Dealing with the Dreaded DELAYED RECOVERY

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Disclosures

- Managing Member/ Owner – CPR
- Share Holder/ Med Executive- Lutheran ASC
- Share Holder/ Med Executive- Belmar ASC
Clarification

- Physical Medicine & Rehabilitation (PM&R)
- PMR = Physiatry

- Physiatrist ≠ Psychiatrist
THE PROBLEM: DELAYED RECOVERY

- FEATURES:
  - Somatization
  - Illness Behavior
  - Secondary Gain
  - Iatrogenic Disability
Delayed Recovery Characteristics

- Job Dissatisfaction
- Depression/Anxiety
- Elevated Pain Scores (VAS)
- Excessive Pain Behaviors
- Victimization
- Fear avoidance behaviors
- Litigation
- Adverse Life Experiences
Delayed Recovery

- Over-utilization of medical services without significant symptomatic/functional benefit

- Large case costs over time with high incidence of drug dependency, debilitation and reactive depression/anxiety.

- DOWC estimates 3-10% of all cases.
Delayed Recovery

- The lack of anticipated functional recovery in a medically reasonable period of time.

- If not identified and treated appropriately may lead to disability.

- However...when identified and addressed properly at an early stage, is largely a preventable or reversible clinical phenomenon.
Somatization disorder

“Conscious or unconscious use of symptoms for psychological purposes or personal gain”

Propensity to:
• report somatic symptoms that have no pathophysiologic explanation
• misattribute these symptoms to disease
• seek medical attention for these unobjectifiable symptoms
Secondary gain

- Relationships Manipulation
- Sick Role Privileges
- Financial gain
- Subconscious defense mechanisms
- Attention of health care providers
- Access to passive, “feel good” modalities
- Relief from home responsibilities
- Relief from occupational responsibilities
- Retribution- “Stick it to the man”
Illness behavior

- Mistaken beliefs
- Rejects alternative explanations of symptoms
- Misattribution of symptoms
- Falsification of information
- Fabrication of complaints
- Manufactured disease
- Exaggeration for profit or revenge

Iatrogenic disability

Disability caused by the health care system, as a result of:

- Incorrect or incomplete clinical assessment (physical, behavioral, psychosocial and psychological)
- False attribution to the etiology of the problems
- Failing to recognize and therefore reinforcing dysfunction behavior
- Inappropriate diagnostic and treatment intervention
- Failure to promote function and effective return to work
Impairment vs Disability

- Impairment
  “Loss of, loss of use of, or derangement of body part, system, or function”
  – a medical determination (often determined by the AMA Guides to the Evaluation of Permanent Impairment)

- Disability
  – Subjective impact of the impairment on a person’s ability to function in life activities
  – Gap: what one needs to do ......what one can do (or willing to do)

Disabled vs Capable

- **Needlessly disabled**—Individual perceives themselves as disabled, despite minimal impairment(s)

- **Exceptionally capable**—Individual is dynamic and productive with his/her life, despite significant impairment(s)
Exceptionally Capable

“Keep me in the game”
Or Needlessly Disabled? “Hurts too much to play”
PAIN THEORIES
Melzack & Casey (1968) Multi-Dimensional Pain:

- **Sensory-Discriminative**
  - Electrochemical reception of noxious stimulus, afferent transmission and central processing
  - Pain intensity, duration, location, quality

- **Cognitive-Evaluative**
  - Perception and appraisal of the meaning of what’s happening
  - Occurs at Whole person level within Social Network

- **Affective-Motivational**
  - Perception of unpleasantness
  - Urge to escape and avoid harm
  - Occurs at Whole person level within Social Network

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Melzack and Casey-1968-In Kemshalo, DR· The Skin Senses
“Sensory, Motivational & Central Control Determinants of Chronic Pain: A New Conceptual Model”
“Pain can be treated not only by trying to cut down the sensory input... but also by influencing the motivational-affective and cognitive factors as well.”

Melzack and Casey (1968)
Addressing the problem of chronic pain in three ways:

- **BIO** = biological considerations (injury or illness)
- **PSYCHO** = how you think and feel about the problem
- **SOCIAL** = how family, work and social pressures contribute to the problem.

Biopsychosocial Model

biopsychosocial model

PAIN from tissue injury or tissue stress

AVOIDANCE of movement and activities (ADL, Work, hobbies...)

WORRY about cause of pain and consequences

DISUSE - decreased fitness, depression, social withdrawal

Stages Towards Chronic Pain

- **Acute Injury Stage**
  - Subjective = objective
  - Impairment correlates with injury/pathology
  - Sensory-Discriminate Dimension Predominates

- **Transitional Period**
  - The Critical Phase
  - Not recovering as expected (Subjective > Objective)
  - Dysfunctional behavior begins

- **Learned Phase**
  - Drug misuse
  - Inactivity and Disuse \(\rightarrow\) Increased disability
  - Predominated by cognitive-evaluative and affective motivational dimensions
Initial Evaluation-Biologic

- Standard medical evaluation
  - Do what you do best!
- H&P
- MOI
- Physical Exam
- Labs/ Radiology
- Causation
Initial Evaluation

- History should include job tasks
- VAS Pain scores
- Pain drawing
- Orthopedic and Neurological tests
- Functional tests
- Waddell’s signs
- Oswestry
- Biopsychosocial Indicators
Waddel’s Signs:

1. Tenderness
2. Simulation Test
3. Distraction Tests
4. Regional Disturbance
5. Overreaction

Presence of 3/5 suggests clinically significant non-mechanical, pain-focused behavior. ‘To determine who require more detailed psychological assessment” prior to surgery.

Waddell’s Signs

- Non-organic signs
- Lack of effort
- Exaggerated pain behaviors
- Subjective symptoms out of proportion
- Inconsistency
- Needs further psychologic evaluation
- Poor surgical prognosis

- Does NOT diagnose MALINGERING
Early Recognition

1. Duration  
2. Dramatization  
3. Drugs  
4. Despair  
5. Disuse  
6. Dysfunction

Presence of 2/6 suggests a dysfunctional pain disorder

Hanley &Belfus, Inc, Philadelphia,p 39
Duration

- Pain persists long after tissue damage would be expected to be healed.
- Disability persists long after impairments expected to resolve.
- Lack of expected response to treatment.
Dramatization

- Use of emotionally charged words describing their pain and suffering.
- Exaggerated Pain Behaviors.
- Histrionic Behaviors/Theatrical Displays of pain.
Drugs

- Substance abuse – drugs/ ETOH
- Prescription drug abuse- drug seeking
Despair

- Embittered
- Defensive
- Depressed
- Apprehensive
- Irritable
- Hostile
Disuse

- Becomes immobile
- Refuses activity
- Non-tolerance to Physical Therapy
- Resistant to return to work
- Dependent on passive modalities/treatments
Dysfuction

- Withdrawl from the fabric of life
- Disengaged from society (family, work, recreational activities)
Job Dissatisfaction

- Multiple international studies indicating strong correlation between job dissatisfaction and incidence of work related injury claims:
Spinal injury was predicted by:
- psychological job demands
- job dissatisfaction
- frequency of job problems

Marginally significant associations:
- low supervisor support
- female gender

ALSO Physical Workload:
- Heavy activities (Cable workers 3x risk over bus drivers)
- Exposure Hours (Full time bus drivers 3x risk than half time)

Conclusions. Physical workload and psychosocial job factors both independently predict spinal injury in transit vehicle operators.
Identify patients sliding down the slippery slope ASAP.

Establish trusting and therapeutic relationship.

Focus on function rather than pain. Reinforce that hurt does not equal harm.

Jurisic, Maja- Concentra Occ Health Research Institute (COHRI), April 2011.
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- Reassure that you are not telling them “it’s all in your head”

- Do not allow comparisons to others with similar injuries.

- Withdraw controlled substance.
  - Detox if necessary.

Jurisic, Maja- Concentra Occ Health Research Institute (COHRI), April 2011.
Empower the patient to take responsibility for their healing.

- Hold them responsible for compliance with treatment
- Engage them in decision making - provide options.
- Do not allow patients to become passive in their own care

Jurisic, Maja- Concentra Occ Health Research Institute (COHRI), April 2011.
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- Counteract Counterproductive Behavior
  - “I can’t Stand it”
  - “Should” - This is how it should happen/ they should act
  - Anxiety Beliefs- Worst case scenario
  - Dependency
  - Catastrophizing
  - Perfectionist- can’t work until I’m 100%

Jurlsic, M, Concentra Occupational Health Research Institute
Focus on FUNCTION

- Immediately have patient actively perform movement at ranges that do not significantly increase pain, to build confidence – “Desensitize Fear Avoidance Behavior”

- Immediately begin stretching, active ROM & walking (multiple times a day)

- Engage family to assist, but do not do everything for the patient. Don’t allow them be enabled.
Dealing With Delayed Recovery

- Focus on Function: RTW-ASAP!
  - Understand work activities
  - Assign reasonable and realistic work restrictions
  - Progress restrictions – even if “baby steps”
  - Sports medicine model- first aid to training room to practice field to gametime
Dealing With Delayed Recovery

- SEEK HELP!
  - Delayed Recovery Specialist
  - Physiatry
  - Psychology
  - Psychiatry
Thanks to...

- Ron Carbaugh, PHD
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- Maja Jurisic, MD
QUESTIONS?