

BRIDGING THE GAP

A biopsychosocial newsletter for healthcare professionals

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Global leader on chronic pain psychology discusses his use of the MMPI-2-RF® for patient evaluations

Andrew R. Block, PhD, is internationally recognized for his research on chronic pain psychology, including the influential model he developed for presurgical psychological screening (PPS). Currently, he serves as Director of Pain Programs at the Texas Back Institute, Plano. His role includes supervising the behavioral medicine department, which conducts presurgical psychological screenings primarily for spine surgeries and spinal cord stimulators. He also oversees the institute’s multidisciplinary chronic pain management program. In addition to his leadership responsibilities, Block spends about 20 hours a week in clinic seeing patients for individual and group therapy.

The seminal PPS model that Block introduced in 1996 featured the MMPI®-2 test as a key component. “I’ve always liked the MMPI instruments,” says Block. “These objective, well-validated tests provide an important cross-check with our clinical impressions. In our research, we found that the MMPI-2 was the single biggest indicator of surgical outcomes, accounting for 60% of the variance.”

Earlier this year, Block began using the recently published MMPI-2-RF test as part of his clinical protocol. Developed by Yossef S. Ben-Porath, PhD, and Auke Tellegen, PhD, the MMPI-2-RF is composed of 338 items, with the RC (Restructured Clinical) Scales at its core. To date, Block has used the instrument with approximately 170 patients, both presurgical and nonsurgical. He and his colleagues are in the process of developing a PPS algorithm that incorporates the MMPI-2-RF. “We’re mapping the MMPI-2-RF to the MMPI-2, analyzing the data as we go, constantly tinkering with the model,” he says.

MMPI-2-RF helps achieve better patient outcomes

Block’s team administers the MMPI-2-RF as part of a comprehensive initial assessment for all patients referred to them. Approximately 60% of referrals come from the Texas Back Institute; the others come from physicians in the community.

The first step in Block’s evaluation process is a questionnaire that patients fill out at home prior to their visit. This form includes all of his standard interview questions, covering medical history and a number of biopsychosocial factors relevant to pain patients such as current emotional status, interpersonal issues, coping skills, and drug use.

On appointment day, patients complete several brief instruments in the waiting room to provide further information on pain severity, coping strategies, drug use, entitlement issues, demoralization, and catastrophizing.

Next, the psychologist conducts a semistructured interview with the patient, reviewing the information provided to date. “During the visit, we also talk with patients about why we are going to give them the MMPI-2-RF, which is administered after the interview,” says Block. “Many pain patients are defensive about taking a psychological test. We reassure them that we’re not giving the MMPI-2-RF because we think the pain ‘is all in your head.’ We let them know that the test results will help us provide them with the best possible care.”

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Assessing surgical readiness

The MMPI-2-RF scales Block’s team looks at most closely to help predict patient outcomes and guide treatment planning are RC1 (Somatic Complaints) and MLS (Malaise) for pain sensitivity, RCd (Demoralization) and RC2 (Low Positive Emotions) for depression, RC4 (Antisocial Behavior) for anger, and RC7 (Dysfunctional Negative Emotions) for anxiety. When there is an elevation on any four of the nine RC scales, the team examines the profile for possible pathological depression.

Based on the test results, patients are assigned a prognostic category from 1 to 5. Approximately two-thirds of the patients are assessed as “good” (1) or “fair to good” (2). “In most of these cases, the patient is green-lighted for surgery,” says Block. “However, if a patient in the 1 or 2 categories expresses a great deal of ambivalence about surgery, we would recommend our pain management program as a viable alternative. In fact, there is a lot of evidence showing that a pain management program can be as effective as certain surgeries, such as a spinal fusion for degenerative disc disease.”

For patients who are deemed “fair” (3) or “fair to poor” (4), the group recommends specific interventions in an attempt to reduce psychosocial risk factors before surgery and help ensure a better outcome. Block notes that when these interventions are unsuccessful it is recommended that surgery be avoided, if medically feasible. Patients in the “poor” (5) category are those who exhibit significant problems, such as serious psychiatric disorders, and surgery is not recommended.

Selecting targeted interventions based on test results

Block gives several examples of how his group applies information gained from the MMPI-2-RF to identify risk factors and recommend targeted interventions. “If a patient has an elevation on RC2 or RCd or if any SUI (Suicidal/Death Ideation) item is endorsed, we would recommend antidepressants before surgery to help ensure a much better postsurgical outcome,” he says. “If RCd is elevated, we’d recommend cognitive behavioral intervention to help the patient become more engaged in life and develop a more positive outlook. If MLS is elevated, I look at this as a somatic kind of demoralization. The patient feels that he isn’t going to be able to make any physical progress. In this case, we’d do pain intervention techniques such as biofeedback or hypnosis to reduce psychosocial risk.”

Block notes that anger is the most common emotion in chronic pain patients. “If we see that the RC4 or ANP (Anger Proneness) Scales are elevated, we would recommend anger management counseling,” he says. He also points out that many pain patients have multiple anxieties specific to pain, such as fear of movement, lifting, or engaging in activities. “If a patient’s RC7 Scale is elevated, we will work to reduce his fear by helping him pace his activities, or by designing a structured exercise program so he can be active without injuring himself,” he says.

“When we recommend holding off on surgery to implement interventions, patients are often not happy about this at first,” says Block. “They are hoping to breeze through the presurgical screening, have the surgery, and be on their way. We explain to them that the steps we are taking are designed to improve their outcomes. Once they have started the intervention, they are usually excited to tell us about the positive difference it’s made in their lives.”

In addition to using the MMPI-2-RF to inform his treatment recommendations, Block uses the test results as a discussion platform with patients during therapy. “Often, the first thing I do is review the MMPI-2-RF results with them,” he says. “The instances in which I am really grateful to be using the MMPI-2-RF are when the test results are inconsistent with my clinical impressions, which is about 20% of the time. I can say to the patient, ‘You told me you are not depressed, but your test score on depression is way up. Can you tell me more about that?’ This approach helps initiate dialogue with patients who are not psychologically oriented—and most surgical patients are not.”

Because Block's team administers the MMPI-2-RF to both surgical candidates and nonsurgical pain patients, they have been able to make preliminary comparisons of test results for the two groups. "We are finding a number of differences," says Block. "For example, nonsurgical patients show much more distress on a number of scales and their K-r (Adjustment Validity) Scale scores are significantly lower. My working theory is that if we do a presurgical screening and the patient's MMPI-2-RF results look like those of nonsurgical candidates, this individual is more at risk."

Characteristics that contribute to the MMPI-2-RF's utility

Block remarks on MMPI-2-RF features that make the test appealing to him. "I am very impressed with the test's psychometrics," he says. "For example, it appears to do an excellent job of helping to detect demoralization, which is a strong predictor of patient outcomes."

He also values the test's efficiency. "The MMPI-2-RF has only 338 items yet provides us with a wealth of information," he says. "This efficiency is tremendously important with chronic pain patients, who have difficulty sitting for long periods."

Another feature Block considers very useful is the detailed technical manual, particularly for his research purposes. He also would see the manual as a benefit to practitioners who are preparing to give court testimony. Plus, he appreciates that the test can be computer-scored, which is an essential time-saver for his busy staff.

Beck inventories add value

In addition to the MMPI family of tests, Block also recommends the Beck inventories. "We use the BAI[®] (Beck Anxiety Inventory[®]) for weekly progress monitoring with patients in our pain management program," he says. "It's a short, reliable instrument that's well-suited for this purpose. We find that BAI scores are the single biggest predictor of success in chronic pain management; patients who do well in our program have a 50% reduction in BAI scores."

He also recommends the BDI[®]-II (Beck Depression Inventory[®]-II). "This test is an excellent brief measure to screen for depression and it helps identify biological symptoms of depression," says Block. "It can be used as a cross-check against MMPI-2-RF scores. For example, if a patient has elevations on the MMPI-2-RF's L-r (Lie) or K-r Scales and no elevation on the RC2 and RCd Scales, then an elevation in BDI scores could help validate a diagnosis of depression."

Making a difference in patient's lives

In discussing his use of psychological tests with chronic pain patients, Block speaks with enthusiasm and compassion. "It's all about gathering the best possible information on patients so that we can provide them with the best possible outcomes," he says. "When patients report back that we have improved the quality of their lives, that is our greatest satisfaction."

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Block's semi-structured interview and the screening questionnaire sent to patients are available in his book *Presurgical Psychological Screening in Chronic Pain Syndromes: A Guide for the Behavioral Health Practitioner* (Lawrence Erlbaum Associates, 1996). He has co-authored several other books, including *The Psychology of Spine Surgery* (Washington, DC: American Psychological Association, 2003) and *The Handbook of Chronic Pain Syndromes: Biopsychosocial Perspectives* (Lawrence Erlbaum Associates, 1999). He recently received a grant from the University of MN Press to study the utility of the MMPI-2-RF in presurgical psychological screening.

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