Impaired, Disabled or Just Stuck?

Managing Ambivalence and Resistance to Returning to Work *

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Individuals who, for no apparent reason, have difficulty in returning to work following an injury or illness create a challenge for employers, insurers and healthcare providers. Are these individuals really disabled, just unlucky, and poorly motivated or malingerers? In fact, these individuals are stuck, unable to move forward due to a constellation of competing psychosocial factors. Central to getting unstuck is the ability to identify and understand the ambivalence and resistance to returning to work. Suggested strategies in managing ambivalence and resistance are presented.

It's Not Just about the Injury! When an injury, illness or chronic disease disrupts one's work, career and life in general, the disruption is usually temporary. Yet, no matter how minor the impairment, some individuals have difficulty adapting to the various physical and emotional demands the injury or illness brings. Moving beyond the injury or illness seems to be difficult, if not impossible. The observed disability or subjective impact of the injury or illness is greater than the observed level of impairment or objective loss. These individuals consume valuable time and talent generating excessive costs while frustrating co-workers, as well as friends and family.

There is substantial evidence indicating the lack of success in returning to work is not the exclusive result of the actual medical problem. Rather, there is a constellation of common psychosocial factors that support or sabotage the return to work effort.

Figures 1 and 2 summarize the key psychosocial factors. In Figure 1, any one of these factors may be sufficient to reduce the likelihood of going back to work. Unfortunately, it is also quite common for several or all of these to be in play at any given time for a single individual.

The research suggests that a low value of work and low job satisfaction coupled with a marginal ability to cope with multiple life disruptions are at the top of the list of RTW barriers.

Figure 1 Evidence Based RTW Saboteurs

- **Low value of work, negative work environment**
- **A belief that recovery to previous work function is unlikely**
- **Presence of multiple impairments, poor medical outcomes**
- **Greater psychological stress, multiple life disruptions**
- **Receiving injury compensation with low economic status**
- **Distrust of employer and/or insurance provider**

Distrust and economic uncertainty appear to be the most significant drivers for acquiring legal counsel in the disability claims process. While these psychosocial factors may be recognized, they are often ignored. In many workers' compensation cases such factors are actively avoided to prevent the psychosocial factors from becoming part of the claim. This defensive logic, while understandable, represents a narrow approach to protecting the productivity of an employer's workforce. The reality is that such factors already are part of the claim, playing an influential role silently, but actively sabotaging any return to work efforts. It is the wise employer and visionary insurer who are able to both recognize and influence these real barriers.

Figure 2 highlights those factors that appear to increase the likelihood of returning to work. Once again, any one of these can be the driving force in increasing the likelihood of returning to work.

Flexible employer policies and a non-hostile work environment appear to be the top indicators for increasing the likelihood of a safe and timely return to work.

Figure 2 Evidence Based RTW Enhancers

- **Boredom (i.e. nothing else better to do)**
- **Individual's Belief in a high probability of returning to work**
- **Flexible employee benefits that support continued work**
- **Ability to cope with change and multiple stressors**
- **Non hostile work environment**

While "boredom" appears to be a RTW enhancer, it is not recommended that it be relied upon as a primary driver in a return to work plan. All too often when a person is unable to be on the job, the person's freed up time can be quickly filled with possibly more rewarding and interesting activities. These competing interests can be the early signs of becoming stuck.

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A Costly Misconception. While these psychosocial factors may be ignored by the employer, the insurer and the practitioner, they are all too often misinterpreted as potential fraud or malingering. By whatever name, fraud or malingering are an intentional effort to create a false belief to gain an advantage or avoid a task, activity or responsibility by pretending, making up or creating fraudulent illness or symptoms. Research indicates that true fraudulent claims occur in an estimated range of 1% to 5% of workers' compensation and short term disability claims.

Attempts to deceive an employer or insurer are perpetuated by individuals who are clearly looking for quick personal gain, possibly retribution or some other manner of taking advantage of the employer/insurer. This person's scam typically has clear gaps, inconsistencies in behavior and intent that are able to be recognized for what they are, stealing. This is not a return to work issue, but an assignment for the employer or insurer's legal team.

Symptom exaggeration is often recognized as malingering and fraud. This is unfortunate in that different dynamics are in play. Symptom exaggeration is characterized by real impairment with disproportionately high subjective disability. Secondary gains may be present, but usually include other functions than financial gain. For example, the exaggerated symptoms may serve to:

- Reduce anxiety
- Support a dependent relationship
- Exempt a person from expected , but undesirable social roles, such as spouse, parent or worker
- Maintain a highly choreographed dysfunctional relationship in a family or workplace

Symptom exaggeration can be a poorly learned adaptive response, the result of an ineffective coping style or a prominent feature of a co-morbid condition, such as depression. Depression as been shown to be a significant barrier to continued productivity. Symptom exaggeration can be fueled by a fear of changes in the status quo highlighted by vacillating feelings of ambivalence and resistance. While the resistance may be strong, it will typically be a more benign type, responsive to intervention.

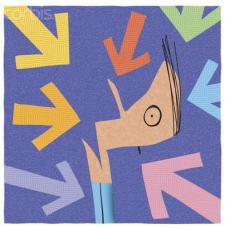
Symptom exaggeration, if not attended to, can become a high stakes poker game as the individual raises the stakes or doubles down to avoid greater loss. Employers and insurers who do not recognize the differences between real fraud/malingering, as opposed to benign symptom exaggeration and those individuals who are stuck take an unnecessary adversarial position. This ultimately leads to excessive legal expense and higher claims costs for the insurer and the employer, alike. Actively dealing with the ambivalence and resistance may offer a more successful, less costly approach than chasing and litigating non fraudulent cases.

Not Motivated? When an individual fails to return to work in a timely manner, employers, insurers and medical providers often look for a quick, simple explanation, e.g. this person is simply not motivated. . It is more likely that the individual is caught in the Motivation Paradox.

The Motivation Paradox suggests that, contrary to the notion that some individuals who do not return to work following an injury or illness are unmotivated, in fact, are stuck. Stuck because they:

- Don't know how or don't have the capacity to solve the health and productivity predicament he or she is in
- Are slowed or even paralyzed by ambivalence and resistance to return to work.

Ambivalence and resistance have been recognized as the primary drivers of being stuck. Ambivalent and resistant to what? That is the question that is not asked enough or sufficiently paid attention to by those working with the individual who has a problem resuming their job. Ambivalence and resistance to going back to work are commonly exhibited by excuses, rationalizations and disengagement leading to an unproductive wrestling match between all parties.



The Sounds of Being Stuck. Ambivalence is the push and pull of competing forces, interests or events on an individual. Ambivalence may produce confusion, hesitancy, uncertainty, indecision, mixed emotions and illustrates the proverbial state of being between a rock and a hard place. Ambivalence does not necessarily mean the person is against going back to work, it suggests he or she is in a state of flux or uncertainty. This person is extremely vulnerable to various types of influences, positive and negative.

Ambivalence and resistance should not be ignored, rewarded or punished, but recognized, understood and acted upon**.** An engaged employer or insurer can be the difference by being a guide that offers clear and consistent direction for mutual benefit. A disengaged employer or insurer will surely create Bureaugenic Disability, that is, unnecessary lost time created by competing or ambiguous return to work policies and practices.

Resistance has been identified as the process of constructing and maintaining barriers to protect the status quo. For example, the individual's logic may be, "Even if my current situation is terrible (i.e. not working, I hurt all of the time and on disability claim), changing my status may make things really worse (i.e. going back to work and getting fired or hurt even more). Resistance can take on the day to day look of: making excuses, avoiding prescribed treatment, arguing, negating, ignoring, devaluing, minimizing, refusing to look at options or presenting a pessimistic view of all things related to going back to work.

Common sounds of being stuck include such statements as:

- I want to go back to work, but am not sure when I will be really ready
- I am not sure I can go back to work, since I still can't do……
- I am afraid to go back to work, I may get hurt again!

Return to work resistance is commonly generated and maintained by negative thinking illustrated by: unrealistic fear or concern of re-injury, conclusions made with inaccurate/ incomplete information, overgeneralizations, or dichotomous, (i.e., yes or no) thinking. Magnification of the real or perceived impact of an injury, surgery or illness can also produce significant barriers to the return to work considerations.

Resistance can also be generated by an individual's belief that going back to work is simply not possible. A lack of focus and concentration invites distractions and detours. Poor decision making and a lack of problem solving skills reduce the capacity to assess the value of and develop a practical RTW plan. The inability to integrate various pieces of work and health information into a cohesive and understandable plan can also produce delays that appear to be resistance. If a person is unlikely to see the value of certain tasks leading to improved RTW outcomes, the resumption of work can be impacted.

A timely return to work discussion focusing on the individual's ambivalence and resistance has shown to be a powerful strategy in achieving change and moving the individual forward. Ignoring the ambivalence and resistance reinforces the person's disability inertia with a reduced likelihood of the person returning to work in a timely fashion or at all.

Measuring the Likelihood of Becoming Stuck. Getting stuck is a very human experience. Everyone has been a little stuck at some point in time. Staying stuck is not a common event. If we asked any person what being stuck feels like; we would get a fairly consistent report…that is, not much fun, frustrating, and scary. I felt stupid, couldn't move or was embarrassed! We often know when we are stuck, but unwilling to seek assistance. When working with an individual who is stuck, it is critical to go beyond typical medical and claims information gathered. By doing so, greater insight is gained as to what may be the contributing factors to how likely the person is to become stuck, how the individual became stuck, how they continue to stay stuck and what resources they have to get unstuck.

There are a number of tools used by employers, medical and behavioral health professionals to gain such insight to the contributing psychosocial factors that create a return to work predicament. Such tools are not clinical assessments of psychopathology or dysfunction, but offer brief, sophisticated assessments of key psychosocial barriers.

Time Warner's, Psychosocial Needs Assessment Model offers a domain management interview format assessing the relative influence of various psychosocial variables on a return to work. They reported significant changes in return to work outcomes and costs when psychosocial factors were well defined and aligned with appropriate resources.

Likewise, the Keele STarT Back Screening Tool (BSBST) offers a brief 9 question format of various psychosocial indicators that reflect the impact chronic low back pain has on day to day activities. Users of the screening tool reported significant success in moving the person with chronic pain back to work or increased activities of daily living. Once again, the success being generated is from the recognition of the interaction between psychosocial factors and pain behavior during day to day activity

The Judgment Index™ (JI) (www.judgmentindex.com) is a unique tool to calibrate various facets of a person's capacity to solve his or her return to work predicament**.** This Index is derived from an instrument developed in the early 1960s called "The Hartman Value Profile (HVP)." The HVP—and now the JI— is uniquely equipped to look at the *judgment* of individuals, and particularly the way that *judgment* is guided by an individual's values. The JI is particularly adept at placing measurable metrics around the outcomes influenced by evaluative judgment in the decisions and choices that people make to guide their lives, especially in planning a return to work.

The Judgment Index™ **is** not: an IQ or intelligence profile such as the WAIS. It is not an assessment of psychopathology, e.g. MMPI or a personality inventory such as the Myers Briggs or DISC.

The assessment asks the individual to rank two sets of 18 statements as to their value and importance. The assessment provides a values index derived from an individual's personal value system (how we evaluate our world) that measures judgment capacity, the power of a person's judgment to accomplish tasks given and live in ways they would like to live.

The Judgment Index measures the strength and weakness of 70+ indicators across both work and personal areas of judgment and decision making. A sample includes:

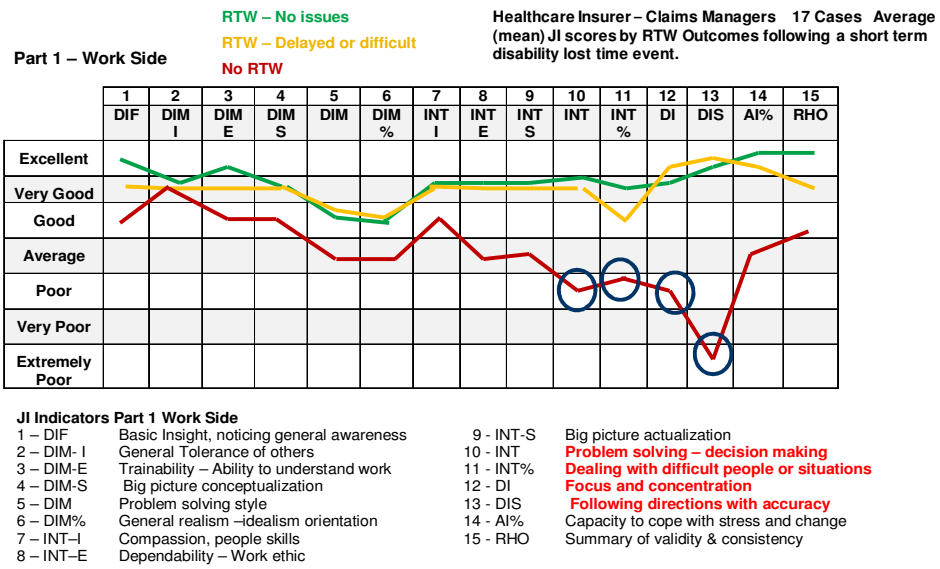
- Dependability, Work Ethic, Value of Work
- Trainability and the Ability to Understand Work
- Noticing, Basic Insight
- Idealism - Realism
- Focus and Concentration
- Resilience and Energy to Change
- Moral Conscience
- Stress and Positive Attitude
- Following Directions with Accuracy
- Understanding What is Important
- Problem Solving & Decision Making Style
- Self Regard

Returning to work following an injury or illness is, indeed, made up of a series of decisions and value judgments. This starts with recognizing the symptoms or avoiding risky behavior, moving on to seeking the appropriate initial medical care and then following a medical treatment plan. Ultimately, determining the value of work, the probability of RTW success and the real cost of going back to work become critical value judgments.

Figure 3 illustrates one JI-RTW study that illustrates the differences in RTW indicators for three groups of medical claims adjustors who were off work for either a work related or personal injury or illness during 2007 – 2010. The three groups were: those who returned to work in the expected time frame, those who returned to work, but in a delayed fashion and those who did not return to work.

Significant differences occurred for those who did not return to work as opposed those who did. The individuals who did not return to work had lower scores in the areas of problem solving, dealing with difficult situations, low levels of focus and concentration and a reduced ability to follow directions. In this same study, the most significant personal JI indicator for those who did not return to work showed extremely high self-criticism.

Figure 3 RTW JI Indicators



JI Indicators Part 1 Work Side

1 – DIF	Basic Insight, noticing general awareness	9 - INT-S	Big picture actualization
2 – DIM- I	General Tolerance of others	10 - INT	**Problem solving – decision making**
3 – DIM-E	Trainability – Ability to understand work	11 - INT%	**Dealing with difficult people or situations**
4 – DIM-S	Big picture conceptualization	12 - DI	**Focus and concentration**
5 – DIM	Problem solving style	13 - DIS	**Following directions with accuracy**
6 – DIM%	General realism –idealism orientation	14 - AI%	Capacity to cope with stress and change
7 – INT–I	Compassion, people skills	15 - RHO	Summary of validity & consistency
8 – INT–E	Dependability – Work ethic		

While these indicators are not necessarily predicative of a return to work or not, they offer very tangible areas of interest to explore with the individual as a return to work plan is being considered and developed. They do illustrate the likelihood of becoming stuck.

Getting Unstuck - Manage the Ambivalence and Resistance! Gaining insight to how a person became stuck and how they continue to stay stuck is critical to moving forward. This insight can be achieved through a focused interview format that invites the individual to recognize and discuss the nature of their ambivalence and resistance to returning to work. Several key discussion areas that produce valuable insight are:

- How has the injury affected the individual emotionally?
- How does the individual describe the predicament they are in?
- How much financial instability and uncertainty is present while on disability claim? How is this being managed?
- How socially isolated is the person and from whom do they get their information from?
- How has the person solved other predicaments in the past? How is this one different?
- What type of effort has been made to solve the predicament?
- How much energy is available to solve this predicament?
- What level of optimism/pessimism does the person present in solving the predicament?
- What level of commitment does the person present in solving the predicament?
- What's good about being stuck for this individual? What is the value of staying on the disability benefit?

A person who is stuck, even the most hostile, angry, typically responds to recognition and empathy, rather than threats, nagging or demands. Indignation and exaggerated hostility are more representative of the individual engaged in a disability scam, It is mutually beneficial for the RTW team, i.e. the employer, healthcare professional, disability manager and claims professional to understand the reasons why an individual became and remains stuck.

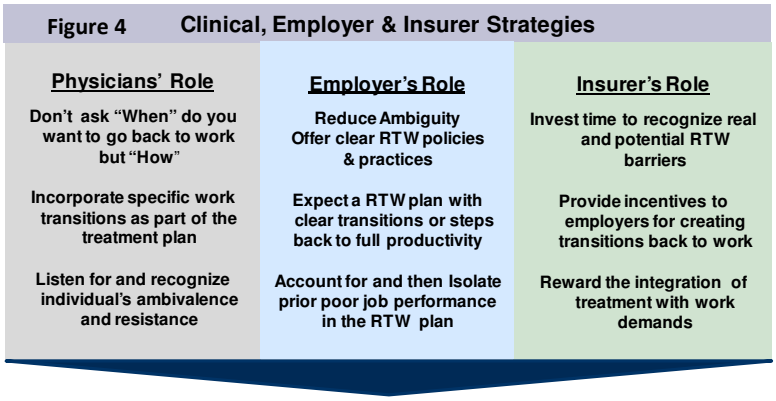
This requires a different and expanded point of view, as well as a different set of skills in managing those who appear to be "less-than-motivated". The development of a different, positive relationship can lead to a timely resolution of the health and productivity predicament. The ability to move the person forward, even slightly, is the first incremental step to achieving the return to work dividend. The following represents the conditions of success in getting the so called poorly motivated person, who is, in fact, stuck to become engaged.

- **Move from an adversary to problem solver** Adversaries make people dig in and defend. Developing a set of skills that are applied in a time sensitive, problem solving focused relationship can lead to desirable changes. The RTW team becomes the guide; the individual is accountable for solving their health and productivity predicament.
- **Recognize the person as being stuck rather than a malingerer** The recognition of the Individual being stuck along with the specific sources of ambivalence and resistance to going back to work invites: 1. an improved understanding of key drivers and 2. Specific steps to solve the predicament. Recognition is transformational.
- **Promote continuous engagement** Reducing isolation creates accountability, consistency and accuracy of information. Correspondingly, continuous engagement creates the opportunity to reinforce incremental success. Time invested pays RTW Dividends.
- **Create incremental change** Incremental steps back to work offer a greater likelihood of success through the accumulative impact of achievable goals leading to repeated success.
- **Reduce ambiguity** Ambiguity is a friend only to the frauds and malingerers. Creating a well-defined pathway (i.e. a formal RTW plan) back to work offers direction, opportunities to redirect if a person gets off track and milestones to measure and reinforce progress.

Collaborative Solutions. Those who are stuck are also equal opportunity annoyers. The individual who is stuck is most likely also seen as a "bad patient", a "difficult claimant" and a "problem employee". Effective collaboration and communication are an absolute element in supporting the individual's goal of getting unstuck.

Depending on role, commitment and available time, the employer, insurer or health care provider need to assume the lead in the RTW dance. Figure 4 illustrates the various collaborative solutions that each of the RTW partners can offer. Ultimately, the individual is accountable for getting unstuck. Each strategy offers a piece of an overall effort. Without all of the segments, the final outcome will be in question.

Figure 4 Clinical, Employer & Insurer Strategies



Summary The Motivation Paradox is not an excuse, apology or rationalization for individuals who file fraudulent claims. Nor is it a cure-all for employees who have difficulty coping with the impact of an injury or illness. It describes a common reality for individuals who are stuck in a health and productivity predicament. It offers the foundation to acquire a proven set of skills within a corporate, insurance and healthcare strategy that helps prevent and solve complex cases. The essence of this strategy is to differentiate between those individuals who are stuck and interested in change from those who are not. More importantly, this approach differentiates between those who are stuck and those who be true malingerers perpetuating fraud.

Finally, employers have the opportunity to reduce the growing cost of lost time and presenteeism generated by those employees who are unable to solve their personal health and productivity crisis. Getting stuck is a common human experience. Staying stuck is not. Labeling an individual as "unmotivated" is a convenient descriptor that tells us nothing, offering little to the solution. It has been demonstrated that gaining insight to an individual's resistance and ambivalence assists the person to begin the process of getting unstuck. Insight to action powers the return to work success.

References

Aliotta S.L., Vlasnik J.J. & Delort B, Enhancing adherence to long term medical therapy: A new approach to assessing and treating patients, Advances in Therapy, 21, 214 – 231, 2004

Beckie TM, A behavior change intervention for women in cardiac rehabilitation, Journal of Cardiovascular Nursing, 21, 146- 153 2006

Bernacki E., Tsa S, Ten Years' Experience Using an Integrated Workers' Compensation Management System to Control Worker's Compensation Costs. JOEM, Vol. 4, May 2003

Brown N, & Thomas N; Exploring Variables among Medical Center Employees with Injuries: Developing Interventions and Strategies. AAOHN Journal, November, 2003, Vol 51. # 11

Byrum, S Engagement, Aging & RTW Indicators, White Paper published by Judgment Index – USA May, 2011, www.judgmentindex.com

Cole D Et. al; Listening to injured workers: how recovery expectations predict outcomes – a prospective study CMAJ, Mar., 2002

Coupland, M, Margison D, Early Intervention in Psychosocial Risk Factor for Chronic Pain, Presentation made at National Seminar on Musculoskeletal Disorders & Chronic Pain: Evidence based approaches for clinical care, February, 2011, Los Angeles, CA.

Eggert S Psychological factors affecting employee abilities to return to work, AAOHN J, 2010, Feb. 54(2):51-5

Gatchel RJ, Polatin PB, Mayer TG The dominate role of psychosocial risk factors in the development of chronic low back pain disability, Spine, 1995, Dec 15:20 (24): 2702-9

Gatchel R, Comorbidity of Chronic Pain and Mental HJealth Disorders: the Biopsychosocial Perspective, November, 2004, American Psychologist. pp 798 – 804

Halligan, PW, Bass, C, Oakley, D; Willful Deception as an Illness Behavior, Chapter 1. Malingering and Illness Deception, Oxford University Press, Oxford, UK, 2003

Hill JC, Dunn KM, Lewis M, Mullis R, Main CJ, Foster NE, et al. A primary care back pain screening tool: identifying patient subgroups for initial treatment. Arthritis Rheum 2008;59(5):632–41

Lerner D, Henke R; What Does Research Tell Us about Depression. Job Performance and Work Productivity? JOEM, Vol. 50, #4, April 2008

Lu X, Laaksonen M, Aittomaki A, Leino-Arjas P; Rahkpnen O, Saatamoinen P, Lahelma, E: Sickness Absence, Employment History and High Risk Employees,: A 10 Year Longitudinal Study, JOEM September, 2010, v.52, Issues 9 pp 913 -919

Macfarlane GJ, et.al Evaluation of work-related psychosocial factors and regional musculoskeletal pain: results from a EULAR Task Force, Ann Rheum Dis, 2009, June; 68 (6):885-91

Mitchell K. The Motivation Paradox: Work, Disability and Being Stuck. Presentation made to Hawaii SHRM Chapter, July 21, 2009 Workrx Group, 2009 www.workrxgroup.com

Mittenburg W, Patton, C, Canyock EM, Condit, DC: Base rates of malingering and Symptom exaggeration, Journal of Clinical Experimental Neuropsychology, 2002, Dec. 24 (8) 1094 -1102

Nahit ES, Hunt IM, lunt M, Silman, AJ, Macfarlane, G.J. ; Effects of psychosocial and individual psychological factors on the onset of musculoskeletal pan: common and site specific effects Ann /Rheum Dis 2003 Aug: 62 (8): 755-60

Oppermann, JD Interpreting the meaning individuals ascribe to return to work after traumatic brain injury, a qualitative approach Brain Injury 2004, September, (9) pp 941 -55

Rollnick, S., Miller, W., Butler, C; Motivational Interviewing in Healthcare Settings Guilford Press, New York, 2008

Rousculp M, Johnston S, Palmer L, Chu, BC, Mahadevia P, Nichol K; Attending Work While Sick: Implications of Flexible Sick Leave policies JOEM, October 2010, v 52, Issues 10 pp 1009 – 1013.

Urnikyte, L Kaminskas, KA Assessment of Psychosocial Risk Factors in Lithuanian Construction Companies; , May, 2010 Presentation to the 10th International Conference Modern Building Materials, Structures and Techniques , Vilnius, Lithuania

Vilaverde L, Bruen, P Health and Disability Integration Effective Cost Management Strategies, Presentation to the Disability Management Employer Coalition, DMEC National Conference, August 3, 2010

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Dr. Mitchell has also served as a Clinical Assistant Professor at the Case Western University Medical School's Department of Rheumatology, as well as the Ohio State University, School of Medicine, Department of Physical Medicine and Rehabilitation.

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With his retirement from Unum, he founded and serves as the managing partner of the WorkRx Group, Ltd. Current activities focus on the relationship between work, disability and judgment. He serves on a number of advisory groups supporting return to work efforts for individuals who are cancer survivors; wounded/impaired veterans and those individuals with traumatic head injury

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