Thanks for joining us on Not Boring CEs, where we don't think you should be bored to death while getting your Continuing Ed. Keep listening here, then hop over to notboringces.com to get all your online CE credits. Alright, y'all, let's get to learning.

Emily Foxen-Craft, Ph.D., is a pediatric pain psychologist with over 7 years of experience, and the enthusiastic owner of Pediatric Pain and Behavioral Health. She provides treatment to children, teens, and young adults with chronic pain, chronic illness, and anxiety. Common concerns include headaches, digestive symptoms, sports injuries, and stress, but she always personalizes care to help the individual and family learn to manage their symptoms, improve functioning, and develop resilience for life. Dr. Foxen-Craft is a licensed psychologist in the State of Michigan, but is also authorized to provide interjurisdictional telehealth to 40 states through PSYPACT. Prior to launching Pediatric Pain and Behavioral Health, she helped found the University of Michigan's pediatric chronic pain program as a postdoctoral fellow and then as a faculty member in the Departments of Pediatrics and Anesthesiology. She continues to conduct and publish research, and to educate psychology trainees as well as pediatricians in pediatric pain management. Welcome, Emily.

Allison Puryear (she/her): Welcome back to Not Boring CEs. I'm here with Emily Foxen-Craft, and today we are talking about pain psychology across the lifespan. If you haven't caught any of Emily's other CEs with us, definitely check those out

Allison Puryear (she/her): and today we're just talking about how I mean, this is, it's not something that just happens, in older age, or middle age or childhood like

Allison Puryear (she/her): we experience pain as a group of people the whole way through this journey. So I'm excited to talk to you about it and learn some more. So where should we start? Should we go? Chronologically?

Emily Foxen-Craft: Sure. Yeah. Well, thank you for having me, and thanks to anybody who's listening in and taking an interest in this subject, and I think it is interesting to think about, first of all, what is similar? What do we kind of what are some universal principles? And I think that word universals just a great place to start like you were saying, pain is a

Emily Foxen-Craft: pretty ubiquitous, universal experience. With the rare exception of some individuals who maybe have some very, very rare genetic abnormalities. We all experience pain, and you know, scientists and researchers debate exactly when that transition starts. But it is in the prenatal period that's pretty universally accepted. And most certainly, you know, early, or from early on on birth

to our to to. Throughout our development. Throughout our lives we all do experience pain, we experience pain acutely, and we all have the capability of experiencing chronic forms of pain. And so that universality, I think, is just an important principle to start with. And to think about, you know the whole lifespan adults in pain often report that their pain started in childhood. So again, considering the individual and their whole lives.

Emily Foxen-Craft: Also, considering that all pain that we all experience, whether it's acute or chronic, is bio/psycho/social in nature. That's part of the definition of pain. Pain, whether it's acute or chronic, has biological components, psychological components, social components that's really hard to disentangle. What's what? Because they all relate in in our dynamic.

Emily Foxen-Craft: all pain hinges on communication. It hinges on communication between the brain and the body, for the pain, experience, and it hinges on our ability to communicate and express that to others and for others to and to appreciate how the unique individual communicates as people

Emily Foxen-Craft: regardless of age cause, I think we often focus on early childhood being a core part of development. But we're all developing throughout our lives. There's constant change to growth and decline constantly throughout our lifespan and then sometimes thinking about less about age and more about the individual and their comorbidity. So there's some

Emily Foxen-Craft: some literature that really suggests that what actually makes a bigger difference in predicting pain and pain related outcomes is less about the age of the individual and more about what they have going on in their lives. Is there a lot the degree of psychological distress, the degree of sleep impairments, other health conditions might impact somebody a lot more than exactly their chronological age. So I really liked this axiom of

Emily Foxen-Craft: focusing on the individual in pain, not the pain in the individual. I did not write that, but I think it's really well well worth remembering.

But then we can start to think about the differences and what might be unique about each stage. And I think we, before again we get into the word stage. really taking a moment and taking a pause. And we're recognizing that ages, you know, and age and development is along the continuum. Although I specialize in pediatrics, we are constantly redefining what the age pediatrics really is.

And when you think about that age range, whether you can cut it off strictly at 18, or maybe more, a developmental stage that might end in, you know. Maybe in young adulthood or early twenties. That is a large age range and a large developmental, psychological, social, biological change. Can you think about a 17 11 month year old, and what they have in common with an infant

Emily Foxen-Craft: There's a big range there. And even in adult care there might be a lot of differences, biologically, psychologically, socially, between a 21 year old and an almost 60 year old.

Emily Foxen-Craft: So again, a lot of differences, and especially that cut off for geriatrics kind of can seem artificial when you compare 65 year old, 1 one month old to a 64 year old, 11 month old. Not a lot of changes that you might think about there. So I think you know, the field is moving more to considering the life span, and I've been really excited as a pediatric specialist to be able to partner

Allison Puryear (she/her): with clinicians and researchers who do work more with different populations to be able to think about. You know people along a continuum and along the course of the trajectory of their lives.

Allison Puryear (she/her): Oh, I have so many questions. Maybe we'll get into it more because you'll probably answer a lot of them as we go. but I'm just thinking about like differences within and differences without, like just how the experience of pain or illness across the lifespan is probably very similar in many ways, but also very different.

Allison Puryear (she/her): so I'm just thinking about those dynamics. I'm also thinking about identity, like

Allison Puryear (she/her): identifying as someone with a disability, for instance, or identifying like there's

Allison Puryear (she/her): a real beauty and acceptance with that in many cases, and to find community and to ask for what you need. And then there's also difficulty for some people in

over identifying with diagnoses or struggles that they have. So I'm also very interested in what that looks like across the lifespan.

Allison Puryear (she/her): If there are peak times for that versus not so basically like. just talk. Tell me everything

Emily Foxen-Craft: very much, I think. Yeah, you're right. No matter. The age is constant interplay between accepting and appreciate what's going on with your life, but also looking forward to change and growth and continued development. And that's a constant interplay. But you can imagine the duration that somebody may have been experiencing their pain or their illness might factor in. So I get the privilege of working with kids, and I think one of the fun things about working with kids is that there is

Emily Foxen-Craft: this appreciation for change and growth and resilience. And you know, I can kind of accept the way my life is right now. Maybe it's a little easier, because, you know, even if some bit a teenager has often they report they've been experiencing pain for many years. It is maybe and it's a large portion of their lives. Maybe it is a little less in duration than an adult who may be experiencing something for decades.

And then there's this, you know, this willingness to try new things and grow where somebody who maybe have has experienced something for decades, or has formed an identity around somebody with an illness

Emily Foxen-Craft: or condition, maybe in some ways

Emily Foxen-Craft: a little bit more resistant or hesitant about change for various understandable reasons. So I think that is, is constant interplay. But some of these concepts, of acceptance and commitment are a little abstract, but I think and so you know, the

Emily Foxen-Craft: tendency in the past has been to save, ACT, basically, or ACT-based treatments for later teens or adulthood. But I think there is some really exciting work being done to adapt it to the mindset and reality of younger children, and just recognize that maybe it looks a little different, or though our language looks a little different.

but we can use the 6 view, those experiential learning techniques and those concepts in younger children to help them grow and develop. So I really, I'm appreciative of the people putting a lot of stock and work into that

Allison Puryear (she/her): about kids. We start to think about these differences and changes that occur in the lifespan. Let's think about what childhood and pediatric development often often involves. And then we can start to think about. Well, how might that affect pain, or how that that affect pain, expression, pain, experience, and pain? Related disability.

So early childhood, you know, thinking little kids, infants, toddlers, preschool age all the way through. Early elementary is really marked by, as we know, rapid brain growth, rapid learning, growing abilities to communicate and express and regulate behavior. And you can imagine, and all of those start to play in to how somebody experiences, expresses and manages

pain. And so all of those factors have to be taken into account when you're starting to assess and treat

Emily Foxen-Craft: we as as people. We typically start to develop our ability to inhibit pain signals for our brain, to send signals back down to our body, to reduce pain signals starts at about one month old. So that's

Emily Foxen-Craft: yeah. So I mean, we have a month where you know, I think we need. We. We need to protect our little babies. But we start to develop these self regulation processes one month into life, which I think is just remarkable, and those continue to develop and grow. Whereas we kind of start to think about middle childhood, early, early adolescent. This is when our nervous system is beginning to mature a little bit more.

Emily Foxen-Craft: It looks quite different than early earlier childhood. There's obviously starts to become pre-pubertal and pubertal factors
. And then

Emily Foxen-Craft: complex social change. That, I think, is just, you know, for those of us who are step removed from that we're starting to appreciate how rapidly things really seem to be for the younger generations. And so.

Emily Foxen-Craft: because of some of these changes, we do see some differences in how pain is experienced or diagnosed. So some conditions seem to be more prominent in pediatric populations, and they, the chronic pain conditions, tend to onset a little bit more in that middle childhood or early adolescence, or in adolescence or so. Some of those factors that I just described really seem to factor in, although I think the challenges with communicating pain, or maybe part of what

Emily Foxen-Craft: challenges clinicians and parents, and working with younger children, and and appreciating that these things might be going on but it is more rare because of some of the development of the nervous system that's still happening, but is so in in middle childhood adolescence, we start to see

Emily Foxen-Craft: you know, more common pain, present chronic pain presentations and the most common ones that typically are reported are headache and migraine conditions, abdominal pain conditions and muscular, widespread, muscular skeletal pain conditions so pain, primary or pain conditions that are occurring in different parts of the body.

Emily Foxen-Craft: So one thing that we start to see is, you know, CRPS or complex regional pain syndrome, which is some widely thought to be a neuropathic pain condition having to do with nervous system dysregulation and or damage and

Emily Foxen-Craft: that really, that can only happen as is when those nervous system reaches a certain stage of development. So we typically only see that beginning around 8 to 10 years old on average, and migraine conditions may also look a little different in pediatrics. So we commonly think of headaches and migraines or migraines specifically in adults as being

Emily Foxen-Craft: very stereotypic. They look a certain way very very consistently. They're usually in one part of the hat on one side. And they have you know, pretty set. An individual might have a pretty set pattern to what they look like and how they feel, and what kind of symptoms they get.

Emily Foxen-Craft: But in pediatrics it's not so clear cut all the time they're described as more and rather than stereotypic, they're more protein. I may have mispronounced that word but they may not be unilateral. They may be bilateral. The symptoms and the qualities can vary from time to time. And they also might present with more abdominal, focused features, more digestive symptoms or pain in the stomach. In addition to, or maybe

more prominent than, any sort of headache pain. And so we can see that there's these 3 categories of conditions that are more prominent in pediatrics.

Emily Foxen-Craft: but and exactly how they present might be a little different, and they might be related to some of these changes that are are occurring, and in their lives, biologically, psychologically, and socially. And so, considering where a child is at is really crucial, in their, you know, ecological context and their development over time is really crucial for being able to assess and treat a child or

Emily Foxen-Craft: teenager or young adult. Yeah, absolutely. I think about like

Allison Puryear (she/her): the I'm thinking about from a parent perspective, how they don't always know, because kids don't always know how to communicate right. I think I shared in. Maybe your talk about headaches and that my daughter had had migraines.

and we had no idea she was having migraines. She was just throwing up a lot so we thought it was maybe her medication. And it wasn't until her neurologist was like, Oh, no, this these are migraines. Then we are like, Oh, my gosh! Because I didn't know a child that Young could get migraines, and she certainly didn't know how to describe it. She was 6

Allison Puryear (she/her): and so just the we're all doing the best we can as parents, and we are going to miss things.

Allison Puryear (she/her): And also we're all doing the best we can as clinicians. When we hear clients talk about like I have stomach issues a lot. We may immediately think of anxiety. We may, you know, talk to the parents about what's like. Is your child eating enough? Are they drinking water like some of the basic self care things? But there may be something else going on that we just miss, because it's not our wheelhouse like, it's your wheelhouse.

Allison Puryear (she/her): So yeah, well, we all you all have our lens and our way of looking at things. And we have to just recognize that's part of life. We can do our best to overcome that and educate ourselves to have a wider lens. But we're all gonna view things at least initially, through our lens of our expertise or experience.

Emily Foxen-Craft: So I think that's completely a normal experience. And I just wanna help any parents or clinicians listening in to, you know. Take a deep breath. It's okay. You don't have to be hyper, vigilant and focusing and searching for all these possibilities because that also could be counter productive. So it's about, you know, educating ourselves, appreciating that these things do happen in childhood and and pediatrics. I think the typically the bias

culturally is to not appreciate these things are going on or not to be aware or not to consider this as one of the concerns that could be going on with a child. I think a lot of people

consciously or unconsciously.

Emily Foxen-Craft: Don't think chronic pain, childhood, recurrent pain or pain, kind of being a concern. And so I think you know, just appreciating that this could be something that's going on for a child that you're working with, or could have been happening for an adult that you're working with since their childhood, that maybe didn't get properly assessed or diagnosed or treated. I think, is a a great place to start, at least.

Allison Puryear (she/her): Do we find, like in the research, the things that a child struggles with in childhood. Whether or not it's addressed, is it typically the same kind of complaints or symptoms in adulthood?

Emily Foxen-Craft: This field is really in its infancy. And so it's challenged because we don't have decades long, longitudinal data to really go back to. So the best data that we have available really takes one or 2 lenses. One is.

Emily Foxen-Craft: you know, retrospective recall asking adults with chronic conditions to ask what they may have experienced in their childhood, and that has it's benefits and flaws, of course, and then, prospective of doing the shorter term longitudinal studies, tracking children or teens into at least their early adulthood, and trying to, you know, figure out what matches on

and so the data is still early and mixed, as you might expect. If you look at the retrospective recall. Again, a few studies have started to look into this maybe as part of their protocols, but maybe not the main focus

Allison Puryear (she/her): and they do find that about one third of adults who are reporting chronic pain report that they did have some sort of chronic pain in their childhood.

Emily Foxen-Craft: whether it resolved for a period, and then showed up again later is a question, I think, still TBD and then but they do also track children or young adults with these conditions and track them into, you know, a few years later some studies have shown recurrence or chronification of certain conditions.

Emily Foxen-Craft: Some have shown that maybe the symptoms show up differently, or there, you know, there may be more likely to have different things in the future. So one study tracked children and teens with abdominal concerns into later and somewhat later in life, somewhat later in life. And they did find that although there wasn't a super high degree of correlation of GI concerns or abdominal concerns in that period. They did have

Emily Foxen-Craft: a higher, those children who did experience those in childhood. Did it have a higher incidence of things like anxiety? You know, it's still in its infancy. We're still kind of figuring out what maps onto what but it is, I think, a reasonable assumption to think about. Maybe somebody has a vulnerability to an illness or pain that has these concomitant

Emily Foxen-Craft: comorbid concerns. Often that are II say, Comorbid, not exactly because it's all intertwined. It's all one thing. It's not these 2 separate things that are just co-occurring in a vacuum.

Emily Foxen-Craft: But maybe you know, somebody a child might experience one kind of pain presentation or psychological presentation in childhood, and then that may show up a little bit differently in adulthood. But again, you throw in the opportunity for treatment into that mix.

If we can treat them, does or provide effective treatment. Does that change the course? This is that change the trajectory of what we see later in life. And that is what I love to do about this field is, I really believe, strongly, although the again, the data is in its infancy that by intervening and promoting healthy, adaptive coping earlier in life, maybe

Allison Puryear (she/her): symptoms show up, you know. Still, things show up later in life. We can't control everything about our genetics or environment or biology. But can we at least change the trajectory of how somebody will experience those symptoms, how they might show up and how they're like, they cope and and manage. Hmm! Got it. So I'm wondering. Is there a correlation at any point in the lifespan between

Allison Puryear (she/her): psychosocial side of things and the physical symptoms like, I think, about like anxiety and tummy troubles. Right?

Allison Puryear (she/her): I feel like that's in the Zeitgeist like, I'm seeing memes about this all the time. Now, right?

Allison Puryear (she/her): is there actually, data correlating like people with these kinds of physical symptoms may be experiencing these kind of emotional or social symptoms

Emily Foxen-Craft: like later in life, or at any point like

Allison Puryear (she/her): you know, 44 year old, with tummy troubles, maybe dealing with anxiety 8 year old, with headaches dealing with

Emily Foxen-Craft: I don't know what depression or making stuff up. Yeah, no, I think those are great questions. There is, you know, there's a lot of research looking at kind of what goes with what at least you know. Cross section right? In a given person at a given time, you know. And we do find a lot of comorbidity or correlation between

chronic pain and health concerns and internalizing symptoms a lot of the time. So anxiety, depression seem to go hand in hand.

Emily Foxen-Craft: there's a lot of questions about chicken or egg, you know what came first, and I think for a lot of people that might vary the temporal chronology of what started and what was a result? For some people they describe

Emily Foxen-Craft: that one led to the other, or one kind of onset it before the other, and at the same time it could be that they're both manifestations of the same central holistic process that's going on in the brain and body but just one showed up before the other, so it could be one spot, the other it could be. They're all unified by central mechanism.

Emily Foxen-Craft: That or process is going on. So and that kind of goes back to, you know the artificial separation between the psychological symptoms and the physical symptoms. But some people do describe very clearly that you know most. Their anxiety, or most of their low mood, is connected with their experiences of their chronic pain or illness.

But there's also data that show us that you know, people who are anxious or depressed, or sleep problems or very stressed that makes them vulnerable for experiencing pain after stress or like surgery.

Allison Puryear (she/her): So I think, is it is very dynamic. And there's probably a lot of you know the idea of like equifinality or multi finality. A lot of ways of getting to the same place. That somebody might show up in your clinic or in a research study with these separate, with the seemingly separate but together processes going on absolutely. Yeah. Okay.

Allison Puryear (she/her): So we've talked a good bit about kids.

Allison Puryear (she/her): Which includes adolescence.

Allison Puryear (she/her): let's move into like some of what we see in adulthood.

Emily Foxen-Craft: Maybe earlier, like earlier up in adulthood up until that random line of now you're

Emily Foxen-Craft: no, you're elderly. Yeah, that's a large swath of life. And I think we typically

Emily Foxen-Craft: typically, think of it as kind of like a homeostatic stage, and maybe this stage of life is characterized, but somewhat relative stability. I think, when you at least compare it to early childhood and all the development and changes that are going on. And then what might be going on in somebody's

Emily Foxen-Craft: older years, post retirement, or whatever. So I think it's marked by somewhat stability. But I think it's important to remember a lot could be going on. But maybe if sometimes it feels like everything's happening at the same time, or maybe it sometimes at least, feels like, you know, these things are happening in some sort of sequence. But things that can happen in adulthood that might affect or might affect presentation of pain or experience.

Emily Foxen-Craft: experience of pain, once it's already happening, are things like injuries. Pregnancy, life changes, work changes, family and relationship changes. All of that is kind of constantly unfolding and role changes and someone's life. And so all of that could certainly

Emily Foxen-Craft: affect things. There was one interesting study that I was reading through, and showed that kind of this mid what they described as middle adulthood. So kind of mid-forties to mid-sixties before again that artificial cut off of of older adulthood and they found that at this age range there was a higher degree of association. They didn't find any major changes with

Emily Foxen-Craft: actual pain, sensitivity, or pain, or sorry. Excuse me, pain, intensity, the, you know, the intensity or severity which people experience pain, but they did find a higher association between the emotional response to the pain and the pain related. Behaviors.

So that could be anything from grimacing and guarding to changing your life related to your pain. And the authors hypothesized. They didn't measure this directly, but they said that it could be generous. Generational changes. Excuse me, because again, we're looking at one snapshot in life. We haven't replicated this across the centuries.

Emily Foxen-Craft: but also they really focused on the idea that you know the cognitive changes. That might be occurring. And by cognitive I don't mean things like memory and attention, but

Emily Foxen-Craft: kind of our interpretation of of pain. And so you might imagine that somebody who is entering this what they described as middle adulthood might have a more difficult time accepting their aches and pains as age related and typical, whereas somebody who might be in their older years might be ex more accepting of their pain, and might be attributing it. So it's it's this attribution

Emily Foxen-Craft: or interpretation attributing it to expected age-related changes. It's also important to recognize that depression is highest in this middle adult age group. And when at least when it comes to primary care presentation. So I think it is interesting to think about. You know how we attribute the pain and how we expected. And again, what is going on in someone's life that it might

Emily Foxen-Craft: it might show up. And again, I think, you know, I see this clinically again. I work more with children and teenagers. But I think there it is interesting when W. What we attribute the pain or the signals in our body to really affect, how we respond to it. So one of the things that I've worked on with children and teens in the past is when we start to experience chronic pain. Wherever it shows up.

Emily Foxen-Craft: In the body, we start to become a little bit hyper, vigilant to it, and we start to notice all the little signals and the twinges realistically cause we're looking for for the next big thing that is gonna really be miserable or set us back in some way. But we start to, maybe over generalize, we start to over interpret every signal that's happening. Similarly, we also might start pulling back from activity. And so then, doing those things starts to hurt more.

Emily Foxen-Craft: But when we start to recognize that oh, I'm doing this thing that's harder for me than usual, and maybe I can interpret that as more soreness

Emily Foxen-Craft: versus pain. And I can I learn to appreciate those differences based on what I'm doing in the expected signal or subtle differentiations in how it feels in my body. That, you know, we can respond to different things differently and in a more adaptive way to what is actually going on. And so I think that that is maybe a process that is also unfolding in a different way in

Emily Foxen-Craft: middle. And later adult. Yeah, I'm thinking, too, about as somebody in my forties, middle and later adulthood, like the

Allison Puryear (she/her): Sandwich generation situation. Right? There's there's a different kind of pressure for most of us at this age, where, if we have children, we're taking care of them. If we have aging parents, we're either waiting for a shoe to drop, or we're taking care of them. There's

Emily Foxen-Craft: I like my interpretation honestly, whenever I feel any sort of pain is like, I don't have time for this. And so I can. Yeah, and and just thinking about how

Emily Foxen-Craft: like wanting to be dismissive. But sometimes it's loud, sometimes it's my body being like you need to calm down yourself down. It's this constant tension between listening to our bodies and what it's trying to tell us versus maybe learning

Emily Foxen-Craft: to pay attention to what that signal is actually telling us. And I. So I think, for individuals who are moving into a chronic pain presentation. Again, some of those signals are being over generalized, or some of those signals are starting to to take over right? So it's really that tension of kind of really, you know, assessing where you're at, or as the clinician helping your client assess

Emily Foxen-Craft: where they're at, where these signals are really coming from. But I think you're right in the Sandwich generation. There's so much in in the air, and we're taking care of so many other people.

Emily Foxen-Craft: especially, you know, people who are prone to taking on a caregiver role that it help it. It kind of leaves somebody deep, prioritizing their own self care. I see that. And a lot of parents of children that I'm seeing is that they are sacrificing their sleep, their self care, their stress management to care for everybody else.

Emily Foxen-Craft: But you know the old saying of not pouring from an empty cup certainly applies here, I think, and easier said than done, I would never presume to tell somebody else just to quick fix. You just need to sleep more. Because that that's hardly realistic for many teenagers with a lot of pressure that they have, and even more so maybe parents who are navigating work and caring for both parents and children of their own.

Emily Foxen-Craft: But certainly, just at least you're right, like kind of a wake up. Call to at least say, what are some baby steps we can take. And you know, if if parents are bringing in children

Emily Foxen-Craft: to see me. I really often try to think, okay, what can we take on as a family? What can we do to work on this together, than, rather than me, kind of coming in and fixing your kid, let's be together and try to help everybody. Make these small but sustainable and impactful changes. Hmm, yeah, I like that.

Allison Puryear (she/her): So what else are we seeing in adulthood?

Emily Foxen-Craft: That maybe we didn't see in childhood and adoles adolescents?

Allison Puryear (she/her): Or is it continuation of what we saw in childhood and adolescence?

Emily Foxen-Craft: Sure. So you know, I think we talked about constant processes of growth and decline? But certainly that latter thing is something we are maybe paying attention to more as individuals age. Certainly our cognitive processes. Some of it is sharpened, some of it is honed, our experiences honed our memory. For certain things might be sharper than and our vocabulary and our ability

Emily Foxen-Craft: to self, assess and and self respect, self self. Reflect that being said, you know, there's a lot of changes that are also happening like muscular skeletal changes. Mobility changes. And then, I think, kind of like a cognitive set of kind of being set in our way of doing things.

Emily Foxen-Craft: kind of comes up more in adulthood. So things like, you know, loss of muscle or an aging musculoskeletal system might lead to more prominence of more back pain, hip pain. So you'd asked earlier about will like, does something show up differently or the same as somebody? Grows older. And these are conditions that are technically more common in adult years. But certainly either could

Emily Foxen-Craft: certainly back pain can present in younger years, but maybe could be maybe good, or maybe not. Connected with different experiences that occurred earlier in life. We also start to accumulate diagnoses.

something that's something that you know, children and teenagers start to experience, too. But we start to have multiple muscular skeletal conditions that are maybe starting to interact with one another or inflammatory processes.

Emily Foxen-Craft: So I think that's an appreciation in adulthood. There's kind of multiple systems that might be going on and that really requires just a broader lens or you know, multiple people, kinda at least working together. You know. And I think there, there some advantages we at growing older into our older years we may have developed a lot of psychological reserve and capacity and resilience factors that have helped us get through life and building on those strengths

Emily Foxen-Craft: and those experiences, I think, is a really beautiful thing. That on the flip side, you know, there, there are Chi unique challenges. To this population, and especially as we move into the older years. When we, you know, when people feel like their lives, are kind of slipping away like their routines are changing family changes.

Allison Puryear (she/her): Loss of work, or meaningful employment possible financial strain. Those things can all certainly be affecting children and teenagers and and younger adults, but certainly become more common themes as we kind of move through the lifespan.

Allison Puryear (she/her): I'm wondering about like you'd mentioned earlier in in a primary care setting. It's that.

Allison Puryear (she/her): that you know, forties to sixties. Where depression shows up more. I know I always hear about the oldest population is having more depression, particularly oldest men

Allison Puryear (she/her): like, has that shifted over time? And my data is just old. Or is it more like this is how it shows up in primary care versus. you know, in a psychiatrist office or in you know, a surgery center or whatever.

Emily Foxen-Craft: Yeah, you're right. I think there's a lot of different data out there. So I would. I, you know I've not myself performed a meta analysis and can give you a a a accurate assessment of the state of the data. But I think it is important to recognize, first of all, how maybe different things present at different ages. And I think that's a helpful perspective as a a therapist to have is that different things might be expressed differently. Shown differently. Age, wise, culturally. Certainly. Factors in. We haven't even addressed that yet.

Emily Foxen-Craft: but but also, you know, a lot of

Emily Foxen-Craft: patients or clients who would benefit from seeing geriatric specialists do not have access to that. So they're seeing somebody who's supposed to be.

Emily Foxen-Craft: You know. It's a challenge to be a specialist or be well versed in the entire lifespan. That's trying what we're trying to accomplish today. But certainly, you know, whether it's a primary care physician or a specialist, physician or a therapist. It is really hard to know.

You know all the unique biological, psychological, social challenges and being adept at appreciating, assessing, and treating all of that is really challenging. And there are, unfortunately, not enough geriatric specialists sometimes. So I think that is one challenge is, you know, people getting access to.

Emily Foxen-Craft: and

Allison Puryear (she/her): providers who really appreciate and understand their unique stage in life. Absolutely so like that makes me think about like the role of psychology

Allison Puryear (she/her): and better health interventions across the lifespan. Like

Allison Puryear (she/her): like you said. It's it's a rare person who would be able to address any age of person with the same level of expertise that somebody who specializes in a specific age group around psychology of pain.

Allison Puryear (she/her): you'd also mentioned that accept acceptance and commitment therapy.

Allison Puryear (she/her): Is being kind of modified, some for children at this point, and that it's used a good bit with

Allison Puryear (she/her): adults.

Allison Puryear (she/her): can we talk some more about like health interventions.

for like psychological health interventions that therapists can either just be aware of

Allison Puryear (she/her): or employ themselves, or refer out to a specialist who provides this

Emily Foxen-Craft: great question. So I think the cool thing about the field is that there is, you know, pain, pain, treatment, pain, research has really to a large extent relatively embraced. The role of psychology. And therapy as a primary form of intervention. Certainly you'll definitely encounter people who don't view things that way, whether it's clients or or other providers or researchers, or policy makers.

Emily Foxen-Craft: But I think with the International Association of the study of pain really defining pain within an inherent emotional, psychological component

Emily Foxen-Craft: really promotes the role of psychology in this field. So I'll tell you at least personally, when I went to pain conferences like pain specific conferences, you would usually get a really even mix between you know, medical providers and psychological providers. And that was researchers. So it was really really cool to see. And

I think it's really great as a therapist to build great relationships and serve as a liaison and an advocate for the role of this kind of work across the lifespan. That being said, there's been a proliferation, a boom of studies into all these different various techniques that therapists can use

to help individuals. That re, one of the best well studied treatments is CBT cognitive behavioral therapy. But there's been a lot of research into ACT there's kind of

Emily Foxen-Craft: all these offshoots of CT like ACT, or some people say ACT or a reprocessing therapy and or more trauma informed interventions. There's always different proliferations or different versions of there be. EMDR, has has some research.

Emily Foxen-Craft: you know, and then kind of, you know, more specific or focused interventions, motivational interviewing solutions, solution, focus, therapy, relaxation or mindfulness based stress reduction. All of these have degrees of evidence and research to support them. So I think the cool thing about the field is that it's starting to grow in a way that is focusing on personalization.

Emily Foxen-Craft: What meets the needs of the unique individual. And so going back to the axiom focusing last on pain

Emily Foxen-Craft: and and pain in the individual. Oh, and I need to apply this treatment to just manage that pain, and focusing instead on the individual and pain and what might suit their needs and their capacity and their strengths. The best. I do think strength based re interventions positive psychology is also a really exciting avenue to grow in and can be applied in different ways across the lifespan. I think in the past it's been

Emily Foxen-Craft: a little subservient to the more traditional focus on. Let's just get rid of the negative but rather than focus growth and well being but I think that is is starting to be a little bit more of a focus across the lifespan, and I'm really excited about that particular intervention that can certainly be combined with it doesn't have to be in

Emily Foxen-Craft: in an exclusion to other kinds of interventions or techniques.

So I think there's common principles across these interventions of focusing on controllable aspects of health with behavior change, cognitive emotional processing of symptoms and promotion of functioning.

all of these things kind of come into play with all of these interventions, maybe in slightly nuanced ways, or with slightly different areas of focus. So I think, you know, if you're a therapist treating somebody with chronic pain really focus on that individual. What do you feel like they need? And if it's something that fits within your capacity and your area of expertise

Emily Foxen-Craft: fantastic. You're great fit, if not that. It's something within your zone of proximal development. Is that something that you can learn and get more training on to be able to meet their needs. If the you know something that they need exceeds your your scope of practice, your area, focus

or it. Maybe you're we're trying to work on multiple things. And pain related topics are starting to distract from the other very important work that you're doing. That might, those might be great opportunities to consult with or bring on an additional specialist, or make a referral to, that another specialist to be able to be part of that person's team.

Allison Puryear (she/her): Wonderful.

Allison Puryear (she/her): can we? Can we talk some about like just the bio/psycho/social model of pain? We've mentioned it a few times, and we've talked about it in another CEU. But can we break that down for people?

Emily Foxen-Craft: Sure. So it's it's kinda artificial to break things down, because the idea is that these components are all intertwined. There's great research and articles trying to summarize these concepts. So it's kind of difficult to just break it down, and just, you know, state it really fast, but in my best, and that this will be my best attempt.

Emily Foxen-Craft: so I think most people start with the biological. It's easier to say first. And I think that's where most of our minds go when we think about pain or other health conditions. Biology. I use the word loosely, and that term is loosely applied because it refers to a lot of different mechanisms of pain processing

in the body and brain. It can go from really micro levels to appreciating the neurochemical changes that occur. Or you know that trigger pain or occur with pain or promote pain. All the way up to, you know, larger scale, muscular skeletal systems, or neuro physiological systems that are occurring in the body. So it goes from the really tiny molecular levels

Emily Foxen-Craft: all the way up to larger interactions and processes in the body. So that's the biological. And then you lay around the cognitive or the psycho component that has to do with different things like our interpretation of the signals. It has to do with our brain stability to send those, you know signals down to our body our interpretation of other things going on like stress.

Emily Foxen-Craft: memory formation, identity, formation, all play into pain. And our expectations are attentional focus are just some of the cognitive processes or psychological processes.

Emily Foxen-Craft: That are occurring with pain. Emotional processes. You can maybe lump into that category. And then the social context. You can imagine where you know the relationships people have that communication and and

Emily Foxen-Craft: interactions people have in their immediate or more distal environment certainly play a role in how we experience pain, how we communicate pain, how we manage pain, and how our pain continues to unfold over life. So all of these processes are going on for young children from babies all the way through life.

And I think just keeping a wide lens on all of these things is important for assessment and appreciation and understanding of what's going on. And then being able to advocate and for the role of therapy and psychology and treating and helping manage

Emily Foxen-Craft: and so all of these processes are going on with any sort of presentation of pain. I think it is fair to say that with different presentations of pain, maybe parts of that triad are more emphasized or more prominent or more impactful. But they are all going on all the time. It's really an artificial

Emily Foxen-Craft: dichotomy to say, that's physical pain, that psychological pain you could imagine as a as a hypothetical, let's say my stress is causing pain. I think I don't like that phrase. But let's even imagine that was that had validity, and that was true. It would still operate both on my emotional and psychological level. It's still happening here. But it's also definitely still happening on a biological level. It is still my body

Emily Foxen-Craft: sending signals down to my body. Communicating through nerves activating different peptides tensing different muscles, and that body giving that those signals back up to my brain. Or even if it's just a headache, there's different, you know, it's all occurring locally, but it's still both happening in both directions. And then my social relationships. Imagine, if I'm a child.

Emily Foxen-Craft: my relationship with my parents, how my parents treat me? How they react to the pain? How my school reacts. Or you know any you know any

Emily Foxen-Craft: relationships I have there. All of that is gonna factor in no matter where the process is starting. So certainly that might affect how we address it. But it does not diminish.

Emily Foxen-Craft: All of those different factors be at play and interacting with each other. And so saying, you know, I think the reason I like to bring this up is just to show the role and validity for psychology in any presentation of pain, whether it starts with an injury or start somewhere else. Also the futility, and always doesn't always make sense to search for when it started.

Emily Foxen-Craft: because we're done. What's going on right now? And then. Also, you know, invalidating any sort of pain experience, because there seems to be an emotional component. I think that's very damaging and very harmful. All pain is real, and that's, I think, one of the main reasons I like to go back to this model is all pain is real

Emily Foxen-Craft: and kind of, you know, I think breaking things up or saying, this is this is all psychological, or this is all physical, is both untrue on, on how it's actually operating and very potentially harmful. I yeah, I think about just the phrase like, Oh, it's just anxiety.

Allison Puryear (she/her): right? Like, when you're talking about a physical

Allison Puryear (she/her): something that physically may be resulting from the anxiety. Possibly we never we can't ever know right? It's it's all so tangled up and feeds into one another. But II can't count the number of times I've heard people say it's just anxiety when somebody's talking about

Allison Puryear (she/her): a stomachache or a headache, or something like that that like it does make it feel less valid when you frame it like that. It makes

Allison Puryear (she/her): whoever's experiencing it feel. or even if they're the one saying it feel like it's more their fault somehow.

Versus this idea that, like a physical malady that just comes onto your body, or whatever like, it's not your fault, but anxiety is

Emily Foxen-Craft: yeah, that's like, A messy, sticky piece of this. Yeah, very much. So it's I think the rosy view on that it was. At least we recognize the role of the mind and the body.

Emily Foxen-Craft: You know how they interact and how they and that's great. That means that you know that if your stomach is hurting because you're anxious. maybe there is a rule, for you know, addressing that and saying, Okay, I appreciate. That is what it is, and maybe I'm vulnerable and sensitive in that way. But maybe there are things I can do to manage and move forward with that. But you're right, it is disempowering, it is blaming, it is often, you know, much more harmful than it is beneficial. But I

II would hope that the the true intentions of trying to say that

Emily Foxen-Craft: whether again, whether somebody intended or not. Maybe there is some silver lining to that statement.

Allison Puryear (she/her): I guess. So. I'm an eating disorder therapist and our sessions. We do talk about food and body, but it's certainly not the bulk of what we talk about. Right? So I'm assuming as a pain specialist. You do talk about the pain, but it's not necessarily the bulk of what you're talking about in session the whole time. Is that accurate?

Emily Foxen-Craft: Exactly. It's always that tension I wanna acknowledge and validate the pain. So we are checking in on it occasionally, but more so we're working on skills or ideas or topics. And I'm really trying to hold that dual focus on both managing the pain symptoms, but also functioning and well being so my goal, you know, I try to help people have multiple goals that they're working on and realizing that they're all valid and that we, you know, having multiple ways of measuring success and multiple things to focus on is the best way of having a successful outcome and therapy versus having this one thing that you're so focused on

reducing. I definitely think that's valid to want to do that. But there's probably multiple things that you're focusing on, and certainly there is a risk of being so hyper, vigilant and attentive to your signals. That we're actually being counterproductive and

Emily Foxen-Craft: noticing and experiencing them more. Yeah, absolutely.

Allison Puryear (she/her): I'm thinking of other like, I'm thinking of some clients I've had over the years. Where I like, didn't know

Allison Puryear (she/her): what to do with the pain, and would like work on the feelings around the pain and say the things that they believed, contributed to the pain, you know, in their either social or emotional environments.

Allison Puryear (she/her): so I guess in those kinds of situations they were clients where, like the pain wasn't the thing bringing them in, and so I continued to see them.

Allison Puryear (she/her): But I'm wondering, like I'm trying to think of where that line is where I would have been like this is somebody I definitely need to refer out, just like anecdotally, or like as an example or a story. Can you think of anything that would help somebody

Allison Puryear (she/her): frame their own client population to make sure

Allison Puryear (she/her): they're not doing harm by continuing to see somebody they can't help.

Emily Foxen-Craft: That's absolutely valid. I wanna reach you. There's no high card line that you just have missed no one with you, and I'm about to tell you the secret and up until now it's been all wrong. There's there's no hard line at.

Emily Foxen-Craft: And I think that's both because everybody's an individual. Our clients, but also us as providers. And so, being able to meet people, might be a little bit different. Whether you label yourself as a generalist or a specialist in a different area versus a pain related specialist. Even amongst pain related specialists, there's different kinds of formats of treatment. So

being in private practice I might take on and work with different individuals. Or might consider more intensive. Rehabilitation interdisciplinary programs for people who need that and so certainly, I think we're all using a lens of. Is is this person the right fit for my practice?

Emily Foxen-Craft: And so I think some things that might help you determine that if somebody's presenting to you initially versus sharing or appreciating these experiences as they unfold in treatment a couple of things that might be. Some ways of thinking about it again are just weighing. How much is this symptom interfering with our treatment that we're already doing? If we're in the middle of treatment.

Emily Foxen-Craft: How much is this taking away from what we're able to discuss? And if we're working on different goals, really, that's kind of what we came to work on. And is that okay? Is okay to shift for a while? Or is it feel like it's distracting from something also equally urgent.

Emily Foxen-Craft: is this causing a high level of distress or debility? Those might be reasons to consider concomit concurrent or or, you know, a separate referral

Emily Foxen-Craft: or if it's a concern that you're not sure has been accurately diagnosed. If somebody has not seen a medical provider that might be a good reason to at least encourage that, just to make sure you know what you're dealing with.

And and educate yourself and help, you know. Help make sure somebody is getting the right level of care.

Emily Foxen-Craft: of course, if somebody is

Emily Foxen-Craft: is experiencing some lability or some risk, behaviors related to their pain. Those might be concerns to, you know, elevate the safety plans or

Emily Foxen-Craft: you know, protocols. And you know somebody is self harming suicidal you know you need to be considering what are the appropriate venues to getting that person in a more stable

place, and maybe that first, that means the safety concerns, and then maybe, secondly, that means bringing on a pain related specialist. But I think sometimes we over interpret that too. Not that we over interpret the risk.

Emily Foxen-Craft: But sometimes, when somebody is presenting as you know, really depressed or suicidal, due to their related to their pain. There's often, you know, those depressed cognitions, or those depressed emotions or things that a therapist who's first in treating depression can certainly help with no matter what the

Emily Foxen-Craft: the actual situational factor that's triggering those processes. So I think I wanna both empower anybody who's taking, you know, taking this course to. Really, you know, believe that you have a lot of skills. If you usual any of your skills that are probably helpful for any other conditions that you tend to work with are probably

Emily Foxen-Craft: to a degree really helpful for people with their pain concerns. But like any of us, you know, they're kind of comes a unique point, whether it's something that's coming from the client or something, as you know, limit on your capacity or a dynamic interplay between the 2 that might tell you it's time to refer. So there's no hard and fast rule if it helps. I sometimes like to think about.

Whatever you're tending to work on. Let's say it's eating disorders or anxiety on some sort of continuum. And then the pain related concerns on a different maybe orthogonal continuum

Emily Foxen-Craft: who are able to see I am holding up kind of like a an Xy graph. on my hands. That's my attempt, anyway. And so you might think about where somebody's landing on those related intersecting concerns, and then using that to really help you consider whether somebody might benefit from different kinds of treatments, of course, also asking them, What have
they already done? What have they already done to address or learn more about these conditions. And considering where somebody might be a best fit. So that's a very long way to answer. There's no

Emily Foxen-Craft: simple little line. And then my, my next question is like a can of worms that we probably can't get into too deeply today. But I'm thinking about the interplay of like medical trauma and pain. And I'm curious how often pain specialists end up seeing that dynamic

Allison Puryear (she/her): it seems like most of the data around

Allison Puryear (she/her): like pain. Psychology is mainly like top down, though it did sound like there's some like EMDR and some other things. But thinking about some of those bottom up

Allison Puryear (she/her): treatments for trauma that can be really helpful like, how do you navigate?

Allison Puryear (she/her): Do you need to work on the trauma before the pain? How does? How do you conceptualize that? I'm sure it's individual for clients. But like, how do you think through that

Emily Foxen-Craft: great question? So you're right. There's both bottom up and top down processes that are occurring with pain very parallel to trauma. So there's a lot of parallels mechanistically that we can think of there and then. Certainly

Emily Foxen-Craft: people with pain, often a report that they've experienced trauma, and it could be trauma from their different parts of their lives. There's certainly relationships with aces and pain later, but also medically related. Trauma could be related to experiences. They have had getting assessed or treated for pain in the past. I don't know if I would qualify. I think there's a healthy debate to be had about what qualifies as trauma, how we define it, what kind of scope and lens we use and benefits of keeping more of more broad or narrow scope.

Emily Foxen-Craft: But I think it is helpful to appreciate that a lot of people with pain, especially when it's chronic or recurrent, have experienced some level of stigma, whether it's in their

families or their communities, or amongst medical providers about that pain, especially with certain subsets of diagnoses. So just appreciating that.

Emily Foxen-Craft: you know somebody is coming. If somebody's coming to talk to you about it, you're like, potentially, but likely not their first person that they've talked to about this or or first experience that they've had trying to work on this. So just appreciating that lens, I think, is just goes a long way.

Emily Foxen-Craft: I think the communication that we do around, you know, acknowledging that both processes at bottom up and top down might be occurring. But in terms of how a therapist can help navigate or what to prioritize, you're right. It is gonna be individual. I think the cool work of being done to appreciate the dynamic interplay in day to day. Lives of different symptoms going on for people and different experiences

is still being just, you know, discussed and investigated through cool new tools of evaluation and assessment. And so, for instance, I have done some work using active and ecological momentary assessment to be able to better understand

Emily Foxen-Craft: what's really affecting, what to eventually be able to help people. And there's other kinds of approaches that have been done to try to help clinicians know

Emily Foxen-Craft: what to focus on first.

Emily Foxen-Craft: Another way that, you know, I think I am really excited to see is, you know, really focusing on working with the clients to set their goals

Emily Foxen-Craft: and really appreciate, you know, and using that as really a framework of what to prioritize. One other common things that we sometimes see at or one of the few things that I think have seen pop out in the literature is being a good target to focus on first

or initially, is sleep.

Emily Foxen-Craft: So I think that's something that sometimes people report. Oh, it's my pain interrupting my sleep, and that might be very valid. But, you know, we we all probably can appreciate that. There's a little bit of a bidirectional relationship there. And even if temporally or chronologically, in somebody's history, the pain started before the sleep problems. We do have some data that shows that addressing the sleep

Emily Foxen-Craft: itself.

Emily Foxen-Craft: Can be beneficial at starting a ripple effect, and then making the other interventions that we might be using a little bit more effective. So I think there is some something there to anchor on to. That being said, I think you're right like there's, you know, whether we start in some sort of desensitization process, whether it's sensory desensitization or desensitization to stress signals.

Emily Foxen-Craft: Or, you know, reprocessing pain signals versus doing more. You know, how do we, you know, challenge our thoughts related to stress, or our functioning doing that first, I think to my knowledge.

Emily Foxen-Craft: Still should be based on clinical judgment. Personally, I do find especially working with younger kids. It's easier to start with some of the behavioral techniques. First work up some rapport and some appreciation for some what somebody might be going

through a little bit more before diving into some of the more cognitive processes. That's my that's my clinical inclination.

Allison Puryear (she/her): What else about pain across the lifespan? Are we? Have we not talked about that? You want people to know.

Emily Foxen-Craft: I think you know, we talked about the lifespan, and I think I've alluded to this, but I think I just wanted to make a plug for pediatric focused work out there for any of you who might be working with children or teens or young adults. This is an incredibly potentially powerful population to be working with, to be able to appreciate that there are, that they may be experiencing pain goes a long way, just being able to recognize it and get kids more into treatment.

Emily Foxen-Craft: And then, potentially that treatment. Could. You know, I think there's a really powerful argument to be made of changing the trajectory of people's lives. So we know that chronic pain is an adult in adulthood, nationally, globally, one of the most devastating, financially, economically.

Emily Foxen-Craft: morbid not mortality, but morbidity. Wise amongst adult populations, and certainly amongst kids, can have that impact on an individual family. But we can maybe change the trajectory of individuals lives, and I think, generationally, by by intervening, recognizing, and intervening early. Currently, it takes

Emily Foxen-Craft: many, many individuals who experience chronic pain. It takes them, you know, often years to get into. See a specialist or somebody who is able to treat it from an interdisciplinary perspective. So any work that you're able to do at helping recognize

Emily Foxen-Craft: assess and treat, or for to treatment, I think, goes a long way, no matter what age that you're going that you're working with, and that we, I think the exciting thing is we do have tools that help. No one tool is going to be a perfect magic bullet, at least as of right now. I know that everybody's desperately working on on the new and latest and greatest things, and I think you know, I think it's exciting to see the investment in this work. But there's no one magic bullet and

Emily Foxen-Craft: But the good news is that there's needs that there's a lot of tools at our disposal. To help

Emily Foxen-Craft: and I think we talked a little bit about the bio psycho social model, and recognizing that therapy and psychology is a great and effective and often should be really considered as a first line approach. So I think there's a lot of like, oh, well, of these other things didn't work. Then we start to bring in psychology. But I really encourage people not to think of us as a last resort, but also recognizing that, you know we may not be the only tool for somebody to use. So I think that's also a

Emily Foxen-Craft: a level of stigma where providers or medical providers just send somebody to us, because it's all anxiety, and not recognizing that we really should be continuing to work together. So the more work that you can do if you're working with this population to have great medical partners, or working with the medical provider. Somebody is already working with considering other complementary treatments. Like fiscal therapy or other complementary and alternative treatments.

Emily Foxen-Craft: I wouldn't lump physical therapy in that. But you know, thinking about building your team if it goes along, no matter what age group you're working with

Allison Puryear (she/her): wonderful Emily. Thank you so much for talking with us today. I feel like people can walk away with much better knowledge around

Allison Puryear (she/her): not only pain psychology, but just like how it shows up differently and same throughout the lifespan, so that they can be more aware with their current clients and clients that come in the future. So thank you very much

Emily Foxen-Craft: for having me.

I hope that broadened your clinical horizons! Head over to notboringces.com to get your CE credit. Wanna have a Not Boring conversation with me about your clinical area of expertise? You can apply there, too. If you like this conversation, leave us a five star review, tell a friend, and be sure to subscribe for future conversations.