BRIDGING THE GAP
A newsletter for medical professionals

Published by Pearson | *Winter 2006*

Psychology and Medicine: Working Together to Unlock the Puzzle

The implications for physicians and psychologists of the interrelationship of body and mind were discussed in a recent workshop sponsored by Pearson entitled "Medical Psychology: The Newest Frontier in Practice Development." Brent Van Dorsten, PhD, John Brendel, MD, and other workshop presenters explained the role of psychology in medical settings and provided participants with information about tools specifically designed for medical patients.

Consider these statistics and how they might apply to a medical patient population:

- Nearly 10% of U.S. adults meet the criteria for a DSM™ diagnosis of depression and more than 18% meet the criteria for a DSM diagnosis of anxiety in any given 12-month period.[1]
- Patients with psychological disorders consistently use medical services more than those without such disorders.[2, 3, 4]
- 80% of all physician visits are for a pain complaint.[5]
- 40-50% of patients with pain disorders also have diagnosable anxiety.[6,7]

A challenge for primary care physicians

Van Dorsten explained the considerable challenge primary care physicians face in accurately diagnosing psychological issues. Patients often visit their primary care physicians with complaints that may mask a depression diagnosis. For example, Van Dorsten mentioned a high symptom concordance between medically diagnosable depression and many medical conditions, including appetite or weight changes, poor sleep, lethargy, reduced libido, optimism or activity.[8, 9]

Even though 80% of all visits to a physician are for a pain complaint, the average primary care physician receives 2 hours or less each year of residency training in pain management—and much of this focuses on medications for treating pain.10 Up to 80% of those patients presenting with back pain will have no abnormal findings on diagnostic testing11, thus increasing the number of referrals for conservative management and behavioral care.

Implications for physicians

Patients with misdiagnosed or undiagnosed depression are at a disadvantage when physicians attempt to treat their medical condition. According to Van Dorsten, medical patients with depression are likely to:

- use more medication but are less likely to adhere to instructions than patients without depression [12, 13, 14, 15]
- have impaired rehabilitation [16]
- terminate their treatment plan early [17]

Depression and/or anxiety are also associated with unhealthy lifestyle behaviors such as smoking, inadequate exercise, and alcohol use.[18] Additionally, patients with anxiety often do not comprehend all the information provided to them during a medical visit. Up to half of such information may be lost on anxious patients.[19]

Van Dorsten presented several other psychosocial threats to medical treatment outcome, then discussed pros and cons of different testing strategies when using psychometric testing in a clinical practice. For example, he mentioned that several measures are sensitive but not specific, often resulting in over-diagnoses. Van Dorsten briefly discussed the various psychological assessments that are commonly used specifically for chronic pain patients, noting that when the tests used are normed on medical patients and the number of subscales is limited, the test is more useful to medical practitioners.

Brief assessments designed for medical patients are available

Van Dorsten said that some brief assessments, such as the BBHI™ 2 (Brief Battery for Health Improvement 2) or P-3® (Pain Patient Profile) test (see sidebar) are inexpensive, normed against medical patients, and address the most prevalent psychological issues with medical patientsódepression, anxiety and somatization. He said these assessments can also inform the physician when more in-depth evaluation is needed and are easy to use for retesting to collect outcomes data.

A pain practitioner's perspective on psychological testing

"Psychological assessment in pain medicine is the key to success," says pain specialist John K. Brendel, MD. Brendel routinely administers a brief assessment to all his patients whom he considers candidates for a certain procedure. He believes doing this helps him run a more efficient practice and helps him be a better doctor.

His workshop presentation provided the basics of what physicians may achieve from testing, including:\

1. patient mental health status in a doctor-friendly format
2. the patient's perceived disability
3. a patient's hidden agenda
4. a comprehensive baseline from which to measure the treatment plan
5. some ability to predict less than desirable outcomes at the outset
6. a guide to promote discussion with the patient that "it's not in your head"
7. pain scores at different locations of the patient's body

Brendel administers brief assessments in his office using a computerized handheld tablet that enables him to read the results before meeting with the patient in the exam room. He also teams with psychologists when his patients' initial assessment calls for more thorough psychological evaluation.

He suggests physicians explain to patients how their mental health affects their pain perception and how the assessment is used to better treat the entire pain problem. He also suggests that a patient's first appointment with a psychologist be made by the physician's office staffóhe says patients are more likely to keep this appointment than make an initial appointment themselves.

Brendel further recommends that physicians not proceed with diagnostic modalities, surgery or interventional treatments until patient readiness has been achieved. He notes that when physicians leave patient "red flags" untended to, the result is generally a "bad marriage" or poor outcomes.

In addition, Brendel uses psychological assessments to help measure treatment outcomes. He says that his ability to provide outcome data on his practice improves his probabilities of receiving payment from insurance companies. He also says reporting his outcomes forces greater transparency of his practice, and in turn, both he and his staff provide their patients improved care. Brendel says physicians who measure outcomes can also use the data to educate their colleagues and raise their status among their peers.

Brendel justifies his practice of using psychological testing by referring to research that indicates that patients free of psychological problems are more likely to benefit from surgery. For example, Schofferman, et al., published an article in Spine in 1992 that says 95% of injured adults who were not abused as children do benefit from surgery, but only 15% of injured adults who were abused as children benefit from surgery. Brendel wants to know at the start of a relationship with a patient if there are any psychological issues that may impede the patient's recovery. The information helps him to provide better patient care and achieve better outcomes.

Brendel suggests other physicians consider the value psychological assessments can provide them, including improved patient communication, more appropriate treatment, and the opportunity to measure treatment outcomes. He is among the many physicians who recognize that psychological factors do influence a patient's recovery and have learned that the use of psychological assessments can help them solve their more puzzling patient problems and, in turn, help them provide improved patient care.

P-3® (Pain Patient Profile)

When research showed that depression, anxiety and somatization are the factors most relevant to pain patients, C. David Tollison, PhD, and Jerry C. Langley, DC, developed the P-3 (Pain Patient Profile) to address these issues.

Tollison presented training on the P-3 test at the recent medical psychology workshop sponsored by Pearson.

The P-3 test is a simple, straightforward instrument with only three scales to address these key factors, along with a validity index. It was written specifically for use by a variety of medical practitioners and is normed on both pain patients and community samples. This brief and inexpensive tool offers several administration and scoring options, including a handheld tablet that provides immediate reports while the patient sits in the doctor's waiting room.

Trial the assessments featured in this newsletter!

Request your complimentary trial* of the P-3®, MBMD™, BBHI™ 2 or BHI™ 2 assessment by calling 1.888.627.7271 or email pearsonassessments@pearson.com

Brent Van Dorsten, PhD, is an associate professor and behavioral medicine specialist at the University of Colorado Health Sciences Center in the departments of rehabilitation medicine and anesthesiology pain management service.

John Brendel, MD, is a board-certified anesthesiologist with a subspecialty in pain medicine, practicing in Rice Lake, WI. Both continue to offer their knowledge and expertise at various presentation opportunities, including a workshop at the 2006 California Psychological Association annual convention.

References

1. Kessler, R.C., Wat Tat Chiu, A.M., Demler, O., & Walters, E.E. (2005). Prevalence, severity, and co-morbidity of 12-month DSM-IV disorders in the National Co-morbidity Survey Replication. Archives of General Psychiatry, 62, 617-627.
2. Barsky, A.J., Orav, E.J., & Bates, D.W. (2005). Somatization increases medical utilization and costs independent of psychiatric and medical comorbidity. Archives of General Psychiatry, 62, 903-910.
3. O'Donohue, W. & Cucciare, M.A. (2005). The role of psychological factors in medical presentations. Journal of Clinical Psychology in Medical Settings, 12, 71-77.
4. Sansone, R.A., Sansone, L.A. & Widerman, M.W. (1996). Borderline personality disorder and health care utilization in a primary care setting. Southern Medical Journal, 89, 1367-1372.
5. Gatchel, R., & Turk, D. (1996). Psychological Approaches to Pain Management: A Practitioner's Handbook. New York: Guilford Press.
6. Gatchel, R. & Young, M. (2005). Premorbid and comorbid personality traits associated with chronic pain disability. Presented at 11th World Congress on Pain, International Association for the Study of Pain, Sydney, Australia.
7. Reid, M.D., Engles-Horton, L.L., Weber, M.B., Kerns, R.D., Fogers, E.L., & O'Connor, P.G. (2002). Use of opioid medications for chronic noncancer pain syndromes in primary care. Journal of General Internal Medicine, 17. 173-179.
8. Boyd, J.H., & Weisman, M.M. (1986). Epidemiology. In E.S. Payke (Ed.), Handbook of Affective Disorders. New York: Guilford Press.
9. Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (1994). Washington DC: American Psychiatric Association.
10. Van Dorsten, B., Dingmann, C., Brewer, A., Bridgewater, J., Davies, H.R., & Benchekroun, S. (August, 2005). A re-assessment of pain education in primary care residency in the United States. Presented at 11th World Congress on Pain, International Association for the Study of Pain, Sydney, Australia.
11. Deyo, R.A. (1986). The early diagnostic evaluation of patients with low back pain. Journal of General Internal Medicine, 1. 328-335.
12. Bane, C., Hughes, C.M., & McElnay, J.C. (in press). The impact of depressive symptoms and psychosocial factors on medication adherence in cardiovascular disease. Patient Education and Counseling.
13. Cramer, J.A., & Rosenheck, R. (1998). Compliance with medication regimens for mental and physical disorders. Psychiatric Services, 49, 196-201.
14. DiMatteo, M.R., Lepper, H.S., & Croghan, T.W. (2000). Depression is a risk factor for non¨compliance with medical treatment: meta-analysis of effects of anxiety and depression on patient adherence. Archives of Internal Medicine, 160, 2101-2107.
15. Gehi, A., Hass, D., Pipkin, S., & Whooley, M.A. (2005). Depression and medication adherence in outpatients with coronary heart disease. Archives of Internal Medicine, 165, 2508-2513.
16. Frank, R.G., Elliott, T., Corcoran, J., & Wonderlich, S. (1987). Depression following spinal cord injury: Is it necessary? Clinical Psychology Review, 7, 611-630.
17. Painter, J.R., Seres, J.L. & Newman, R.I. (1980). Assessing the benefits of the pain center: Why some patients regress. Pain, 8, 101-113.
18. Niles, B.L., Mori, D.L., Lambert, J.F. & Wolf, E.J. (2005). Depression in primary care: Comorbid disorders and related problems. Journal of Clinical Psychology in Medical Settings, 12, 71-77.
19. Belar, C.D. & Deardorff, W.W. (1995). Clinical Health Psychology in Medical Settings. Washington, DC: American Psychological Association.

To request a copy of this article and the complete newsletter, please call 1-888-627-7271 and reference F12W06.