Chronic Pain Clinical Guideline

Developed in collaboration with the mental health centers associated with FBHP, Arapahoe House, and Beacon Health Options

Purpose and Disclaimer:

This Chronic Pain Clinical Guideline was developed by FBHP, its affiliated mental health centers and Arapahoe House clinicians primarily for use by practicing clinicians. It does not constitute a formal reference and therefore deliberately provides little explanation or background to the conditions and treatment outlined. It is designed to acquaint the reader rapidly with the clinical problem and provide practical advice regarding assessment and management. The guideline does not necessarily represent the views of all the clinicians. The recommendations contained in this guideline do not indicate an exclusive course of action, or serve as a standard of medical or behavioral health care. Variations, taking individual circumstances into account, may be appropriate. The authors of this guideline have made considerable efforts to ensure the information upon which it is based is accurate and up to date. Users of this guideline are strongly recommended to confirm that the information contained within them, especially medication algorithms and doses (if present), are correct according to independent sources. The authors and the organizations accept no responsibility for any inaccuracies, information perceived as misleading, or the success of any treatment regimen detailed in the guideline

Background and Annual Prevalence Rates:

Pain is a very common symptom. In fact, pain is the main reason for seeking medical care in the United States. Approximately 20–35% of adults experience chronic pain each year. Pain affects more Americans than diabetes, heart disease, and cancer combined (per the National Institute of Nursing Research). Prevalence is higher among females than males and increases with age. Low household income and unemployment are correlated with chronic pain. Pain relievers are the second most commonly prescribed medications in physicians' offices and emergency rooms.

Assessing Pain:

Chronic pain is often defined as any pain lasting more than 12 weeks. Acute pain is a normal sensation that alerts us to possible injury or disease; chronic pain is much different. Chronic pain persists, often for months or even years. Although chronic pain may begin with an acute injury or illness, it does not always have a clearly identifiable cause. Chronic pain often is associated with other health concerns, such as appetite loss, fatigue, mood changes and sleep disturbances. It may limit a person's daily functioning, stamina, flexibility and strength. When it is not resolved effectively, chronic pain can result in feelings of despair and a loss of enjoyment in life's everyday activities.

Pain is a very personal and subjective experience that is modified by a variety of biomedical, psychosocial and behavioral factors. Consequently, a person's pain experience must be assessed across multiple domains to properly direct clinical interventions. A clinician should take a careful history of the client's pain complaint. For example, the clinician should ask the following questions:

- Where is the pain located?
- How intense is the pain?

- Was there a specific injury or known start to the pain?
- How long has the pain persisted?
- What is the quality of the pain (e.g., burning, stabbing, throbbing or crushing)?
- Does the pain vary in quality or intensity over the course of the day or over a longer period of time?
- Are you taking any medications or other treatments for the pain?
- How effective are these treatments?
- How does the pain affect your mood?
- Are you using any non-prescribed substances to treat you pain, including alcohol?
- How does the pain affect other aspects of your functioning (e.g., sleep, activity level, work, appetite).
- How does the pain affect your relationships with others?

To facilitate evaluation of the patient's pain complaint, it may be helpful to administer one or more standardized assessment instruments. Many of these instruments are available in the public domain without cost to the user. For example, the Brief Pain Inventory-Short Form (Cleeland and Ryan, 1994) is a nine-item, self-administered rating scale that covers most of these domains. The patient provides a numerical rating of each item, which can then be followed-up with additional questioning. Likewise, the Medical Outcomes Scale SF-36 is a relatively brief, self-administered questionnaire that identifies the various ways pain might affect daily functioning, mobility and mood (Ware and Sherbourne, 1992). The McGill Pain Questionnaire is a commonly used instrument for assessing pain quality and intensity (McGill, 1975).

It also may be helpful to have the client complete a daily pain log or journal to understand his/her pain patterns. See http://www.emergingsolutionsinpain.com/content/tk3docs/ESP_Pain_Log.pdf for a helpful example.

Chronic pain often occurs in combination with one or more mental health or substance use disorders. Therefore, it is important to assess for these conditions as part of a comprehensive evaluation. If the patient is taking medications for pain control, their use should be assessed and monitored. Coordination with medical providers is essential.

Disorders Associated with Chronic pain:

1. **Somatic Disorders** (DSM 5) Pain disorders can be somatic in nature or can have somatic components. Somatic Symptom Disorder should be considered when there is the presence of positive signs and symptoms such as "distressing somatic symptoms plus abnormal thoughts, feelings and behaviors in response to these symptoms," regardless of a medical explanation for the somatic complaints.
2. A **factitious disorder** is a condition in which a person acts as if they have an illness by deliberately producing, feigning, or exaggerating symptoms. A factitious disorder imposed on another is a condition in which a person deliberately produces, feigns, or exaggerates the symptoms of someone in his or her care.
3. Pain can be part of traumatic re-creations in **Post-Traumatic Stress Disorder**.

4. **Co-morbid disorders.** In addition to medical conditions, pain can be associated with co-morbid mental disorders including anxiety and panic disorders, depression, delusional disorder, obsessive-compulsive disorder and body dysmorphic disorder.

Additional Considerations:

1. **Older adults** may be under-diagnosed, as certain somatic symptoms such as pain and fatigue are considered to be a normal part of aging, as are concurrent medical illnesses. Illness worry is considered more acceptable in older adults with medical illnesses and medications. Concurrent depressive disorder is common in older people who present with somatic complaints. Assessment of pain may be more complicated in adults who suffer from **dementia** or other **cognitive or communication impairments**.

2. **In children**, the most common pain symptoms are recurrent abdominal pain, headache, fatigue and nausea. A single somatic compliant is more common in children than adults. Children do not always worry about illness prior to adolescence. Note that parent response is important, as this may determine the level of associated distress. A parent may report/interpret the degree of severity based upon number of missed school days and frequency of medical visits. Assessment of pain can be especially difficult in children with communication or developmental limitations. Consider using pain rating scales that utilize pictures.

3. **Cultural factors** should be explored, as somatic symptoms are prominent in various "culture-bound" syndromes.

4. **Risk factors and complications** associated with chronic pain include a higher prevalence of *suicide*, although it is not clear whether chronic pain is associated with suicide risk independent of its association with depressive disorders. The presence of anxiety or depression is common, and may increase symptom severity and overall impairment.

   Those experiencing chronic pain are at a significantly increased risk of *substance use/dependency* (for example: Opioid use/dependency), and this condition should be evaluated as a possible primary or secondary diagnosis. Chronic pain and addiction can fluctuate in intensity over time and require ongoing management and coordination between behavioral health and medical providers. At a minimum, substance use/dependence should be evaluated every 6 months.

   The presence of anxiety or depression is common among patients with chronic pain and may increase symptom severity and overall impairment. Somatic symptom disorder is another condition associated with increased pain.

   As described within the DSM V, *cognitive factors* may impact the clinical course due to "sensitization to pain, heightened attention to bodily sensations, and attribution of bodily symptoms to a possible medical illness rather than recognizing them as a normal phenomenon or psychological stress."

Adapted from: Diagnostic and Statistical Manual of Mental Disorders
http://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596

Evidence-based treatments for chronic pain:

There are many options for the treatment of chronic pain. Pharmacological, surgical and physical therapy techniques for pain management are varied, and a comprehensive review of these approaches is beyond the scope of this guideline. Instead, this section provides a brief overview of the psychological approaches that have demonstrated some success for patients with chronic pain. Generally, these approaches are combined with other medical interventions for the best outcomes. For an excellent review, please see the article by Roditi and Robinson (2011) listed in the references for this guideline.

1. **Psychophysiological techniques**—Biofeedback is a technique that helps patients learn to identify and modify certain physiological functions, such as muscle tension or peripheral blood flow. For example, a patient may use biofeedback equipment to identify areas of muscular tension in his/her body and subsequently learn to relax those areas of tension. Biofeedback has been designated as an efficacious treatment for pain associated with headache and temporomandibular disorders (TMD).

2. **Behavioral approaches**—Stress is a key factor in chronic pain maintenance. The focus of relaxation training is to reduce mental and physical tension, thereby achieving reductions in pain and increasing control over pain. Patients can be taught various relaxation techniques, which can be used individually or in conjunction with one another. These techniques include the following popular relaxation procedures:
   - Diaphragmatic breathing
   - Progressive muscle relaxation
   - Autogenic training
   - Visualization/guided imagery

3. **Operant behavior therapies**—The central idea behind operant therapies is that pain-related behaviors (e.g., avoidance or over-reliance on medication) are learned, and they are maintained by their positive and negative consequences. Changing behavioral contingencies can result in significant gains in coping behaviors, such as increased physical or social activity. Specific operant techniques include:
   - Graded activation
   - Time-contingent medication schedules
   - Fear avoidance associated with medical procedures

4. **Cognitive-behavioral approaches**—CBT interventions for chronic pain are used to effect changes in the patient's behaviors, thoughts, expectations, motivations and emotions. Psycho-education and cognitive restructuring are used to identify and change maladaptive beliefs about the patient's particular pain syndrome. Behavioral components might include relaxation skills or other coping strategies. Often, CBT techniques are used to enhance

motivation for treatment and to re-set expectations about the degree of disability associated with a client's chronic pain.

5. **Acceptance-based approaches**—These newer approaches focus on facilitating psychological flexibility and choosing to live a more fulfilling life, while acknowledging the limitations resulting from chronic pain. Acceptance and Commitment Therapy (ACT) is the most common therapy in this group. Briefly, this technique encourages patients to embrace their condition and its sequelae, rather than attempting to change it.

References:

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The role of psychological interventions in the management of patients with chronic pain, 2011

http://www.apa.org/helpcenter/chronic-pain.aspx
Link on Chronic Pain from the APA: coping with chronic pain

http://www.integration.samhsa.gov/clinical-practice/pain-management
includes resources