



Psyche - Soma - Work

Dr Ken Larsen, Chairperson

Dr Ken Larsen on “Psyche at Work”

Dr John Otis speaking on “Anxiety and Work Injuries”,

Dr Chris McDonough on “Psychologically-Informed
Physical Therapy”

Phyllis Phillips, JD on “Advocacy-Based Claims
Management”

Monday, March 28th, 2022

3:30-4:40pm



2022

Work Related Injuries
Workshop

Psyche at Work

Ken Larsen, DMin, PhD

American Board of Medical Psychology

New England Baptist Hospital

Organizations have a Psyche too

Companies; Governments; Families; Religious Groups; Hospitals

- Thanks to Lew Millender we recognize that Injured Workers have a Psyche as well as a Body
- DIA Guideline #27 has given teeth to the Expectation of Treatment for Pain & Psychological Symptoms related to work injuries for over 20 years now
- Behind each worker, however, is a family, company or organization with a powerful conscious and unconscious influence on both the injury and the outcome of that injury



Organizations have a Psyche

Companies; Governments; Families; Religious Groups; Hospitals

Organizations have Powerful Psyches with beliefs, behaviors and attitudes that have influence on how workers are treated at work, and how they are treated after they are injured at work.

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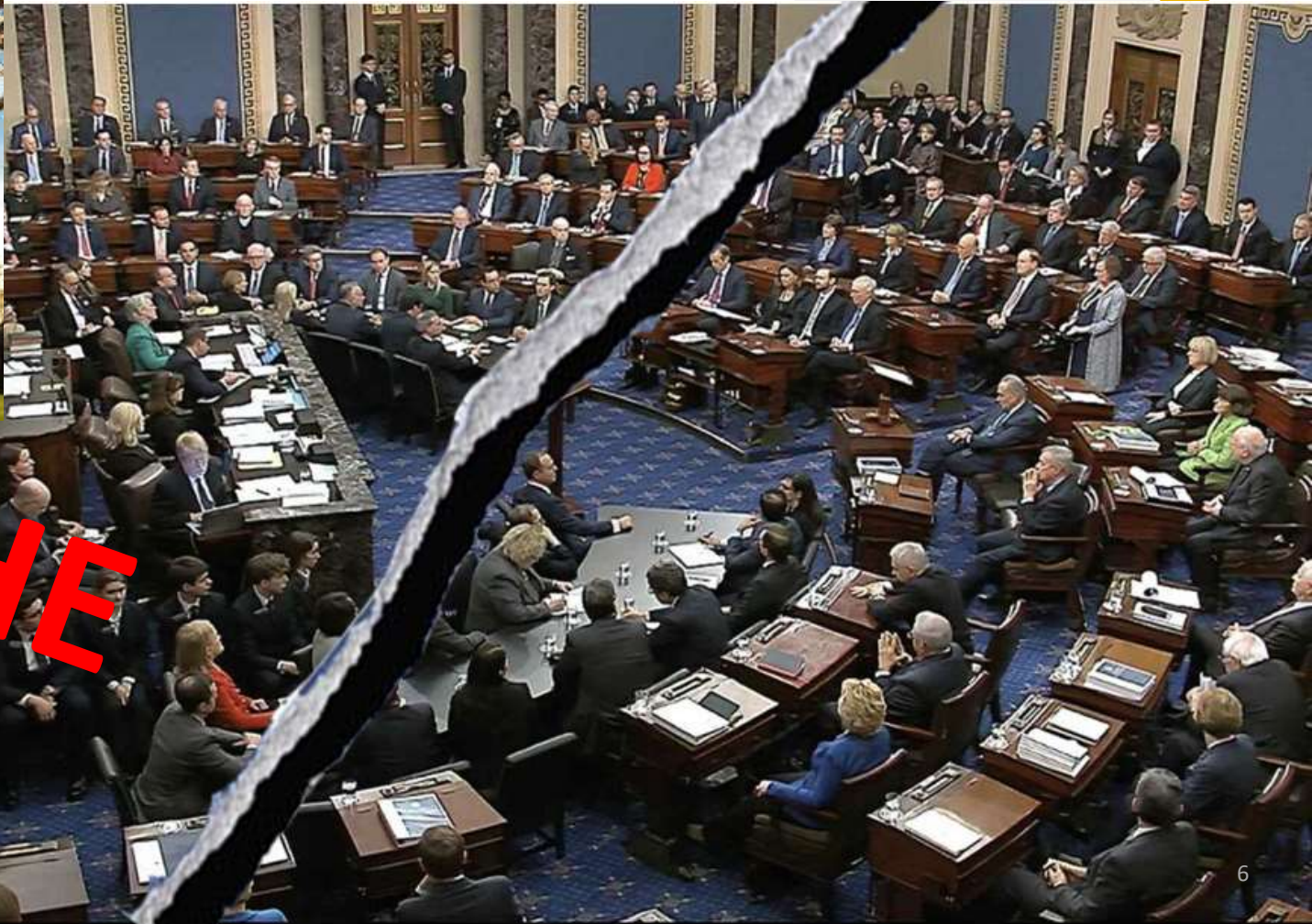
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ROYAL PSYCHE

Government
Big Business
Family

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PSYCHE-DYNAMICS

There are Conscious & Unconscious Forces within all Organizations

“Within a pluralistic society, sociocultural factors along with a company’s culture will directly or indirectly affect the personal narratives of workers”*

There are psychological and organizational dynamics in every company and institution that serves as the backdrop of an injured worker’s situation.

POSITIVE: Policies & Procedures that ensure Safety, Wellbeing & Respect

NEGATIVE: Rule by Division & Threats, Emphasis on Dollars over Empathy

* Robert J. **Gatchel** and Dennis C. **Turk**, Guilford Press NY London **1999**

Employer Influence on RTW

There are Conscious & Unconscious Forces within all Organizations

A 2019 Australian “Safe Work” Study showed

Key Employer Influencing Factors on RTW to include:

- Workplace culture prior to the injury
- Employer’s response to the injury
- Early contact from workplace vs no contact (abandonment)
- Employer pre-claim assistance
- Employee fear or concern about lodging a claim (fear for job)
- Disagreement and disputes as to the claim
- Accessibility to the claims organization (discouraging initiation)

Analysis of the Return to Work – A Safe Work Australia Project, by Dr Mary Wyatt, Occupational Physician
& Dr Tyler Lane, Research Data Analyst at the Institute for Safety, Compensation and Recovery Research. 2019

Employer Influence on RTW

Employees who did RTW answered positively to the following Study Questions:

Percentage who agreed with employer response questions	Physical	Psychological
Your employer did what they could to support you	75%	27%
Employer made an effort to find suitable employment for you	72%	34%
Employer provided enough information on rights and responsibilities	68%	32%
Your employer helped you with your recovery	67%	23%
Your employer treated you fairly DURING the claims process	79%	30%
Your employer treated you fairly AFTER the claims process	79%	35%

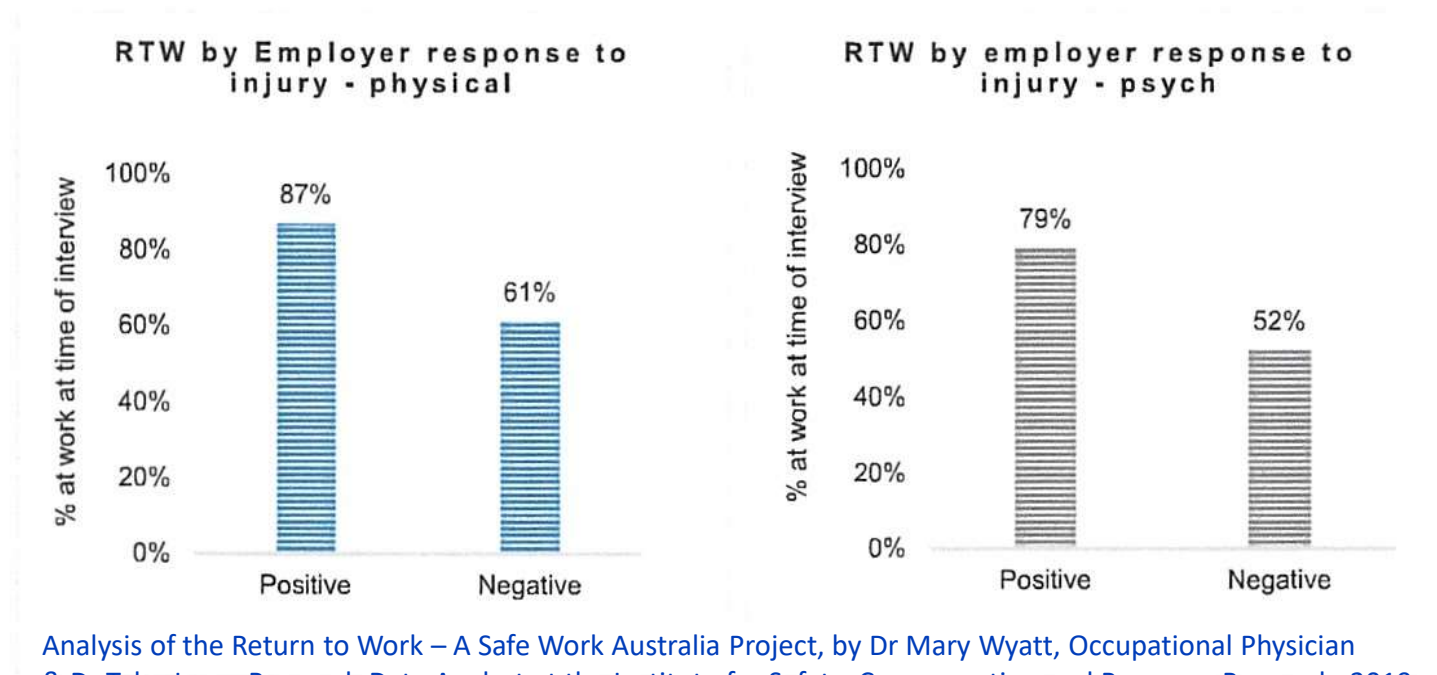
Those with psychological injuries fared worse than those with physical injuries

Analysis of the Return to Work – Sponsored by “A Safe Work Australia” Project, lead by Dr Mary Wyatt, Occupational Physician & Dr Tyler Lane, Research Data Analyst at the Institute for Safety, Compensation and Recovery Research. Published 2019

Employer Influence on RTW

There are Conscious & Unconscious Forces within all Organizations

RTW rates are higher in Companies who treat their workers better; and those with physical injuries RTW at higher rates than those with psychological injuries



Analysis of the Return to Work – A Safe Work Australia Project, by Dr Mary Wyatt, Occupational Physician & Dr Tyler Lane, Research Data Analyst at the Institute for Safety, Compensation and Recovery Research. 2019

Employer Influence on RTW

There are Conscious & Unconscious Forces within all Organizations

Evidence from a range of workplace mental health and RTW research along with this Australian Safety Analysis supports the conclusion that:

- The timeliness and supportiveness of the employer response,
- Perceptions of employer support and fairness,
- Worker's involvement in decision-making about work demands
- The quality of the organizational climate (people management)

Significantly facilitates or hinders RTW of individuals with physical or psychological injuries.

Analysis of the Return to Work – A Safe Work Australia Project, by Dr Mary Wyatt, Occupational Physician
& Dr Tyler Lane, Research Data Analyst at the Institute for Safety, Compensation and Recovery Research. 2019

Employer Influence on RTW

There are Conscious & Unconscious Forces within all Organizations

Workers with **psychological** injury claims were more likely to report:

- Lower rates of employer and/or co-worker contact from the workplace
- More disputes within the work organization
- More often report a negative experience with the claims process
- Lower levels of overall support (family, work, workers comp experience)

It is likely this occurs through two mechanisms:

- Employees with a psychological injury have lower levels of resilience
- Employers and supervisors may be less confident in communicating with employees with a psych claim or a physical claim with a psych component

Analysis of the Return to Work – A Safe Work Australia Project, by Dr Mary Wyatt, Occupational Physician
& Dr Tyler Lane, Research Data Analyst at the Institute for Safety, Compensation and Recovery Research. 2019

Employer Influence on RTW

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There are Conscious & Unconscious Forces within all Organizations

Future Considerations

More effort and programs to educate Organizations how to more effectively address the needs of injured workers, and particularly to increase their understanding of the needs of those workers with a psychological component to their experience.



Anxiety, Pain & Work Injuries

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Today's Agenda

- The Impact of Pain
- Anxiety and Pain
- The Cycle of Pain
- Cognitive Behavioral Therapy for Chronic Pain

What is Chronic Pain?

Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

Chronic pain = Pain with a duration of 3 months or greater that is often associated with functional, psychological and social problems that can negatively impact a person's life.

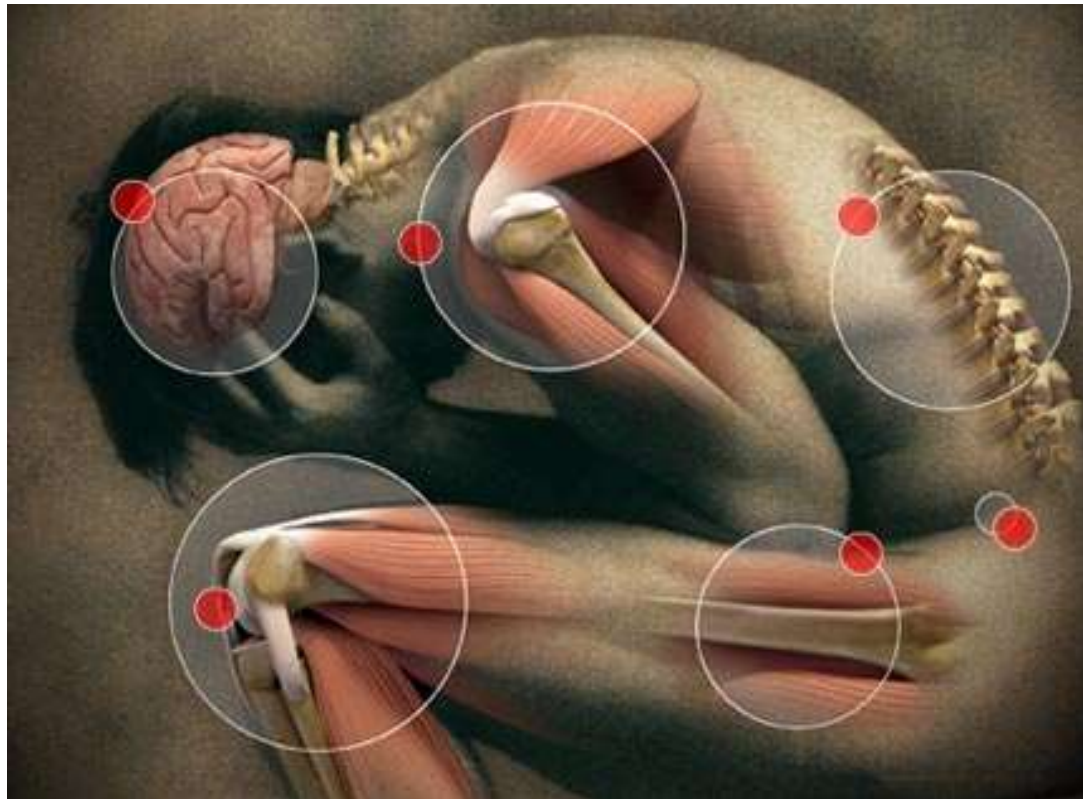


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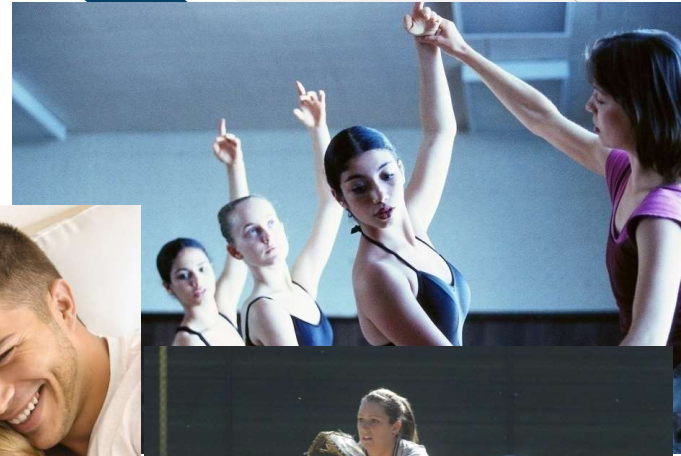
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What is the true impact of PAIN?

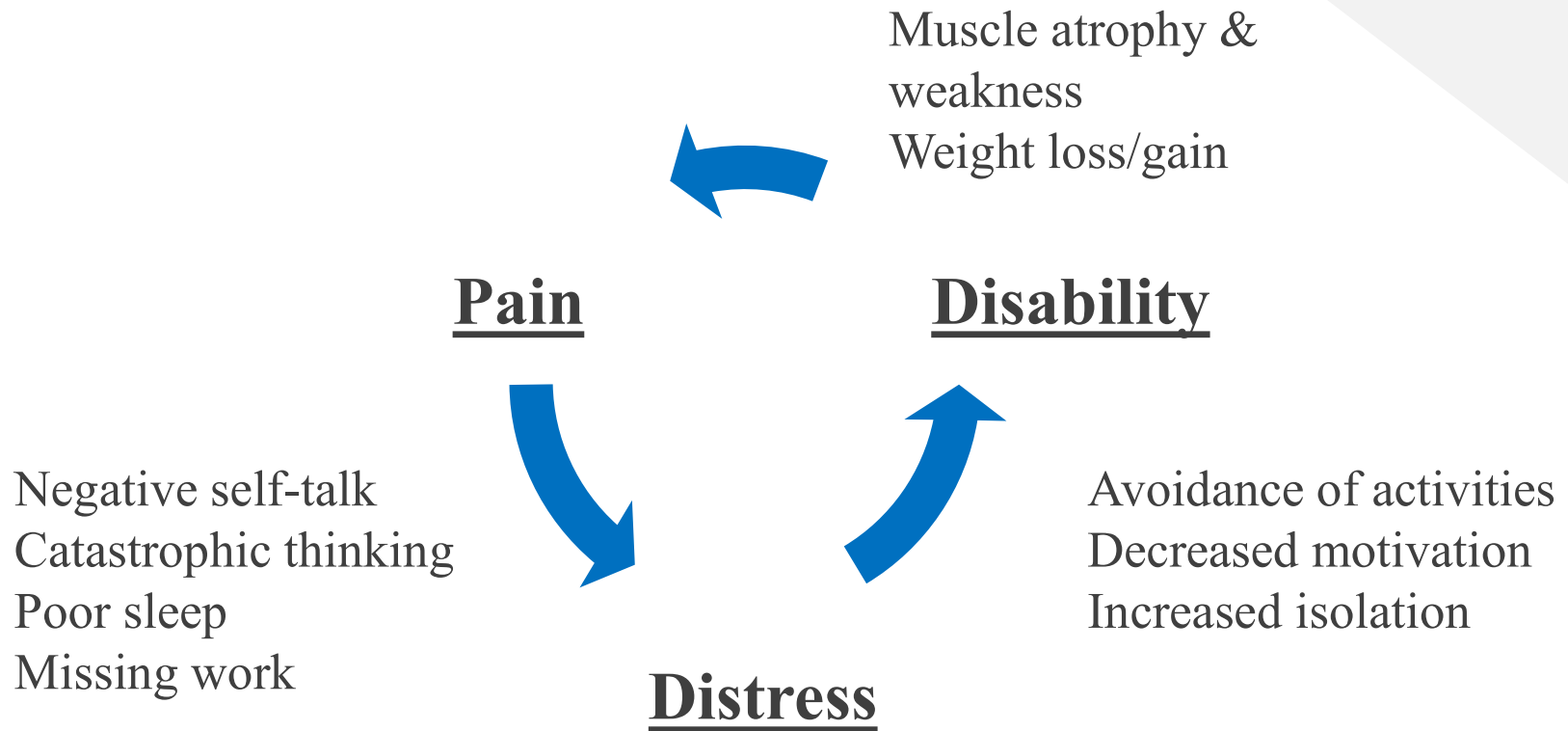


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The Pain Cycle



Anxiety and Pain

- What is anxiety? = our mind and body's reaction to stressful or unfamiliar situations.
- Rates of anxiety in the general population is approximately 10.1%
- Rates of anxiety in samples of chronic pain patient are estimated to be high as 45%
- The most common types of anxiety disorders observed in patients with chronic pain are Generalized Anxiety Disorder (GAD) and Panic Disorder
- What are the factors driving the high rates of comorbidity between pain and anxiety?

How do Anxiety and Pain Interact?

- Catastrophizing = the tendency to believe that there will be terrible outcomes associated with events in the future.
- Hypervigilance = the excessive tendency to attend to pain/somatic sensations, or the excessive readiness to select pain-related information over other information from the environment.
- OUTCOME = Patients with chronic pain and anxiety experience significantly greater pain severity, pain-related disability, and impairments in health-related quality of life. In addition, anxiety can contribute to poorer pain treatment outcomes including functional limitations, impaired social functioning, higher unemployment, and reduced treatment satisfaction.

Fear-Avoidance Model of Pain

This model has served to demonstrate the potential influences of avoidance, hypervigilance, and catastrophizing on the development and maintenance of chronic pain, and has guided the development and refinement of cognitive and behavioral treatments for chronic pain



Vlaeyen & Linton, 2000

The Challenge of Pain

Over time, negative thoughts and anxiety about pain, and behaviors related to pain can become very resistant to change.

Thoughts

- My body has failed me
- This pain is never going to end
- I'm worthless
- I'm disabled
- Pain is a sign of damage
- I'm a bad parent, spouse, and provider

Behaviors

- Staying in bed all day
- Staying away from friends
- Decreasing activities that have the potential to increase pain
- Taking more medication than prescribed

How do we treat Chronic Pain?

<u>Session 1</u>	Education & Treatment Rationale
<u>Session 2</u>	Theories of Pain, Breathing
<u>Session 3</u>	Relaxation Training
<u>Session 4</u>	Cognitive Errors
<u>Session 5</u>	Cognitive Restructuring
<u>Session 6</u>	Stress Management
<u>Session 7</u>	Time-Based Activity Pacing
<u>Session 8</u>	Pleasant Activity Scheduling
<u>Session 9</u>	Anger Management
<u>Session 10</u>	Sleep Hygiene
<u>Session 11</u>	Relapse Prevention

Otis, J. D., (2007). *Managing Chronic Pain: A Cognitive-Behavioral Therapy Approach*, Therapist Guide. Treatments that Work Series, Oxford University Press, NY.

Goal Setting and Exposure

- Treatment Goals are set at the beginning of treatment
 - Activities done in the past but now avoided
 - New hobbies they would like to explore
 - Tasks they want to accomplish
- Weekly Goals
 - Small achievable goals that help the patient to move towards achieving overall treatment goals
 - Example: If the goal is walking you could start with walking to the mailbox once a day.
 - Example: If the goal is working on the computer you could start by having the person work for 10 minutes a day.
- These assignments help patients to gain confidence in their ability to complete desired tasks, and to realize that “avoidance” is not adaptive.

Challenging Negative Thinking

- Using “Cognitive Restructuring” we can teach patients to recognize negative automatic thoughts that contribute to anxiety and avoidance of physical activities.

Common negative/maladaptive thoughts

- I can't deal with my pain
- My pain is going to kill me
- If do _____ I'm going to hurt
- Pain means I'm doing damage to my body
- I can't do anything because of my pain

RESTRUCTURING THOUGHTS

Situation	Emotion	Automatic Thought	Evidence for	Evidence against	Positive Coping Thought
Describe the event that led to the unpleasant emotion	Specify anxious, sad etc. and rate the emotion from 0 to 100%	Write the automatic thought that preceded the emotion	What is the evidence that this thought is true?	What is the evidence that this thought is false?	What else can I say to myself instead of the automatic thought?
<i>My boss gave me an assignment that I have to complete by the end of the week, but my back is hurting.</i>	<i>Anxious – 90%</i> <i>Sad – 80%</i>	<i>I'm <u>never</u> going to be able to get this done.</i>	<i>It sometime takes me longer to complete tasks.</i>	<i>I always get my work done.</i>	<i>Even if it does take me a little longer to complete this assignment I know I can do it and I will likely do a good job.</i>
		<i>I don't deserve to be here.</i>	<i>None</i>	<i>People sometimes come to me for advice on how to do tasks.</i>	<i>I will take breaks along the way and use the skills I have learned in therapy</i>
		<i>Others are so much better than me.</i>	<i>None</i>	<i>I'm good at solving problems.</i>	
		<i>I'm going to get fired</i>	<i>None</i>	<i>I have received good feedback from my boss.</i>	
					Emotion
					Re-rate the emotion from 0 to 100%
					<i>Anxious – 30%</i> <i>Sad – 35%</i>

Time-based Activity Pacing

- Activity breaks are based on time intervals, not on how much of the job is completed
- Ideal for the patient who tends to over-do it
 - The weekend warrior
 - “This is the way I was trained”
- The Professional Athlete example.
 - How do they perform at their best?

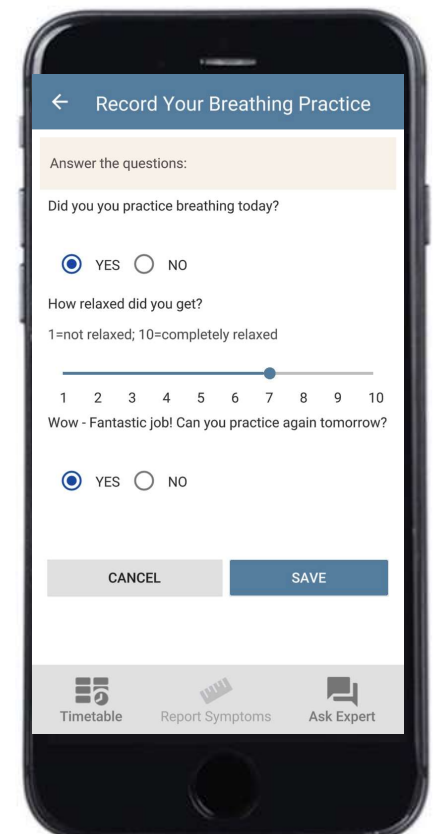
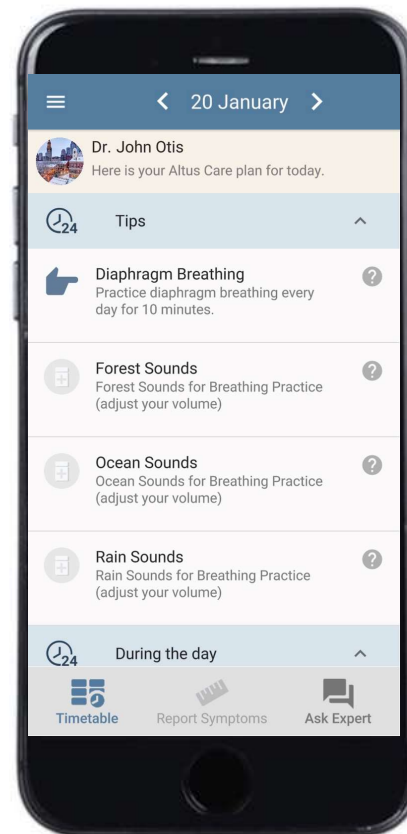


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Increasing Patient Access to Evidence-based Pain Treatments.

- Current research is examining ways of increasing “the reach” of evidence-based treatments for the management of chronic pain and emotional disorders.





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Psychologically-Informed Physical Therapy

Lessons from Low Back Pain

Christine McDonough, PT, PhD

Assistant Professor of Physical
Therapy and of Orthopaedic
Surgery, University of Pittsburgh

Psychologically-informed Practice

- Biopsychosocial Treatment/Management framework
- Clinical Practice Guidelines
- International Association for the Study of Pain (IASP)
- American Physical Therapy Association's (APTA) call to standardize pain education
- Evolution of PiP: focus in PT (PIPT) in musculoskeletal disorders and low back pain
- A secondary prevention approach developed for LBP (Main and George)
 - identify those at high risk → chronicity
 - add within-scope methods (e.g. cognitive behavioral) to impairment-focused treatment

Main CJ and George SZ Psychologically Informed Practice for Management of Low Back Pain: Future Directions in Practice and Research PTJ 2011; (91) 5: 820-824.

Qaseem A et al. Clinical Guidelines Committee of the American College of Physicians. Noninvasive treatments for acute, subacute, and chronic low back pain: a clinical practice guideline from the American College of Physicians. Ann Intern Med. 2017;166(7):514-520. Available from: [https://www.iasp-pain.org/PublicationsNews/NewsDetail.aspx?](https://www.iasp-pain.org/PublicationsNews/NewsDetail.aspx?ID=1000)

Evidence to Date: Mixed

- Varies by condition, outcome, timeframe, intervention components, research design
 - Stronger evidence of effect for cognitive-behavioral intervention
 - More evidence in low back pain; explanatory vs pragmatic trials
- Need to examine training, fidelity and implementation factors

Amanda A, et al (2018) Physiotherapist delivered cognitive-behavioural interventions are effective for low back pain, but can they be replicated in clinical practice? A systematic review, Disability and Rehabilitation, 40:1, 1-9,

O'Keeffe M et al. Comparative Effectiveness of Conservative Interventions for Nonspecific Chronic Spinal Pain: Physical, Behavioral/Psychologically Informed, or Combined? A Systematic Review and Meta-Analysis. J Pain. 2016 Jul;17(7):755-74.

Silva Guerrero AV et al. A Systematic Review and Meta-Analysis of the Effectiveness of Psychological Interventions Delivered by Physiotherapists on Pain, Disability and Psychological Outcomes in Musculoskeletal Pain Conditions. Clin J Pain. 2018 Sep;34(9):838-857

Ballengee LA et al. Implementation of Psychologically Informed Physical Therapy for Low Back Pain: Where Do We Stand, Where Do We Go? J Pain Res. 2021 Dec 7;14:3747-3757.

Wilson S, and Cramp F (2018) Combining a psychological intervention with physiotherapy: A systematic review to determine the effect on physical function and quality of life for adults with chronic pain, Physical Therapy Reviews, 23:3, 214-226, DOI: [10.1080/10833196.2018.1483550](https://doi.org/10.1080/10833196.2018.1483550)

Coronado RA et al. Psychologically informed physical therapy for musculoskeletal pain: current approaches, implications, and future directions from recent randomized trials. Pain Rep. 2020 Sep 23;5(5):e847

PIPT as a Management Framework

Integrating contextual, behavioral, and physical treatments

- Educational: threat reduction and activation
- Behavioral: adapting behaviors in response to pain
- cognitive-behavioral: cognition and coping skills
- Psychophysiological: stress reduction and mindfulness
- contextual cognitive-behavioral: Acceptance and Commitment Therapy

Main CJ and George SZ Psychologically Informed Practice for Management of Low Back Pain: Future Directions in Practice and Research PTJ 2011; (91) 5: 820-824.

Ballengee LA et al. Implementation of Psychologically Informed Physical Therapy for Low Back Pain: Where Do We Stand, Where Do We Go? J Pain Res. 2021 Dec 7;14:3747-3757.

PIPT Components: Empirical Evidence in Musculoskeletal Pain

- Graded activity or graded exposure
- Cognitive-behavioral-based physical therapy
- Acceptance and commitment-based physical therapy
- Internet-based psychological programs and physical therapy

PIPT Treatment Components: TARGET

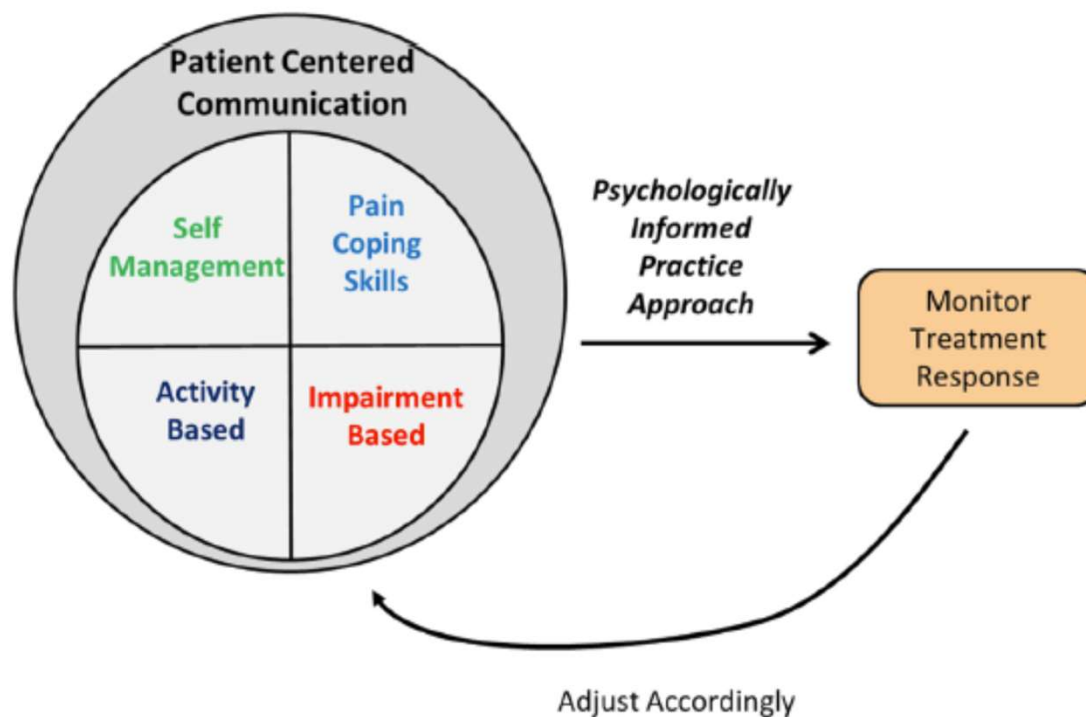


Fig. 2 Overview of key psychologically informed physical therapy (PIPT) treatment components for high-risk patients in the TARGET trial

Example: TARGET Trial PIPT Training



Fig. 1 Psychologically informed physical therapy (PIPT) training program iterative process for development, testing, and modification

PIPT Training

Table 1 Psychologically Informed Physical Therapy Training Course Learning Objectives.

1. Summarize relationships between pain neuroscience, pain models, and the development and maintenance of chronic low back pain.
2. Identify patients at high risk for transitioning from acute to chronic low back pain.
3. Apply targeted treatment for patients at high risk for transitioning from acute to chronic low back pain.
4. Understand primary assumptions of CBT and specific skills associated with CBT based interventions.
5. Recognize effective communication skills and be able to implement as a key component to PIPT.
6. Differentiate key principles and application between graded activity and graded exposure.
7. Review the Low Back Pain Clinical Practice Guidelines from the Orthopaedic Section of the American Physical Therapy Association to become familiar with: 1) ICF-based classifications; 2) symptoms; 3) impairments; and 4) suggested intervention strategies.
8. Be able to implement PIPT practice principles for patients with low back pain.

PIPT Psychologically Informed Physical Therapy, *CBT* Cognitive-Behavioral Therapy, *ICF* International Classification of Functioning, Disability, and Health

PIPT Training Example

Overview

- Pain Science
- PIPT
- Risk Stratification
- Targeted Treatment
- Cognitive Behavioral Therapy
- Self-reflection

PIPT Management

- Patient-centered communication
 - Active Listening
 - Motivational Interviewing
 - Goal-setting

PIPT Training Example cont'd

Pain Coping Skills

- Physiological relaxation
- Imagery
- Replacing Cognitive Distortions Patient Education

Activity-based

- Graded Exercise
- Graded Exposure

Impairment-based

- Clinical practice guidelines

Treatment monitoring

Challenges and Opportunities

Example: TARGET Trial

- Pragmatic, cluster-randomized clinical trial of patients seen in the primary care setting with acute LBP
- The STarT Back Tool
 - Risk stratification
 - Screen for modifiable prognostic factors
 - Inform clinical decision-making to match patients to different care pathways.”

PIPT Results

Clinical Orientation

Pain Attitudes and Beliefs Scale for Physical Therapists (PABS-PT)

- Biomedical scale (10 items) score range: 10-60 indicates biomedical orientation
- Biopsychosocial scale (9 items) score range: 9-54 indicates biopsychosocial orientation

Pre-post results for 431/471 course participants

- Decrease in biomedical orientation
 - from 31.1 (SD = 6.8) to 25.0 (SD = 7.1) ($P < 0.001$)
- Increase in Biopsychosocial orientation
- Behavioral scores from 36.8 (SD = 4.8) to 41.4 (SD = 5.2) ($P < 0.001$)

PIPT Results

Confidence in PIPT Skills

- (453/471) of course participants immediately after training
- increased from 4.8 (SD = 2.2) to 7.3 (SD = 1.9) ($P < 0.001$). The regression model explained 27% of the variance in post-course confidence scores.
 - Greater post-course confidence scores for those who viewed modules when compared with those who did not (mean = 7.7 (SD = 1.3) versus 7.2 (SD = 1.7), $P = 0.004$).
 - After adjustment for pre-course scores, differences in confidence change scores between TARGET site locations were observed ($P < 0.001$).

PIPT Results

Implementation Challenges

- Need for specialized post-professional training
- Especially where biomedical or impairment-based focus during entry-level education and clinical practice
 - fewer years in clinical practice was associated with less improvement in confidence after attending the live PIPT workshop,
 - less-experienced physical therapists (i.e., new graduates) may not be adequately prepared to successfully implement PIPT strategies with patients or who require additional training.

Current Training Initiatives

All include didactic, experiential, mentoring approaches

- Duke: PIPT treatment manual, experiential workshops, and ongoing supervision with consultation and feedback
- Veteran's Affairs Health System: PT train-the-trainer based on the International Association for the Study of Pain (IASP) pain education curriculum

Ballengee LA et al. Implementation of Psychologically Informed Physical Therapy for Low Back Pain: Where Do We Stand, Where Do We Go? J Pain Res. 2021 Dec 7;14:3747-3757.



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Thank you!



Advocacy-Based Claims Management: The Advantages of Being Nice

Phyllis Phillips, Esq.

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**“Tart words make no Friends:
Spoonful of honey will catch more flies
than Gallon of Vinegar.”**

Benjamin Franklin, *Poor Richard's Almanack* (1744)

Advocacy-Based Claims Management: What is it?

- ❖ A process grounded in **values of respect and transparency**, rather than one characterized by black-and-white, task-based administration of state-mandated benefits
- ❖ **Holistic view of injured worker as the “customer”** at the center of the claim; a person with fears and feelings, not just a collection of injuries or complaints
- ❖ **Support system mentality**, with Day One focus on recovery (though not necessarily RTW)

Advocacy-Based Claims Management – Does it Work?

- ❖ **Psychosocial issues** (e.g., fear, poor coping skills, limited English proficiency, troubled home/work life) are the #1 barrier to successful claim outcomes*
- ❖ **Increased training in “soft skills”** (empathy, communication, active listening, customer service, critical thinking) leads to faster recovery, decreased litigation, and higher claim closure rates*

*Rousemaniere, P. and Fikes, R., “How to Overcome Psychosocial Roadblocks: Claims Advocacy’s Biggest Opportunity,” *Rising Medical Solutions* (2016), https://www.risingms.com/research-knowledge/workers-compensation-benchmarking-study/overcoming-psychosocial-roadblocks-claims-advocacys-biggest-opportunity/#_ednref2

Advocacy-Based Claims Management – Adjuster “How-to’s”*

- ❖ Initial contact with injured worker is an extremely powerful moment; **attitude/tone of voice sets stage** for everything that follows
- ❖ Explain the process; set realistic timeframes and expectations; **be transparent**
- ❖ **Do what you say you’re going to do**; accountability creates credibility
- ❖ **Practice active listening and problem-solving** to identify and address unanticipated or unusual barriers
- ❖ **Cultivate a vision of successful recovery**; focus on ultimate outcome, not painful present

*See, e.g., “Why Workers’ Recovery,” by Claire Muselman, director of Workers’ Compensation Recovery Unit, Continental Western Group; *Workers’ Compensation.com*, July 23, 2019, https://www.workerscompensation.com/news_read.php?id=33167

Advocacy-Based Claims Management – Other Strategies for Effective Results

- ❖ **Be alert to injured worker's fear** (of reinjury, activity, job loss, etc.); left unaddressed, fear is highly predictive of poor claim outcomes
- ❖ **Consider team-based approach**, e.g. CBT, health coaching for better sleep or diet, etc.
- ❖ Avoid “medicalizing” psychosocial issues; **not every life predicament has a medical solution**

Advocacy-Based Claims Management – Last Words

Remembereth this, ye who seek succour:

**“Workers’ Compensation is a detour, not
a destination.”**

Benamina Fronkline, *Poor Rikki’s Almanac (unpublished)*