UVM Project ECHO: Chronic Pain

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Agenda

• Introductions and announcements
• Session objectives
• Didactic presentation (20-25 min)
  • Q & A
• Case presentations
  • Clarifying questions
  • Discussion
    • First, participants – then program faculty
  • Summary of recommendations
• Session parking lot items for follow up
• Closing reminders
  • Complete session evaluation (session recording info included in this email)
  • Session slides posted at www.vtahec.org
  • Submit a new case, template posted at www.vtahec.org
Objectives

• Review the role of psychological factors associated with chronic pain

• Understand how psychological factors may show up during patient interactions

• Explore ways to work with people who suffer with both chronic pain and mood disorders
CME Disclosures

University of Vermont (UVM) Office of Continuing Medical and Interprofessional Education (CMIE) is approved as a provider of Continuing Medical Education (CME) by the ACCME.

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Participants should claim only the credit commensurate with the extent of their participation in the activity.

Interest Disclosures:

• As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.
UVM Project ECHO Chronic Pain: Psychological Factors Associated with Chronic Pain

Speaker: Heather Finley, PhD
Licensed Psychologist-Doctorate
Sept 6, 2019
Imagine...
1.5 Billion Worldwide

Most common cause of disability in US (100 mil)
Risk Factors For Chronic Pain

- Injury or illness
- Having surgery
- Being female
- Being overweight or obese
- Previous trauma
- Anxiety
- Depression
- High stress
- Sleep impairment
The Big 5 – Risk Factors and Sources of Suffering

✓ Depression
✓ Previous trauma
✓ Anxiety
✓ High stress
✓ Sleep impairment
Chicken AND Egg

Bidirectional Relationship

- Depression
- Anxiety
- Stress
- Sleep
Chronic Pain

1. NERVOUS SYSTEM CHANGES
   After an injury, pain nerves (see darkened areas) can regrow to connect with other types of nerves. So a touch elsewhere on the body can trigger pain.

2. TENSED MUSCLES
   Pain can trigger muscle tension, making muscles extra sensitive.

3. MENTAL STRESS
   Stress increases release of the “fight or flight” chemical norepinephrine, leaving both body and mind tired.

   Norepinephrine

4. DEPRESSION
   Exhaustion is linked to depression, which magnifies physical pain and restricts serotonin, a neurotransmitter that boosts mood.

   Serotonin

5. DISTURBED SLEEP
   Sleeplessness may follow, exhausting the supply of endorphins, which normally blunt pain.

6. GUARDED POSTURE
   Odd positions taken to avoid pain put strain on other muscles, spreading agony to different parts of the body. Unused muscles lose strength, creating more discomfort.

   Source: Adapted from Pain Center, Columbia Hospital, Milwaukee, Center for Pain Studies, Rehabilitation Institute of Chicago, original drawings from M. Comarte, 2009.

PAIN’S VICIOUS CYCLE
Chronic pain plunges sufferers into a self-perpetuating cycle of maladies. A back injury, for example, can lead to changes in the body, brain, and behavior, making pain worse.
Stress and Chronic Pain

Chronic Stress Response (fight or flight)

Sadness
Anger
Hopelessness
Isolation
Financial struggles
Loss of independence

Treated like addict
Loss of job
Loss of friends

“Feel like less of a man”
Misunderstood because “I look fine”

Others expect to “get better”
People think I’m lazy
People think I’m faking it
Sleep and Chronic Pain

Prospective, longitudinal studies (2005-2012) support unidirectional:

- **Insomnia** → **Pain**
  - Frequent “sleep problems” → More likely develop Fibromyalgia (10 years)
  - Insomnia → Increased risk of chronic musculoskeletal pain (17 years)
  - “Restorative Sleep” → Widespread pain symptom resolution (15 months)
Depression and Chronic Pain

Depression
- Decreased energy & motivation
- Social withdrawal
- Lack of interest (anhedonia)
- Sleep problems
- Self-blame/shame

Chronic Pain
- Trouble sleeping
- Decreased ability to work & play
- Physical deconditioning
- Misunderstood in relationships
- Shame and worthlessness
- Loss of identity

Patients with chronic pain:
- 61% “probable depression”
- 34% “severe depression”
Rayner et al, 2016, Pain Jul, 157(7)

75% with depression in primary care have pain-related symptoms
Lepine, Briley, 2004, Hum Psychopharmacol, 19
Depression and Chronic Pain

May Show up in Office
• Does not follow through on recommendations
• Learned helplessness
  “Nothing works!” “Yes, but...”
• External Locus of Control
  Focus on medication
  Passive recipient
• Irritability & anger
  Power struggles

Helpful to Remember
• It is not laziness
• Reframe resistance to increase empathy
• Be sure depression is being diagnosed and treated
• Help them connect with what matters – and encourage
• Acknowledge anger
• Consider what fear or desperation underlies face of anger
Anxiety and Chronic Pain

**Increased physiological arousal**
- Increased muscle tension
- Difficulty relaxing

**Catastrophic thinking**

**Avoidance**
- Ongoing and increasing fear
- Physical deconditioning

**Believe hurt = harm**
- Reinforces false sense of danger
- Increased activation of nervous system
- Avoidance
Anxiety and Chronic Pain

May Show up in Office
• Afraid to follow through on recommendations (esp activity-based)
• May misinterpret information
  Catastrophic thinking
  Difficulty concentrating
• May seek additional tests & specialists
  Focus on medication
  Passive recipient

Helpful to Remember
• Educate
  Hurt ≠ Harm
  Motion is lotion
  Role of nutrition
• Provide info and recs in writing
• Repeat and Reassure
• Consider language
  “Normal age-related changes in your spine.”
• Encourage them to set time limit for seeking cure
• Don’t take it personally if they don’t seem to trust opinion
Trauma and Chronic Pain

• Not a cause, but increased susceptibility

• Prevalence Stats
  • 90% women w/ Fibromyalgia: trauma as child or adult
  • 76% people w/ low back pain: trauma history
  • 66% women w/ chronic headaches: physical/sexual abuse
  • 60% people w/ arthritis: trauma history
  • 58% people w/ migraines: childhood abuse (phys/sex/neglect)
  • 56% women w/ chronic pelvic pain: sexual abuse history

www.InstituteforChronicPain.org
Trauma History and Chronic Pain

**Trauma History**

- **Persistent, heightened reactivity**
  - Increased physiological arousal
  - Hypervigilance
- **Avoidance**
  - Ongoing and increasing fear

**Chronic Pain**

- Heightened reactivity to pain
- Alarm, distress signal
- Increased focus on danger
- Avoidance
- Guarding
- Rest
- Decreased activities that increase pain

Primed for Central Sensitization
Central Sensitization and Chronic Pain

Response to Acute Pain

- Heightened reactivity to pain
- Alarm, distress signal
- Increased physical reactivity
- Increased focus on danger & further harm
  - Avoidance
  - Guarding
  - Rest
  - Decreased activities that increase pain

Chronic Response

Central Sensitization
Trauma and Chronic Pain

May Show up in Office
- Increased need for control
- Increased need for safety
- Fear about procedures
  Invasiveness
- Discomfort
  Personal space
  Physical touch
- Distrust of authority
- Distrust/fear of (male) provider
- May get triggered
  Smells
  Sensations

Helpful to Remember
- Offer choices when possible
- Involve in decision-making
- Ask permission before touch
- Decrease power differential
  - Speak eye-to-eye
    (avoid standing over)
  - Match body language
  - Acknowledge their expertise
- Allow clear path to exit
- Attend to comfort
  - Lighting
  - Temperature
  - Water
Addressing Psychological Factors - Relationship

• Adopt position as collaborator/facilitator

• Identify and reflect at least one strength you see
  • Courage
  • Determination
  • Commitment to family

• Celebrate steps made to improve quality of life
Addressing Psychological Factors – Include Patient

• Help increase personal power (internal locus of control)
  • Less emphasis on medication being primary treatment
  • More emphasis on psychotherapy, psychologically-informed physical therapy, mindfulness and relaxation training
• Find out what increases vitality, encourage and reinforce
  • Relationships, Physical Activity, Creativity, Spirituality
• Encourage connections
  • Grandchildren, Pet, Nature, Spiritual Community

• Educate
  • Chronic pain cannot be cured at this time
  • Goal is to improve quality of life (reduce suffering)
  • Hurt ≠ harm
  • Motion is lotion
Addressing Psychological Factors – Expand treatment

• Treat psychological concerns simultaneously
  • Assess for and monitor depression

• Prioritize sleep and physical activity

• Expand team of providers
  • Community Health Team – Dietician, Health Coach
  • Psychologically-Informed Physical Therapists
  • Psychotherapists

• Expand offerings in primary care home
  • Support Groups
  • Educational Sessions
  • Group Medical Visit
The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.
• STOP RECORDING
Case 1
Reminders

• Volunteers to present cases (key to the Project ECHO)
• Use the case template form posted at www.vtahec.org
  • Return completed case forms to: Mark.Pasanen@uvmhealth.org
• Please complete evaluation survey after each session
• Claim your CME at www.highmarksce.com/uvmmmmed
• Please contact us with any questions, concerns, or suggestions
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