



## Biopsychosocial assessment

The underlying concept of the biopsychosocial model of pain is that pain perception and its effects on the patient's function is mediated by multiple factors (e.g., mood, social support, prior experience, biomechanical factors) and not just physiology alone (*IOM, 2011*). The following recommendations address key components of the biopsychosocial assessment and should be tailored according to the pain phase. It is expected that providers will increase the number, frequency and depth of the assessments as a patient continues opioid therapy and that the treatment plan is tailored accordingly.

Note: Certain recommendations are indicated for a specific pain phase. The relevant pain phase is provided after the recommendation.

## Clinical recommendations

1. Assess and document pain, function and quality of life using validated (if available) or standardized assessment tools. Validated tools include the Three Item Pain Intensity, interference with Enjoyment of life and interference with General activity (PEG) Assessment Scale (<http://www.mytopcare.org/wp-content/uploads/2013/06/PEG-Pain-Screening-Tool1.pdf>) (*Krebs, 2009*), the Pain Numeric Rating Scale (NRS) ([https://www.va.gov/PAINMANAGEMENT/docs/Pain\\_Numeric\\_Rating\\_Scale.pdf](https://www.va.gov/PAINMANAGEMENT/docs/Pain_Numeric_Rating_Scale.pdf)) (*Krebs, 2007*) and the Brief Pain Inventory (BPI) ([https://legacybhsapps.beaumont.edu/Global/Urology/Brief\\_Pain\\_Inventory\\_WUC.pdf/](https://legacybhsapps.beaumont.edu/Global/Urology/Brief_Pain_Inventory_WUC.pdf/)) (*Tan, 2004*).
  - Assess and document the patient's presentation of pain at every clinical encounter. Documentation of pain should include use of the pain scale as a relative tool and concordance of the patient's assessment of his or her own pain with the prescriber's objective observations. [*All pain phases*]
  - Assess and document the patient's diminished physical function at every clinical encounter. Use functional assessments—in concordance with pain assessments—to guide patient-provider conversations about pain management and psychosocial factors that may contribute toward the experience of pain. [*All pain phases*]
  - Assess and document how the patient's pain and diminished function affect quality of life prior to initiating chronic opioid analgesic therapy (COAT) and at every follow-up visit for pain management. [*Chronic Pain*]
2. Review the patient's medical record prior to continuing opioid analgesic therapy in order to understand **why opioids were initially prescribed**. [*Post-Acute Pain; Chronic Pain*]
3. Assess and document **other medical conditions** that may complicate pain symptoms and/or treatment. [*All pain phases*]

4. Screen patients for depression and anxiety using a brief, validated tool at each follow-up visit for pain management.
  - If screening tools indicate an active mental health condition, provide aggressive treatment concomitant to analgesia strategies. [*Post-Acute Pain*]
  - Refer patients with depression or anxiety that has not been previously treated or successfully treated for appropriate psychotherapy. [*Chronic Pain*]
5. Assess and document suicidality in every setting for every initial opioid prescription. Reassess suicidality in patients receiving COAT at least once a year. [*Acute Pain; Chronic Pain*]
6. Screen patients for substance use disorder (SUD) using a brief, validated tool. Conduct a structured interviewing using the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria when the patient screens positive, or refer to a specialist for diagnosis.
  - Screen patient for SUDs one week after the acute event, or at the first opioid refill request. If assessment indicates elevated risk for substance abuse, review and determine tapering strategy. [*Post-Acute Pain*]
  - Assess patients for substance use prior to initiating COAT. If assessment indicates an active SUD, provide the patient evidence-based treatment or refer to a specialist. Continue to screen for SUDs for the duration of the opioid therapy. [*Chronic Pain*]
7. Assess patient for fear avoidance tendencies or pain catastrophizing using a brief, validated tool. If assessment indicates the presence of fear avoidance and elevated risk for chronicity, consider referring patient to a physical therapist or a pain psychologist. [*Post-Acute Pain; Chronic Pain*]
8. Assess patients for a history of trauma or abuse if depression or anxiety screening tool scores remain elevated during initial treatment. If a patient has a history of trauma or abuse, clinicians should not initiate COAT. Refer patients with a history of trauma or abuse who have not been previously treated for appropriate psychotherapy. [*Post-Acute Pain; Chronic Pain*]
9. Discuss with the patient sources and/or targets of anger or injustice related to his or her pain. Consider using the Injustice Experience Questionnaire (IEQ) when a patient's pain is related to an occupational injury or motor vehicle accident. [*Post-Acute Pain; Chronic Pain*]
10. Ask patients about their beliefs and attitudes about pain, its origin and what it represents during an initial clinic visit. [*Chronic Pain*]

## Discussion

### Pain, function and quality of life assessments

It is the consensus of the Opioid Prescribing Work Group that standardized assessment procedures will minimize variability and potential bias, stereotyping and prejudice among health care providers towards pain patients. Standardized assessment procedures will improve the accuracy of pain assessment. It is important that health care providers develop a standardized approach to the assessment process, given the inherent difficulty of assessing a subjective experience.

Pain, function and quality of life assessments should guide clinician-patient conversations about pain and selection of treatment modalities. Assessment and reassessment of pain and function following an acute event is especially important in tracking improvement and gauging whether healing and recovering is progressing normally.

## Depression and anxiety

A strong relationship exists between chronic pain and mental health conditions. Evidence suggests that a bidirectional relationship exists between chronic pain and mental health disorders, meaning that depression and anxiety are predictors of chronic pain and chronic pain is a strong predictor of depression and anxiety (*Hooten, 2016*). Among Minnesota Health Care Program (MHCP) enrollees, approximately 80% of chronic opioid users had a mental health diagnosis within the past two years (*2013 MHCP administrative claims data*).

Screening and treatment of mental health conditions will likely lead to better pain-related treatment goals. Depression symptoms, including fatigue, insomnia and dysphoric mood can limit the patient's ability to follow the treatment plan. Patients experiencing chronic pain and mild-to-moderate major depression should be treated concomitantly for both conditions (*Bair, 2003*). If a patient is diagnosed with severe major depressive disorder concurrent with chronic pain, the depressive symptoms should be the primary focus of treatment (*Kroenke, 2009*).

## Suicidality

A number of observational and epidemiological studies suggest that certain chronic non-cancer pain conditions represent an independent risk factor for suicide (*Chou, 2015; Fishbain, 2009; Ilgen, 2013; Ilgen, 2008; Ratcliffe, 2008; Scott, 2010; Tang, 2006*). Among the conditions that represent an independent risk factor are back pain and migraine headaches. Emerging evidence also suggests an association between opioid dose and suicide mortality. A recent study among Veteran's Affairs patients found that higher prescribed opioid doses were associated with elevated suicide risk (*Ilgen, 2016*).

Use clinical judgement to determine the appropriate method of screening for suicidality and document the assessment. Suicide risk screening tools include the Columbia-Suicide Severity Rating Scale (C-SSRS) ([https://www.integration.samhsa.gov/clinical-practice/Columbia\\_Suicide\\_Severity\\_Rating\\_Scale.pdf](https://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf)) and the SAFE-T (Suicide Assessment Five-Step Evaluation and Triage) ([https://www.integration.samhsa.gov/images/res/SAFE\\_T.pdf](https://www.integration.samhsa.gov/images/res/SAFE_T.pdf)).

## History of trauma and PTSD

Given the sensitive nature of the topic, clinicians should judge whether asking the patient about a history of trauma or using a formal assessment is appropriate. Documentation should include a summary of the conversation or the results of a screening tool. The Primary Care Post-Traumatic Stress Disorder (PTSD) screening tool (PC-PTSD) (<https://www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf>) is a commonly used tool to screen for PTSD. The *Institute for Clinical Systems Improvement Pain Guideline (2017)* addresses elevated risk of developing chronic pain among patients with a history of trauma or abuse:

When evaluating patients with pain, it is important to determine whether there is a history of trauma/abuse. A meta-analysis by Afari, et al. (2014) found that individuals who reported exposure to trauma (psychological, emotional, sexual, physical, combat) were 2.7 times more likely to have a functional somatic syndrome. Sexual abuse and rape victims have been shown to be 2.4 to 4 times more likely to develop functional gastrointestinal disorders and chronic pelvic pain. In addition, sexual abuse is associated with non-specific chronic pain and psychogenic seizures, while rape is associated with fibromyalgia (Paras, 2009).

Adverse childhood experiences (ACEs) are a strong predictor for multiple chronic illnesses in adulthood. These include both depression and substance abuse, conditions that exacerbate the pain response and impede treatment response. A review of the literature shows that abuse in childhood is a strong predictor of depression and physical complaints, both explained and unexplained, in adulthood (Arnow, 2004). (pg. 30)

## Anger and injustice

A common negative emotion associated with chronic pain is anger, arising through frustration of personal goals and unmet expectations. Anger may block motivation for and acceptance of, treatments oriented toward rehabilitation and disability management rather than a cure (Scott, 2013). Research suggests that both anger intensity (state/trait) and regulation style (inhibition/expression) negatively impact pain outcomes (Bruehl, 2006; Burns, 2008).

Perceived injustice is an appraisal reflecting the severity and irreparability of pain-related loss, blame and unfairness (Sullivan, 2008). Perceptions of injustice can ensue from acts or conditions that might cause someone to suffer hardship or loss undeservedly (Hamilton, 1992; Lind, 1988). The potential devastating consequences of debilitating injury have been well documented. At least for a certain percentage of individuals, life following injury will be characterized by persistent physical and emotional suffering (Berglund, 2006). In addition, post-injury life might be replete with losses such as the loss of employment, the loss of financial security, loss of independence and loss of sense of identity (Lyons, 1998; Sullivan, 2002). Some of these losses might be temporary, while others might be permanent. Recent research suggests that perceived injustice consequent to injury might represent one of the strongest predictors of problematic outcomes. Injured individuals who report high levels of perceived injustice also experience more intense pain, more severe depression and are less likely to return to work. Individuals with high levels of perceived injustice display more pain behavior and rate themselves as being more severely disabled. Perceptions of injustice are also associated with the persistence of post-traumatic stress symptoms consequent to injury.

## Fear avoidance and pain catastrophizing

Negative appraisals of pain or maladaptive beliefs about pain increase pain and dysfunction, as well as slow recovery and adjustment. Pain catastrophizing and fear avoidance are common maladaptive beliefs found in patients with chronic pain. Pain catastrophizing can be defined as an exaggerated negative orientation toward actual or anticipated pain experiences (*Gatchel, 2007*). Individuals ruminate about their pain, magnify pain sensations and feel helpless about their ability to manage the pain. Patients who catastrophize their pain both increase pain and dysfunction, as well as slow recovery and adjustment (*Sullivan, 2001; Keefe, 2009*). The Pain Catastrophizing Scale ([http://sullivan-painresearch.mcgill.ca/pdf/pcs/Measures\\_PCS\\_Adult\\_English.pdf](http://sullivan-painresearch.mcgill.ca/pdf/pcs/Measures_PCS_Adult_English.pdf)) is a brief, validated screening tool for patients experiencing pain and is not condition-specific. The Keele's STarT Back Screening Tool (<https://www.keele.ac.uk/sbst/startbacktool/>) is a brief, validated screening tool for patients with chronic back pain in primary care settings (*Hill, 2008*).

The fear avoidance model articulates the maladaptive belief that pain means harm and activity should be avoided in order to prevent future harm. The tenets of contemporary fear avoidance models can be summarized as follows: When pain is perceived following injury, an individual's idiosyncratic beliefs will determine the extent to which pain is catastrophically interpreted. A catastrophic interpretation of pain gives rise to physiological (arousal), behavioral (avoidance) and cognitive fear responses (*Gatchel, 2007*). The cognitive shift that takes place during fear enhances threat perception and further feeds the catastrophic appraisal of pain (*Asmundson, 2004*).

The fear avoidance model describes how individuals experiencing acute musculoskeletal pain may develop chronic pain as a result of avoidance behavior based on fear. The Keele's STarT Back Screening Tool is a brief, validated screening tool for patients in primary care (*Hill, 2008*). The Pain Catastrophizing Scale is a brief, validated screening tool for patients experiencing pain and is not condition-specific (*Sullivan, 1995*).

If the assessment indicates the presence of fear avoidance or pain catastrophizing, consider whether the patient's risk from continued opioid treatment outweighs the benefit and refer the patient to a physical therapist or pain psychologist. If needed, include in the discussion supporting family members and/or caregivers identified by the patient.

## Substance use disorders (SUDs)

A number of brief, validated substance use screening tools are used in clinical settings. The tools include:

- The National Institute for Drug Abuse (NIDA) Quick Screen (<https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen>) is a single screening question that identifies substance use in primary care patients (*Smith, 2010*).
- The Tobacco, Alcohol, Prescription medication and other Substance abuse (TAPS) tool (<https://cde.drugabuse.gov/instrument/29b23e2e-e266-f095-e050-bb89ad43472f>) consists of a four-item screening for tobacco use, alcohol use, prescription medication misuse and illicit substance use in the past year (*McNeely, 2016*).
- The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) ([http://apps.who.int/iris/bitstream/10665/44320/1/9789241599382\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/44320/1/9789241599382_eng.pdf)) is an eight-item questionnaire designed to be administered by a provider to a client.

- [CAGE-AID \(Adapted to Include Drugs\)](https://www.integration.samhsa.gov/images/res/CAGEAID.pdf) (<https://www.integration.samhsa.gov/images/res/CAGEAID.pdf>) is a version for the CAGE alcohol screening questionnaire, adapted to include drug use. It assesses likelihood and severity of alcohol and drug abuse (*Leonardson, 2005*).

Consider using a urine drug screen (UDS) in conjunction with other screening tools to identify patients who may need further assessment for SUD. Discuss abnormal UDS results with a patient in order to identify the underlying issue. Refer patients with SUD to an addiction specialist.

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