Psychosocial Assessment of a Chronic Pain Patient

Snehal Bhatt, MD
December 1, 2014

Objectives

- Appreciate the various psychosocial factors that contribute to the pain experience
- Be able to use appropriate screening tools
- Formulate a targeted psychological assessment for patients on chronic opioids in the primary care setting

Pain= Biopsychosocial Phenomenon

- “In the context of disabling pain, psychosocial factors are better predictors of pain intensity, pain-related disability, & response to treatment than are physical or pathophysiological factors.”

Hoffman, et al. (2007)

Factors to consider:

A History of Addiction

Screening: SOAPP- R

- 24 item patient reported mood sx, family history, legal history, designed to predict which pts require more monitoring, has associated monitoring/treatment recommendations.
- Sensitivity 81%, specificity 68%, PPV 57%, NPV 87%
- Cutoff score of 18

Suggestions for high risk SOAPP-R category [score >21]

- Review past medical records; contact prior providers
- Stated expectation of UDS at every visit
- Provide smaller amounts of meds [eg. 2 weeks]
- Family involvement
- Consider consultation with addictions specialists and/or psychiatrists
- Less abusable formulations should be considered (e.g., long-acting versus short-acting opioids, transdermal versus oral preparation, tamper-resistant medications)
- Early signs of aberrant behavior and a violation of the opioid agreement should result in a change in treatment plan. Depending on the degree of violation, one might consider more restricted monitoring, or, if resources are limited, referring the patient to a program where opioids can be prescribed under stricter conditions. If violations or aberrant behaviors persist, it may be necessary to discontinue opioid therapy

Suggestions for moderate risk SOAPP-R category [score 10-21]

- Periodic urine screens are recommended.
- Psychiatric consultation if appropriate
- After a period in which no signs of aberrant behavior are observed, less frequent clinic visits may be indicated. If there are any violations of the opioid agreement, then regular urine screens and frequent clinic visits would be recommended.
- After two or more violations of the opioid agreement, an assessment by an addiction medicine specialist and/or mental health professional should be mandated.
- After repeat violations referral to a substance abuse program would be recommended. A recurrent history of violations would also be grounds for tapering and discontinuing opioid therapy

Suggestions for moderate risk SOAPP-R category [score <9]

- Review of SOAPP-R questions is not necessary, unless the provider is aware of inconsistencies or other anomaly in patient history/report.
- Frequent urine screens are not indicated.
- Less worry is needed about the type of opioid to be prescribed and the frequency of clinic visits.
- Efficacy of opioid therapy should be re-assessed every six months, and urine toxicology screens and update of the opioid therapy agreement would be recommended annually.

Obtaining a substance history

- age at 1st use
- age at regular use
- peak use
- current/most recent use
- route of administration
- prior treatment history
- effects of substance [physical, social, psychological]- “positive or negative”
- Motivations [or lack thereof] for stopping- elicit ambivalence

Factors to consider: Depression

Pain and Depression co-exist

- Pain and depression frequently co-exist: 30-50% co-occurrence
- Pain is a strong predictor of onset and persistence of depression
- Depression is a strong predictor of pain, particularly chronic pain
- Relative to people with no pain, odds ratio for depression 1.8 with single site pain, and 3.7 with multi-site pain [Kroenke et al., 2009]

Co-existence= worse outcomes

- **Pain negatively effects depression response to treatment, and vice versa**

- **Additive adverse impact on**

  - Quality of life
  - Disability
  - Response to treatment
  - Pain outcomes, including chronicity
  - Patient satisfaction with treatment
  - Self-rated health
  - Functional limitations
  - Deteriorating social and occupational functioning
  - Greater use of medical services
  - Higher medical service costs

- **Baseline depressive symptoms and pain permanence beliefs most powerful predictors of chronic disability**

- **Baseline depression also the strongest independent predictor of subsequent pain at 3 months**

Screening for depression

- Clinical interview = GOLD STANDARD
- “SIG E CAPS”
- HAM-D
- CES-D
- Beck Depression Inventory: 21 questions; self administered
- Zung self rated depression scale
- PHQ-9

PHQ-9

- Patient self-administered
- Quick
- Useful for monitoring change over time
- Scores of 10 or above 88% sensitive and 88% specific for MDD
- Remember 5, 10, 15, 20 [mild, moderate, moderately severe, and severe]
- 5 point decrease is significant improvement
- Response: a 50% decrease, or a score under 10
- Remission: score under 5

PHQ-9

- <10: reassurance, supportive therapy
- 10-15: watchful waiting, supportive therapy; antidepressant if no improvement in 1 month
- 15-19: counseling or antidepressant [patient preference]
- 20 or above: antidepressant, alone or with counseling

- Factors to consider: Anxiety

Anxiety and chronic pain co-exist

- 35% of those with chronic arthritic pain have an anxiety disorder [vs 17% in general population] [NCS, 2003]
- Similar prevalence in patients with migraine and chronic back pain
- People with back or neck pain 2-3x more likely to have had PD, SAD or agoraphobia in past year
- People with back or neck pain 3-4x more likely to have had past year PTSD and GAD
- Women with fibromyalgia 4-5x more likely to have lifetime diagnosis of OCD, PTSD, or GAD
- Kuch et al. [1991]: 40% of consecutively referred patients with PD had chronic pain- usually head, shoulders, lower back- and 10% were on opioid analgesics
- Schmidt and Telch [1997]: in patients with PD, 46% had chronic back pain and 22% had arthritis
- Asmundson et al. [2000]: SAD may have similar prevalence of chronic pain
- Patients with anxiety disorders 2-3x more likely to have a painful condition [Sareen et al., 2005]

Co-existence = worse outcomes

- Teh et al. [2009]: Patients with high pain interference at baseline significantly less likely to respond to treatment for GAD or PD [OR 0.28]
- Bair et al. [2008]: secondary analysis of SCAMP data
- Patients who had pain + depression + anxiety had greatest pain severity and pain related disability
- Disability days in past 3 months:
  - 18.1 in those with pain only
  - 32.2 in those with pain + anxiety
  - 38.0 in those with pain + depression
  - 42.6 in those with pain + depression + anxiety

Screening

- **Ask a single question about four most common anxiety disorders [simple, quick, sensitive]:**

- **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 un comfortable 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, but fairly accurate for panic, social anxiety, and posttraumatic stress disorders
- excellent negative predictive value
- only one half of patients with a positive screen actually have generalized anxiety disorder or panic disorder
- Use when clinical evidence of anxiety
- Treat if score > 10

PTSD

- People 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

- Hypervigilance
- Avoidance
- Re-experiencing

Psychosocial factors to consider

- Sociocultural: gender, cultural beliefs, occupation, disability
- Psychological: Personality, anxiety, attribution
- Studies show positive association between negative pain beliefs, such as **permanence and constancy**, and pain chronicity
- Depression associated with learned helplessness, cognitive distortions, and pessimistic future beliefs
- Factors such as unemployment, inability work, and kinesiophobia all associated with worse pain outcomes [Ang et al., 2010]

Anxiety Sensitivity

- Fear of anxiety based on belief that anxiety may have harmful consequences
- Increased in most anxiety disorders
- May also be increased in some chronic pain conditions [Asmundson et al, 2000]
- AS correlated with PTSD severity
- AS correlated with severity of labor and dental pain
- AS increases the risk of pain-related avoidance and disability following physical injury in adults and children with chronic pain
- Influenced by genetic and environmental factors

Selective attention to threat

- Directing attention to feared objects or situations
- Robust findings for many anxiety disorders
- Less robust findings for chronic pain
- Patients with greater pain severity and pain-related disability more likely to selectively pay attention to trauma related stimuli than those with less pain [Beck et al., 2001]

Lower threshold for alarm

- Pain and anxiety both lead to physiologic arousal
- Prolonged states of arousal can be detrimental to health
- Anxiety disorders, particularly PTSD, see increased sympathetic activity
- This can lead to further avoidance

THE CYCYLE OF ANXIETY

STRESSORS

Medical illness
Pain
Family or Marital problems
Work problems

HEALTH HABITS

Poor diet
Inadequate sleep
Caffeine and alcohol use
Lack of exercise

GENETIC FACTORS

Family history of panic
Early childhood anxiety

THOUGHTS AND FEELINGS

Something is wrong with my body
Worry about everything
Can't cope
I'm out of control
Depression

PHYSICAL

Muscle Tension
Shortness of breath
Flushing & chills
Palpitations
Chest Pain
Dizziness

BEHAVIOR

Increased doctor visits because of health worries

Avoidance of places that make me anxious

Use of alcohol to cope

CBT TO IMPROVE COPING

MEDICATIONS

Example

- Physiological, affective, and behavioral components of PTSD maintain and exacerbate pain AND vice versa
- Example:
- Person with PTSD and musculoskeletal pain experiences pain and arousal
- Pain and arousal are constant reminders of trauma that caused the pain
- Trauma recollection leads to physiological arousal
- This leads to avoidance of pain-related activities
- This leads to deconditioning, which then worsens pain

Cognitive Processes

- Attitudes
- Beliefs
- Expectations
- Self-efficacy
- Coping resources

Examples

- All pain must be abolished before return to work/activity
- Pain is uncontrollable
- Passive attitude to rehabilitation
- Expect increased pain with activity
- Lack of ability to predict capability

Self efficacy

- Person’s confidence in ability to engage in a course of action that will lead to desired outcome
- If low: pain-related fear >greater pain, disability is a high likelihood
- If high: lower levels of pain, psych distress, & negative medical outcomes

Coping

- Active/Adaptive skills are the key
- Catastrophizing: magnifies pain, helplessness, negative orientation to pain & life circumstances and may increase pain, distress, disability
- Misinterpreting bodily symptoms

Social support

- Those who have it do better than those who don’t
- Key is healthy, helpful balance
- Over-protective partner/spouse, emphasizes fear of harm
- Solicitous behavior (taking over tasks)
- Socially punitive responses (ignoring, frustration)
- Family support of attempts to return to work
- Lack of support person to talk to about

Loss/Grief

- Job loss
- Loss of identity
- Meaning, purpose
- Role in family, friendships
- Hobbies, pleasurable activities
- Sex life

Additional factors

- Chronic illness
- Financial issues
- Family discord
- Compensation issues
- Legal concerns
- Systems issues
- Anger
- Fear
- Media/advertisements
- **Relationship with providers**

Provider factors

- Persist in biomedical approach
- Difficulty addressing psychosocial issues
- Frustration with complexity, lack of tx response
- Lack of sufficient time to address patients' goals in detail
- Communication skills
- Nonverbal
- Not recognizing emotions/feelings: Patient's Clinician's Relationship