Psychological Assessment of Patient with Low Back Pain

Why Assess?
- May predict outcome - evidence equivocal
- More importantly, may prevent disaster

Psychological factors critical to outcome
- Multiple studies show correlation with psychological factors and poor outcome in pain
- History of abuse/neglect correlates with poor outcome

Know your patient
- "there is no free lunch"
- George Engel’s “biopsychosocial approach”
- Semi-structured interview
- History - “those who cannot remember the past are condemned to repeat it” (Santayana)

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Mood/Anxiety and pain

- Pain matrix includes sensory and affective components
- Overlap of mood and pain (amygdala, prefrontal cortex, limbic system) now well documented

Chronic Pain and Mood/Anxiety

- Chronic Stress (Pain) predisposes to mood and anxiety disorders
- Activation of Bipolar Diathesis - watch out for TCA's (cyclobenzaprine), steroids
- Major Depression rates high in Chronic Pain

Depression and Physical Symptoms in Primary Care

- 50-70% of patients with MDD present to primary care physicians with physical complaints
- 80% of patients with MDD or anxiety disorder (panic disorder and/or agoraphobia) presented with exclusively physical symptoms

Previous Trauma and Pain

- Multiple studies have shown relationship between physical & sexual abuse & various types of pain
- Correlation of failed low back surgery/chronic low back pain & childhood psychological risk factors:
  - Physical abuse, sexual abuse, emotional neglect, abandonment & chemical dependence

- Linton, SJ. Pain. 73 (1997) 47-53
Screening tests
- MMPI (gold standard?) - hypochondriasis & hysteria relative to depression scales - neg. outcome
- Beck Depression Inventory
- Ham D Inventory
- CAGE inventory

Effectiveness of MMPI
- Not normed in ill population
- Elevations of hysteria and hypochondriasis scales vs depression
- Most misused instrument in pain - contradictory results

Contraindications to Surgery/Interventions
- Active psychosis
- Delusional beliefs re pain
- Actively suicidal/homicidal

Relative Contraindications
- Personality Disorders - Axis 2
- Bipolar Disorder
- Severe depression
- Lack of social support
Cluster B Personality Disorders (Danger)

- Borderline - “you are the best doctor I have ever had”
- Anti-social - charming, history (dishonorable d/c, legal difficulties)
- Histrionic - global cognitive style
- Narcissistic - “what does that have to do with me?”

Risk factors: relative contraindications

- Drug dependence/abuse - smoking
- Unstable relationships
- Poor vocational adjustment
- Neurocognitive deficits

Relative Contraindications

- Inability to participate in active rehabilitation
- Unreasonable expectations of procedure
- Ongoing litigation
- Symptoms inconsistent with pathology

from: Disordered Personalities
Rapid Cycle Press
Negative Predictors

- External locus of control - “just fix me”
- High fear-avoidance - correlates with inability to actively exercise
- Catastrophizing cognitive style - “Henny Penny”

Positive Predictors

- History of adherence to treatment regimen (active)
- Positive support system currently and historically
- Appropriate expectations (educable re such)

Conclusions

- Psychological factors contribute to pain and influence outcome
- There is no simple screening tool
- Therefore, one must know his/her patient
- History repeats

Bibliography

Schofferman & White, ed Stensetting MA Journal of Neuroradiology 2001; Dec;18(12):399-403