Identifying psychological factors and maximizing therapeutic alliance in clinical practice

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Following this presentation attendees will be able to...

1. Describe ways to identify psychosocial factors (therapeutic alliance, expectation, patient beliefs) that are predictors of pain-related disability.

2. Describe the concepts of therapeutic alliance and patient expectation, and their use to improve outcomes.

3. Broadly describe cognitive-behavioral principles (restructuring, behavioral strategies, and pain-coping skills) and their current and potential future role in physical therapist practice in helping manage chronic pain.
“the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research.” (Sackett D, 1996)
Mounting Evidence

• Limits of biomechanical approach in chronic pain management
• Effectiveness of behavioral approaches in decreasing pain and improving function
• Psychosocial factors play a role in
  • maintenance of musculoskeletal symptoms and disability
  • direct development of disability in various musculoskeletal conditions.
Special Edition

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Journal of the American Physical Therapy Association

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### Embedding Psychosocial Perspectives Within Clinical Management of Low Back Pain

<table>
<thead>
<tr>
<th>Entry-Level Physical Therapy Training</th>
<th>Current Physical Therapist Practice</th>
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<tr>
<td>The focus and priorities of entry-level training emphasize anatomical, biomechanical, and biomedical models.</td>
<td>Physical therapy “culture” and current physical therapist practice propagate anatomical, biomechanical, and biomedical models.</td>
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<td>The lack of cohesion across entry-level clinical education environments means that opportunities to reinforce application of key psychological informed management principles are lost.</td>
<td>The focus of continuing education for physical therapists reinforces the biomedical emphasis from entry-level training.</td>
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<td>Patients’ expectations of low back pain and physical therapy can raise challenges, such as their expectations about diagnostic certainty and hands-on treatment approaches.</td>
<td>There is uncertainty about the key psychosocial factors and how to assess and manage them in ways that fit into busy clinical practice.</td>
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<td>Reimbursement systems and service priorities do not value management of psychosocial factors.</td>
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**Figure 1.**
Key challenges to integrating psychosocial perspectives in clinical practice.

Nadine E. Foster and Anthony Delitto
PHYS THER May 2011 91:790-803
Physiotherapists’ Assessment of Patients’ Psychosocial Status: Are we skating on thin ice?

“Factors which restrict progression of treatment … these are the psychosocial factors … these [may] not be related to the injury but might be related to their personal life, to their work, or the situation.”

William

“… for a while and then I haven’t done any sort of formal questionnaire and the … ‘Someone with workers compensation can be the best example progress.’ … for this, because not many private patients would have … psychosocial aspects other than those with long standing treatment.”

Max

“Not sure whether I am aware of anything else other than questioning from the subjective examination and the outcome measure [to assess psychosocial factors].”

Ethan
Proposed Model for Integration

Figure 3.
A suggested model for integration: the psychosocial factors pyramid.
Patient beliefs and expectations, as potential influences on adherence, precursors of behavior change and mediators of outcome, are at the heart of the consultation process.

THE CONSULTATION
Identifying Nature of Consultation

• Central role of the interview
• May not always be clear
• Common reasons for consultation
  – Cure/symptom relief
  – Diagnostic clarification
  – Seek reassurance
  – Seek “legitimization of their symptoms.”
  – Express frustration and/or anger

C'mon Doc, when are we going to get to the bottom of this?

My my, always in such a hurry aren't we?
Psychological Models

Fear-Avoidance Models

Acceptance and Commitment Model

Misdirected Problem-Solving Model

Self Efficacy Model

Stress-Diathesis Model

Catastrophizing

Fear of Pain

Pain Anxiety

Negative Affect

Threatening Illness Information
Pain Catastrophizing Scale

- Widely used instruments
- Measures catastrophic thinking related to pain
- Associated with a number of important pain-related outcomes
- Suggest

- Compared to other ways of measuring pain-related thoughts, this questionnaire is unique in that the individual

The Pain Catastrophizing Scale: Development and validation.
Psychological Assessment; 7: 524-532
Fear-Avoidance Belief Questionnaire

- Developed to investigate fear-avoidance beliefs
- 16 items (scored 0-6)
  - Higher scores indicative of greater fear and avoidance beliefs
- 2 Subscales:
  - Physical Activity and Work
- Valid and reliable in a chronic LBP population
- Strong relationship exists between elevated fear avoidance beliefs and chronic disability secondary to LBP
The STarT Back Tool

• Multi-dimensional
• Simple prognostic questionnaire to identify modifiable risks
• 9 items
  – “Agree” or “Disagree”
• Acceptable test-retest reliability
• Designed to support clinical reasoning and decision making
• Recommended currently for LPB
• No present evidence for non-spine conditions

http://www.keele.ac.uk/sbst/
STarT Back Tool

Thinking about the last 2 weeks, tick your response to the following questions:

1. My back pain has spread down my leg(s) at some time in the last 2 weeks
   - Disagree
   - Agree

2. I have had pain in the shoulder or neck at some time in the last 2 weeks
   - Disagree
   - Agree

3. I have only walked short distances because of my back pain
   - Disagree
   - Agree

4. In the last 2 weeks, I have dressed more slowly than usual because of back pain
   - Disagree
   - Agree

5. It's not really safe for a person with a condition like mine to be physically active
   - Disagree
   - Agree

6. Worrying thoughts have been going through my mind a lot of the time
   - Disagree
   - Agree

7. I feel that my back pain is terrible and it's never going to get any better
   - Disagree
   - Agree

8. In general I have not enjoyed all the things I used to enjoy
   - Disagree
   - Agree

9. Overall, how bothersome has your back pain been in the last 2 weeks?
   - Not at all
   - Slightly
   - Moderately
   - Very much
   - Extremely

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The STarT Back Tool Scoring System

- **Total score**
  - 3 or less
  - 4 or more

- **Sub score Q5-9**
  - 3 or less
  - 4 or more

- **Risk categories**
  - Low risk
  - Medium risk
  - High risk
Effective communication is considered to be an essential skill that clinicians need to master in clinical practice to improve quality and efficiency of care

-Mauksch et al, *Archives of Internal Medicine* 2008
Improved communication helps...

- Maximize function, QOL, Pain reduction
- Improved Patient Satisfaction
  - We have highest scores, yet lots of chronic pain
- Patient Engagement
  - Attendance of visits
  - HEP Compliance
  - Improved long-term adherence and outcomes
- Financial savings
Components of Communication

• **Verbal factors** include greetings, facilitation, checking, open-ended, and encouraging questions.

• **Non-verbal** factors include posture, facial expression, and body orientation.
“Coming together is a beginning; keeping together is progress; working together is success.”

Henry Ford
Therapeutic Alliance (TA)

- “interplay of technical skill, communicative competence, and the reflective capacity to respond to the patient in the moment of therapy”
- more than the communication between the patient and the therapist – TA involves the sense of collaboration, warmth, and support
Supporting evidence

- Correlated with **treatment adherence and positive outcomes** in several disciplines, including medicine, psychotherapy, and physical rehabilitation.²
- **Strong TA** up to 40% **higher global perceived effect self-rating** than low TA⁷
- Studies have shown higher levels of therapeutic alliances associated with **better health outcomes**²
- *Disability and function* were recently found to be **more strongly associated with TA than pain level**²
A recent study: 2014 RCT

- 117 participants with CLBP, mean 30 yrs²
- Therapeutic Alliance (high vs. low) & IFC (sham vs. real)
- Measured pain intensity and PPT lumbar paraspinals after 1 session
- Effectively blinded
Better gains in PPT, Pain, GROC
How did the authors create TA?

- PTs formally trained by a clinical psychologist to create limited vs enhanced TA
- Used scripts for their interactions by a training manual and *role playing* with simulated patients
- Active listening:
  - repeating the patient’s words, asking for clarifications
- **Tone of voice**, nonverbal behaviors (eye contact, physical touch), empathy (such as saying
  - “I can understand how difficult LBP must be for you.”
- PT always present
- Verbal interaction was encouraged
How to make TA low

- Participants told a “scientific study” and the PT was instructed not to converse with them.
- After setting up treatment parameters, left the room and returned 15 & 30 minutes into the treatment.
How to make TA low

• Non-verbal factors, asymmetrical arm posture, crossed legs, and body orientation away from patient
  • negative association w/TA^4
Interaction style

• A communication factor, exhibits aspects of both verbal and non-verbal factors

• 3 types out of 36 are most important to better therapeutic alliance\(^4\)
Most important styles

- Therapeutic Alliance
  - Involving
  - Facilitating
  - Supporting
Patient *Facilitating and Involving*

- Letting the patient tell the story
  - Let them speak a little bit

- Taking time to discuss patient concerns
  - Can be informed by measures

- Being available when needed
  - Doesn’t mean on call, but being attentive in the clinic. Let them know to contact you and ask Q’s
Patient *Facilitating and Involving*

- Treating patient on the same level
  - Just think how you want to be treated

- Respecting opinions and feelings
  - Check your ego – it’s not about you

- Checking patient understanding
  - “Does that make sense?” “Tell me what if not”
Patient Facilitating and Involving

• Working to adjust treatment
  • Let them know it will change if needed – everyone is different

• Partnership building
  – Encouraging questions
  – Discussing options/asking patient’s opinion
  – After building credibility, ask “What do you think or prefer?” can say “your preference and experience matters to me”
Patient Supporting

- Be...
  - Gentle during examination
    - Break the stereotype
    - No need for inflicting pain
  - Comforting and caring
  - Truthful and frank
    - Can sense “BS”

- Showing patience, caring and concern
  - What if this was your family member?
  - Sensitive to their concerns

- Provide...
  - Reassurance and Emotional support
“Toward an evidence-based patient-provider communication in rehabilitation: Linking communication elements to better rehabilitation outcomes”

-Jesus TS et al 2015
Intervention model in health psych for rehab

1) Knowing the person and building a supportive relationship
2) Effective info exchange & education
3) Shared goal setting and action plan
4) Fostering a positive, realistic, cognitive and self-reframing
Knowing the person and building a supportive relationship

- Expression of a genuine interest into knowing the patient as a person understanding the person’s story beyond the disability story

- Open-ended questions can promote re-telling personal stories
  - Let them talk it out a bit
  - Helps the person to make sense of life events
  - Integrate disability/pain into the lived experience & help reestablish the sense of coherence and identity
Knowing the person and building a supportive relationship

- Continuous rapport and trustful alliance during interactions

- Shared decision-making, creates an optimal atmosphere for emotionally supportive interactions

- Showing *respect*, eliciting and actively listening to patient’s emotions/ concerns, followed by empathetic reassurance
“The most basic of all human needs is the need to understand and be understood. The best way to understand people is to listen to them.”

- Dr. Ralph Nichols
Effective information exchange and education

- Avoiding premature closure of conversation topics (such as psychosocial issues)

- Reflective listening (interpreting content listened, then asking for clarification).
"I know exactly how you feel."
Effective information exchange and education

- Empathetic reassurance of their perspectives with positive reframing, normalcy, give personal / pt examples

  - Ex. PT didn’t work before; sore after first session; exercise hurts or harmful; my back is “shot”; how can you help OA/DJD/DDD/slipped disk?

- After explanation, give rationale on mechanisms & importance of interventions, reiterate pain science

- Always providing evidence of safety during sessions (Lotze, Moseley et al)
Shared goal-setting and action planning

- Having “Shared mind”
  - Goals in alignment, empathic (think in their shoes)
- Goals are
  - Concrete
  - Measurable
  - Ambitious
  - Achievable
Shared goal-setting and action planning

- Agree on defining both meaningful and feasible rehabilitation goals
- Joint exploration of alternatives
  - no one-way arguing toward convincing the other
Fostering a positive, yet realistic, cognitive & self-reframing

- *Expectations* need to be *realistic*, otherwise unrealizable expectations may lead to frustration

- Be up front with prognostic uncertainty – *reduce unfounded expectations*
Disappointment?

How I think I look when I go jogging

How I really look when I go jogging
Reality is some pain is likely to remain, but they CAN improve it.

- They can also improve their life and function!
Keep them positive

• Frequently and early emphasize both previous and ongoing patient’s achievements

• Reinforcement of the person’s unique strengths, values and resources
When to refer to psychological professionals

- Risk level on STarT Back Tool (SBT)
- Depression
- Talk about self-injury or suicide
- History of psychiatric condition or abuse
- Avoidance, hopelessness, projected hostility
- Social reliance, blame, substance abuse
- Severe anxiety
- Post-traumatic cognitions
- Magnified appraisals of losses
- Catastrophizing of symptoms
- Beyond your training
Summary

• Maximizing TA is important for best outcomes in most healthcare fields
• Patient Facilitating, Involving, and Supporting are best interaction styles to build TA
• Expectations need to be realistic, otherwise unrealizable expectations may lead to frustration
• Understand the patient’s story
• Empathetic reassurance needed with a spin towards positive reframing – focus on strengths and gains


• Jesus TS, Silva IL. Toward an evidence-based patient-provzder communication in rehabilitation: Linking communication elements to better rehabilitation outcomes. *Clinical Rehabilitation.* 2015

References


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• Lotze M, Moseley GL. Theoretical Considerations for Chronic Pain Rehabilitation. Phys Ther. 2015;95: 1316-1320
Questions?

Thanks for coming!!