

## The Report of Findings from a Biopsychosocial Context

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Our profession was not happy with the recent Cherkin study which the media trumpeted as claiming that a simple booklet outperformed chiropractic care (Cherkin 1998). While the study's methodology certainly had its limitations, its results were consistent with other studies which have shown how valuable appropriate patient advice can be (Malmivaara 1995, Waddell 1998), in particular, when that advice is given in a biopsychosocial context which reduces pain-related anxiety and encourages patients to gradually resume normal activities (Fordyce 1986, Linton 1993).

The advice that we give patients can have powerful effects on their recovery. Patients need reassurance that they don't have serious diseases as well as the steps they should take to facilitate recovery. Chiropractors have always been more successful than their medical counterparts in providing helpful advice for spinal trouble (Cherkin 1989). According to Deyo, 20-25% of patients are dissatisfied with their care for back and neck pain (Deyo 1996). However, there is room for improvement in how we combine the report of findings with advice which will lessen the chances of chronic disability. One of the most important factors in this is fear avoidance behavior in an acute pain patient. Teaching patients that hurt does not necessarily equal harm and that the road to recovery is through activity is essential for a positive outcome.

### What Should Be Included in a Report of Findings?

With new studies showing that simple educational booklets can be highly effective and sometimes even superior to aggressive conservative care programs, it is incumbent on chiropractors to give appropriate advice during our report of findings. Advice should not promote the "sick role," but rather encourage patients that they are not damaged and that resuming activities as normally as possible will actually speed up their recovery (Waddell, Main 1998; Waddell et al. 1999). Some of the key points to make with patients include:

- reassurance that there are no serious diseases (i.e. tumor, infection, fracture);
- reassurance that there is a positive prognosis so long as the person doesn't decondition;
- provide general advice about how to gradually (step by step) resume normal activities;
- explain that the road to recovery is through activity!

When is it most important to give biomechanical advice as well? In cases where clinical evidence or judgement suggests that a medium term outcome depends on it. Examples include cases like the following:

1. The first few days of an acute episode where hurt does equal harm.

- Advice: short-term (non-bed) rest until pain abates enough to start more active treatment.

2. Where anatomical integrity has been lost.

Example 1: Knee meniscus injury

- Advice: avoid squatting or kneeling

Example 2: Lumbar nerve root compression due to a bulging disc

- Advice: limit forward flexion (sitting, bending forward, etc.)

3. Where specific pathology or structural abnormality threatens damage if tissues are stressed.

Example: Lumbar spinal stenosis

- Advice: limit spinal extension

It must be kept in mind that all biomechanical advice should be given within a biopsychosocial framework. Rest deconditions and results in a poor recovery, while activity and sometimes even training are necessary to promote healing and recovery and reduce the risk of serious recurrences.

The McKenzie Approach

The patient learns through a rigorous history and examination of the mechanical behavior of their symptoms what positions or movements provoke, peripheralize, relieve or centralize their symptoms. When such an assessment is performed, a prescription of specific postures or activities to modify is arrived at. The goal is clearly on a gradual reactivation of the patient and thus is consistent with the biopsychosocial message that rest deconditions and activity facilitates recovery. This approach relates well to categories 2 and 3 (above), but less well to states in which tissues are not materially compromised.

According to McKenzie, "If you adopt certain positions or perform certain movements that cause your back to 'go out,' then if we understand the problem fully, we can identify other movements and other positions that, if practiced and adopted, can reverse the process. You put it out -- you put it back in." (McKenzie 1998)

Another manual medicine specialist, Lewit says, "The first treatment is to teach the patient to avoid what harms him!" (Lewit 1997) This is completely different from avoiding discomfort. Pain is not a reliable guide as to what to avoid!

What Are the Pros and Cons of This Approach From a Biopsychosocial Context?

Pro: It empowers patients to become active without fear of doing damage. It also gives them a strategy for achieving this. In the case of pain which centralizes, the patient learns that hurt does not always equal harm.

Con: It can promote fear-avoidance behavior if used where there is no real threat to tissues. It may also lead to deconditioning based merely on the expectation that a certain activity is associated with pain.

The Stabilization Approach

This is very similar to the McKenzie system. A very thorough history and examination seek out the mechanical sensitivity of the patient. Postures, movements, gravity (weightbearing) or even pressure sensitivities are identified. The patient is advised to perform both activities and exercises in their "functional range." This is defined as the range which is "both relatively painless and appropriate for the task at hand." The main difference between the stabilization and McKenzie approaches is that in the stabilization program, the patient learns to perform activities/exercises with proper form or coordination as well as stay in a relatively painless or pain centralizing range.

On the topic of assessment, Vollowitz says, "People with low back disorders present with special sensitivities to position, weight bearing, and constrained postures and pressure ... Traditional methods of patient evaluation directed toward diagnosis and work capacity assessment do not thoroughly address these special areas of functional loss." (Vollowitz 1988) However, it is essential to differentiate functional loss from fear-avoidance.

Regarding patient education, Morgan explains, "The patient must first learn to recognize the functional limits of his or her low-back and then be trained to control the spine so as to stay within those limits." (Morgan 1988) However, this level of conscious control can work against good neuromuscular coordination. In general, unnecessary conscious control of spinal movements is to be avoided if possible, in favor of activity alteration. Postural awareness is initially very important so the patient can learn better biomechanical habits of sitting and lifting, but such conscious control should become automatic (i.e. subcortical) as soon as possible, or else the patient may become overly fearful of pain with activity if the activity is not performed "correctly."

What Are the Pros and Cons of This Approach From a Biopsychosocial Context?

Pro: It teaches patients under structural threat that they can become active and gives them a strategy for achieving this.

Cons: If they are not well motivated, this approach may be difficult for them because it requires a certain amount of concentration. High levels of anxiety may lead to fear-avoidance behavior based on the expectation of pain.

The Operant Conditioning Approach

This approach teaches that hurt does not equal harm (Fordyce 1986). Patients learn to exercise to a quota regardless of symptoms. Psychological counseling regarding affective (i.e., anxiety) responses to pain and cognitive (i.e., coping behaviors) strategies for dealing with pain is utilized.

Pro: It is well suited for patients with high levels of anxiety and fear-avoidance behavior who expect pain with all activities/exercises.

Con: In situations where patients actually do have clinically significant biomechanical dysfunctions, the problem is not addressed and can be aggravated.

How to Take a Psychosocial Approach

Identify the patient who is fearful and avoid encouraging him or her to take on a "sick role." Malmivaara et al., found good evidence that simple advice to continue or resume normal activities is therapeutic for acute low back pain. The study found that advice to continue normal activities as

tolerated resulted in better outcomes than patients resting two days or performing back mobilization exercises (Malmivaara 1995).

Fear-avoidance behavior should be identified and addressed. According to Troup, "If fear of pain persists, unless it is specifically recognized and treated, it leads inexorably to pain avoidance and thence to disuse." (Troup 1988)

And Finally ...

Identify what psychosocial factors are operating and what you can and cannot help your patient with. Pain related anxiety that is secondary to financial, marital or work problems should be identified. Establishing appropriate goals is a key to recovery from disability and prevention of chronic pain. Appropriate goals include: controlling pain; learning how to modify activities (i.e. sitting or lifting advice); reducing activity limitations (i.e. sitting, standing, walking intolerances); return to work; and beginning an exercise program.

The biopsychosocial approach teaches us that the old adage "let pain be your guide" can actually reinforce illness behaviors such as fear-avoidance behavior in our patients. The more modern report of findings reassures patients that they do not have a disease (tumor, infection, fracture) and that staying active will actually speed recovery. Learning that pain does not always warn of impending harm or damage can empower patients to remain active, avoid disability and prevent the transition from acute to chronic pain.

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