Chronic Pain, Depression and PTSD

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Disclosures

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Chronic Pain and Depression

- Overlap in the experience of pain and depression
- Diagnostic challenges
- Epidemiology
- Assessing suicide
- Treating depression and pain
Chronic Pain and PTSD

- Epidemiology of PTSD and chronic pain
- What is PTSD?
- PTSD and chronic pain affect each other
  - PTSD and opioid pain medication
- Screening for PTSD
- Treatments for PTSD
- Challenges in working with PTSD patients

Experience of Pain and Depression

- Isolation and social disconnection
  - Pain is a subjective certainty
  - Chronic pain is suspicious to the objective observer
- Patients may become afraid to "complain"
- Helplessness and frustration among friends and family
- Tunnel vision

Symptom Overlap

- Negative affect and pain are correlated
- Difficulties sleeping
- Poor concentration
- Low energy
- Psychomotor retardation
- Decreased interest
- Suicidal ideation
Depressed Affect and Pain

Predisposing factor in the experience of pain
Precipitating factor in the experience of pain
Exacerbating factor in the experience of pain
Consequence of pain
Perpetuating factor in pain

Assessment Tools

• Beck Depression Inventory (BDI)
• Inventory of Depressive Symptomatology (IDS/QIDS)
  – 30/16 item self rating questionnaire
  – Available online for free
  – Used in STAR*D and other depression treatment trials

Epidemiology

• Overlap of depression and pain states
  20% in most clinical settings (1.5 – 100%)
• Depression associated with poor pain outcomes
• Pain patient depression often untreated
• Population surveys from around the globe
  – Depression twice as likely with one pain site
  – Four times as likely with multiple pain sites
Suicide Epidemiology

- 11th leading cause of death in the USA (2007)
- 34,000 die of suicide each year
- 10.7 suicides per 100,000 per year
- 376,000 ED visits for self-inflicted injuries
- Incidence of attempts: 0.7% per year
- Incidence of ideation: 5.7% per year

Suicide: Standard Mortality Ratios

- Chronic Pain 2
- Prior suicide attempt 38.36
- Eating disorders 23.14
- Major depression 20.35
- Mixed drug abuse 19.23
- Bipolar disorder 15.05
- Opioid abuse 14.00
- Mental retardation 0.88

Psychosocial Factors Risk Factors

- Recent lack of social support
  - Including living alone
- Unemployment
- Drop in socioeconomic status
- Recent stressful life events
- Domestic partner violence
- Poor relationship with family
- Childhood trauma and sexual abuse
- Access to fire arms
Psychological Risk Factors

- Hopelessness
- Severe or unremitting anxiety
- Panic attacks
- Impulsiveness
- Aggression, including violence against others
- Agitation
- Insomnia

Suicide Risk: Protective Factors

- Children in the Home
  - Except postpartum psychosis/mood disorder
- Pregnancy
- Religiosity
- Life Satisfaction
- Positive Social Support

Clinician Responsibilities

- Ask the patient
- Assess risk factors
- Assess protective factors
- Weigh the evidence for imminent harm
  - Refer to an emergency room
  - Obtain consent to talk to other clinicians
  - Suggest consent to talk to family members/friends
Suicide Assessment

- Is a process, not an event
- Don’t use suicide prevention contracts
- If a family member is present, talk to them
  - 25% of patients deny suicidality to clinician but talked about it to a family member

Assessment

- Acute versus chronic suicide risk?
- Imminent danger or increased risk?
- Danger to self and/or danger to others?
- Duty to protect (or warn)

Depression and Opioid Use

- Daily opioid use associated with
  - More severe pain
  - More disability
  - Depressive symptoms
- Especially high doses
- Temporary depression relief, followed by worsening and character change
- Objective worsening, subjective improvement

Depression Treatment

• Rule out bipolar disorder

Mania/hypomania

• Distractibility
• Impulsivity increased (spending, traveling)
• Goal directed behavior increased
• Racing thoughts
• Pressured Speech
• Noted by others
• Got patients in trouble

Depression and Pain
Psychotherapies

• Cognitive Behavioral Therapy
  – improving mood
  – reducing pain-related catastrophic thinking
  – increasing functional ability despite pain
• Supportive Psychotherapy
  – Acknowledge (your job)
  – Bear (your job & the job of the patient)
    • Practice diaphragmatic breathing & grounding yourself
  – Put in Perspective (the job of the patient)
First line antidepressants

- Selective Serotonin Reuptake Inhibitors, SSRIs
  - citalopram, sertraline, fluoxetine, and others
- Serotonin Norepinephrine Reuptake Inhibitors, SNRIs
  - venlafaxine SR, duloxetine
- Others
  - bupropion SR or XL

Chronic Pain and PTSD

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- Challenges in working with PTSD patients

Epidemiology of PTSD

- 60% of American men and 50% of women experience at least one major trauma
- 8% of Americans develop PTSD
- PTSD point prevalence for Veterans
  - Vietnam male 15%, female 8% (1986-89)
  - Gulf War 12% (1995-97)
  - 13% Afghanistan/Iraq (2008)

http://www.ptsd.va.gov/
Co-occurrence: PTSD and pain

- 35% current PTSD diagnosis in a sample of chronic pain patients
- 50% current PTSD in a sample of patients with pain after motor vehicle collision


PTSD Symptom Cluster

- Intrusive recollection
  - Distressing, intrusive memories
  - Flashbacks (with or without dissociation)
  - Distressing dreams
- Avoidance/Numbing
  - Efforts to avoid thoughts, conversations, places
  - Inability to recall important aspects of trauma
  - Detachment, restricted affect
  - Sense of doom, foreshortened future

PTSD Symptom Cluster

- Hyper-arousal
  - Difficulty falling or staying asleep
  - Irritability or outbursts of anger
  - Difficulty concentrating
  - Hyper-vigilance
  - Exaggerated startle response
PTSD and chronic pain amplify each other

• Pain serves as a reminder of trauma
  – Amplification of PTSD avoidance behavior

• Physiological arousal in response to traumatic recollection
  – Amplification of pain related avoidance

• Physical deconditioning
• Increased odds of pain experience

PTSD avoidance and increased use of opioids

• 600 civilian patients in PCP and OB/GYN clinics: no PTSD vs. past vs. current PTSD

• Current PTSD correlated positively with pain and functional impairment

• Current PTSD correlated with opioid use
  – Only avoidance symptom cluster, but not intrusive memory and hyper-arousal was correlated


Primary Care PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?
   YES NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES NO
Primary Care PTSD Screen

3. Were constantly on guard, watchful, or easily startled?
   YES NO
4. Felt numb or detached from others, activities, or your surroundings?
   YES NO

Positive Screen: Any 3 YES answers

www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp

Discuss PTSD Screen

• Provide context and respond empathically
• Clarify responses
  – Did patient actually experience trauma?
  – Are the reported symptoms trauma related?
  – Are the symptoms disruptive to the patient’s life?
• Ascertain if traumatic events are ongoing
  – Acknowledge difficulty seeking help
  – Safety plan, support, mandated reporting?

Domestic Violence Support

• National Domestic Violence Hotline
  1-800-799-SAFE (1-800-799-7233)
  http://www.thehotline.org/
• Massachusetts Statewide Hotline
  1-877-785-2020
PTSD treatment

- Cognitive Reprocessing
- Prolonged Exposure
- Stress Inoculation
- Eye Movement Desensitization and Reprocessing (EMDR)
- Adjunctive Psychopharmacology
  - SSRIs, SNRI (venlafaxine)
  - Clonidine, prazosine (nightmares)

Challenges in working with patients suffering from PTSD

- Patient avoid talking about anything related to the trauma, including PTSD symptoms
- Clinicians typically collude with avoidance
- Patient and clinician may unconsciously re-enact perpetrator-victim-bystander scenarios
- Responding to acute dissociation

Summary PTSD

- 10 – 50% of chronic pain patients may suffer from PTSD
- PTSD symptom clusters include:
  - Intrusive recollection
  - Avoidance and numbing
  - Hyper-arousal
- PTSD and chronic pain amplify each other
- 4 questions screen for PTSD
- Ongoing traumatic events -> Hotline
Summary PTSD

- Avoidance/numbing may be associated with higher use of opioid pain medication
- Evidence-based PTSD treatments
  - Cognitive Processing Therapy
  - Prolonged Exposure Therapy
  - Stress Inoculation Training
  - EMDR (Eye Movement Desensitization Reprocessing)
  - Adjunctive Psychopharmacology

Summary Depression

- High overlap between depression and pain
- Address increased risk for suicide
  - Ask
  - Assess risk factors
  - Assess protective factors
  - Weigh evidence for imminent harm & respond
- Differentiate unipolar & bipolar depression
- Treat or refer to treatment

Selected References