Patient Communication

What Do Pain Behaviors Tell Us?

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Pro Sports Behavioral Medicine

Return to Work Barriers: Assessing and Addressing Fear of Re-injury

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Work Related Injuries Workshop
April 30th & May 1st, 2018

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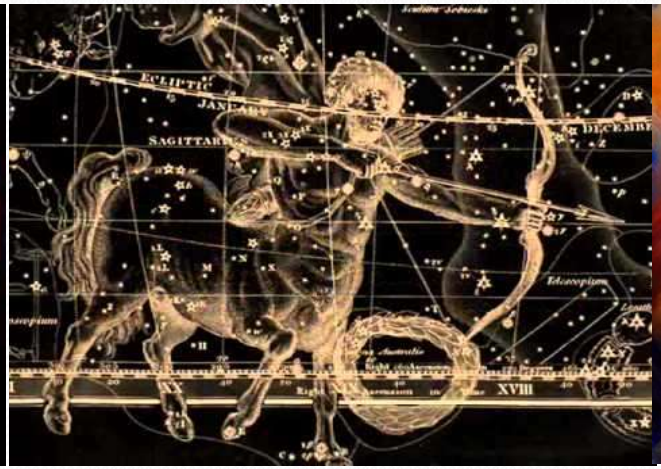
The Wounded Healer Archetype

One's personal wound is a precursor to establishing a therapeutic alliance
Recognizing our own wounds activates the inner healer in the patient



Listening is “Evenly Hovering Attention”

Listen Deeply to your own personal inner voice of woundedness and pain

Listening is “Evenly Hovering Attention”

By deeply listening to our patients’ suffering we can begin to understand their language of pain and pain behaviors

Listening is “Evenly Hovering Attention”

This becomes the connective tissue between the patient and caregiver

Subjective Expressions of Pain

1 2 3 4 5 6 7 8 9 10

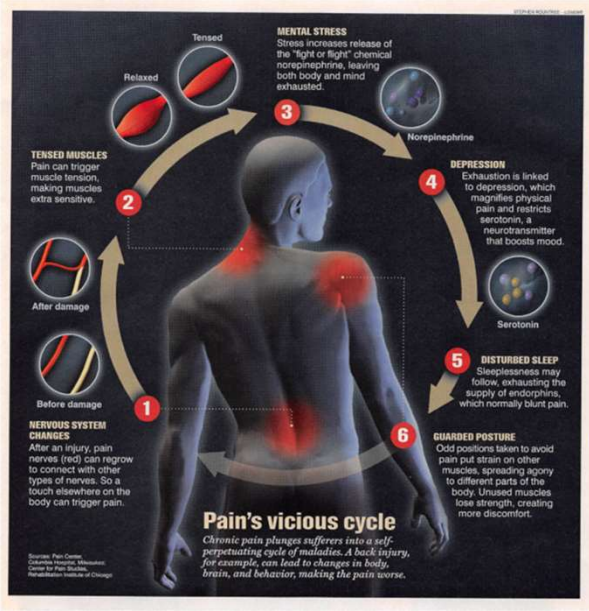
Subjective Expressions of Pain

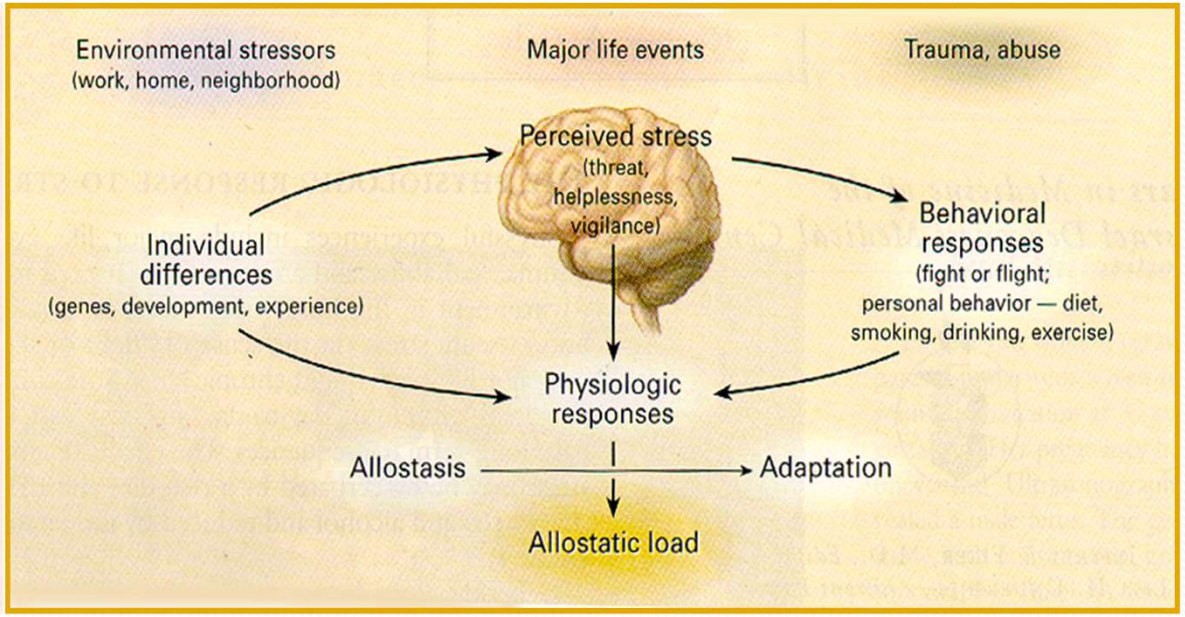
What does your pain feel like? Ronald Melzack, PhD [McGill University]

Flickering, Throbbing, Shooting, Pricking, Drilling, Sharp, Pinching, Gnawing, Tugging, Burning, Stinging, Heavy, Splitting, Tiring, Suffocating, Terrifying, Punishing, Blinding, Intense, Radiating, Piercing, Squeezing, Freezing, Nagging, Torturing, Hot, Cold, Brutal, Streaming, Pressure, Numbing, Exploding, Clawing, Pounding, Tearing, Exhausting

Assessing Wounds <> Accessing the Healer

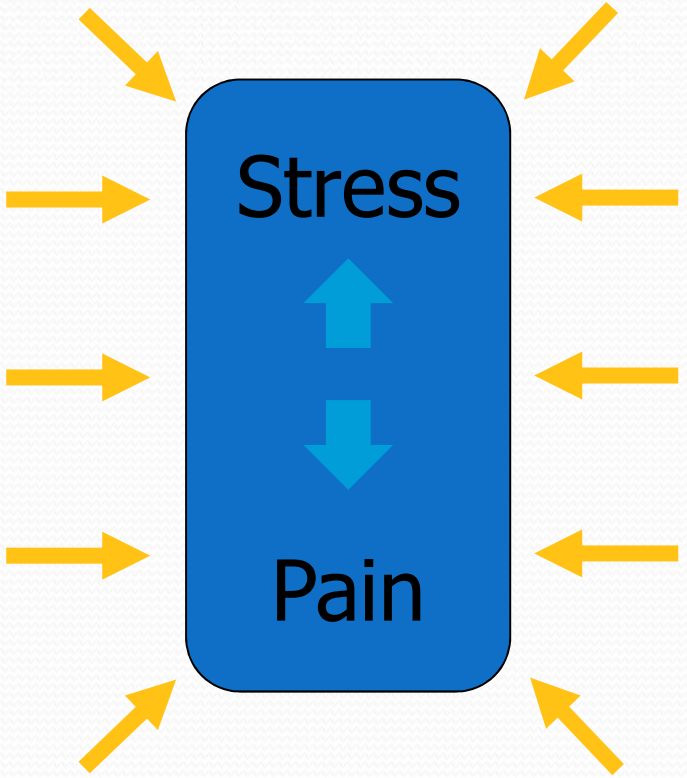
The human body is not just a physical machine - it is a dynamic, ever changing river of intelligence, information, and recorded experience





Psychosocial Factors in Pain Behaviors

- Maladaptive Attitudes & Beliefs
- Their fear of movement
- Their Anticipatory bracing
- ↑ Emotional Reactivity
- Influence from Family & Work
- Level of Social Support or Lack of
- Unconscious Secondary Gain
- Life Job Dissatisfaction
- Trauma, and Abuse History



TWO SPECIAL NOTES:

1. Pain behaviors are **NOT** evidence of malingering or of a lack of physical disorder (as are often interpreted by the presence of Waddell signs)
2. Workers **can** have pain behaviors **as well as** a medically treatable pathology

"Psychosocial Factors in Pain," R. Gatchel, D. Turk, 2012

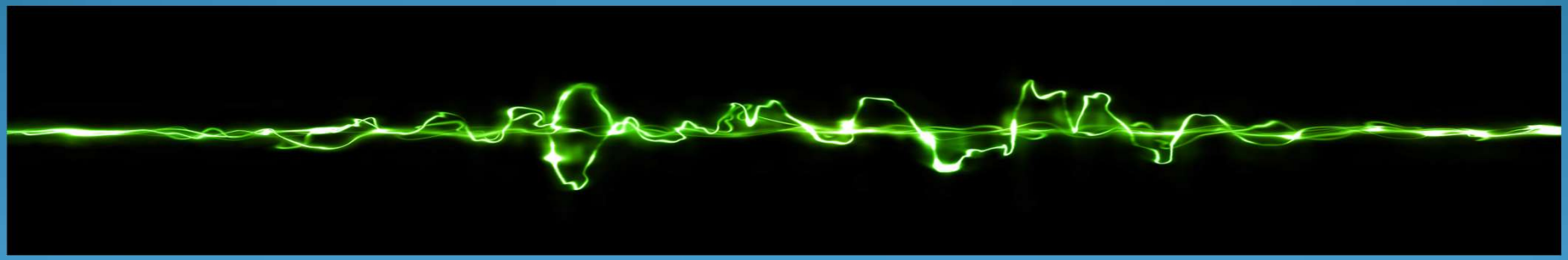
Final Thoughts

KNOW OUR OWN WOUNDS

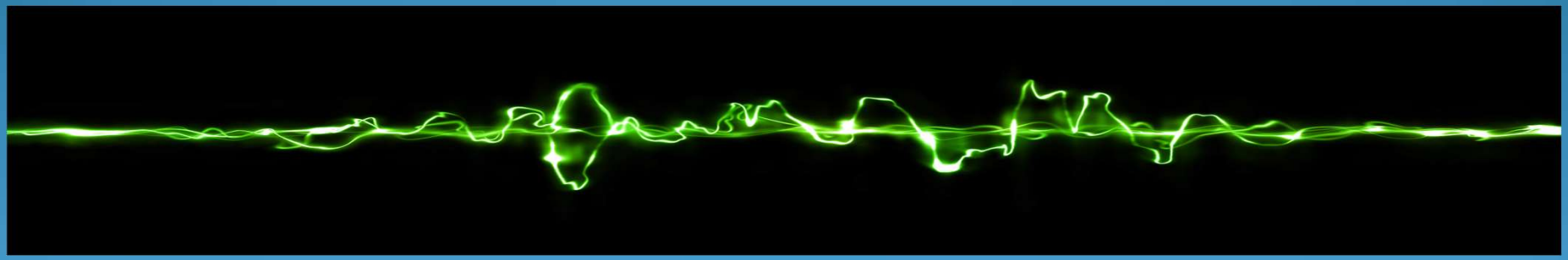
LISTEN Deeply

Build Compassionate Therapeutic Alliance

Lead Patients To Self-Empowerment



Thank You



Return to Work Barriers: Assessing and Addressing Fear of Re-injury

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"We'll know more once we do an MRI, but, yes, this could be a career-ending injury."

Return to Work Barriers: Assessing and Addressing Fear of Re-injury

COMMON RETURN TO WORK BARRIERS FOR PEOPLE WITH INJURIES/DISABILITIES

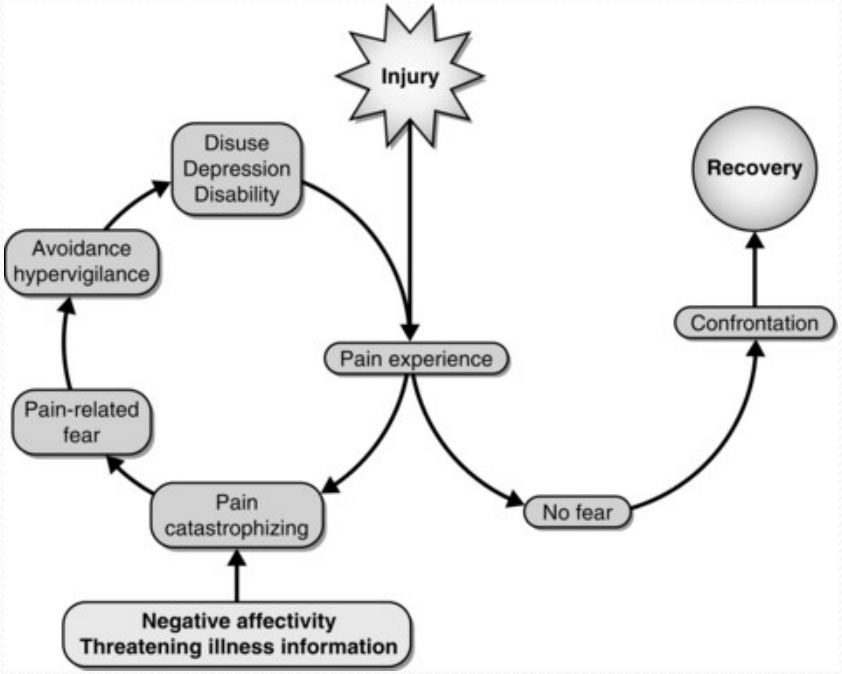
- Amount of time off work
- Physical restrictions
- Limited transferable skills
- Low or limited education
- Limited technology skills
- Transportation
- Geographical area
- Psychosocial barriers

Return to Work Barriers: Assessing and Addressing Fear of Re-injury

Psychosocial barriers:

- ***Catastrophizing***
  - *What if I need surgery, end up in a wheelchair or death*
- ***Fear / Avoidance***
  - Activity will hurt thus making it worse
- ***Disability Beliefs***
  - *My doctor says I may never be able to work*
- ***Perceived Injustice***
  - *Nothing will ever make up for what's happened to me*

Return to Work Barriers: Assessing and Addressing Fear of Re-injury



Fear Avoidance Model [2]

Return to Work Barriers: Assessing and Addressing Fear of Re-injury

Blue Flags on Individuals Perceptions About Work

- Heavy physical demand level
- Inability to modify work
- Stressful work demands
- Lack of workplace social support
- Job dissatisfaction
- Poor expectation of recovery
- Fear of re-injury

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- Validated screening tools used by physical therapists
  - FABQ (Fear Avoidance Behavior Questionnaire)
    - 2 subscales
      - FABQ-PA (fear avoidance behavior questionnaire-physical activity)-total possible points 42, high>34
      - FABQ-W (fear avoidance behavior questionnaire-work)-total possible points 24, high>15
      - A study by George et al found the FABQ work scale was the better predictor of self-report of disability in a sample of LB patients participating in physical therapy clinical trials.[1]
      - MCID (minimal clinically important difference) -13 points

Return to Work Barriers: Assessing and Addressing Fear of Re-injury

- Other functional tools
  - ODI (Oswestry Disability Index)
    - MCID-6 points
  - Roland Morris Disability Questionnaire (RMDQ)
    - MCID 30% of baseline score is considered the cut-off point for detecting change, or 3 point change.
    - If the patient has a score of greater than 7, then the MCID = 3 points.
    - If the score is less than 7, then the MCID = 30% change in score.

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- Treatment strategies
  - Cognitive Behavioral Therapy
    - Refers to a number of patient-counseling strategies that are intended to change dysfunctional thoughts, feelings and behaviors [3]
    - Patient self-reflection of thought processes guided by analysis of patient's thinking by a clinician
    - Guide to Physical Therapist Practice states CBT mirrors the PT examination and evaluation process and addresses the client educational deficits that may contribute to diablement[4]
    - Initial therapy for these "at risk" patients should be physical therapy exercise instruction, using a cognitive motivational approach to PT.[8]

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Identifying and responding to workplace factors in back disability

Workplace factor:	Sample interview question:	Possible actions:
Heavy physical demands	Are you concerned that the physical demands of your job might delay your return to work?	• Assemble list of problem job tasks • Conduct work-site walk through • Identify temporary sources of help
Inability to modify work	Do you expect your work could be modified temporarily so you could return to work sooner?	• Modified or alternate duty program? • Brainstorm with injured worker • Assess job flexibility
Stressful work demands	Are there stressful elements of your job that might be difficult when you first return to work?	• Modify speed or time pressures • Recognize stressful job elements • Assess usual coping strategies
Lack of workplace social support	What kind of response do you expect from co-workers and supervisors when you return?	• Establish more contact with co-workers • Encourage employer communication • Involve trusted co-workers
Job dissatisfaction	Is this a job you'd recommend to a friend?	• Assess weather career goals have changed • Clarify worker options and responsibilities • Motivational interviewing
Poor expectation of recovery and return to work	Are you concerned that returning to work may be difficult given your current circumstances?	• Clarify nature of concerns • Realistic messages conveyed by all medical providers • Employer encouragement and reassurance
Fear of re-injury	Are you worried about any repeat episodes of back pain once you return to work?	• Develop action plan if symptoms recur • Plan for a more gradual return to work • Counter belief that activity is dangerous

Outline from Shaw et al [5]

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- Progressive Goal Attainment Program (PGAP)-CBT technique
  - Achieved through treatment of psychosocial risk factors, structured activity schedule, graded activity involvement, goal setting, problem solving and motivational enhancement
  - Structured program where the client and PGAP provider meet 1X/wk for 1 hour for a maximum of 10 weeks
  - PGAP can be offered by clinicians from mental health providers as well as a variety of rehabilitation disciplines, such as occupational therapy, physical therapy, kinesiology, vocational rehabilitation, nursing, social work and psychology
  - Must be trained and have certification

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Work Conditioning[7]

- Work conditioning eval/work tolerance screen
- Single discipline
- Up to 5 days/week
- Up to 4 hours/day
- PDL
- 10 visits over 4 weeks equivalent to 30 hours
- Can be working to participate
- No psych component

Work Hardening[7]

- Work hardening eval/ Functional Capacity Eval
- Multidisciplinary
- Up to 5 days/week
- Up to 8 hours/day
- PDL
- 20 full day visits over 4 weeks no > 160 hours
- Can be working to participate
- Psych/Behavioral component

Return to Work Barriers: Assessing and Addressing Fear of Re-injury

- Final Thoughts
  - Successful RTW is achieved by having all involved (the injured person, treating MD practitioner/Occ health provider, employer and therapist) in the process of communication and expressing the same things
  - The therapist should be proactive in providing an outline with recommendations for RTW to the MD practitioner/Occ health provider
  - Get informed consent from injured person and consider a direct discussion with the employer

Return to Work Barriers: Assessing and Addressing Fear of Re-injury

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THANK-YOU