

Biopsychosocial Model of Pain



What is it



- While the traditional medical model views pain as a direct result of disease or trauma, the biopsychosocial model of pain considers the interaction of biological, psychological and sociological factors that influences a patient's experience with pain.
- This experience is unique to the individual person- two people with the same injury can experience different degrees of pain or disability. Taking these factors into account helps address potential barriers to recovery and develop more effective treatment goals.



Why it matters



- People living with pain are at a higher risk for depression, anxiety and substance use disorders. The way they think about their pain during an acute episode can put them at a higher risk of delaying their recovery, making an acute problem become a chronic condition.
- There are many reasons why a person may choose to not seek behavioral health care, including lack of access to providers, racial disparities and mental health stigma. Sometimes the only clinician they will see is their PCP or chiropractor. A biopsychosocial model assists in identifying patients that are at a higher risk, tailoring treatment goals for success and coordinating services and referrals as needed.



What it looks like in practice



- Identifying patients at higher risk through use of appropriate screenings and tools. Higher risk factors could include certain lifestyle behaviors, comorbidities, cultural backgrounds, etc. Screenings such as PHQ-9, Promis-PI and STarT Back are examples of evidence based tools.
- Fear avoidance vs. self-efficacy: acute pain can be scary, but long term avoidance of physical activity for fear of pain can result in bigger issues. Using helpful language, addressing patient catastrophizing and reinforcing a patient's self efficacy to take control of their pain can go long ways to prevent chronic pain.

Mental Health Strategies to Integrate in Time-Limited Medical Appointments

Words that hurt vs. Words that heal

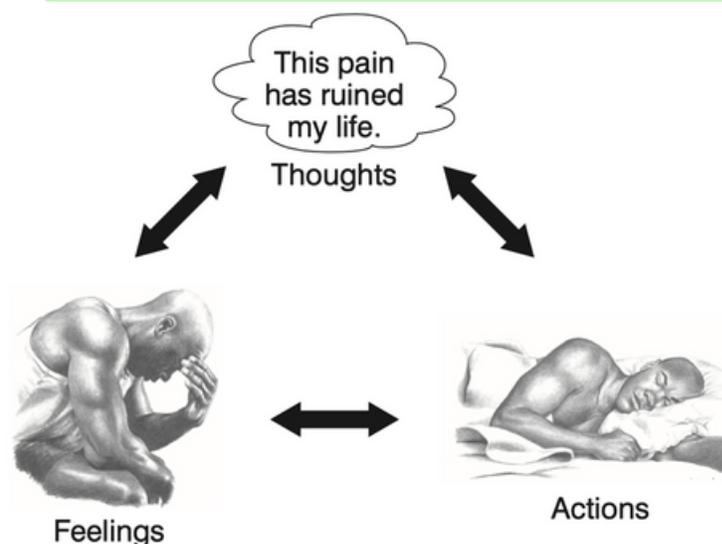
Consider the difference between the two statements: “You’re going to have to live with this” and “having pain at times is a normal part of life but together we can help you overcome it.” The first conveys a sense of hopelessness that it will never get better, while the second validates the pain and reinforces the patient’s self-efficacy to manage their condition. This can be true with documentation, as well.



Using Helpful Language

Psychotherapists utilize the following therapeutic skills to develop rapport with patients, which can easily be incorporated into medical appointments:

- Empathy: Validating the patient’s experience. *“It must be really difficult to have this pain”*
- Genuineness: Being authentic and free of judgement, including tone of voice, facial expressions, body postures, etc.
- Positive Regard: Showing patients respect and not minimizing a person’s experience
- Active Listening: receiving a message, processing it, sending it back (verbal and nonverbal)



Address Pain Catastrophizing

Pain catastrophizing includes magnifying the threat of pain, ruminating about pain, feeling helpless in coping, etc. It is associated with greater pain severity, physical disability and poor prognosis. Research shows that Cognitive Behavioral Therapy (CBT) is effective in addressing the thoughts that can impact perceived pain and depression.

Principles of CBT can be incorporated in medical appointments by doing the following:

- Catch: Help patients catch or identify the unhelpful thought
 - Notice patient’s language: *“always, never, every, no one, all the time”, “I can’t do anything anymore”*
- Check: reflect on how accurate and useful the thought is
 - What is the factual evidence that the thought is true ALL the time
 - What is the evidence that the thought is not true
- Change: Change the thought to a more accurate or helpful thought
 - *“You might have pain now, but it won’t always feel like this.”*
 - Remember: Brief interventions can trigger change