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HEPMP: HIGHER EDUCATION OF PAIN MEDICINE IN WESTERN BALCAN COUNTRIES
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PSYCHOLOGICAL SCREENING IN CRONIC PAIN PATIENT ASSESSMENT

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Background 1/3

Neuromodulation: Technology at the Neural Interface

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High Rates of Undiagnosed Psychological Distress Exist in a Referral Population for Spinal Cord Stimulation in the Management of Chronic Pain

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- Anxiety symptoms were screened posivetely by BAI in 23% of patients
- Depression symptoms were screened posivetely by BDI in 63% of patients
- ONLY 20% of patients had an established diagnosis of anxiety/depression

Background: NACC Guidelines 2/3

Neuromodulation: Technology at the Neural Interface

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The Appropriate Use of Neurostimulation of the Spinal Cord and Peripheral Nervous System for the Treatment of Chronic Pain and Ischemic Diseases: The Neuromodulation Appropriateness Consensus Committee

Table 7. Recommendations for Perioperative Management Made by the Neuromodulation Appropriateness Consensus Committee of the International Neuromodulation Society Using U.S. Preventive Services Task Force (USPSTF) or Centers for Disease Control Criteria.

Perioperative management	USPSTF evidence strength (9); see Table 1	USPSTF and CDC recommendation strength (9,12); see Table 4
Preoperative risk assessment		
The use of a psychological assessment to address any concerning psychiatric comorbidities before proceeding with an implant (82–86); use of standardized questionnaires for psychological assessment (87)	II-2	B

Table 11. Inappropriate Practices and Disease-Specific States Identified by the Neuromodulation Appropriateness Consensus Committee of the International Neuromodulation Society Using U.S. Preventive Services Task Force Criteria.

Inappropriate practices	USPSTF evidence strength (9)	USPSTF recommendation strength (9)
Patients with inadequately controlled psychiatric/psychological problems should not be implanted (84).	II-3	B

BACKGROUND 3/3

- **Depression** (Olson et al., 1998; Jamison et al., 2008; Schocket et al., 2008)
- **Anxiety** (North et al., 1996; Schocket et al., 2008)
- **Hysteria** (Olson et al., 1998; Brandwin and Kewman, 1982)
- **Hypocondriasis** (Kupers et al., 1994; Brandwin and Kewman, 1982)
- **Drug or alcohol abuse** (Ackroyd R. et al., 2005)

92% of the studies find a positive relationship between psychological factors and poor outcome (Celestin J. et al., 2009)

DEPRESSION & SCS

High level of depression is a risk factor for failure SCS

(Sparkes et al. 2010)

DEPRESSION → SUBOPTIMAL OUTCOME

ROLE

MECHANISM OF ACTION ?

(Wolter, Fauler & Kieselbach, 2013)

HADS Depression	Baseline (56 = 100%)	6 Mths (56 = 100%)	12 Mths (56 = 100%)
Normal	25 (44,6%)	32 (57,1%)	32 (57,1%)
Middle	16 (28,6%)	12 (21,4%)	12 (21,4%)
High	15 (26,8%)	12 (21,4%)	12 (21,4%)

(Sparkes, Duarte, Mann, Lawrence, & Raphael, 2015)

ANXIETY & SCS

Panic Disorder
+
depression/dysthymia

↓

Multidisciplinary Approach

(Howe, Robinson, & Sullivan, 2015)

NO Predictive factor for SCS

Anxiety improves in ALL patients after SCS

(Fama et al., 2015)

OTHERS PSYCHOLOGICAL FACTORS & SCS – COPING STYLE

Cognitive, affective and behavioural response to stressful events – Stable trait of personality

Sparkes, Duarte, Mann, Lawrence, & Raphael, 2015 :

Self efficacy to manage stressful events

Pain Coping Strategies Questionnaire

Subjective perception about own skills

POORER OUTCOME

Paroli, et al., 2017 :

PRE-IMPLANT coping style
***Multidimensional Pain Inventory* (MPI)**

- ***Adaptive Coping Profile* (AC)**
- ***Interpersonally Distress* (ID)**
- ***Dysfunctional Profile* (DYS)**

- **Catastrophyzing**
- **High Pain intensity**
- **General dysfuctions**

NEGATIVE OUTCOME

Spinal Cord Stimulation:

NO STRONG PREDICTORS OF GOOD/POOR OUTCOME

- QUESTIONNAIRE
- SAMPLE
- DIFFERENT OUTCOME MEASURE

- DEPRESSION ↑
- ANXIETY ↑

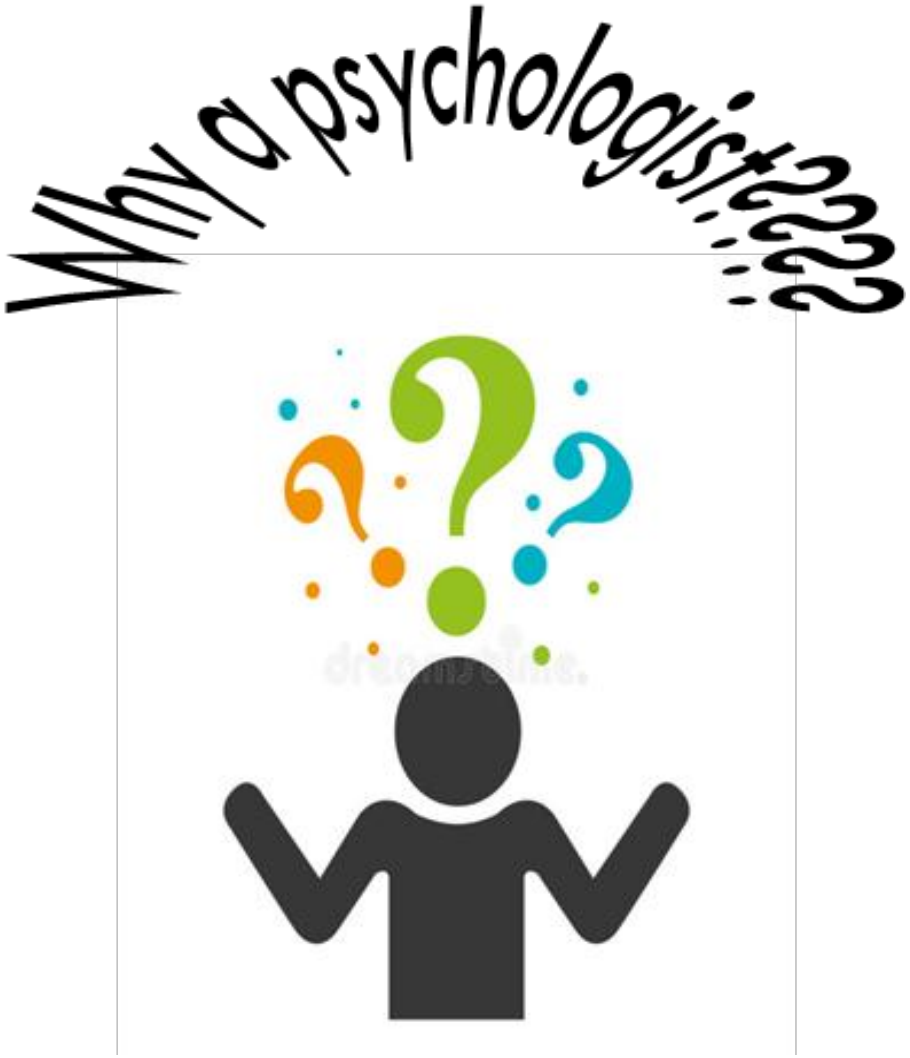
PRE – IMPLANT ASSESSMENT IS CRUCIAL

Surgical procedure

↓

Patients psychological characteristics

How to refer a patient to a psychologist



Q: Does a referral to a psychologist mean my surgeon thinks I'm crazy or will go crazy after the stimulator placement?

A: No, but not everyone responds well psychologically when a foreign device is implanted into their body. For some, the stimulator can cause an increase in worry and anxiety.

Unfortunately, this stress can reduce the effectiveness of the stimulator placement. In part, the pre-surgical clearance examination helps your physician prepare you for the procedure and make recommendations to help you adjust to this new part of your body.

Psychological assessment can improve the patient's overall experience and enhance the outcome of SCS

Q: What happens during the pre-surgical psychological examination?

A: Typically, the examination consists of a conversation between you and the psychologist about your medical history, including your chronic pain struggles. It also involves a social history, family history, information about previous alcohol or substance use, and what kind of psychological treatment you may have had in the past. You'll also fill out a few questionnaires about how you manage your pain, your current mood, and your treatment goals. The conversation remains confidential between you and your psychologist unless you disclose that you plan to hurt yourself or someone else. In order for the psychologist to share the information with your surgeon, you will need to sign a release form.

Psychologist doesn't judge you!

Q: What if I am depressed or anxious? Will that stop me from having the stimulator placement?

A: No. In fact, chronic pain patients are much more likely to suffer from depression and anxiety than the general public. It is typical and expected that people living with chronic pain will have high levels of irritability, anxiety, and depression.

Also, pain relief often helps decrease depression and anxiety. If you are struggling with depression and/or anxiety, the pre-surgical clearance evaluation will offer recommendations to help diminish these feelings.

Psychologist can help you to manage with your pain

Q: Are most people cleared to proceed with spinal cord stimulation?

A: While most people are cleared to have the trial placement of the stimulator, a small number of people are not. Those who are experiencing hallucinations, delusions, and cannot understand and follow post-operational directions should not have a stimulator. Instead, complementary and holistic interventions such as mindfulness, cognitive-behavioral therapy, or biofeedback may be a more effective option for pain management.

Individuals, who scored higher in psychiatric, behavioral, affective or cognitive issues might do better with a multidisciplinary approach tailored to their chronic pain experience by addressing a combination of physical, psychosocial and behavioral aspects.

Conclusion

Remember…
when you implant a stimulator in these patients you are marrying them

Dance with them before jump into a marriage!

Thanks for your attention

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