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# Chronic Pain Management Mini Series

## Session Three: Cognitive and behavioural approaches

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**Chronic pain, mood and risk assessment**

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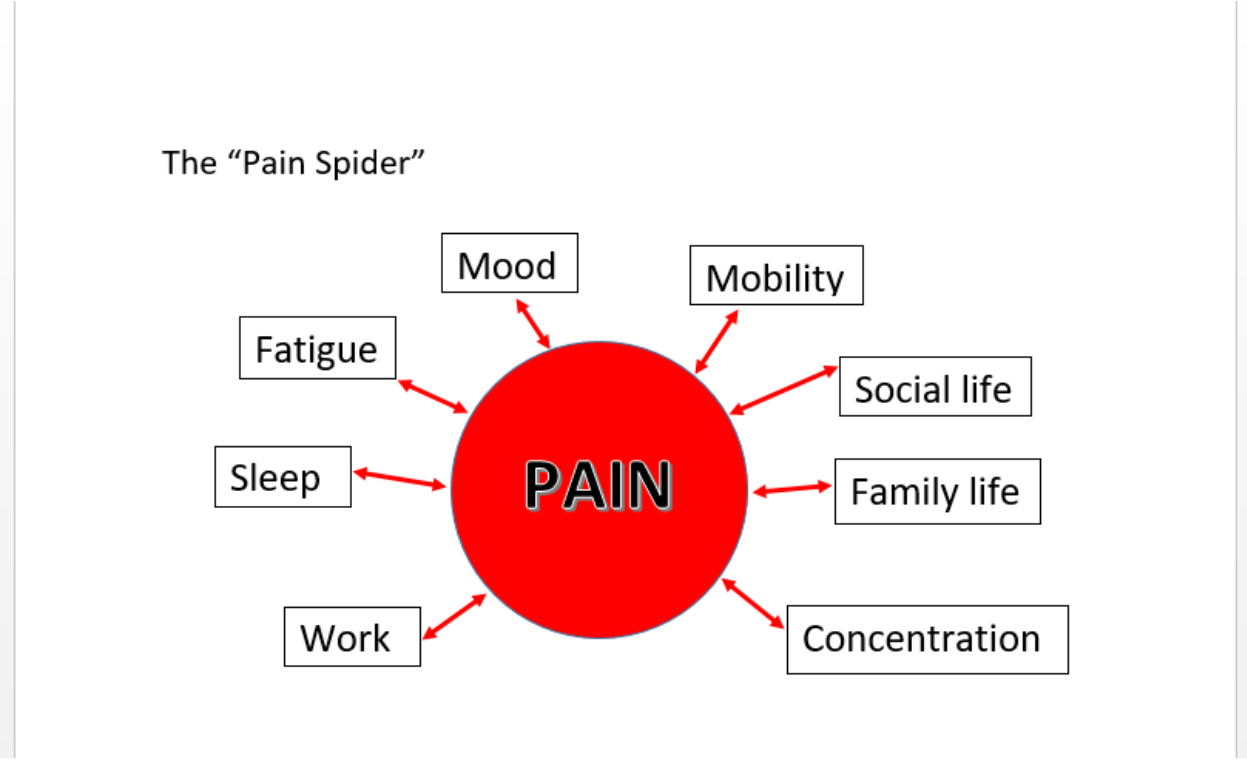
Living with chronic pain is associated with a wide range of difficulties which operate across several domains, including mood. As physiotherapists working with patients who experience chronic pain, we need to have a full understanding of these consequences, so that we can help the patient to manage them. At the same time, we need to be aware of our own personal scope of practice, and be aware of situations when we need to be referring a patient on for more specialist support. In particular, we need to be alert to any indication that the patient may be considering self-harm, and to be prepared to seek help on behalf that patient.




The diagram above indicates some of the consequences of living with pain which are not simply predicted by pain severity. All of these consequences can be managed, to improve the overall situation for the patient. This is sometimes known as the "pain spider" because of its shape. It is fairly simple to draw a diagram like this at the end of an assessment, in order to highlight the wide-ranging effects of chronic pain. This can be a helpful exercise if the patient's agenda is to seek pain relief, but the assessing physiotherapist has not been able to identify evidence-based pain relieving treatments which are likely to resolve the patient's pain. It is possible then to explain that the primary problem (the pain) may not be resolvable, but that it may be possible to make some progress in terms of quality of life by managing the consequences of the pain. It can be helpful to highlight the interactions between all of these consequences: for example, reduced mobility can feed into poor sleep, and pain-related insomnia can feed into fatigue, which can then feed into poor concentration, which can then feed into mood issues, and so on. These complex interactions or "vicious circles" indicate the complexity of living with chronic pain, and the requirement for a biopsychosocial approach which incorporates cognitive and behavioural approaches.

If the assessment indicates that the mood issues are interacting unhelpfully with optimal pain management, then the physiotherapist and the patient will need to consider whether these interactions have the potential to improve as a result of improved pain management and rehabilitation. For example, if the patient is expressing frustration and low mood as a result of limited mobility and activity, then it is reasonable to assume that there is scope for improvement in mood if the patient engages well with rehabilitation and is able to make progress with function. However, it will be important for the physiotherapist to monitor the mood issues through the rehabilitation process, and to seek further help if required. Help may be available from specialist pain management services, from the GP, or from local mental health services.

If the assessment indicates significant mood issues which put the patient at risk of self-harm then the physiotherapist has a "duty of care" to inform the GP and any other relevant agencies about any such concerns. Whilst the physiotherapist is unlikely to be trained in a full risk assessment, and would not be expected to take responsibility for the patient's mood or to make any firm judgement about risk, physiotherapists should be aware of suicidal thinking and have an understanding of how to assess for risk, in order to improve the care of the patient.

There is guidance about risk assessment available from:
The Chartered Society of Physiotherapy: https://www.csp.org.uk/frontline/article/suicide-awareness-csp-gives-accessible-overview

The University of Oxford Centre for Suicide Research:
https://www.psych.ox.ac.uk/research/csr
and:
http://cebmh.warne.ox.ac.uk/csr/clinicalguide/index.html

Gaining insights into the risk factors for suicide can inform physiotherapists working in a wide range of settings, and this knowledge is helpful within a chronic pain setting. Approximately 70% of patients with chronic pain will have had suicidal thoughts at some time, and these thoughts may be expressed to others in ways that are not immediately obvious. For example, a patient may say "Sometimes I don't feel it's worth getting up in the morning", or "I'm not sure if I can carry on like this". These kind of statements allow the physiotherapist to ask more about how the patient is feeling, for example by asking open questions such as "Could you tell me more about that?" If there is any doubt it is reasonable to ask the patient questions such as "Have you had thoughts about ending your life?" or "Have you ever thought about ending it all?" or "Have you had thoughts about not being here anymore?"

Many people living with long term pain will have suicidal thoughts without having a clear plan, but those who have a clear plan are thought to be more at risk of carrying out that plan. Other risk factors include social isolation, a history of previous suicide attempts and self-harm, severe depression, anxiety, feelings of hopelessness, alcohol abuse and/or drug abuse, and male gender. This is not an exhaustive list, and it is helpful for physiotherapists to be aware of the risk factors presented in the sources above. Below is a list of questions which has been developed within the North Bristol NHS Trust Pain Management Service to guide clinicians in gathering information about risk. These are presented here for information, to give some indication of the kind of questions which can be asked to explore risk issues. Physiotherapists reading this document should consult their managers to find out what the risk management guidance is within their departments, and they should also be aware of local arrangements for assessing people who are at risk of self-harm. In some areas, the duty of care is to report directly to the duty doctor at the patient's GP surgery, but in some other areas it is possible to make a direct referral to the mental health crisis team to request an assessment. If there is any indication of immediate risk, it is possible to call 999 to request an ambulance to take a patient directly to Accident and Emergency for an assessment by a liaison psychiatrist.

It is important that the physiotherapist is clear to patients that they cannot keep confidential any information which indicates risk of harm to the patient, or to anyone else. It is possible to explain this to the patient at the start of the assessment, so that it is then easier to explain to the patient that you have a duty of care to seek help if there is evidence of risk.

**North Bristol NHS Trust pain management service: risk assessment**

Risk to self

Have you had thoughts that life isn't worth living? Y / N

Have you thought about harming or injuring yourself? Y / N

Have you thought about suicide? Y / N

Have you thought you might act on this plan? Y / N

If yes to any of these, ask about frequency and intensity
Clinical note:

Have you made any plans? Y / N
Clinical note (if yes):

Have you acted on these thoughts in the past? Y / N

Are there things/reasons that stop you from acting on these thoughts? Y / N
Clinical note:

How likely do you feel you are to act on these thoughts? 0 – 5
*(0 = not at all & 5 = very likely)*
Do you have access to means to carry out your plan? Y / N

Social support; is there anyone you talk to about these thoughts? Y / N

Do you feel able to keep yourself safe? Y / N

Other risks considerations

Exploitation or victimisation by another person
Inability to properly self-care / self-neglect
Alcohol / drug misuse

**Overall risk rating: Low / Moderate / High**