CHRONIC PAIN BATTERY REPORT

The Chronic Pain Battery Report-Patient Version 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 experiencing chronic non-malignant pain. This report cannot rule out physical disorders. The statements below are neither diagnoses nor definitive judgments nor conclusions. They represent a narrative based on the patient's self-report along with inferences and suggestions which can be used to help understand and manage the problem. No decisions should be based solely on the contents of this report. This report is of a personal nature and the content should be kept confidential, with any release soley determined at the discretion of the test taker.

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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 negative indications in areas of psychological function. Patient's average level of reported symptomatic distress is neither high nor low relative to a chronic pain population. Patient tends to report an average number of psychologically related symptoms for chronic pain patients.

Note: This report contains trade secrets. HIPPA exempts trade secret information from manditory release.

1. PAQ-R is Copyright 2014 Pain Resource Center, Inc.
2. SCL-90 is published in Psychopharmacology Bulletin 9, 13-28, 1973

PAIN HISTORY

Before the present problem, Patient reports experiencing a prior pain problem. That problem involved head pain of 6-12 months duration and pain onset was associated with an accident. Patient's present problem involves lower back 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. Patient indicates that pain occurs in separate episodes. A pain episode usually lasts hours and pain comes on suddenly with full intensity. Patient states that during the past two weeks, pain was usually present 90 per cent of the time, and seems to be increasing lately. Pain is described as throbbing or pounding, shooting or spreading, and stabbing or sharp. On a scale of 0-10, where 10 equals "the most pain I could imagine," pain intensity is rated as: Usually 8, Least 4, and Most 10. This is contrasted with the average intensity of other past pain experiences, rated as 1. On a scale of 0-10, where 10 equals "suffering so bad I would kill myself," pain suffering is rated as: Usually 6, Least 3, and Worst 9. Average suffering with other common pain experiences is rated as 0.

PAST TREATMENT

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

MEDICATIONS

Careful consideration of all current medications is always important, including dosage, frequency, results, and side effects. Patient does not acknowledge receiving pain medication from more than one physician at the same time. Patient indicates using habituating substances in an attempt to control pain. These include narcotic analgesics and sedatives and sleeping pills. Patient does not report that the amount of habituating substances used for pain relief is increasing. Patient does not

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

RECOMMENDATION -- The use of narcotic analgesics and other medications where tolerance and physical dependence can develop is often contraindicated for chronic non-malignant pain. In fact, detoxification and withdrawal from such drugs often leads to overall improvement in symptoms and level of function.
RECOMMENDATION -- Medication used on a "time-contingent" (by-the-clock) rather than a "pain-contingent" (prn or 'as needed') basis may decrease reinforcement of pain-related behaviors and reduce psychologic dependency.
RECOMMENDATION -- Obtaining further education regarding medication and treatment is indicated.

MEDICAL HISTORY

A thorough medical history, review of systems, physical examination, and appropriate lab tests are part of a complete evaluation. Patient does not report significant psychological problems or serious physical illness in childhood. Patient indicates other diagnosed illness, not related to pain, and is presently taking medications for illness unrelated to pain. Patient reports allergies to certain medications. Current weight is reported as 250 pounds. Preferred weight is 200 pounds. Patient does not indicate a past history of alcohol abuse, and present use of alcohol is claimed to be none. Patient reports present overall intake of caffeine is none and tobacco is none. Patient does not report recently using illicit drugs. Patient does not indicate increasing problems with memory or intellectual abilities.

RECOMMENDATION -- Based on Patient's preferred weight, Patient may need a weight reduction program, including appropriate exercise and proper nutritional counseling.

PERSONALITY - PAIN COPING STYLE

Patient self-identifies a personality style described as quiet, sociable, and cooperative. In addition, Patient's scores do not indicate a significant amount of obsessive-compulsive thought patterns. Patient does not report difficulty expressing feelings, especially angry ones, to other people. Patient states there is some possibility that pain might be influenced by stress, emotional tension, or difficult circumstances such as family or work problems. Therefore, Patient acknowledges some psychologic (as opposed to somatic) perception of the pain

experience. Patient admits to problems in life other than pain. Patient does not identify as a sickly person with suffering as a way of life. This response is inconsistent with a self-concept of invalidism. Patient's responses do not indicate experiencing low self-esteem. In addition, there is no indication for possible perception of body image distortion. Patient's responses imply a tendency to rely on themself rather than others (doctors, family, friends, etc) regarding what mainly affects their pain. Concerning evaluation and treatment, Patient would like to know enough information to generally understand. Patient 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 -- Patient's internal locus of control (tendency to rely on themself regarding what affects their pain) suggests that self-help approaches such as relaxation exercises and biofeedback may prove beneficial.

PATIENT GOALS

Patient reports presently searching for a pain "cure." Patient 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, reduced use of drugs, improved mood, and reduced tension. If pain cannot be completely eliminated, Patient states that a 50 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 a Patient can work. It is important to avoid unrealistic expectations of "cure", unless well justified, since this can lead to further frustration and disappointment. In some situations it is helpful to understand a chronic non-malignant pain problem, not as pain but as "disability" and to pursue a "pain control" approach while working towards such objectives as increased activity and return to work.

PSYCHOSOCIAL FACTORS

STRESS: Original pain onset was reportedly preceeded by no apparent external stressor or symptoms of psychological stress. Pain intensity presently is perceived to be associated with psychosocial stressors. These include disturbed sleep. Stress may result from discrete or chronic stressors. Stressful situations or changes encountered or anticipated by Patient this past year include change or difficulty in job and financial problems. Patient reports an average amount of chronic stress based on self-imposed pressures, which would imply an average tendency to suffer stress related illness. Overall, Patient

describes this past year as above average in stress, thereby implying an above average chance of developing a stress related illness this year.

RECOMMENDATION -- It is important to carefully assess and be aware of the relationship of pain to external events and psychologic stress. This may require a professonal evaluation since depression, an unresolved grief reaction, and some types of psychological problems may present as pain and should be diagnosed and treated appropriately.
RECOMMENDATION -- Remain alert to detect the early signs of illness associated with significant levels of perceived stress this past year.

PSYCHOLOGIC DYSFUNCTION: Patient does not acknowledge 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 Patient does not appear motivated to explore emotional issues. Patient does not appear to be experiencing a significant level of overall psychological distress.

DEPRESSION: Patient states that before pain began, life was usually viewed in a relatively optimistic fashion. Such a pre-pain view is a positive prognostic sign and should help Patient to cope with pain. Patient’s present view of life reportedly is mixed optimistic/pessimistic. Patient’s scores indicate a borderline significant level of depression. Reportedly, there are more than moderate vegetative signs including decreased libido, initial insomnia, middle insomnia, terminal insomnia, and decreased appetite. Suicidal thinking appears absent. Patient does not report a past suicide attempt. Patient does not indicate being hopeless about the future.

RECOMMENDATION -- Patient’s mixed optimism/pessimism does not necessarily weigh heavily toward a positive or negative outcome. Supportive interventions can be helpful here.
RECOMMENDATION -- Many chronic pain patients experience a reactive depression (sometimes called an Ajustment Disorder) 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 prudent to have a health professional rule out a possible medical etiology for depression when present, including drug side-effects and undetected medical illness.

SOMATIZATION (distress arising from percepton of bodily dysfunction): Patient’s scores indicate a significant amount of

distress from perception of bodily dysfunction. Patient does not fear or believe that he has a serious disease that doctors have not found.

RECOMMENDATION -- Elevated somatization can be related to a number of causes including stress, anxiety, depression, other psychological causes or physical illness and further evaluation may be helpful here.

ANXIETY: Patient's scores do not indicate a significant level of anxiety. Patient 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. Patient's reported attitude would predict neither strongly stoical nor hypochondriacal trends.

THOUGHT DISORDER: Patient's scores do not indicate a significant level of suspiciousness. In addition, there is a borderline significant indication for psychoticism (a continuum from interpersonal alienation to psychosis.)

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

SUPPORT SYSTEM AND INTERPERSONAL RELATIONSHIPS: Support system can have a major impact on coping and outcome. When pain increases, Patient's reported ability to accept help from others is that Patient accepts it but does not like it. Patient 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. Patient's scores indicate that feelings of personal inadequacy, discomfort in interpersonal interactions, and negative expectations of others are not apparent. In addition, Patient's scores do not indicate a significant level of hostility.

RELATIONSHIP WITH HEALTH PROVIDERS: Patient reportedly does feel he is taken seriously by doctors. Patient indicates being uncertain about getting help from their doctor.

BEHAVIORAL - LEARNING FACTORS

PRIOR MODELS: Patient does not report awareness of significant others who have experienced pain problems and therefore might

serve as prior models for pain.

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

ILLNESS BEHAVIOR REINFORCEMENT: Patient feels that without verbalizing it, others often don't know that pain is present. Therefore, Patient's perceptions appear inconsistent with a tendency to utilize non-verbal pain communications. In the presence of worsening pain, those around Patient appear to respond by producing a greater number of reinforcers of illness behavior as opposed to well-behavior. Patient'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) may not ultimately be helpful in chronic non-malignant pain. These responses can, unwittingly, reinforce illness behavior and reduced function. Education of both patient, family and significant others is an important aspect of chronic pain management, with a goal of reinforcing "well" vs "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, Patient reports sitting for 4 hours and lying down for 8 hours because of pain. Patient claims pain has severely affected overall activity level. Patient does not try 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 Patient working toward increasing "quotas" below pain tolerance should be considered. This will help provide a series of "success experiences" which can behaviorally reinforce well-behaviors as opposed to illness-behaviors, leading to improved function and quality of life. Working or exercising to quotas, followed by rest, makes rest (a positive reinforcer) contingent on quotas rather than on pain.