Dynamic Chiropractic

BACK PAIN

The Psychology of Chronic Back Pain

PSYCHOLOGICAL RISK FACTORS FOR CHRONICITY AND OUR CHALLENGE AS CLINICIANS: FINDING THE RIGHT TREATMENT MIX.

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In 1986, Nortin Hadler commented in *The New England Journal of Medicine* that regional back pain had a tendency to become worse the more it was treated.[1] And the *Scandinavian Journal of Rheumatology* quotes Aage Indahl: " The multitude of different treatments offered to patients must be regarded as pain-modulating modalities and not as cures for low back pain. There is no treatment that has been proven to be highly effective."[2] A systematic review on the effectiveness of physical and rehabilitation interventions for chronic nonspecific low back pain, published this year in the *European Spine Journal,* concluded that "only multidisciplinary treatment, behavioural treatment, and exercise therapy should be provided as conservative treatments in daily practice in the treatment of chronic low back pain."[3] A June 2011 update of a Cochrane review regarding spinal manipulative therapy for chronic low back pain stated: "[T]here was no clinically relevant difference between spinal manipulative therapy and other interventions for reducing pain and improving function in patients with chronic low-back pain."[4]

Chronic Pain Psychological Measurement Tools

• *The Fear of Daily Activities Questionnaire (FODAQ):* George SZ, Valencia C, Zeppieri G, Jr., Robinson ME. Development of a self-report measure of fearful activitiesfor patients with low back pain: the fear of daily activities questionnaire. *Phys Ther*, 2009;89:969-79.

• *The Pain Anxiety Symptoms Scale (PASS):* McCracken LM, Zayfert C, GrossRT. The Pain Anxiety Symptoms Scale: development and validation of a scale tomeasure fear of pain. *Pain*,1992;50:67-73.

• *The Fear of Pain Questionnaire (FPQ):* McNeil DW, Rainwater AJ III.Development of the Fear of Pain Questionnaire -III. *J Behav Med,* 1998;21:389-410.

• *The Pain Catastrophizing Scale (PCS):* Sullivan M, Bishop SR, Pivik J. Thepain Catastrophizing Scale: development and validation. *Psych Assess*, 1995;7:524032.

• *The Fear Avoidance Beliefs Questionnaire (FABQ):* Waddell G, Newton M,Henderson I, Somerville D, Main CJ. A Fear-Avoidance Beliefs Questionnaire(FABQ) and the role of fear-avoidance beliefs in chronic low back pain anddisability. *Pain*,1993;52:157-68.

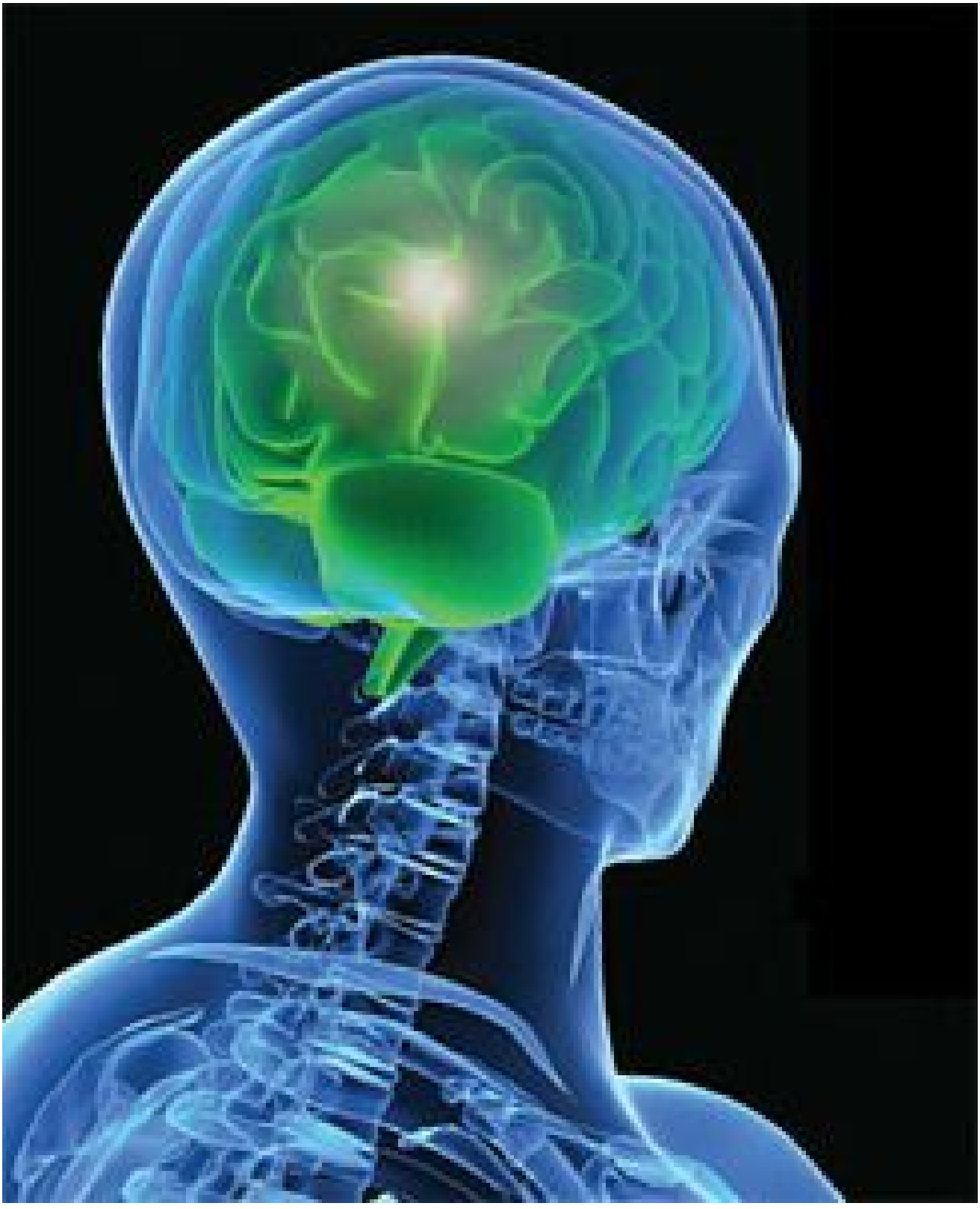
• *The Tampa Scale for Kinesiophobia (TSK):* Woby SR, Roach NK, UrmstonM, Watson PJ. Psychometric properties of the TSK-II: a shortened version ofthe Tampa Scale for Kinesiophobia. *Pain*,2005;117:137-44.

The topic is still controversial, not because there are so many scientific studies, clinical reviews and anecdotal reports of miraculous treatments for low back pain (as well as dismal failures), but because so much suffering continues despite such great effort and expense.

Back pain was "medicalized" for most of the 20th century in terms of an "injury model." Disc disease and degeneration were identified as the culprits, so victims were advised to rest, avoid strenuous activity and medicate. When that approach logically failed, surgical treatments became *de rigueur* for decades.

Alternative treatment, including chiropractic, became popular as education and personal wealth improved. The "wellness movement" has empowered patients to manage their own health care needs and share decisions with health care providers of their choice. Cognitive behavioural treatment (CBT) and educational approaches increasingly emphasize a "non-injury model" of back pain, which articulates "that the back is strong, that loads normally do not cause any damage despite occasional temporary pain, that reducing the focus on pain might facilitate more natural and less painful movements, and that it is beneficial to stay physically active."[5]

However, despite this early optimism, nearly 34 percent of individuals who suffer an episode of low back pain will continue to experience recurrent episodes.[6] With so much evidence and expertise available, is the problem all in their heads? The fear-avoidance model (FAM) suggests that a unique minority of individuals do possess an exaggerated pain perception and a robust psychological avoidance strategy that often contribute additional physical and psychological layers to their original musculoskeletal complaint.[7]



As doctors of chiropractic, we know that even with appropriate care, some patients retain such high psychological distress that their clinical outcomes are poor. These patients demonstrate negative appraisal of their internal and external stimuli, leading to poor self-efficacy and suboptimal performance of requested tasks. These patients often exhibit pain intensity that is atypically elevated.

Their escape/avoidance behaviour becomes enhanced such that their movements are intensely guarded, leading to deconditioning and disuse. The result is that the patient's physical impairments are increased and their disability prolonged.[8-9] Wideman and Sullivan describe the process as a cascade of pain-related fear that devolves into pain catastrophizing, depression and long-term disability.[10]

The extent to which the appropriate patient receives the correct treatment mix is the new clinical challenge. Evaluating the various psychological risk factors against the patient's physical capacity for change and improvement may be enhanced through the use of validated psychological measurement tools. These tools have been found to be useful in classifying chronic pain patients into more homogenous groupings that encourage better treatment plans, outcome management and continuing care.

References

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