Management of Psychosocial Yellow Flags

The information presented here is taken entirely, without any content modification from: Kendall, N A S, Linton, S J & Main, C J (1997). Guide to Assessing Psychosocial Yellow Flags in Acute Low Back Pain: Risk Factors for Long-Term Disability and Work Loss. Accident Compensation Corporation and the New Zealand Guidelines Group, Wellington, New Zealand. (Oct, 2004 Edition).

These suggestions are not intended to be prescriptions, or encouragement to ignore individual needs. They are intended to assist in the prevention of long-term disability and work loss.

Suggested steps to better early behavioural management of low back pain problems

1. Provide a positive expectation that the individual will return to work and normal activity. Organize for a regular expression of interest from the employer. If the problem persists beyond 2-4 weeks, provide a reality-based warning of what is going to be the likely outcome (eg, loss of job, having to start from square one, the need to begin reactivation from a point of reduced fitness, etc).

2. Be directive in scheduling regular reviews of progress. When conducting these reviews shift the focus from the symptom (pain) to function (level of activity). Instead of asking "How much do you hurt?", ask "What have you been doing?". Maintain an interest in improvements, no matter how small. If another health professional is involved in treatment or management, specify a date for a progress report at the time of referral. Delays will be disabling.

3. Keep the individual active and at work if at all possible, even for a small part of the day. This will help to maintain work habits and work relationships. Consider reasonable requests for selected duties and modifications to the workplace. After 4-6 weeks, if there has been little improvement, review vocational options, job satisfaction, any barriers to return to work, including psychosocial distress. Once barriers to return to work have been identified, these need to be targeted and managed appropriately. Job dissatisfaction and distress cannot be treated with a physical modality.

4. Acknowledge difficulties with activities of daily living, but avoid making the assumption that these indicate all activity or any work must be avoided.

5. Help to maintain positive cooperation between the individual, an employer, the compensation system, and health professionals. Encourage collaboration wherever possible. Inadvertent support for a collusion between 'them' and 'us' can be damaging to progress.

6. Make a concerted effort to communicate that having more time off work will reduce the likelihood of a successful return to work. In fact, longer periods off work result in reduced probability of ever returning to work. At the 6-week

point consider suggesting vocational redirection, job changes, the use of 'knight's move' approaches to return to work (same employer, different job).

7. Be alert for the presence of individual beliefs that he or she should stay off work until treatment has provided a 'total cure'. Watch out for expectations of simple 'techno-fixes'.

8. Promote self-management and self-responsibility. Encourage the development of self-efficacy to return to work. Be aware that developing self-effiacy will depend on incentives and feedback from treatment providers and others. If recovery only requires development of a skill such as adopting a new posture, then it is not likely to be affected by incentives and feedback. However, if recovery requires the need to overcome an aversive stimulus such as fear of movement (kinesiophobia) then it will be readily affected by incentives and feedback.

9. Be prepared to ask for a second opinion, provided it does not result in a long and disabling delay. Use this option especially if it may help clarify that further diagnostic work up is unnecessary. Be prepared to say "I don't know" rather than provide elaborate explanations based on speculation.

10. Avoid confusing the report of symptoms with the presence of emotional distress. Distressed people seek more help, and have been shown to be more likely to receive ongoing medical intervention. Exclusive focus on symptom control is not likely to be successful if emotional distress is not dealt with.

11. Avoid suggesting (even inadvertently) that the person from a regular job may be able to work at home, or in their own business because it will be under their own control. This message, in effect, is to allow pain to become the reinforcer for activity—producing a deactivation syndrome with all the negative consequences. Self employment nearly always involves more hard work.

12. Encourage people to recognise, from the earliest point, that pain can be controlled and managed so that a normal, active or working life can be maintained. Provide encouragement for all 'well' behaviours—including alternative ways of performing tasks, and focusing on transferable skills.

13. If barriers to return to work are identified and the problem is too complex to manage, referral to a multidisciplinary team as described in the *New Zealand Acute Low Back Pain Guide* is recommended.

Toward Optimized Practice

IHE INSTITUTE OF HEALTH ECONOMICS ALBERTA CANADA