Low Back Pain: Management of the Psychosocial Component

January 01, 2003 | Depression [1]  
By Christopher Connelly, DO [2]

Back pain is second only to upper respiratory tract infection as the most frequently reported illness in the United States; up to 20% of Americans experience back pain each year.¹

Back pain often has a psychosocial component. This can be any strong emotion and/or psychopathology that results in worsening-or perceived worsening-of symptoms. Two psychosocial issues commonly associated with low back pain are:

- Anger that stems from distressed interpersonal relationships at home or at work.²
- Desire for secondary gain.

Fifty-nine percent of patients with low back pain have psychological disorders,³ including depression, substance abuse, and anxiety disorders; some have multiple disorders.⁴ Other types of psychopathology that may be involved in low back pain include personality disorders, somatoform disorders, fictitious disorders, and malingering.

Psychosocial issues often impede recovery. Patients whose low back pain has a large psychosocial component are likely to be noncompliant with treatment (while at the same time complaining of the failure of the prescribed treatment), often exaggerate their symptoms (which in most cases are not substantiated by a search for objective physical signs of injury), and frequently resist or refuse to follow suggestions to return to work or to increase activities.

Here I offer strategies to help manage the psychosocial aspects of low back pain and to help even your "difficult" patients recover.

**ENLISTING THE PATIENT'S HELP**

With noncompliant patients who resist active cooperation with the recovery process, it is sometimes useful to define the roles of patient and physician. Explain that the physician's role is to examine, evaluate, educate, and advise⁵ and that the patient's role is to help himself or herself get better.

Stress that the patient is responsible for adhering to treatment recommendations, such as therapeutic icing, medication regimens, physical therapy sessions, and work restrictions.

**THE SOFT CONFRONTATION**

When appropriate, try softly confronting the incongruities between the patient's complaints and the results of the physical examination and history taking (Box). After you point these out, ask "Are there other issues in your life that are making your back pain worse?" or "What else is going on in your life?" When such a question is asked in a genuinely caring fashion, the patient becomes aware that the physician is aware of the real problem. This usually elicits 1 of 2 reactions-either of which can lead a patient to desist in exaggerated complaints:

- The patient realizes for the first time the connection between his personal problems and his back pain.
- The patient feels guilty or ashamed—as though a ruse has been exposed.

This approach will lead some patients to bring up troublesome issues in their life for discussion. Merely vocalizing these issues can be therapeutic. In addition, the physician is often able to offer helpful advice. Frequently, much of the psychosocial aspect of the patient's back problem will disappear after 1 or 2 visits.

This technique may not be completely effective, but it permits patients to change gradually and to preserve their self-esteem.

**WALKING DOWN THE LONG, ROUGH ROAD**

This technique has proved successful with many "difficult" patients. Such patients are likely to be better educated, more sophisticated, and more calculating. In addition, they may have a documented injury; there may not be an obvious gross discrepancy between the complaints and the physical findings. Such patients may respond to soft confrontation calmly and coolly, undisturbed by the awareness that the physician doubts their sincerity.

"Walking down the long, rough road" involves repeated thorough examinations and history takings.
along with the use of imaging results, physical therapy reports, and so forth, to prove to the patient that he has recovered. Ask the patient to face the mounting evidence of normal results and reports. However, when you tell him that a thorough evaluation has revealed no pathology or abnormalities, be prepared for an argumentative response. Although numerous examinations and studies may be required to prove to the patient that the chief source of his pain is not physical, this approach can often be effective.

**THE HARD CONFRONTATION**

There comes a point when a more stern approach is necessary. This usually occurs when the physician becomes convinced that the patient can increase his work activities—although the patient objects. The data that are required to reach this conclusion can include numerous normal examinations, improved examinations that approximate normal, complaints that are unsubstantiated or contradictory (such as pain at work but not at home), normal imaging studies, and documented improvement from physical therapy or other procedures.

The hard confrontation is similar to the soft confrontation—but with a bottom line. Begin by reevaluating the entire situation with the patient. Reiterate what the diagnosis is—and what it is not—as corroborated by examinations and testing. A brief discussion of time lines (dates of the patient's injury, onset of symptoms, start of treatment, and change in symptoms—compared with the natural history of the ailment and published recovery periods) can be useful. Then tell the patient that you recommend increasing work activities. Reassure him that your recommendation is safe (within a reasonable degree of medical certainty). Discuss again the issue of pain and pain management.

The patient may respond to this recommendation with objections, protests, and/or refusal. Discuss all specific objections, with an eye to identifying an underlying issue or problem that may be of significance. Discuss outright refusal as well. Patients may sometimes attempt to elicit approval for a refusal to return to work. Do not give such approval. Explain to such patients that they are free to choose not to follow medical recommendations; however, also point out that failure to comply with these recommendations may have administrative or even legal consequences.

**HANDLING UNSUBSTANTIATED PAIN**

Patients whose back pain has a sizable psychosocial component sometimes say that they are in too much pain to return to work, increase their activities, or make progress. When this protest is not justified by the results of the physical examination, the following is an effective counter:

Acknowledgment that you understand that the patient has pain. An empathetic remark at this point can go a long way toward building patient cooperation (e.g., "I know you have pain; I am sorry that you hurt and we are working together so that you do not hurt anymore."). Review the pain treatment plan in detail:
- Pain medications.
- Physical modalities (ice, heat, rest).
- Physical therapy.
- Work restrictions.

Point out that this plan has been carefully designed to ensure the patient's safety and control his pain—and that it is your recommendation that he can return to work and increase activities if the plan is followed.

Good judgment is essential in treating pain. Consider all aspects of the situation: mechanism of injury, diagnosis, age and condition of the patient, how much time has elapsed since the injury, past and present complaints. Finally, apply the Golden Rule: Is the patient's pain being treated the way you would want the pain of a friend or family member to be treated? A potentially superfluous narcotic prescription—limited and mild—may be preferable to inadequate treatment of a patient's pain.

**References:**


Source URL:

Links:
[1] [http://www.psychiatrictimes.com/depression](http://www.psychiatrictimes.com/depression)
[2] [http://www.psychiatrictimes.com/authors/christopher-connelly-do](http://www.psychiatrictimes.com/authors/christopher-connelly-do)