

All information, content, and material of this handout is for informational purposes only and are not intended to serve as a substitute for the consultation, diagnosis, and/or medical treatment of a qualified physician or healthcare provider. The information is not intended to recommend the self-management of health problems or wellness. It is not intended to endorse or recommend any particular type of medical treatment. Should the reader have any health care related questions, that person should promptly call or consult your physician or healthcare provider. This information should not be used by any reader to disregard medical and/or health related advice or provide a basis to delay consultation with a physician or a qualified healthcare provider.

Managing Psychological Contributors to Pain

Taken from Sheera Lerman, PhD – Assistant Professor of Psychiatry & Behavioral Sciences, Johns Hopkins University School of Medicine

Definition of Pain and Associated Terms

- **Nociception:** the processing of painful stimuli by the nervous system, initiated by stimulation of pain receptors (nociceptors).
- **Pain:** a subjective experience including unpleasant thoughts, emotions, and behaviors that come with nociception.
 - Pain is a complex experience. It is influenced by several factors including: beliefs and expectations, coping abilities, attention, stress, and emotions.
- **Pain** is a threat to the body. **Suffering** is a threat to the self and identity.

Psychological Factors Associated with Chronic Pelvic Pain (CPP)

Emotional Distress – 26-52% of people with CPP have depression and 39-73% have anxiety. Depression, anxiety, and pain are interrelated. Depression or anxiety associated with CPP is related to lower quality of life, lower treatment response, and increased disability.

Sleep Disturbances – Poor sleep is very common for people with CPP – up to 80% report poor sleep. Sleep disturbance is associated with increased pain and inferior mood and quality of life.

Maladaptive Coping – Catastrophizing is a negative response to pain that includes magnification, restlessness, and rumination (constantly thinking or worrying about pain). Catastrophizing is a major predictor in one's experience of pain and is associated with increased pain, poor quality of life, and poor treatment response.

History of Trauma – People with CPP are more likely to report a history of abuse compared to those without pain. This information is important for assessing and treating pain.

Management of CPP – Using Psychological Interventions

Treatment of CPP should include several approaches, including psychological interventions. These interventions focus on improving mood, sleep patterns, relationships, stress, and coping mechanisms. Psychological treatments include:

1. Self-regulatory approaches include relaxation training, mindfulness, distraction, and positive thinking.
 - Uses the mind-body connection to increase a person's sense of control over their physiological and emotional states.
2. Cognitive behavioral therapy (CBT)
 - The goal is to challenge automatic negative thoughts associated with pain and construct alternative positive responses while decreasing the stress-pain connection and working on relaxation with behavioral changes.
3. Acceptance Commitment Therapy (ACT)
 - Acceptance of how you feel without trying to control it. Committing to choices not based on feelings but on values.

Report by Riley Young, MD, Obstetrics and Gynecology Resident Physician, Mayo Clinic, Rochester, MN

Mentored by Lori Haring, PT, MS

Last revised 11.15.2021