Natives have repeatedly been found to have higher prevalence of several pain conditions
  - severe headache or migraine
  - low back pain
  - neck pain
  - joint pain

- A 2013 study began trying to identify specific factors to determine the “why” of specific pain syndromes thru a study of pain processing found
  - “dampened pain and pain signaling”

- Screening tools are used and recommended by IHS but have not been sufficiently studied in our patients.

- Suicide risks are higher among all Native Americans
  - Rates 8.5 to 11.2 per 100,000
  - Males ages 15-24
Clinical interview

George L Engel

• “The interview is the most powerful, encompassing and versatile instrument available to the physician”

Joanne Katzman

• “Personal and Emotional Story”
As providers
  • Sigmund Freud
    • Transference and countertransference
  • Danielle Ofri
A twist on the pain scale
Screening Tools

Ideally

• Are evidenced based ....
  • Native Americans
  • Chronic pain
  • Anxiety
  • Depression
  • Outpatient
  • Primary care

• Fit well with your clinical interview style.

• Improve the quality of patient care.
What Screening tools are available for

- Depression
  - Clinical Interview is the “gold standard”.
- Anxiety
  - Panic Disorder
  - Generalized Anxiety Disorder
  - Social Anxiety Disorder
  - PTSD
- Suicide Risk
Anxiety Screening

A simple interview that helps you identify panic attacks, general anxiety, social phobia, and post traumatic stress disorder

- Have you:
  - Had a spell or attack where all of a sudden you felt frightened, anxious or uneasy (Panic)
  - Been bothered by nerves or feeling anxious or on edge for 6 months? (GAD)
  - Had a problem being anxious or uncomfortable around people? (SAD)
  - Had recurrent dreams or nightmares of trauma or avoidance of trauma reminders? (PTSD)
GAD-7

• Designed for use in primary care
• Designed to detect generalized anxiety disorder
• Only one half of patients with a positive screen actually have generalized anxiety disorder
• Use when clinical evidence of anxiety
• Treat if score > 10
PTSD

• Chronic pain patients with PTSD report:
  • More intense pain
  • Higher levels of life interference by pain
  • Greater disability by pain
  • Lower pain threshold and pain tolerance, leading to higher perceived disability
  • PTSD related re-experiencing associated with pain severity, self-reported physical symptoms, and limitations in functional ability
PTSD Screening

• Gold Standard is again the structured clinical interview
• Primary Care PTSD Screen (PC-PTSD)
• PTSD Checklist – Civilian Version
  • PCL-CL (PCL-5)
Primary Care PTSD Screen (PC-PTSD)

• The PC-PTSD is a 4-item screen

• In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you: (yes or no)
  • Have had nightmares about it or thought about it when you did not want to?
  • Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
  • Were constantly on guard, watchful, or easily startled?
  • Felt numb or detached from others, activities, or your surroundings?

• Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.
PCL-CL
Developed for primary care

• Answer 17 Questions

• Two briefer version are available by asking specific questions
  
  Number One Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?

  Number Four Feeling very upset when something reminded you of a stressful experience from the past?

• A total severity score of 17 to 85

• No absolute cut-point for treatment ranges in our population 30 to 50
  
  Higher scores indicate greater symptoms severity
Screening for Depression

• “SIG E CAPS”
• HAM-D
• CES-D (Center for Epidemiological Studies Depression Scale)
• Beck Depression Inventory: 21 questions; self-administered
• Zung Self Rated Depression Scale
• PHQ-9
• PHQ 2
“SIGE CAPS”

Sleep
Interest
Guilt, hopelessness, worthlessness
Energy
Concentration
Appetite
Psychomotor agitation
Suicidal thoughts
PHQ-9

• Patient self-administered
• Quick
• Useful for monitoring change over time
• Scores 5, 10, 15, 20 [mild, moderate, moderately severe, and severe]
  • 5 point decrease is improvement
  • Response:
    • 50% decrease
    • Remission
      • A score under 5
PHQ 2 Question Screener with “help”

• During the past month, have you often been bothered by:
  • Feeling down, depressed, or hopeless?
  • Little interest or pleasure in doing things?

• If yes to either or both of these 2 questions, do you want help with this?
  • No
  • Yes but not today
  • Yes

• Mental Health Screening in the IHS population. David Price, MD. May 2011
Brief Psychosocial Screening:

ACT-UP

• Activities: How is your pain affecting your life (ie, sleep, appetite, physical activities, relationships)?
• Coping: How do you deal/cope with your pain (what makes it better/worse)?
• Thinking: Do you think your pain will ever get better.
• Upset: Have you been feeling worried (anxious)/depressed (down or blue)?
• People: How do people respond when you have pain

• DURING THE Last MONTH, HAVE YOU OFTEN BEEN BOTHERED BY:
  • FEELINGS DOWN, DEPRESSED OR HOPELESS
  • HAVING LITTLE INTEREST OR PLEASURE IN DOING THINGS?

• IF YES
  • DURING THE LAST MONTH HAVE HAVE YOU OFTEN BEEN BOTHERED BY
    • FEELINGS OF WORTHLESSNESS
    • POOR CONCENTRATION
    • THOUGHTS OF DEATH
  • HOW LONG HAVE YOU FELT THIS WAY?
  • HOW DOES IT AFFECT YOUR DAY-TO-DAY FUNCTIONING AND RELATIONSHIPS?
  • DO YOU FEEL ISOLATED?
  • IS THERE ANY HISTORY OF PSYCHIATRIC PROBLEMS?
PROPOSED SCREENING QUESTIONS FOR PATIENTS WITH LONG-TERM HEALTH PROBLEMS

• DURING THE LAST MONTH, HAVE YOU OFTEN BEEN BOTHERED BY:
  • FEELING DOWN, DEPRESSED OR HOPELESS?
  • HAVING LITTLE INTEREST OR PLEASURE IN DOING THINGS?

• IF NO?
  • DURING THE LAST MONTH, HAVE YOU BEEN BOTHERED BY PAIN?
  • YES
    • WHERE IS THE PAIN?
    • HOW SEVERE IS YOUR PAIN ON A SCALE OF 0-10 WITH 0 BEING “NO PAIN” AND 10 BEING “THE WORST POSSIBLE PAIN”
Suicide Facts

• 64% of people who attempt suicide visit a doctor in the month before their attempt, and 38% in the week before

• The trend will now be a limitation of opioids in non-cancer chronic pain

• Three risk factors associated with chronic pain referred to a pain clinic
  • Hx of sexual/physical abuse
  • Family hx of depression
  • Being social withdrawn

• There is no way of truly knowing if an overdose is accidental or intentional suicides in the majority of cases
## Suicide Risk
### In the last 12 months in US

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<th>N=5692</th>
<th>Chronic Headache</th>
<th>Chronic Body Pain</th>
<th>Co-morbid Anxiety</th>
<th>Co-morbid depression</th>
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<td>Suicidality</td>
<td>4.3 X</td>
<td>2.1X</td>
<td>OR 4.1</td>
<td>OR 6.9</td>
</tr>
<tr>
<td>Plan</td>
<td>4.6 X</td>
<td>2,6 X</td>
<td>7.1</td>
<td>OR 12.2</td>
</tr>
<tr>
<td>Attempt</td>
<td>6.5 X</td>
<td>4.4x</td>
<td>OR 5.3</td>
<td>OR 7.3</td>
</tr>
</tbody>
</table>
Suicide Assessment

- Assess for depression
- Thomas Stern’s
  - The little voice
- Columbia Suicide-Severity Rating Scale
- Safe-T (Suicide Assessment Five-Step Evaluation and Triage)
- SBQR-R (Suicide Behaviors Questionnaire-Revised)
Suicide Risk Assessment

• According to Peter Stuart MD
  • Psychiatrist in Chinle, Az
  • With at least 15 years of experience at IHS
• Use a gradual sensitive approach
  • How does the future look for you?
  • Living with (pain/anxiety/patients symptoms) can be very difficult. Do you sometimes wish your life was over?
  • Have you had thoughts of hurting yourself?
  • Have you had thoughts that you would be better off dead?
  • Have you had thoughts you might hurt yourself?
Resources

• SAMSHA Specific Screening Tools


• Guideline concordant detection and management of depression among Alaska Native and American Indian people in primary care
• Hiratsuka, V, Smith, J et etal. The majority of AN/AI adults who screen positive received guideline concordant International Journal of Circumpolar Health. Management in the 12 weeks after positive screening 29 October 2015
• Urban Indian Health Institute, Seattle Indian Health Board
  Addressing Depression Among American Indians and Alaska Natives: