

BRIDGING THE GAP

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PEARSON

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Psychological tests give pain management team confidence in pre-surgical evaluations

For psychologist Deborah Kukal, PhD, the field of behavioral medicine is not simply a professional focus, it’s a passion. “Some years ago, I became intrigued by the impact of psychophysical interactions on health,” she says. “I started attending workshops to learn as much as I could — and since then, I’ve decided it’s just about the most exciting thing in the world.”

Kukal serves as psychology clinical team leader at the Center for Pain Management–St. John’s Hospital, Springfield, Missouri. In 1997, when St. John’s decided to develop a multidisciplinary pain department, Kukal played a key role in determining the direction they would take.

“Our pain doctors were interested in the mind/brain/body connection,” Kukal says. “They knew they needed help from psychologists in diagnosing and treating pain patients. A group of us — psychologists, anesthesiologists, rehabilitation doctors, physiologists, and hospital administrators — worked together to develop our protocols. We looked at the theory behind pain management treatment, we discussed what kind of approach we wanted to use. It was a lot of work — and a lot of fun.”

In the pain center’s early years, the team opted to use non-standardized, patient self-report inventories, plus an interview, to assess key psychological factors such as depression and anxiety. Their primary goal in using these tools was to determine whether the patient was capable of participating in their newly introduced 6-week pain management program.

However, as St. John’s expanded their pain medicine services, including spinal cord stimulators, intrathecal pumps, and spine surgeries, the team recognized the need for objective, norm-referenced testing to identify risk factors with candidates prior to these major medical procedures. For these patients, they developed an extended evaluation protocol that includes use of the MMPI®-2 (Minnesota Multiphasic Personality Inventory®-2) and the MBMD™ (Millon™ Behavioral Medicine Diagnostic) tests.

Norm-referenced tests help inform decisions

“We knew it was important that we use respected, research-backed instruments to support our decisions on major medical procedures,” says Kukal. “The MMPI-2 test was an easy one to pick. It’s the gold standard in psychological assessments, with a long tradition of clinical experience and research — including studies that show its strength in predicting outcomes with spine surgery patients.”

Kukal notes several MMPI-2 scales that the team considers particularly useful. “Scales 1 and 3 help predict health-related behaviors,” she says. “Plus, the PK scales help identify trauma; these scales have consistently have been associated with PTSD syndrome. Trauma is a critically important issue for us, since childhood and adult trauma are strong predictors of health problems. Psychophysical reactivity is very salient to how our bodies work, and this absolutely is true with pain patients.”

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In addition, Kukal finds the MMPI-2’s chronic pain profile to be a clinically useful feature. “The MMPI-2 test is an excellent instrument to help us identify risk factors as well as patient problems that might cause difficulty for the physician,” she says.

To complement the MMPI-2 instrument, the team selected the MBMD test, which helps assess psychosocial factors that can affect a patient’s response to medical treatment. “We had tried a couple of other standardized instruments, but they just didn’t click for us,” says Kukal. “We liked the MBMD test because it references medical patients. And, it gave us very specific predictions on a patient’s potential coping problems and the outcomes of medical interventions, to help inform our decision on whether or not to do a procedure. We also like the test’s brevity.”

Objective instruments give team a leg to stand on

Kukal emphasizes that using the MMPI-2 and MBMD tests gives the team confidence. “We like to write reports with the worst-case scenario in mind — if we had to go to court and defend how and why we came to our decisions,” she says. “Many of our candidates for medical interventions, especially workers’ compensation patients, are in an adversarial position. If we say ‘No’ to a procedure, they may want to challenge that decision. These objective tests give us strong evidence with which we could defend our position in court. The worst-case scenario hasn’t happened, but we want high-quality, research-backed evidence that would stand up if the need arose.”

“Everyone involved — from the physicians to the insurance companies to court to workers’ compensation personnel — is familiar with respected, standardized tools such as the MMPI-2 and the MBMD tests,” says Kukal. “When we use these instruments, they recognize that our decisions are backed by scientific evidence.”

Offering appropriate levels of evaluation

Patients receive psychological evaluations mainly based on referrals from physicians within St. John’s system. The team currently provides three levels of evaluation.

Level 1 evaluations are given to pain patients who are not candidates for surgery but are simply being assessed for participation in the center’s 6-week pain management program. This evaluation comprises non-standardized questionnaires and an interview and does not include the use of norm-referenced tests.

In some cases, however, patients who are not candidates for interventional surgery will receive level 2 extended testing, including the MMPI-2 and MBMD tests. “We move to this level of testing if there is a concern that the patient may have extensive needs that could cause problems in the medical system, or if the pain physician is concerned that the patient is a danger to themselves or others, or if the physician is facing a perplexing situation and simply can’t figure out the root cause of the pain problem,” says Kukal.

Level 3 presurgical evaluations are conducted with candidates for spinal cord stimulators, spine surgery, and implantable pumps, with referrals provided by physiatrists, orthopedic surgeons, and neurosurgeons in St. John’s Spine Center. At times, pain physicians refer patients for psychological evaluation to ascertain whether surgery is a viable option before referring the patient to a surgeon.

Helping ensure positive outcomes

In conducting presurgical evaluations, the team talks to the patient about the benefits of the testing. “We explain to patients that the MMPI-2 and the MBMD tests can provide us with objective information to help ensure the best possible outcome for them,” says Kukal. Patients take the tests prior to the clinical interview. The battery also includes a self-report symptom checklist, a behavioral health evaluation, and a history questionnaire. Most patients complete the battery within 2 hours.

“We do a lot to make the patients comfortable during the testing,” says Kukal. “We administer both the MMPI-2 and the MBMD tests on computer, which saves time and is easier for most patients than paper-and-pencil format. We bring patients coffee, we give them hot packs if needed, we encourage them to take breaks, to take a little walk.”

After reviewing the test and questionnaire results, history, and any physician notes, the psychologist interviews the patient, then writes up a report. Next, the psychologist meets face-to-face with the rest of the pain management team to discuss the information gathered and develop recommendations. The surgeons are kept in the loop throughout the process via phone and e-mail.

“All of us on the team want our patients to have the best outcomes possible,” says Kukal. “While there is a cost associated with testing, I point out to both patients and staff that it’s a very valuable step in determining whether a surgery will have positive results — it’s a heck of a lot less expensive than proceeding with a surgery that may not be efficacious.” She also notes that test results help determine whether the patient should be referred out for substance abuse treatment or for classic psychotherapy, such as for borderline personality disorder or chronic mental illness.

Educating patients on the science behind their pain

Kukal’s role at the clinic also includes providing patient education as part of the pain management treatment program. Her specialty is trauma. Other team members specialize in individual neurofeedback and cognitive behavioral therapy, and all contribute to a variety of pain management treatment groups.

“Any trauma has brain impact,” says Kukal. “When I talk with patients, I prefer to use the terminology ‘mind/brain/body connection,’ not ‘mind/body connection’ — because patients hear ‘mind/body connection’ and they think of a magician bending spoons with his mind. It’s not that! It’s that a person’s pain and trauma experience causes changes in the brain, and then there are downstream effects of how those changes in the brain affect the body.” Kukal describes to her patients a study in which rats were repeatedly exposed to the smell of a cat, which over time caused a change in the rats’ brain connections. “I ask the patients, ‘Is the smell of a cat as serious as the pain you are feeling?’” says Kukal

Kukal strives to assure patients that what they are feeling is a reality, which is likely to be a shift in how they have perceived their pain. “I talk about big fun words like psychoneuroimmunology because this gives honor and respect to what they are experiencing,” she says. “And I give the example of a broken car alarm: If the car alarm is going off and nobody is trying to steal the car, is the sound real or just in your head? I tell patients, ‘Your pain is very real and it can drive you nuts, just like that car alarm. With chronic pain, the pain system is broken. It’s been hypersensitized; it’s functioning on its own — a classic example is phantom limb pain.’”

The classes educate patients about research on brain function, teaching them the science behind their condition in a patient-friendly way. “I explain to patients: ‘These particular behaviors can have a positive effect on restructuring your pain system; you can do these things and begin to turn the ship so that you don’t run into the iceberg,’” she says.

The team has found that the treatment is very empowering for patients. “When they come to us, they are often scared,” says Kukal. “They feel insulted at being referred to a psychologist. Their great fear is that we are just trying to prove that their pain is all in their head, that they are ‘crazy’. And that fear causes the most resistance to psychological testing. Our program helps relieve that fear.”

Research-based program from A to Z

Kukal speaks enthusiastically about the multidisciplinary pain department, which continues to evolve as the team explores new avenues for helping chronic pain patients. “I love the approach we take, which is research-based from A to Z,” says Kukal. “With everything we do — from patient education to evaluation protocols to treatment decisions — we want to base our choices on scientific evidence that shows these actions will have a positive impact on the patient’s outcome.”

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