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Psychiatry and Addictions Case Conference

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**PAIN AND DEPRESSION: MY PATIENT IS
STUCK IN A PAIN AND DEPRESSION
CYCLE AND "NOTHING HELPS" EXCEPT
OPIOIDS. WHAT CAN I DO ABOUT IT?**

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

✓ No conflicts of interest

OBJECTIVES

1. Describe the long-term risks and processes connecting chronic pain and depression
2. Describe practical, best-practice approaches for treatment of patients with chronic pain, depression, and opioids
3. Explore strategies for talking to patients about opioids and helping patients manage pain and depression

OVERLAP OF MDD AND CHRONIC PAIN

- In chronic pain populations, MDD prevalence is 30-54% (5-17% in general population)
- Mutual influence between pain and depression
 - Comorbid depression/pain leads to greater pain, worse prognosis, more disability, and higher health care costs
- Depression is underdiagnosed in primary care, particularly in patients with chronic pain

DIFFICULTIES IN ASSESSING DEPRESSION IN CHRONIC PAIN

- Several symptoms of depression are common in chronic pain
 - Fatigue/low energy
 - Poor sleep/appetite
 - Irritability
 - Psychomotor slowing
 - Low motivation/anhedonia
- Pain is common in severe depression
- Common theme: “Depression/motivation will get better if my pain does”

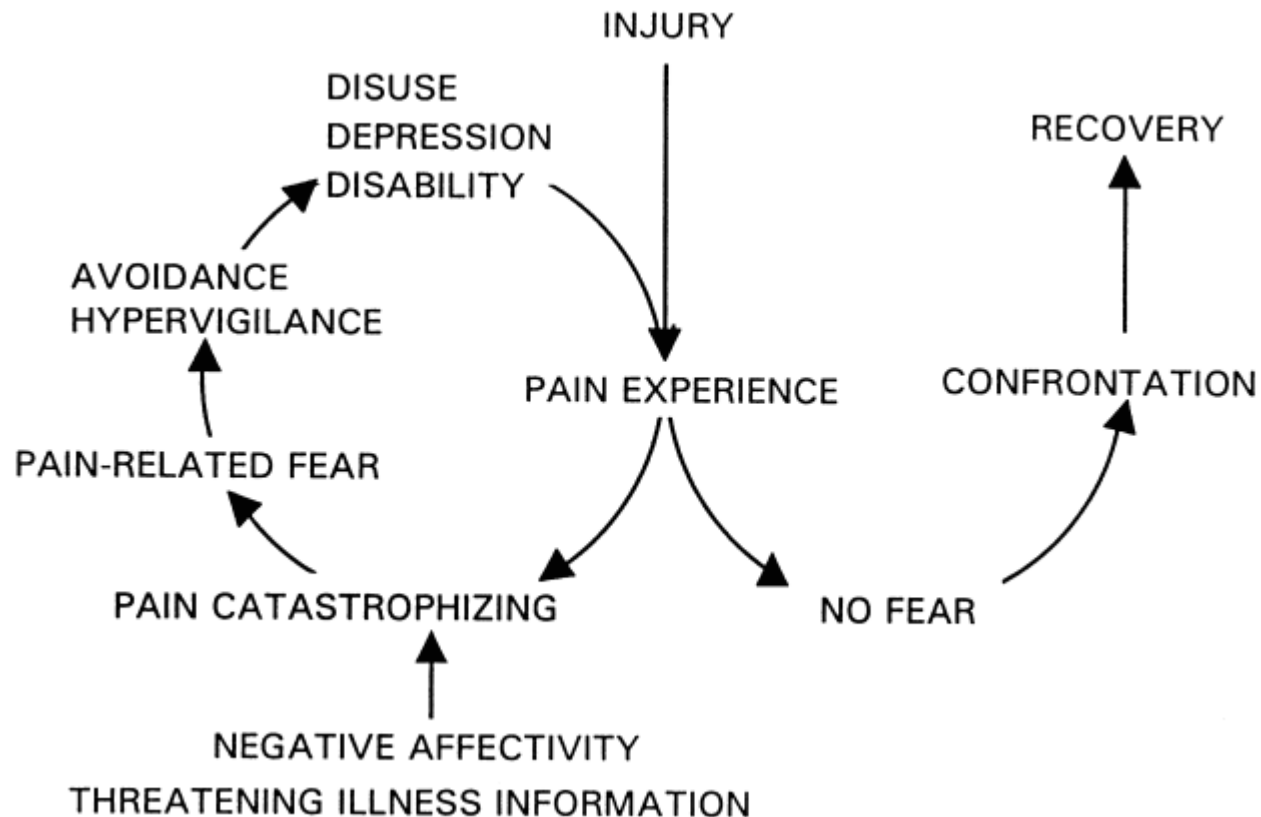
COURSE OF MDD AND CHRONIC PAIN

- Bidirectional relationship between pain and depression
 - Pain predicts onset/poor treatment response to depression
 - MDD increases risk of transition to chronic pain/opioid use
- Treatment-resistant depression risk increases with longer time on opioids
 - Long-term opioid treatment may reduce analgesic benefit and interfere with treatment of depression
 - Long-term use of antidepressants may decrease their efficacy
- Takeaway point: Treating depression may help with pain treatment
- Takeaway point: Emphasizing sustainable and active behavioral approaches may yield best long-term benefit for both pain and depression

MDD AND PAIN – COMMON PROBLEMS

- Pain can contribute to behavioral avoidance
 - Fatigue, post-exertional symptoms, anhedonia, poor sleep
 - Deconditioning, loss of financial/psychosocial resources, and sensitization of pain processing
- Increased social isolation/conflict
 - Reduces availability of protective, positive emotions
 - Increases negative emotions and maladaptive coping
- Thought patterns affect mood and coping responses
 - Pain catastrophizing, fear of pain, helplessness, injustice beliefs related to pain

CYCLE OF PAIN, AVOIDANCE, AND DEPRESSION



BEST PRACTICE FOR PAIN/MDD

- Multidisciplinary care:
 - Combination of medical intervention, physiotherapy, and psychotherapy
 - May not be available and/or cost-effective
- Addressing avoidance is key component of treatment
 - Behavioral/social reactivation
 - Desensitization/reconditioning
 - Effective stress/emotion coping

AVOIDANCE AND CHRONIC PAIN

- Fear of injury
- Fear of pain flares
- Anhedonia
- Lack of opportunity (e.g., isolation)
- Fatigue
- Frustration

ADDRESSING FEAR OF INJURY

- May involve conversation with physician about acceptable movements
- Discussion about acute pain (i.e., signaling injury) vs. chronic pain (no imminent risk of re-injury)
- Best treatment: Patient education and gradual re-exposure to activity

ADDRESSING FEAR OF PAIN

- Post-exertional symptoms (e.g., “If I move now, I will hurt much worse later”)
- Discussion of restoring strength/flexibility, “desensitization” of nerves/tissues through physical activity
- Best treatment: Time-based activity pacing, graded activity exposure, exercise therapy, PT

ADDRESSING ANHEDONIA

- “Why bother? I won’t enjoy it anyway”, “I just don’t feel up to it”
- Behavioral inertia: it is harder to get someone moving than it is to keep them moving
 - Pain relief is a reinforcer, so goals need to be more immediately rewarding than pain relief
- Best treatment: Patient-centered goals (start small!), positive/enjoyable activity scheduling, emphasizing regularity of enjoyable activities as part of treatment

ADDRESSING ISOLATION

- “I don’t have anyone that I can spend time with”, “Other people don’t get what I’m going through”
- Social support/activities are protective for mood, provide opportunities to be active and engaged
- Best treatment: Emphasizing contact with any positive influences in life, finding new opportunities to socialize (e.g., online meetup groups, support groups from ACPA, church or community groups), adapting efforts to allow socializing (even if done in a new way)

ADDRESSING FATIGUE

- Fatigue is complex and has multiple causes (depression/anxiety, poor sleep, medications, pain, deconditioning, caffeine)
- Best practice may be to address one issue at a time
- Best treatment: Mood management, gradual activity increases, sleep improvement (e.g., CBT-I), medication adjustments, physical reconditioning may help

ADDRESSING FRUSTRATION

- “I can’t do things the way I used to, so why bother?”, “Every time I try, my pain gets so bad that I end up feeling even worse”
- Best treatments: Normalizing frustration/flare/setbacks, interpreting pain flares as useful information for future behavioral efforts, emphasizing patience and pacing of behavior

MECHANISMS OF IMPROVEMENT- PAIN AND DEPRESSION

- Behavioral activation (exercise, work, recreation)
- Social activation/reintegration
- Effective stress/distress management
- Improved sleep
- Increased positive emotions
- Pain acceptance
- Formal pain coping skills/plans

PSYCHOTHERAPY FOR PAIN/MDD

- Few studies of psychotherapy for comorbid depression and chronic pain
- Some treatments show conceptual or preliminary empirical promise for application in both disorders:
 - CBT
 - MBCT/MBSR
 - ACT
- Key takeaway: Seeing a psychologist to treat pain does not disqualify them from medical care, nor does it mean that their pain isn't real

TALKING ABOUT OPIOIDS

- Use of opioids increases risk long-term
 - Increased pain, depression, medical risk, poor sleep
- Reducing opioids does not mean that the patient is misusing or a “drug addict”
 - Goal is to put safer, more sustainable treatments in place
 - Pain levels may decrease after reduction of opioids and cessation of withdrawal symptoms
 - However, more research still needed
- Distinction between short-term relief versus long-term health/function

PAIN/DEPRESSION AS CHRONIC ILLNESSES

- Emphasize a “management” approach rather than a “curative” approach
 - e.g., diabetes, heart disease
- Prioritizing reduction of pain/depressive symptoms may be counterproductive
 - Fearful appraisal/rumination/behavioral avoidance may worsen future episodes
- Emphasizing importance of meaningful function as primary goal, rather than total remission of symptoms (which may be impossible)
 - May help increase acceptance of pain/mood states

RESOURCES

- American Chronic Pain Association (www.theacpa.org)
- MBSR/MBCT instructors:
<http://w3.umassmed.edu/CFMInstructorSearch>
- ACT providers: <https://contextualscience.org>
- Books
 - Manage Pain Before it Manages You – Caudill
 - Quiet your Mind and Get to Sleep – Carney & Manber
 - The Chronic Pain Solution – Dillard & Hirschman
 - Full Catastrophe Living – Kabat-Zinn
 - The Feeling Good Handbook - Burns