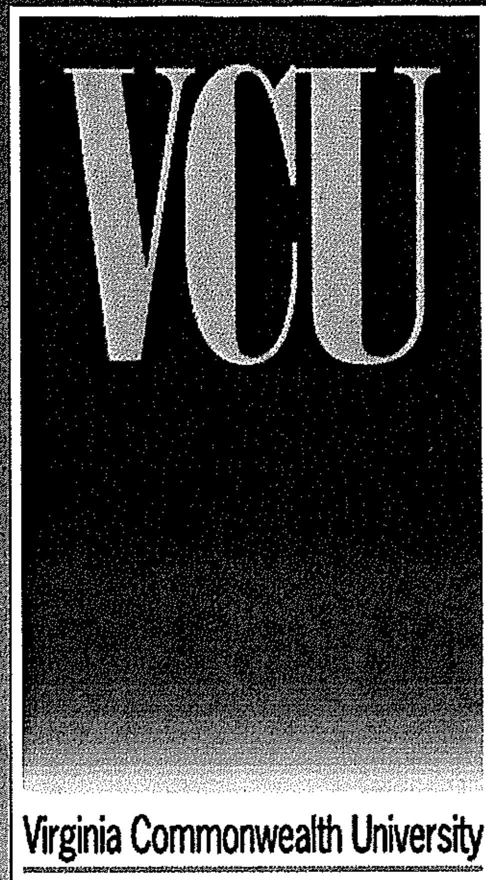


Functional Capacity Evaluation Course

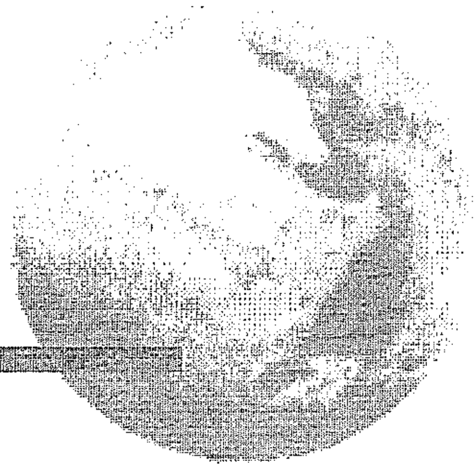
Williamsburg, Virginia
September 14, 2000

ARCON

VerNova FCE

Part 5 Psychosocial Aspects

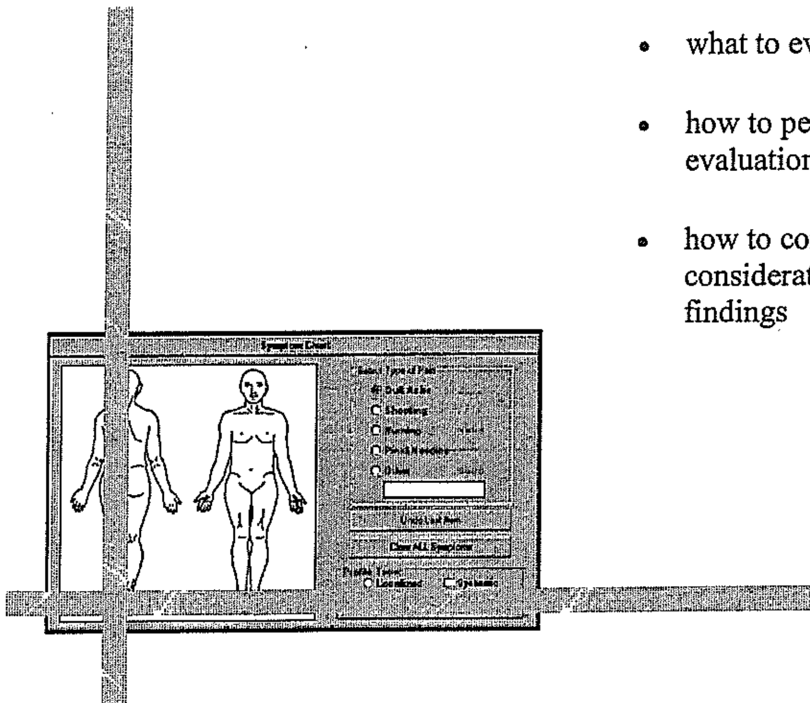
psychosocial aspects



I. Psychosocial Factors in Disability
II. Psychological Diagnosis
III. Pain
IV. Issues in Testing and Interpretation

WHAT YOU NEED TO KNOW

- what to evaluate
- how to perform the evaluation
- how to complete an FCE in consideration of positive findings



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CO-MORBIDITY

Many studies presented in this section have found that disability rates and return to work outcomes are as attributable to psychosocial factors as physical abilities. There is a preponderance of co-morbidity of psychological distress at sub-clinical levels and disturbance at clinical levels that exacerbates the evaluee's physical complaints evaluees present.

The most troublesome factor contributing to delayed recovery is pain. Pain is difficult to document objectively and often unretractable even with treatment. Pain presentation leaves the health care professional in a quandary; reluctant to push the patient beyond their pain, yet failing in treatment outcomes unless they do so effectively.

DEFINITIONS:

Psychosocial factors are the inter-related personal and psychological circumstances related to personal distress or disturbance.

Psychological Conditions are diagnoses of mental and cognitive impairments.

Pain is an injury signal, indicating impending or current trauma and need for convalescence. Pain may be acute or chronic.

Anxiety is the unpleasant emotional state consisting of psychophysiological responses to anticipation of unreal or imagined danger, ostensibly resulting from unrecognized intrapsychic conflict. Physiological concomitants include increased heart rate, altered respiration rate, sweating, trembling, weakness and fatigue. Psychological concomitants include feelings of impending danger, powerlessness, apprehension and tension.

Depression is a catch-all term used to describe any of several complex, and sometimes extreme psychological states where the emotions are affected, either by internal factors such as low spirits and low self-esteem, or external factors such as traumatic events in someone's life.

Conversion disorder (somatization) is a loss or change in bodily functioning that results from a psychological conflict or need. The bodily symptoms cannot be explained by any known medical disorder or pathophysiological mechanism.

Delayed Recovery is an unexpected duration of disability relative to guidelines of disability duration by diagnosis.

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Symptom magnification is a constellation of behaviors to communicate or display physical impairments, often which are undocumented by objective medical testing.

Disability behavior is a reaction and/or adjustment to environmental reinforcers brought about by the social or administrative systems of illness and compensation.

Malingering is deliberate behavior representing greater impairment to influence compensation decisions.

RESEARCH:

Studies have determined that factors other than physical impairment are related to duration of disability and time off work.

The 'Survey of Ontario Workers with Permanent Impairments' found that socioeconomic characteristics, economic incentives and job characteristics had a significant impact on return-to-work outcomes (Baldwin, Johnson and Butler, 1996). Krause, Dasinger and Neuhauser (1998) report from 23 years of research on return-to-work programs that workers who are offered modified duty return to work twice as often as those who do not have such programs, and modified work programs cut the number of lost days in half. A large industrial study at Boeing found that psychosocial factors were more predictive of disability than medical factors. Foreman assessment of the worker prior to injury was the best predictor. Other studies have found alcohol and drug problems, age, poor education and lack of transferable skills relate to disability rates. (Gamborg, Elliot and Curtis, 1991).

Milhous et al. (1989) performed a longitudinal multivariate study of disability determination and found that various psychosocial factors (age, length of time off work, current activity level, psychological factors) were related while lift capacity was not a determinant. Yelin, Henke and Epstein (1986) performed a large study of SSA clients and determined that musculoskeletal condition was a poor predictor of disability, while the nature of the work was the most discriminate variable. The authors suggest the 'interaction between functional limitations and work requirements are the strongest factors affecting work outcome".

While many of these factors might not be in the domain and expertise of the Functional Capacity Evaluator, it is crucial that a good understanding is developed and tools to screen, diagnose and differentiate are utilized.

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FUNCTIONAL ASSESSMENT:

The Functional Assessment Inventory (FAI) was developed to assess the multivariate predictors of disability and allow analysis for case management. The FAI is a 30 item questionnaire with norms on disability populations (Crewe and Athelstan, 1984). The FAI has been used in many state Vocational Rehabilitation systems. The FAI predicts outcome on four variables: rehabilitation costs, case closure, work status at closure, earnings at case closure. The FAI requires knowledge of the evaluee on these items:

• General learning ability	• Stability of condition
• Ability to read/write English	• Quality of work history
• Memory	• Acceptable to employers
• Spatial aptitude/form perception	• Personal appearance/hygiene
• Vision	• Skills
• Hearing	• Economic disincentives
• Speech	• Access to job opportunities
• Language function	• Requirements for special working conditions
• Upper extremity function	• Work habits
• Hand function	• Social support system
• Motor speed	• Accurate perception of capabilities and limitations
• Ambulation and mobility	• Effective interaction with employers and co-workers
• Capacity for exertion/strength	• Judgment
• Endurance (full-time vs part-time work ability)	• Congruence of behavior with rehabilitation goals
• Loss of time from work	• Initiative and problem solving

Other tools that exist for psychosocial investigation include the Battery for Health Improvement, Work Readiness Profile, Work Adjustment Inventory, Personal Problems Checklist, Substance Abuse Subtle Screening Inventory, and numerous other scales that have been developed and published.

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II. PSYCHOLOGICAL DIAGNOSIS

SCREENING

Pre-existing conditions and the results of the disability both contribute to the psychological condition. It is important to assess the severity of psychological distress and discriminate between those who have a high state of psychological distress versus those who present with clinically elevated levels of disturbance. Various screening and diagnostic tools have been developed and validated for this purpose and are accessible to the evaluator. Differential diagnosis of psychological overlay versus disability behavior is critical in the evaluation and treatment process.

psychosocial factors

ANXIETY

Anxiety may accompany a disabling condition. In early treatment anxiety may complicate organic disease and may produce painful muscle contraction. The evaluee is likely anxious about the occupational, social role and economic effects from their disabling condition. There is often fear of re-injury and exacerbation of pain from activity the evaluator is requesting. Evaluees that exhibit anxiety need to be reassured that the evaluation is in their control, they will be kept from re-injury and the pain they experience is not harmful.

DEPRESSION

Reactive depression is common among the disability evaluation population. Depression may serve to amplify minimal organic pathology. Chronic depression is thought to be a major factor in chronic pain and other somatic symptoms. Anti-depressants have shown effectiveness in this population for pain management as well as mood elevation.

SOMATIZATION

Somatization can contribute significantly to an evaluee's presentation of symptoms and response to evaluation. There is low awareness within the evaluee that this dynamic contributes to functional ability, hence there is poor prognosis for change while this remains unresolved. Evaluees with somatization hold an intensely concrete perception of their world, and the causality of a physical injury to their internal distress is reinforcing and unretractable. Insight therapy is not realistic for these evaluees, and solutions founded in concrete treatments such as work hardening are more attractive.

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SCREENING TOOLS

The Symptom Checklist 90 (SCL-90) or its shorter version, the Brief Symptom Inventory (BSI), can be used by any licensed health care professional for psychological screening. The subscales on the SCL-90 and BSI include:

- ☑ Somatization
- ☑ Obsessive Compulsive
- ☑ Interpersonal Sensitivity
- ☑ Depression
- ☑ Anxiety
- ☑ Hostility
- ☑ Phobic Anxiety
- ☑ Paranoid Ideation
- ☑ Psychotocism
- ☑ Global Severity Index
- ☑ Positive Symptom Index

A clinically elevated score on the screening tool would suggest referral for further assessment and intervention, while non-elevated scores suggest the evaluator take appropriate response to the distress indicated, but that clinical psychology is not likely necessary at that point in time.

The DUKE Health Profile and DUKE Severity of Illness Checklist are other useful screening tools for the disability evaluation. The DUKE will be presented in the LEARNING section.

* **Psychological overlay of distress or disturbance often leads to poor effort, motivation and low pain threshold for the assessment.**

* **If the evaluator has screened for psychological overlay they may feel more prepared to motivate the evaluee to perform to a greater degree than if they were unaware that physical distress is confounded with psychological distress.**

* **The evaluator is able to respond with more appropriate verbal support knowing the evaluee's emotional state.**

* **There is opportunity to use the consistency indicators from the evaluation to most appropriate advantage when the relationship to psychological factors is known.**

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AMBIGUOUS RELATIONSHIP

Studies have demonstrated that the association between pain and physical impairment is often ambiguous and poorly correlated. No physiological response has been identified to characterize pain.

Self report measures have been the utilitarian solution. Although concern exists that self report measures may be biased, many studies have shown high correlation between these measures and concurrent objective measures, functional capacities and therapist ratings.

PAIN EVALUATION

The most common measures of pain self report are:

- ☑ Visual Analogue scale
- ☑ McGill Pain Questionnaire
- ☑ Roland and Morris Disability Questionnaire
- ☑ Oswestry Low Back Pain Disability Questionnaire
- ☑ Psychosocial Pain Inventory

Many would prefer to use an objective pain evaluation. The UAB Pain Behavior Scale (Richards et al., 1982) is a validated instrument for that purpose. It has eight items:

- ☑ Medication
- ☑ Stationary Movement
- ☑ Use of Supportive Equipment
- ☑ Body Language
- ☑ Mobility
- ☑ Standing Posture
- ☑ Facial Grimaces
- ☑ Down Time
- ☑ Vocal Complaints: Non-Verbal
- ☑ Vocal Complaints: Verbal

The evaluator should screen for pain and make appropriate intervention and/or further evaluation recommendations. Pain is highly complex and should be evaluated by the appropriate professionals when it appears to be a primary factor in disability.

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SCREENING RECOMMENDATIONS

The most important issue in this area of the evaluation is to use validated screening tools and make appropriate recommendations from those measures. The evaluator must not avoid these important psychosocial factors and the role they may be playing in the disability, but also should not go beyond their area of expertise for diagnosis.

The disability insurance process inadvertently fosters disability behavior, providing powerful reinforcers for secondary gain. Traditional medical treatments are not successful when these factors are prevalent and active exercise rehabilitation, early return to work and case management counseling have been most effective.

INTERPRETATION

Interpret results indicating that the results 'suggest' <findings>. Do not put forward opinion that the evaluee 'is depressed' or 'is somaticizing', unless this is your area of expertise.

Interpret physical capacity results in light of remarkable findings on the psychosocial factors, using the flexibility the evaluation tools and methodologies to present results in the direction expected with resolution of the psychosocial issues.

The evaluee has elevated scores on work dissatisfaction and substance abuse screening. Therefore the results of the functional capacity evaluation tests may be lower than expected if these issues were not present. Recommendation is made for work adjustment counseling that should include subtance abuse evaluation and management

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SUMMARY

The learning objective of this section was to:

- ✓ Introduce the purpose and reason for pain evaluation
- ✓ Acquaint the evaluator with screening and diagnostic tools
- ✓ Outline the major issues in pain evaluation

LEARNING EXERCISE:

The DUKE Health Profile be presented:

Raw Score: ___	Reference Adjusted Score: ____	Physical Health
Raw Score: ___	Reference Adjusted Score: ____	Mental Health
Raw Score: ___	Reference Adjusted Score: ____	Social Health
Raw Score: ___	Reference Adjusted Score: ____	General Health
Raw Score: ___	Reference Adjusted Score: ____	Perceived Health
Raw Score: ___	Reference Adjusted Score: ____	Self Esteem
Raw Score: ___	Reference Adjusted Score: ____	Anxiety
Raw Score: ___	Reference Adjusted Score: ____	Depression
Raw Score: ___	Reference Adjusted Score: ____	Anxiety-Depression
Raw Score: ___	Reference Adjusted Score: ____	Pain
Raw Score: ___	Reference Adjusted Score: ____	Disability

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