A Protocol for the medico-psychosocial evaluation of patients with chronic pain

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A protocol is presented for the full medico-psychosocial evaluation of patients with chronic benign pain. Complete history taking is often difficult with these patients. However, this can be accomplished with a combined approach by an anaesthetist and a psychiatrist following a structured interview pattern which respects the patient's attitude towards psychological factors. The specific format of this interview is described.

Key words

PAIN: chronic, assessment protocol.

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The essential need for psychological evaluation in the assessment of patients with chronic pain has been recognized by many authors.[1-4] However, just how this evaluation should or can be done seems to depend upon how various authors have conceived the role of psychological and emotional factors in the production and maintenance of pain perception. For instance, Sternbach[3] suggests that the emotional symptomatology presented may be secondary to the physical pain state. Others have approached the problem purely from the psychological or psychiatric perspective and describe most symptoms in psychological terms.[5] More recently there has been an emphasis on the inter-relation of these two components, the psyche and the soma.[6-8] However, attention has generally focused upon the behavioural aspects[4,9] since these are more readily and objectively observed and do not require the cooperation or agreement of the patient.

Indeed Fordyce[4] has relied upon psychological tests and the physical examination in assessing patients with chronic pain and has not used the psychological or developmental history for this purpose. He states that it is "hard to get a handle on the actual psychological processes." Consistent with this difficulty, most reports in the literature have described psychological functioning by means of psychological tests. This is an acknowledgement of the importance of assessing psychological function as well as an admission to the difficulty of doing so clinically.

We, on the other hand, believe that there is a need to understand the developmental processes in the evolution of chronic pain. In particular, we emphasize the need to understand the relationship between the emotional and physical aspects of the pain. However, we are also confronted with the generally acknowledged fact that these patients do not readily

accept psychological interventions or interpretations.[10] Indeed the experience of many clinicians working in this field has been that these patients reject referrals to psychiatry, and that the conventional psychiatric approach is usually non-contributory.[10] One solution to this problem has been for an anaesthetist and a psychiatrist to take the history together.[11] It is this approach which we have followed in the Pain Management Unit.[12] We share the history taking and are both present at the physical examination. Afterwards, we discuss our findings, attempt to synthesize a diagnostic profile and then jointly present our treatment proposal to the patient. We use classical history taking techniques[13] and in this context, we are able to trace the development of the pain. Gradually, a consistant pattern of history taking has evolved. We accept the patient's presentation of his problems in his own terms, whatever they may be (i.e., we accept the contract that the physical pain is the only important aspect). The terms used by the patients to describe their problems are nearly always physical. Consequently, we proceed with this understanding to a full evaluation of the patient's medical and life history, always remaining within the context of how this relates to the patient's pain problem. It seems that this is an acceptable format in which the patient may express otherwise difficult concepts and feelings.

We would like to submit this protocol in a condensed but complete form for use as it is, or as a model from which others may make further advances. In actual practice, the protocol occupies 12 pages. The patient's history is transcribed directly by hand onto the protocol. Only the diagnostic profile, the summary and the treatment program at the end are typed, copies of which may be used as a consultation report. The summary is used as a reminder during subsequent visits, with the detailed history always available to refresh our memories on specific points, or for research data processing of particular characteristics of pain patients. We have reported an example of this use.[14]

The actual questions used are familiar to all physicians, but we believe it is the sequential evaluation and progress which is important. For instance, at item Number 22, the first association of the physical and psychological enquiry occurs. Questions 25 and 26 give insight into the patient's present emotional state and may be accompanied by an emotional response. The behavioural responses to the pain are evaluated by Questions 29 to 32 and these seem to be readily accepted, perhaps due to their direct relationship to pain. Questions 35 and 36 relate to possible pain models, and as well often yield helpful information and seem to be easily accepted by the patient. Similarly, Questions 37 to 41 are accepted in the context of the ordinary medical enquiry and the psychological aspects are usually answered, albeit sometimes with difficulty because the patient may lack the words to describe their character.[15–17] This leads to Questions 42 and 43 which are mainly psychological but by this time the majority of patients appear to feel comfortable with the more psychological emphasis. Although if there is to be a protest it is usually at this point, but usually it is no more than a mild protest and a simple explanation indicating the necessity for completeness seems to suffice in reassuring the patient.

From the moment of first contact with the Pain Management Unit the importance of the presence of the spouse is stressed. Consequently, topics covered in Questions 46 to 49 which deal with the primary relationship are in part anticipated. As can be imagined, this segment may yield significant information.

Questions 51 to 58 concentrate on particular personality characteristics and on the patient's awareness and expression of feelings. Conventional psychiatric examination of mental status is completed with Questions 59 to 70.

The evaluation is completed with a thorough physical examination (section 71 to 92) at which both examiners are present, preserving to the end the physical and psychiatric liason.

It is important to stress that this progression has evolved as one which appears to be acceptable to the majority of patients since in our experience all patients have co-operated in completing the evaluation. When we, or especially when trainees have deviated from the protocol, the history that has been obtained was usually incomplete. Therefore, it is only under unusual circumstances that we do not follow the protocol. (Copies of the full protocol may be obtained by sending a self-addressed envelope to the authors.)

Pain Management Unit, Royal Victoria Hospital, Montreal – Summary of case history protocol

Name,	*Referring Physician,*	*Present at Interview:*
Address,	*Date of interview,*	*Patients,*
Telephone & D.O.B.	*Report sent: Whole/Summary*	*Staff*

Pain History

(1) Presenting symptom and duration
(2) Onset and subsequent course
(3) Pain related investigations

Characteristics of the Pain

(4) Location
(5) Radiation
(6) Patient's word descriptors (eg. throbbing, stabbing)
(7) Temporal quality
(8) Pattern over 24 hours
(9) Long term pattern
(10) Severity rating (0–10)
(11) Deep or superficial
(12) Tenderness (local, remote)
(13) Exacerbating factors (incl. emotional)
(14) Relieving factors (incl. emotional)

Associated Physical Findings related to Pain

(15) Changes in sensation
(16) Muscle weakness (local, general)
(17) Visible and/or autonomic changes
(18) Interference with normal functioning
(19) Pain related medication
(20) Other medication
(21) Attitude to medication

Effects of Pain upon Associated Emotional Characteristics

(22) Sleep disturbance detailed, incl. dreaming
(23) Appetite and weight
(24) Sexual function

Does Pain Make You:
(25) Nervous (anxiety)
(26) Depressed (behaviour)
(27) Other (irritable, anger outbursts, withdrawn, etc.)

(28) Other Pains (eg. headaches, etc. in detail)

Behavioural Patterns and Coping Mechanisms

(29) Home and family (incl. roles)
(30) Social and recreational activity
(31) Work
(32) Monetary support related to pain (W.C.C., Insurance)

Other Medical History

(33) Other medical history
(34) Substance abuse (Drugs, Alc.)

Developmental and Psychosocial History

Possible Pain Models

(35) Childhood pain experiences and family response
(36) Pain symptoms in historically significant others

Family of Origin & Premarital Period

(37) Country of birth & arrival in Canada

Description of, & relationship with:
(38) Mother
(39) Father
(40) Siblings (number)

(41) Parental relationship
(42) Pattern of family emotional interactions
(43) Childhood and adolescence (incl. sexual where approp.)
(44) Educational history
(45) Early & subsequent work history incl. relationship

Present Family

(46) History of marital relationship, incl. sexual
(47) Present age and personality of spouse
(48) Relationship with children
(49) Illness in children
a. Behaviour problems of children

Significant losses

(50) Losses and reaction to them (family, friends, body organs, pets)

Individual Characteristics

(51) Habitual activity pattern (eg. compulsive, overdriven, lethargic)
(52) Dependency/independence pattern
(53) Helping/asking for help pattern

Awareness and expression of feelings:
(54) Anger
(55) Sadness
(56) Guilt (shame)
(57) Love, Happiness
(58) Self esteem

Name,	*Referring Physician,*	*Present at Interview:*
Address,	*Date of interview,*	*Patients,*
Telephone & D.O.B.	*Report sent: Whole/Summary*	*Staff*

Mental and Physical Examination

Mental Status

(59) Behaviour in interview	(65) Psychotic or borderline	(70) Personality profile (excl. clear disorder. hyst., obs/comp., depend., pass/aggr. paranoid, masoch., immat., depress.)
(60) Manifest attitude to pain	(66) Memory	
(61) Psychomotor activity level	(67) Concentration	
(62) Anxiety	(68) Intelligence	
(63) Depression	(69) Present level of psychological self awareness (insight)	
(64) Phobic or obs/comp symptoms		

Physical Examination

(71) General appearance	(73) Impairment: mild, mod. severe, bedridden	
(72) Pain behaviour		

Specific Pain Region (Specify locus, laterality, and stimulus)

(74) Gross observations	(81) Motor; wasting, power	(84) Tender points, trigger points
(75) Hypoaesthesia	(82) Reflexes, deep and superficial	(85) Joints, ROM
(76) Hypoalgesia	(83) Trophic (swelling, atrophy, hair loss, rash, nail & cutaneous changes, sweat pattern, colour)	
(77) Hyperaesthesia		
(78) Hyperalgesia		
(79) Hyperpathia		
(80) Dysaesthesia		

Other Regions and Systems

(86) Head & Neck	(88) Chest	(91) Lower limbs
(87) Upper limbs	(89) Abdomen	(92) Back
	(90) Perineum	

Diagnosis

Physical

(93) Primary	(94) Secondary	(95) Tertiary

Psychophysiological

(96) Psychophysiological

Functional Psychiatric

(97) Primary	(98) Secondary	(99) Tertiary

Summary

(100) Summary

Key Words

(101) Key Words

Management Plan

(102) Consultation	(105) Physiotherapy	(109) Behaviour Modification
(103) Block	(106) Medication	(110) Return Visit
(104) Transcutaneous nerve stimulation	(107) Psychotherapy	(111) Other
	(108) Biofeedback	

Summary of the complete medico psychosocial history and examination. Photocopy of full history is available on request.

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Résumé

On présente ici un protocole sur l'évaluation complète médico-psychosociale des patients présentant un syndrome de douleur chronique. Il est souvent difficile d'obtenir l'histoire complète chez ces malades. Cependant, nous avons trouvé que ceci était possible avec une approche combinée d'un anesthésiste et d'un psychiatre, en suivant un modèle d'entrevue structuré et précis tout en respectant l'attitude du malade envers l'aspect psychologique. Le modèle spécifique de cette entrevue est présenté.