


Acute Pain

- Normal physiological response
- Enhances survival
- Warns of disease progression
- Prolonged acute pain can lead to changes in the tissue and CNS/PNS
- Management of acute pain can prevent the onset of physiological changes that lead to chronic pain

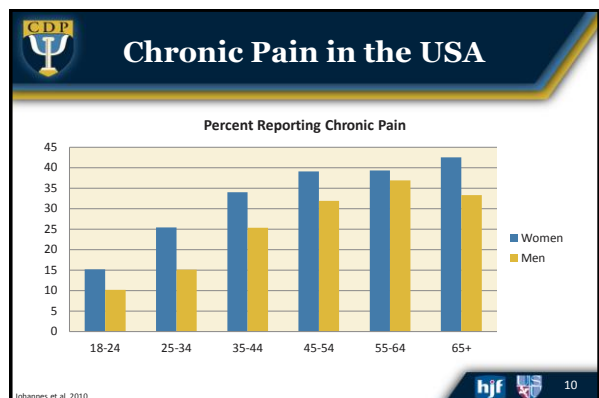
Chronic Pain

- Changes in the central nervous system
- Serves no apparent useful purpose



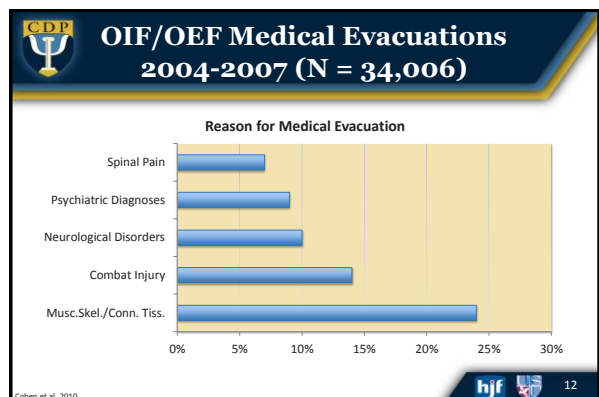
Chronic Pain in the USA

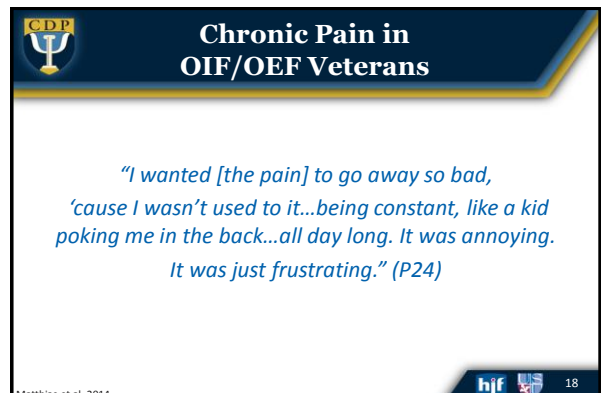
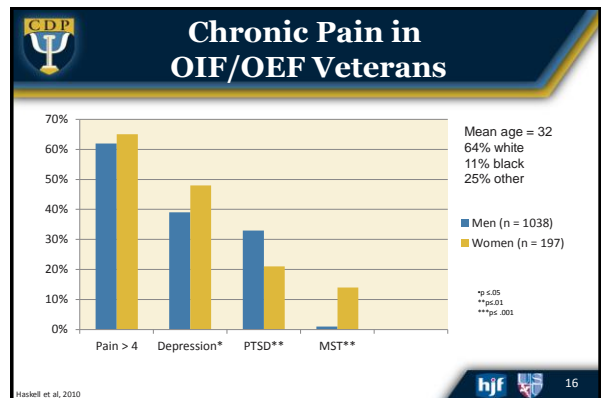
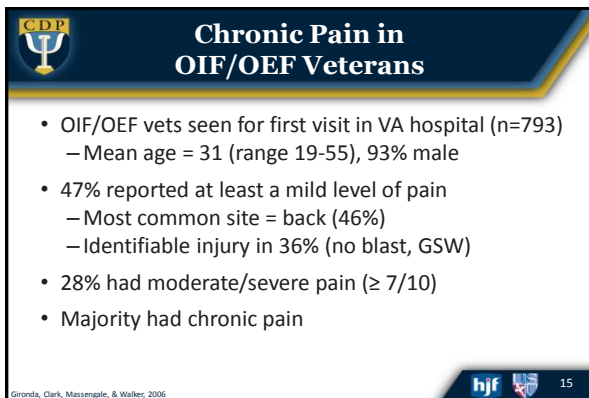
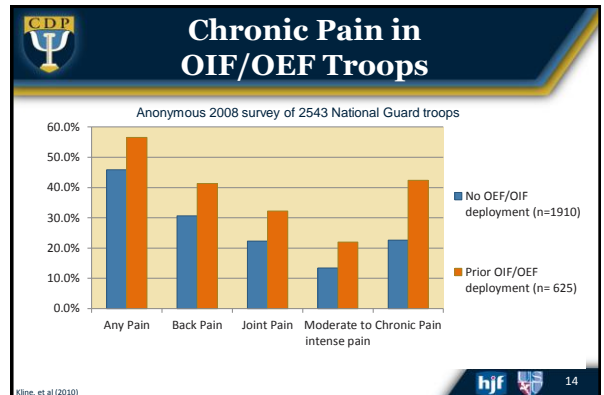
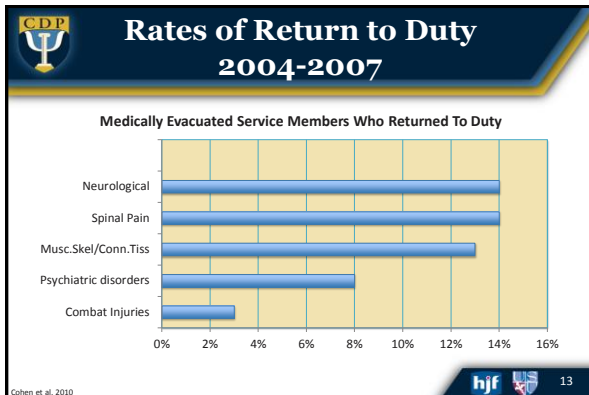
- 2010 cross-sectional survey of 27,035 adults
- Chronic pain present in 30.7%
 - “chronic, recurrent, or long-lasting pain lasting for at least 6 months”
- Prevalence higher for females (34%) than males (27%)



Pain and the Military

- Chronic pain is the most common reason for OIF and OEF medical evacuation & medical boards across services
- 47% of new OIF/OEF vets report pain
- 48% of total veteran population reports pain
- Pain disorders account for the largest proportion of total compensation costs






Chronic Pain in OIF/OEF Veterans

"He likes to go four-wheeling. After a period of time it makes my back hurt 'cause you're...bouncing up and down. So he won't take me to do that because he thinks he's gonna hurt me. Or if I'm lifting something, he'll be like, oh no don't, you might hurt yourself. A lot of times I just keep my mouth shut." (P20)

Matthias et al. 2014

Pain Issues Specific to the Military

- Military culture and training




Pain Issues Specific to the Military

- Physical fitness tests




Pain Issues Specific to the Military




Removal from mission & deployment

- Loss of identity and community
- Escaping from distressing situation



Theories of Pain



Theories of Pain

Specificity Theory

- Level of pain= tissue damage

Biomedical Model

- Symptoms are either somatogenic or psychogenic
- Distress regarding pain seen as secondary condition that will vanish when pain is cured

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BioPsychoSocial Model

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The Gate Control Theory

Nerve “gate” in spinal cord controls level of pain signals that reach the brain

3 systems at work:

- Sensory-discriminative
- Motivational-affective
- Cognitive-evaluative

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The Body-Self Neuromatrix

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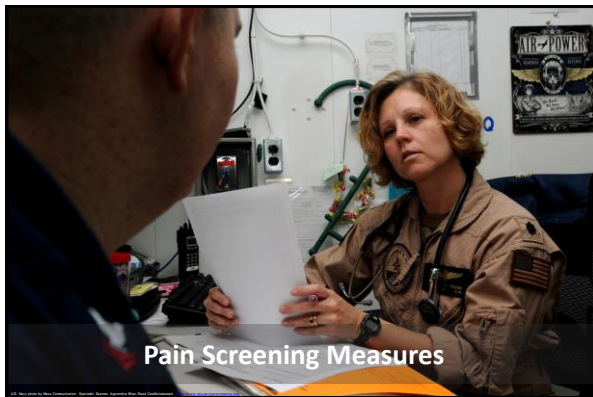


Psychological Factors Predict Pain Outcomes

- Depression and anxiety
- Coping style
- Beliefs about pain, employers, medical system
- Fear-avoidance
- Traumatic life events
- Social support

- Transition from acute to chronic pain
- Return to work
- Levels of pain medication
- Outcome of lumbar surgery


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Pain Screening Measures

Assessment Methods

- On a scale of 0 to 10 with 0 being no pain at all and 10 being the worst pain imaginable
 - Current, worst, least, usual pain
- Visual analog scales
 - Pain faces, line scales



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Visual Analog Scales

Visual Analog Scale (VAS)*

No pain Pain as bad as it could possibly be

*10-cm baseline is recommended for VAS scales.

0	1	2	3	4	5	6	7	8	9	10
No pain	Mild, annoying pain	Nagging, uncomfortable, troublesome pain	Distressing, miserable pain	Intense, dreadful, horrible pain	Worst possible, unbearable, excruciating pain					

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Defense and Veterans Pain Rating Scale

Defense and Veterans Pain Rating Scale

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Defense and Veterans Pain Rating Scale

DoD/VA PAIN SUPPLEMENTAL QUESTIONS

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your **ACTIVITY**:
 0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes
2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your **SLEEP**:
 0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes
3. Circle the one number that describes how, during the past 24 hours, pain has affected your **MOOD**:
 0 1 2 3 4 5 6 7 8 9 10
Does not affect Completely affects
4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your **STRESS**:
 0 1 2 3 4 5 6 7 8 9 10
Does not contribute Contributes a great deal

*Reference to pain literature: Cleeland CS, Dunbar KB. The cancer pain scale: the brief pain inventory. An updated approach. JCO. 2001;19:168-169. © 2002

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Overview of Cognitive-Behavioral Therapy Interventions for Chronic Pain

CDP CBT for Chronic Pain

- Widely recognized components of Cognitive Behavioral Therapy (CBT) for pain
 - Psychoeducation
 - Relaxation
 - Activity modification
 - Behavioral activation
 - Sleep hygiene
 - Cognitive restructuring

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CDP CBT for Chronic Pain

- CBT for pain often also includes
 - Anger control techniques
 - Mindfulness
 - Biofeedback
 - Relationship interventions
 - Assertiveness training
 - Planning for setbacks

Problem coming up with a standard protocol that addresses needs of diverse population

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CDP Outcomes of CBT for Chronic Pain

- How do you measure outcome?
 - Disability
 - Mood
 - Pain level
 - Coping strategies
 - Observed pain behaviors
- Consider ongoing medical treatment

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CDP Multidisciplinary Pain Treatment

- Pain centers or clinics offering combined treatment with CBT plus medical and physical therapy interventions
- 2008 review (27 studies, 2047 patients), inpatient and outpatient centers, 4-15 weeks
 - Moderate-strong evidence for multidisciplinary care for low back pain and fibromyalgia compared to usual care
 - Mixed chronic pain patients did less well
 - Inpatient programs did moderately better than outpatient
 - No effect for duration of treatment or specific program components

Scarcieghini et al. 2008

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CDP Additional Training Opportunities

deploymentpsych.org




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CDP Website: Deploymentpsych.org

Features include:

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, mTBI, depression, and insomnia
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed



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Online Learning

The following online courses are located on the CDP website at:
<http://www.deploymentpsych.org/content/online-courses>

NOTE: All of these courses can be taken for free or for CE Credits for a fee

- Cognitive Processing Therapy (CPT) for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Prolonged Exposure Therapy for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Epidemiology of PTSD in Veterans: Working with Service Members and Veterans with PTSD (1.5 CE Credits)
- Provider Resiliency and Self-Care: An Ethical Issue (1 CE Credit)
- Military Cultural Competence (1.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 1 (2.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 2 (1.75 CE Credits)
- The Fundamentals of Traumatic Brain Injury (TBI) (1.5 CE Credits)
- Identification, Prevention, & Treatment of Suicidal Behavior in Service Members & Veterans (2.25 CE Credits)
- Depression in Service Members and Veterans (1.25 CE Credits)

All of these courses and several others are contained in the Serving Our Veterans Behavioral Health Certificate program, which also includes 20+ hours of Continuing Education Credits for \$350.



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Provider Support

CDP's "Provider Portal" is exclusively for individuals trained by the CDP in evidence-based psychotherapies (e.g., CPT, PE, and CBT-I)

Features include:

- Consultation message boards
- Hosted consultation calls
- Printable fact sheets, manuals, handouts, and other materials
- FAQs and one-on-one interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids



Participants in CDP's evidence-based training will automatically receive an email instructing them how to activate their user name and access the "Provider Portal" section at Deploymentpsych.org.




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How to Contact Us

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