

Fibromyalgia: Assessment of Exposure to Traumatic Life Events

Lesley Green¹, Jacqui Peacock²

1 Consultant in Anaesthesia & Pain Medicine, 2 Clinical Nurse Specialist in Pain Management
Stobhill Pain Clinic, NHS Greater Glasgow & Clyde

lesley.green2@ggc.scot.nhs.uk



Background Exposure to traumatic life events may predispose to the development of fibromyalgia syndrome (FMS). These patients may develop a worse clinical phenotype which may affect patients' ability to improve quality of life. Adverse events in secondary care assessment of FMS have been studied, with some recommending that traumatic events such as abuse be enquired about in all patients evaluated for FMS. We have already embedded sensitive questioning on traumatic life events and ongoing psychological sequelae but the magnitude of these issues in our practice is not established. We hypothesised that there would be a significant number of patients presenting to the pain clinic who would benefit from early recognition of the psychological impact of traumatic events and that this would meaningfully direct further care.

Aims The aim was to establish the burden of psychological sequelae from exposure to traumatic events at first contact in the pain clinic, and to consider whether evaluation of the impact of traumatic life events, would influence patients' best-directed onward care.

Methods The local ethics committee confirmed that approval was not required. Caldicott guardian approval was obtained. One hundred sequential patients with FMS underwent a standard, new patient, face-to-face assessment by one of two practitioners (consultant anaesthetist or clinical nurse specialist) in the pain clinic. This assessment included detailed psychological questioning and PHQ-9/GAD-7 questionnaires as per normal practice. Structured interviewing was not used. Data was collected from both patient consultation and the electronic notes system. Data was anonymised and collated. Microsoft Excel was used for chi-squared and Fisher's exact test analysis where applicable.

Results One hundred patients were reviewed: 93% female, 7% male. Mean (SD) age: 47(12). Mean (SD) FMS onset age: 35(13). Adverse childhood experiences (ACE) were experienced by 54%; ACE only in 11%; mixed childhood and adulthood adverse experiences in 43%. ACEs included neglect (25%), sexual abuse

Figure 1. Traumatic events exposure

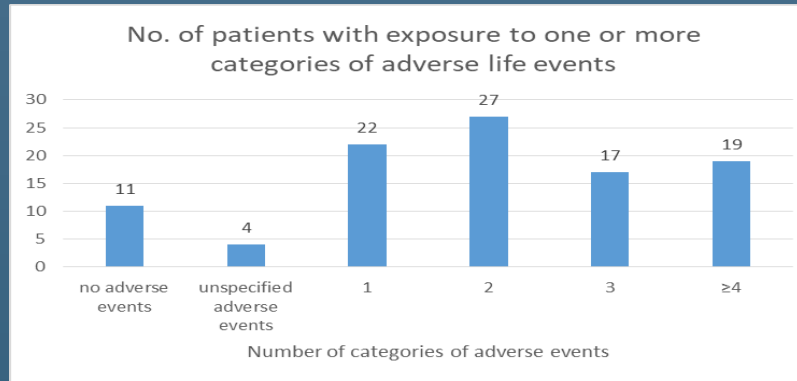


Figure 2. Mental health history in 100 FMS patients.

Active or previous mental health history	Traumatic events history n= 89	No traumatic events history n=11
Depression	80 (89.9%)	5 (45.5%)
Anxiety	69 (77.52)	5 (45.5%)
Suicide attempts	24 (27%)	0
Addiction	19 (21.3%)	1 (9.1%)
Personality disorder	9 (10.1%)	0
OCD	0	1 (9.1%)
PTSD	8 (9%)	0
Functional disorder	6 (6.7%)	0
Eating disorder	4 (4.5%)	0
Self-harm	4 (4.5%)	0
Bipolar disorder	2 (2.2%)	0

(22%), physical abuse (20%). 25% had experienced adult domestic violence. Patients with a history of adverse events had exposure to a median of 2 categories of adverse events with approximately one-third being exposed to ≥ 3 types of adverse events (Figure 1). Previous or active mental health issues were also assessed (Figure 2).

Median(IQR) PHQ-9 score was 17(14-22) (moderate-severe depression), median(IQR) GAD-7 score was 15(10-19) (severe anxiety). Higher PHQ-9 scores ≥ 10 were associated with a history of adverse events vs no history (90.9% vs 63.6%, $p=0.009$). Severe anxiety (GAD-7 ≥ 15) was noted in 55.7% vs 18.1% ($p=0.09$) of those with and without a history of adverse events, respectively. All 15% of patients with suicidal ideation were in the adverse events group. In total, 89/100 (89%) had experienced adverse childhood and/or adulthood experiences of which 40 (44.9%) had significant ongoing mood issues wholly or partly related to previous adverse events. Fifty patients were referred on to an appropriate psychological service (including 34% to pain psychology) with a trend towards greater referral in those with history of traumatic events vs no history (52.8% vs 27.2%, $p=0.11$).

Conclusion As part of a biopsychosocial assessment, we have used questioning on traumatic events and the psychological sequelae in recognition that these may influence individuals' ability to engage in a rehabilitative approach, with an underlying assumption that this model of care represents best practice. Patients with FMS presenting to the North Glasgow pain clinic have a significant risk of multiple traumatic life event histories and of co-existent mental health issues secondary to pain and/or these adverse events. Identifying these patients at first contact ensured appropriate, timely, onward psychological assessment and we recommend that practitioners involved in evaluating FMS adopt this approach.