Listen Carefully to Catastrophizers of Chronic Pain

BY KATE JOHNSON

EXPERT ANALYSIS FROM THE WORLD CONGRESS ON PAIN

MONTREAL – Personality and attitude play a major role in shaping a patient's experience of chronic pain, and understanding this dynamic may help physicians overcome obstacles in treating some of their unresponsive patients, according to Michael Sullivan, Ph.D.

In fact, in recent studies, catastrophizing has emerged as "the most powerful psychological predictor of problematic pain outcomes," said Dr. Sullivan, professor of psychology, medicine, and neurology at McGill University in Montreal.

Helping patients shift their focus from fighting to accepting their pain is particularly tricky. For new pain, 'acceptance is not the message that should be given by the doctor.'

In the context of pain, catastrophizing is defined as the tendency to worry and focus on the pain. Individuals who score high on the Pain Catastrophizing Scale (PCS), which was developed by Dr. Sullivan in 1995, tend to magnify and ruminate over their symptoms while feeling helpless about addressing them. "These individuals have an excessively alarmist attitude toward their pain and seem to have a lot more difficulty dealing with it," he said at the meeting.

In the office setting, chronic pain patients who catastrophize "display more pain behavior such as holding, rubbing, [and] guarding, as well as vocalizations such as moans and sighs," he said at the meeting, sponsored by the International Association for the Study of Pain.

"Research shows that not only are catastrophizers going to have more difficulty in pain situations, they are also going to respond less well to the interventions that we offer them," he said. In studies, Dr. Sullivan and his colleagues have shown that, compared with noncatastrophizers, catastrophizers are at greater risk of chronic pain following knee arthroplasty (Pain Res. Manag. 2008;13:335-41) and have more difficulty returning to work after whiplash injuries (J. Occup. Rehabil. 2007; 17:305-15).

For patients whose chronic pain stems from an accident, perceptions of injustice also are common and can be expressed as anger or noncompliance. "Some of our recent research [Pain 2009;145:325-31] shows that perceptions of injustice are often associated with prolonged disability following a pain-related injury," he said. For the treating physician, "validation techniques can be useful in reducing the negative impact of the catastrophizing patient's perceptions of injustice."

By identifying catastrophizers early, physicians can avoid pitfalls that contribute to treatment failure in chronic pain. "There are some very concrete ways in which physicians could be reacting differently with these patients" to make patient management easier, he pointed out.

First and foremost, catastrophizers need to express their suffering and anxiety. "This person does have a story to tell and they need someone to listen. By not listening properly to that story initially, you are going to hear it again every time the patient comes, because the patient is going to feel that the doctor doesn't understand. So, increasing the time you initially spend with the patient can save a lot of headaches further down the line," Dr. Sullivan explained.

Active listening has even been shown to reduce a patient's perception of pain, at least in the context of acute symptoms, said Dr. Sullivan, who has published several studies showing that allowing catastrophizers to disclose their fear and worry prior to routine dental hygiene procedures can reduce their perception of pain by as much as 50% (J. Indiana Dent. Assoc. 2000-2001;79:16-9; Pain 1999;79:155-63).

Although a patient's basic personality is a challenge for physicians to work around, attitude – which is also an extremely powerful modifier of pain – is somewhat easier to mold, suggested Stefaan Van Damme, Ph.D., of the department of experimental clinical health and psychology at Ghent (Belgium) University.

In approaching pain control as a goal, chronic pain patients fall into two distinct categories: those who try to overcome it (assimilators) and those who accept it (accommodators). Both attitudes can be helpful or harmful, depending on how realistic pain control is for a particular patient, he said at the meeting.

"When pain is controllable, assimilative coping works. But when it is not controllable, it can be maladaptive because it can exacerbate catastrophizing, hypervigilance, and distress," he said. In a study, he demonstrated that, when attempts to avoid pain are unsuccessful, "individuals persist in their avoidance attempts, try harder, and narrow their focus of attention upon the problem to be solved" (Pain 2008;137:631-9).

Helping patients shift their focus from fighting to accepting their pain is particularly tricky for physicians, commented Dr. Sullivan, who is a psychologist.

"I only get sent the patients when their pain has been long-standing. The concept of acceptance works when the pain has been there for 5 years," he explained, "but for new-onset pain, acceptance is not the message that should be given by the doctor. This should only come up after we've offered everything else we can offer."

Physicians should also be aware of their own personal psychology when dealing with catastrophizing patients, because catastrophizing personalities are not confined to the patient world. Physicians who are catastrophizers may inadvertently increase a patient's perception of suffering.

"Some of our research suggests that if you're a catastrophizer you see 30% more pain in these individuals," he said, and this could impact a physician's decisions about treatment intervention as well the physician's advice surrounding acceptance. ■

Disclosures: The speakers did not declare any conflicts of interest.

Hospitalized Children With Acute Pain Often Underdosed

BY PATRICE WENDLING

EXPERT ANALYSIS FROM THE PEDIATRIC HOSPITAL MEDICINE 2010 MEETING

MINNEAPOLIS – Clinicians consistently undertreat acute pain in hospitalized children, despite parents' expectations that everything possible is being done to relieve their children's suffering.

Data show that with the same procedure, adults are getting many more pain doses than children, Dr. Stefan J. Friedrichsdorf said at the meeting. "Even among children, a 10-year-old is likely to get better analgesia than a 10-day-old for exactly the same procedure," he added.

Several myths contribute to the abysmal management of acute pain in children, with concern about inducing addiction at the top of the list, said Dr. Friedrichsdorf, a pediatrician and medical director of pain and palliative care at Children's Hospitals and Clinics of Minnesota, Minneapolis.

While there have been reports of opioid use leading to addiction in children with chronic pain, no such cases have been reported in children treated with strong opioids for acute pain, he said.

What's more likely to occur is for staff to confuse tolerance with addiction if children have received opioids for more than 3 days and display signs of withdrawal if the drug is abruptly discontinued instead of carefully titrated down. Still others, out of a belief that the pain is "not that bad" or that pain medications mask the underlying symptoms, will administer such small doses of morphine that the child repeatedly asks the nursing staff for more.

"When you arrive the next day, the nurse says, 'I think he's becoming addicted; shouldn't we switch to codeine?' When, in fact, we are just underdosing," Dr. Friedrichsdorf said. "This is pseudoaddiction."

Evidence shows that it is possible to assess symptoms with adequate pain management, with the possible exceptions being compartment syndrome and intracranial injuries, he said at the meeting, which was sponsored by the Society of Hospital Medicine, the American Academy of Pediatrics, and the Academic Pediatric Association.

'The golden rule is that we must schedule analgesia and then … use p.r.n. analgesia and titrate to effect.'

DR. FRIEDRICHSDORF

Respiratory depression is a common concern in pain management, but should not deter providers from using opioid patient-controlled analgesia (PCA) in children.

A recent meta-analysis involving 14 studies and 402 patients indicates that the addition of a continuous infusion to intravenous opioid PCA is associated with a higher incidence of respiratory events, compared with demand intravenous PCA in adults, but not in pediatric patients (J. Opioid Manag. 2010;6: 47-54).

Several professional organizations have weighed in on pediatric pain management, with a recent systematic review identifying no less than 25 cancer-related pain management guidelines published between 2000 and May 2006 (Clin. J. Pain 2010; 26:449-62).

Dr. Friedrichsdorf advised providers to familiarize themselves with the Principles of Pediatric Acute Pain Management in the 1998 World Health Organization report: "Cancer Pain Relief and Palliative Care in Children" and the WHO's three-step "ladder" for cancer pain relief. The principles address opioid analgesics commonly used for moderate to severe pain, routes of administration, initial pediatric doses, and dosing intervals.

For example, the initial dose for intravenous or subcutaneous morphine ranges from 0.05 mg/kg to 0.1 mg/kg. Because of the wide variability in individual responses to opioids, this should not be interpreted to mean that all patients should start at 0.05 mg/kg, Dr. Friedrichsdorf said.

"For small kids with small pain, use the lower end of the dose range; use a big dose for big kids with big pain," he said.

As-needed orders for opioids are commonly used to provide flexibility in dosing, but frequently result in the patient receiving nothing or seesawing between under- and oversedation, Dr. Friedrichsdorf said.

"The golden rule is that we must schedule analgesia and then on top of that, of course, use p.r.n. analgesia and titrate to effect," he said. ■

Disclosures: Dr. Friedrichsdorf reported having no conflicts of interest.

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