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Why Some Patients Don't Get Better With Traditional Chiropractic Care, and How Rehabilitation Can Help

By Craig Liebenson, DC

There are many reasons why a patient does not recover. Some have to do with an individual's structure or function, but others have to do with the individual's social environment (workplace or home life), psychological beliefs and attitudes, or health care provider attitudes. Regardless of the cause, a patient whose recovery takes longer than he or she expects will be dissatisfied with the care received. Fortunately, chiropractors generally get excellent results with most patients. However, those few patients who don't respond well to adjustments require a different approach. Rehabilitation strategies are invaluable for these patients and are an excellent complement to traditional chiropractic care.

Which Patients Respond Best to Chiropractic Care?

Stig, et al., studied patients with episodes that lasted at least two weeks, and pain of at least four weeks in the prior 12 months.¹⁵ Fully fifty percent of patients were found to be significantly better within four visits or two weeks of starting chiropractic care; 75 percent were much better by 12 visits.

However, according to Axen, et al., the chance of being recovered by the fourth visit was only 30 percent if all of the following criteria were present:

- no immediate improvement immediately after visit one;
- no decreased pain at visit two;
- no decreased disability reported at visit two; and
- an uncommon reaction (local pain or fatigue lasting more than 24 hours, new radiating pain, or other reactions) to the first treatment.

Flynn, et al. (2002), demonstrated a "clinical prediction rule" for the identification of patients most likely to respond to spinal manipulation.³ Low back pain (LBP) patients most likely to respond to manipulation had:

1. segmental dysfunction/pain upon springing palpation over lumbar facets;
2. acute onset of pain <16 days;
3. no pain distal to the knee;
4. limited hip internal rotation; and
5. low fear avoidance beliefs score.

The presence of four out of five of these variables (positive likelihood ratio = 24.38) increased the probability of success with manipulation from 45 percent to 95 percent. Thus, patients in whom three or fewer of these variables were present had a less than 50 percent chance of satisfactory recovery.

Other Factors Related to a Poor Prognosis

Health Care Provider:

- Insufficient evidence that treatments to cure pain work (manipulation, medication, injections, surgery, etc.)
- Ongoing passive treatment can be iatrogenic.²
- Focusing on pain relief before activation can reinforce the avoidance of pain.
- While psychosocial factors are significant in those not returning to work, trials indicated only 0.5 percent of injured workers who had not returned to work within six months had treatment that addressed such factors.¹⁷

Social Environment:

- Job dissatisfaction is a significant predictor of workers reporting back injury and developing chronic disabling pain.¹⁴
- Employers using proactive policies that facilitate a return to work reduce the amount of time off work for injured workers.¹⁴

Reactivation/Rehabilitation Treatments to Complement Chiropractic Care

Level One - Reassurance and Reactivation Advice: A 1995 study showed that those LBP for 8-12 weeks, who are worried about reactivation, can be successfully reassured and encouraged to gradually resume activities.⁷

Additionally, a 1992 study found that similar patients given a structured exercise program following behavioral principles was successful.⁸

What to offer **acute** patients at risk of not responding to chiropractic:

- **advice** that gradual resumption of activity will speed recovery;
- **manipulation and mobilization** of stiff areas such as hips or thoracic spine; and
- **exercise instruction**, such as following McKenzie or stabilization principles that teach patients how to safely reactivate.

Level Two - Brief Cognitive-Behavioral Approach: However, it was reported that 30 percent of patients did not respond to the above approach.⁷ Studies in 2000 and 2001 found that such nonresponsive patients - at six months - can respond to a cognitive-behavioral (CB) program focusing on teaching coping strategies for handling persistent pain.^{9,10} The program included six two-hour sessions with a clinical psychologist, plus rehabilitation. One-year follow-up was successful in both studies. *Pain* reported that a brief CB approach was more effective for recently injured than longer-standing problems.¹²

What to offer **subacute** patients at risk of not responding to chiropractic:

- **advice** that hurt does not equal harm;
- **advice** that pain is usually not due to irreversible structural pathology or injury;
- **manipulation/mobilization** of stiff areas, such as the hips or thoracic spine;
- **exercise instruction**, such following McKenzie or stabilization principles that teach patients how to safely reactivate; and
- **exercise instruction** involving "graded exposures" to feared stimuli, following cognitive-behavioral principles.

Researcher S. J. Linton noted the following concepts must be addressed in patients not responding to care within four to six weeks:¹¹

1. causes of pain and prevention of chronic problems - problem-solving, applied relaxation, learning and pain;
2. managing your pain - activities, maintain daily routines, scheduling activities, relaxation training;
3. promoting good health, controlling stress at home and at work - warning signals, cognitive appraisal, beliefs;
4. adapting for leisure and work - communication skills, assertiveness; risk situations, applying relaxation;
5. controlling flare-ups - plan for coping with flare-ups, coping skills review, applied relaxation, own program; and
6. maintaining and improving results - risk analysis, plan for adherence, own program finalized.

Level Three - Comprehensive Multidisciplinary Biopsychosocial Approach: Patients with chronic problems lasting more than one year may respond to a more extensive and comprehensive multidisciplinary approach.^{5,17} Von Korff and Moore¹³ pointed out that traditional medical treatment for chronic LBP - such as diabetes or asthma - is seldom effective without adequate self-care by the patient. Doctor and patient should negotiate their roles, responsibilities and expectations. They should negotiate agreed-upon goals for the treatment plan. Without agreed-upon goals, patient participation is unlikely.

What to offer **chronic** patients at risk of **not** responding to chiropractic:

- **advice** that hurt does not equal harm;
- **advice** that chronic pain is not due to irreversible structural pathology or injury;
- **advice** that chronic pain is usually due to central sensitization of pain; pathways leading to reduced pain thresholds and tolerance;
- **manipulation/mobilization** of stiff areas such as hips or thoracic spine;
- **exercise instruction**, such as following McKenzie or stabilization principles that teach patients how to safely reactivate;
- **exercise instruction** involving "graded exposures" to feared stimuli following cognitive-behavioral principles; and
- **referral** for co-management with a multidisciplinary team, including a pain psychologist.

According to Harding, et al., when treating chronic patients it is very important to prescribe exercises in a paced manner,⁶ while Butler and Moseley emphasize the need to recommend a gradual step-by-step reactivation.³ This is appropriate for patients who either are sedentary or weekend warriors.

Summary

Reactivation and rehabilitation are the ideal complements to chiropractic care. They involve both physical and psychological issues. Two excellent new books help frame the paradigm shift from passive care to active care. The first is *Explain Pain*, by David Butler and Dr. Lorimer Moseley, and is presented in such an easy-to-read style that it can even be given to patients. The second is *New Avenues for the Prevention of Chronic Musculoskeletal Pain and Disability* by Steven Linton; it offers a tremendous depth and scope on handling those patients who don't respond to chiropractic care.

Fortunately, most "state of the art" methods for handling difficult patients can be learned and incorporated by chiropractors. MSc. programs around the world, such as those offered by Anglo-European College of Chiropractic (England) and Murdoch University (Australia), have been teaching this paradigm to chiropractors since 1996. In North America, the Southern California University of Health Sciences (formerly LACC) has been teaching this approach in over 90 cities since 1991.

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