Evaluation and Treatment of Common Mental and Behavioral Disorders Among Injured Workers

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Workers’ Compensation Benchmarking Study - How to Overcome Psychosocial Roadblocks: Claims Advocacy’s Biggest Opportunity

(Rousmanierre & Fikes, Rising Medical Solutions, 2016)

What are the greatest obstacles to achieving desired claim outcomes? (492 responses) –

• Lack of RTW options/accomodations
• Litigation
• Employee/employer relations
• Proactive/timely communication with stakeholders
• Access to care
• Psychosocial/co-morbidities
Workers’ Compensation Benchmarking Study - How to Overcome Psychosocial Roadblocks: Claims Advocacy’s Biggest Opportunity
(Rousmanierre & Fikes, Rising Medical Solutions, 2016)

“It is the negative impact of personal expectations, behaviors, and predicaments that can come with the injured worker or can grow out of work injury.

This suite of roadblocks is classified as “psychosocial” issues – issues which claims leaders now rank as the number one barrier to successful claim outcomes.”
PURPOSE OF BEHAVIORAL HEALTH SERVICES IN WC MEDICAL SETTING

• To reduce or eliminate attitudes and behaviors ("psychosocial issues") that interfere with medical recovery and return to work

• To directly improve the medical conditions, symptoms and outcomes
BIOMEDICAL MODEL OF INJURY/DISEASE

Assumes a specific traumatic physical cause, which once found and eradicated, returns the individual to a baseline of full health and functioning (‘fix the pain generator’)

Flawed assumptions when applied to musculoskeletal pain:

• Pain occurs in multiple episodes
• Clear traumatic causes are rare
• Total symptom elimination is often not possible or necessary

• Ignores other influences on behavior
BIOPSYCHOSOCIAL MODEL OF INJURY/DISEASE

A complex, dynamic interaction of multiple factors that affect the presentation of a medical condition and its treatment:

• Biological – tissue changes
• Psychological – mood, attitude, beliefs
• Social – culture, family, work, legal
ILLNESS AND DISABILITY BEHAVIOR

Broader than medical symptoms alone:

- Complaints
- Compliance
- Health care seeking
- Test inconsistency
- Return to work

Only 12-25% of utilization predicted by objective physical morbidity. *Most are psychosocial factors.*
RISK FACTORS FOR DELAYED RECOVERY AND EXTENDED DISABILITY

(NOT MENTAL DISORDERS!)
MUSCULOSKELETAL PAIN

• 85% - lifetime rate of missed work or seeking medical care
• 66% - 1 year prevalence rate, of which 25% had intense pain or loss of function
• 5-10% of annual total will go on to chronic pain/work loss (over 6 months)
• <10% use 70-80% of the healthcare resources

SO WHY DO SOME HAVE DELAYED RECOVERY?
RISK FACTORS

Individual social, economic, and psychological factors play important roles in the manifestation of:

• Treatment seeking
• Physical complaints
• Response to treatment
• Length of disability
• Return to work
Maintenance of disabling pain and off-work status is primarily based on psychosocial factors, not physical pathology.

Purely biomedical approaches have limited ability to resolve many musculoskeletal problems or change health behaviors.
PSYCHOSOCIAL ‘YELLOW FLAGS’

• ‘Red flags’ - potentially dangerous physical risk factors for pain and disability

• ‘Yellow flags’ - potentially significant psychosocial risk factors for developing long term disability or work loss

ABCDEFW

PSYCHOSOCIAL ‘YELLOW FLAGS’

ATTITUDES – fear avoidance, catastrophic thoughts

BEHAVIORS – passivity, withdrawal, substance use

Compensation Issues

Diagnosis and Treatment

EMOTIONS – fear, anxiety, depression, anger, futility

FAMILY – overprotective, punitive

Work
FEAR-AVOIDANCE

- Avoidance of movement or activity based on the belief it will cause injury or damage (kinesiophobia)
- Catastrophic Thinking: Negative appraisals of pain and its consequences (“My back is breaking.” “I’ll be paralyzed.”)
- Because avoidance occurs in anticipation of pain, it reduces opportunities to correct erroneous beliefs about pain and activity
- 7X more powerful than any clinical or historical data in predicting chronic pain one year after a low back injury
YELLOW FLAGS

Emotions

• Fear of pain with activity or work
• Depressed mood or irritability
• Anxiety about, and heightened awareness of, body sensations
• Feelings of stress and lack of control
• Loss of interest in social activity
• Feeling useless and not needed
YELLOW FLAGS (NZ)

Action Steps:

• If less progress than expected at 2-4 weeks after injury use screening approach (Örebro Musculoskeletal Pain Screening)

• Scores over 105 identify 80-85% of those who go on to extended lost time

• EARLY INTERVENTION WITH IDENTIFIED HIGH RISK CASES
ODG - LOW BACK

• “Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs.

• Initial therapy for these “at risk” patients should be physical therapy exercise instruction, using a cognitive motivational approach to PT.

• “Consider separate CBT referral after 4 weeks if lack of progress from PT alone.”
ACUTE PHASE OF INJURY

• Short term cognitive-behavioral interventions are recommended

• Not yet developed a mental disorder, or identified if a pre-existing condition exists

• Regardless, not necessary to treat as a ‘mental disorder’ or with ‘psychotherapy’ - just address risk factors!

These are psychosocial risk factors, NOT mental disorders or conditions that receive a mental disorder diagnosis

How treat without taking on a “mental/psych claim?”
HEALTH AND BEHAVIOR CPT CODES

• The focus of the assessment is on the biopsychosocial factors important to physical health problems and treatments. Not on mental health.

• The focus of the intervention is to improve the patient’s health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease related problems.

• Ties to the physical medical diagnosis, *not for evaluation or treatment of mental disorders. Not ‘psychotherapy.’*
MENTAL DISORDERS: COMMON DIAGNOSTIC CATEGORIES
EFFECTS OF ‘NEGATIVE EMOTIONS’

Depression, anxiety and anger negatively effect outcome in:

• Pain, disability, & impairment reports
• Conservative therapy
• Spine surgery
• Spinal cord stimulators
• Multidisciplinary programs
PSYCHOSOCIAL PREDICTORS OF POOR RESPONSE TO TREATMENT

• Depression
• Somatization
• History of childhood abuse
• Psychiatric disturbance
• Personality disorder
DEPRESSIVE DISORDERS

• Depressed Mood
• Cognitive Distortions - negative, self-critical, hopeless
• Neurovegetative - sleep, appetite, energy
• Reduction in drive, motivation, pleasure
EFFECTS OF DEPRESSION

Depression Associated With Greater:

• Pain Levels
• Time Off Work
• Amount Of Disability
• Cognitive Distortion
• Complaints And Physical Findings
• Adverse outcomes in many medical conditions
DEPRESSION

• 5% - 25% lifetime rate in the general population (women > men)
• 7% Annual prevalence rate
• 12% - 56% in out-patient primary care settings
• 20-25% of patients with chronic health conditions (diabetes, heart disease, etc.)
• Burn patients – Acute: 2 - 53%, at 2 yrs: 9 - 27%
• Upper Extremity Amputation – 21-64% acutely, 14% at 18 months
• Lower Extremity Amputation – 30-50%
DEPRESSION AND CHRONIC PAIN

• 30%-54% current rate across studies
• 18% - 12 month rate in spinal pain
  (Von Korff et. al. 2005)
• Episodes Last 2 - 5 Years
• Cause/onset - Majority of studies show reciprocal effects. Small number of studies show one precedes the other
ANXIETY DISORDERS

• Fear, Apprehension, Worry
• Autonomic Hyperarousal
• Vigilance And Scanning
• Avoidance Behavior
• Includes Panic Disorder
• Pain And Anxiety Both Warning Signals
• Anxiety Lowers Pain Threshold
• Often the Source of “Poor Effort”
ANXIETY

• 12 Month Prevalence Rates:
  • Generalized anxiety disorder – 2.9%
  • Panic disorder – 2-3%

• Lifetime Risk
  • Generalized anxiety disorder – 9%

• Burn patients - any anxiety disorder 29%

• Upper Extremity Amputations – 34%-48%, 6% at 18 months
ANXIETY AND CHRONIC PAIN

• 31% lifetime rate in chronic pain population
• 16%-29% current rate among chronic pain patients across studies
• 26.5% 12 month rate in spinal pain
  (Von Korff et. al. 2005)
POSTTRAUMATIC STRESS DISORDER (PTSD)

• Experience or witness actual or threatened death or serious harm
• Persistent re-experiencing
• Persistent autonomic nervous system arousal
• Persistent avoidance of stimuli associated with the trauma
POSTTRAUMATIC STRESS DISORDER (PTSD)

Annual Rate – 3.5%
Lifetime prevalence rate – 8.7%

Burn Patients:
• Acute: 8 - 45%
• At 1 year post: 9 - 45%
• At 1-4 years 8%, 13% partial criteria
POSTTRAUMATIC STRESS DISORDER (PTSD)

Upper Extremity Amputation
• 25-75% - decreases over time
• 40% still have flashbacks at 1 year
• 30% of severe hand injury have some depression, anxiety, or PTSD at 1 year

Lower Extremity Amputation
• 5-77%, higher figure with traumatic limb loss vs. planned amputation
POSTTRAUMATIC STRESS DISORDER (PTSD)

• Affected by predictability, controllability, intensity, type of trauma, psychological history

• Should be treated early and aggressively with medications (SSRIs) and psychotherapy including ‘re-exposure’ and cognitive-behavioral therapy

• 65%-83% success with proper treatment
SOMATIZATION DISORDERS

• Use Of Body To Communicate Psychological Issues
• Occurs With And Without Actual Physical Disorder
• Can Be Conscious Or Unconscious (Factitious vs. Mental Disorder)
• Can Solve An Internal Or External Problem (Primary vs. Secondary Gain)
SOMATIZATION DISORDERS

• Somatized Anxiety And Depression
• Hypochondriasis
• Psychalgia/Physiological Malfunction Arising From Mental Factors (ICD Only)
• Pain Disorder Associated With Psychological Factors & General Medical Condition (DSM-IV)/Somatic Symptom Disorder – Pain (DSM-5)
• Conversion Disorder (Sensory/Motor Symptoms Only)
SOMATIZATION DISORDERS

• Factitious Disorder
• Psychological Factors Affecting A General Medical Condition (DSM)/ Psychic Factors Affecting Diseases Classified Elsewhere (ICD)

Adverse Effects On Recovery, Extremely High Utilization And Costs
ADJUSTMENT DISORDERS

• Maladaptive Reactions To Identifiable Psychosocial Stressors
• Usually Not Longer Than A Few Months
• Does Not Meet Criteria For Other Mental Disorder
PERSONALITY DISORDERS

• Traits: Characteristic, Enduring Patterns Of Perceiving, Relating To, And Thinking About The Environment And Oneself

• Disorders: Patterns Become Inflexible, Maladaptive, Cause Significant Impairment Or Distress

• While Pre-existing, Interact With And Complicate Medical Presentation
SUBSTANCE ABUSE/DEPENDENCY

• Abuse: A Pathological Pattern of Use That Impairs Functioning

• Dependence: Physical Dependence (Tolerance/Withdrawal) And Pathological Impairment
PSYCHOLOGICAL ASSESSMENT AND TESTING
PURPOSE IN MEDICAL SETTINGS

• To evaluate the emotional, cognitive, perceptual, social, personality, and coping functions in terms of their effects on, and interaction with, a medical condition, in order to assist with diagnosis and treatment.
PURPOSE OF EVALUATION IN MEDICAL MANAGEMENT

• Identify known factors affecting pain, disability, compliance, and treatment
• Readiness and ability to benefit
• Adjust/focus treatment to fit patient’s unique needs, including level of care
• Monitor progress/outcomes
• Advise other healthcare providers on management issues/strategies
CLINICAL INTERVIEW

• Mental Status Exam
• Direct Observation
• History Of Mental Disorders +/or Intervention
• Current Psychological Disorder (Onset, Course, Impairment)
• Injury-Related vs. Other Stressors

OTHER SOURCES

• Review Of Records
• Collateral Interviews: Family, Case Manager, Employer
BASIC REQUIREMENTS FOR PSYCHOLOGICAL TESTS

• Validity: Measures What It Claims To Measure
• Reliability: Measures It Consistently
• Development: Documented To Current Standards
• Administered And Interpreted By Qualified Professional (Psychologist)
COGNITIVE ASSESSMENT

• Intellectual Assessment
  • WAIS-IV, Shipley

• Concentration, Attention, Memory
  • Digit Span (limited), Wechsler Memory Scales
  • IVA Continuous Performance Test, CVLT, Rey-Osterrieth Visual Memory Test

Rarely used in workers’ comp claims unless there is suspected brain injury or for one part of impairment rating for mental disorders
NEUROPSYCHOLOGICAL ASSESSMENT

• Assesses the effects of brain injury through comprehensive, systematic testing of a wide spectrum of cognitive functions
PAIN AND DISABILITY

- Pain Drawing: extent, quality, severity, consistency
- Disability/Interference with Activity:
  - Dallas Back Pain Questionnaire
  - Oswestry (back) and Neck Disability Index
  - Lower Extremity Functioning Scale
  - Disability of the Arm, Shoulder, Hand (DASH)
  - Headache, facial pain, etc.
  - Functional Complaint Scales on BHI-2
How bad is your pain?

NO PAIN | WORST POSSIBLE

5-10
PAIN AND DISABILITY

• Attitudes and Beliefs about Pain:
  – Pain and Impairment Relationship Scale (PAIRS): belief cannot function in pain, entitlement
  – Behavioral Assessment of Pain (BAP): expectations and responses when pain increases
  – Tampa Scale for Kinesiophobia (TSK): Belief that movement will cause injury
  – Fear Avoidance Beliefs Questionnaire (FABQ): belief pain is a sign of harm
  – Pain Catastrophizing Scale (PCS): negative beliefs about pain
PAIN AND DISABILITY

• Pain Coping Strategies:
  • In general passive is bad, active is good
    • Coping Strategy Questionnaire -Rev (CSQ-R)
EMOTIONAL/MOOD SCREENING INSTRUMENTS

• Beck Inventories (Depression, Anxiety, Hopelessness)
• Pain Patient Profile (P-3): depression, anxiety, and somatization compared to pain population
• BBHI-2: depression, anxiety, physical complaints in community and medical patient comparison groups
PERSONALITY TESTING

• General: MMPI-2/MMPI-2-RF, SCL-90R, PAI
• Medical Settings: MBMD
• Rehabilitation Settings: BHI-2, BBHI-2
• Assess emotional, behavioral, and interpersonal patterns and their effects (positive and negative) on medical condition, presentation in clinic, response to treatment, utilization
PSYCHIATRIC AND PERSONALITY FACTORS

**MMPI-2/MMPI-2-RF** (Minnesota Multiphasic Personality Inventory – 2, Restructured Form)

- Looks at psychopathology. Compares patient to average, psychiatric, forensic, medical populations
- Contains scales to detect exaggeration or minimization of psych, physical, cognitive sx
- Extensive research in pain and other medical conditions, presurgical evaluations
MMPI-2-RF Validity Scales

Raw Score: 2 13 5 2 2 15 11 11 9
T Score: 43 65 T 65 59 58 73 76 91 55
Response %: 100 100 100 100 100 100 100 100 100
Cannot Say (Raw): 0
Percent True (of items answered): 25%

Comparison Group Data: Chronic Pain Evaluee (Women), N = 886

Mean Score (ϕ–ϕ): 51 51 F 69 53 67 75 68 55 48
Standard Dev (±1SD): 10 9 16 10 18 13 15 10 9
Percent scoring at or below test taker: 31 96 52 86 46 51 73 99.9 84
MMPI-2-RF Higher-Order (H-O) and Restructured Clinical (RC) Scales

| Raw Score: | 14 0 0 5 18 10 3 1 0 2 1 2 |
| T Score: | 56 39 32 53 86 73 43 39 43 41 47 31 |
| Response %: | 100 100 100 100 100 100 100 100 100 100 100 |

Comparison Group Data: Chronic Pain Evaluee (Women), N = 886

| Mean Score (---): | 63 53 45 63 73 63 48 49 53 54 53 44 |
| Standard Dev (±1 so): | 12 10 9 12 11 12 9 10 11 11 11 8 |
| Percent scoring at or below test taker: | 33 21 7 22 87 84 40 21 45 13 40 4 |

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.

- EID: Emotional/Internalizing Dysfunction
- THD: Thought Dysfunction
- BXD: Behavioral/Externalizing Dysfunction
- RCd: Demoralization
- RC1: Somatic Complaints
- RC2: Low Positive Emotions
- RC3: Cynicism
- RC4: Antisocial Behavior
- RC6: Ideas of Persecution
- RC7: Dysfunctional Negative Emotions
- RC8: Aberrant Experiences
- RC9: Hypomanic Activation
PERSONALITY FACTORS MEDICAL PATIENTS

MBMD (Millon Behavioral Medical Diagnostic)

• For use with medical patients
  • Negative Health Habits
  • Psychiatric Indicators:
  • Coping Style
  • Stress Moderators
  • Treatment Prognostics
  • Adjustment Difficulties
  • Psych Referral
PERSONALITY FACTORS
MEDICAL PATIENTS

**BHI-2** (Battery for Health Improvement-2)

- For use in medical, physical rehab, and vocational rehab settings. Has community and medical norms for comparison.
  - Somatic, Pain, and Functional Complaints
  - Depression, Anxiety, Hostility, Borderline
  - Symptom Dependency
  - Chronic Maladjustment (historical)
  - Doctor Dissatisfaction, Job Dissatisfaction
  - Substance Abuse
ADVANTAGES OF TESTING

• Objective scoring and interpretation
• Appropriate normative groups
• “Validity” scales: consistency, exaggeration, minimization
• Well researched
• Use to increase objectivity of diagnosis, causality, impairment rating
• Practical applications
• Predictive value
CAUTIONS WITH TESTING:

• Hypotheses Only – Need History, Observations
• Still Requires Interview
• Requires Trained Interpreter
• Avoid "Blind" Interpretation From Canned Programs - Risk Of Error
PRESURGICAL PSYCHOLOGICAL ASSESSMENT AND INTERVENTION

• Surgery corrects structural problems, but goal is to change behavior – increase functioning
• Psychological/psychosocial factors are the best predictors of failure to report reduced pain and improved functioning after spine surgery
PSYCHOLOGICAL RISK FACTORS FOR SPINE SURGERY AND SCS

Acute or Chronic Emotional Distress

- Depression
- Anxiety and fear
- Anger
- Personality disorder
- Suicidal/homicidal thoughts
- Severe mental illness
PSYCHOLOGICAL RISK FACTORS FOR SPINE SURGERY AND SCS

Pain Sensitivity/Somatization

- Abnormal pain drawing
- Exaggerated, inconsistent, medically impossible symptoms

Cognitions/Thoughts

- Catastrophizing
- Perceived lack of control
- Unrealistic expectations from surgery
PSYCHOLOGICAL RISK FACTORS FOR SPINE SURGERY AND SCS

Impaired Cognitive/Intellectual Functioning
- Inability to understand procedures, required compliance

Substance Abuse and Misuse
- Opioids
- Other drugs
- Alcohol

Interpersonal Issues
- Reinforcement of pain behavior
- Abuse or abandonment
- Lack of current social support
PSYCHOLOGICAL RISK FACTORS FOR SPINE SURGERY AND SCS

Vocational
- Job dissatisfaction
- Work comp claim

Medical
- Prior significant medical history or surgeries
- Smoking
- Obesity
- Highly destructive surgery

Unresolved litigation
PSYCHOLOGICAL RISK FACTORS FOR SPINE SURGERY AND SCS

ASSESSMENT:

• Review of Records

• Diagnostic Interview with full review of personal, psychological, medical, claim history

• Formal Psychological Testing:
  - Pain, Disability, Coping Questionnaires
  - Objective Personality Testing – MMPI-2, MMPI-2-RF, BHI-2. Scales measure risk factors objectively and which patients may not report or even be aware of
PSYCHOLOGICAL RISK FACTORS FOR SPINE SURGERY AND SCS

Predictive Weighted Models:

• Block et. al.
• Bruns – MIR

• Apply data to model to assess risk level
• Use results to advise surgeon: proceed, issues to monitor, post-op compliance and behavioral interventions, delay surgery until risks have been addressed (CBT), avoid elective invasive procedures if possible
MENTAL HEALTH AND BEHAVIORAL TREATMENT
GENERAL GOALS:

• Reduce Mood Disorders
• Correct Cognitive Distortions
• Increase Active Coping/Self-Care
• Reduce Adverse Family/Social Influences
• Reduce Adverse Effects On Medical Condition
GENERAL GOALS:

• Reduce Adverse Effects On Compliance/Recovery
• Speed Acceptance Of, And Adjustment To, Permanent Disability
• Expedite MMI And Minimize Impairment Rating
• Expedite Return To Work
COGNITIVE-BEHAVIORAL APPROACH

• Focus is on:
  • Thoughts and Beliefs that affect mood
  • Behaviors

• Most commonly used and best researched
Cognitive Goals:

- Identify and correct cognitive distortions that produce:
  - Fear-Avoidance
  - Catastrophic Thinking
  - Passivity
  - Negative Emotions and Distress
  - Interference with Recovery and Return to Work
COGNITIVE-BEHAVIORAL APPROACH

Cognitive Interventions:
• Education
• Information
• Analysis of beliefs and assumptions
• Development of more accurate adaptive thoughts and beliefs
• Learn to do it independently
COGNITIVE-BEHAVIORAL APPROACH

Behavioral Goals:
• Increase activity
• Decrease pain behavior
• Make pain predictable
• Reduce need for pain medication
• Increase independent self-management of pain
COGNITIVE-BEHAVIORAL APPROACH

Behavioral Interventions:
- Pain diary and activity schedule
- Pacing/task rotation
- Exercise to target rather than tolerance
- Relaxation training to increase awareness and control of physiology: muscle relaxation and breathing
- Biofeedback generally NOT supported by evidence based guidelines for musculoskeletal pain
BENEFITS AND OUTCOMES FROM BEHAVIORAL HEALTH INTERVENTIONS
COGNITIVE-BEHAVIORAL APPROACH

• Demonstrated effectiveness in outcome research in mood disorders, musculoskeletal injuries, chronic pain, and other medical conditions

• STRONGLY supported by evidence based guidelines

• Reduced medical utilization: acute high risk injuries, chronic pain, cardiac, arthritis, diabetes, asthma, somatization, general medical settings

• Reduced disability and lost time in acute high risk musculoskeletal injuries
DEPRESSION OUTCOMES

- 50 - 85% recovery rate with proper treatment: cognitive-behavioral (CBT) or interpersonal psychotherapy (IPT), anti-depressants (SSRI), or both
- Addition of CBT reduces relapse rate (25%) vs. medications alone (80%)
- Proper application of therapy essential
ANXIETY OUTCOMES

• 40 - 60 % improvement in Generalized Anxiety Disorder with CBT

• 70 - 100% of Panic Disorder symptom free with different types of CBT and/or medication (not benzodiazepines)

• Specific therapies and their application is essential
POSTTRAUMATIC STRESS DISORDER OUTCOMES

• 65%-83% success with proper treatment:  
• A variety of cognitive-behavioral therapies depending on symptoms  
• Medication: SSRIs, with sertraline, paroxetine, venlafaxine having strongest support (DoD/VA guidelines)
PRACTICAL OUTCOMES

Reduced Medical Utilization: chronic pain, cardiac, arthritis, diabetes, asthma, somatization, general medical settings, on the job injuries

• Reduced Length Of Hospitalization
  ▪ Patients receive information, relaxation, active coping - 2 hours of intervention ($250 or less)
  ▪ Average 1.5 days shorter hospitalization
Reduce aggravation of medical symptoms by learning self-control of nervous system arousal (relaxation, stress management, meditation, etc.)

• 10-WK Relaxation/Stress Management course
• At 2 yr. follow-up 70% decrease in doctor visits
• Control group had 26% increase in doctor visits
PRACTICAL OUTCOMES

• Reduce unnecessary visits and overutilization of medical services by accurately diagnosing and treating mental disorders driving the symptoms and health seeking behavior.

• Depressed chronic pain patients who reduced negative thoughts accompanying depression reduced doctor visits by 36%
EARLY INTERVENTION
Linton and Andersson (2000)

Back and neck pain with less than 90 days of lost time in prior 12 months

1) **Pamphlet Group**: advice to remain active and think positively, confront fear of activity

2) **Information Package Group**: weekly packet encouraging activity, posture, proper lifting

3) **Cognitive-Behavioral Group**:
   - 12 hours of therapy
   - Used instruction with practice exercises and homework
EARLY INTERVENTION
Linton and Andersson (2000)

Over the next 6 months:

• Groups 1 and 2 increased healthcare use and sick days, while CBT group decreased

• Post-intervention Groups 1 and 2 increased days off per month (3) while CBT group decreased days off (0.5)
EARLY INTERVENTION
Linton and Nordin (2006)

5 YEAR FOLLOW UP

• CBT Group had significantly:
  • Less pain, greater daily functioning
  • Less total time off work or on LTD: 12 vs. 41 days - 71% LESS
  • Lower total healthcare and disability costs:
    • $2,604 vs. $7,253 (annualized) – 64% LESS
EARLY INTERVENTION - AUSTRALIA

• Injured hospital workers screened for psychosocial risk factors in first week after injury (modified Orebro Questionnaire)

• Those in the ‘high risk’ group received 6-12 sessions of cognitive-behavioral therapy focusing on psychosocial and behavioral “yellow flag” issues identified for each injured worker

• Intervention group had 25% lower total claim costs even with the costs of the program included

• Lost time was reduced compared to prior years with the same employer and compared to similar employers.
EARLY INTERVENTION FOR YELLOW FLAGS CURRENT APPROACHES IN USA

• Data Mining – opiate use, “fear” in claims record (Travelers, Hartford)

• Informal Screening – expectations of return to work exceeding 2 weeks, expression of fear avoidance or catastrophic health beliefs, emotional distress, “poor coping,” presence of other family and work yellow flags (Hartford)

• Formal Screening - Orebro Questionnaire, active case monitoring for yellow flags (Albertsons, Lockton Biopsychosocial Injury Recovery Model with ‘Warning Indicators for Delayed Recovery’)
EARLY INTERVENTION FOR YELLOW FLAGS CURRENT APPROACHES IN USA

Early reports of 40-50% reduction in total claims cost (Travelers)

Expectation of at least 20% cost reduction over time (Albertsons)
SUMMARY

• The biopsychosocial model is a powerful model for understanding health behavior and disability
• We know many of the risk factors for transition from acute injury to chronic disability
• Screen for these factors economically at 4-8 weeks, focusing resources on the high risk cases
• There are effective, time-limited, cognitive-behavioral interventions that can be administered economically, without a mental disorder or “mental injury” claim
• These interventions can significantly reduce lost time and overall costs of claims, but still is not a standard practice!
SUMMARY

• For those who develop more significant psychological or chronic pain disorders, there are focused, effective, empirically-validated cognitive-behavioral treatments to reduce barriers to recovery
• ODG and other Evidence Based Guidelines direct to the most effective treatments and prevent ongoing treatment without evidence of improvement
• Providers vary widely in use of EBP, understanding of work injuries, and outcomes. Use providers who have the correct skills and an understanding of the workers’ compensation system.
WHY COVER BEHAVIORAL HEALTH SERVICES?

• Maintenance of disabling pain and off-work status is primarily based on psychosocial factors, not physical pathology.
• Assist in accurate diagnosis and targeting effective treatment
• Assess brain damage and its effects
• Clarify exaggeration, psych effects on medical complaints, non-injury related factors
WHY COVER BEHAVIORAL HEALTH SERVICES?

• Prevent delayed recovery and chronicity in high risk cases
• Hasten adjustment to permanent disability if present
• Presurgical screening for psych/behavioral risk factors
• Remove /reduce barriers to treatment and recovery
• Expedite recovery and return to work
RECOMMENDATIONS

• Adopt A Broader Perspective Of Psychological/Behavioral Influences On Injury, Recovery, and Return to Work

• Address Mental/Behavioral Health Issues Directly To Control Recovery And Costs
CASE STUDY – PAIN, PTSD, DEPRESSION

- 45 y.o. correctional officer, assaulted with facial, neck, shoulder sprain/strain injury, mild concussion.
- PT, NSAID, muscle relaxer, with improvement but continuing 3-5/10 pain and headaches at 2 months. Off work.
- Reporting psychological reaction to assault with anxiety, fear, nightmares, sleep loss, intrusive memories, general distress, depression. Somatic anxiety symptoms including increased pain. (New and different from daily job stress.)
- History of abuse as child and young adult with anxiety, depressive episode from separation at 33, stressful job with fluctuating anxiety. No prior treatment. (Risk factors for PTSD, chronic pain.)
CASE STUDY – PAIN, PTSD, DEPRESSION

• Already prescribed Paxil when referred but not taking due to one kidney.

• Test results: Moderate pain and fear of reinjury, elevated health concern (possible over-reporting), psychological factors exacerbating medical conditions. Depression and anxiety moderate on self-reports but severe on formal personality testing. Verification of symptom clusters of PTSD, no evidence of exaggeration.

• Injury Related Diagnoses: Acute PTSD, Adjustment Reaction with Depressed Mood, Psychological Factors Affecting Medical Conditions

• Non-injury Diagnoses: Other Anxiety Disorder - Long-term General Anxiety
CASE STUDY – PAIN, PTSD, DEPRESSION

• Plan: 1) Start Paxil once cleared with nephrologist, 2) CBT for anxiety, depression, PTSD including relaxation training, 3) cognitive therapy, 4) systematic desensitization/ exposure therapy (including gradual return to work), 5) behavioral pain management skills (muscle relaxation with hourly tension scans, activity pacing).

• 10 sessions over 4.5 months, weekly at first and then less frequent due to improvement and job accommodation issues. Modified duty was not available.

• Paxil changed to Zoloft due to side effects, then increased.

• Systematic desensitization (imaginal) to reduce fear in workplace. Lead to increased concern about safety at work.
CASE STUDY – PAIN, PTSD, DEPRESSION

• Cognitive therapy to reduce thinking errors in general, in particular regarding workplace – risks, coworkers, inmates, options, etc.

• Exploration of career goals, risk factors, approach to workplace and dealing with inmates, with conscious decision about whether to return or not.

• Decision to return to work. While no formal modified duty for gradual exposure, she did have to complete retraining, so in facility without inmate contact for a month. Anxiety faded with daily attendance in workplace and using CBT.

• Due to shift change, job changed. Position was off inmate units, with more structured and limited contact with less violent inmates.
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