

Fragility and Back Pain: Lessons From the Frontiers of Biopsychosocial Practice

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There has been a lot of movement in physical therapists' attitudes toward back pain in recent years. This appears to have been driven by a shift in the discourses shaping musculoskeletal physical therapy. There seems to be a desire on the part of many therapists to do less hands-on treatment and more empowering, motivational, exercise-based facilitation. The manual therapies that had been so popular over the past half century are now considered passé: too passive for patients and therapists both. There is also the growing sense that physical therapists are now beginning to feel more comfortable with discourses of the body, movement, and health that deviate from the traditional biomechanical view; embracing more psychological and experiential concepts, such as *behaviorism* and *enactivism*. However, although we might be getting a better grip on how we could adapt these approaches to physical therapy, we are much less clear about why we might be changing to them in the first place. After all, the biopsychosocial model has been around for half a century, and psychology and exercise-based rehabilitation are hardly new. So, why change? Why change these things? And why now?

Fortunately, there are examples from our own professional history that might provide some good pointers to explain what is now happening in musculoskeletal physical therapy. And perhaps the paradigm case comes from the unlikely field of cardiac rehabilitation, whose history bears some striking resemblance to the way physical therapists are now talking about pain. For instance, although heart disease once had been the leading cause of death in high-income countries since 1900, accounting for 40% of all deaths,¹ chronic pain is now considered to be equally significant, with low back pain alone “the leading cause of global disability,”² with 80% of adults experiencing a “significant episode of disabling low back pain over their life,”² and with 10% to 15% of those adults progressing to chronic low back pain. Unlike heart disease, though, Godfrey et al² tells us that 90% of people with chronic low back pain “have a non-specific problem with no clearly identifiable cause,” and that the increasing prevalence of chronic low back pain makes it “the second most frequent reason for time off work” globally, with “total

costs associated with back pain in the United States [alone . . .] estimated at between \$100 and \$200 billion per year, one-third due to healthcare costs, with the remainder due to lost wages and lower productivity.”

In addition to the comparably monstrous disease burdens, our attitude toward heart disease also has had some interesting similarities to the way we now think about chronic pain. Up until World War II, people who survived a heart “attack” were considered to be so *fragile* that they often spent the rest of their lives cosseted on long-term bed rest, permanently convalescing, with activity and exertion considered to be a serious risk to their recovery. The same attitude has been taken in the past for people with an acute back “injury.”

But the 1940s brought 2 important shifts in cardiac care. The first were the advances in medical investigations into the etiology of heart disease, brought about by the widespread use of electrocardiograms and angiography—which revealed, with great clarity, the nature and extent of the heart lesions. This, in turn, led to the development of a raft of new drugs to manage cardiac output and clotting, all of which resulted in a critical discursive shift in the way cardiologists and cardiac surgeons saw “heart attack victims.” Perhaps they weren't as fragile as first thought, and perhaps exercise was better than rest? Tellingly, this message started to be heard more and more at the exact moment when heart disease in the high-income countries of North America and Europe was becoming epidemic.³

But attitudes toward fragility and rest had been changing since World War I. As early as 1900, it was recognized in the United States that the federal government could no longer afford to pension men off who had been injured in war. The policy of honoring veterans from the American Civil War had almost bankrupted the government by 1900, so, rather than raise taxes, a decision was made to change the way injured war veterans were spoken about. While honoring their service, government policies started suggesting that injury and disability need not hamper a person's contribution to society and that it was a moral duty for men to rehabilitate: of course a young man wants to restore his pride by returning to work. Or so the rhetoric went.⁴

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In a comparable turn—with the realization that people who had had acute cardiac disease were less fragile than previously thought—the same language started to be applied to recovery from heart attacks,³ and the same call to use physical rehabilitation as the vehicle to restore the person to normal social function went out. Throughout the last century, the physical therapy profession has been the beneficiary of this kind of cultural shift many times. From the care of neurasthenics in Gilded-Age America and Europe,⁵ to the rehabilitation of men injured in war, to children afflicted by polio, physical therapy has picked up the work of bodily reconstruction whenever patients were no longer deemed too fragile to rehabilitate.

The course we are now following in the profession's relationship to back pain feels, in some ways, remarkably similar. For instance, when we lacked the technology to *see* what was causing a person's back pain and we were anxious about the irritability of the condition, bed rest and passivity were the safe option. Rest appeared the logical choice because, prior to modern industrial design, many people had dangerous jobs that seemed to predispose them to acute back injury. Rest was also heavily endorsed by the medical profession, to whom physical therapy was deeply tied. And, in some countries, physical therapists had secured their professional status as *the* primary, state-sponsored provider of physical rehabilitation services after its work tending patients on prolonged bed rest in hospitals. So many within the physical therapy profession were disinclined to change what seemed a safe practice.

But concern for the time lost through recumbency persisted, especially for governments that became increasingly concerned with the cost of welfare support for a population of people who seemed remarkably prone to lifelong disability after even the most banal everyday event, such as bending to put on socks or lifting a baby from the cot. New approaches to back pain management needed to be found, and the solution came, in part, from revolutionary manual therapists, orthopedic surgeons, and ergonomists, who argued that manual therapies, surgical repairs, and workplace adjustments could fix the “broken patient.” Although this approach perpetuated the concern for the fragility and irritability of the spine, at least it offered the belief that the original cause could be fixed, allowing the person to resume normal social functions.

This move conferred enormous prestige and social capital on musculoskeletal physical therapists and fed into the idea that they could diagnose the physical basis for a pathological problem and, with skilled hands, manipulate the patient back to health. The patient, already made passive by the fragility of their spine, had no role to play here, beyond complying with the therapists' instructions and diligently doing their (passive) exercises.

Now, as before with cardiac disease, shifts in technology and people's attitudes toward rest and fragility have once again changed, and we have arrived at the point where we can no longer afford to see people with back pain as fragile, passive recipients of care. Unlike cardiac disease, however, we are *untethering* back pain from the evidence of underlying pathology not *because* medicine has mastered screening and the management of acute illness, but because it hasn't. Our magnetic resonance imaging and pathology-hunting tests have failed to show why a person feels pain when so many with comparable pathological changes do not. And so, new ways of thinking about this debilitating social ill are needed.

Much of the pressure to change the way we think about back pain can be attributed to discourses beyond physical

therapy's direct control: in the globalized new economics of health care; in the rise of consumer choice and people's desire to be heard by professionals; in the gradually declining public trust for authority figures such as physicians and physical therapists; in the growing competitive marketplace in health care; in the perceived failure of passive treatment to reduce need and dependency; and so on. But perhaps the biggest shift “internal” to physical therapy—one that directly responds to the need for new approaches to back pain—has come from the adoption of the socioeconomic discourses of independence, self-care, and personal responsibility.

We can see this in the way that the traditional manual therapies have been marginalized. These therapies had come to represent the “old ways”: the patient as passive recipient, dependent and over-reliant on the help of others; therapies that were too tied to the body-as-machine, paying little regard to subjective, lived experience. What is more, these “low-value” therapies could no longer be justified given the lack of strong evidence in their favor. (It is perhaps worth noting that the “new” psychologically informed therapies escape this scrutiny for the time being, as advocates argue they are too young, yet, for us to fully evaluate their efficacy).

But we cannot knock off the king's head just yet, and replacing the manual therapies with behavioral, cognitive functional, neuropsychologically informed, and enactivist acceptance and commitment therapies will not happen simply because proponents believe they should. There are some crucial questions to be answered by any successors to the musculoskeletal physical therapy throne that have important implications for the whole of the physical therapy profession into the future. Not least of these questions is that of how the profession retains its status as a key provider of back pain help, care, and treatment—if what it offers can no longer be said to be ostensibly “physical.”

Perhaps the biggest gamble being taken by advocates of the various “psychologically informed” (PIPTs) is that governments, funders, and regulators will reward physical therapists for promoting personal responsibility and productivity despite ongoing pain. This is primarily a political gamble based on the belief that the *prevailing* discourse in today's neoliberal, small-government, late-capitalist marketplace is one in which the overstretched health care system reduces the cost of all back pain-related disability. Governments in all high-income countries are actively shifting the responsibility from the professional to the consumer.

So, in much the same way that the discourse of opportunities, rights, *and* responsibilities shifted for patients receiving cardiac rehabilitation after World War II, people with back pain are now increasingly being encouraged to see themselves as much less fragile: to take more personal responsibility for their care, to rely less on passive cures, to consider how their personal beliefs define their back pain, and to accept that pain is a normal part of life and learn to live with it. People with back pain are increasingly being seen as “culpable in the face of known risk,”⁶ with the therapist seen as a hands-off facilitator and enabler.

Discourses of independence and self-care are powerful because they seem so obvious. Who, after all, would not want to take control of their care, make their own choices, and feel empowered? But if such beliefs are so obvious, should we not, at the same time, be asking why the biopsychosocial model is only *now* penetrating physical therapy? Why have we only recently turned to behaviorism, cognition, the language of

psychological flexibility, and therapeutic alliance? And why is it only really musculoskeletal physical therapists who are moving this way? (Much of the rest of the profession has remained staunchly biomechanical.)

The reason cannot be because these concepts are new, because most have been available and open to use for half a century or more. And it cannot be because of evidence, because the current evidence for the efficacy of psychological management of pain is hardly any more convincing than the evidence for the manual therapies that psychological management claims to supersede.^{7–8} And the reason is just as unlikely to be because physical therapists suddenly now want to give greater attention to individual, subjective understandings of the lived experience,^{9–13} given that the methodologies these approaches demand cannot be addressed through randomized controlled trials and the manipulation of objective variables that are the currency of contemporary scientific health care. These approaches are also more time consuming and costly to deliver, which is exactly the opposite of what most governments and funders are calling for.^{14–18}

But even these questions are not the biggest ones now being posed by the PIPTs. The elephant-in-the-room question that advocates for new behavioral, cognitive, and enactivist approaches to physical therapy have so far failed to address is: How far can physical therapy move into hands-off, “active,” behavioral, cognitive, and existential therapies before our work ceases to be physical at all? How far can we push the boundaries of legitimate physical therapist practice before we remove the physical from physical therapy entirely?

A similar concern hangs around physical therapy’s adoption of the biopsychosocial approach to health care. Within this approach, there is no clearly delineated space marked out for physical therapy, or for *any* professional discipline, for that matter. And all can make the claim that they are now biopsychosocial. So where does one profession begin and another end today? What defines our point of difference and justifies our unique professional status?

Perhaps cardiac rehabilitation offers us one final comparative lesson here. Over the past 2 decades, cardiac disease has become a much smaller concern for many health authorities, as defibrillation, better paramedic care, preventive cardiac surgery, the development of wearable technologies, and better pharmaceutical management have made acute infarct much less common. Consequently, rehabilitation has become less important, and health authorities are less disposed to fund bespoke cardiac rehabilitation services. Other community-based professionals—many now state licensed—have taken over the exercise component of the programs, and physical therapists have slipped somewhat out of the picture.

Like those with back pain today, people with heart disease were once told to take greater personal responsibility for their health and well-being. At least their efforts were supported by improvements in preacute and postacute cardiac care. Few such changes are taking place in the management of back pain, and the failure to find effective surgical options for spinal pain, ongoing doubts about the value of mobilization and manipulation, and the opioid epidemic have only hardened people’s belief that orthodox health care has little to offer.

We are at a crucial juncture in the profession’s evolution, then. We are being asked to provide health care to people in a neoliberal age that privileges self-care and personal responsibility, while holding on to a professional culture that is steeped

in objective, third-party assessment and treatment designed to treat and rehabilitate physical problems in human bodies. In response, we are advocating for approaches that remove much of the physical from the physical therapies. In fact, we are arguing for a philosophy of practice that is so diffuse it is impossible to see where physical therapy begins and other health care providers end.

If today’s psychologically informed physical therapists are the shock-troops of a new postprofessional frontier—as cardiac rehabilitation practitioners were in the 1940s and 1950s—their efforts are to be celebrated. They are performing a hugely important task in opening physical therapists’ minds to the possibility of thinking in a new way.¹⁹ But we also need to watch closely: as we enter this new era, those who are advocating for more psychologically informed physical therapies need to be aware that we are in the midst of perhaps the most turbulent period in the profession’s history. Anyone with a mind for disruption must be sensitive to just how fragile the foundations of the profession really are.

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