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## **PSYCHOSOCIAL ASSESSMENT OF PATIENTS WITH CHRONIC PAIN**

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## **CHAPTER ONE**

### **FUNCTIONS OF A PSYCHOSOCIAL ASSESSMENT**

Experience and research has established that psychosocial factors influence the pain patient's adaptation to their illness and disability. Thus it is essential, that clinicians treating patients with chronic pain have the ability to evaluate and manage the psychosocial factors contributing to the patient's predicament.

The style and extent of the psychosocial assessment will be influenced by the purpose for which it is being undertaken. A psychosocial assessment may be used for any of the following:

- To identify factors contributing to a patient's illness, their pain perception and their experience of suffering and their disability
- To establish the relationship among these factors (the mechanisms of action), for example, anxiety and depression altering perceptions and priorities, as well as increasing muscle tension, and decreasing sleep
- To facilitate treatment planning i.e. assess suitability for:
  - Comprehensive Treatment Programs
  - Educational Programs
  - Individual Counseling
- To identify psychological and social barriers to treatment
- To determine if whether further psychological treatment is required prior to starting a pain management program
- To evaluate treatment outcome
- For research
- For third party reports (insurance, superannuation, personal injury litigation, workers' compensation, social security)

*(Modified from "Pain Management: An Interdisciplinary Approach", M Maine and Spanswick; "Psychological and Psychosocial Evaluation", pages 187-189.)*

The purpose of the psychosocial assessment may influence the relationship between the patient and the clinician particularly in domains such as the development of rapport, a therapeutic alliance, and compliance with treatment.

The clinician should establish the purpose of the assessment because although there are many issues in common the differences in focus and technique can lead to a focus on different aspects. Clinicians usually are required to develop the skills appropriate to several of these areas.

## **CHAPTER TWO**

### **DATA COLLECTION**

In order to assess the various aspects of the life of a person with persistent pain, several dimensions of their experience are considered, using multiple sources of information and types of assessment. Such information may be obtained by specific and indirect, often informal observations.

Specific sources of information include:

- Clinical interview
- Examination and investigation
- Psychometric tests
- Collateral sources of information
- Ongoing observation
- Evaluating response to interventions

If large numbers are to be **screened** quickly there is little choice but to use a questionnaire. Problems may arise with potentially large numbers of at risk people identified. It is necessary to minimize the number of **false positives** ie those identified who are not actually at risk.

If the goal is the most accurate identification of risk factors prior to intervention clinical assessment is preferred. Suitably skilled clinicians with adequate time must be available. Questionnaires can be used to screen for those needing further assessment, though in this instance the number of **false negatives** (those who have risk factors but who are missed by the screening test) must be minimized.

Some factors may appear to be mutually exclusive, but are not. For example, partners can alternate from being socially punitive (ignoring the problem or expressing frustration about it) to being over protective in a well-intended way (and inadvertently encouraging extended rest and withdrawal from activity, or excessive treatment seeking.) In other words both factors may be pertinent. (NZ Guidelines Group)

### **Advantages and Disadvantages of Questionnaires and Clinical Assessment**

#### **Advantages of questionnaires**

- Quick to administer
- Useful for screening large numbers
- Little skill needed
- Interpretation is usually unequivocal
- Can be statistically based on evidence

#### **Disadvantages of questionnaires**

- Require time to score, need to check for missing information
- Unsuitable for those with reading problems
- May not be applicable to all those in a community e.g. new immigrants
- May only predict one goal e.g. work loss but not pain
- May be too sensitive to time of measurement

- Susceptible to confounding factors, such as social desirability or impression management (a person telling what they want to be heard)

**Advantages of clinical assessments**

- Clinician can adapt readily to characteristics of the individual
- Incorporates clinical experience
- Facilitates establishing potential goals for intervention
- Less susceptible to confounding factors such as social desirability or impression management
- Judgments about severity can be made

**Disadvantages of clinical assessments**

- Potentially time consuming
- May result in confused picture unless clinical skill level is adequate
- Possibility of observer bias or prejudice

**Advantages of combination of questionnaires with clinical assessments**

- Improved accuracy
- Clinician can integrate quantitative information with clinical data
- Can use two stage process with questionnaire as first stage filter to target clinical assessments

**Disadvantages of combinations of questionnaires and clinical assessments**

- Requires more resources including the need for adequate organization and training
- More time needed, potential for delays

(NZ Guideline Group)

During this time of accumulating information, it is usual to **generate a range of hypotheses** seeking to explain the patient's predicament, which can then be tested against further information as it becomes available. This aspect of the assessment is a test of professional skill and judgment, with the practitioner being required to approach the problems in a way that allows them to retain an open mind, but to also exclude possibilities when this is appropriate. Thoughtful use of experience helps the clinician develop this judgment.

The issue is to decide the appropriate level of confidence to attach to the hypothesis under consideration. **Greater levels of confidence are obtained by consistency**, which can be evident:

- Several sets of data
- Different times
- Multiple observers
- Various situations
- With provocative testing.

Measuring the parameters of pain is challenging, because of the ultimately subjective nature of pain, the variety of opinions about the nature of pain in both the lay and general medical communities, and because of the limits of our own expert knowledge.

During this process, it is important for the practitioner to be confident about what they know, about what they don't know, and to develop the personal skill to be able to acknowledge professional limitations without loss of face. This is particularly important when under

pressure from patients in distress, their families, and other practitioners. There have been too many instances of patients being disadvantaged by the reluctance of practitioners to **tolerate uncertainty**, instead acting on assumptions without appropriate evidence and experience.

There is good agreement that the following factors are important, and consistently **predict poor outcomes**.

- Presence of a belief that back pain is harmful or potentially severely disabling
- Fear-avoidance behaviour and reduced activity levels
- Tendency to low mood and withdrawal from social interaction
- An expectation of passive treatments rather than a belief that active participation will help

The most important method of data collection is **the clinical interview**. Interviews have varying degrees of structure, each with advantages and disadvantages, as previously described.

The style and extent of the clinical interview will depend upon the purpose. When ongoing treatment is anticipated, the **assessment** will overlap with the process of therapeutic **engagement**. The initial aim is to establish the confidence and trust of the patient in the interviewer so that they will be reasonably willing to confide details of their experience often at a time when they feel vulnerable because it is common to re-experience the distress while providing the history. A demonstration that the interviewer is aware of this vulnerability and will appropriately take it into account may reduce this distress. This can be accomplished by informing the patient that an effort has already been made to understand the situation by prior reading of the reports provided on referral, by discussing the interviewer's understanding of those reports, and by seeking the patient's own view of these reports, particularly with an opportunity for the patient to express any differences of opinion.

A **medico-legal assessment** will involve a rather more distant approach, with a very detailed interest in issues such as phenomenology, causation and disability, rather than how to overcome anxiety, or to establish a trusting relationship, or to motivate the patient to change his or her behaviour.

The **Three Function model of Medical Consultation** provides a template for the parallel functions of the interview for clinical purposes.

## **THE THREE-FUNCTION MODEL OF MEDICAL CONSULTATION**

### **1 Build a Relationship**

- Greet the patient warmly by name
- Active listening
- Detect and respond to emotional issues

### **2 Collect Data**

- Don't initially interrupt the patient
- Consider other factors than the presenting problem
- Elicit the patient's explanatory model
- Develop a shared understanding of the problem

### **3 Agree on a Management Plan**

- Provide information and explanations
  - Make links
  - Appropriate use of reassurance
  - Negotiate a mechanism for behaviour change
  - Negotiate a management plan
- (Gask and Usherwood, BMJ, 2002)

## **CHAPTER THREE**

### **INTERVIEW TECHNIQUES**

Listening to the **patient's opening statements** without interruption allows them to introduce the issues, which are of most concern to them. Once interrupted the patient may not return to the same issues again. If uninterrupted, most patients stop talking within sixty seconds, often before, allowing the opportunity for discussion to clarify issues raised. The doctor can then ask if the patient has any further concerns, summarise their own understanding of what the patient has said, and can propose an agenda. The issues listed in this agenda should take into consideration the patient's order of priorities.

It is useful after the initial **introduction** to familiarize the patient with the usual course of events. Confirming **the patient's personal demographic details** including their age, where they live and with whom, their source of income, and the circumstances of the referral allows the patient to be aware that the focus is not only on their pain and their physical complaints but also on general aspects of their where and how they live.

A **review of the information known** before arrival provide the patient with some indication as to where they might be able to start adding new information. Patients may appreciate a **suggestion about how to prioritize** their history and what is required of them.

The clinician should request information in a manner that is very clear and understandable to the patient. **Active listening**, indicated by the clinician's expression, gestures, comments and accurate feed-back informs the patient that their history is being heard and understood, which is very encouraging for the development of trust and confidence, and engagement. For the same reasons, physical symptoms must be taken seriously and adequately evaluated to determine the extent to which they concern for the patient and/or reflect physical pathology.

#### **Active Listening Skills**

- Open-ended questions – questions that cannot be answered in one word and require the patient to expand
- Open-to-closed questions – move towards closed questions towards the end of the consultation
- Checking – repeat back to the patient to ensure that you have understood
- Facilitation – encourage patient verbally (“Go on, please.”) and non-verbally (nodding)
- Legitimising patients' feelings – “This is clearly worrying you a great deal”, followed by “You have an awful lot to cope with”, or “I think most people would feel the same way”.
- Surveying the field – repeated signals that further details are wanted “Is there anything else?”
- Empathic comments “This is clearly worrying you a great deal”.
- Offering support “I am worried about you, and I want to know how I can help you best
- Negotiating priorities –with several problems, make a list and negotiate which to deal with first
- Summarising – check what was reported and use this as a link to the next part of the interview. This helps to develop a shared understanding of the problems and controls the flow of the interview if there is too much information.
- Confronting – to clarify with inconsistencies and contradictions.

***Gask and Usherwood, BMJ, 2002.***

At the same time, the clinician should be **observing** the changes during the progress of the interview, noting the processes of thinking that the patient is using, as well as the content of thinking. They should also be noting and beginning to understand the behaviour and emotional responses of the patient, and be relating these to the issues being considered at the time (see mental state examination).

Interviewers need to be aware of their own personal emotional and behavioural **counter-transference** responses, and link these to the issues and the behaviour presented by the patient.

Establishing a good **rapport** encourages the patient to take the risk of revealing further sensitive information, which would not be discussed in a social setting. They may not have considered issues, which may be relevant, and they may need to be given permission to disclose other aspects such as criticisms, or disappointment. This might be because of embarrassment, self-consciousness, taboos, or lack of awareness of its relevance.

When **providing information** to a patient the clinician should consider three questions:

- What does the patient already know? This emphasises the importance of building upon the patient's existing explanatory model, adding to what they already know, and correcting inaccuracies.
- What does the patient want to know? This addresses the patient's agenda.
- What does the patient need to know? This addresses the doctor's agenda.

(Gask & Usherwood, BMJ 2002)

From the patient's point of view the relevance is to obtain the information that would assist them to recover, and to get relief of symptoms, and to improve their functioning. The aim of the doctor is to help the patient to obtain a clear understanding of their situation in areas that they might not have already considered. The clinician's task is to adopt a technique that is suitable for that particular patient at that particular time. For example if the patient is very distressed, or tired, sedated or disinterested, their ability to manage a large volume of complicated material will be limited, and the effort to provide this information may be misguided, futile, and misleading. A good rapport allows the clinician to check the ability of the patient to process information at each stage of the interview.

**Closing an interview** requires care and attention especially when further treatment is anticipated because closing on good terms helps to cement the therapeutic relationship and may promote compliance with treatment recommendations.

Preparations for closing the clinical interview should begin at the start of the interview with an explanation about follow-up or management options. The clinician should allocate time at the end of the clinical interview to provide the patient with a summary of the data, the clinician's opinion and recommendations and invite any last questions. On many occasions, the work is incomplete, uncertainties remain, and differences of opinion may continue. When acknowledged by both parties, this may promote trust and helps set the agenda for future issues to be discussed and possibly resolved.

Unfortunately it is occasionally necessary for the practitioner to terminate an interview unilaterally if such cooperation is not available, though the same issues can be addressed along with clear suggestions to the patient about a reasonable way to proceed subsequently. When

this is done “**softly, slowly, while sitting**” with a reasonable offer to the patient, this may often mollify a frustrated and desperate patient.

### Detecting Emotional Issues

Even when there are prominent psychological or social problems, patients often give priority to presenting physical symptoms, a form of **somatization**. **Verbal and non-verbal cues** hint at the psychological and social problems. As well as the actual words used, the clinician can be attentive to the tone of voice, the content and timing of comments, accompanying facial expression, posture and behaviours that can convey a wide range of meanings, even with precisely the same words. Often a patient might not be aware of their “non-verbal communication”, or lack of it, and tactful reflection can lead to fruitful discussion regarding their distress.

#### Responding to the Patient’s Cues

##### VERBAL CUES:

- State your observation  
*“You say that you recently have been feeling fed up and irritable”*
- Repeat the patient’s own words  
*“Not well since your mother died”*
- Seek clarification  
*“What do you mean when you say you always feel tired? When does that happen? Why do you think that happens?”*

##### NON-VERBAL CUES:

- Comment on your observation –  
*“I can hear tears in your voice”.*
- Ask questions –  
*“I wonder if that upset you more than you like to admit?”*

Gask and Usherwood, BMJ, 2002.

**Inconsistencies** limit the development of trust, but discussion in a sensitive manner, may lead to disclosure of useful information, clarification of the inconsistency and may help the clinician understand the patient’s interpretation of the events and their belief system. This helps develop rapport, reciprocal trust, and promotes the therapeutic alliance.

During the interview, it is very important to observe the patient’s **reaction to unpleasant information**, and to information that is contradictory to their hopes and dreams, for example, “no cure”. Observing their behaviour in such situation provide substantial information as to how they are likely to respond to ongoing difficulties in the future, including advice and recommendations that are unexpected, not wanted, or contrary to their own ambitions and beliefs.

**Confronting** a person with their inconsistencies can be threatening because they may take offence, though with tactful sincere explanation as to how their explanation of such issues can be helpful, most people are accepting and cooperative.

### **ASPECTS OF INTERVIEW STYLE THAT AID ASSESSMENT OF PATIENTS' EMOTIONAL PROBLEMS**

#### **Early in the Interview**

- Make good eye contact
- Clarify presenting complaints
- Begin with open-ended questions, moving to closed questions later
- Use directive questions for physical complaints

#### **Interview Style**

- Empathetic comments
- Verbal and non-verbal cues
- Do not read notes while taking patient's history
- Deal with over talkativeness
- Ask questions about the history of the emotional problem
- Communicate on a verbal and non-verbal level
- Deal with silences

**Gask and Usherwood, BMJ, 2002.**

## CHAPTER FOUR

### NON – ENGLISH SPEAKING PATIENTS

Early in the interview, it is polite and helpful to gain an understanding of the **ability of the patient to comprehend, and to express** his or her own ideas. This can easily be accomplished by asking them to confirm details that are known to both the patient and the interviewer, such as their name, age, and address to begin with, before proceeding to more complicated issues depending upon the results.

Levels of communicating range from

- Use of gestures,
- Basic survival communication,
- Managing simple practical arrangements,
- General conversation
- Discussion of complicated abstract issues involving belief systems which are culturally determined, with an explanation of the differences.

Depending upon the aims of the interview, a specialist interpreter should be considered, bearing in mind that a properly trained interpreter is able to assist with the cultural context of the issues as well. Interpreting requires a significant level of professional training, such that it is not sufficient to use a relative, or a convenient member of staff.

Use of an interpreter also requires knowledge, skill and practise. The clinician should arrange seating so that the clinician is the main focus of the patient's attention so as to allow rapport to develop between the patient and the clinician. This can be achieved by arranging the seating with the interviewer and the interpreter side by side, together facing the patient so that there is very little need for the patient to redirect his gaze and the interpreter is seen to be an extension of the clinician.

It is most important that the interpreter merely interprets for both parties, accurately reports all comments made, and does not enter into spontaneous discussion or questioning. However, explaining the cultural context to the clinician is often useful.

As with all patients, the aim is to obtain a body of data, an understanding of the patient's thinking, of their belief system regarding the pain, its cause, heir expectations of treatment, of the doctors, and of themselves, all of which are subject to cultural influence. It is the patient's point of view that has to be understood before progress can be made towards the development of a useful therapeutic alliance.

## **CHAPTER FIVE**

### **BELIEF SYSTEMS**

The **patient's explanatory model** is important to their subsequent management, as their behaviour, particularly in relation to their health, is largely determined by their belief system. Without knowledge of the patient's perspective, agreements are not well informed, a close working relationship cannot be established, and the risks of complications are considerable.

Patients' explanation of their pain problems, values, and priorities are based on their own personal experiences. It is therefore important not to make assumptions about a patient's beliefs, concerns and expectations, but to elicit these from the patient.

To take a patient's belief system into account does **not** require the practitioner to believe it as well, but to learn the areas where there is sufficient agreement to proceed. An aim of treatment is to help the patient develop an appropriate, well-founded and useful belief system. This is expected outcome of the considerable investment in Educational Programmes, Cognitive Behavioural Therapy, Occupational Therapy, Physiotherapy and Medical treatment. Improvement in function does wonders for confidence and understanding of their potential - "I didn't think I could do it but I can."

The following **concerns** of pain patients have been recognized to be **of major importance** for a considerable period. Substantial research has taken place in how these concerns are influenced and modulated by factors such as Self Efficacy, Locus of Control, Dependence vs. Independence, Patient Rights & Responsibilities, Assertiveness vs. Aggression and Submissiveness, the Sick Role, Illness and Treatment Behaviour.

#### **Concerns of Pain Patients**

- The cause of their pain.
- The adequacy of the previous investigations and how are these judgments decided.
- The treatment outcome. Cure or manage pain?
- Control over the pain, over their life, over doctors.
- Who has responsibility for their pain, themselves or others (or shared)?
- Does pain mean danger?
- The place of rest and activity.
- The place of work and leisure, tolerance of pain and the relevance of functioning.

Very often, by the time a patient has been referred to a Pain Specialist, they have been through a steep "learning curve" which they did not anticipate and which has not been very welcome. People generally expect to get better and they haven't. They expect if they don't get better, then at least they would not suffer, yet they do. The hurt, disappointment, confusion, and reluctance to trust others, including (perhaps particularly) medical practitioners, is to some extent understandable at least, in terms of their *perception* of their experiences.

**Eliciting a belief system** is not always a straightforward task. Patients do not usually use such a framework, they are not always aware of the relevance of their ideas, and they often assume that others think the same so that a specific comment does not seem to them to be required.

The beliefs may be revealed **spontaneously** during history taking in response to open ended questions, by **directive inquiry** by the interviewer based on experience with other patients, or while **clarifying** uncertainties or inconsistencies. The use of **specific structured interviews** prepared for research purpose can be useful e.g. the Pain Beliefs Inventory. **Collateral interviews** with others who are familiar with the patient may be very useful, either because they share the same beliefs and may be more willing to express these, or because they have formed their own opinions.

The clinician should be aware that eliciting patient beliefs may provoke hurt and anger. This may occur if the patient realizes that the basis for their pursuing a particular course of action (such as prolonged resting or multiple operations) has been incorrect, and may have worsened their predicament. There is also a potential for a split to occur between the pain clinician and other medical professionals, on whom the patient has relied on for a long time and in difficult circumstances, as pain beliefs are clarified and corrected.

Considerable skill, tact and diplomacy may be required, because patient's who have already had many changes forced upon them have built up a resistance to further change. Some pain patients may be angry and angry patients are not usually receptive to new ideas. A good therapeutic relationship may assist the clinician and patient work through the issues leading to his anger, help resolve it so that the patient can adopt helpful new ideas which may ease their suffering or improve their functioning.

#### **Assessment of Family Influences on Decisions to Treat**

Very few people live alone and the beliefs of those close to the patient can either help or hinder recovery. They can also be open to change, which should be considered at times.

##### **Interviews of family can help by:**

- Corroboration of factual information
- Psychological effect on family members (functional, social)
- Family perception of the nature of pain and disability (and expectations)
- Family's role in treatment-seeking (referral process, agenda, motivation, locus of control, coercion)
- Acceptance of shared goals for intervention
- Role of family support in the rehabilitation process
- Resistance to change

(Page 225 "Pain Management: An Interdisciplinary Approach" Maine & Spanswick)

##### **When a family member attends with a patient:**

- Acknowledge their presence
- Check that the patient is comfortable with their presence
- Clarify the reasons for their attending
- Ask for their observations and opinions
- Be very cautious about taking sides
- Provide a summary of assessment and treatment to date, for confirmation by the patient and for the information of the relative, (if the patient consents).
- Provide the best available answer to questions, acknowledging appropriate limitations
- Ask for their help in treatment if appropriate
- if agreeable, suggest ways in which others can help, being mindful of maintaining the patient's independence, personal responsibility, boundary issues and appropriate expectations

(modified from Gask & Usherwood, BMJ,2002)

## **CHAPTER SIX**

### **COPING STRATEGIES**

Patients respond in a variety of ways, determined by their emotional reactions, belief systems, habits, and social influences. We all have coping strategies as an essential tool to deal with life's stressors that vary between individuals, cultures, contexts, and times, and a history of the development of their responses is useful in understanding the strategies employed. Although the clinician may disagree with the patient's approach, the clinician should appreciate that the patient's responses are his or her best means of dealing with a threatening situation.

Coping strategies may be assessed by history, observation and by use of rating scales such as Ways of Coping Questionnaire, and the Coping Strategy Questionnaire. It is also useful to obtain history from others (local doctor, family, employers) and the observations of the waiting room and nursing staff.

**Behavioural coping strategies** include

- Help seeking
- Avoidance or change of activities
- Use of aids, medication
- Education
- Rest
- Increased activity
- Alcohol, drugs

**Cognitive coping strategies** include

- Cognitive restructuring
- Information seeking
- Self blame
- Wish fulfilling fantasy
- Emotional expression
- Diverting attention
- Reinterpreting pain sensation
- Coping self statements
- Ignoring pain sensation
- Praying and hoping
- Catastrophising

Unfortunately some coping strategies, which may have short-term benefit, can in the long run be unhelpful, a distraction, or even harmful. Excessive rest is a common example. No one mechanism is inherently good or bad but must be viewed in the overall context. An imbalance or excessive use of any particular response is much more likely to be harmful than helpful. The practitioner needs to form **an opinion** as to their benefit for the patient.

This evaluation requires the practitioner to have a clear set of **outcome objectives**, which involves value judgements. It is important to **individualise** the management by also considering the patient's values where appropriate. Not everyone wants to run marathons, or return to work. Many factors may have changed in the patient's view of the world. This often occurs following trauma, especially if life threatening, and their priorities may have changed accordingly. The

alternative support available in “the Sick Role” can be a powerful influence on the strategies chosen, especially if alternative income is available in a way that allows avoidance of a job that was unpleasant.

**Assessment of coping strategies**

- What coping strategy does the patient use?
- Do these strategies vary according to pain severity and/or environmental factors?
- How are the patient’s choices or strategies related to his beliefs about the nature of pain and disability?
- How effective does the patient believe their coping strategies are?

(Page 225 Pain Management: An Interdisciplinary Approach, Main & Spanswick)

## **CHAPTER SEVEN**

### **PAIN BEHAVIOURS**

The concept of Pain Behaviours overlaps with Coping Strategies and Belief Systems. The latter two however may be entirely intellectual processes, and not as observable as behaviour. The concept of Pain Behaviour relies only on a description of the behaviour, without any conclusion about the motivation. Some pain behaviours are reflex actions, such as changes of posture as a result of muscle spasm, or automatic responses, such as the spinal processes resulting in withdrawal or limping on a sore foot.

These include thinking (catastrophising, organising appropriate medical care), emotional responses, emotional expression, alterations of posture, gait and more organised activity such as health seeking behaviour and sick leave. There is also a wide range of interpersonal responses.

Observations are made of types, frequency and duration of behaviours, which need to be interpreted in the light of the sampling procedure, either by continuous observation, time intervals, interval recording, with clear criteria for behaviours to be observed.

#### **Factors influencing Pain Behaviour**

- The context
- Their understanding of the pain (their belief system)
- Personal experiences, early and recent
- Personality style
- The family style and experiences
- Cultural patterns
- Social reinforcers, past and present.

The behaviour also differs depending upon the stage of their illness, with acute pain behaviours, at the beginning of a condition, being much more oriented towards obtaining assistance from others and medical cure. Those with chronic pain face a more complex dilemma. The phenomenon of chronic disability is relatively recent in our human history to the extent that we currently witness, as previously such people would usually have died.

The familiar concepts of Illness Behaviour and the Sick Role are most applicable to acute short-term physical illnesses (e.g. Appendicitis). Chronic disability, and therefore chronic pain behaviour, is far more variable in its presentation. The behaviour of any one individual will change as they progress through the stages of their condition (presentation, acute treatments, stabilisation, rehabilitation, re-establishment in the community). Disability, and therefore behaviour in relation to the pain, is much more influenced by psychosocial factors (job demands, social expectations, resources available, attitudes and education).

Particularly as the condition of that person “evolves” imperceptibly from an acute to a chronic process, the general community is usually less inclined to accept the appropriateness of the sick role, and to introduce issues of morality, and will. We live in a society in which we expect people to tolerate their distress unless they are “(acutely) ill” and to endure, to preserve their independence and to take personal responsibility for their own welfare. At the same time the community, often ambiguously, still expects people to seek and accept help if they have

difficulties. The “rules” as to when this is deemed to be acceptable are inconsistent, unclear and poorly communicated.

The longer a period of disability continues, the more difficult it is to maintain the support, trust and confidence of others in the community particularly when there are few objective signs, and when it is often deemed to be inappropriate to continue “complaining” in a manner that is considered acceptable and tolerated when associated with conspicuous short term illnesses.

To further complicate the picture the level of pain and disability experienced can vary from time to time with many conditions both through the day, and in different environmental conditions (e.g. the effect of wind on the face of a person with allodynia associated with Trigeminal Neuralgia).

### **Types of Pain Behaviour**

#### **Observed**

- Facial grimacing
- Sighing, groaning, verbalising
- Altered posture and gait
- Touching, rubbing of the affected area
- Bracing, reduced movement
- Reaction to examination
- Behavioural signs on examination
- Use of supports and equipment

#### **Mental State Observations**

- Mood (anxiety, depression, anger) reactivity, appropriateness and congruity with expectations
- Thought (beliefs, sense of control, distractibility, preoccupation)
- Level of arousal, sense of emergency, safety
- Concentration, memory
- Alertness
- Insight, judgement.

#### **Reported**

- “Down time” (not working, resting, laying down)
- Health care usage (medication, potency of medication, injections, operations, doctors’ visits, alternative medical care, physiotherapy)
- Medico legal activity
- Substance use (alcohol, illicit drugs, caffeine)
- Amount of physical activity

#### **Behavioural Symptoms** (boom and bust, fear avoidance, inconsistencies)

(Modified from Pain Management- an Interdisciplinary Approach Main and Spanswick Page 177)

Pain behaviour does not actually confirm the presence or absence of pain, the pain severity, or, the seriousness of the diagnosis of the underlying condition.

There are many anecdotes of people undertaking extraordinary activity despite fractures, such as rushing out of burning buildings, when the occasion demands it. There are also the examples of the opposite, extraordinary levels of disability with negligible physical injury and little apparent nociceptive activity. The confidence of the medical practitioner will rely on consistency between expectations and observations, over time, in different situations, between different observers after a thorough medical assessment.

An important aspect of the assessment of pain behaviour is the history of the person's **own management** of their pain, and of other **health care behaviours**. These include smoking, use of alcohol, drugs, caffeine, exercise and the tendency to take the initiative in developing their life, by engaging in a new range of activities, individually, domestically, socially, and vocationally.

There is a social expectation that people will be able to judge when to tolerate pain, and when to seek the assistance of others, particularly medical practitioners. People's confidence in differentiating between normal and abnormal experiences can be greatly affected by other events in their life, such as illness of others, pathology lectures for undergraduate medical students, past experiences, a nervous insecure personality style, or a dominant assertive entitled style.

It is expected that when self-help is inappropriate and when reasonable professional advice is offered, that the person will comply in a manner that indicates their intention to return to useful functioning and with as much independence as is feasible. The judgement of the practitioner when assessing the appropriateness of the behaviour observed will very often be guided by their own education, their clinical and personal experiences, and the adequacy of their examination.

**CHAPTER EIGHT****CLINICAL ASSESSMENT OF PSYCHOSOCIAL RISK FACTORS**

These headings (Attitudes and Beliefs about Back Pain, Behaviours, Compensation Issues, Diagnosis and Treatment, Emotions, Family and Work) have been used for convenience in an attempt to make the job easier. They are presented in alphabetical order since it is not possible to neatly rank their importance. However, within each category the factors are listed with the most important at the top of the list.

***Attitudes and Beliefs about Back Pain***

- Belief that pain is harmful or disabling resulting in fear-avoidance behaviour, eg, the development of guarding and fear of movement
- Belief that all pain must be abolished before attempting to return to work or normal activity
- Expectation of increased pain with activity or work, lack of ability to predict capability
- Catastrophising, thinking the worst, misinterpreting bodily symptoms
- Belief that pain is uncontrollable
- Passive attitude to rehabilitation

***Behaviours***

- Use of extended rest, disproportionate 'downtime'
- Reduced activity level with significant withdrawal from activities of daily living
- Irregular participation or poor compliance with physical exercise, tendency for activities to be in a 'boom-bust' cycle
- Avoidance of normal activity and progressive substitution of lifestyle away from productive activity
- Report of extremely high intensity of pain, eg, above 10, on a 0 to 10 Visual Analogue Scale
- Excessive reliance on use of aids or appliances
- Sleep quality reduced since onset of back pain
- High intake of alcohol or other substances (possibly as self-medication), with an increase since onset of back pain
- Smoking

***Compensation Issues***

- Lack of financial incentive to return to work
- Delay in accessing income support and treatment cost, disputes over eligibility
- History of claim(s) due to other injuries or pain problems
- History of extended time off work due to injury or other pain problem (eg more than 12 weeks)
- History of previous back pain, with a previous claim(s) and time off work
- Previous experience of ineffective case management (eg absence of interest, perception of being treated punitively) Diagnosis and Treatment
- Health professional sanctioning disability, not providing interventions that will improve function
- Experience of conflicting diagnoses or explanations for back pain, resulting in confusion
- Diagnostic language leading to catastrophising and fear (eg fear of ending up in a wheelchair)
- Dramatisation of back pain by health professional producing dependency on treatments, and continuation of passive treatment
- Number of times visited health professional in last year (excluding the present episode of back pain)
- Expectation of a 'techno-fix', eg, requests to treat as if body were a machine
- Lack of satisfaction with previous treatment for back pain
- Advice to withdraw from job

***Emotions***

- Fear of increased pain with activity or work
- Depression (especially long-term low mood), loss of sense of enjoyment
- More irritable than usual
- Anxiety about and heightened awareness of body sensations (includes sympathetic nervous system arousal)
- Feeling under stress and unable to maintain sense of control
- Presence of social anxiety or disinterested in social activity
- Feeling useless and not needed

**Family**

- Over-protective partner/spouse, emphasising fear of harm or encouraging catastrophising (usually well-intentioned)
- Solicitous behaviour from spouse (eg taking over tasks)
- Socially punitive responses from spouse (eg ignoring, expressing frustration)
- Extent to which family members support any attempt to return to work
- Lack of support person to talk to about problems

**Work**

- History of manual work, notably from the following occupational groups:
  - fishing, forestry and farming workers;
  - construction, including carpenters and builders;
  - nurses;
  - truck drivers;
  - labourers
- Work history, including patterns of frequent job changes, experiencing stress at work, job dissatisfaction, poor relationships with peers or supervisors, lack of vocational direction
- Belief that work is harmful; that it will do damage or be dangerous
- Unsupportive or unhappy current work environment
- Low educational background, low socioeconomic status
- Job involves significant bio-mechanical demands, such as lifting, manual handling heavy items, extended sitting, extended standing, driving, vibration, maintenance of constrained or sustained postures, inflexible work schedule preventing appropriate breaks
- Job involves shift work or working 'unsociable hours'
- Minimal availability of selected duties and graduated return to work pathways, with unsatisfactory implementation of these
- Negative experience of workplace management of back pain (eg absence of a reporting system, discouragement to report, punitive response from supervisors and managers)
- Absence of interest from employer

Remember the key question to bear in mind while conducting these clinical assessments is 'What can be done to help this person experience less distress and disability?'

(NZ Guidelines Group)

## **CHAPTER NINE**

### **DEVELOPMENTAL HISTORY**

The significance of a developmental history from the psychological point of view lies in defining the strengths and vulnerabilities of a person, and gaining a better understanding of their current attitudes. This involves a history of the past events of their life, influential cultural and role models and their thoughts, feelings, reactions. This includes the early family functioning, their experiences of school years, and their employment, social and recreational life.

Behaviours which are not logical and reasonable in the current context can often be explained in terms of these experiences, and the practitioner can define the particular issues which need to be addressed before effective changes can occur by comparing their own perspective with that of the patient. Awareness of their pattern of problem solving, their level of initiative, flexibility, and ability to develop their lives is useful because they are required to be actively involved.

This history is usually obtained by asking questions about events in a **chronological** order. Some flexibility will allow the patient to elaborate on particular issues, but many people may be hesitant, as indicated by their manner, tone of voice, body language, changing the topic, being quiet, or becoming anxious, depressed, or annoyed. Tactful enquiry in areas of obvious tension, allowing the patient to express their views on issues, might be quite revealing. However it is also important to be wary about being intrusive or forceful in areas in which a patient is not prepared to allow further enquiry, at least until further justification, trust and confidence has been established. Previous trauma may have left significant damage that may need specific attention, such as the posttraumatic psychological impact of childhood maltreatment.

Another style of history taking, using an **anamnestic** technique, highlights the usefulness of being aware of the patient's reactions. At times of obvious emotion, leading questions such as "Have you ever had this experience before? Can you recall times when you felt the same? Can you recall any other situations when you had the same thoughts and feelings?" follow the **emotional** cues and threads of the patient's experiences rather than the temporal, or intellectual sequence. This allows the patient to describe events that are connected by similar feelings and reactions, which are after all how these memories, are prioritised within our own minds, how they are recalled, and how they influence our response to events.

A combination of the two approaches is often very productive.

It is notable that early life disadvantage does not always have a detrimental effect, with some people learn how to constructively deal with these situations, and accomplishing much in life. However the considerable threats imposed by disability, loss of self control and continuing pain, can overwhelm the strategies that have been developed, especially when the similarity between the present and past circumstances arouse painful old memories, feelings and (involuntary, automatic) patterns of behaviour.

Helping patients develop insight about the relevance of connections between past and present circumstances is achieved by increasing their understanding of the significance of their own belief systems, how we acquire these, and how these may influence our current lives. This is an important step towards their being able to resume control and independence in their lives, a state demonstrated to involve less stress and suffering and a better level of functioning.

"Knowledge is power" and self-efficacy is greatly improved by education, if accurate.

**CHAPTER TEN****MEDICO-LEGAL HISTORY**

Some subjects are widely understood to be out of favour with medical practitioners including litigation, alcohol abuse, illicit drug abuse, and “doctor shopping.” A careful history taking is required in order to obtain an accurate assessment. These issues can be approached gradually, with general screening “open” questions followed by more specific questions depending on the importance of the issue and the early responses. These include statements of the patient, their manner when they express them (the non-verbal communication) and the likelihood of the issue being relevant based on the context. Judgement about this comes from training and experience.

The involvement of litigation and other third party providers is a special issue with pain patients because of its influence on their behaviour, expectations, attitudes, belief systems, mood and manner. The following **relationships between level of compensation and claims** have been demonstrated

- No evidence that it changes the injury rate
- 10% increase in compensation level produces 1 – 11% increase in claims’ rate
- 10% increase in compensation level produces 2 – 11% increase in duration of disability
- This affects “verifiable” injuries such as fractures as much as more subjective soft tissue injuries.

**Effects of Compensation on Surgical Outcome**

- Compensation patients are less likely to have a good result from back surgery
- These findings have been criticised. These people often have heavier physical jobs, and they may get over-aggressive surgical intervention
- Despite this, more than 75% return to their previous work.

**Effects of Compensation on Rehabilitation Outcome**

- Compensation patients respond less well to pain management and rehabilitation
- These findings have been criticised because there are methodological flaws in many of these studies.
  - Small samples
  - Highly selected patients
  - Poor diagnostic criteria
  - Poor follow up
  - Other factors such as job demands.
 However differences are small.

- Despite this, many compensation patients do benefit.

(Waddell. The Back Pain Revolution 1998, Page 219)

It is important to keep in mind the **effect** of a clinician’s knowledge **of** the patient’s involvement in **litigation on** the belief system, attitude, mood, and behaviour of **the interviewer**, in a manner analogous to the effects on the patient.

### Influence of Litigation on Clinical Decision Making

- Distrust of veracity of patient's complaint
- Dislike of patient
- Fear of future litigation in the event of unsuccessful treatment
- Concern that the patient may not be able to focus fully on rehabilitation

(Page 229 Pain Management: an Interdisciplinary Approach. Main and Spanswick).

“Compensation” can take many forms, including personal injury, litigation, superannuation claim, disability support pension, relief from unpleasant tasks, obtaining a special role within the family and community. When this effect does not result in long-term improvement (as judged by a balance of measures such as symptoms, psychosocial functioning, health care consumption) this leads to **Abnormal Illness Behaviour**.

Particularly in situations when an external influence such as litigation is apparent, extra care and clarification of the patient's expectations and beliefs can be useful in designing a management plan. Hopefully the treating practitioners will also be aware of their own counter-transference and of the potential for this to result in **Abnormal Treatment Behaviour** in a manner analogous to the Abnormal Illness Behaviour of the patient.

Many people involved with third party and compensation issues **do** respond well to pain management and rehabilitation and their involvement in litigation alone does not determine the outcome. Outcome assessment relying upon observable parameters of activity and functioning is useful.

### **Malingering**

This is a contentious topic. While it is of great importance for medical practitioners to form a judgement as to whether this is relevant in the case before them, in a forensic setting malingering is not recognised as a medical condition but an example of corrupt behaviour and therefore outside the province of expert medical witnesses. The decider of fact in this legal jurisdiction is the judge of the court.

Medical practitioners should accept that the presence of an inconsistency in the patient's behaviour does not, of itself, constitute malingering. While it is quite reasonable, indeed a responsibility, for medical practitioners to develop an opinion as to whether this is likely, confirmation relies upon the demonstration that a person **knew they were not ill, and they intended to deceive others into believing they were ill**.

A crucial issue here is **knowing** what the patient believed, which cannot be objectively verified. As in many other situations the confidence of the observer can be significantly improved by consistency between observations and expectations, over time, in various situations, and between different observers. Not all situations will be clarified as easily as by finding the patients putting blood in their urine and some uncertainty may remain. However it is wise to employ the strategy, as in many other situations “When all else fails, ask the patient.” At times a surprisingly illuminating and often innocent explanation can explain an otherwise tense situation.

## **CHAPTER ELEVEN**

### **DELICATE SITUATIONS**

Many predicaments require careful interviewing. Some behaviour is accepted as “normal” and routine without recognition of its potential significance. The **oral contraceptive pill** and “**sleepers**” are often not considered as “medications” and are usually overlooked when information about “medication” is requested. Similarly, **over-the-counter** and **alternative medications** will frequently not come to mind for the patient, and sometimes present considerable concerns such as with Serotonergic Syndromes. A special issue is that of **injections**, particularly if not given as a routine, such as by after hour’s house calls.

The use of **marihuana** is extraordinarily common in the community, and is not considered by many to be “a drug.” Specific enquiry is often required. At times when use is likely, leading questions such as “how much do you use” rather than “do you use” will elicit a greater frequency of reported use.

A particularly careful history of **work practices** is often very useful. People vary widely in their assumptions as to what is standard or “normal” and enquiries regarding

- Paid hours of work
- Actual hours of work
- Number of days per week
- Rates of pay
- Use of lunch, tea and rest breaks
- Holiday frequency, duration and activities
- Pace of work
- Recovery times
- Injury rates
- Staff turnover rates
- The work environment
- Time off

Are important in assessing the stressors the patient was subject to, their past and current attitude to these and the likelihood of relapse because of the work environment and/or their attitude.

This is also important because of the **significance of the injury to the patient** (“I told them to fix it many times”), which influences their tolerance of the pain and disability. A decrease in this tolerance of distress, as well as the loss of trust, loyalty and commitment to those who were responsible for their welfare and safety, very often makes the difference between the person “carrying” their injury, as they may have done before, seeking health care (becoming a patient, adopting a **sick role**,) commencing litigation, and seeking the support of the community (sick leave).

Important behaviours such as “boom and bust,” working until stopped by intense pain followed by prolonged recovery periods, may reveal useful information for rehabilitation, because the continuation of such inappropriate behaviours can overcome the beneficial effects of most physical improvements, particularly if people deem it acceptable to stop on a new level of activity only when they are once again distressed, exhausted, disabled, and beaten in their attempts to keep going despite the pain.

## **CHAPTER TWELVE**

### **SENSITIVE ISSUES**

Sensitivity surrounds issues such as childhood maltreatment, infectious diseases (HIV, Hepatitis C), suicidal and deliberate self-harming behaviour, use of illicit drugs particularly in hospital, psychiatric admission, cultural issues, sexual orientation, relationship issues such as domestic violence and, illiteracy. These are often associated with other indicators of family and social dysfunction.

Some **management issues** have a similar effect such as the prescription and withdrawal of narcotic medication and benzodiazepines, referral to a psychiatrist, requests for further investigation and treatment particularly surgery and injections, and discharge from hospital and further treatment.

Discussion of these issues can be regarded as being very intrusive and it is useful to ensure the patient's permission before proceeding. Without this, proceeding is futile as the responses are not reliable.

It is useful to begin a **hierarchy of questions** with a very open form of questioning, as an invitation for the patient to elaborate as much as they are may be comfortable. Rapid progress can be made but occasionally this might takes months to years before the full information can be made available.

For example with respect to **suicidal ideation**, the subject may be approached initially by

- enquiries about a person's views of the future,
- then
- whether they anticipate enjoying life,
  - do they have plans for their life,
  - do they ever wish that they were not alive,
  - did they wish they were dead,
  - have they have any thoughts of taking their own life,
  - have they made any specific plans to take their life,
  - have they made preparations for their death,
  - recently?
  - have they decided a time and place for their dying,
  - have they ever engaged in any deliberate self harm behaviour,
  - do they intend to take their own life, and when?

These answers along with the history of past behaviours and associated risk factors (depression, past attempts, substance abuse, family history, other stressors, available supports, opportunity for relief from suffering, available means) provides as reasonable an estimation of their degree of suicidal risk as can be obtained, which is limited in any single individual.

Similar hierarchies of enquiry should be developed and practised by all practitioners dealing with patients.

## **CHAPTER THIRTEEN**

### **MENTAL STATE EXAMINATION**

Changes in mental state can be both a consequence and a contributor to pain. A mood disorder can result in a considerable change in perception and interpretation of the world leading to changes in posture, activity, understanding of events, and tolerance. The extent to which changes in mental state are relevant is assessed by also considering other factors - history, physical assessment and progress.

The mental state assessment is assessed by interview and observation, before making inferences about the emotional state, thought, perceptual, and intellectual processes and forming opinions regarding these in relation to the observers own understanding of the world.

Many personal, cultural and social variations need to be taken into account when forming these judgements. For example, the significance of some phenomena (eg hallucinations) varies with the state of consciousness, medical illness, age, and grief, and religious and cultural contexts. This is particularly important for pain patients as, by the time they have reached the Pain Clinic, they have come through a range of experiences that differentiate them from most people in the community, and an important issue is to consider how “normal” a particular reaction such as depression or suspiciousness is, given their past experiences – “What would you be like if you had gone through all that?” Caution is needed **interpreting** the significance of the mental state findings. In particular, dramatic improvements in a person’s mental state can occur quickly following good analgesia.

**Appearance and Behaviour** For patients with chronic pain this is a particularly important aspect of their mental state examination because pain affects many parameters of function. However, these are often difficult to describe because the practitioners response includes their own emotional reactions, which may be at a subliminal or unconscious level, and at times can be quite considerable. Clinicians who are aware of this, and who are able to use their own reactions in an educated manner will provide a better assessment.

The patient’s themselves may have very little awareness of changes in their own behaviour so that a collateral history from a close informant is often very productive. Many will make very clear their distress and their opinions, though others can be very sensitive especially with respect to judgements about degrees of control, intentionality and personal responsibility and may be very hesitant about disclosing information until they have obtained their confidence. It is not unusual for patients with chronic pain to be relatively inexpressive, reserved in their description of personal responses, yet strongly opinionated with respect to their interpretation of events and expected outcomes. They are often more assertive, and seek to persuade with a somewhat confrontationist style which is at times demanding, emphasised by body language, expression, and expectation. The types of pain behaviours should be noted and opinion later expressed as to their appropriateness (under Insight and Judgement).

An early judgement regarding the **level of consciousness** (which can be affected by analgesic, sedative and illicit medications) is important, because this mental state finding influences most other mental state findings. General presentation such as dress, aids, general level of self care, tattoos, scars, deformities, nicotine marks, skin texture of the hands, injection marks, etc can lead to consideration of several issues to be later clarified with the patient.

**Pain Behaviours** should be noted such as facial expression, manner in the interview, gait, expressions of distress, preoccupations, accompanying x-rays and notes, use of splints, braces

and aids, responses to examination and discussion of particular issues. The practitioner is required to form an opinion regarding the appropriateness of these behaviours.

**Mood** The patients' description of their subjective emotional state is noted along with observable phenomena (facial expression, posture, eye contact, tone of voice). It is useful to observe the reactivity of mood, including the response to attempts to lift their mood, responses to particular subjects discussed, and to movements.

It is common for chronic pain patients to become more sensitive and wary, hopeless and helpless, irritated, frustrated, or paradoxically restrained in their expression, until a rapport develops. Frequently there are a considerable number of grievances from previous losses and treatments, which may not have been expressed previously.

It is useful to deliberately take steps to develop a rapport, and to note the result when the patient is (politely) challenged. It is also useful to note the changes that can occur during the progress of the interview particularly if a considerable period of time is allowed for the patient to first "unwind and unburden."

Occasionally **alexithymia** (literally "no words for emotions") will be identified. This refers to a state of varying degree in which a patient will be unable to recognise, describe or use his or her own emotions. In a severe degree, such a person is severely disadvantaged because they lack the advantage of emotions as an alerting system, drawing our attention to areas of need.

**Thought** Eliciting the patient's belief system allows an understanding of their point of view, necessary when deciding the priorities of management, and to be able properly conduct an educational and cognitive behaviour therapy approach.

These beliefs can be elicited by **direct enquiry** and further **clarification**, particularly in relation to obvious sensitivities and apparent contradictions is very revealing. Encouragement to further clarify their approach may be required, as the patient's usual responses may seem very ordinary, sensible, and self-explanatory to them. They have been using these beliefs all their life, often derived from their family and their culture, and they can be surprised, and not always tolerant of different points of view. This is particularly so in relation to adjustments to long-term pain and disability. They are disadvantaged, defensive and have often encountered confusing and contradictory behaviours from others in the community, including medical practitioners. Society has developed consistent and well-known ways to respond to people with short-term conspicuous problems (eg a broken arm) but there is less consistency in the community in the models for responding to long-term pain and disability. Assumptions about the patient's beliefs should not be made.

**Locus of Control** refers to the sense of control over one's decisions, and life in general. Some experience life as if their decisions are not the result of their own careful considered reasoning and logical use of experience, but are forced upon them with little choice. **Dependent** people feel vulnerable, tend to be wary about upsetting those they depend on, and may seek to satisfy their needs to avoid criticism, or abandonment. **Obsessional** people respond to a very strong personal demand to satisfy very high standards to avoid intense self-criticism. In moderation all such personal styles can be very appropriate and constructive, though in extremes they are acted on without question despite repeated adverse outcomes. The practitioner needs to not only identify such patterns but to develop a well-grounded opinion as to whether such approaches are indeed adaptive or problematical.

Although the pain patient may have delusional ideas, fixed false beliefs which cannot satisfactorily be explained on the basis of cultural, religious or commonly accepted community ideas, it is much more common for them to have **overvalued ideas** understandable in terms of their personality style, social reinforcers, or experiences.

The **speed of thought processing** may be increased (agitation) or decreased (depression, or sedation). There should be an enquiry regarding **self-destructive thought**, and the potential for **danger to others**.

Those with **obsessive-compulsive behaviours** (as opposed to an obsessional style) usually have some degree of insight that the obsessional ideas they experience are inappropriate. They experience resistance to compulsively acting on the ideas, but they may be unsuccessful because of the dread of being overwhelmed by distress of catastrophic proportions if they do not complete behaviour, which have a personally symbolic but otherwise irrational pattern.

**Perception.** Hallucinations are false perceptions experienced without a stimulus activating the sensory receptor concerned. Illusions are distortions of actual stimuli. These are individual **subjective experiences** which can't be disproved by others. This is often a central issue for the patients with chronic **pain**, who frequently relate a history that their complaints of pain have not been accepted. There remains a widespread misconception in the lay and general medical community that it is possible to tell if another person is in pain or not. It frequently becomes an issue when those observing are responding not to the complaints of pain per se, but to the inconsistency between the complaints, observed pain behaviour, and lack of demonstrated physical cause. The lack of confidence of the observer is often based on the false premise that pain is synonymous with nociception, and proportional to the severity of physical damage.

It is possible but rare for patients to experience hallucinatory experiences of pain, with most cases being explained by further examination and investigation, and by a better understanding of the contributions to their pain experience from psychosocial factors.

**Dissociation** refers to a sense of detachment from the world, which may lead them to experience circumstances as an outsider, without the usual sense of being included or involved, as if watching a TV. They may lack the usual emotional rapport with their surroundings and they report feeling "different." This can take the form of **depersonalisation** and **derealization**, including "out of body" experiences. This has frequently been associated with PTSD (Post Traumatic Stress Disorder), Panic Disorder, and altered states of consciousness (Sleep Disorders, sedation, intoxication, use of psychoactive drugs).

**Cognitive Processes.** **Orientation** is assessed by enquiring regarding the person's sense of time, place, person, and space, as well as by observing their ability to move around the ward, or their community.

**Concentration** refers to an ability to maintain attention, and can be assessed by observing the patient's ability to follow the process of the interview, and ordinary daily activity. People with pain may have difficulty concentrating because of the intrusive nature of pain or because of the cognitive effects of some of their medications.

Asking a patient to perform a task, which requires few other skills, best assesses concentration. For this reason **reversing the months of the year**, the days of the week, or counting backwards from 20, is preferred over "serial sevens" which also requires ability in simple mathematics. The issue is to overcome the temptation to be distracted by other intrusive thoughts and impulses. Concentration can be impaired by emotional arousal (anxiety, anger,

depression) lack of intention (poor rapport, lack of understanding) or organic impairment (sedation, cerebral insult, withdrawal).

Assessment of this skill is most important when providing a patient with information about their predicament, when discussing management, and when the patient's own learning is paramount such as in rehabilitation.

**Memory** is usually assessed with respect to three functions,

- **Registration** (by immediate recall)
- **Short-term** (recall after a distraction and a short interval) and
- **Long-term** (recall of information relevant to the patient from their previous experiences). This is assessed by observing their recall of information provided during the interview, and of recent experiences known also to the assessor.

**Assessment of immediate recall** is undertaken by the patient initially learning new information (name and address, or several words) and immediately relating these back without interruption. No "storage" of this information is required to perform adequately.

**Short-term memory.** Recording the time, the assessor requests the patient to recall information provided after there has been an interruption to their focus on remembering these items by discussion of unrelated issues, preferably without extraordinary emotional arousal. This tests the ability of information to be placed in short term storage and to then be retrieved for use.

**Long-term memory** is assessed from the patient's own context, using recall of information that is reasonably understood to have been familiar to them. This assesses longer-term storage and retrieval mechanisms.

Each sense has its own memory, and the memory process is composed of several steps relying on other cognitive functions – attention, intention to remember, immediate registration, intention to recall, recall. Different neurophysiologic processes responsible for each stage. Psychological factors, including will, can also interfere. Relevance to the patient, whether the task sufficiently attracts their attention, is important. A patient only intent on another operation is unlikely to recall much of an educational programme.

Simple standardised psychometric tests can be used to provide consistency and reliability to cognitive testing interviews. Very detailed neuropsychological assessment is available if this is required.

**Literacy** There is an association between limited literacy the development of chronic pain and prognosis. Illiteracy limits rehabilitation and retraining, as well as being embarrassing. Patients frequently do not spontaneously report such difficulties especially as it is often associated with considerable past and present psychosocial deprivation. An index of suspicion and a specific enquiry is required to identify this important problem.

Clinical testing is simple, by asking the patient to read aloud passages of varying complexity, and seeking their explanation of the passages (**comprehension**). A similar approach applies for testing **numeracy**. It is worth noting that most newspapers are written to be understood at the level of a child in Year 6.

**Insight and Judgement** The patient's history, investigations, and mental state should have provided the practitioner with an understanding of the way a patient is thinking about their

predicament, their belief system, and their usual patterns of response. A statement regarding insight and judgement is a comment on the depth of understanding achieved by the patient, and the assessor's professional opinion regarding the appropriateness of these. This will of course also reflect upon the assessor's own understanding, level of insight, and judgement.

Insight is best viewed on a continuum (rather than comments such as "Has insight" or "No insight") with levels including

- No abnormality acknowledged by the patient at all.
- A change, but not considered an illness.
- An illness, but type (physical and/or psychological) not specified.
- An illness, though with a limited acknowledgement of all the features (eg physical only).
- A diagnosis with awareness of symptoms, signs, but without an understanding of aetiology.
- An understanding of the immediate pathology leading to the illness but without an understanding of the cause of this pathology.
- An understanding of the development of the pathology, predisposing and precipitating factors but without an understanding of the mechanism by which these have acted.
- An in depth understanding of the illness, its precipitating cause, predisposing factors, consequences, and of the nature of the relationship between these factors from a biopsychosocial point of view.
- The above plus similarly detailed understanding of the management.

Assessments of the **judgement** of a person needs to first take into account their level of insight, for the practitioner to be able to decide if the patient's decisions were reasonable in the light of their understanding.

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## **CHAPTER FOURTEEN**

### **PSYCHIATRIC DIAGNOSES**

The most commonly used diagnostic classification is the DSM IV (Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> edition, American Psychiatric Association). DSM-IV adopts an atheoretical stance with regards to causation and describes mental disorders in accordance with specific diagnostic criteria. DSM IV also describes the mental disorders in terms of familial patterns, prevalence, incidence, predisposing factors and possible differential diagnoses. Finally, the mental disorders are also described according to age, culture, and gender related features.

DSM-IV aims to provide clinical utility in many settings also aims to assist in education and research. It is a consensus document partly supported by research. It is not a definitive or permanent taxonomy. It does not claim that all its diagnostic categories are valid and uses the term disorder and not disease because it does not assume that entities it describes are diseases.

DSM-IV has attracted criticism for a number of reasons:

1. It emphasises consensus and acceptability more than validity
2. Co-occurrence or co morbidity of DSM IV categories are higher than in other branches of medicine. This raises the question do the DSM IV categories represent discrete entities or are they different aspects of larger symptom complexes?
3. Most categories lack an adequate empirical database and thus it is uncertain if the nosology is consistent with the database
4. The atheoretical stance has failed to involve developments in theory of causation
5. The use of a categorical approach in DSM IV is easy to use for those with medical training. There is little evidence to suggest that such an approach is more useful or valid than a dimensional system.
6. The DSM IV multi-axial system implies differences across Axis 1 (mental disorders), Axis 2 (personality disorders) and Axis 3 (medical disorder). This distinction between psychiatric and medical conditions makes less sense as knowledge accumulates concerning the biologic basis of psychiatric disorder and the effects of psychosocial variables on medical illnesses.

It is probably useful to see “DSM-IV as a practically oriented, consensus system incorporating clinical belief and research data. Limitations are direct consequences of its intentionally descriptive approach; others stem from across the board adoption of a quasi-categorical system using polythetic criteria. To its credit it has an acceptable level of face validity and a more modest level of descriptive validity. It is an open system for clinicians and researchers and is **intended to be replaced in the future** by more definitive and research based nosological system which incorporates aetiology and pathology”. (Bogenschutz M, Nurnberg G, page 839)

The multi-axial system of diagnoses used is described below: The five axes include:

- **Axis I Clinical Disorders**  
Other conditions that may be a focus of clinical attention
- **Axis II Personality Disorders**  
Mental retardation
- **Axis III General Medical Conditions**
- **Axis IV Psychosocial and Environmental Problems**
- **Axis V Global Assessment of Functioning**

The **definition of Mental Disorder** requires that there be a clinically significant impairment or distress. This criterion helps establish the threshold for the diagnosis of a disorder in those situations in which the symptomatic presentation by itself (particularly in its milder forms) is not inherently pathological and may be encountered in individuals for whom a diagnosis of a "Mental Disorder" would be inappropriate. All human distress is not necessarily a psychiatric disorder. Assessing whether the criterion of "a Disorder" is met, especially in terms of role function, can be a difficult clinical judgement. Reliance on information from family members and other third parties (in addition to the individual) regarding the individual's performance is often necessary. (DSM IV: Coding and Reporting Procedures).

Pain may be the presenting symptom of virtually all psychiatric diagnoses although the priority given to the pain as the main focus of clinical attention will vary.

Many psychiatric disorders (Depressive Disorder, Anxiety Disorders, some Personality Disorders) predispose to people having difficulty tolerating their pain, and to their seeking specialised help for the pain. Disorders may co-exist resulting from the same causative factors (a physically and psychologically traumatic accident and PTSD), or the psychiatric disorder may be a direct consequence of the condition causing the pain (Depressive Disorder, Anxiety Disorder, Adjustment Disorder, Pain Disorder).

**The Somatoform Disorders Group** have the common feature of physical symptoms that suggest a general medical condition but which is not fully explained by the general medical condition, or by the direct effects of a substance or by another mental disorder (e.g. Panic Disorder).

The symptoms must cause clinically significant distress or impairment in social, occupational, or other areas of functioning. In contrast to Factitious Disorder and Malingering, the physical symptoms are not intentional (i.e. judged to be not under their voluntary control). The somatoform disorders, factitious disorder, and malingering may be illness-affirming forms of **Abnormal Illness Behaviour**.

### **Somatoform Disorders Group**

**1. Somatization Disorder** is a poly-symptomatic disorder that begins before the age of 30, extends over years, and is characterised by a combination of pain, gastro intestinal, sexual, and pseudo neurological symptoms. To satisfy the diagnosis requires

- Four pain symptoms.
- Two gastro intestinal symptoms.
- One sexual symptom.
- One pseudo neurological symptom.
- No general medical condition, or substance use to explain the above satisfactorily.
- The symptoms are not intentionally produced

**2. Undifferentiated Somatoform Disorder** requires

- One or more physical symptoms.
- Unable to be satisfactorily explained by a general medical condition or substance use.
- Clinically significant stress or impairment.
- Duration of at least 6 months.
- Not better accounted for by another mental disorder.

- The symptom is not intentionally produced.

**3. Conversion Disorder** could be considered as having “signs without symptoms” i.e. La belle indifference, although this is uncommonly seen in extreme forms now.

- One or more symptoms or deficits affect voluntary motor or sensory function in a manner that suggests a neurological or other general medical condition.
- Psychological factors are judged to be associated with the symptom or deficit because conflicts or other stressors precede the initiation or exacerbation of the symptom or deficit.
- The symptom or deficit is not intentionally produced.
- This cannot be fully explained by a general medical condition, or by the use of a substance, or as a culturally sanctioned behaviour or experience.
- The symptom causes clinically significant distress or impairment, or warrants medical evaluation.
- The symptom or deficit is not limited to pain or sexual dysfunction, it does not occur exclusively during the course of somatization disorder, and is not better accounted for by another Mental Disorder.

**4. Hypochondriasis** can be described as having “symptoms without signs” (based on anxiety about being ill), in contrast to conversion disorder with a lack of concern

- a) Preoccupation with fears of having, or the idea that one has, a serious disease based on the person’s misinterpretation of bodily symptoms.
- b) The preoccupation persists despite appropriate medical evaluation and reassurance.
- c) The belief is not of delusional intensity (as in Delusional Disorder, Somatic Type) and is not restricted to a circumscribed concern about appearance (as in Body Dysmorphic Disorder).
- d) The preoccupation causes clinically significant distress or impairment.
- e) The duration of the disturbance is at least 6 months if the preoccupation is not better accounted for another psychiatric disorder.

**5. Pain Disorder.** The DSM IV deliberately separates Pain from Conversion Disorders within the Somatoform Disorders Group, even though some of the psychological mechanisms for the symptom formation and exacerbation may be the same. Pain is seen to be less well-defined and more complex than only involving psychological mechanisms.

- a) Pain in one or more anatomical sites as a predominant focus of the clinical presentation, which is of sufficient severity to warrant clinical attention.
- b) The pain causes clinically significant distress or impairment or social, occupational, or other important areas of functioning.
- c) Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
- d) The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
- e) The pain is not better accounted for by a mood, anxiety, or psychotic disorder and does not meet criteria for Dyspareunia.

This diagnosis is further sub-categorised to

- **Pain Disorder associated with psychological factors**, acute and chronic.
- **Pain Disorder associated with both psychological factors and a general medical condition**, acute and chronic.

**Pain Disorder associated with a general medical condition** (alone) is **not** considered to be a mental disorder, but can be considered as a differential diagnosis. This is considered if

- A general medical condition has a major role on the onset, severity, exacerbation or maintenance of the pain.
- If psychological factors are present, they are not judged to have a major role.

**Anxiety Disorders** are sub-classified into

- Post Traumatic Stress Disorder
- Acute Stress Disorder
- Panic attack.
- Agoraphobia.
- Specific phobia.
- Social phobia.
- Obsessive Compulsive Disorder.

Note that the latter is not the same as Obsessive Compulsive Personality Disorder (see below).

An essential feature of **Post Traumatic Stress Disorder** is the development of characteristic symptoms following exposure to an extremely traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's personal integrity. The exposure might occur by witnessing such events occurring to others, or about learning of such events experienced by close associates.

The person's response must involve intense fear, helplessness, or horror. The characteristic symptoms resulting from the exposure include persistent re-experiencing, persistent avoidance of stimuli associated with the trauma, and a numbing of general responsiveness, along with persistent symptoms of increased arousal (insomnia, irritability, difficulty concentrating, hyper-vigilance, exaggerated startle).

The full symptom picture must be present for more than one month and cause clinically significant distress or impairment of functioning.

An **Acute Distress Disorder** has similar features, which occur within one month after the exposure to an extreme stressor. Dissociative symptoms include the subjective sense of numbing, detachment, an absence of emotional responsiveness, a reduction in awareness of surroundings, de-realisation, depersonalisation, and dissociative amnesia. This disorder must last for at least two days but does not persist beyond four weeks after the traumatic event.

Those with a **General Anxiety Disorder** have excessive anxiety and worry (apprehensive expectation) occurring more days than not for a period of at least six months about a number of events and activities. The person finds it difficult to control the worry

Symptoms include

- restlessness or feeling keyed up or on edge
- being easily fatigued
- difficulty concentrating
- irritability
- muscle tension
- insomnia.

The General Anxiety Disorder needs to be differentiated from an **Anxiety Disorder due to the direct physiological effects of a general medical condition, or use of substances.**

**Major Depressive Disorder** have a disturbance in mood as the predominant feature with a period of at least two weeks during which there is either depressed mood, or loss of interest or pleasure in nearly all activities. The individual must also experience at least four additional symptoms including

- Change in appetite or weight, sleep, psychomotor activity.
- Decreased energy.
- Feelings of worthlessness or guilt.
- Difficulty thinking, concentrating, or making decisions.
- Recurrent thoughts of death or suicidal ideation.

To count towards a major depressive episode, a symptom must be either nearly present or must have clearly worsened compared to a person's pre-episode status. The symptoms must persist for most of the day, nearly every day, for at least two consecutive weeks, and be accompanied by a clinically significant distress or impairment. For milder episodes, functioning may appear to be normal, but requires markedly increased effort.

**Dysthymic Disorder** refers to a chronically depressed mood that occurs for most of the days for at least two years with at least two additional symptoms of Major Depressive Disorder. The symptoms may become a part of the individual's day to day experience, and are differentiated from major depressive episodes by severity.

**Adjustment Disorders.** The essential feature of an Adjustment Disorder is the development of clinically significant emotional or behavioural symptoms in response to an identifiable psychosocial stressor. These symptoms must develop within three months after the onset of the stressor and the clinical significance of the reaction is indicated either by marked distress in excess of what would be expected, given the nature of the stressor, or by significant impairment and social or occupational functioning.

This category should not be used if the disturbance meets the criteria for another Axis I Disorder that accounts for the pattern of symptoms. An **uncomplicated bereavement reaction** is not considered pathological, and therefore not an Adjustment Disorder.

The symptoms may persist for a prolonged period (longer than six months) if they occur in response to a chronic stressor (e.g. a chronic disabling general medical condition) or to a stressor that has enduring consequences (financial and emotional difficulties resulting from the onset of a disability). In other circumstances an Adjustment Disorder is considered to resolve within six months of the termination of the stressor or its consequences.

## **CHAPTER FIFTEEN**

### **PERSONALITY DISORDER**

**Personality traits** are enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute personality disorders.

A **personality disorder** is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. Such disorders may be "ego syntonic" such that the individual may have little distress, or if they do, little insight that their distress is the result of difficulties of their own judgement.

Pointers for suspecting a personality disorder include:

- Long-term psychosocial difficulties inconsistent with the person's culture.
- Relationship problems, family, social, work colleagues, authorities, intimate relationships.
- Impulse control problems – substance abuse, gambling, financial problems, relationship problems, itinerant lifestyle, multiple jobs, doctors, residences.
- Cognitive problems – ways of perceiving and interpreting self, other people, events.
- Affectivity – problems with the range, intensity, stability, and appropriateness of emotional response.
- Forensic problems – history of recurrent prosecution, conflict with authorities, litigiousness.
- Employment problems – an inability to maintain a consistent work record, frequent changes in occupation, absenteeism.

It should be noted that these criteria are substantially subjective and matters of opinion of the observer and would be significantly affected by the observer's own personal experience, culture, resources etc. The appropriateness of personality functioning is often determined significantly by the socio-cultural context. The essence of a Personality Disorder is that a person had difficulties over a long period of time over a considerable range of situations without learning and changing from the experiences.

It is useful for the practitioner to have a conceptual model of appropriate functioning and boundaries accepting that these issues continue to be the subject of considerable debate, with relatively limited inter-rater reliability. The "operational criteria" for personality, and for each disorder, have limited substantiation, reflecting the subjective nature of the issues under consideration. There is no requirement to specifically categorise each individual into one particular personality type, and it is recommended that those assessing consider using several different personality descriptors where appropriate. From a clinical, as opposed to a research perspective, a useful approach is to understand the particular individual presenting, how they have reacted to their own particular experiences of life, and how these experiences may have shaped their responses to their current and anticipated situations. It is the clinicians understanding of their patient's personality functioning, rather than their ability to diagnostically categorise the patient, that will be important in deciding such issues as appropriate management to be offered, and prognosis.

### **Different Categories of Personality Disorder**

#### **Odd, eccentric cluster (Cluster A)**

- **Paranoid** (a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent).
- **Schizoid** (a pattern of detachment from social relationships and a restricted range of emotional expression).
- **Schizotypal** (a pattern of acute discomfort in close relationships, cognitive and perceptual distortions, and eccentricities of behaviour.)

#### **Dramatic, emotional, erratic cluster (Cluster B)**

- **Antisocial** (a pattern of disregard for and violation of the rights of others).
- **Borderline** (a pattern of instability in interpersonal relationships, self image, affects, and marked impulsivity.)
- **Histrionic** (a pattern of excessive emotionality and attention seeking.)
- **Narcissistic** (a pattern of grandiosity, a need for admiration, and a lack of empathy.)

#### **a) Anxious, fearful cluster (Cluster C)**

- **Avoidant** (a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluations)
- **Dependent** (a pattern of submissive and clinging behaviour, related to an excessive need to be taken care of.)
- **Obsessive-compulsive** (a pattern of preoccupation with orderliness, perfectionism, and control.)

## **CHAPTER SIXTEEN**

### **DIFFICULT PATIENTS**

Difficult patients may be defined as patients who do not conform to the practitioner's expectations, who do not change in response to advice or requests, yet, who present a frustrating predicament of continuing to expect support, relief, and satisfaction.

While some such patients might have elusive physical pathology, this is not usually the case. They may not present a complete history, or it may be confusing. The development of rapport and of a therapeutic alliance may be limited because of anxiety, depression, or anger and distrust. These features may be evident during an interview, by a limited involvement in treatment, with non-compliance, opposition, or by criticism of the practitioner. In extreme cases this might involve threats to the practitioner.

The practitioner is presented with a contradictory picture of a person asking for help but seeming to block progress. Other issues apart from the presenting physical symptoms and medical complaint need to be considered.

Such patients are often using psychological **defence** mechanisms, a term which clearly describes the reason for their existence. Defence mechanism defends the patient from the threat of overwhelming distress or threats their ability to function, to be independent and secure. No sensible person would give up such a defence unless they were confident that their safety was assured. People in distress need to have good grounds to believe that a better future awaits them if they do relinquish their defences. To change involves risk. . At times those with judgement that is impaired, often by past experiences, hold on to defences in situations when the "defence" actually becomes harmful. Such people need extra assistance to overcome the fear of future harm from movement, and the associated pain, in order to negotiate the changes required for their return to health.

Presentations with syndromes that continue to be the subject of considerable debate (**Fibromyalgia, Chronic Fatigue Syndrome, Myalgic Encephalopathy**) are a special challenge. During the interview the patients often have a very fixed opinion about their own predicament and are not seeking further explanation, clarification, or education about their disorder. They may be well acquainted with the literature about these issues, either from support groups, Internet sites, or their own doctors. Attendance at a Pain Clinic is often with a limited aim in mind, usually with an exclusively physical focus, without seeking substantial changes in their approach.

Considerable effort is usually needed to develop a good rapport, which can be assisted by an explanation of the current knowledge and theory regarding the issues. It is useful to acknowledge the uncertainty about the field, the lack of objectivity any firm scientific basis, while at the same time making clear an acceptance of the patient's suffering, including their experience of pain. The interviewer needs to be careful that non-acceptance of the patient's explanation does not lead to non-acceptance of their distress; the patient, if they are to be able to be helped, needs to also accept that the two issues are not inextricably linked. Considerable tolerance of uncertainty is required from all parties; at times making this explicit allows the assessment to proceed.

Very often the resolution of the difficult situations presenting can be found in answering the question "Why does this particular patient present, to me, at this particular time?" Very often the reason given for presenting is "Pain" but when it is considered that the patient has been

experiencing pain for years this alone cannot be the only reason for the current presentation. It must have something to do with the **effect** of the pain at this time, some extra hope (eg new internet information) or greater difficulty tolerating their pain. It can be informative to review the referral process particularly when there have been third parties involved such as Health Department concerns regarding opiate use. These may not be “voluntary” patients.

## The Angry Patient

Being confronted with a patient who is very angry represents a special difficulty, not the least because it is more difficult to get close to them, to provide the care that might well be required to relieve their distress. Anger differs markedly from anxiety and depression, which elicit care giving responses from others. Anger tends to have the effect of dividing people, with either a defensive retreat or an angry aggressive response in retaliation. It is particularly important for medical practitioners to be aware of their own responses, or counter transference reactions, to angry patients.

### Causes

The most common cause is **unrelieved distress**. This might well be a direct response to unrelieved pain, or an indirect response to the pain as a measure of the patient's desperation, disappointment, or lack of acceptance that they are not going to get the comprehensive relief and return to usual functioning that they had expected. The anger is commonly in response to a perception of poor treatment, a sense of entitlement, and a growing distrust. It is important to not automatically dismiss these sentiments as inappropriate, but to hear both sides before making a judgment.

Anger can be a feature of **disordered mental states**, most importantly intoxication, withdrawal, and delirium, or a manifestations of mood disorders such as depression, anxiety, and, uncommonly, mania. Occasionally these may be emotional responses to severely disordered states such as psychotic phenomena, notably those associated with substance abuse.

It is important to consider potentially serious and easily treatable **medical conditions** such as hypoglycemia, epileptic phenomena as well as head injury.

Some people have a history of recurrent, angry episodes, which are more likely to be a reflection of their **personality style**. This can result from poor impulse control, poor problem solving skills, limited communication abilities, long term experiences with suffering, neglect and deprivation, or, uncommonly, the sub-cultural learning to use aggression as an accepted means of dealing with problems and protecting oneself. Those who have been treated frequently in an aggressive manner will "learn", and are more inclined to use the same mechanisms themselves.

These responses need to be differentiated from the **intentional and willful use** of anger and aggression to manipulate and bully medical practitioners to submit to inappropriate treatments such as inappropriate prescription of narcotics for drug abuse. This is uncommon.

It is important to recognize the far more common phenomena of patients experiencing a grief reaction with their anger being a manifestation of this. They have experienced multiple, major and enduring losses, without adequate replacement, and they are often poorly equipped and not well supported, predisposing them to such **morbid grief reactions**.

### Assessment

It is useful to differentiate an **angry mood** and **angry behaviour** as separate issues. A judgment is required as to whether each, separately, is either appropriate or inappropriate.

One can only satisfactorily identify an angry mood, directly, with the willing cooperation of the patient as it is, like pain, a subjective experience. Ask the patient.

As with pain, there is not a directly proportional relationship between observations of angry behaviour, and the intensity of the angry experience of the patient.

Like other assessments, the medical practitioner can be guided by a high index of suspicion, directly asking the patient, and by observations of their expression and behaviour. As with pain, it is of fundamental importance that a medical practitioner does not assume to know the patient's experience, to tell them how they feel. Assessments are made by using a variety of parameters, including the patient's own report, with the degree of confidence in the judgment relying upon consistency between the observations, and over time.

### **Presentations**

Anger may manifest in many ways. Paradoxically, an excessively "agreeable", familiar attitude – "Can't do enough for you doctor" - may be stimulated by a reaction formation to angry sentiments that the patient finds annoying.

More commonly, a marked withdrawal with silence, a lack of spontaneity, limited rapport, poor compliance and poor eye contact is evident.

More active forms of expression of anger include abuse, yelling and gestures. Less obvious expression may include continuing complaints of symptoms after full explanation. Complaints and criticism may be directed at others even when the anger might arise in the relationship with the medical practitioner. Excessive praise of the treating medical practitioner and criticism of other staff can lead an unwary practitioner into contributing to splitting, with the effect that staff can get into conflict, in an indirect response to the patient's anger. This transfer of anger, with indirect results, is particularly notable in association with people with Borderline Personality Disorders. Some people "act out" their anger by use of deliberate self-harm.

Anger is frequently initiated the prime precipitating and motivating factor for litigation, rather than such action only commencing just because the patient experienced harm. Many litigants complain about the manner in which they have been treated, with this being very influential in their decision to seek an explanation, apology, and compensation.

### **Management**

There are immediate, short and long term issues to consider.

The **immediate** issues are to diffuse any sense of threat, to remove danger, and to obtain an assessment of the patient's immediate concerns.

Rapport may be developed by acknowledging the patient's anger, not automatically dismissing it, and by demonstrating a willingness to seriously consider the patient's point of view. This may require clear indications to the patient that adequate time will be set aside, that the practitioner is actively listening, and that while the practitioner cannot reasonably commit to agreeing with all the points of view of the patient, some effort will be made to respond to relieve distress where possible, or at least to provide a clear explanation as to why this is not possible.

If in the immediate situation a full resolution is not possible, a commitment to further attend to the issues can provide considerable relief.

**Direct confrontation** is not commonly required. In these situations it remains important to offer reasonable face-saving options, including recognition that the patient has rights and freedoms. It is also important to courteously make the point that the patient also has responsibilities, and that the practitioner has rights and responsibilities as well.

For example “No Mr Bloggs you don’t have to come into hospital / have an operation / take medication, but I don’t have to prescribe pethidine / valium / arrange surgery / give you an injection. I am not permitted to provide treatment unless I believe it is in your best interest. Perhaps we can consider other ways to help you.”

It is of crucial importance to **identify and negotiate areas of agreement**, seeking to develop a **therapeutic alliance**. In an environment of angry rejection and distrust, these may be few grounds to begin with but those that do exist can be used as a significant starting point. It remains the patient’s choice as to whether their limited beginnings are worth their while pursuing. It remains important for the practitioner to recognize that some options have to be “packaged together” and for them to be wary of excessively compromising standards, safety, and effectiveness. For example opiates may be provided, but only after adequate supervision has been established. Most people, with an adequate explanation, will accept recommendations when it has been clearly explained why these would assist their own welfare.

### **Cautions**

The medical practitioner needs to be careful in observing the progress of the interview particularly looking for the patient’s sensitive issues, opportunities to provide relief, or indications that the patient is not settling but “winding up.” It is crucial to detect when the patient is simply not able to process or consider the issues required. Even mild intoxication can severely impair problem-solving abilities, which, when combined with disinhibition of emotional reactions, presents a situation of some danger to both the patient and the practitioner because of a much higher risk of impulsive, reckless behaviour.

It is useful to also observe the mood and attitude of others nearby, perhaps moving to a quiet, well-lit area where a person is more likely to concentrate without interruption or interference.

Sensitive enquiries about intentions to be violent, a past history of violence, possession of weapons, any future hopes and planning are important. “Trigger points” of sensitive issues are useful to know.

In situations of obvious higher risk it is **important for a practitioner to ensure their own safety**, to have an avenue of escape and support, guided by their own level of confidence as an important indicator. An anxious medical practitioner will be much less effective in reassuring a distressed patient. Providing for the practitioner’s safety is useful also for the patient.

The practitioner needs to be very mindful of all their **communications** particularly **non-verbal** as well as **the verbal**. An excellent clinical assessment and formulation may be not much use if it is not conveyed with the gestures, tone of voice, manner and responsiveness that assists a patient to build trust. Being seated on the patient’s level, making eye contact, seriously listening, allowing the patient to ventilate are very useful in the development of the trust and hope which are very powerful weapons against desperation and despair. Feedback summarizing the clinician’s understanding of what the patient has just said, with an outline of proposed responses, assists.

The practitioner needs to be aware of their own **counter transference** responses, being careful to channel these in a constructive manner rather than impulsively, as the patient may be doing. After a difficult interview it is useful for the practitioner to reflect on the experience, both to review the difficulties presented by the patient's problems and manner, as well as to review their own responses. Medical practitioners need to look after themselves as well. The option of consulting with an experienced and trusted colleague should be considered, with an indication present if the practitioner does not settle in their own responses quite readily, particularly if their own reaction has a tendency to interfere with other relationships both professional and private.

**Common causes of anger, hostility and resentment**

- Causal agent – chronic pain.
- Doctors – because of diagnostic ambiguity, treatment failure.
- Psychiatrists/Psychologists – because of suggestions the pain may be psychogenic  
Or the patient has some form of psychopathology.
- Lawyers – because of adversarial nature of the legal system, because of scrutiny and arbitration.
- Insurance companies/social security – because of inadequate monetary coverage or inadequate compensation.
- Employer – because of cessation of employment, job transfer, job retraining.
- Significant others –because of lack of interpersonal support.
- God – because of predetermined injury and consequences, fate.
- Self – because disablement, disfigurement makes the patient less than he or she was
- The whole world – because of alienation

(Modified from Ferdenandez E and Turk DC 1995 P Volume 61 pages 165 – 175, 1995)

**CHAPTER SEVENTEEN****ABNORMAL ILLNESS BEHAVIOUR**

This concept, elaborated by Professor Issy Pilowsky of Adelaide, is fundamental to our understanding of pain patients and provides a model for explaining many of the unusual presentations and behaviours of our patients. It should not however be considered a diagnostic entity but rather a way of understanding patterns of behaviour.

**By first considering “normal” Illness Behaviour and the associated concepts of the Sick Role, and Treatment Behaviour can understand Abnormal Illness Behaviour.**

Practitioners use their own training and experience to judge the appropriateness of behaviour observed, usually based on the common responses of people with unambiguous uncomplicated short-term physical disorders such as appendicitis and pneumonia. These concepts are most clearly defined in relation to these situations. The task is to apply the principles to the more complicated situations when illness is prolonged, not conspicuous or even measurable, and variable.

People generally accept that life will at times require them to endure and persist even if uncomfortable as long as they are not suffering an illness. The designation of a state of “illness,” the altered social relationships and the associated behaviours of “being ill,” -“the sick role” - confer a set of privileges and expectations upon an individual by the community, with problems arising as a result of non-compliance, or perceptions of non-compliance.

Most people will try to endure, for example with a fever, but they

- Become aware that this is interfering with their functioning
- Decide if they can deal with it themselves or if it requires professional attention
- Arrange professional attention
- Make their own judgement regarding the urgency of the matter
- Provide the medical practitioner with all the information available to them
- Subject themselves to appropriate examination and investigation
- Participate in a discussion about diagnoses and therapeutic options
- Develop a therapeutic alliance, and management plan

Subsequently the individuals who are **now agreed as being “sick.”**

**Society**, when recognising somebody as ill, has **expectations** as to how they will behave. The “patient” is now allowed to

- Relinquish certain responsibilities,
- Complain,
- Seek and accept caring and support (emotional, personal, financial)

The **patient** is now required to

- Comply with treatment, which involves at times
- Apply their own effort,
- Tolerate some discomfort (pain, side effects of medications)
- Continue to report and to seek to resolve difficulties
- Intend to return to usual health, good functioning, and independence within the shortest possible time.

The **doctor** is also expected to

- Be available for patients (to a reasonable degree),
- Listen to the patient's complaints (providing a history)
- Conduct an adequate examination and investigation
- Consider the appropriate diagnoses
- Demonstrate a professional interest in the patient's welfare
- Take into account their socio-cultural context,
- Design the management approach with that particular individual in mind at the particular time in question.

Illness behaviour, the sick role, and treatment behaviour, can all become disordered by either being excessive (**illness affirming**), insufficient (**illness denying**) or **complicated** by being used for some purpose not directly related to the illness (recreational substance abuse, unreasonable avoidance).

Examples of **Abnormal Treatment Behaviour** which have been demonstrated to predispose to chronicity include

- Reliance on a narrow medical model of pain
- Emphasis short term palliative care, with no long term management plan
- Discouragement of self care and failure to instruct the patient in self management
- Sanctioning disability
- Lack of provision of interventions that will improve function
- Over-investigation, perpetuating the belief in the "broken part" hypothesis

**Somatization** can be often be minimised by explanation. Most people are very easily able to recall incidents in ordinary life in which they have provided emotional support to a person who is physically injured and noted the marked improvement this brings, with a reduction of suffering and increased functioning following this. This occurs when parents comfort their children who have been hurt.

There are many subjects which a patient, particularly early in the period of contact, may be reluctant to discuss, being uncomfortable, embarrassed, ashamed, or be simply unaware and naive regarding their importance. This particularly relates to the relevance of psychosocial issues for pain patients with pain, attributed by learning and physiology (attentional focus) to a physical focus of concern. It is only by a more mature abstract consideration of experience and the interrelationship of the factors in a person's life that confidence can be obtained regarding the relevance of many other factors as well as the physical. The ability for this type of conceptual thinking varies markedly between people. Those with obsessional personality style for example have a marked tendency towards concrete thinking, a physical focus, an intolerance of doubt and uncertainty, being much more responsive to physical explanation because of the apparent opportunity for relief from such objective approaches.

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## **CHAPTER EIGHTEEN**

### **MAKING A LINK (between emotions and physical symptoms).**

Special strategies are required to help people with physical symptoms and psychological distress who cannot make the link between the symptoms and their emotional and life problems.

Commonly the process begins by assisting the patient to have **confidence** that their complaints have **been heard and considered**, and that there is an understanding for them. It is often useful to start from the patient's viewpoint, to find out their ideas about the cause of the symptoms.

Depending upon the response of the patient, and the extent to which rapport has been established, it is useful to broaden the discussion to cover physical, psychological and social issues. After a detailed description of the patient's pain and how the current predicament has developed, enquiries can be broadened to the psychosocial effects of their pain including the **changes to their life**.

It is usually very easy to sympathise with the patient's hurt in the context of the substantial disruption to their life and expectations, especially in the light of their efforts to improve their circumstances and their families. This does not unfortunately guarantee good **judgement**, particularly by those attending Pain Clinics. Pain Clinic patients have been differentiated as a special group in the general community who, even before their injury, have been at much greater risk of the development of chronicity because of their adverse life experiences.

The links between symptoms, physical and emotional, may be made during a reflective summary with the patient, associating these life events and their responses where appropriate.

Various techniques can be employed, including

- Simple explanation in a manner that the patient can understand. (It is often useful to check their understanding by having them repeat this in their own words.)
- A Time Line, with "Pain Events" on one side of a line marked off, and psychosocial events marked off on the opposite side with a corresponding chronology.
- Appropriate and timely interpretation during interviews, and during the progress of treatment, such as when it can be observed that a patient experiences more pain when discussing particular subjects. This may be obvious by their comment, by their uncomfortable "pain" behaviour, or by their distraction or avoidance from the subject on the basis of pain.
- Contradictions in approaches and behaviours indicating likely emotional contributions to be further explored by frank, sensitive discussion with the patient (not **"at"** the patient). These should **not** be prematurely considered as malingering.

Confidence in such linkages develops with consistency of such observations, though care is needed to avoid premature closure on opinions formed. Considerable skill is also required to constructively manage the **confrontations** involved as these can be very sensitive times for patients who become aware of the inappropriateness, and perhaps considerable damage, that has come from their own approaches. A lot of personal skill and self control is needed to manage this insight, which in this "damaged" population cannot always be taken for granted.

Management of **denial** can be difficult. Patients should not automatically unquestioningly be forced to confront their illness. The decision to confront denial must be based on whether the denial is adaptive, whether support is available to the patient, and whether the patient is willing

to deal with the fears, which underlie the denial. If early attempts to broach the issue are met with increased protest, this should cause the practitioner to be cautious, to consider whether important issues have been addressed sufficiently, or whether a reasonable therapeutic alliance exists.

At times a “patient” **does not comply** with all the requirements to improve. This is usually because of a lack of understanding, or a lack of trust and acceptance of advice offered. On occasions there will be other powerful motivations reinforcing Illness Behaviour. These may be better managed by specialist referral to deal with personal issues in a more focussed way, or tactical withdrawal from involvement in specific pain management therapies until an appropriate therapeutic alliance can be established. It is frequently the case that people develop a different attitude at a later date after they have satisfied doubts about other issues such as the likelihood of cure by the use of further investigations, surgery or medications.

Once the patient and doctor have agreed that psychological distress is an important factor in the patient’s illness, they can start to discuss management options.

**CHAPTER NINETEEN****HELPING CHANGE**

Most assessments will occur in a clinical setting. Especially for those in chronic pain with no cure available, passive approaches by the patient, reliant upon activity by the practitioner alone, is unlikely to improve to their situation. Given that pain itself is unlikely to be eliminated altogether, a change in the patient's response to their problem of living with their pain is required.

**Explore motivation for change.**

- Build a rapport and be neutral.
- Help draw up a list of problems and priorities.
- Is problem behaviour on a patient's agenda?
- If not raise it sensitively.
- Does the patient consider the behaviour a problem?
- Do others?

**Clarify patient's view of the problem**

- Help draw up a balance sheet of pros and cons.
- Empathise with the difficulty of changing.
- Reinforce statements that express a desire to change.
- Summarise frequently.
- Discuss statements, which are contradictory.

**Promote resolution.**

- Enable informed decision-making.
- Give basic information about safety or risks of behaviour.
- Provide results of any examination or test.
- Highlight potential medical, legal, or social consequences.
- Explain likely outcome of potential choices or interventions.
- Get feedback from patient.
- Give patient responsibility for decision.

Gask and Usherwood. BMJ 2002

**CHAPTER TWENTY****MANAGEMENT PLANNING**

This should be the culmination of a quality assessment process which provides the answers to the following questions, which has successfully engaged the patient in a cooperative process with the practitioner, and which can smoothly and predictably lead on to productive responses.

- **Ascertain expectations.**

What does the patient know?

What does the patient want? (Investigation, management, outcomes)

What are the patient's priorities?

- **Advice on options.**

Elicit patient preferences, priorities.

- **Develop a plan.**

Involve patient in discussion and planning.

Tailor preferred option to patient needs and situation.

Think of family.

- **Check understanding.**

Ensure that patient is clear about plan.

Consider a written summary.

- **Advise on contingency management.**

What should the patient do when outcomes are not according to plan.

- **Agree to arrangements for follow up and review.**

## Drug and Alcohol History

Although the drug and alcohol history is acknowledged as an important part of the medical evaluation of the pain patient it may be overlooked or done in a non-systematic way. Some attitudinal factors contributing to this include:

1. The clinician believing that he/she inadequately trained or too busy
2. The area is too difficult or too sensitive

These beliefs may be reinforced seeing patients with drug or alcohol problems in an intoxicated, aggressive or suicidal state.

Integrating drug and alcohol history taking into the overall pain assessment and, raising this topic after the establishment of a therapeutic relationship, may avoid making this aspect of history taking non-confrontational and less difficult.

## Alcohol History

Consider alcohol use in the context of the patient's background history

1. **Family history.** Family attitudes to alcohol and the drinking history of parents, significant others and siblings; family history of alcoholism, drug abuse and psychiatric disorder.
2. **Personal history.** School attendance and performance; truancy; conduct problems.
3. **Occupational history.** Working in alcohol related industry, work problems related to alcohol (dismissal, absenteeism, frequent job changes).
4. **Sexual & marital history.** Sexual problems, history of childhood sexual abuse (particularly in women with alcohol problems); marital problems related to drinking, separation, divorce, problems with children.
5. **Financial & housing history.** Rent arrears; eviction; problems with neighbors.
6. **Forensic History.** Convictions for drink driving, drunk & disorderly, violent behaviour.

## Drinking History

1. Evolution of drinking and alcohol consumption

Age of:

- First drink
- Regular weekend drinking
- Regular evening drinking
- Regular lunchtime drinking
- Early morning drinking

Record type of beverage and quantity consumed at each stage. Binge drinking? Does the patient like drinking alone or in a group? Duration of a period of abstinence, if any?

2. Evolution of alcohol dependence

Note age of onset of

- Withdrawal
- Compulsion to drink
- Difficulties in controlling alcohol consumption
- Tolerance

- Progressive neglect of alternative pleasures or interests
- Persistence despite clear evidence of overtly harmful consequences

### 3. Alcohol related problems

- Physical  
Gastritis, hepatitis, cirrhosis, pancreatitis, peptic ulcer, oesophageal varices, oesophageal carcinoma, seizures, cognitive impairment, peripheral neuropathy, cerebellar degeneration, anaemia, cardiomyopathy, myopathy, head injury, etc
- Neuropsychiatric  
Memory blackouts, pathological intoxication, delirium tremens, depression, phobic anxiety, suicide attempts, pathological jealousy, personality change, sexual dysfunction, auditory hallucination during withdrawal, alcoholic hallucinosis
- Social  
Marital, Occupational & financial problems. Forensic problems.

**Get the patient to describe a typical recent day of heavy drinking.** Ask the patient to start the description from the moment of wakening.

#### **Treatment History**

GP, outpatient or inpatient treatment by drug and alcohol services, use of anticraving agents. Residential Rehabilitation.

#### **Drug Use History**

The goals of this history taking are to establish;

1. Whether the patient is a dependent drug user
2. What risks he or she is taking in relation to the drug use
3. Whether there are current problems related to drug use

Important elements of this history are listed below:

1. Which drug(s) is the patient using?
2. What is the frequency of use?
3. What is the pattern of a typical drug-using day or week?
4. What is the route of use (e.g. oral, smoked, snorted, injected)?
5. What effect is the patient seeking when using the drug? Is there evidence for physical and psychological features of dependence on the drug(s)?
6. What risk behaviours does the patient engage in (e.g. injecting, sharing needles, unsafe sex, sex for drugs).
7. How long is the history of drug use and how has it evolved?
8. What complications of drug use has the patient experienced (physical, psychological, family, occupational, and legal problems)?
9. Have there been any periods of abstinence and, if so, what has helped the patient achieve this? What triggers have brought on relapses?

The schema used for this section has been sourced from Goldberg D & Murray R, the Maudsley handbook of practical psychiatry, fourth edition, 2002, pages 110-114.

**Chronic Pain Management in the patients dependent on prescription opioids**

It can be difficult to establish the amount of medication being used by this group of patients. The use of prescription opioids for this patient group is a “controversial area because of conflicting interpretations of the literature, and because of the need to set limits, a process in which many doctors often have little training.” (Streltzer J, page 491).

Streltzer has devised a type of history taking in which clinician takes a “pain oriented” rather than “drug oriented” questions. The examples Streltzer gives have been reproduced below:

| <b>Drug-oriented history</b>   | <b>Pain-oriented history</b>   |
|--|--|
| <p>Q: how many pills do you use?<br/>                     A: I'm prescribed one or two every 4-6 hours</p> | <p>Q: how many pills does it take to relieve your pain?<br/>                     A: 2 to just to take the edge off; yes sometimes I need 3 but I never take 4 , so I won't get addicted</p>  |
| <p>Q: how often do you take them?<br/>                     A: it depends on the pain</p>                   | <p>Q: how long do they really work for your pain?<br/>                     A: only about 2 hours-I'm getting immune, so I take them more often to keep the pain away</p>   |
| <p>Q: do you use other drugs?<br/>                     A: not too much – they don't help the pain</p>      | <p>Q: do you wake with pain; do you need more medication to get back to sleep?<br/>                     A: yes, even my sleeping pills only give me 4 hours of sleep, then the pain wakes me up; I try not to take more pills, but sometimes I have to</p> |
| <p><b>A- patient answers; Q- physicians question.<br/>                     Page 494</b></p>                |  |

**Appendix 1**

**Outline of psychosocial assessment**

Quality of the referral

- Information on medical problems
  - Psychological consequences
  - Any information of the patients relationship with the doctor
1. History and current subject of experience of pain
    - A. Onset and course
    - B. Present description
  2. Conceptualisation of the pain problem and treatment
    - A. Cause of pain
    - B. Goals for treatment outcome and activities if pain decreases
  3. Previous treatment and responses
  4. Drug and alcohol use
    - A. Narcotic and sedative-hypnotic medication use-type and amount
      1. Past use -amount
      2. Current use- amount
    - B. Alcohol use
      1. Past use-amount
      2. Current use--amount
    - C. Past and current use of other psychoactive drugs
  5. Behavioural analysis
    - A. Changes in patient activities because of pain
    - B. Changes in spouse activities because of pain
    - C. Patients behaviour when in pain
    - D. Family members response to pain behaviours
    - E. Family members' responses to well behaviours
    - F. Factors that increase and decrease pain
    - G. Time patterns to pain
    - H. Impact of pain on marital, sexual and family relationships
  6. Vocational assessment and compensation and litigation status
    - A. Educational and work history
    - B. Vocational plans
      - Return to work a realistic goal?
      - Job availability?
      - Retraining needed?
    - C. Compensation status
      - Amount received now, and amount received from former job
      - Expected duration of compensation
    - D. Any Current litigation or past litigation
    - E. Implications of improved health status for litigation and compensation claims
  7. Social history
    - A. Family of origin
      1. Family relationships
      2. History of pain and disability in family members
      3. History of drug and alcohol abuse in family members
      4. History of abuse and neglect
      5. Family and sub cultural attitudes towards pain, illness and disability
    - B. Marital history
    - C. Quality of current marital and family relationships

8. Assessment of psychological/psychiatric problems
  - A. Depression; anxiety and panic disorders; somatisation disorders
  - B. History of psychological and psychiatric disorders and treatment
  - C. Family history of psychological and psychiatric disorders and treatment and from an early age
9. Recent life stresses
  - A. Type & time course of stresses
  - B. Association of stresses with pain, activity changes and psychological status
10. Mental State Examination
  - Appearance and behaviour (especially note pain behaviour)
  - Relationship with clinician
  - Speech
  - Affect (observable mood, range of emotional expression, concern or lack thereof)
  - Mood (subjective emotional state)
  - Thought content including pain models, expectations of treatment
  - Abnormal experiences
  - Cognitive state, sensorium clear or clouded, orientation, memory, concentration, language, construction, executive functioning, judgment and insight

**Summary statement**

This is an integration of history, physical findings, mental state findings to explain the patient's presentation. in his or her current state. This should then generate a problem list for treatment planning and which can leave to treatment planning.

Dx DSM IV-TR

I- Psychiatric Disorder


II- Personality disorder

III- Physical disorder

IV Stressors

V Level of functioning this

**Appendix 2**  
**Mini-Mental State Examination**

|  | <i>Score</i> | <i>Points</i> |  | <i>Score</i> | <i>Points</i> |
|--|--------------|---------------|--|--------------|---------------|
| <p><b>Orientation</b></p> <p>1. What is the</p> <p style="padding-left: 20px;">Year? _____ 1</p> <p style="padding-left: 20px;">Season? _____ 1</p> <p style="padding-left: 20px;">Date? _____ 1</p> <p style="padding-left: 20px;">Day? _____ 1</p> <p style="padding-left: 20px;">Month? _____ 1</p> <p>2. Where are we</p> <p style="padding-left: 20px;">State? _____ 1</p> <p style="padding-left: 20px;">County? _____ 1</p> <p style="padding-left: 20px;">Town/city? _____ 1</p> <p style="padding-left: 20px;">Floor? _____ 1</p> <p style="padding-left: 20px;">Address/name of building? _____ 1</p> <p><b>Registration</b></p> <p>3. Name three objects, taking one second to say each. Then ask the patient all three after you have said them. Repeat the answers until the patient learns all three. _____ 3</p> <p><b>Attention and Calculation</b></p> <p>4. Ask for serial sevens. Give one point for each correct answer. Stop after five answers. Alternative: Spell <i>world</i> backward. _____ 5</p> <p><b>Recall</b></p> <p>5. Ask for names of three objects learned in question 3. Give one point for each correct answer. _____ 3</p> |              |               | <p><b>Language</b></p> <p>6. Point to a pencil and a watch. Have the patient name them as you point. _____ 2</p> <p>7. Have the patient repeat "No ifs, ands, or buts." _____ 1</p> <p>8. Have the patient follow a three-stage command: "Take the paper in your right hand. Fold the paper in half. Put the paper on the floor." _____ 3</p> <p>9. Have the patient read and obey the following: "Close your eyes." _____ 1</p> <p>10. Have the patient write a sentence of his or her own choice. (The sentence should contain a subject and an object and should make sense. Ignore spelling errors when scoring.) _____ 1</p> <p>11. Enlarge the design printed below to 1 to 5 cm per side and have the patient copy it. (Give one point if all the sides and angles are preserved and if the intersecting sides form a quadrangle.) _____ 1</p> <div style="text-align: center; margin: 10px 0;">  </div> <p><i>Total</i> _____ 30</p> |              |               |

**Appendix 3****Audit Questionnaire**

Circle the number that comes closest to the patient's answer.

**1. How often do you have a drink containing alcohol?**

- (0) Never (1) Monthly or less  
(2) 2-4 times a month (3) 2-3 times a week  
(4) 4 or more times a week

**2. How many drinks containing alcohol do you have on a typical day when you are drinking? (Code number of standard drinks)**

- (0) 1 or 2 (1) 3 or 4 (2) 5 or 6  
(3) 7 or 8 (4) 10 or more

**3. How often do you have six or more drinks on one occasion?**

- (0) Never (1) Less than monthly (2) Monthly  
(3) Weekly (4) Daily or almost daily

**4. How often during the past year have you found you were not able to stop drinking once you had started?**

- (0) Never (1) Less than monthly (2) Monthly  
(3) Weekly (4) Daily or almost daily

**5. How often during the past year have you failed to do what was normally expected from you because of drinking?**

- (0) Never (1) Less than monthly (2) Monthly  
(3) Weekly (4) Daily or almost daily

**6. How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?**

- (0) Never (1) Less than monthly (2) Monthly  
(3) Weekly (4) Daily or almost daily

**7. How often during the past year have you felt guilt or remorse after drinking?**

- (0) Never (1) Less than monthly (2) Monthly  
(3) Weekly (4) Daily or almost daily

**8. How often during the past year have you been unable to remember what happened the night before because you had been drinking?**

- (0) Never (1) Less than monthly (2) Monthly  
(3) Weekly (4) Daily or almost daily

**9. Have you someone else been injured as a result of your drinking?**

- (0) No (1) Yes, but not in the last year  
(4) Yes, during the last year

**10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?**

- (0) No (1) Yes, but not in the last year  
(4) Yes, during the last year

**Total score 40**

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