Letter to the Editor

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

Nicholls DA. *Phys Ther*. 2023;103:pzad040. https://doi.org/10.1093/ptj/pzad040.

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[H1] Psychologically informed Practice: Let's Not Throw the Baby Out with the Bath Water

Nicholls[1] offers an interesting lens on psychologically informed practice (PiP) and back pain using cardiac disease management as a historical comparison. Although Nicholls addresses the implication of shifting treatment paradigms from a physical therapy perspective, the changes he identifies are consistent with a broad reconsideration of health care and, in particular, the core competencies required for professional accreditation and reimbursement. However, in responding to Nicholls's essay, we note several concerns, including: (1) conceptualizing "change" in the physical therapy profession; (2) suggesting that much of the "physical" from physical therapy has been removed with such change; and (3) purported future implications for the profession.

Physical therapy is responding to the public health problem of chronic pain: Although our understanding of pain processing has not fundamentally changed over the past half century, we do have a clearer picture of factors that influence chronic pain development and its impact on function, quality of life, and work capability. Our understanding of low back pain has shifted from a narrow biomedical or biomechanical model toward a broader biobehavioral patient-centered model. Nonetheless, legions of health care professionals are poorly equipped to implement PiP. One reasonable response to this change is to ensure that physical therapists gain exposure to PiP principles and strategies to better optimize patient engagement.

Although it is tempting to call for a complete realignment of physical therapy training and coverage, PiP has always resisted such a doomed enterprise. Stemming from early pain management literature,[2] multidisciplinary care for low back pain has remained grounded on a solid clinical foundation, with early dissemination efforts presenting PIP as an updated framework for physical therapist practice. Cardiology has historically relied on life-saving surgical procedures and risk-reducing medications and only recently has recognized the role of the patient in secondary prevention. By contrast, patient behaviors have long been recognized as pertinent in the management of low back pain, especially as it relates to secondary prevention.

Physical therapist management of people with low back pain is not currently, and was never intended to be, only physical: With respect, Nicholls's lament for the loss of the "physical" aspect of physical therapy suggests a misunderstanding of PiP and of current strategies based on modern pain theories (eg, Melzack's neuromatrix theory of pain[3]) that reject dualistic (physical versus psychological) sources of pain. Newer pain management strategies focus not only on identifying physical impairments and biomechanical abnormalities but also on contextual factors (anxiety, depression, poor social support) that adversely impact function and patient-directed reactivation. Accordingly, recent physical therapist clinical practice guidelines

recommend manual and other directed interventions to address a broader range of biological and behavioral factors influencing low back pain.[4] Therefore, referring to physical therapists as "hands-off facilitator and enablers" perpetuates a dualistic mindset that is inconsistent with our current understanding of pain management. Furthermore, it is inconsistent with current evidence that does not support the use of "hands-off" treatments alone (eg, patient education) but instead supports their use as adjuncts to "physical" treatments such as exercise and manual therapy.

In many respects, physical therapists have always delivered interventions with psychological inputs, whether through education about prognosis that helps reduce anxiety or by instilling self-confidence with challenging new exercises. The term "PiP" was introduced into the physical therapy mainstream via a 2011 PTJ special issue,[5] which proposed PiP as a method for integrating management of unhelpful psychological responses to pain (particularly patient attitudes, beliefs, emotional responses, and pain coping strategies) into standard practice.

Indeed, the PiP framework introduced in that special issue never advocated for separate lanes of "physical" and "psychological" practices, instead striving for one practice in which those were integrated when patients may benefit from such an approach. We fully acknowledge that work prior to 2011 inspired the PiP term.[2] However, the special issue provided an opportunity to label a management approach that—though clearly related to cognitive behavioral therapy—also had important distinctions, namely the use of "physical" treatments with evidence of the potential for pain relief.

Future implications of PiP should be viewed as data-informed evolution in clinical practice that will benefit the physical therapy profession and patients who seek our care: We note Nicholls's concerns about the potential for "over-correction" in clinical practice. Our concerns, however, surround reluctance to evolve toward a broader biobehavioral patient-centered treatment approach when evidence supports the benefits of such an approach. To minimize both types of concerns, future PiP training needs to intentionally model care that

integrates traditional treatments (eg, exercise and manual therapy) with interventions that address patient attitudes, beliefs, emotional responses, and pain coping strategies. To reiterate, PiP maintains exercise and manual therapy as its cornerstone, while integrating psychologically focused interventions as needed to best engage patients in their care and optimize outcomes.

Evidence supports the benefits of patient-centered approaches that fit under the PiP umbrella. For example, cognitive functional therapy, which shares many principles and treatment strategies with PiP (emphasizing patient beliefs, motivation, pain related emotions, and behavioral-based exercise) has shown large treatment effects when compared to usual care.[6] Perhaps more important, PiP creates opportunities to facilitate cooperative care around issues that are important to patients ie, reducing pain-related anxiety, improving confidence with performing desired activities despite pain) yet not commonly evaluated or addressed by other musculoskeletal providers. For example, the PiP Consultation Roadmap[7] promotes establishing a therapeutic relationship, developing patient-centered communication, and guiding effective pain self-management while also accommodating individual patient differences. Empowering patients to play an active role in their pursuit of optimal function might be more beneficial for patients as compared to typical directive or prescriptive care approaches.

In closing, we echo Nicholls's sentiment about being at a critical juncture in the physical therapy professional evolution. However, rather than holding on to the prescriptive, biomechanically focused approaches to low back pain management of the past, we continue to advocate for and recognize the positive impact that physical therapists offer health systems and patients through their expanded use of psychologically informed treatments.

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