Psychosocial Factors in Low Back Pain

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Objectives

• Recognize contributions of yellow flags, green flags, black flags, and blue flags in effective management of low back pain.
• Understand differences with treatment mediators, treatment moderators, and prognostic factors.
• Synthesize different biopsychosocial pain models.
• Outline problems with the biomedical pain relief model in musculoskeletal pain conditions.

Objectives

• Demonstrate understanding of the fear-avoidance model including the important role of health care provider beliefs.
• Recognize the role of fear, catastrophizing, depression, and self-efficacy in low back pain and methods used to measure meaningful change.
• Identify the role of central sensitization.
• Assimilate strategies to address biopsychosocial factors to enhance therapeutic efficacy.

Models to Predict Low Back Pain

If one prognostic factor is good….

145
221
1500

(Hayden, 2010; Kent 2006)

Nature of Low Back Pain

• Typically see a rapid improvement in 4 weeks (BMJ 2003)
• 90% with LBP stop consulting in 3 months
• Persistent symptoms typical
• 1-year incidence between 1.5% and 36% (Wheeler, 2014)
• Neither constant pain nor complete pain relief is typical

Lots of Complexity!!!
Risk Factors for Onset of LBP

- Women > men
- Older > younger (until age 65)
- Lower education
- Workplace factors (blue flags)
- Psychosocial factors (somatization, anxiety, depression, fear)
- General health
- Cultural factors
- Hypertension, smoking, obesity risk factors are associated with sciatica.

(Delitto, 2012, JOSPT)

Red Flags

- Sudden change in bowel/bladder, saddle area anesthesia
- Sustained fever, IV drug user, weak immune system
- Trauma, fall, osteoporosis
- History of cancer (prostate, breast, lung), unexplained weight loss, unchanging lasting weeks
- 1:20 with LBP, 15-35 yo, right pain, 1+ hours morning stiffness
- Inflammatory (45)

NASCAR - Yellow Flags

- Yellow Flag: Means there is a hazard on the track ahead, slow down and no overtaking.

Screening for Back Pain Yellow Flags

Yellow flags are factors that increase the risk of developing, or perpetuating long term disability and work loss associated with low back pain.

Includes Blue, Black, and Yellow Flags.

(Kendall et al, 1997)

Blue Flags

**Big 7 Work Issues**

1. Heavy physical demands (self-reported)
2. Inability to modify work
3. Lack of workplace support
4. Increased job stress
5. Job dissatisfaction
6. Poor expectations for return to work
7. Fear of re-injury (patient thinks they need to be 100% to return to work)

**Less likely to return to work if newer worker or with increased time passed before reporting symptoms.**

(Lea, Spine 2003; Carragee, Spine 2005; Shaw, JOEM, 2010)
Returning to work

Dramatic decrease in probability of returning to work over time.

Black Flags

- Policies/Compensation issues
  - Financial disincentive
  - Reimbursement
- Lower Income/Education
- Comorbidities
  - Smoking history
  - Number of surgeries
  - Chronic pain states

Newsweek Article

“The Price of Pain”

2-12-08

“In part, we’re just guilty of trying to keep hitting things with the same hammer over and over again and not taking a step back and rethinking the problem and considering whether an exercise program, more physical therapy, may be beneficial.”

– Richard Deyo

Green Flags

- Centralization
  - Powerful predictor of improvement
  - Patients will likely benefit from directional preference exercises
- Clinical Prediction Rules
  - Manipulation (Flynn, 2002; Childs, Annals Int Med, 2004)
  - Stabilization (Hicks, Phys Ther, 2005)

Yellow Flags – Psychosocial Factors

- Emotional issues (Lipton, Spine 2000)
  - Depression
  - Anxiety/Distress
  - Social Withdrawal
  - Self-Efficacy
  - Passive Coping Style
- Family issues
- Fear avoidance issues
  - Fearful, Fear avoidant, Kinesiophobia
  - Catastrophizing

**Catastrophizing and kinesiophobia predicted low back pain and disability cohort of 1845 subjects (Picavet 2002)**
Prognostic Factors for Development of Chronic LBP

- Symptoms below the knee
- High pain intensity
- Widespread pain
- Low expectations of recovery
- Higher baseline disability
- Being non-employed

(De Lint, 2012, JOSPT; Grotle 2010, Pain; Turner 2008, Spine; Pinious 2008, Arth Rheum)

Psychosocial Pain Models

1. Stress-diathesis model (Schultz, 2004)
2. Self-efficacy model
3. Acceptance/contentment model
4. Mis-directed problem solving model (Crombez, 1997)
5. Fear-avoidance model (Lethem & Troup, 1983)

(Self-Efficacy Model)

Acceptance/Contentment Model

- Coping strategies are dependent on person’s acceptance of current state
- Rx with minimizing their focus on factors out of their control
- Focus on acceptance of current condition
- Become content to manage current state
- Move forward/turn the page
Misdirected Problem Solving Model

- Worry about current situation
- Ruminate
- Hyper-vigilance to pain
- Therapy involves cognitive behavioral therapy to overcome misdirected focus on pain and current state.

(Crombez, 2007)

Fear Avoidance Model

- LETHAM ('83) & TROUP ('87)
- "Fear avoidance model of exaggerated pain perception (FAMEPP)"

Updated Fear-Avoidance Model

- Belief that pain is harmful
- Belief that all pain must be abolished before returning to activity
- Expectation of increased pain with activity or work
- Expecting the worst
- External locus of control, belief that pain is uncontrollable
- Passive attitude to rehabilitation

Fear of Low Back Pain

... Disability depends more on the fear avoidance than on pain or physical pathology --- The fear of pain is more disabling than the pain itself.


Confronters

- Strong desire to return to normal activities
- Confront pain barriers
- Adaptive response
- Synchronous sensory and emotional components of pain
- Gradual return to activity
Avoiders

- Fear of harm and reinjury with activity
- Reduced activity
- Maladaptive response
- Exaggerated pain perception
- Desynchronous relationship between sensory and emotional pain components
- Increasing disability

Screening for Fear-Avoidance Beliefs

- Self Report Questionnaires
  - Fear Avoidance Beliefs Questionnaire (FABQ)
  - Tampa Scale for Kinesiophobia (TSK)
- Can we just tell by looking?
- Scanner?

Identifying Fear-Avoidance Beliefs by Therapists
Managing Patients with Low Back Pain
(Calley et al, 2010, JOSPT)

80 Subjects from 3 PT clinics with LBP completed FABQ, TSK, PCS, ODI, 2 item brief fear avoidance
8 Therapists performed blinded ratings of perceived subject fear avoidance based on the clinical exam

Results
- Therapists consistently under-rated actual fear avoidance scores
- Therapists ratings had moderate reliability (ICC=0.6 to 0.8) but poor accuracy
- Therapist ratings were actually predictive of baseline elevated disability scores, and some association with catastrophizing
- The 1 item screening question, “are you afraid that physical activity will increase your LBP?” may have value as a 1 question screen for elevated fear avoidance beliefs (a no response is more meaningful, -LR=−.027).

Elevated Fear-Avoidant Belief Correlations Seen During Physical Exam

- Decreased walking speed
- Limited lumbar flexion
- Decreased spinal extensor strength
- Decreased lifting capacity
- Decreased trunk muscle surface EMG (49.5% lower)
- Decreased lumbar velocity during reaching task
- Decreased ability to lift 7 kg from floor to table height
- No change with limited hip flexion or limited thoracic flexion
(Thomas, Eur Spine J 2008)

How to Quantify Fear-Avoidance Beliefs and Fear of Activity

- Fear-Avoidance Beliefs
  - FABQ – Fear Avoidance Beliefs Questionnaire
  - TSK – Tampa Scale of Kinesiophobia
- Fearful Activities
  - PHODA (Kugler, 1999; Trost, Pain, 2009)
    http://www.phodase.org/Phoda-SeV_UK.htm
  - FDAQ (George, Phys Ther, 2009)
    http://www.phodase.org/Phoda-SeV_UK.htm

FABQ – What is it good for?

- Reliable and valid way of identifying patients who have high pain avoidance beliefs.
- Useful with various clinical prediction rules (Lumbar/thoracic spinal manipulation or stabilization prediction rules)
  - FABQ-W <19 = one of 5 criteria predicting positive lumbar manipulation outcome
  - FABQ-PA ≤ 9 = one of 4 criteria predicting negative stabilization outcome
  - FABQ-PA <12 = one of 6 criteria predicting positive thoracic manipulation in patients with neck pain
- FABQPA scores were more predictive of 1 year disability in subjects with chronic low back pain. (Grube, Spine 2008)
FABQW – What is it good for?

• Identifies individuals with a high likelihood of developing chronicity (at risk of not returning to work)
  • >34 FABQ-W have a +LR=3.33
  • <29 FABQ-W have a –LR=0.08
  (Fritz, Phys Ther. 2002)

• Acute LBP – 6 month predictive value
  • >20 FABQW were 5 times more likely to not improve
  • <5 FABQW were 3 times more likely to have improvement
  (George, JOSPT 2008)

• Insurance – No predictive value with private insurance patients.
  FABQW predicted disability in workers comp patients.
  (Cleland Euro Spine J. 2008)

Catastrophizing

Catastrophizing is a maladaptive response defined as an exaggerated orientation towards pain stimuli and pain experience.

If you’ve heard of other catastrophies…

Catastrophizing = Tendency to ruminate, magnify … or feel helpless about pain.

How to Quantify Catastrophizing

Pain Catastrophizing Scale (PCS): a 13-item self-report questionnaire used to quantify patient pain catastrophizing.

Items on the PCS are rated on a 5-point scale and the questionnaire can be subdivided into three components:
• rumination
• magnification
• helplessness

Pain Vigilance and Awareness Questionnaire

(Sullivan, 1995; Kraaimaat, 2003)

Depression

**Quite possibly the most important yellow flag we should be screening for** (Haggman et al. 2004).

15-22% incidence of all patients seen in primary care (5-8% major depression)

How to Quantify Depression

• Beck Depression Inventory
• Zung Depression Scale
• Geriatric Depression Scale
• 9-question Patient Health Questionnaire (PHQ-9)
• 2-question Patient Health Questionnaire (PHQ-2)

How to Screen for Depression

Two questions are as good as many (PHQ-2):

1. “During the past month, have you often been bothered by feeling down, depressed, or hopeless?”
2. “During the past month, have you often been bothered by little interest or pleasure in doing things?”
   If responses to either of the above are yes, then follow up with the question:
3. “Is this something that you would like help with?”

(Arrol, 2005)
How to Screen for Depression

Want a screening tool with high sensitivity

**How to Address Depression**

- Referral to Primary Care
- Anti-Depressant Medications
- Exercise
- Cognitive Behavioral Therapy
- Education - Inspire Hope

(Arroll, 2005)

How to Address Self-Efficacy

- Patient Centered Care
- Motivational Interviewing
- Active Listening
- Graded Exposure/Exercise
- Education - Inspire Hope

How to Address Self-Efficacy

- Pain Self Efficacy Questionnaire (PSEQ)
  - 10 questions about the patient's confidence in carrying out various normal activities despite the pain.
  - Total score ranges from 0 to 60 points with higher scores indicating higher perceived pain self-efficacy.

Chronic Pain Self-Efficacy Scale (CPSS)

- 22-item questionnaire, 3 factors: Self-efficacy for pain management, coping with symptoms, and physical function.

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Problems with Pain Relief Model

1. High number of false positives with imaging (Chau, 2007)
2. Variability in nervous system processing (Coghill, 2003)
3. Variability in pain location (O’Neill, 2009)
4. Very controlled force of pain stimulus has poor correlation with pain intensity

Biomedical Management

Feedback given to patients:
- Base explanation on anatomical model
- Abnormality in anatomy = pathology
- Pain is a sign to limit activities
- Interventions are a “progression”

Biopsychosocial Model

View: LBP is a common condition or experience strongly influenced by psychosocial factors, not a serious disease.
Management: Identify patients at risk for chronicity, and use interventions that decrease the likelihood they will become chronic including graded exercise and graded activity.

Biopsychosocial Management

- De-emphasizes anatomical findings
- Encourages patient to take an active role in his or her recovery
- The Back Book is an educational tool used to lower fear-avoidance
  - Teach patients to remain active
  - Become confronters not avoiders
  - Back pain is a common experience
  - Graded exercise
  - Graded exposure to activities that are perceived as painful

Current Management of LBP

Mental Health Practice

Consideration of Physical Factors

2011 Standard Practice

PT, May 2011
Patient asks, “How can I exercise when everything I do hurts?”

**Biomedical**
- Let pain be your guide
- How’s your pain now?
- Does this exercise hurt?
- Just try your best.
- Let’s get rid of your pain
- Ignore psychosocial factors

**Biopsychosocial**
- Explain that hurt ≠ harm
- Educate on chronic pain changes brain processing
- Set quota based goals
- Do not keep asking patient how their pain is doing
- Give positive expectations of improved function
- Address psychosocial factors

**Effect of Physical Activity on Pain-Related Fear**

- Elfving, Phys Ther Res, 2007
  Subjects with low back pain that reported lower physical activity levels had higher pain catastrophizing and fear avoidance beliefs.

- Lin, Pain, 2011
  Persons with chronic LBP have lower activity levels. Persons with acute/subacute LBP have variable activity levels.

**How to Address Fear-Avoidance & Catastrophizing**

**Graded Exercise**
- Goal: improved activity tolerance, not pain
- Prescription based on therapist determined quota of intensity, duration, & repetition, NOT on patient response to pain
- Positive reinforcement given when quotas are met
- Quota is progressed until desired functional level is reached (~10% increase once each quota is reached is recommended)
- Encourage positive expectations
- Avoid anatomical explanation of pain
- Regularly review clinic performance
- Positive feedback

(Butler D. & Moseley GL. Explain Pain. Noigroup, 2003)

**Can fear avoidance be lowered in 1 session?**

Jellema found no changes in FABQ scores at baseline, 6 weeks and 52 weeks in two groups of subjects with subacute low back pain managed by their general practitioner.

**Group A** – minimal intervention strategy aimed at identifying and addressing psychosocial factors including fear avoidance, catastrophizing, distress – one 20 minute intervention session.

**Group B** – standard care

(Jellema, 2005)

**Using Neurophysiology Education to Lower Patient Fear**

**Explain:**
- -Neurophysiology
- -Nociceptive pathways
- -Spinal inhibition and facilitation
- -Peripheral & central sensitization
- -Nervous system plasticity

(Butler D. & Moseley GL. Explain Pain. Noigroup, 2003)
Therapeutic Neuroscience Education
Name recognition

• David Butler
• Neuro Orthopaedic Institute
• Lorimer Moseley
• Body in Mind
• Adriaan Louw
• International Spine & Pain Institute
• Jo Nijs
• Pain in Motion

Overview of Nociceptive Input
Anterolateral System (ALS) / Spinothalamic Tract (STT)

First order neuron (Aδ and C fibers)
  • Free nerve ending → DRG → Lamina I & II
Second order neuron
  • Decussate → Rostral to Ventral Posterior Lateral Nucleus of Thalamus
Third order neuron
  • Synapse on primary somatosensory cortex

(Purves et al, 2001)

What is pain and how do we describe it?

International Association for the Study of Pain:
• “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”
• Activity in the nociceptor and nociceptive pathways by a noxious stimulus is not pain
• Pain is always a psychological state
• Pain most often has a proximate physical cause

IASP Taxonomy

<table>
<thead>
<tr>
<th>Pain</th>
<th>Hypoaesthesia</th>
<th>Nociceptive stimulus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atodynia</td>
<td>Neuropathy</td>
<td>Nociceptor</td>
</tr>
<tr>
<td>Analgesia</td>
<td>Neuropathy</td>
<td>Nociceptive stimulus</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Neuropathy</td>
<td>Nociceptive stimulus</td>
</tr>
<tr>
<td>Causalgia</td>
<td>Central neuropathic pain</td>
<td>Pain tolerance level</td>
</tr>
<tr>
<td>Dysesthesia</td>
<td>Peripheral neuropathic pain</td>
<td>Fasciculation</td>
</tr>
<tr>
<td>Hypersensitivity</td>
<td>Neuropathy</td>
<td>Sensitization</td>
</tr>
<tr>
<td>Hypoesthesia</td>
<td>Nociception</td>
<td>Central sensitization</td>
</tr>
<tr>
<td>Hypersensitivity</td>
<td>Nociceptive neuron</td>
<td>Peripheral sensitization</td>
</tr>
<tr>
<td>Hypoesthesia</td>
<td>Nociceptive pain</td>
<td></td>
</tr>
</tbody>
</table>

Cerebral Signature of Acute Pain

Brain regions that activate during a painful experience
• Bilaterally active
• Increased activation on the contralateral hemisphere.

“We do not yet have a central signature that unequivocally reflects peripheral nociceptive inputs.”

(Tracey & Mantyh 2007)

Descending Pain Modulation

+/− indicates pro- and anti-nociceptive influences, respectively

(Tracey & Mantyh 2007)
Pain production, processing, mediation

Where have we come?

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

Clinical Application
Examination and plan
- A 64-year-old female with history of CLBP
- Outcome tools (initial visit, immediately after first session, 7-month follow-up)
- NPRS = 9/10, ODI = 54%, FABQ-W = 25/42, FABQ-PA = 20/24 and Zung Depression Scale = 58
- Treatment
  - abbreviated NE approach
  - exercises (range of motion, stretches, and cardiovascular),
  - aquatic therapy
- Twice a week for 4 weeks, (8 visits)

Clinical Application
The Peripheral Nervous System
“In your case, you developed back pain and based on many issues (pain, treatment, explanations, job and family) the nerves in your back have become very sensitive, but because your nervous system is one large, attached system that connects your low back to your hip, legs, neck and shoulders, the “system” wakes up. The good news is that we can explain this and the more you understand about this, the more your nerves will calm down.”

Clinical Application
CNS and Neuromatrix
“Pain is a response by the brain based on the perceived threat. Your pain is real. The pain you experience though may not be a true reflection of your tissues. Your whole brain is involved in processing the pain.”

Clinical Application
Output Systems
“These systems are there to protect you. It is normal. However, these systems need to be restored to normal resting levels. Why are they active? Threat. Every time you experience pain and not understand it (which we already discussed) your systems will get activated. Can you now see why understanding your pain better can help? Basically the large lion (big threat) becomes a small lion cub which is less threatening and you need not call on these systems too much to protect you.”
Clinical Application
Subsequent PT visits

- Reinforce the neuroscience message
- Explain back to you their understanding of the sections above
- Focus on cardiovascular exercise
- Develop a home exercise program
- Work on setting goals for their job, ADL’s, exercise, recreation and social interaction
- Set goals for therapy – especially prognosis

(Louw, Puentedura, Mintken 2012)

Clinical Application
Outcomes

![Graph showing outcomes](image)

Outcomes

Louw, Puentedura and Mintken 2012

In the Clinic
Patient education tools

Understanding Pain: What to do about it in less than five minutes?

TEDxAdelaide
Lorimer Moseley - Why Things Hurt

Neurophysiology of Pain Questionnaire
(True or False)

1. Receptors on nerves work by opening ion channels (gates) in the wall of the nerve.
2. When part of your body is injured, special pain receptors convey the pain message to your brain.
3. Pain only occurs when you are injured.
4. The timing and intensity of pain matches the timing and number of signals in nociceptors (danger receptors).
5. Nerves have to connect a body part to your brain in order for that body part to be in pain.
6. In chronic pain, the central nervous system becomes more sensitive to nociception (danger messages).
7. The body tells the brain when it is in pain.

(Moseley 2003)

Neurophysiology of Pain Questionnaire
(True or False)

8. The brain sends messages down your spinal cord that can increase the nociception (danger message) going up your spinal cord.
9. The brain decides when you will experience pain.
10. Nerves adapt by increasing their resting level of excitement.
11. Chronic pain means that an injury hasn’t healed properly.
12. Nerves can adapt by making more ion channels (gates).
13. Worse injuries always result in worse pain.
14. Nerves adapt by making ion channels (gates) stay open longer.
15. Second-order nociceptor (messenger nerve) post-synaptic membrane potential is dependent on descending modulation.

(Moseley 2003)
Neurophysiology of Pain Questionnaire
(True or False)

16. When you are injured, the environment that you are in will not have an effect on the amount of pain you experience.
17. It is possible to have pain and not know about it.
18. When you are injured, chemicals in your tissue can make nerves more sensitive.
19. In chronic pain, chemicals associated with stress can directly activate nociception pathways (danger messenger nerves).


Central Sensitization

Defined as:
• augmentation of responsiveness of central neurons to input from unimodal and polymodal receptors

Encompasses:
• altered sensory processing in the brain
• malfunctioning of descending anti-nociceptive mechanisms
• increased activity of pain facilitatory pathways
• temporal summation of second pain or wind-up
• long-term potentiation of neuronal synapses in the anterior cingulate cortex

(Nijs, 2010)

Recognition of Central Sensitization

Table 1

<table>
<thead>
<tr>
<th>Method of diagnosis</th>
<th>Increased responsiveness of central neurons to</th>
<th>Chronic low back pain</th>
<th>Chronic headaches</th>
<th>Carpal tunnel syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>input from unimodal and polymodal receptors</td>
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</table>

*Based on evidence from Nijs et al., 2000.

(Nijs, 2010)
Recognition of Central Sensitization

Table 2: Overview of the clinical examination of patients with suspected central sensitization.

- Assessment of pressure pain thresholds at sites remote from the symptomatic site.
- Measurement of allodynia to touch during manual palpation at sites remote from the symptomatic site.
- Assessment of sensitivity to vibration at sites remote from the symptomatic site.
- Assessment of sensitivity to hair at sites remote from the symptomatic site.
- Assessment of tenderness to palpation at sites remote from the symptomatic site.
- Assessment of pain assuming thresholds during and following exercise.
- Assessment of joint end feel.
- Brachial plexus-prediction test.

Note: the test used for the assessment of central sensitization, representing to a stimulus tend to be demonstrated at both symptomatic and distant sites.

(Nijs, 2010)

Other Tools to Screen for Psychosocial Factors for LBP

1. Orebro Pain Questionnaire
2. Cassandra Prediction Rule
3. Large Databases - FOTO
4. STarT Back Screening Tool

5-Item Cassandra Predictive Rule

In the past month, how much were you disturbed by:

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>More than a little</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2-Troubles getting your head</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3-Troubles eating</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4-Troubles sleeping</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5-Pain in your heart or chest</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(Hockings, J Clin Epidemiol, 2011)

Orebro Musculoskeletal Pain Questionnaire

A systematic review found that the CMQ had moderate ability to predict long-term pain and disability.

25 items

(Hockings, Spine, 2008)

FOTO – Focus on Therapeutic Outcomes

Concept of subgroup & targeting for primary care low back pain

Psychological obstacles to recovery (limited package of care, complex)

Physical obstacles to recovery (physical, psychological, treatment)

Low risk of disability (active, reassessment & education)

Targeted treatments

Patients are not all the same

(Hill, J Eur Pain, 2009)
**STarT Back Screening Tool in Physical Therapy Settings**

Foster, Ann Int Med, 2014 -
Patients (n = 922) given usual care or stratified via STarT back tool and given matched treatment. Clinically important improvements in RMDQ scores for high risk group 2.3 (95% CI, 0.8-3.9) and smaller significant changes in medium risk group 0.7 (95% CI, 0.1-1.4).

- Patients with subacute (4-12 week) LBP participated
- Completed FABQ, Quebec Back Pain Disability Scale, Hospital Anxiety Depression questionnaire
- Average Scores
  - FABQ-PA = 9.2
  - FABQ-W = 16.7
  - 10% of physicians had high (>14) FABQ-PA scores
- Foster, Ann Int Med, 2014

**Influence of Practitioner Beliefs**


- 286 Rheumatologists participated
- Completed modified self rated FABQ
- Average Scores
  - FABQ-PA = 16.7
  - FABQ-W = 19.3
  - 68% of patients had high (>14) FABQ-PA scores

**Practitioner Beliefs Matter**

Coudeyre reported a correlation in general practitioner FABQ-PA scores and patient scores on the FABQ-PA and FABQ-W.

General Practitioner (n=709): FABQ-PA 9.6, FABQ W 17.4

Patients with Acute LBP (n=2727): FABQ-PA 16.8, FABQ-W 19.5

(Coudeyre, 2007)
Clinical Application
Self reflection for integrating into clinic

Self reflection on self-assess your own beliefs
1. Are we fear avoidant?
2. Are we helping build confronters or avoiders?
3. Are we biomedically or bio-psychosocially oriented?
4. Can we communicate about psychosocial factors in a helpful way to the patient?

How to Self-Assess Your Own Beliefs

- Pain Attitudes and Beliefs Scale for Physiotherapists (PABS-PT)
- Health Care Providers’ Pain and Impairment Relationship Scale (HC-PAIRS)

Do what we do best…..

- Be Positive!
- Active listening
- Provide reassurance
- Artful communication
- Explicit interest and consideration of psychosocial factors
- Educate about LBP as a common experience
Take Home Messages

1. Need to be aware of and screen for red, yellow, black, blue, green flags.
2. There are multiple prognostic factors, moderators, mediators.
3. Several psychosocial pain models exist.
4. Psychologically informed PT practice is a proposed paradigm shift.
5. Need to quantify and address patient fear, catastrophizing, depression, self-efficacy.

References


Take Home Messages

6. Utilize Graded Exercise, Graded Exposure or Neuroscience Education to lower fear-avoidance.
7. Central Sensitivity can be identified.
8. Therapist beliefs matter.
9. Screening tools exist to guide psychosocial management (ie StarT Back Tool).
10. Recognize your biomedical vs biopsychosocial orientation.

References


References


References


