



THE
AUSTRALIAN
PAIN SOCIETY

**Australian Pain Society Position Statement:
The Role of the Psychologist in the Management of Persistent Pain**

Purpose

This position paper aims to outline the key roles played by psychologists in the evaluation and management of individuals with persistent pain, and to provide guidelines for timely access to psychological services. This is not a guideline on Pain Management Programs and the significant role of psychologists therein, but a guide to the role and expectations of psychologists in assessing and managing individuals with pain. As such, although psychologists are frequently involved in the delivery of high quality training, supervision and research, these important aspects of psychological practice are acknowledged but not discussed herein as the focus is on direct patient care. Moreover, these guidelines, although grounded in evidence-based best practice approaches, are meant to be neither prescriptive nor proscriptive; with clinical decisions about the most appropriate care pathway being informed by case-specific information. That is, treatments should be tailored to individuals. In addition, recognising the complex nature of persistent pain and the involvement of a range of health care professionals, this paper has been devised to inform a broad multidisciplinary audience, including, but not limited to, clinicians entering the persistent pain field, provisional and student psychologists, and other clinicians/individuals/services interested in psychological approaches to persistent pain.

Introduction

The International Association for the Study of Pain (IASP) has defined pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (Merskey & Bogduk, 1994, pg. 210). From this broad definition, pain can be categorised into various forms; most commonly acute

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versus chronic, or persistent, pain. Acute pain, with its adaptive evolutionary role, provides a warning signal that is vital for the minimisation/prevention of bodily damage and supports the recovery process. However, when pain persists beyond the normal period of healing and occurs at least most days in a three (or more) month period, it has ceased to be adaptive and is considered to be chronic or persistent (Treed et. al, 2015). Persistent pain can be difficult to localise, is less effectively relieved by standard analgesics (including opioids) and is often unresponsive to, or may even be exacerbated by, surgical intervention. Although it may be related to a defined disease process, persistent pain is generally linked to increased sensitivity and reactivity in the nervous system. Here, pain reflects the degree of neurophysiological central sensitisation, which is modulated by ascending and descending processes (inhibitory and facilitatory). Persistent pain is the country's third most costly health problem and around 80% of those living with this condition fail to receive an intervention that could improve their functioning and quality of life (Blyth et al., 2001; National Pain Summit Initiative, 2011). As such, access to timely and evidence-based treatments, from appropriately skilled clinicians, is critical to the health and wellbeing of the nation.

It is widely acknowledged that the experience of persistent pain will be influenced by a range of factors including the physiological state, thoughts, emotions, behaviours and social influences of the individual living with the condition (Epker, 2013; Greve, Bianchini & Ord, 2011; Roditi & Robinson, 2011; Turk & Robinson, 2011). It is common for individuals with persistent pain to have co-morbid physical (e.g., cardiovascular, endocrine, inflammatory) and psychological conditions (e.g., symptoms of anxiety, depression, Post-Traumatic Stress Disorder (PTSD)) that interact with, and contribute to, their pain experience. It is also common that social and/or cultural environments impact the way that the pain is experienced by both the individual living with the condition and those supporting him/her (Blyth, Macfarlane, & Nicholas, 2007). Consequently, best practice guidelines for the management of persistent pain recommend that, in many cases, a coordinated interdisciplinary assessment - addressing the multiple life domains that can be afflicted by a painful condition (physical, psychological, social, environmental) - and then relevant treatment is required

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(Brage, Ris, Falla, Sogaard, & Juul-Kristensen, 2015; Costa, Melina, Sansalone, & Iannacchero, 2015; Critchley, Ratcliffe, Noonan, Jones, & Hurley, 2007; Morley & Williams, 2015; National Pain Summit Initiative, 2011; van Tulder, 2008; Williams, Eccleston, & Morley, 2012). Therapeutic success is typically defined by improvements in factors such as quality of life, functional capacity and harm minimisation, rather than reduction in pain severity per se (Chou et al., 2009).

Psychologists as Part of the Treating Team

Adopting a biopsychosocial approach (Turk & Monarch, 2002) to the management of persistent pain sees the psychologist playing a crucial role in supporting individuals to improve both physical and psychological wellbeing. Psychologists can provide specialised support to target symptom reduction for co-morbid mental health conditions, whilst also focusing more broadly on the range of factors influencing the individual's pain experience (e.g., attention, learning and memory, beliefs and thought processes). Moreover, as part of the treating team, psychologists can provide specialised input to inform care planning around areas such as psychological and socio-cultural factors impacting an individual's progress, assessment of suitability to participate in a pain management programme, information on patient insight and judgement, and identification of other critical factors such as personality structure that may impact treatment outcomes (i.e. 'yellow flags'); the latter being especially prudent when considering more invasive treatments. Psychologists can also provide valuable support and strategy guidance to other clinicians engaged in care provision when struggling with issues such as barriers to treatment, uncertainty regarding treatment sequencing and understanding co-morbid mental health conditions.

It is important to note that while therapeutic input from a range of disciplines facilitates a shared understanding of the 'whole person' experience (Turk & Robinson, 2011), interdisciplinary care can occur in many formats, not all of which are directly tied to tertiary pain centres. In fact, in many areas, access to tertiary services are limited, resulting in lengthy wait-times that can erode patient wellbeing and quality of life (Lynch et al., 2008).

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Increasingly, persistent pain services are being appropriately based in community health care settings, with specialist multidisciplinary support provided from the tertiary sector as required (Hayes & Hodson, 2011). Individuals with persistent pain will therefore engage psychologists from a range of service settings and practice models. Although not physically located in a multidisciplinary team, psychologists working independently in the community can still maintain the core attributes of an interdisciplinary approach by involving all stakeholders in the patient's care; thus enabling the development of common goals, clear and frequent communication, and an integrated approach to treatment based in a shared philosophical framework. Ultimately, effective treatment for persistent pain relies on ALL members of the treating team providing a consistent and cohesive message.

Psychological Assessment

Accredited training for psychology includes rigorous skill development in conducting comprehensive psychosocial assessments. However, there is no single or simple instrument that can objectively measure pain and its psychological impact. The procedures and measures used by a psychologist in the assessment of individuals living with persistent pain will depend on the purposes(s) of the assessment, the unique characteristics of the individual being assessed (e.g., age, cultural background, educational level, ability to communicate verbally) and the context in which the assessment is taking place (e.g., clinic, emergency department, medicolegal setting). Generally, a psychologist's assessment is used for diagnosis, to inform treatment-related decisions and/or planning - including pre-medical procedure or pre-surgery screening (e.g., for neuromodulation or intrathecal drug delivery devices), to inform disability determination, to monitor treatment progress or to evaluate treatment effectiveness (Turk & Robinson, 2011). During an assessment, the psychologist seeks to develop a broad understanding of both the pain itself and how it impacts the life of the individual living with it; thus enabling identification of key issues and barriers to progress (e.g., low self-efficacy, unhelpful beliefs about pain, distress, fear and anxiety, depression, readiness for change and unrealistic expectations).

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Issues typically covered in a psychological assessment

The most common approach to psychological assessment is a semi-structured interview (Jamison & Edwards, 2012, Turk & Robinson, 2011). Here, the psychologist collects information (noting both the words and the manner in which the information is conveyed), observes pain behaviours and begins to develop some working hypotheses about the processes underlying the individual's pain experience (Keefe, Somers, Williams, & Smith, 2011). A detailed psychological assessment would include exploration of the following areas:

- Pain (e.g., location; description of physical sensations; events surrounding pain onset and/or exacerbation; the individual's understanding of his/her condition, prognosis, coping strategies).
- Awareness and understanding of pharmacological and non-pharmacological treatment(s) – current and historical.
- Predisposing factors (e.g., history of childhood hospitalization; sickness modelling by significant others; abuse history (emotional, physical, sexual), job dissatisfaction).
- Risk factors (including suicidal and/or homicidal risk).
- Behavioural changes in various areas (e.g., occupational, domestic, recreational activities; social, marital, family roles; sleep; medication use, substance misuse).
- Emotional functioning - presence and severity of a range of emotional states (e.g. anxiety, depression, anger/hostility, guilt, shame). Specific attention should be given to the identification of PTSD symptoms (these may have a role in maintaining physiological arousal and impact the pain experience) and whether they were pre-existing or arose from the incident causing the pain.
- Cognitive factors (e.g., attitudes; expectations; beliefs - rehabilitation vs cure etc.).
- Coping styles (e.g., under/over-doing; avoidance; help-seeking).
- Pre-existing personality factors.

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- Learning factors (e.g., functional analysis of pain/wellness behaviours; avoidance of unpleasant activities; pain and illness behaviour).
- Financial factors (e.g., compensation/litigation; financial pressures).
- Responses of those close to the patient (family, friends, workplace) and the impact of the pain on those relationships.

Psychometric measures

Numerous assessment measures with robust psychometric properties (e.g., high validity and reliability) are available for use in this area and may provide informative screening data to: (a) supplement clinical information obtained from the assessment interview; (b) highlight key issues for further exploration during subsequent sessions (Turk & Robinson, 2011); or (c) evaluate treatment outcomes. Psychometric measures can be useful in quantifying an individual's level of pain intensity, emotional distress and functioning. Moreover, they can provide important information about an individual's belief systems (e.g., pain beliefs) and can assist in assessing a wide range of behaviours (e.g., use of coping strategies). Specific measures will often be chosen on the basis of clinical presentation. Where appropriate, psychologists may wish to consider those used by the Electronic Persistent Pain Outcomes Collaboration (ePPOC – refer University of Wollongong) and the Agency for Clinical Innovation (ACI – refer New South Wales Health), as they were determined by national reference group consensus and permit comparison of one's own practice with a national database. Of note, although psychometric measures can provide useful information, they should not be interpreted in isolation of clinical interview data. Moreover, while psychologists are trained in the use of cognitive screening measures, detailed assessment of cognitive function may require specialist neuropsychological assessment.

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Specific comment on pre-procedural assessment

The psychologist has a specific role in the assessment and treatment of patients prior to surgery and, in particular, in the assessment of patients prior to neuromodulation techniques (e.g., implantation of spinal cord stimulators and intrathecal drug delivery devices) (Epker & Block, 2001). It is important to note that pre-procedure psychological assessment has a number of functions, including the identification of: significant psychopathology (which may in turn lead to post-procedure psychological distress and treatment adherence difficulties); understanding of, preparedness for, or acceptance of, the procedure; and 'yellow flags' (psychological factors known to predict poor surgical outcome). There is strong empirical research regarding psychological factors that predict poor surgical outcomes (e.g., Block, Gatchel, Dearorodd & Guyer, 2003; Bruns & Disorbio, 2009; Voorhies, Jiang & Thomas, 2007) including financial incentives, history of abuse or abandonment, job dissatisfaction, poor social support, substance abuse, pre-existing psychopathology, anxiety/depression, pain catastrophising and treatment engagement difficulties. Where such risk factors are identified, continuation of relevant psychological, physical and supportive treatments, in preference to, or in conjunction with, more invasive intervention may be prudent (Greve, Bianchini & Ord, 2011).

Psychological Treatment

Psychological approaches to persistent pain emphasise self-management, with the ultimate goal of improving an individual's functioning and ability to manage the pain, thereby improving overall life quality. Treatment by a psychologist directly targets relevant barriers; with a focus on behavioural change and functional re-engagement. Evidence-based psychological interventions for persistent pain may be undertaken on an individual or group basis, delivered face-to-face or via electronic mediums (e.g., telehealth, internet-based programs) and cover a range of therapeutic approaches including Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT), Mindfulness and

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Hypnosis/Hypnotherapy/Hypnotic Cognitive Therapy (HCT). Rather than adopting a standard 'one size fits all' approach, psychologists are responsible for matching the treatment to the patient in order to maximise therapeutic engagement and outcomes (Williams, Eccleston, & Morley, 2012).

Irrespective of the treatment modality adopted, psychologists working with persistent pain may address a range of psychological issues affecting the individual. Co-morbid mental health conditions in particular, are a serious and significant barrier to return to health and function, and require the whole person approach adopted by psychologists. Across the course of therapy, a variety of interventions may be utilised including, but not limited to:

- Education of the individual and, where possible/appropriate, significant others (e.g., information about pain processes - including aspects of neuroplasticity and neurochemistry, treatment options - including limitations of some techniques, the importance of the individual's active involvement in treatment, strategies for managing crises).
- Anxiety management strategies, particularly relating to fear of pain.
- Treatment of PTSD symptoms.
- Depression management.
- Management of relationship or sexual difficulties, including family interventions to improve family resources for coping.
- Sleep management strategies.
- Assertiveness and communication skills training.
- Anger and/or perceived injustice management.
- Goal setting and problem-solving.
- Treatment adherence.
- Relaxation training, which may target the physiological and/or psychological impact of pain and may include biofeedback (Schneider, 1987).
- Activity pacing and activity scheduling.

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- Reinforcement of the appropriate use of medication - as prescribed by the treating medical team and including provision of support for medication reduction/withdrawal.
- Vocational rehabilitation, including assessment of the potential for vocational retraining. This area includes liaison with rehabilitation providers and case managers to inform work placement and development of effective return to work strategies.

Anticipated therapeutic outcomes

In line with the use of evidence-based interventions, treatment outcomes should be regularly assessed. Psychologists frequently examine the effectiveness of interventions at both an individual- and group-level, continually adding to the knowledge underpinning best practice. In doing so, it is important to remember that the definition of 'treatment success' will vary as a function of who is asking the question. For example, an individual with persistent pain may define treatment success solely as a function of pain severity; a health service provider may consider both pain reduction and functional outcomes as important; and a workers' compensation carrier may prioritise the ability to return to gainful employment with little consideration for pain severity (Turk & Robinson, 2011). Hence, it is important that the definition of treatment success be clearly defined at the outset of therapy and that evaluation of therapeutic outcomes be designed in a way that captures the shared agreement. As outlined previously, reasonable outcomes that can be obtained with psychological intervention are improved psychological, physical, occupational and domestic function, with pain that is less intrusive and dominant in the life of the individual. The primary goal is not to achieve significant reduction in pain intensity, but rather, to improve function and life quality in the presence of pain.

Timing and extent of psychological intervention

There are currently no clear guidelines regarding appropriate wait-times to access psychology services for persistent pain, however current evidence suggests that early referral for, and delivery of, psychological intervention for those judged to be at risk of poor

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long-term prognosis and/or delayed recovery, offers substantial benefits compared with a more passive 'monitoring' approach. This is perhaps unsurprising given that the majority of risk factors are psychosocial in nature and therefore often amenable to treatment (Gopinath et al., 2015). Some suggestions regarding the appropriate duration and frequency of psychology consultations are presented as a guide for clinicians in Appendix 1.

Links between primary healthcare and tertiary pain services

As previously stated, best practice for individuals with persistent pain is for them to be self-managing under a biopsychosocial framework of care. For many, this work will occur in the primary healthcare setting, with individuals receiving input in their communities as required from appropriate medical, nursing and allied health professionals - including psychologists. Individuals may be referred to a tertiary pain service when standard treatment has failed, when they are unable to access pain services in the community, or when they remain significantly disabled despite the input of a range of primary healthcare practitioners.

Tertiary pain services usually offer both group interventions and specialist tailored individual treatment programs – in which psychologists perform a key role. It should be noted that psychologists working in these services frequently offer treatment of pain-related psychosocial issues only. Where the primary clinical presentation is not specifically pain-related (e.g., unstable addiction, unrelated mental health conditions, housing concerns, domestic violence) then other services are best utilised. This may involve referral to another specialist service, such as drug and alcohol services, or to a community based psychologist, possibly via the 'better access' scheme of the Australian government. Tertiary pain services aim to return care to the primary healthcare provider within a reasonable timeframe, as persistent pain is a chronic condition that requires ongoing self-management. Good communication between the tertiary centre psychologist and the local provider is essential to ensuring an informed understanding of the individual's progress and ongoing health goals.

Specific populations: Compensation schemes

For individuals with persistent pain, participation in the compensation system (workers compensation or motor vehicle accident) is typically associated with increased distress and poorer vocational and clinical outcomes compared with non-compensable peers. This has been attributed to factors such as: trying to recover within a system that is often confusing and adversarial in nature, and frequently associated with treatment delays and/or non-support of recommended help; and a process that, by its very nature, may not acknowledge continuing pain-related factors, thereby entrenching an individual's focus on illness and disability, rather than wellness behaviours - oftentimes opposing evidence-based rehabilitation (Newton-John & McDonald, 2012). Early access to psychological treatment that is focussed on function (vocational and lifestyle) has been identified as a key factor in improved outcomes. The following five principles for treatment have been identified: (1) measure and demonstrate the effectiveness of treatment; (2) adopt a biopsychosocial approach; (3) empower the injured person to manage their injury; (4) implement goals focused on optimising function, participation and return to work; and (5) base treatment on best available research evidence (Victorian WorkCover Authority, 2012).

Relevant qualifications

It is recommended that assessment and treatment of individuals with persistent pain be undertaken by psychologists with appropriate supervised clinical training and experience working with physical health populations generally, and the management of persistent pain specifically. This is particularly salient for psychologists working as independent sole practitioners in the community. All practising psychologists must be registered with the Australian Health Practitioner Registration Agency (AHPRA) but, as there are currently several routes to registration, it is beyond the scope of this paper to advocate for any particular training pathway or area of specialist endorsement.

References

- Block, A. R., Gatchel, R. J., Deardorff, W. W., & Guyer, R.D. (2003). *The Psychology of Spine Surgery*. Washington, D.C: American Psychological Association.
- Blyth, F. M., March, L. M., Brnabic, A. J. M., Jorm, L. R., Williamson, M., & Cousins, M. J. (2001). Chronic pain in Australia: A prevalence study. *Pain*, *89*(2-3), 127-134.
- Blyth, F. M., Macfarlane, G. J., & Nicholas, M. K. (2007). The contribution of psychosocial factors to the development of chronic pain: The key to better outcomes for patients? *Pain*, *129*, 8-11. doi: 10.1016/j.pain.2007.03.009.
- Brage, K., Ris, I., Falla, D., Sogaard, K., & Juul-Kristensen, B. (2015). Pain education combined with neck- and aerobic training is more effective at relieving chronic neck pain than pain education alone: A preliminary randomized controlled trial. *Manual Therapy*, *20*(5), 686-693. doi: 10.1016/j.math.2015.06.003.
- Bruns, D., & Disorbio, J. M. (2009). Assessment of biopsychosocial risk factors for medical treatment: A collaborative approach. *Journal of Clinical Psychology in Medical Settings*, *16*(2), 127–147. doi: 10.1007/s10880-009-9148-9.
- Chou, R., Fanciullo, G. J., Fine, P. G., Adler, J. A., Ballantyne, J. C., Davies, P., . . . Miaskowski, C. (2009). Opioid treatment guidelines: clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *The Journal of Pain*, *10*(2), 113-130. doi: 10.1016/j.jpain.2008.10.008,
- Costa, A., Melina, F., Sansalone, A., & Iannacchero, R. (2015). P004. Evidence based psychological treatments in pain management: A review of controlled and randomized trials about chronic headache, neuropathic pain and fibromyalgia. *The Journal of Headache and Pain*, *16*(Suppl 1), A151. doi:10.1186/1129-2377-16-S1-A151.
- Critchley, D. J., Ratcliffe, J., Noonan, S., Jones, R. H., & Hurley, M. V. (2007). Effectiveness and cost-effectiveness of three types of physiotherapy used to reduce chronic low back pain disability: A pragmatic randomized trial with economic evaluation. *Spine*, *32*(14), 1474-1481. doi: 10.1097/BRS.0b013e318067dc26.

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- Epker, J., & Block, A. (2001). Presurgical screening in back pain patients: A review. *Clinical Journal of Pain, 17*, 200-205.
- Epker, J. (2013). Psychometric methods for measuring pain. *The Clinical Neuropsychologist, 27*(1), 30-48. doi: 10.1080/13854046.2012.739203.
- Gopinath, B., Jagnoor, J., Nicholas, M., Blyth, F., Harris, I. A., Casey, P., & Cameron, I. D. (2015). Presence and predictors of persistent pain among persons who sustained an injury in a road traffic crash. *European Journal of Pain, 19*(8), 1111–1118. doi: 10.1002/ejp.634.
- Greve, K. W., Bianchini, K. J., & Ord, J. S. (2011). The psychological assessment of persons with chronic pain. In G. J. Larrabee (Ed.), *Forensic Neuropsychology: A Scientific Approach* (pp. 302-335). New York: Oxford University Press.
- Hayes, C., & Hodson, F. J. (2011). A whole-person model of care for persistent pain: From conceptual framework to practical application. *Pain Medicine, 12*(12), 1738-1749. doi: 10.1111/j.1526-4637.2011.01267.x.
- International Association for the Study of Pain Task Force on wait-times, IASP (2010). Summary and Recommendations. Retrieved June, 2015, from http://assets.listpilot.net/iasp/files/Wait_Times_Document_February_2010.pdf
- Jamison, R. N. & Edwards, R. R. (2012). Integrating pain management in clinical practice. *Journal of Clinical Psychology in Medical Settings, 19*(1), 49-64. doi: 10.1007/s10880-012-9295-2.
- Keefe, F. J., Somers, T. J., Williams, D. A., & Smith, S. J. (2011). Assessment of pain behaviors. In D. C. Turk & R. Melzack (Eds.), *Handbook of Pain Assessment* (pp.134-150). New York: The Guilford Press.
- Lynch, M. E., Campbell, F., Clark, A. J., Dunbar, M. J., Goldstein, D., Peng, P., . . . Tupper, H. (2008). A systematic review of the effect of waiting for treatment for chronic pain. *Pain, 136*(1–2), 97-116. doi: <http://dx.doi.org/10.1016/j.pain.2007.06.018>.
- Merskey, H., & Bogduk, N. (Eds.) (1994). *Classification of Chronic Pain* (2nd ed.). Seattle: IASP Press.

PSYCHOLOGY AND PERSISTENT PAIN

- Morley, S., & Williams, A. (2015). New developments in the psychological management of chronic pain. *Canadian Journal of Psychiatry, 60*(4): 168-175.
- National Pain Summit Initiative. (2011). National pain strategy: Pain management for all Australians Retrieved November, 2012, from <http://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1320268502&sid>
- Newton-John, T & McDonald, A (2012) Pain management in the context of worker's compensation: a case study. *Journal of Translational Behavioural Medicine, 2*(1): 38–4. doi: 10.1007/s13142-012-0112-0.
- Roditi, D. & Robinson, M. E. (2011). The role of psychological interventions in the management of patients with chronic pain. *Psychology Research and Behavior Management, 4*, 41-49. doi: 10.2147/PRBM.S15375.
- Schneider, C. J. (1987). Cost effectiveness of biofeedback and behavioural medicine treatments: A review of the literature. *Biofeedback and Self-Regulation, 12*(2), 71-92.
- Treede, R.-D., Rief, W., Barke, A., Aziz, Q., Bennett, M. I., Benoliel, R., . . . Wang, S-J. (2015). A classification of chronic pain for ICD-11. *Pain, 156*(6): 1003-1007. doi: 10.1097/j.pain.000000000000160.
- Turk, D. C., & Monarch, E. S (2002). Biopsychosocial perspective on chronic pain. In: D. C. Turk & R. J. Gatchel (Eds). *Psychosocial Approaches to Pain Management: A Practitioner's Handbook* (pp. 3-29). 2nd edition. New York: The Guilford Press.
- Turk, D. C., & Robinson, J. P (2011). Assessment of patients with chronic pain. In D. C. Turk & R. Melzack (Eds.), *Handbook of Pain Assessment* (pp. 188-210). New York: The Guilford Press.
- van Tulder, M. (2008). Conservative non-pharmacological treatment for chronic low back pain. *BMJ, 337*, a974. doi: 10.1136/bmj.a974.
- Victorian Workcover Authority (2012) *Clinical Framework for Health Services*, Melbourne Australia. Retrieved December, 2015, from https://www.comcare.gov.au/_data/assets/pdf_file/0010/127468/Clinical_Framework_for_the_Delivery_of_Health_Services_state.pdf

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Voorhies, R. M., Jiang, X., & Thomas, N. (2007). Predicting outcome in the surgical treatment of lumbar radiculopathy using the pain drawing score, McGill short form pain questionnaire, and risk factors including psychosocial issues and axial joint pain. *Spine Journal*, 7(5), 516-524.

Williams, A. C. d. C., Eccleston, C., & Morley, S. (2012). Psychological therapies for the management of chronic pain (excluding headache) in adults (Review). *The Cochrane Library*(11). doi: 10.1002/14651858.CD007407.pub3.

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APPENDIX 1: Proposed timeframe for psychological intervention

Assessment

A psychological assessment is typically conducted in a single 1 hour session. For complex presentations and/or medicolegal purposes though, this can extend to 3 sessions.

Treatment

(a) *Intensive (early) phase*: Individuals may initially attend 6-12 individual sessions, typically 50 minutes in duration, occurring on a weekly or fortnightly basis (or less frequent depending on practice setting and clinical need). Progress should be reviewed after 6 sessions to determine ongoing need for intensive intervention.

(b) *Intermittent (follow-up) phase*: Individuals may then require episodic (1-6 monthly) psychological review to facilitate maintenance of treatment gains and/or provide support as they solidify behavioural changes within the context of their everyday life. For most individuals, discharge will be possible within a few sessions. In some rare instances, patients may need to be reviewed intermittently on a longer-term basis. Indicators for this may include psychological intervention preventing functional deterioration, medication increases, medical/service presentations and/or other management complications.

(c) *Crisis/flare-up phase*: Following a period of flare-up, individuals may occasionally require psychological review and brief therapeutic intervention to reinforce coping strategies and facilitate stabilisation. Discharge is often possible after a limited number of sessions.

(d) *Exceptional circumstances*: Pre-existing/long standing personality or psychological problems, which were in existence prior to the onset of pain and have been exacerbated by, or integrated with, the pain problem, may require more extensive therapeutic intervention. Involvement with legal action and compensation processes can create a significant barrier to self-management and stabilisation. These individuals need to be clearly distinguished from those requiring more targeted pain management and such decisions should be balanced against risk of fostering dependency.