Psychological Assessment in Patients with Chronic Pelvic Pain

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Outline of talk

Psychological aspects of Chronic Pelvic Pain (CPP)

Assessing patients in the clinical setting

- Why do we need to assess?
- How do we assess?
- Tools for assessing psychological aspects of pain
- What to do after the assessment

- Case illustrating assessment

Psychological Aspects of CPP

The problem…

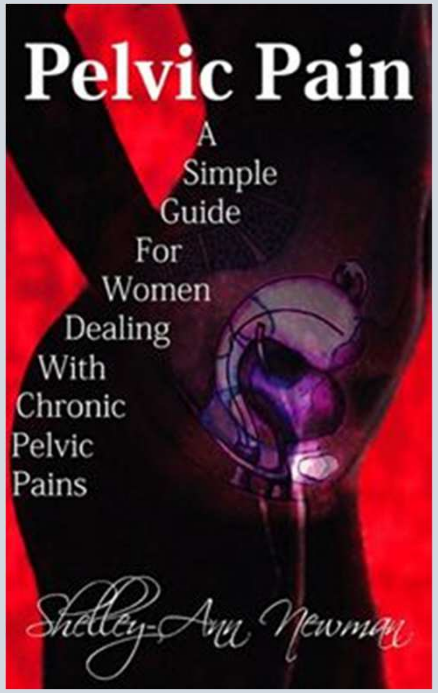
Clinical knots

Chronic pelvic pain: clinical dilemma or clinician's nightmare

Ahmos F F Ghaly, Patrick F W Chien

Chronic pelvic pain is a common problem presenting a major challenge to healthcare professionals. This is partly due to the lack of understanding of the aetiology and natural history of the disease. This condition is best managed using a multidisciplinary approach. In recent years, the emphasis in the clinical management has tended towards psychosocial or psychosexual involvement after organic disease has been excluded.

(*Sex Transm Inf* 2000;76:419–425)



The personal cost

Consequences for
- Employment (49%)
- Social relationships (49%)
- Intimate relationships (25%)
- Being a parent (21%)
- Self-esteem – “unable to be ideal self” (19%)

(Hatchett et al., J Health Psychol 2009;14: 741-750)

Relationship with depression
- 86% of women with CPP vs 38% gynae controls

(Lorencatto et al., 2006, Acta Obs Gyne Scand 2006; 85: 88-92)

- Cause or consequence?

Pelvic pain associated with psychological comorbidities

CPP and associated psychological risk factors

- Drug and alcohol abuse (OR 4.61)
- Sexual or physical abuse (OR 1.51-3.49)
- Anxiety (OR 2.28)
- Depression (OR 2.69)
- Multiple somatic problems (OR 4.83)

(Fall et al 2008)

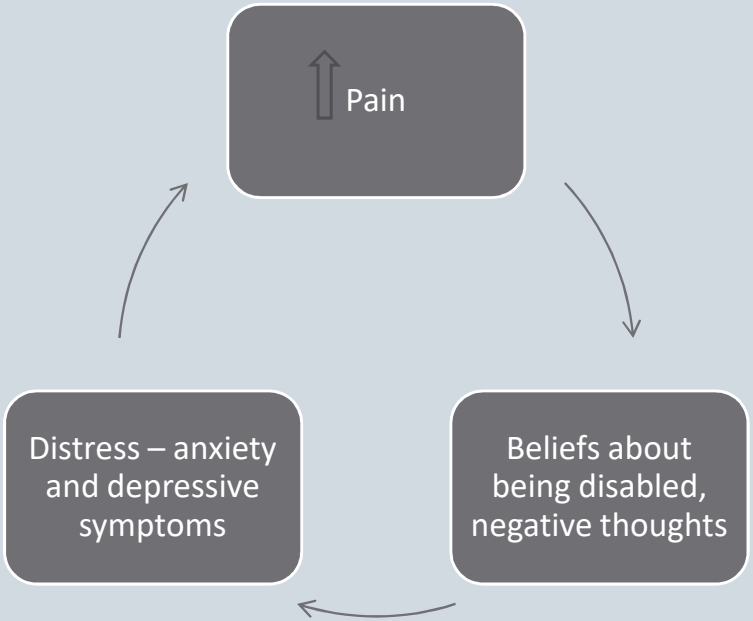
In a cohort of 713 women with Chronic Pelvic Pain aged 18-63 years

- 34.5% reported having a history of sexual abuse
- 28.9% reported physical abuse
- 46.8% reported having sexual or physical abuse
- 31.3% screened positively for PTSD

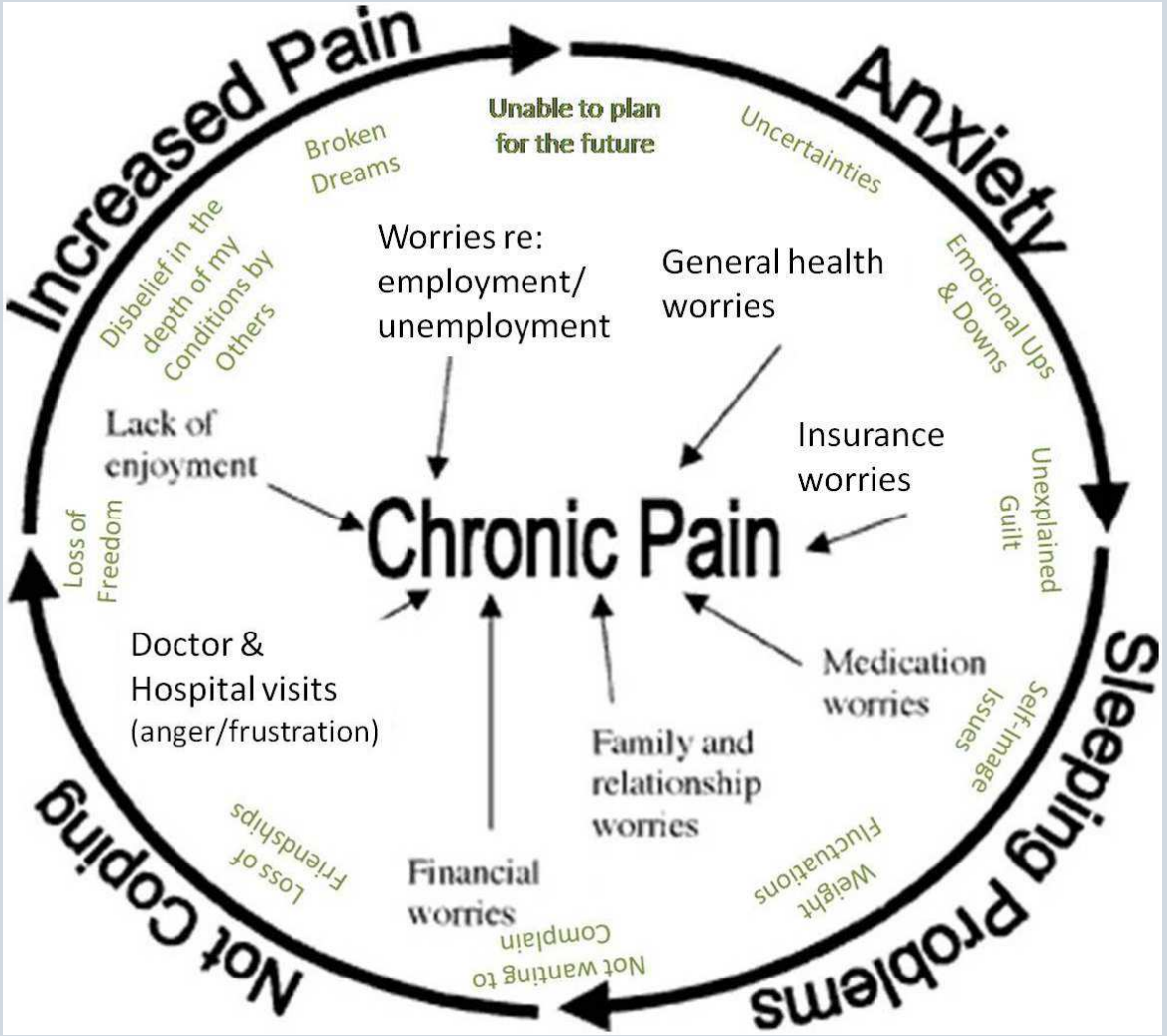
(Meltzer-Brody et al., 2007)

Why undertake a psychological assessment?

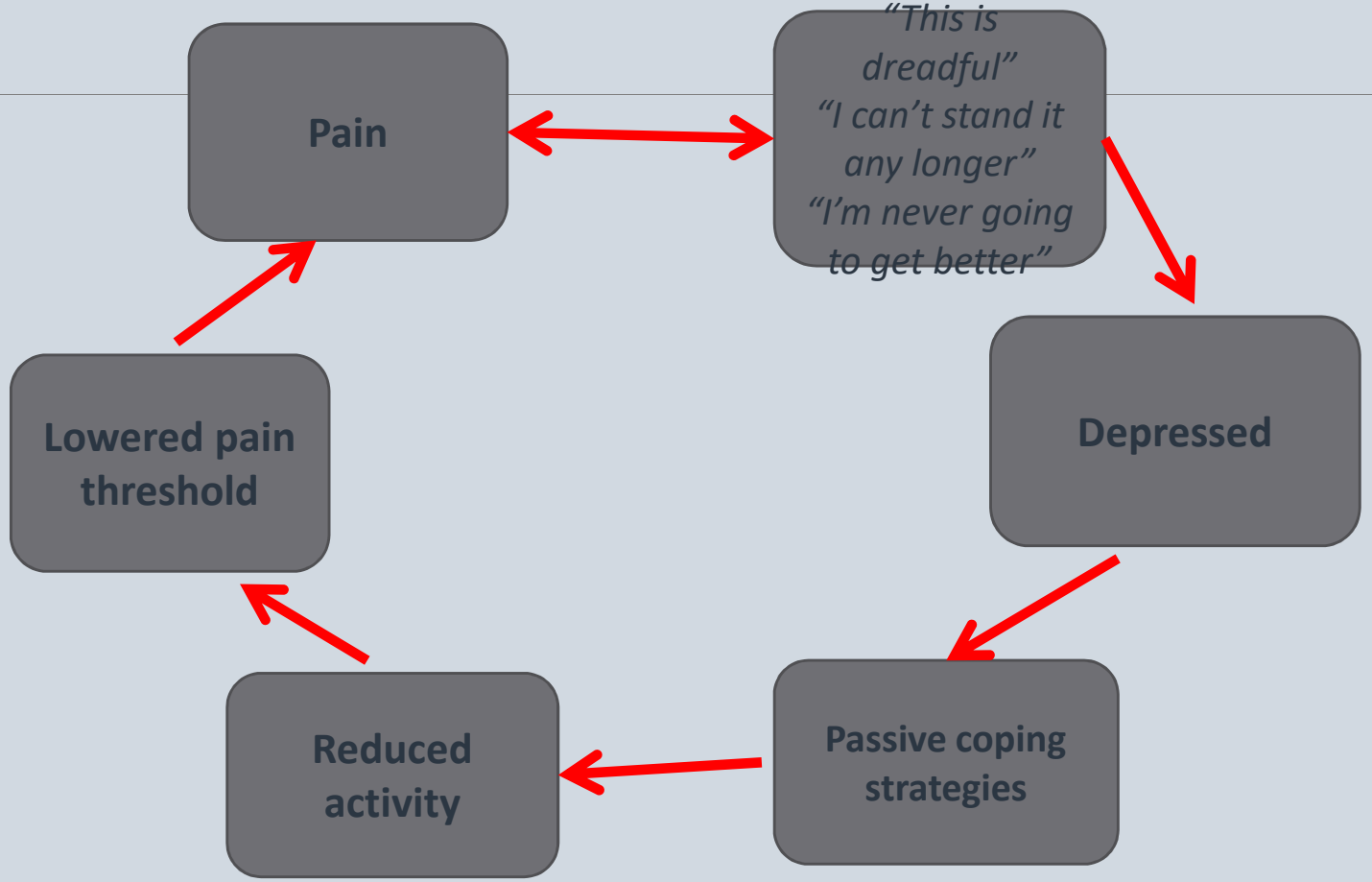
The Pain Cycle



Psychological factors such as mood, beliefs about pain and coping style have been found to play an important role in an individual's adjustment to persistent pain


Increased Pain
Anxiety
Sleeping Problems
Not Coping
Chronic Pain
Broken Dreams
Unable to plan for the future
Uncertainties
Disbelief in the depth of my Conditions by Others
Worries re: employment/ unemployment
General health worries
Emotional Ups & Downs
Lack of enjoyment
Insurance worries
Loss of Freedom
Unexplained Guilt
Doctor & Hospital visits (anger/frustration)
Medication worries
Family and relationship worries
Self-Image Issues
Financial worries
Loss of Friendships
Weight Fluctuations
Not wanting to Complain

The depression-pain trap



Goals of the assessment

1. Some evaluation of the physical aspects of the pain
2. Understanding of personal history including trauma
3. A functional analysis
4. An understanding of specific thought patterns
5. An understanding of beliefs about pain – what it means to the person
6. Screening for anxiety and depression

How to assess psychological aspects of pain

Psychological measures for pain assessment

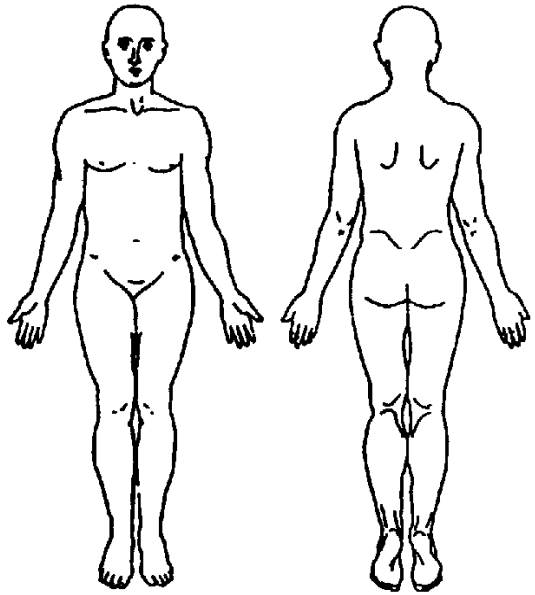
Self-report measures: commonly used measures include:

- Pain VAS and BPI
- Pain diaries
  - Pain Coping Strategies Questionnaire (Rosentiel & Keefe, 1983)
  - McGill Melzack Pain Questionnaire (Melzack, 1975)
  - Beliefs About Pain Control Questionnaire (Brown & Nicassio, 1987)
  - Pain Stages of Change Questionnaire (Kerns et al., 1997)
  - Pain Self Efficacy Scale (Nicholas et al. 1989)

Pain assessment

Pain rating scales: usually on a 0-10 point scale, sometimes represented as a visual analogue scale (VAS)

Pain assessment



Please mark on the drawings the areas where you feel pain. Put E if external or I if internal near the areas where you mark. Put E I if both external and internal.

BPI, Cleeland & Ryan, 1994)

1. Where is your pain?
2. What does it feel like?
3. How does it change with time?
4. How strong is it?

(McGill Melzack Pain Questionnaire, 1975)

Pain Diaries

Pain diary: including information on pain intensity, control over pain and the intake of analgesic medication, bodily locations where pain is experienced and triggers for the pain

Example of pain diary:

Time	Activity	Pain Severity (0-10)	Irritability/distress (0-10)	What did you do to cope? How effective was it? (0-10)

Use of pain diary information

Pain diaries:

- Provide a large amount of data which can be used in therapy
  - i.e., are there any times when the pain is absent? If so, when?
  - What is it about this situation or time?
  - How does the pain relate to mood?
  - Are there times when the pain is worse? Why?

- Central to treatment strategies such as
  - observation/monitoring exercises,
  - behavioural experiments and
  - as a baseline measure to compare at the end of treatment

Pain Coping Strategies Questionnaire (Rosentiel & Keefe, 1983)

Useful for identifying individual coping strategies for pain – especially the catastrophising subscale

- Sample items include:
- I It is awful and I feel that it overwhelms me
- Although it hurts, I just keep going
- I ignore it
- I do something I enjoy, such as watching television or listening to music

Pain catastrophising

1. **I worry all the time about whether the pain will end.**

(0) Not at all	(1) To a slight degree	(2) To a Moderate degree	(3) To a great degree	(4) All the time
☐	☐	☐	☐	☐

2. **I feel I can't go on.**

(0) Not at all	(1) To a slight degree	(2) To a Moderate degree	(3) To a great degree	(4) All the time
☐	☐	☐	☐	☐

3. **It's terrible and I think it's never going to get any better.**

(0) Not at all	(1) To a slight degree	(2) To a Moderate degree	(3) To a great degree	(4) All the time
☐	☐	☐	☐	☐

4. **It's awful and I feel that it overwhelms me.**

(0) Not at all	(1) To a slight degree	(2) To a Moderate degree	(3) To a great degree	(4) All the time
☐	☐	☐	☐	☐

Pain Self Efficacy Scale (Nicholas et al., 1989)

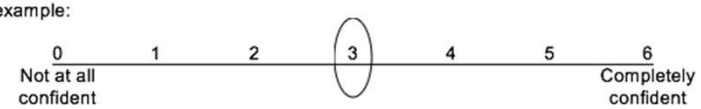
- Assesses the extent to which an individual is able to maintain activities *despite* the pain
- Is useful for baseline assessments and may indicate readiness for treatment
- Low PSE very common in persistent pain populations
- Improvements in PSE a common goal of pain management

Self-efficacy

Pain Self Efficacy Questionnaire

Please rate how **confident** you are that you can do the following things at present, **despite the pain**. To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.

For example:



Remember, this questionnaire is not asking whether or not your have been doing these things, but rather **how confident you are that you can do them AT PRESENT, despite the pain.**

		Not at all confident						Completely confident
1.	I can enjoy things, despite the pain	0	1	2	3	4	5	6
2.	I can do most of the household chores (e.g. tidying -up, washing dishes, etc.), despite the pain	0	1	2	3	4	5	6
3.	I can socialise with my friends or family members as often as I used to do, despite the pain.	0	1	2	3	4	5	6
4.	I can cope with my pain in most situations	0	1	2	3	4	5	6
5.	I can do some form of work, despite the pain. ("work" includes housework, paid and unpaid work)	0	1	2	3	4	5	6
6.	I can still do many of the things I enjoy doing, such as hobbies or leisure activities, despite the pain.	0	1	2	3	4	5	6
7.	I can cope with my pain without medication.	0	1	2	3	4	5	6
8.	I can still accomplish most of my goals in life, despite the pain	0	1	2	3	4	5	6
9.	I can live a normal lifestyle, despite the pain	0	1	2	3	4	5	6
10.	I can gradually become more active, despite the pain	0	1	2	3	4	5	6

Beliefs About Pain Control Questionnaire (Brown & Nicassio, 1987)

- Contains six-point Likert scale (1=strongly disagree, 6= strongly agree)
- Examines perceived locus of control – internal, powerful doctors, chance
- Some items include:
  - *If I take good care of myself, I can usually avoid pain*
  - *Whenever I am in pain, it is usually because of something I have done or not done*
  - *I cannot get any help for my pain unless I go to seek medical help*
  - *People who are never in pain are just plain lucky*
  - *I am directly responsible for my pain*
  - *No matter what I do, if I am going to be in pain, I will be in pain*

Pain Stages of Change Questionnaire (Kerns et al., 1997)

Understand patients readiness to adopt a self-management approach to persistent pain (especially required for CBT)

Uses a 5-point Likert scale (1= strongly disagree, 5=strongly agree)

Sample items include:

- *I have been thinking that the way I cope with my pain could improve*
- *I am developing new ways to cope with my pain*
- *I have learned some good ways to keep my pain problem from interfering with my life*

Assessing depression

- Screening instruments
  - Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1983)
  - PHQ 2 (Kroenke & Spitzer, 2002)
- Clinical interview
  - The gold standard

PHQ-2 Questions

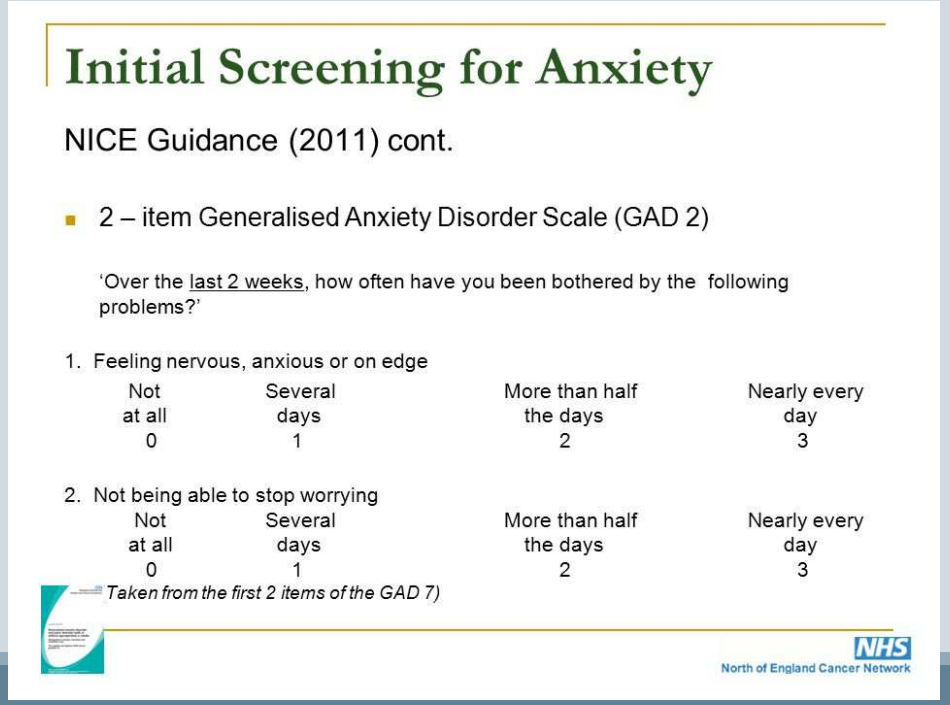
Over the last 2 weeks how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

- A cut-off score ≥ 3 is positive

Assessing anxiety

- Screening instruments
  - Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1990)
  - GAD 2 (Kroenke et al., 2007)

- Clinical interview
  - The gold standard as it can assess multiple types of anxiety
  - Assessment of trauma can be highly complex
  - PC-PTSD-5 (Prins et al., 2015)



Initial Screening for Anxiety

NICE Guidance (2011) cont.

- 2 – item Generalised Anxiety Disorder Scale (GAD 2)

'Over the last 2 weeks, how often have you been bothered by the following problems?'

1. Feeling nervous, anxious or on edge

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

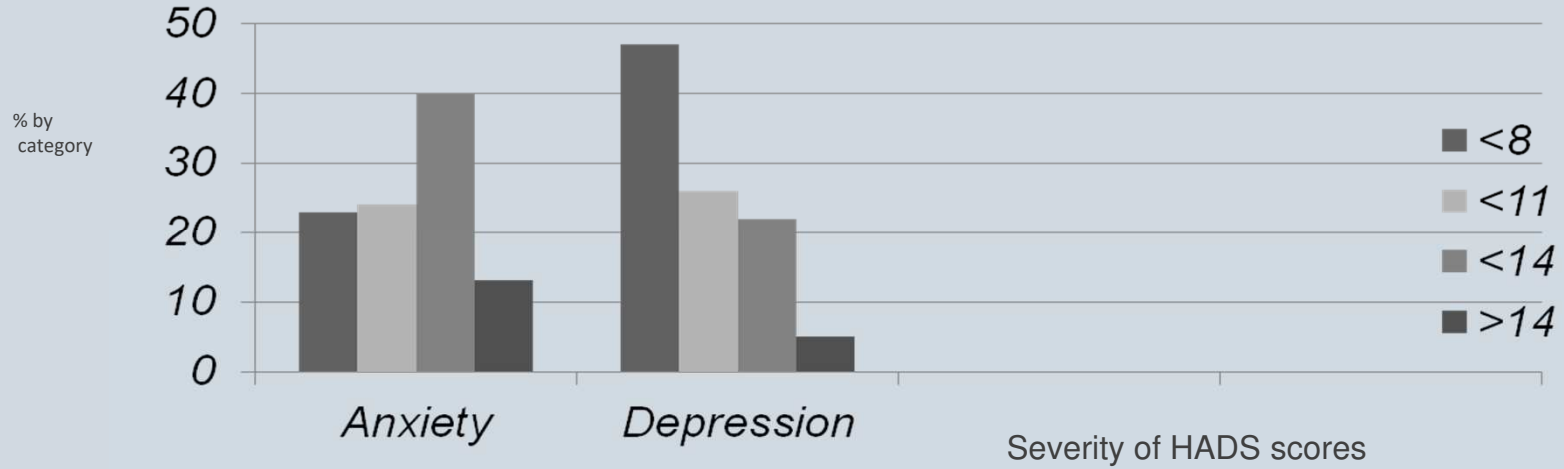
2. Not being able to stop worrying

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

Taken from the first 2 items of the GAD 7)

NHS
North of England Cancer Network

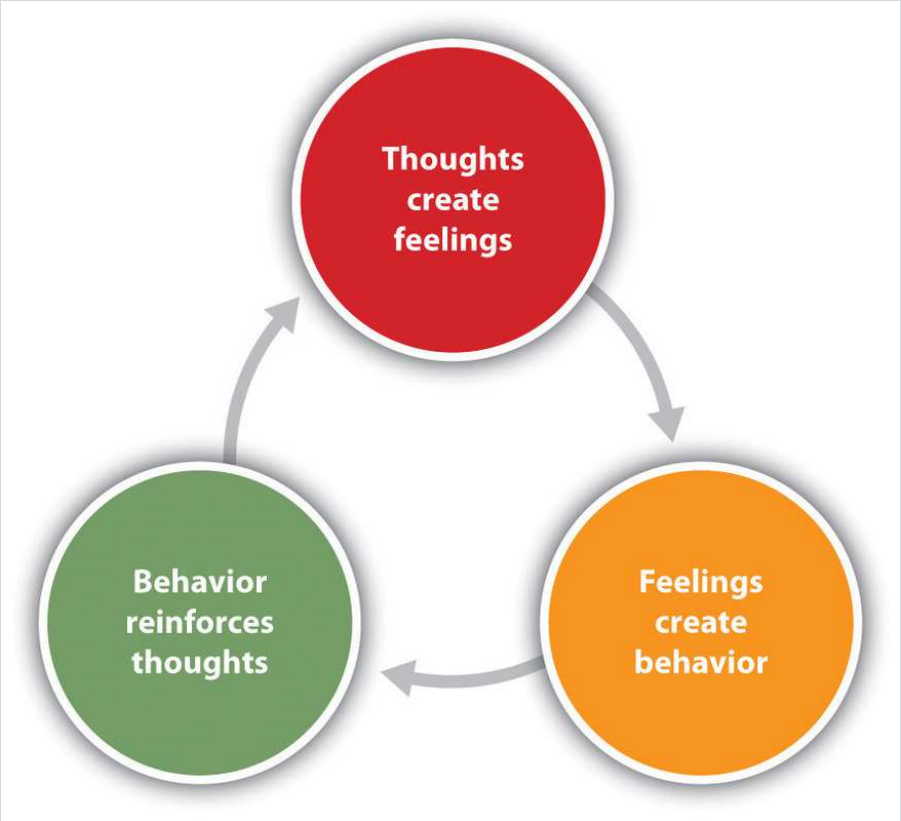
Anxiety and Depression



Severity of HADS scores
< 8 = normal range; <11 = mild;
<14 = moderate; > 14 = severe

Bryant et al. (2016).The psychological profile of women presenting to a multidisciplinary clinic for chronic pelvic pain: high levels of psychological dysfunction and implications for practice". *Journal of Pain Research.*

Fundamental role of thoughts



Illness representations or perceptions

- ***Important that these are assessed in people with persistent pain***

- *Some questions to help identify pain representations:*

  - *What do you think causes your pain?*
  - *What do you think will happen to the pain in the future?*
  - *What have you been told about your pain?*
  - *How do you explain things when the pain gets better/worse?*
  - *What have you had to give up since the pain has become a problem?*
  - *Are there things that you would like to be able to start again?*
  - *What things would you like to be able to do in the future?*
  - *What is the main reason that you do not do as much as you used to?*

Illness Perceptions

The length of time a person expects to have their condition; likely course:

- *"I expect to have this pain for the rest of my life"*

Its interference with their life:

- *My pelvic pain affects the way other people see me"*

Sense of personal and treatment-related control

- *"Nothing I do will affect my pelvic pain"*

Sense of coherence

- *"My pain is a mystery to me"*

Impact of IPs

- Widely studied in many conditions including chronic pain
- Found to relate to the people's engagement with treatment and course of illness
- Patients who perceive their pain as unremitting, uncontrollable and as having serious consequences for their well-being experience
  - greater pain severity
  - impaired functioning
  - significant psychological distress
  - poorer adherence to and outcomes from pain-management and treatment programs
- No previous research in CPP → study at RWH

Illness Perceptions

In study of women at RWH strong belief that CPP was
- Chronic
- With serious consequences for their relationships and functioning

Weak coherence belief
- Pain perceived to be “a mystery”
- Little understanding of their symptoms

The belief that pain was unresponsive to personal control or treatment control was associated with higher levels of anxiety (r = .44 and .56)

(Bryant, Fitzgibbon & Chia, J Psychosomatic Res 2103)

Sexual Functioning

Female Sexual Functioning Index (FSFI) (Rosen et al., 2000)

- 20 items addressing desire, arousal, orgasm, satisfaction and pain
- Can use pain items alone:
  1. Over the past 4 weeks, how often did you experience discomfort or pain during vaginal penetration?
  2. Over the past 4 weeks, how often did you experience discomfort or pain following vaginal penetration?
  3. Over the past 4 weeks, how would you rate your level (degree) of discomfort or pain during or following vaginal penetration?
- Also need sensitive clinical enquiry

Where to after the assessment?

Need multi-disciplinary approach

Multidisciplinary assessment and treatment

Psychological assessment includes

- History of pain with emphasis on functional impairment
- Detailed personal history
- Detailed history of psychological symptoms/disorders and their treatment
- Eliciting beliefs about pain
- Existing coping
- Establishing goals and agreed formulation

Cf. Weijenborg et al., J Psychosom Obs Gyne, 2009; 30, 1-7.

Team meeting crucial

Treatment is individualised and includes pain education - but…

The Clinical Interaction

- Women often feel misunderstood by their treating clinician
  - "You think the pain is all in my head..."
  - "This pain is real, you know..."
  - "I don't see what all these questions have to do with it..."
  - "People don't understand this pain"

    (E.g., Grace, Bailliere's Clin Obs Gynae, 2000; 3, 525-539)
- Patients become resistant to attempts to address "psychological factors"
- Clinical resources are in short supply but…

How to develop a treatment plan

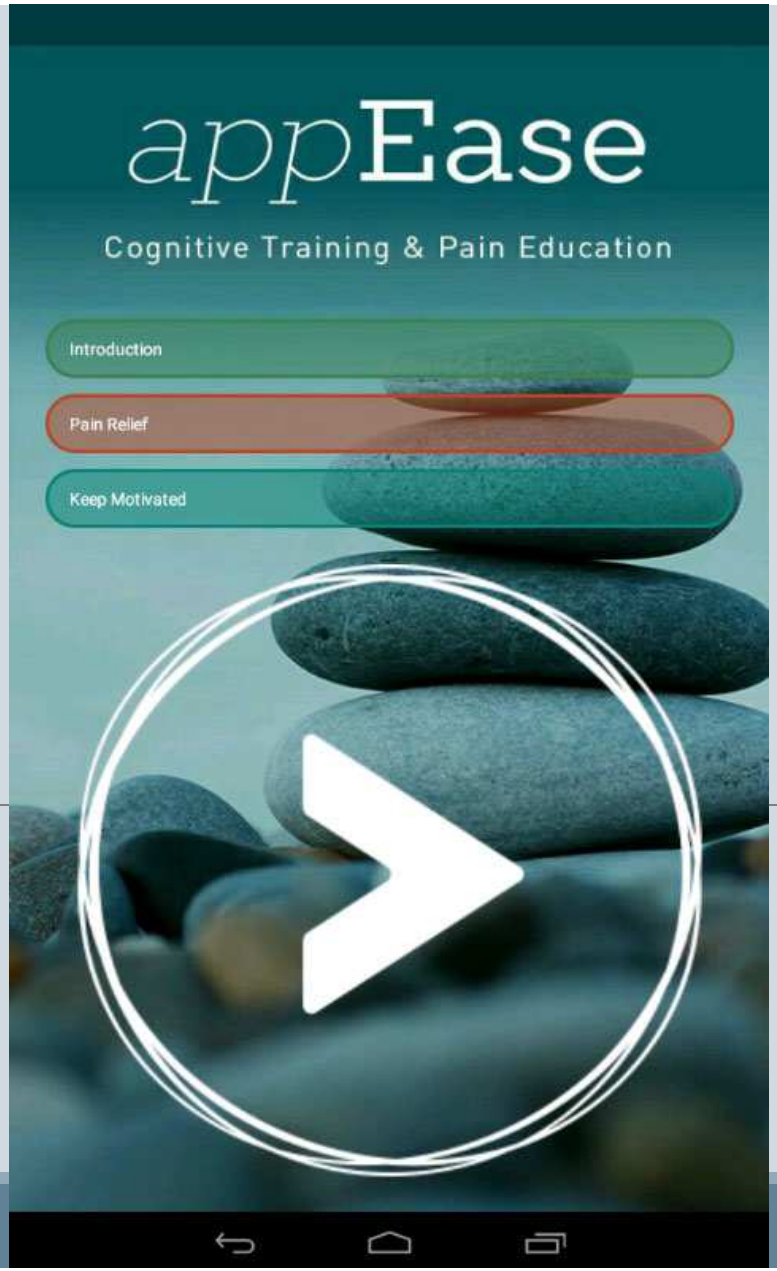
- Strong correlations between anxiety, depression, catastrophising and self-efficacy
- Need to help patient
  - to understand relationship between thoughts, feelings, behaviours and pain, sexual function and emotions
  - To develop self-management skills to promote personal control

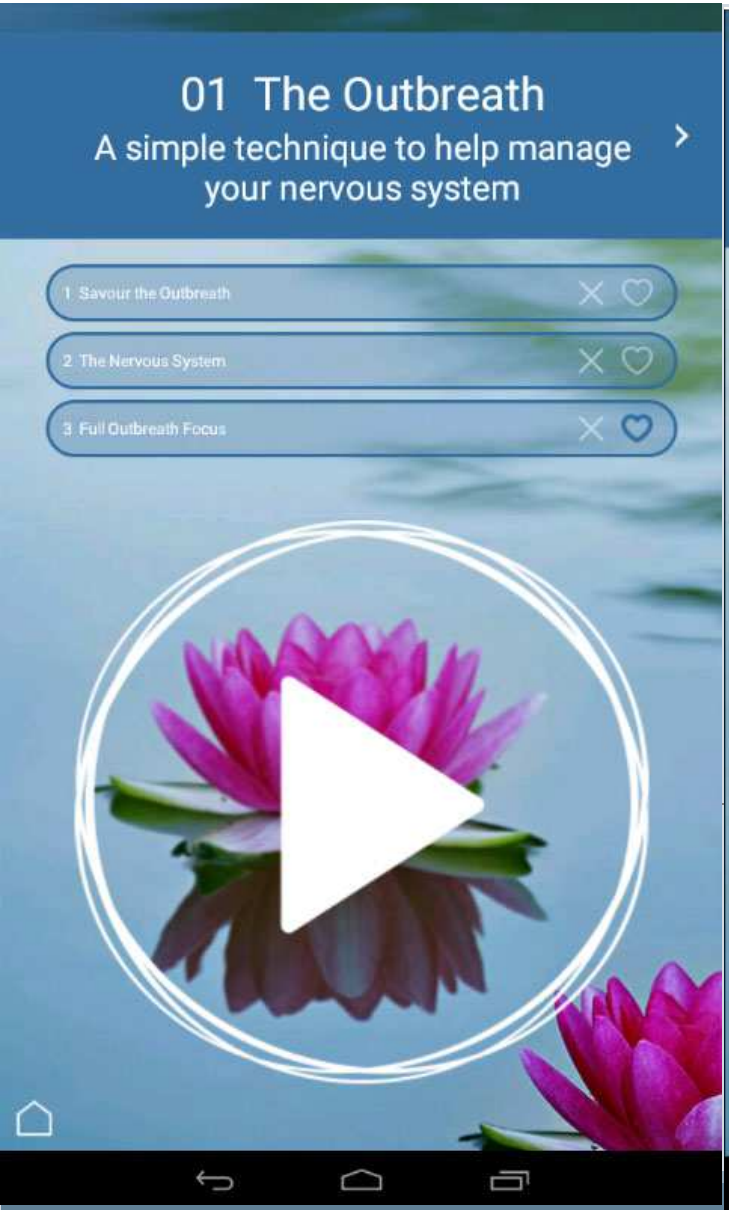
(Masheb, Kerns, Lozano, Minkin, & Richman, 2009)

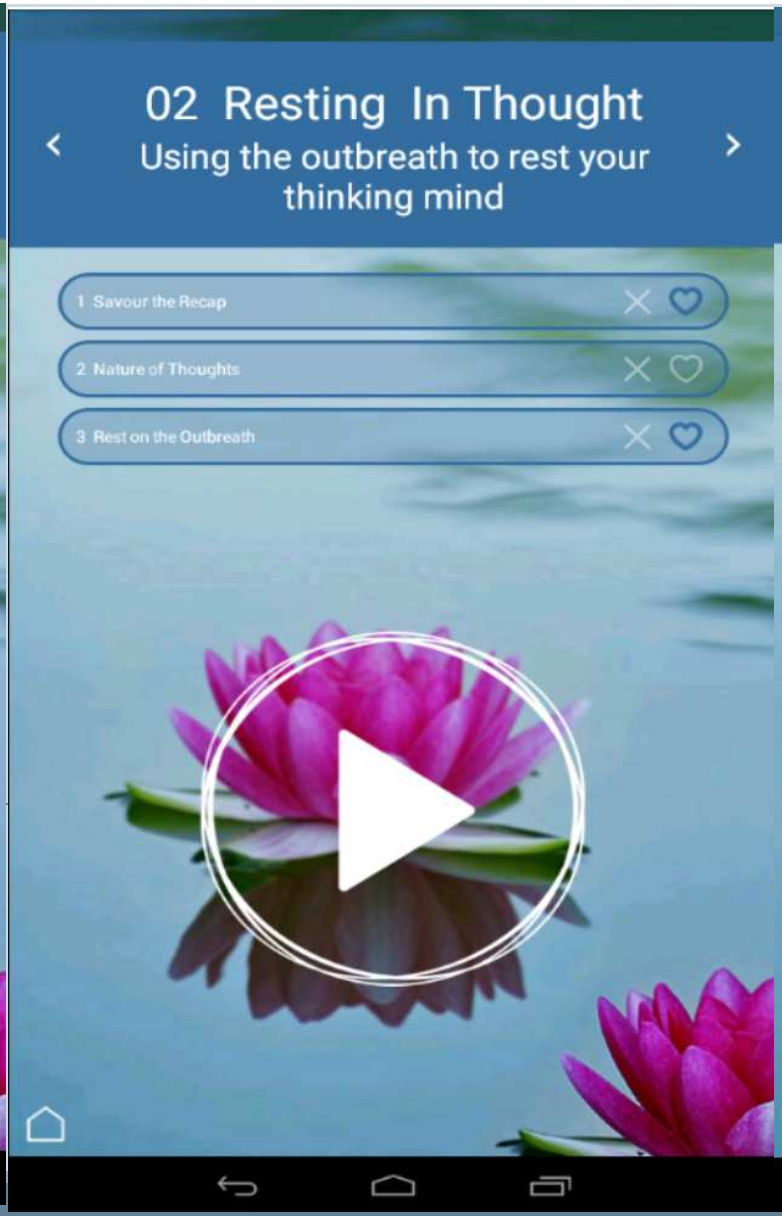
Where to from here?

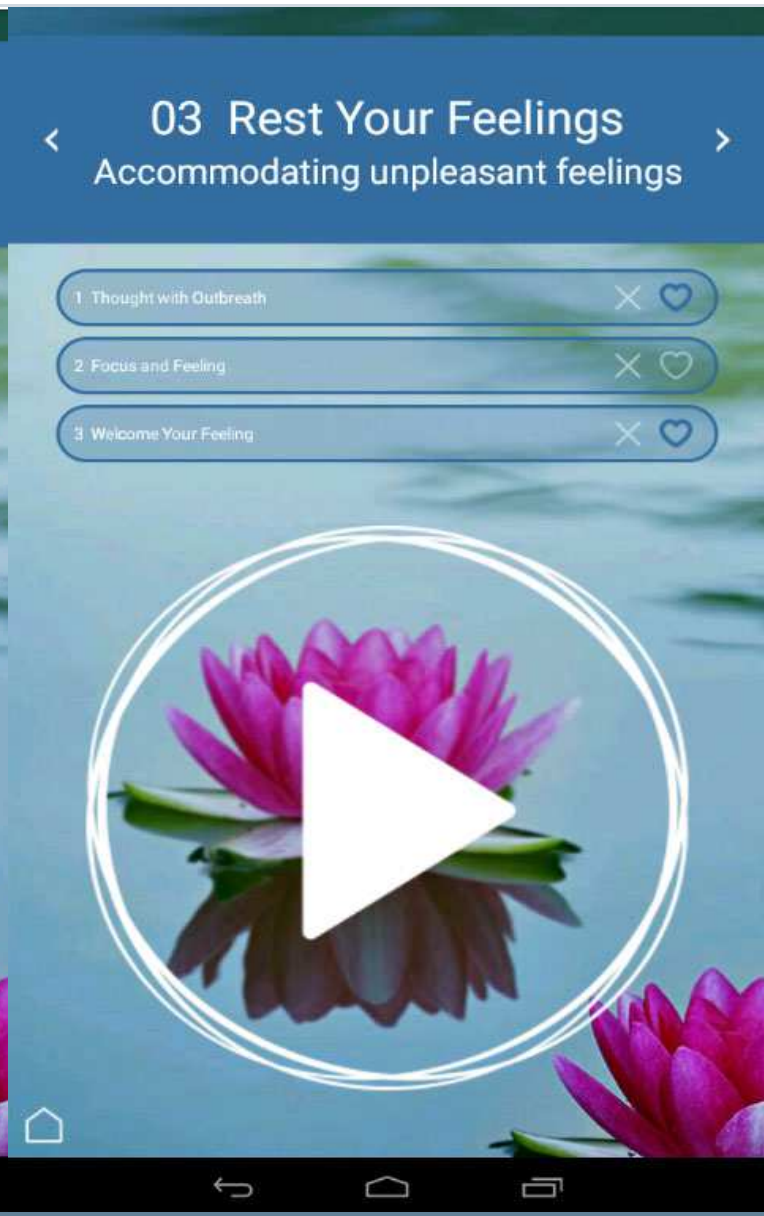
- There is evidence for the efficacy of multi-disciplinary treatment (Stones et al., Cochrane Database of systematic Reviews, 2010)

- Current treatment seeks to develop sense of control and pain self-efficacy
  - But - we need to do better
- How?
  - Intervene earlier in the pain /treatment trajectory
  - Use new technologies


appEase
Cognitive Training & Pain Education
Introduction
Pain Relief
Keep Motivated


01 The Outbreath
A simple technique to help manage your nervous system
1 Savour the Outbreath
2 The Nervous System
3 Full Outbreath Focus


02 Resting In Thought
Using the outbreath to rest your thinking mind
1 Savour the Recap
2 Nature of Thoughts
3 Rest on the Outbreath


03 Rest Your Feelings
Accommodating unpleasant feelings
1 Thought with Outbreath
2 Focus and Feeling
3 Welcome Your Feeling

Example of an assessment

The case of “Leanne” (1)

- A 54-year old single woman, works full-time
- Referred by her gynaecologist for assessment and management of anxiety associated with interstitial cystitis and the fear of incontinence leading to urinary frequency. Has never had “ an accident”.
- Assessment:

1. Detailed history - no trauma but as a child often went to the toilet “to take a break from being with people”.
2. Personality – “A control freak”, socially anxious
3. Depression (mild symptoms) and anxiety (panic attacks when fears may be trapped/unable to get to the bathroom)

The case of “Leanne” (2)

Explore thoughts about bladder control

1. “ If I can control my bladder I am in control of my life”
2. “What if I wet myself?”

Explore behaviours

1. Frequent toilet visits
2. Avoidance of social activities

Explore feelings

1. Fear of being trapped
2. Anxiety

Conclusions

1. Psychological assessment is needed because
    1. High levels of depression and anxiety in CPP population
    2. Many women have histories or current experiences of trauma
    3. Beliefs and thinking patterns are related to readiness to engage in and benefit from treatment
2. Psychologists are trained to integrate information from several sources to develop a case formulation
3. Treatment works best when the psychologist is part of an MDT

Thank you for your attention

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