



- **FACT SHEET NO. 6**

Behavioral Risk Factors and Interventions, Including Hypnosis, for Acute and Chronic Pain After Surgery

Medical observers have long pointed out that the stronger a patient's expectation for acute pain relief from an illness or procedure, the more likely such relief will occur [3]. As the field of acute pain medicine began to differentiate from more general perioperative care, even the earliest studies emphasized the importance of behavioral factors for acute pain control. This continues through the present time [15].

- Controlled trials from more than five decades ago reported that patients who participated more in community activities or felt a positive personal connection with the staff caring for them were more likely to enjoy a positive response to placebo pain medication after surgery [10].
- Nearly 50 years ago, controlled trials of preparing preoperative patients with detailed information about the operations and related procedures they were about to undergo, including the expected pain intensity and duration, reduced their need for morphine analgesia [4].

The picture has emerged of a spectrum of patient preparation and attributes that influence the experience of acute pain after surgery.

- At one end are anxious patients: ill-informed, with few social supports, lacking confidence in the persons or system caring for them, focusing upon and catastrophizing about their pain, feeling little or no control over surgery and their recovery, and lacking commitment to return to their preoperative employment. In recent years, high-dose, long-term preoperative opioid therapy has been added to this list as increasing numbers of patients present for surgery after such exposure.
- At the other end are patients who trust their families and health-care providers, expect a good surgical outcome, feel in control (including being able to relax at will), turn their attention away from their pain, and are motivated to return to their previous level of function.

To some degree these attributes are traits, but they also are states that patients can learn to achieve. For decades, multiple trials have shown that behavioral modalities are effective in decreasing acute postsurgical pain and other symptoms such as anxiety [6,12,20].

In addition to patient education, these modalities include:

- Standard scripts for use during procedures that prepare patients to reframe sensory input in emotionally neutral rather than threatening terms (e.g., “warmth” or “discomfort,” rather than “needle stick”).
- Hypnotic suggestion or training in autosuggestion in advance of a procedure [9].
- Cognitive behavioral techniques such as guided imagery.
- Modification of attention including distraction, virtual reality, and music.
- Relaxation, including biofeedback and controlled breathing exercises.

Chronic Postsurgical Pain (CPSP)

CPSP affects 10 percent to 20 percent of patients. Estimates of its incidence and prevalence vary according to the methods used to identify it, the nature of the operation, and the population surveyed. The transition of acute postsurgical pain to CPSP is complex and reflects biological, psychological, and socioenvironmental factors [5]. Sensory pathways transmit information from damaged tissue to the central nervous system, where psychological factors modulate the experience of pain and individual pain responses.

Psychological factors that predict CPSP include:

- Preoperative depression [11]
- Preoperative anxiety [17]
- Preoperative pain catastrophizing [16,17]
- Preoperative posttraumatic stress disorder symptoms [8]
- Preoperative fear of surgery [13,18]
- Early postsurgical kinesiophobia [2,14]

The foregoing factors may coexist and synergize for greater effects. Younger age and female sex may increase their impact. The factors may vary according to the type of surgery. Social factors may mediate or moderate psychological influences.

Evidence-Based Treatments to Prevent CPSP

To date, there have been few well-designed, prospective randomized controlled outcome studies of psychological treatments that specifically target preoperative risk factors aimed at preventing or reducing CPSP. However, six-week cognitive-behavioral-based physical therapy appears to hold promise as an integrated treatment [1], and there is evolving evidence of the efficacy of mind-body interventions [19] and hypnosis [7] improving pain, disability, and mood in acute trauma and postoperative pain



© Copyright 2017 International Association for the Study of Pain. All rights reserved.

IASP brings together scientists, clinicians, health-care providers, and policymakers to stimulate and support the study of pain and translate that knowledge into improved pain relief worldwide.

conditions respectively. Targeted, scalable, and widely accessible treatments are needed to meet the needs of the hundreds of millions of individuals across the globe who undergo surgery each year.

REFERENCES

- [1] Archer KR, Devin CJ, Vanston SW, Koyama T, Phillips SE, George SZ, McGirt MJ, Spengler DM, Aaronson OS, Cheng JS, Wegener ST. Cognitive-behavioral-based physical therapy for patients with chronic pain undergoing lumbar spine surgery: a randomized controlled trial. *J Pain* 2016;17:76–89.
- [2] Archer KR, Seebach CL, Mathis SL, Riley LH, 3rd, Wegener ST. Early postoperative fear of movement predicts pain, disability, and physical health six months after spinal surgery for degenerative conditions. *Spine J* 2014;14:759–67.
- [3] Benedetti F. *The patient's brain*. Oxford: Oxford University Press; 2011.
- [4] Egbert LD, Battit GE, Welch CE, Bartlett MK. Reduction of postoperative pain by encouragement and instruction of patients. A study of doctor-patient rapport. *N Engl J Med* 1964;270:825–7.
- [5] Katz J, Seltzer Z. Transition from acute to chronic postsurgical pain: risk factors and protective factors. *Expert Rev Neurother* 2009;9:723–44.
- [6] Kay E. Hypnosis and the relaxation response. In: Ferrante FM, VadeBoncoeur TR, editors. *Postoperative pain management*. New York: Churchill Livingstone; 1993. p. 477–84.
- [7] Kendrick C, Sliwinski J, Yu Y, Johnson A, Fisher W, Kekecs Z, Elkins G. Hypnosis for acute procedural pain: a critical review. *Int J Clin Exp Hypn* 2016;64:75–115.
- [8] Kleiman V, Clarke H, Katz J. Sensitivity to pain traumatization: a higher-order factor underlying pain-related anxiety, pain catastrophizing and anxiety sensitivity among patients scheduled for major surgery. *Pain Res Manag* 2011;16:169–77.
- [9] Lang EV, Benotsch EG, Fick LJ, Lutgendorf S, Berbaum ML, Berbaum KS, Logan H, Spiegel D. Adjunctive non-pharmacological analgesia for invasive medical procedures: a randomised trial. *Lancet* 2000;355:1486–90.
- [10] Lasagna L, Mosteller F, von Felsinger JM, Beecher HK. A study of the placebo response. *Am J Med* 1954;16:770–9.
- [11] Lewis GN, Rice DA, McNair PJ, Kluger M. Predictors of persistent pain after total knee arthroplasty: a systematic review and meta-analysis. *Br J Anaesth* 2015;114:551–61.
- [12] Peck CL. Psychological factors in acute pain management. In: Cousins MJ, Phillips GD, editors. *Acute pain management*. New York: Churchill Livingstone; 1986. p. 251–74.
- [13] Peters ML, Sommer M, de Rijke JM, Kessels F, Heineman E, Patijn J, Marcus MA, Vlaeyen JW, van Kleef M. Somatic and psychologic predictors of long-term unfavorable outcome after surgical intervention. *Ann Surg* 2007;245:487–94.
- [14] Roelofs J, van Breukelen G, Sluiter J, Frings-Dresen MH, Goossens M, Thibault P, Boersma K, Vlaeyen JW. Norming of the Tampa Scale for Kinesiophobia across pain diagnoses and various countries. *Pain* 2011;152:1090–5.
- [15] Schug SA, Palmer GM, Scott DA, Halliwell R, Trinca J; APM:SE Working Group of the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. *Acute pain management: scientific evidence*, 4th ed. Melbourne: ANZCA & FPM; 2015.
- [16] Sullivan M. *The Pain Catastrophizing Scale user manual*. Available at: http://sullivan-painresearch.mcgill.ca/pdf/pca/PCManual_English.pdf. 2009.
- [17] Theunissen M, Peters ML, Bruce J, Gramke HF, Marcus MA. Preoperative anxiety and catastrophizing: a systematic review and meta-analysis of the association with chronic postsurgical pain. *Clin J Pain* 2012;28:819–41.
- [18] Theunissen M, Peters ML, Schouten EG, Fiddelaers AA, Willemsen MG, Pinto PR, Gramke HF, Marcus MA. Validation of the surgical fear questionnaire in adult patients waiting for elective surgery. *PloS One* 2014;9:e100225.

- [19] Vranceanu AM, Hageman M, Strooker J, ter Meulen D, Vrahas M, Ring D. A preliminary RCT of a mind body skills based intervention addressing mood and coping strategies in patients with acute orthopaedic trauma. *Injury* 2015;46:552–7.
- [20] Williams DA. Acute pain (with special emphasis on painful medical procedures). In: Gatchel RJ, Turk DC, editors. *Psychosocial factors in pain: critical perspectives*. New York: Guilford Press; 1999. p. 151–63.

AUTHORS

Beth Darnall, PhD
Clinical Associate Professor
Stanford University School of Medicine
Department of Anesthesiology, Perioperative and Pain Medicine
Palo Alto, Calif., USA

Robert I. Cohen, MD
Pain Medicine Consulting
Newton Center, Mass., USA

REVIEWERS

Daniel B. Carr, MD, DABPM, FFPANZCA (Hon)
Professor of Public Health and Community Medicine
Professor of Anesthesiology and Medicine
Founding Director, Tufts Program on Pain Research, Education, and Policy
Boston, Mass., USA

Martin D. Cheatle, PhD
Associate Professor and Director, Pain and Chemical Dependency Program
Department of Psychiatry
Perelman School of Medicine
University of Pennsylvania
Philadelphia, Pa., USA

About the International Association for the Study of Pain®

IASP is the leading professional forum for science, practice, and education in the field of pain. [Membership is open to all professionals](#) involved in research, diagnosis, or treatment of pain. IASP has more than 7,000 members in 133 countries, 90 national chapters, and 20 Special Interest Groups.

As part of the Global Year Against Pain After Surgery, IASP offers a series of Fact Sheets that cover specific topics related to postsurgical pain. These documents have been translated into multiple languages and are available for free download. Visit www.iasp-pain.org/globalyear for more information.



© Copyright 2017 International Association for the Study of Pain. All rights reserved.

IASP brings together scientists, clinicians, health-care providers, and policymakers to stimulate and support the study of pain and translate that knowledge into improved pain relief worldwide.