CHRONIC PAIN BATTERY REPORT

The Chronic Pain Battery Report is based in part on the analysis and integration of information obtained from the Pain Assessment Questionnaire--Revised (PAQ-R) [1] and the Symptom Checklist 90 (SCL-90) [2]. It assumes the Chronic Pain Battery was completed by a person undergoing evaluation or treatment for chronic non-malignant pain. This report cannot rule out physical disorders. The statements below are not diagnoses nor definitive judgments. They represent a narrative based on the patient's self-report and inferences which can be used to supplement other aspects of a thorough evaluation by clinicians. No decisions should be based solely on the contents of this report. This report is of a personal nature and best understood in the context of a clinical evaluation. Therefore, the content herein is for professional use only, should be kept confidential, and should not be made available to patients or their families.

Patient ID No.: Def-12-345A Date CPB completed: 06/11/08

Report date: 06/30/08 Clinician ID: Abc

REPORT CONFIDENCE

Report confidence appears to be acceptable with no careless, confused nor random responding. This report is developed using an English-speaking non-psychiatric normative population in the U.S. Psychiatric patients will tend to produce somewhat enhanced levels of psychopathology. P's mean level of reported symptomatic distress appears elevated relative to a chronic pain population. P tends to report an above average number of psychologically related symptoms for chronic pain patients. Such a test-taking stance can significantly affect the results of this report, and this bias should be considered when interpreting report results.

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1. PAQ-R is (C) 1980, 1982, 1983-2008 Stephen R. Levitt, MD, PhD and used by permission of the author.
2. SCL-90 is published in Psychopharmacology Bulletin 9, 13-28, 1973

SUMMARY

The following is a brief narrative summary of some important findings in the CPB, as well as a review of the recommendations made in the body of the report. The full text of the CPB Report should always be consulted before acting on any of these statements.

The patient's problem involves head, right jaw joint, neck, lower back, and right hip pain of 1-2 years duration and pain onset was reportedly associated with an accident at work. Present alcohol use is reportedly moderate. Diagnosed illnesses unrelated to pain are present. An above average level of chronic stress is indicated. Overall stress this year has been very high. Pain is associated with psychosocial stressors. Habituating substances are being used for pain control. Medicines are taken on a pain-contingent basis. Illicit drugs have recently been used. P is seeking a pain "cure." P indicates some psychological mindedness regarding pain. P has an external locus of pain control. Low self-esteem is apparent. P experiences anger or hostility. Expressing anger is problematic. Litigation is pending. P's scores indicate depression. Suicidal ideation appears present. Symptomatic anxiety is indicated. Somatization is elevated. P's psychoticism score is elevated. Illness-behaviors are reinforced more than well-behaviors. Overall level of activity is severely affected.

RECOMMENDATION REVIEW

MEDICATIONS

*** Thoroughly assess present drug use and detoxify P from habituating drugs where possible.
*** Change P from pain-contingent to time-contingent medication.
*** Provide P more education regarding medication use.

MEDICAL HISTORY

*** Take a thorough history of all physical illnesses and treatments.
*** Consider a weight reduction program.
*** Evaluate present alcohol use, detoxify P if indicated.
*** Counsel P regarding reduction in caffeine and/or nicotine intake.

PERSONALITY - PAIN COPING STYLE

*** Help P to overcome low self-esteem.
*** P's external locus of control may reduce the effectiveness of self-help approaches.

PATIENT GOALS

*** Clarify unrealistic expectations of pain cure and set realistic goals.

PSYCHOSOCIAL FACTORS

STRESS
*** Evaluate the impact of reported psychosocial stressors on the pain experience.
*** Reduce chronic stress through stress management approaches.
*** Remain alert to detect the early signs of illness associated with recent stress.
PSYCHOLOGIC DYSFUNCTION
*** Provide large amounts of support to counteract P's pessimism.
*** Evaluate carefully for a depressive disorder.
*** Carefully evaluate suicidal risk.
*** Monitor and attempt to reduce hopelessness.
*** Rule out physical illnesses and masked depression, which may account for elevated somatization.
*** Assess physical and psychological causes of anxiety and provide anxiolytic interventions.
*** Attempt to reduce isolation and social alienation.
SUPPORT SYSTEM AND INTERPERSONAL RELATIONSHIPS
*** Help P find suitable expression for anger and hostility.
*** Clarify with P mutual expectations and roles to avoid counter-productive interactions.

BEHAVIORAL - LEARNING FACTORS

*** Evaluate P's prior models for coping with pain and illness.
*** Educate both P and family to better reinforce well-behaviors rather than illness-behaviors.
*** Institute an exercise and activity program based on increasing quotas.

DEMOGRAPHIC AND SOCIAL HISTORY

Patient (P) is a 40 year old married white female with 2 year(s) of college education. P is currently living with spouse and with her children in an urban setting. P is currently working part-time and P's total family income is $20-50,000 per year. Sources of income include work income and spouse's work income. P reports childhood and home life while growing up as fairly unhappy. P describes schoolwork as average. Before the present pain problem work was not very satisfying nor enjoyable. Pain has caused a change in job situation. P reports fair

relationship with spouse.

PAIN HISTORY

Before the present problem, P reports experiencing a prior pain problem. That problem involved lower back pain of 1-2 years duration and pain onset was associated with an accident. P's present problem involves head, right jaw joint, neck, lower back, and right hip pain of 1-2 years duration and pain onset was reportedly associated with an accident at work. Pain is usually experienced as deep and reportedly migrates. P indicates that pain occurs in separate episodes. A pain episode usually lasts hours and pain comes on suddenly with full intensity. P states that during the past two weeks, pain was usually present 100 per cent of the time, and seems to be increasing lately. Pain is described as shooting or spreading, aching or cramping, and stinging or electrical. On a scale of 0-10, where 10 equals "the most pain I could imagine," pain intensity is rated as: Usually 7, Least 4, and Most 10. This is contrasted with the average intensity of other past pain experiences, rated as 2. On a scale of 0-10, where 10 equals "suffering so bad I would kill myself," pain suffering is rated as: Usually 7, Least 4, and Worst 9. Average suffering with other common pain experiences is rated as 1.

PAST TREATMENT

During the past year, P has been seen by 3 physicians, has made 2 trips to the emergency room, and has not been hospitalized for pain. P has had 1 operation and has had 2 nerve blocks for the present pain problem. P does not feel surgery is the only solution to stop the pain. Other treatments have been tried. Reportedly, non-narcotic pain medicines, unspecified medications, cold, physical therapy and exercise, and sexual activity resulted in pain worsening or no relief at all. P indicates that narcotic pain medicines, sleeping pills, anti-depressants, heat, massage, and lying down and resting resulted in some temporary relief.

MEDICATIONS

An exhaustive medication history is always necessary, including names, dosage, frequency and duration of use, results, side effects, and names of all clinicians and pharmacies involved. P acknowledges receiving pain medication from more than one physician at the same time. P indicates using habituating substances in an attempt to control pain. These include narcotic analgesics, sedatives and sleeping pills, and alcohol. P reports that the amount of habituating substances used for pain relief is increasing. P reports often being afraid

to be far from pain medicines. P indicates taking pain medications only after pain worsens. With regard to proper uses, side effects and precautions with present medications, P claims that she understands some but wants to know more.

RECOMMENDATION -- A complete drug history and thorough assessment of present drug use is indicated. The use of narcotic analgesics and other medications where tolerance and physical dependence can develop is usually contraindicated for chronic non-malignant pain syndrome. In fact, detoxification and withdrawal from such drugs often leads to overall improvement in symptoms and level of function.
RECOMMENDATION -- Medication should be used on a "time-contingent" (by-the-clock) rather than a "pain-contingent" (prn) basis. This may decrease reinforcement of pain-behaviors and reduce psychologic dependency.
RECOMMENDATION -- Further education of P regarding medication and treatment is obviously indicated here.

MEDICAL HISTORY

A thorough medical history, review of systems, physical examination, and appropriate lab tests are part of a complete evaluation. P does not report significant psychological problems or serious physical illness in childhood. P indicates other diagnosed illness, not related to pain, and is presently taking medications for illness unrelated to pain. P does not report allergies to certain medications. Current weight is reported as 175 pounds. Preferred weight is 140 pounds. P does not indicate a past history of alcohol abuse, and present use of alcohol is claimed to be moderate. P reports present overall intake of caffeine is heavy and tobacco is none. P admits to recently using illicit drugs. These include marijuana. P does not indicate increasing problems with memory or intellectual abilities.

RECOMMENDATION -- A careful history of all physical illnesses and treatments is indicated here.
RECOMMENDATION -- Based on P’s preferred weight, P may need a weight reduction program, including appropriate exercise and proper nutritional counseling.
RECOMMENDATION -- The frequency and quantity of P’s present alcohol consumption should be closely assessed. Development of tolerance and dependence should be considered and P should be carefully detoxified. The use of alcohol to cope with pain should be discouraged.
RECOMMENDATION -- Caffeine and nicotine in moderate to heavy amounts are both well known significant physiologic stressors, and may lead to habituation, intoxication, or withdrawal states. These stressors can significantly affect pain perception and emotional concomitants. Appropriate counseling is advised here,

with reduction and discontinuation of these substances where possible.

PERSONALITY - PAIN COPING STYLE

P self-identifies a personality style described as quiet, low self-esteem, conscientious, dissatisfied, and dependent. In addition, P's scores indicate a significant amount of obsessive-compulsive thought patterns. P reports difficulty expressing feelings, especially angry ones, to other people. This is often found with chronic pain patients and unexpressed anger is frequently associated with depression. P states there is some possibility that pain might be influenced by stress, emotional tension, or difficult circumstances such as family or work problems. Therefore, P acknowledges some psychologic (as opposed to somatic) perception of the pain experience. P admits to problems in life other than pain. P does not identify as a sickly person with suffering as a way of life. This response is inconsistent with a self-concept of invalidism. However, P's responses indicate experiencing low self-esteem. For example, P is not satisfied to be who she is, P feels inferior to others, and P feels down on herself or inadequate. In addition, there is no indication for possible perception of body image distortion. P's responses imply an external locus of control regarding pain. Concerning evaluation and treatment, P would like to know nothing and would rather leave that to the doctor. Your approach to P should take this attitude and coping style into account. P reportedly has not learned very well how to deal with the pain problem and ability to tolerate pain now is claimed to be fair but less than usual.

RECOMMENDATION -- Helping P alter the way she perceives herself, to counteract low self-esteem or a self-concept of invalidism, can have therapeutic value and alter the pain experience.
RECOMMENDATION -- P apparently believes that pain is either mainly affected by what others do (such as doctors, family, friends, etc.) or is a matter of fate. Patients with an external locus of control often depend on others for their treatment and do less well with such self-help approaches as relaxation exercises and biofeedback.

PATIENT GOALS

P reports presently searching for a pain "cure." P lists goals in working with present doctors in decreasing order of preference as complete pain relief, partial pain relief, increased job activities, increased general activities, improved mood, reduced tension, and reduced use of drugs. If pain cannot be completely eliminated, P states that a 70 per cent reduction in pain would be acceptable.

RECOMMENDATION -- With chronic non-malignant pain, it is important to establish a set of realistic, obtainable goals toward which P can work. Then you should clarify with P unrealistic expectations of "cure." It is often helpful to redefine the problem, not as pain but as "disability" and to pursue a "pain control" approach while P works towards such objectives as increased activity and return to work.

PSYCHOSOCIAL FACTORS

STRESS: Original pain onset was reportedly preceeded by trouble falling or staying asleep, feeling tired or run down, feeling tense or worried, feeling under a lot of stress, and experiencing or anticipating the death of a family member or close friend. Pain intensity presently is perceived to be associated with psychosocial stressors. These include stress or worry, disturbed sleep, certain unspecified situations, and sexual activity. Stress may result from discrete or chronic stressors. Stressful situations or changes encountered or anticipated by P this past year include change or difficulty in job, illness in family, sexual problems, financial problems, and pain. P reports an above average amount of chronic stress based on self-imposed pressures, which would imply an above average tendency to suffer stress related illness. Overall, P describes this past year as very high in stress, thereby implying a very significant probability of developing a serious physical or psychological illness this year.

RECOMMENDATION -- It is important in this patient to carefully assess the relationship of pain to external events and psychologic stress. A primary depression, unresolved grief reaction, and conversion reaction may all present as pain and should be ruled out or diagnosed and treated appropriately.
RECOMMENDATION -- P’s answers imply that P is hard-driving, impatient, and has difficulty relaxing and slowing down. Treatment should include attempts to reduce stress, such as through relaxation exercises and stress management techniques.
RECOMMENDATION -- You should remain alert to detect the early signs of physical or psychological illness associated with significant levels of perceived stress this past year.

PSYCHOLOGIC DYSFUNCTION: P acknowledges having blood relatives with a history of emotional problems. Before pain onset, there is no reported history of psychological dysfunction. Since pain occurred, psychiatric treatment apparently has not been recommended, and P appears motivated to explore emotional issues. Psychometrically, P appears to be experiencing a significant level of overall psychological distress.

DEPRESSION: P states that before pain began, life was usually viewed in a mixed optimistic/pessimistic fashion. Such a pre-

pain view should not have strongly positive or negative effect on P's ability to cope with pain. P's present view of life reportedly is relatively pessimistic. P's scores indicate a significant level of depression. Reportedly, there are prominent vegetative signs including decreased libido, initial insomnia, middle insomnia, terminal insomnia, decreased appetite, and overeating. Suicidal ideation appears present. P does not report a past suicide attempt. P indicates being quite hopeless about the future.

RECOMMENDATION -- Large amounts of support are indicated here to counteract a reportedly pessimistic present attitude that may be associated with a relatively poor prognosis.
RECOMMENDATION -- Depression requires careful evaluation. A primary affective disorder may present as pain. Also, many chronic pain patients experience a reactive depression which is often masked. Depression is associated with decreased pain tolerance. Successful pharmacological treatment of depression often also results in improved sleep, increased pain tolerance with less distress, and sometimes reports of decreased pain intensity as well. Of course, it is always recommended to rule out possible medical etiology for depression, including drug side-effects and undetected medical illness.
RECOMMENDATION -- The presence of suicidal ideation requires very thorough evaluation, especially for the level of immediate risk.
RECOMMENDATION -- The presence of hopelessness requires careful clinical evaluation, as it often correlates both with depression and suicidal risk.

SOMATIZATION: P's scores indicate a significant amount of distress from perception of bodily dysfunction. P does not fear or believe that she has a serious disease that doctors have not found.

RECOMMENDATION -- P's elevated somatization score can be related to a number of causes, including stress, anxiety, depression, or physical illness. Remember to evaluate for a masked depression which may present as somatic symptoms with vegetative signs such as sleep or appetite disturbance, without complaint of depressed mood. P's responses imply a tendency to react to psychological stress through physical symptoms. However, a variety of physical disorders, if present, can produce false positive elevations on this scale, and need to be ruled out.

ANXIETY: P's scores indicate a significant level of anxiety. P reports an average pre-pain level of concern and fears about health, symptoms of illness, and pain. This would imply an average ability to cope with pain. P's reported attitude would predict neither strongly stoical nor hypochondriacal trends.

RECOMMENDATION -- There are numerous possible causes for symptomatic levels of anxiety, both physical and psychological.

Anxiety may also be an appropriate response to certain life situations, rather than signal a pathological anxiety disorder. It is important to rule out an organic etiology, including a variety of medical disorders, medication side-effects, and drug withdrawal reactions. Anxiety may also signal failing psychologic defenses and requires careful evaluation. Elevated anxiety is often associated with increased pain perception. Therefore anxiolytic interventions (pharmacological, behavioral, psychological) may reduce distress and allow more adaptive coping strategies.

THOUGHT DISORDER: P's scores do not indicate a significant level of projective thought and suspiciousness. In addition, there is a borderline significant indication for psychoticism.

RECOMMENDATION -- P does not report some first-ranked symptoms of schizophrenia requiring further psychiatric evaluation. P's elevated psychoticism score also reflects isolation and social alienation, commonly experienced by chronic pain patients. Attempts to remedy this situation should prove helpful.

SUPPORT SYSTEM AND INTERPERSONAL RELATIONSHIPS: Support system can have a major impact on coping and outcome. When pain increases, P's reported ability to accept help from others is that P accepts it but does not like it. P perceives an above average amount of family or social support and concern, which is an above average prognostic sign. Note that although an adequate support system is important, caring others often unwittingly reinforce chronic pain behaviors through excessive sympathy and attention. P's scores indicate that feelings of personal inadequacy, discomfort in interpersonal interactions, and negative expectations of others are borderline apparent. In addition, P's scores indicate a significant level of hostility.

RECOMMENDATION -- Although not an easy task, it is often therapeutic to help a patient vent anger and frustration. In particular, these emotions often concern experiences with other health professionals. This may be an important step in forming a therapeutic alliance with P. In addition, one view of depression is that it represents anger turned in on the self.

RELATIONSHIP WITH HEALTH PROVIDERS: P reportedly does not feel she is taken seriously by doctors. In the past, P felt doctors or other health professionals were somewhat unsympathetic. P indicates being uncertain about getting help from you.

RECOMMENDATION -- Patients who do not believe they are taken seriously by health providers are often found to engage in counter-productive "pain game" transactions and behaviors. A health provider can also unwittingly participate in such interactions. Clarification of patient and health provider roles and expectations may be helpful here.

BEHAVIORAL - LEARNING FACTORS

PRIOR MODELS: P reports awareness of significant others who have experienced pain problems and therefore might serve as prior models for pain.

RECOMMENDATION -- A patient's perception of and reaction to pain is often influenced by exposure to pain experiences in significant others or in themselves during earlier development. One dramatic example of this is an unresolved grief reaction, presenting as pain. Thorough evaluation of the relationship of P's perceived pain to prior models may lead to a better understanding of and a more specific treatment approach in this patient.

LITIGATION - COMPENSATION: P has or plans to have an attorney helping with a lawsuit, compensation, or disability determination related to the pain problem. P is not presently nor will be in the future receiving income which would stop if P's pain problem were resolved (Example: Disability payments, workmen's compensation, lawsuits, etc.) P's income is now 50-75 per cent of pre-pain income.

ILLNESS BEHAVIOR REINFORCEMENT: P feels that without verbalizing it, others often know that pain is present. Therefore, P's perceptions appear consistent with a tendency to utilize non-verbal pain communications. In the presence of worsening pain, those around P appear to respond by producing a greater number of reinforcers of illness behavior as opposed to well-behavior. P's family reportedly has drawn closer together to help cope with pain.

RECOMMENDATION -- The behaviors associated with pain, once present for months or longer, become influenced by learning and environmental reinforcement. The natural responses to someone with acute pain (such as providing sympathy, attention, rest and relief from responsibilities) are contraindicated in chronic non-malignant pain. These responses often reinforce illness behavior and provide secondary gain. Re-education of both patient and family is an important aspect of chronic pain management, with a goal of reinforcing "well" versus "illness" behaviors through behavioral changes.

ACTIVITY: On a typical twelve hour day (for example, 8:00 am - 8:00 pm) during the past two weeks, P indicates carrying on normal pre-pain activities for 4 hours. P reports sitting for 3 hours and lying down for 3 hours because of pain. P reports sitting or lying down for 2 hours for reasons such as fatigue, depression, etc. P claims pain has severely affected overall activity level. P tries to work or be active until reaching maximum pain tolerance before stopping.

RECOMMENDATION -- If not medically contraindicated, a slowly progressive exercise and activity program with P working toward increasing "quotas" below pain tolerance should be implemented. This will help provide a series of "success experiences" which will behaviorally reinforce well-behaviors rather than illness-behaviors. Working or exercising to quotas, followed by rest, makes rest (a positive reinforcer) contingent on quotas rather than on pain.

PATIENT PROBLEM RATINGS

The following represent P's identification of various problem areas. These may be compared with the inferences made earlier in this report, and thereby help elucidate P's perception of difficulties and style of reporting. Such voluntarily identified problems are often a useful focus for further evaluation and management-treatment approaches.

0	1	2	3
no problem	mild problem	moderate problem	extreme problem

	During the year before pain began	Presently	
A)	1	3	Work
B)	1	1	Family
C)	1	2	Marriage
D)	0	2	Sex
E)	1	2	Personality-Emotional (depression, anxiety, etc.)
F)	0	1	Social Relationships (friends)
G)	0	2	Social Activities (parties, clubs, church, etc.)
H)	1	3	General Activity Level (walking, bending, etc.)
I)	0	2	Hobbies and Recreation (bowling, fishing, etc.)
J)	1	3	Financial
K)	0	1	Alcohol/Drug Use
L)	1	2	Physical Health
M)	1	2	Self-Esteem (feeling down on yourself)
N)	0	1	Suicidal Impulses
O)	1	3	Feeling in Control of Your Life
P)	0	1	Support System (getting adequate help from those around you)
Q)	0	2	Health Care (doctors, nurses, etc.)
R)	1	3	Difficulty Relaxing and Feeling Under Stress

* indicates "no response"

Patient ID No. def-12-345A