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Recommended approaches to assessing and managing physiotherapy clients experiencing psychological distress: a systematic mapping review

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ABSTRACT

Background: Some physiotherapists find assessing and managing clients experiencing psychological distress challenging and are uncertain regarding the boundaries of the profession’s scope.

Objective: To map the approaches recommended for physiotherapists in scholarly literature, with respect the assessment and management of clients experiencing psychological distress.

Methods: A systematic mapping review was conducted. CINAHL, APA PsycINFO, Embase, and Medline ALL databases were systematically searched for secondary and tertiary literature relevant to the research objective. Recommended approaches were extracted from each article and analyzed descriptively and thematically.

Results: 3884 records were identified with 40 articles meeting the inclusion/exclusion criteria. Most recommendations related to identifying, assessing, and managing pain-related distress, with depression screening and referral also receiving some attention. Three approaches to detecting and assessing psychological distress were identified: 1) brief depression screen; 2) integrated suicide/nonsuicidal self-harm and depression screen; and 3) multidimensional screen and health-related distress assessment. Regarding the management of psychological distress the main approaches identified were: 1) education and reassurance; 2) cognitive-behavioral approaches; 3) mindfulness; and 4) case management.

Conclusion: While assessment and management of health-related distress by physiotherapists is commonly recommended, further guidance is needed to differentiate various forms of distress.

Introduction

In 1975, Emeritus Professor and prominent psychiatrist Beverley Raphael published an article in the Australian Journal of Physiotherapy arguing that physiotherapists, due to the nature of the clients with whom they work and whether employed in public or private practice, need to be prepared to support clients who are experiencing overwhelming feelings of anxiety, anger, sadness, loss, resentment, fear, or disappointment (Raphael, 1975). Despite almost 50 years having passed since the publication of Raphael’s paper and the knowledge that physiotherapists frequently encounter people experiencing psychological distress, it appears that many physiotherapists lack confidence in the assessment and management of clients experiencing psychological distress (Driver, Kean, Oprescu, and Lovell, 2017; Henning and Smith, 2022; Lucas and Parker, 2022; McGrath, Verdon, Parnell, and Pope, 2023; Singla, Jones, Edwards, and Kumar, 2015).

While there is no universally accepted definition of psychological distress, it is often described in terms of symptoms of depression and anxiety (Drapeau, Marchand, and Beaulieu-Prévost, 2012; Mirowsky and Ross, 2003; Phillips, 2009). However, focusing only on these symptoms fails to capture the entire spectrum of psychological distress, which may also include grief, rumination, feelings of vulnerability, despair, sadness, anguish, helplessness, fear, hopelessness, loneliness, worthlessness, and irritability (Laporte and Aita, 2021; Mirowsky and Ross, 2003). Psychological distress may also emerge in the presence or absence of a stressor (Drapeau, Marchand, and Beaulieu-Prévost, 2012; Ridner, 2004). When referring to psychological distress that is, at least in part, associated with a specific stressor, some researchers use more specific terminology such as trauma-, poverty-, illness-, or pain-related distress (Cano and Goubert, 2017; DePrince, Chu, and Pineda, 2022).
Given the variability in the forms of psychological distress that can be experienced, it is unsurprising that physiotherapists have reported encountering clients experiencing psychological distress associated with a range of different stressors, with illness/injury-, financial-, andbereavement-related distress frequently encountered (McGrath, Parnell, Verdon, and Pope, 2022; McGrath, Verdon, Parnell, and Pope, 2023). In total, the physiotherapists participating in the study by McGrath, Verdon, Parnell, and Pope (2023) perceived that approximately 36 out of every 100 clients they encountered experienced some degree of psychological distress, of which almost half were perceived to be experiencing severe psychological distress. The frequency and variety of the forms of client psychological distress encountered pose a significant clinical challenge to physiotherapists, and this challenge is likely worsened by a lack of clarity around the role of physiotherapists in working with clients experiencing psychological distress (Lord, 2018; McGrath, Parnell, Verdon, and Pope, 2022; McGrath, Verdon, Parnell, and Pope, 2023; Ribeiro et al., 2022; van Dijk et al., 2023).

While physiotherapists should not attempt to subvert the role of mental health professionals, their exposure to clients experiencing psychological distress necessitates recognition of, and at least some involvement in the management of the distress (Connaughton, 2018; Watson and Kendall, 2000). According to the International Organization of Physical Therapy in Mental Health (IOPTMH), all physiotherapists should be able to engage with and explore the perspectives of clients experiencing distress, and assist them to navigate the mental health care system (Probst et al., 2020). Furthermore, as primary contact health professionals, physiotherapists have a responsibility to respond appropriately to presenting problems identified during the consultation, which may involve screening for psychological distress and considering its management within care planning (American Physical Therapy Association, 2023; Physiotherapy Board of Australia, Physiotherapy Board of New Zealand, 2015). The purpose of screening is generally described as identifying important areas which may need further evaluation (American Psychological Association, American Psychological Association Practice Organization Work Group, 2014; Franzen, 2003). While sometimes considered interchangeably with screening, assessment aims to identify and comprehensively understand the construct at issue (e.g. anxiety), including its severity and the broader context in which it is occurring (American Psychological Association, American Psychological Association Practice Organization Work Group, 2014; Franzen, 2003).

When faced with uncertainty in clinical practice, physiotherapists may find it useful to draw on clinical guidelines, approaches, protocols, pathways, and instruments to guide their practice (Almond, Zou, and Forbes, 2021; Djulbegovic, Hozo, and Greenland, 2011; Scurlock-Evans, Upton, and Upton, 2014; Timmermans and Angell, 2001; Woolf et al., 1999). While physiotherapists generally acknowledge the importance of drawing on the literature to inform their practice, barriers such as limited time and skills in locating, appraising, and extracting relevant information from research articles have been found to impede this process (Scurlock-Evans, Upton, and Upton, 2014). Lennon et al. (2020) and Keefe, Main, and George (2018) argued that there is a paucity of clear guidance to assist physiotherapists in assessing and managing clients experiencing psychological distress or mental illness. Consequently, there is a lack of clarity around the role and scope of practice of physiotherapists in supporting clients experiencing psychological distress (Lennon et al., 2020; Lucas and Parker, 2022; McGrath, Verdon, Parnell, and Pope, 2023; Ribeiro et al., 2022).

Cupler et al. (2020) posited that the development of an “evidence map” may help improve the translation of research to practice by providing practitioners with a concise, and comprehensive clinic-friendly tool that summarizes the evidence. Rather than mapping evidence, the aim of this review was to systematically map recommendations for physiotherapists published in the scholarly literature regarding approaches to the identification, assessment, and management of clients experiencing psychological distress.

Method
Research design
A systematic mapping review methodology was adopted. According to Hansen, Præstegaard, and Lehn-Christianesen (2021) systematic mapping reviews analytically describe and interpret the research field, rather than identify scientific evidence. Systematic mapping reviews are particularly well suited to practice-relevant review questions (Grant and Booth, 2009). The protocol for this systematic mapping review was registered with Open Science Framework on July 13th 2022 (McGrath, Pope, Parnell, and Verdon, 2022). As there are no reporting guidelines for systematic mapping reviews, the Preferred Reporting Items for Systematic Reviews and Meta-analyses Extension for Scoping Reviews
(PRISMA-ScR) was used (Tricco et al., 2018). While the initial aim was to map recommendations published in any type of scholarly literature such as research reports, journal articles, research theses and clinical guidance articles, after familiarity with the nature and breadth of the literature was gained during the initial title and abstract screening, the scope of our review was narrowed to only include secondary and tertiary literature that provided guidance on approaches to the identification, assessment, and management of psychological distress for physiotherapists based on pragmatic (i.e. resource and time limitations) and methodological considerations. While the definitions of secondary and tertiary literature vary, in the context of this review, secondary literature refers to literature that involves interpretation, synthesis or evaluation of primary sources, while tertiary literature refers to literature that includes distillation and collection of primary and secondary sources, and these sources are often composed of commentary and discussion of literature (Howlett and Rogo, 2021). The reviewers concluded that mixing primary research articles with secondary and tertiary literature would complicate analysis and mapping. The recommendations from primary research articles we screened tended to relate to future research rather than clinical practice, limiting their relevance to this review. Furthermore, when clinical recommendations were included in primary research articles, they tended to be highly tentative and specific to the results of the particular study being reported. In contrast, clinical recommendations from secondary and tertiary literature tended to be more general and aimed at translating a broader range of knowledge or evidence to practice. Articles published between January 1, 1990 and May 30, 2023 inclusive were eligible for inclusion. The year 1990 was chosen as the start date of the search as the “1990s saw evidence-based practice emerge as a new paradigm” (Turner, 2001). While systematic mapping reviews share similarities with both umbrella reviews and scoping reviews, umbrella reviews only include systematic reviews and meta-analyses and scoping reviews typically include primary research (Aromataris et al., 2015; Paolo and Joaquim, 2018; Pham et al., 2014).

**Eligibility criteria**

The inclusion and exclusion criteria for the systematic mapping review (Table 1) were developed using the Population/Concept/Context Framework (Peters et al., 2020). For the purpose of this review, VandenBos’s (2015) definition of “approach” as a particular method or strategy used to achieve a goal or purpose was used. Based on the existing work of key authors in the area (Drapeau, Marchand, and Beaulieu-Prévost, 2012; Laporte and Aita, 2021; Mirowsky and Ross, 2003; Payton, 2009), psychological distress was defined as follows. Psychological distress is a subjective, unpleasant emotional state that may be transitory, episodic, or permanent. Psychological distress is often characterized by depressive and anxiety symptoms but may also include a range of other negative emotions such as anger, frustration, grief, rumination, obsession, and feelings of being isolated or vulnerable. Psychological distress exists on a continuum, ranging from low to very high levels of psychological distress. Psychological distress may occur in response to a specific stressor or multiple stressors, or it may emerge in the absence of a stressor. The emotional symptoms of psychological distress may in some instances be the same as symptoms

<table>
<thead>
<tr>
<th>Element</th>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
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<tbody>
<tr>
<td>Population</td>
<td>The approach recommended is specifically recommended for physiotherapists to use with clients experiencing psychological distress. If published in a physiotherapy journal it is assumed that it is recommended for physiotherapists unless otherwise stated.</td>
<td>May mention health professionals in general but the approach does not specifically mention relevance for physiotherapists.</td>
</tr>
<tr>
<td>Concept</td>
<td>Discusses an approach that is consistent with the VandenBos (2015) definition of an approach. Discusses an approach that provides guidance on assessing and managing clients experiencing psychological distress or mental disorders</td>
<td>Discusses an approach that does not provide guidance for assessing and managing clients experiencing psychological distress.</td>
</tr>
<tr>
<td>Context</td>
<td>Discusses an approach relevant to an area of clinical physiotherapy practice.</td>
<td>Discusses an approach relevant to non-clinical areas of physiotherapy practice (e.g. clinical educators identifying distress among physiotherapy students)</td>
</tr>
<tr>
<td>Type of literature</td>
<td>Published between 1/1/1990 and 30/05/2023 inclusive. Secondary or tertiary literature (e.g. reviews, clinical practice guidelines, masterclasses, and commentaries) Literature which has been published in an academic journal.</td>
<td>Original research articles (e.g. trials, observational studies, and case reports). Literature which has not been published in an academic journal, such as magazine articles, news articles, books and book chapters.</td>
</tr>
</tbody>
</table>

Table 1. Inclusion and exclusion criteria.
related with mental disorders such as major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder.

Given the ambiguity around the scope of practice of physiotherapists in the identification, assessment, and management of psychological distress, the eligibility criteria were designed to ensure included articles provided recommendations that have been made explicitly for physiotherapy practice, to enhance understanding of current perceived role boundaries for physiotherapists (Table 1).

**Search strategy**

The literature search was completed on May 30th, 2023, using the search terms reported in Table 2. The search terms were informed by the literature on psychological distress and a review of the controlled vocabulary used in the selected databases. A preliminary search of CINAHL (EBSCO) was conducted in order to pilot the search strategy. No amendments to the search strategy were required. After piloting the search strategy, CINAHL (EBSCO) was searched again, along with the databases of APA PsycINFO (Ovid), Embase (Ovid), and Medline ALL (Ovid). The search strategy used to query the Medline ALL (Ovid) database is presented in Table 3 as an example, with the search strategies for the APA PsycINFO (Ovid), Embase (Ovid), and CINAHL (EBSCO) databases reported in Supplemental Material 1. A citation search and reference list screening of potentially relevant and included articles was performed. Additionally, the reference lists of two recent reviews conducted in the general topic area were screened (Heywood et al., 2022; Ribeiro et al., 2022).

**Screening and selection methods**

The citation details for literature identified via the search strategy were imported into EndNote (Version 20) and Covidence (https://www.covidence.org/). Once imported, duplicates were removed and the titles and abstracts each screened by a single reviewer (RLM or SS) with only clearly irrelevant articles excluded at this stage. Each article identified as potentially relevant was assessed against the eligibility criteria by two reviewers (RLM or SS) independently. Any inconsistencies were handled by a discussion between the reviewers (RLM or SS) and if resolution could not be achieved, a third reviewer was consulted. Review by a third reviewer was not required as all inconsistencies were resolved through discussion between RLM or SS. The results of the search, screening and selection processes were documented in a PRISMA flow diagram (Haddaway, Page, Pritchard, and McGuinness, 2022).

**Data extraction, analysis and presentation**

Data from the included literature were extracted using a data chart form (Supplemental Material 2). RLM performed data extraction, with SS reviewing the extracted data to confirm accuracy. Data analysis involved descriptive analysis, interpretive thematic mapping, and summarizing of the data. Zotero (version 6.0.19), and Microsoft Excel (version 365) were used for the descriptive analysis. Thematic mapping was informed by Iterative Thematic Inquiry as described by Morgan and Nica (2020). As per Iterative Thematic Inquiry, RLM drafted preliminary themes based on knowledge of the literature, which was continually updated as new data (i.e. the articles identified) reinforced, challenged, or expanded understanding. Once all data had been

<table>
<thead>
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<th>Table 2. Search terms.</th>
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<tr>
<td><strong>Concept</strong></td>
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<tr>
<td>Physiotherapist</td>
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<tr>
<td>Psychological Distress Approach</td>
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<tr>
<th>Table 3. Search strategy for Medline ALL on the Ovid platform.</th>
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</thead>
<tbody>
<tr>
<td><strong>Query</strong></td>
</tr>
<tr>
<td>1 (Physiotherapist or “Physical therapy” or “Physiotherapist” or “Physical therapists”),tw. or (exp Physical Therapists/)</td>
</tr>
<tr>
<td>2 (distress* or depress* or anxii or suicid*, “self-injury,” “self-harm” or “mental health” or “mental illness” or “mental illnesses” or “mental disorder” or “mental disorders” or “psychosocial factor” or “psychosocial factors” or “psychological factor” or “psychological factors”),tw. or (exp Psychological Distress or exp Depression or exp Anxiety or exp Self-Injurious Behavior or exp Mental Health)</td>
</tr>
<tr>
<td>3 (guide* or protocol* or pathway* or screen* or assess* or manag* or tool* or instrument* or questionnaire* or refer* or “decision making”),tw. or (exp disease management or exp Practice Guidelines as Topic or exp risk assessment or exp Decision Making or exp Mass Screening or exp Surveys and Questionnaires or exp Referral and Consultation/)</td>
</tr>
</tbody>
</table>

Note: tw = Text Word (title and abstract); exp = Exploded Subject Heading. The Boolean operator “and” combined queries 1 and 2 and 3. Limiters of publication date (1/1/1990 to 30/05/2023 inclusive) will be used. Terms sourced from the Ovid MEDLINE controlled vocabulary thesaurus are preceded by “exp.”
Results

Overview

The search returned 6925 articles (Figure 1). After the removal of duplicates (3041) the titles and abstracts of 3884 articles were screened for relevance. Of these, 185 articles were identified as potentially relevant. Subsequent full text review identified 21 articles as meeting the eligibility criteria of the systematic mapping review. Screening of the reference lists and a citation search using Scopus led to the identification of 13 further articles eligible for inclusion. Six other eligible articles known to the authors were also included in the review. In sum, 40 secondary or tertiary scholarly articles met the eligibility criteria and were included in the review.

Table 4 summarizes the topics covered in the included articles and the contexts for which the recommendations they contained were intended. The majority of the articles (31/40) primarily offered guidance for physiotherapists on assessing and managing psychological distress in the context of people experiencing pain. Of these, eight articles focused on low back pain with other conditions of focus including: pelvic pain (3); pain associated with whiplash injuries (3); patellofemoral pain (1); cancer-related pain (1); and pain associated with temporomandibular disorders (1). The remaining articles provided guidance on the identification, assessment, and management of psychological distress in various other contexts including: acute care (1); post-intensive care (1); return to work rehabilitation (1); care of older adults (1); care of people with chronic physical illness (1); running activities postpartum (1); care of people with mild brain injuries (2); and care of people with depression (1).

Types and distribution of included articles

The articles identified were published from 1999 to 2023, with a majority (22/40) having been published during or after 2018 (Figure 2). The types of articles identified included thirteen perspectives, ten commentaries, nine reviews, four clinical practice guidelines, three masterclasses, and an editorial. One masterclass was published in two parts (Sterling, 2009; Sterling and Kenardy, 2008) and two perspectives were published as companion papers (Main et al., 2023, 2023). For the purpose of the current review, each article published in multiple parts or as companion papers was counted as a single article, given the close relationships between the components or companion parts. The articles were published across 13 journals, with over half published in...
Table 4. Recommended approaches identified in the review.

<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Country</th>
<th>Type</th>
<th>Topic</th>
<th>Clients</th>
<th>Identification/Assessment</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alappattu and Bishop (2011)</td>
<td>USA</td>
<td>Perspective</td>
<td>Treating pain-related fear</td>
<td>People with chronic pelvic pain</td>
<td>Routinely screen psychological variables, particularly pain-related psychological factors, using measures such as the STAI, FPQ, PCS. Continue to monitor psychological variables over the course of treatment. Pain-related fear assessment should be informed by the score on the screening tools, and interpreted through the FAM.</td>
<td>Physiotherapists can address pain-related fear using cognitive coping strategies, pain and psychological education, and appropriate trained physiotherapists could use cognitive-behavioral interventions. Refer to a mental health professional, such as a psychologist and/or sex therapist, if the results of screening tools warrant further evaluation. Use exercise as an intervention for depression, and adapt management to promote self-efficacy and empowerment, through strategies such as graded activity and offering clients “some choice.” Allow clients to vent therapeutically and involve others to reinforce social support. Clients with depression should be referred to mental health professionals, and those at risk of suicide should be immediately evaluated by a medical or mental health professional.</td>
</tr>
<tr>
<td>Billek-Sawhney, Wagner, and Braun (2014)</td>
<td>USA</td>
<td>Perspective</td>
<td>Screening for, and managing depression</td>
<td>People in acute care settings</td>
<td>Be observant to the signs and symptoms of depression. In inpatient settings, screen for depression using the 2-item PRIME-MD with Arroll’s “Help” question. Also mentions a three-question tool (Jamison, 2006). In outpatient settings, also consider screening through the interview and with intake forms, using the longer tools such as the GDS-15, BDI-II, or SDS. If risk of suicide is perceived, ask directly about suicidal ideation, and if confirmed, ask about plans, means, and intent.</td>
<td>Management of pain-related fear involves helping the person make sense of their pain along the five dimensions of the CSM, reflecting on the basis of these beliefs, discussing how these beliefs influence behavior, presentation of new information, and adopting new behaviors. Offer management strategies such as education and reassurance in relation to mild traumatic brain injury symptoms and prognosis, sleep hygiene, stress management, CBT, and collaborate with other health professionals when needed.</td>
</tr>
<tr>
<td>Bundi et al. (2017)</td>
<td>Australia</td>
<td>Commentary</td>
<td>Understanding pain-related fear</td>
<td>People with low back pain</td>
<td>Assess pain-related fear using the CSM framework, which involves asking questions such as “do you worry that your low back pain will impact all the other things you need to get done?” and “how hopeful are you for the future?” during the interview.</td>
<td>To address pain-related fear, using CFT (e.g., exposure with control, and making sense of pain) as an approach to promote safety learning. Refer to (and facilitate) co-care as needed.</td>
</tr>
<tr>
<td>Cancelliere and Mohammed (2019)</td>
<td>Canada</td>
<td>Commentary</td>
<td>Assessing and psychosocial factors</td>
<td>People with mild traumatic brain injury</td>
<td>Screen for common mental disorders (depressive disorders, anxiety disorders including PTSD), emotional regulation issues, apathy, aggression, irritability using the ACE symptom checklist, PHQ-9, GAD-7, PC-PTSD-5, and PCL-5. Screening for anxiety and depression should occur whenever the physiotherapist observes symptoms.</td>
<td>Use behavioral learning, and education to empower self-management and disconfirm unhelpful beliefs. Refer to a psychologist when comorbid mental health conditions (e.g. emotional distress and depression) are identified, ideally as part of integrated MDT.</td>
</tr>
<tr>
<td>Caneiro et al. (2022)</td>
<td>Australia</td>
<td>Perspective</td>
<td>Treating pain-related fear</td>
<td>People with musculoskeletal pain</td>
<td>Prior to the interview, screen all clients using a multidimensional screening tool such as the short form OMPBSQ-SF, SBST, or STAR! Musculoskeletal Tool. Use scores of individual items to guide interview. During the interview, explore client’s story, fears, worries, and concerns. Explore pain-related emotions with the CSM framework. Use behavioral experiments to explore emotional response to pain.</td>
<td>Use behavioral learning, and education to empower self-management and disconfirm unhelpful beliefs. Refer to a psychologist when comorbid mental health conditions (e.g. emotional distress and depression) are identified, ideally as part of integrated MDT.</td>
</tr>
<tr>
<td>Caneiro, Bunzi, and O’Sullivan (2021)</td>
<td>Australia</td>
<td>Masterclass</td>
<td>Role of beliefs</td>
<td>People with musculoskeletal pain</td>
<td>Prior to the interview use a multidimensional screening questionnaire (OMPSQ-SF). Use relevant items to guide the interview and to facilitate disclosure. During the interview, assess pain-related distress using the CSM, asking questions such as “does this pain get you down” and “do you worry about your pain?” In addition, explore general mental health including anxiety, mood, and stress. Use guided behavioral experiments to assess emotional response. If psychological factors are identified, or suspected, during the interview, follow-up with a screening tool or tools. Examples include the 2-item PRIME-MD, PROMIS Depression Item Bank, PROMIS Anxiety Item Bank, PROMIS Anger Item Bank, GAD-7, DRAM, SBST, PCS, FABQ, and TSK.</td>
<td>If screening is positive, particularly score for the DRAM and SBST, engage or refer for PIP, and/or a MDT approach with a psychologist. When psychosocial factors are identified, consider cognitive-behavioral therapy – informed techniques, education, and manual therapy.</td>
</tr>
<tr>
<td>Chimento, Frey-Law, and Sluka (2018)</td>
<td>USA</td>
<td>Perspective</td>
<td>Mechanism-based approach to physiotherapy</td>
<td>People with acute or chronic pain</td>
<td>If psychological factors are identified, or suspected, during the interview, follow-up with a screening tool or tools. Examples include the 2-item PRIME-MD, PROMIS Depression Item Bank, PROMIS Anxiety Item Bank, PROMIS Anger Item Bank, GAD-7, DRAM, SBST, PCS, FABQ, and TSK.</td>
<td>If screening is positive, particularly score for the DRAM and SBST, engage or refer for PIP, and/or a MDT approach with a psychologist. When psychosocial factors are identified, consider cognitive-behavioral therapy – informed techniques, education, and manual therapy.</td>
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**Table 4. (Continued).**

<table>
<thead>
<tr>
<th>Author</th>
<th>Country*</th>
<th>Type</th>
<th>Topic</th>
<th>Clients</th>
<th>Identification/Assessment</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daley et al. (2021)</td>
<td>USA</td>
<td>Clinical practice guideline</td>
<td>Assessment and management</td>
<td>People returning to work post injury/illness</td>
<td>During history taking, screen for yellow flags, including catastrophizing, fear aversion beliefs, kinesiophobia, low self-efficacy, and enquire about comorbidities such as anxiety and depression. When screening for yellow flags, use reliable and valid tools, such as the OMPSQ, WHQ, PACE Tool, BDRQ, TSK, PRODI, CPFI and FABQ, as part of the evaluation and throughout treatment.</td>
<td>If psychosocial barriers are present, then coordinate care and referral to a psychologist with the employer, worker, and other key stakeholders. Additionally incorporate PIP strategies, such as individual goal setting, motivational interviewing, education regarding activity pacing, problem solving, relaxation, and coping techniques into the plan of care.</td>
</tr>
<tr>
<td>De Baets et al. (2023)</td>
<td>Belgium</td>
<td>Commentary</td>
<td>Management of fear of movement</td>
<td>People with chronic musculoskeletal pain</td>
<td>Use a combination of an in-depth interview, screening tools (TSK, FABQ) and behavioral assessment to identify pain-related fear and avoidance. When screening using self-reported measures, item-based analysis is recommended over total score analysis.</td>
<td>To address pain-related fear, the authors recommend in vivo exposure therapy and discourage safety behavior.</td>
</tr>
<tr>
<td>Delitto et al. (2012)</td>
<td>USA</td>
<td>Clinical practice guideline</td>
<td>Assessment and management</td>
<td>People with low back pain</td>
<td>Effective screening for depression involves more than just generating a clinical impression. Use screening tools, such as the 2-item PRIME-MD, to screen for depression. When the screen is positive, the client should then complete a full-length depressive symptom questionnaire such as the PHQ or BDI. Similarly, screen for other severe psychiatric disturbances (e.g., anxiety), and pain-related distress (using FABQ and PCS). If affective symptoms are noted, consider diagnosis of (i) acute or subacute low back pain with related cognitive or affective tendencies, or (ii) chronic low back pain with related generalized pain.</td>
<td>Use education, counseling, graded exercise to address cognitive factors, affective tendencies and pain behaviors (e.g., depression, fear avoidance, and pain catastrophizing). Refer to a medical professional or mental health professional if the results of the interview and questionnaire suggest the presence of depressive symptoms. An immediate assessment by a medical professional and/or mental health professional is indicated for safety reasons if the client had a plan to harm himself/herself or others. A similar process could be used for clinicians who screen for other psychopathology (e.g., anxiety).</td>
</tr>
<tr>
<td>Donnelly, Brockwell, Reuning, and Moore (2022)</td>
<td>UK</td>
<td>Commentary</td>
<td>Whole-systems assessment</td>
<td>People returning to running postpartum</td>
<td>Screen psychological well-being using a validated tool, such as the EPDS or the CAPS-5. Consider assessment of fear of movement using the TSK, and if running being used as a coping strategy.</td>
<td>Refer to specialist clinicians when signs of excessive and obsessive beliefs and behaviors are observed, or when the results of the screening tests are suggestive of poor psychological wellbeing.</td>
</tr>
<tr>
<td>Edgerton et al. (2019)</td>
<td>USA</td>
<td>Literature review</td>
<td>Role in the BPS approach</td>
<td>People with chronic pain</td>
<td>Use the clinical interview to subjectively explore a person’s pain experience and psychosocial symptoms such as anxiety, trauma, and depression. Consider using tools such as the OMPSQ, SBST, FABQ, and PCS to assess for mental impairment.</td>
<td>Employ an interdisciplinary approach involving a psychotherapist. Education and exposure learning to target fear avoidance, and maladaptive thoughts, and CBT for pain-related distress.</td>
</tr>
<tr>
<td>Faulkner and Snell (2023)</td>
<td>New Zealand</td>
<td>Perspective</td>
<td>Framework for understanding psychosocial factors</td>
<td>People with persistent post-concussion symptoms</td>
<td>Screen for (i) acute psychological distress following concussion using the DASS-21 or HADS, (ii) preinjury mental health status using the STAI, or ASI, (iii) processes that drive psychological distress using tools such as the FAB-TBI, IPQ-R, C-scale, and SF-36.</td>
<td>Normalize emotional symptoms of concussion and acute stress reaction through education. Offer strategies, such as diaphragmatic breathing, to manage emotional symptoms of concussion. Referral for specialized mental health treatment, when indicated, such as in the presence of preexisting mental health problems.</td>
</tr>
<tr>
<td>George and Zeppieri (2009)</td>
<td>USA</td>
<td>Commentary</td>
<td>Fear-avoidance model</td>
<td>People with chronic low back pain</td>
<td>During the first session, assess fear-related to specific activities using the FDAQ. Reassess during management using the FDAQ. Also mentions the FABQ for assessment of general pain-related fear. The assessment is informed by the fear-avoidance model.</td>
<td>Manage pain-related fear and fear of activities using a behavioral approach. Items ranked 40/100 on the FDAQ or higher are targeted as part of graded exposure. Education is used to support adaptive coping strategies, and exercise prescription is a part of graded exposure.</td>
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<tr>
<td>Harland and Lavallee (2003)</td>
<td>UK</td>
<td>Literature review</td>
<td>Psychological assessment and management</td>
<td>People with chronic low back pain</td>
<td>Routinely screen for depression and anxiety using the HADS, and SDS, or DRAM. Also mentions the YFQ, and CSQ. However, results from the HADS and SDS should only be used in audit measurement and as referral criteria for psychological input, unless trained and authorized to act on these assessments.</td>
<td>Referral is recommended when scores suggest the presence of anxiety or depression, which requires an evaluation from a mental health professional. Management when psychological factors are present involves taking an active, rather than passive treatment approach to avoid reinforcing maladaptive behaviors.</td>
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<tr>
<td>Harrison, Thorp, and</td>
<td>USA</td>
<td>Commentary</td>
<td>Diagnostic classification People with</td>
<td>People with temporomandibular disorders</td>
<td>Screening for psychological issues occurs during the clinical interview, or in the waiting room prior through the use of questionnaires such as the PHQ-ADS. During the clinical</td>
<td>Provide education and use pain-modulation strategies such as stress reduction, sleep hygiene,</td>
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<td>and Ritzline (2014)</td>
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<td>interview, listen for signs and disclosures of depression, anxiety, and psychological stress. When diagnosing temporomandibular disorder, the examination involves</td>
<td>physical activity and diaphragmatic breathing. When major psychological disorders such as moderate</td>
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<td>psychosocial aspects (such as depression anxiety, fear and anger) that either foundationally or indirectly contribute to the primary symptoms.</td>
<td>to severe depression, anxiety, and/or pain-related disability are identified, refer to a</td>
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<td>behavioral health specialist.</td>
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<tr>
<td>Hodges (2019)</td>
<td>Australia</td>
<td>Commentary</td>
<td>Hybrid approach to a model of care People with low back pain</td>
<td>SBST. After stratification, those classified as medium risk have their pain mechanism classified using the combination of interview, questionnaires, and clinical</td>
<td>For those classified as high-risk, consider/use psychological treatments including behavioral therapies, pain coping</td>
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<td>examination of pain system function. As part of this process, psychological features are assessed using the DASS-21, CES-D, FABQ, and PCS.</td>
<td>treatments such as stress reduction, sleep hygiene, physical activity and diaphragmatic breathing.</td>
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<td>For those classified as medium-risk, treatments vary depending on pain mechanism and may include</td>
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<td>pain education, reassurance, psychologically informed interventions, fear conditioning, acceptance,</td>
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<td>graded activity and social intervention. Referral to a psychologist for specialist psychological</td>
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<tr>
<td>Linton and Shaw (2011)</td>
<td>Sweden</td>
<td>Perspective</td>
<td>Incorporating psychological factors into</td>
<td>People with chronic pain</td>
<td>Routinely screen for mood symptoms during intake and initial consultation. After 2 weeks, if no immediate resolution screen for yellow flags and take a thorough clinical</td>
<td>Psychological treatments is indicated for those classified as high risk, and those classified as</td>
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<td>history looking for pain-related distress (e.g. fear avoidance and pain catastrophizing) and other forms of preexisting distress.</td>
<td>medium risk with neuropathic pain and central pain mechanisms.</td>
</tr>
<tr>
<td>Linton, Flink, and</td>
<td>Sweden</td>
<td>Perspective</td>
<td>A psycho-etiopathological approach People with chronic pain</td>
<td>Through the combination of a clinical interview and psychological screening with tools such as the OMPSQ, transdiagnostic factors can be identified. These</td>
<td>Treatments target transdiagnostic factors to deal with problem as a whole, such as those factors that underpin pain-related distress. Examples of interventions include education/communication, exposure training, and coping planning.</td>
<td>Physiotherapists can address pain-related fear through graded exposure, self-management, problem-solving strategies, and return-to-work planning. Appropriately trained clinicians can address pain-related distress (fear, anxiety, depression) with acceptance and commitment, cognitive-behavioral therapy, activation, relaxation, and positive psychology techniques.</td>
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<tr>
<td>Vlaeyen (2018)</td>
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<td>transdiagnostic processes include forms of distress such as worry, general anxiety, avoidance, and catastrophizing. Pain-related fear should be assessed subjectively and with</td>
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<tr>
<td>Main and Watson (1999)</td>
<td>UK</td>
<td>Review</td>
<td>Psychological aspects of pain</td>
<td>People with pain</td>
<td>behavioral indicators of fear such as guarded movement. Tools used to screen and identify pain-related distress may include pain drawing (not as a standalone), behavioral</td>
<td>If pain-related distress is observed, psychologically oriented treatment such as a pain management program may be needed. Physiotherapists should offer education and reassurance to the client about their pain. Pain-related depression may be treated with a cognitive behavioral approach. Unless psychiatrically ill, a referral may be harmful and magnify distress.</td>
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<tr>
<td>Main et al. (2023) and Main et al. (2023)</td>
<td>USA</td>
<td>Perspective</td>
<td>Communication in psychologically informed practice</td>
<td>People with chronic pain</td>
<td>Prior to the interview, have the client complete a tool such as the SBST, OMPSQ-SF, or OSPRO-YF. Facilitate self-disclosure by being open about the context of the consultation and the focus of the assessment. Use the aforementioned tools to inform the interview. Ask about pain interference to explore its impact and how they are coping with it using questions such as “You noted that pain here was an 8/10, so your pain is clearly significantly troublesome.” Consider using the aforementioned tools as a treatment monitoring tool.</td>
<td>The role of the physiotherapists in management is like that of a coach, with the focus on re-engagement in usual activities. Management has a specific focus on addressing obstacles, which may include psychological factors. Addressing psychological factors may involve facilitating behavior change to help the client cope with their pain through education, CBT, ACT, motivational interviewing, guarded optimism, stress reduction and mindfulness. The management approach should be the product of shared decision-making. It is also important to revisit any psychological obstacles during management.</td>
</tr>
<tr>
<td>Nijs et al. (2019)</td>
<td>Belgium</td>
<td>Masterclass</td>
<td>Pain neuroscience education</td>
<td>People with cancer-related pain</td>
<td>Consider assessing pain-related distress through the interview and with questionnaires such as the Brief IPQ, PCS, TSK, PIPS, and FPQ. Use the STAI, BDI, and HADS to screen for depression and anxiety.</td>
<td>Management pain-related distress with biopsychosocially-driven pain management strategies, including acceptance-based interventions, stress-management, graded exposure and education (including pain neuroscience education).</td>
</tr>
<tr>
<td>O’Sullivan et al. (2018)</td>
<td>Australia</td>
<td>Perspective</td>
<td>Description of CFT</td>
<td>People with low back pain</td>
<td>Prior to interview, use a multidimensional screening questionnaire (e.g. the OMPSQ). Explore the client’s story and listen for any signs of fear and pain-related distress. During the interview, directly ask clients about their emotional response to pain, such as depressed mood (e.g. does it get you down? In what way?) and anxiety (e.g. Do you worry about the pain?). Use guided behavioral strategies to assess pain response such as pain-related distress.</td>
<td>Manage pain-related distress with biopsychosocially-driven pain management strategies, including acceptance-based interventions, stress-management, graded exposure and education (including pain neuroscience education).</td>
</tr>
<tr>
<td>O’Sullivan, Smith, Beales, and Straker (2017)</td>
<td>Australia</td>
<td>Commentary, Multidimensional Perspective</td>
<td>Adolescents with low back pain</td>
<td>During the clinical interview, explore the adolescent’s story and concerns noting signs of psychological distress (anxiety and depressed mood) and other psychosocial factors. To facilitate this, use a multidimensional screening questionnaire, such as the OMPSQ, and SBST.</td>
<td>As part of a CFT management approach, provide education regarding the association between pain and distress, provide reassurance, and reinforce learning through experiential learning. Consider support from others including guardians and a psychologist (and other health professionals) when pain is disabling, and related with high levels of depressed mood, anxiety, and social stress.</td>
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<tr>
<td>Rabey and Moloney (2022)</td>
<td>UK</td>
<td>Perspective</td>
<td>Integrating allostatic load into practice</td>
<td>People with musculoskeletal pain</td>
<td>Through the clinical interview and use of screening tools, screen for psychological stressors (e.g. anxiety). Use screening tool (e.g. OMPSQ) prior to consultation or at the start of the consultation. If indicated, explore further during the interview and consider a more specific questionnaire (e.g. DASS and FABQ). During the interview, explore potential psychological stressors (e.g. adverse childhood experiences, sustained emotional stress, and severe trauma), their relevance to the presentation, and management of such stressors. Be observant for signs of hyper-related or hypo-arousal states. Examine pain/ movement-related distress responses through movement-based physical examination. Use a clinical reasoning framework (Mitchell, Beales, Slater, and O’Sullivan, 2018) or a bubble diagram to clinically reason the relative contributions of the examination results.</td>
<td>If psychological assessment and management is beyond the individual scope of the clinician, refer onwards to a health professional skilled in that area. Management is likely to be highly individualized and emerges from a client-centered shared-decision process. Examples of management approaches may include mindfulness, stress inoculation, meditation and breathing practices, sleep interventions; however, consider timescales/resources available such as access to psychotherapy if necessary. Management may be multidimensional, however, a predominantly unidimensional approach with limitations discussed may also be appropriate.</td>
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<tr>
<td>Rebbeck (2017)</td>
<td>Australia</td>
<td>Commentary</td>
<td>Review of exercise, education, and behavioral interventions</td>
<td>People with whiplash</td>
<td>For WAD grades I to III, assess psychological distress (including post-traumatic stress), pain catastrophizing, and fear avoidance during initial consult for chronic whiplash, or 3 weeks after for acute whiplash. In some instances, assessment of psychological factors before 3 weeks may be indicated for acute whiplash. For chronic whiplash, reassess psychological distress again before 6 months. Consider exercise plus behavioral therapy approach when person is experiencing high pain levels, high disability, and psychological distress. Consider referral to a psychologist if high levels of psychological distress are noted.</td>
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<tr>
<td>Simon and Hicks (2018)</td>
<td>USA</td>
<td>Perspective</td>
<td>Comprehensive management approach</td>
<td>Older adults with low back pain</td>
<td>Screen for depression using the GDS or CES-D. With the exception of depressive symptoms, which the authors state is beyond the scope of physiotherapists to assess, they recommend assessment of pain-related fear using the PCS or FABQ, and assessment of pain catastrophizing using the PCS. Use cognitive-behavioral physical therapy to manage psychological distress when it is a symptom of client's low back pain. Cognitive-behavioral physical therapy include mindfulness, mindfulness-based exercise (e.g. tai chi and graded tasking). The mindfulness interventions may help with general distress. Refer/communicate with the primary care physician when depressive symptoms are identified.</td>
<td>Refer to a physician and/or a mental health professional if the EPDS score is 10 or above. For suicidal ideation, if any positive response to item 10 on the EPDS, should be considered a red flag and immediately referred to the emergency department. Physiotherapists should establish connections with mental health professionals in anticipation of referrals.</td>
</tr>
<tr>
<td>Simonds, Abraham, and Spitznagle (2022)</td>
<td>USA</td>
<td>Clinical practice guideline</td>
<td>Assessment and management</td>
<td>People with pelvic girdle pain during the postpartum period</td>
<td>Screen for mood disorders and suicidal ideation using the EPDS. Consider screening for aspects of low mood and anxiety not captured by the EPDS using additional scales. Also consider use of questionnaires for fear and kinesiophobia, particularly for those with persistent pelvic girdle pain or those not responding well to management. Coordinate care with an interprofessional team, when symptoms of depression, anxiety, and PTSD in clients are identified. This may involve a referral to a mental health professional or other specialists. Consider encouraging clients to access peer-support groups where survivors of critical illness can connect and support each other's recovery.</td>
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<tr>
<td>Smith et al. (2020)</td>
<td>USA</td>
<td>Perspective</td>
<td>Assessment and management</td>
<td>People with post – intensive care syndrome</td>
<td>Screen all clients with a history of hospitalization, particularly those who required intensive care unit (ICU) care, for depression and anxiety using the HADS. The authors also mentioned the 2-item PRIME-MD but caution against its use in this context. Use the IES-R to screen for PTSD symptoms. For clients with chronic physical illness, general advice to promote wellbeing would be staple practice for many therapists, for example: promoting healthy eating, avoiding excess alcohol and smoking, and taking regular exercise. All clients suspected to be experiencing depression to be referred for a full evaluation and diagnosis.</td>
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<tr>
<td>Spearling and Bailey (2012)</td>
<td>UK</td>
<td>Analytical literature review</td>
<td>Screening for, and managing depression</td>
<td>People with chronic physical illness</td>
<td>Screen all clients with the 2-item PRIME-MD. If positive, follow up with a validate measure of depression, such as the PHQ-9, BDI-II, BDI-PC, CES-D, and SDS. Engage in further questioning regarding depressive symptoms if competent to do so.</td>
<td>(Continued)</td>
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<tr>
<td>Stearns et al. (2021)</td>
<td>USA</td>
<td>Commentary</td>
<td>Screening and managing psychosocial factors</td>
<td>People with musculoskeletal pain</td>
<td>Screen all clients using a multidimensional screening tool such as OSFRO-YF, SBST, and OMPQ. Also cites the PROMIS Depression Item Bank and PROMIS Anxiety Item Bank. Alternatively, screen clients who don’t respond to routine care after 4–6 weeks. Assess psychosocial factors identified during initial screening with multidimensional measures and relevant unidimensional screening tools, such as the PCS, TSK, FABQ, PASS-20. Scores on screening tools can guide the clinical interview. Psychological factors should be reassessed every 2 weeks to monitor progress.</td>
<td>Management of psychosocial factors is largely within the scope of physiotherapy, and physiotherapists should establish a referral network. Management options include standard physiotherapy, psychologically informed physiotherapy, psychologically informed physiotherapy with referral, and immediate referral. Psychologically informed physiotherapy involves motivational interview, self-management, cognitive behavioral strategies, and coping skills. If the physiotherapist feels ill equipped to manage pain-related distress, perceives that additional specialized care may be beneficial, or there are symptoms of mental illness then a referral should occur. Cotreating after referral to a psychological service is appropriate. In the event of signs of serious mental illness such as clinical depression and suicidality, an immediate referral is indicated.</td>
</tr>
<tr>
<td>Sterling (2014)</td>
<td>Australia</td>
<td>Review</td>
<td>Physical and psychological assessment</td>
<td>People with whiplash injuries</td>
<td>Based on client history and interview, select a questionnaire based on the symptoms noted. For example, the IES for post-traumatic stress symptoms, PHQ-9 for depression, or the PCS for pain catastrophizing.</td>
<td>If moderate levels of psychological distress are measured with the relevant questionnaire, physiotherapists can address this as part of psychologically informed physiotherapy if they are confident to do so. If high levels of distress are identified, or the distress is persisting after a period of psychologically informed physiotherapy, a referral to the client’s general practitioner or a clinical psychologist is recommended. Advice and reassurance may help alleviate some distress during the initial period post injury. Referral for a psychological evaluation should occur after 3 to 4 weeks if recovery is not apparent, because early psychological referral could interfere with normal recovery. If referral for a psychological evaluation is indicated, co-care should occur.</td>
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<tr>
<td>Sterling and Kenardy (2008), Sterling (2009)</td>
<td>Australia</td>
<td>Masterclass</td>
<td>Physical and psychological assessment</td>
<td>People with whiplash injuries</td>
<td>Use the IES (or IES-R) to screen for post-traumatic stress symptoms, and the GHQ-28 and SF-36 for general psychological distress. Fear-avoidance and catastrophizing could also be assessed.</td>
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<tr>
<td>Van Wyngaarden, Noehren, and Archer (2019)</td>
<td>USA</td>
<td>Restricted literature review</td>
<td>Assessing psychosocial profile</td>
<td>People with musculoskeletal pain</td>
<td>Screen all clients with the PHQ-2 and OSFRO-YF. With clients with LBP, use SBST and then the OSFRO-YF at follow-up to reduce client burden. If PHQ-2 is positive, complete PHQ-9. Based on scores of OSFRO-YF, classify as noncontributory psychosocial profile, moderate psychosocial profile, moderate-to-high psychosocial profile, or high psychosocial profile. Consider further assessment using unidimensional assessment tools such as the PCS and TSK. Continue to monitor psychosocial profile using screening tools.</td>
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<tr>
<td>Vandyken and Hilton (2017)</td>
<td>Canada</td>
<td>Literature review</td>
<td>Treatment of Central Pain Mechanisms</td>
<td>Women with sexual pain</td>
<td>During history taking, look for personal challenges or threats that occurred when the pain began. Use screening tools to assess pain-related negative appraisals and cognitions, such as the PCS and TSK. Assess for mental distress using the DASS-21.</td>
<td>Engage in the following management if within the individual physiotherapist’s scope of practice or refer on if not. To manage stress, anxiety, catastrophizing, and fear avoidance, suggested interventions include pain education, mindfulness meditation, and CBT. In addition, breathing exercises, yoga, and sleep hygiene for stress, a self-soothing routine and gratitude training for anxiety, social support is recommended for catastrophizing, and CFT, graded exposure, and graded motor imagery for fear avoidance.</td>
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<tr>
<td>Varela and Melvin (2023)</td>
<td>USA</td>
<td>Narrative Review</td>
<td>Role of physiotherapy</td>
<td>People with depressive disorders</td>
<td>Screen for depressed mood and diminished interest as part of the standard health status intake questionnaire. To assess severity of depression, use the PHQ-9. Screening for suicide occurs as part of the assessment of depression, with item nine on the PHQ-9 being used to screen for suicide. Assessment of depressive symptoms continues after the initial screening process.</td>
<td>When depression is suspected, collaborate with mental health professionals. Immediately refer any client at imminent risk of suicide or self-harm to the client’s health care team. Suicidality without immediate risk should still be communicated with a mental health professional and referer. While direct treatment of depression is beyond scope, interventions of the mind and body awareness (e.g. physical activity), mindfulness training, and sleep hygiene education can have an impact on depression. PHQ-2 scores of 2 or 3+ should be referred to for a mental health evaluation. Physiotherapists play a role in facilitating referrals, which may involve education, mirroring the client’s language, encouragement, and discussing referral in the context of other mental health conditions (e.g. poststroke depression). Clients experiencing persistent depressive symptoms should also be referred.</td>
</tr>
<tr>
<td>Veira, Brown, and Ruas (2014)</td>
<td>USA</td>
<td>Selective literature review</td>
<td>Screening for, and managing depression</td>
<td>Older adults</td>
<td>Screen clients with the PHQ-2, and if positive, complete PHQ-9. Also consider using the GDS-15. Suggests that physiotherapists go beyond the use of screening tools in their assessment; however, does not provide further details, instead referring the reader to other training material.</td>
<td>Physiotherapists play a key role in managing pain-related distress, such as targeting treatment at reducing fears and increasing activity. Non-pain-related distress, such as distress related with marriage or financial issues should prompt a referral to a mental health professional. Management may also involve joint multidisciplinary or interdisciplinary management.</td>
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<tr>
<td>Watson (1999)</td>
<td>UK</td>
<td>Editorial</td>
<td>Psychological assessment</td>
<td>People with musculoskeletal pain</td>
<td>Use the clinical interview to explore client’s psychological wellbeing, and if the client does not respond to treatment, formally screen for depression, anxiety, poor coping, injury/pain-related fear, avoidance beliefs, somatic anxiety stress high self-report of stress or anxiety, using psychosocial questionnaires such as DRAM, and the OMPSQ.</td>
<td>During pain neuroscience education, if pain-catastrophizing, anxiety, depression, perceived injustice, PTSD, and stress are identified, then education between the interplay of mental health and the pain neuromatrix is provided. In addition, basic psychological support should be included such as acknowledgment, and comfort. To inform referral, physiotherapist asks themselves “is this patient (with chronic pain) in the right place here with me, or should he/she be treated in a multidisciplinary setting or referred to another provider?”</td>
</tr>
<tr>
<td>Wijma, van Wilgen CP, Menus, and Nijs (2016)</td>
<td>Belgium</td>
<td>Perspective</td>
<td>Biopsychosocial assessment</td>
<td>People with chronic pain</td>
<td>Ask specifically about emotional factors related to pain, such as psychological issues arising from work, family, financial, or social stressors; psychological traumatic onset of the pain, and fear of movement. Screen for perceived injustice (a form of anger) using the IEQ. To assess pain-related distress, use the PCS, Brief IPQ, and if necessary, the TSK. To screen for anxiety and depression use clinical questioning. If necessary, consider using a tool such as the STAI-CED-S, PHQ-2, and PHQ-9. Screen for PTSD and stress through the clinical interview.</td>
<td>Based on screening and examination, determine whether the client is (i) appropriate for physiotherapy alone, (ii) appropriate for physiotherapy as a part of co-care with another mental health professional, or (iii) not appropriate for physiotherapy. If psychosocial factors are identified, consider cognitive behavioral treatments, reassurance, and graded exposure to activity.</td>
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<tr>
<td>Willy et al. (2019)</td>
<td>USA</td>
<td>Clinical practice guideline</td>
<td>Assessment and management</td>
<td>People with patellofemoral pain</td>
<td>Screen for psychological factors that require a referral to a mental health professional. Screen for anxiety, depression, fear avoidance, kinesiophobia, and catastrophizing using the OSPRO-YF, FABQ, and the PCS.</td>
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</table>

36-Item Short Form Survey (SF-36), Acute Concussion Evaluation symptom checklist (ACE), Beck Disability Risk Questionnaire (BRDQ), Beck Depression Inventory (BDI), Beck Depression Inventory 2ND Edition (BDI-II), Beck Depression Inventory for Primary Care (BDI-PC), Brief Illness Perception Questionnaire (Brief IPQ), Center for Epidemiological Studies Depression (CES-D), Clinician-Administered PTSD Scale for DSM-5 (CAPS-5), Cognitive Behavioral Therapy (CBT), Cognitive Functional Therapy (CFT), Cogniophobia Scale (C-scale), Cumulative Prognostic Factor Index (CPF1), Depression Anxiety and Stress Scales (DASS), Depression Anxiety and Stress Scales – 21 item (DASS-21), Distress and Risk Assessment Method (DRAM), Edinburgh Postnatal Depression Scale (EPDS), Fear Avoidance Behavior after Traumatic Brain Injury Questionnaire (FAB-TBI), Fear Of Daily Activities Questionnaire (FADQ), Fear of Pain Questionnaire (FPQ), Fear-Avoidance Beliefs Questionnaire (FABQ), General Anxiety Disorder-7 (GAD-7), General Health Questionnaire (GHQ-28), Geriatric Depression Scale (GDS), Hospital Anxiety and Depression Scale (HADS), Impact of Event Scale (IES), Injustice Experience Questionnaire (IEQ), Optimal Screening for Prediction of Referral and Outcome (OSPRO-YF), Osteoarthritis Pain Question – short form (OMPQ-5F), Osteoarthritis Musculoskeletal Pain Question (OMPSQ), Pain Anxiety Symptom Scale (PASS-20), Pain Catastrophizing Scale (PCS), Patient Health Questionnaire (PHQ-2), Patient Health Questionnaire (PHQ-9), Patient Health Questionnaire Anxiety and Depression Scale (PHQ-ADS), Patient-Reported Outcome Measurement Information System Anger (PROMIS Anger), Patient-Reported Outcome Measurement Information System Depression (PROMIS Depression), Plan of Action for a Case (PACE Toolkit), Posttraumatic Stress Disorder Scale (PTSD), Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5), Psychological Flexibility in Pain Scale (PFP), Psychosocial Risk for Occupational Disability Instrument (PRODI), Revised Illness Perception Questionnaire (IPQ-R), Revised Impact of Event Scale (IRES-S), START Back Screening Tool (SBST), State-Trait Anxiety Inventory (STAI), Tampa Scale for Kinesiophobia (TSK), Work and Health Questionnaire (WHQ), Zung Self-Rating Depression Scale (ZDS).
either the Journal of Orthopaedic and Sports Physical Therapy (12) or the Physical Therapy and Rehabilitation Journal (11). The most common country listed as the address for the corresponding author was the United States (17). Of the authors whose clinical backgrounds could be ascertained (n = 122) there were 94 physiotherapists, 18 psychologists including one in training, one dual-qualified physiotherapist and psychologist, five physicians, two chiropractors including one in training, a counselor, and a nurse practitioner. With the exception of three articles (Cancelliere and Mohammed, 2019; Faulkner and Snell, 2023; Linton, Flink, and Vlaeyen, 2018) all were authored or coauthored by at least a physiotherapist. Fifteen articles were authored by at least one psychologist.

**Identification and assessment of psychological distress**

All articles recommended the use of the clinical interview and/or a screening or assessment tool to identify and evaluate psychological distress. The screening and assessment tools identified in this review as recommended for use by physiotherapists are listed in Table 5. Screening for psychological distress was recommended and considered within the scope of physiotherapy practice in all included articles, for example:

- Screening and addressing behavioral and mental health concerns is within the scope of the physiotherapy practice guidelines (Varela and Melvin, 2023).

However, there was a consensus that the formal assessment of psychopathology is beyond the scope of physiotherapy.

It is rightly beyond the scope of physiotherapy practice formally to assess and treat specific psychological disorders (Watson, 1999).

It was suggested that physiotherapists have a responsibility to screen for depression and other mental disorders, such as generalized anxiety disorder and post-traumatic stress disorder (Donnelly, Brockwell, Rankin, and Moore, 2022; Smith et al., 2020; Varela and Melvin, 2023). Further limitations on the scope of physiotherapy in the assessment of mental health were highlighted by Harland and Lavallee (2003). Harland and Lavallee (2003) noted that without training, physiotherapists may not be able to use some questionnaires due to practical and legal issues:

- Recognised training is necessary, both practically and legally, when dealing with questionnaires such as the Hospital Anxiety and Depression scale and Zung Depression Inventory (Harland and Lavallee, 2003).

In contrast, the assessment of psychosocial factors, including health-related psychological distress (i.e.
mainly pain-related distress) was generally viewed to be within the scope of the physiotherapy profession. This assessment of health-related psychological distress allows physiotherapists to determine whether or not its management falls within their individual scope of practice.

The assessment of mental distress is another central aspect of pain research and treatment. When failing to measure these psychosocial factors, physical therapists lose the opportunity to address them in treatment when it is within their scope of practice (Vandyken and Hilton, 2017).

It was commonly acknowledged that there are differences between the scope of the physiotherapy profession in assessment of health-related distress, and the scope of an individual physiotherapist, for example:

It is acknowledged that each clinician has an individual scope of practice and may need to upskill or refer onwards for some components of multidimensional assessment/management (Rabey and Moloney, 2022).

Three general approaches to the identification and assessment of psychological distress were identified in this review and are now discussed in turn. Other approaches were also identified and are reported in Table 4.

**Brief depression screen**

An approach for physiotherapists recommended by several authors was to routinely screen for depression using a brief 2-item depression screen, followed by a longer screening tool when the 2-item screen is positive (Delitto et al., 2012; Spearing and Bailey, 2012; Vieira, Brown, and Raue, 2014; Wijma, van Wilgen CP, Meeus, and Nijs, 2016).

An efficient strategy is to complete the PHQ-2 and then complete the 7 remaining symptoms [in the PHQ-9] for those with a positive initial screen (Vieira, Brown, and Raue, 2014).

Due to its brevity, the brief 2-item depression screen could be verbal administered during the consultation or completed via self-report using the Patient Health Questionnaire-2 (PHQ-2).

Verbally Screening for Depression: 1. During the past month have you been feeling down, depressed, or hopeless? 2. During the past month have you been bothered by having little interest or pleasure in doing things? (Billek-Sawhney, Wagner, and Braun, 2014)

In addition to administering a longer depression screen, Delitto et al. (2012) and Spearing and Bailey (2012) suggested that physiotherapists should further explore the person’s depressive symptoms through the clinical interview, if competent.

A patient with a positive screening result for major or severe depressive symptoms should receive a focused clinical interview and should complete a full-length depressive symptom questionnaire (Delitto et al., 2012).

Billek-Sawhney, Wagner, and Braun (2014) recommended a similar approach to screening for depression in the inpatient acute care setting. However, instead of completing the nine item Patient Health Questionnaire (PHQ-9) or a similar tool, Billek-Sawhney, Wagner, and Braun (2014) recommended a third question, “is this something with which you would like help?” be added to the initial two screening questions, due to time constraints faced by physiotherapists in this context. Smith et al. (2020) cautioned against the use of the 2-item depression screen with people experiencing post - intensive care syndrome, as the approach has not been validated with this population. While the above approach was described in reference to depression, Delitto et al. (2012) suggested that a similar process could be used for clinicians who screen for other psychopathology (e.g. anxiety).

**Integrated suicide/nonsuicidal self-harm and depression screen**

As part of the depression screening, several authors also suggested that nonsuicidal self-harm and suicidal distress should be screened for (Delitto et al., 2012; Harrison, Thorp, and Ritzline, 2014; Simonds, Abraham, and Spitznagel, 2022; Stearns et al., 2021; Van Wyngaarden, Noehren, and Archer, 2019; Varela and Melvin, 2023; Vieira, Brown, and Raue, 2014). For example:

The screening for suicide occurs in part through assessment of depression (Varela and Melvin, 2023).

While not all authors who recommend the use of the PHQ-9, Patient Health Questionnaire Anxiety and Depression Scale (PHQ-ADS), Edinburgh Postnatal Depression Scale (EPDS), Beck Depression Inventory (BDI), or Zung Self-Rating Depression Scale (ZSDS) mentioned that these questionnaires ask about some aspect of suicidality, Varela and Melvin (2023) and Simonds, Abraham, and Spitznagel (2022) drew specific attention to this, within the PHQ-9 and EPDS, respectively:

The 9-item questionnaire . . . include[s] suicidal ideation . . . [Specifically] the sense of hopelessness is elaborated upon in the ninth question that screens for suicidal ideation . . . Higher scores on the ninth
question prompts clinicians to discuss suicidal ideations with their patients, referring practitioners, and mental health providers (Varela and Melvin, 2023).

Any positive response to the suicidal ideation on item #10 [of the EPDS] (even with a score < 10) should be considered a red flag . . . (Simonds, Abraham, and Spitznagel, 2022).

When suicidal ideation was identified, Billek-Sawhney, Wagner, and Braun (2014) and Varela and Melvin (2023) recommended that these thoughts be explored, such as if the person has a plan for suicide and means available to them:

Any messages expressed by the patient related to suicide must be followed up . . . Follow-up questions should explore whether the patient has a plan, has means/access, and has intent to harm. ‘Attempted suicide should be considered a cry for help’ (Billek-Sawhney, Wagner, and Braun, 2014).

Multidimensional screen and health-related distress assessment

An approach commonly recommended for physiotherapists practicing in pain, disability, and musculoskeletal settings involved conducting an initial screen of all patients attending with pain-related issues followed by further assessment of positive or concerning findings (Caneiro et al., 2022; Caneiro, Bunzli, and O'Sullivan, 2021; Hodges, 2019; Main et al., 2023, 2023; O'Sullivan et al., 2018; O'Sullivan, Smith, Beales, and Straker, 2017; Rabey and Moloney, 2022; Stearns et al., 2021). It was recommended that a multidimensional screening tool, such as the Örebro Musculoskeletal Pain Questionnaire (OMPQ), the Optimal Screening for Prediction of Referral and Outcome Yellow Flag (OSPRO-YF), the Keele STarT Back Screening Tool (SBST) or the Keele STarT Musculoskeletal Tool be employed as the use of multiple full-length unidimensional tools to assess several psychological constructs could result in an excessive administrative burden for the client and the physiotherapist during an initial consultation. To further reduce administrative burdens it was recommended by several authors that screening prior to the physiotherapy consultation be carried out using self-report questionnaires and multidimensional instruments, for example:

Multidimensional tools (eg, the OSPRO-YF and the Örebro Musculoskeletal Pain Questionnaire) are an attractive option for screening because they evaluate multiple dimensions of distress with low response burden (Stearns et al., 2021).

Relevant items from the multidimensional screening tools can subsequently be explored by the physiotherapist as part of the clinical interview and with unidimensional tools, exploring constructs relating to pain such as pain and/or movement-related fear and anxiety.

The use of a screening questionnaire prior to the interview provides the clinician with a perspective on the person’s pain and disability levels, cognitions, and emotions, providing opportunity for targeted exploration of their concerns within the interview (Caneiro et al., 2022).

Unidimensional tools, such as the Pain Catastrophizing Scale, the Tampa Scale of Kinesiophobia, and the Fear-Avoidance Beliefs Questionnaire were commonly recommended in the included articles (see Tables 4 and 5). The exploration of pain-related distress as part of a clinical interview was informed by several psychological theories and approaches, including the Fear Avoidance Model, the transdiagnostic approach, fear learning, and the Common-Sense Model (Bunzli et al., 2017; Caneiro et al., 2022; George and Zeppieri, 2009; Linton, Flink, and Vlaeyen, 2018). For example, Bunzli et al. (2017) described how the Common-Sense Model can be used as a clinical framework to assess pain-related fear. While the Common-Sense Model primarily explores illness representations, the construct referred to as emotional response requires specific questioning to identify and characterize pain-related distress (Caneiro, Bunzli, and O'Sullivan, 2021):

How does the pain make you feel?
How do you feel about losing the ability to do things you love?
Does this pain get you down?
Do you worry about your pain?
Do you fear your pain or doing damage to yourself?

To understand the experience of a person’s pain-related distress, it was recommended that physiotherapists adopt a narrative style of assessment in which the lived experience and context of the person’s pain and movement-related fears are considered (Caneiro et al., 2022; Caneiro, Bunzli, and O'Sullivan, 2021; De Baets et al., 2023; O'Sullivan et al., 2018; O'Sullivan, Smith, Beales, and Straker, 2017). Similarly, Linton, Flink, and Vlaeyen (2018) emphasized the importance of physiotherapists understanding the person’s broader context, as this might shed light on the mechanisms shared by co-occurring problems such as pain and generalized anxiety. Going further, Rabey and Moloney (2022) recommended a thorough assessment of pain-related stressors, including concurrent generalized psychological distress, early-life stress and trauma including
adverse childhood experiences and episodes of extreme stress.

The clinical interview allows in depth exploration regarding potential physical and psychological stressors, their relevance to the individual’s presentation, and any management of such stressors undertaken (eg, psychotherapy, sleep hygiene, alterations to training) (Rabey and Moloney, 2022).

In addition, several authors recommended guided behavioral assessments/experiments as part of a movement and activity-related fear assessment conducted by physiotherapists (Caneiro et al., 2022; De Baets et al., 2023; O’Sullivan et al., 2018).

Thorough behavioral assessment is imperative, even for patients who do not self-report high levels of fear of movement as it may highlight within-person discrepancies. An emotional response may only be triggered when one is confronted with the feared activity or when one believes the task needs to be performed (De Baets et al., 2023).

Van Wyngaarden, Noehren, and Archer (2019) recommended an approach for physiotherapists which combined the brief depression screen, and the multidimensional screen and health related distress assessment approach. In this approach, during the first consultation with someone experiencing musculoskeletal pain, the PHQ-2 and OPRO-YF are administered, with the exception of people with low back pain. If the presentation involves low back pain, the PHQ-2 and SBST are administered, with the OPRO-YF administered at the second consultation to reduce client burden. If the PHQ-2 is positive, the PHQ-9 is completed.

It is recommended that the PHQ-2 be administered to all physical therapy patients upon initial intake. The PHQ-9 only needs to be administered when a patient scores ≥3 on the PHQ-2 (Van Wyngaarden, Noehren, and Archer, 2019).

If high scores are identified on specific subscales of the OPRO-YF, unidimensional tools which assess pain-related distress are used.

**Management of psychological distress**

The direct treatment of generalized psychological distress (e.g. depression, anxiety, and post-traumatic stress) and non-pain-related psychological distress (e.g. relationship issues and financial strain) was generally viewed in included articles as outside the scope of physiotherapy practice, for example: Directly treating depression is not in the scope of practice for physiotherapists; however, a respectable knowledge of the condition contributes to the therapeutic plan of care within the interdisciplinary team (Varela and Melvin, 2023).

However, the management of health-related distress, particularly pain-related distress (e.g. pain-related fear and kinesiophobia) was generally described as within the scope of physiotherapy practice:

Managing the distress that is primarily related to a patient’s pain and physical incapacity has to be part of the physiotherapist’s responsibility to the patient. In contrast, it is not the physiotherapist’s obligation to directly manage distress that is primarily due to other factors (e.g. marriage breakdown and financial worries) (Watson, 1999).

The management of psychosocial factors, including health-related distress, as part of psychologically informed physiotherapy was the topic of most of the recently published literature included in this review. Psychologically informed physiotherapy has been described as follows:

[Psychologically informed physiotherapy] focuses on addressing psychological factors related with rehabilitative outcomes like pain and physical function, rather than on mental illness requiring specialist care (Main et al., 2023).

Several approaches for physiotherapists to managing psychological distress and health-related distress were described in the included articles, these being: 1) education and reassurance; 2) cognitive-behavioral approaches; 3) mindfulness; and 4) case-management including referral. In addition to these approaches, exercise, relaxation, sleep interventions, coping skills training, stress inoculation, problem solving, emotional ventilation, and resilience training were also briefly mentioned as interventions worthy of consideration by physiotherapists (Billek-Sawhney, Wagner, and Braun, 2014; Cancelliere and Mohammed, 2019; Daley et al., 2021; Donnelly, Brockwell, Rankin, and Moore, 2022; Faulkner and Snell, 2023; Harrison, Thorp, and Ritzline, 2014; Hodges, 2019; Rabey and Moloney, 2022), for example:

[In the management of] acute psychological distress . . . provide strategies to assist with the management of these emotional symptoms (ie, relaxation strategies such as diaphragmatic breathing) (Faulkner and Snell, 2023).

**Education and reassurance**

There was a general consensus across the included articles that physiotherapists should use education
and reassurance to manage client psychological distress (Cancelliere and Mohammed, 2019; Chimenti, Frey-Law, and Sluka, 2018; Delitto et al., 2012; Faulkner and Snell, 2023; Main and Watson, 1999; Smith et al., 2020; Vieira, Brown, and Raue, 2014), for example:

In treating patients with heightened somatic awareness [e.g. concern or fear], it is important for manual therapists to offer repeated explanation and reassurance to the patients about the nature of their pain (Main and Watson, 1999).

The educational and reassurance-based approaches recommended for physiotherapists generally consisted of providing informative resources, de-threatening symptoms, normalizing emotional responses, establishing recovery expectations, and outlining management options. With regard to supporting people experiencing generalized psychological distress such as depression, Vieira, Brown, and Raue (2014) recommended that physiotherapists provide appropriate education to older adults with depression or suspected depression in order to facilitate referral to a mental health professional:

It is critical to use appropriate patient educational materials about depression and the need for a referral for further evaluation (Vieira, Brown, and Raue, 2014).

In comparison to supporting someone with generalized psychological distress, the role of physiotherapists in supporting people experiencing health-related psychological distress was more involved. It was generally recommended that physiotherapists provide condition-specific education and reassurance regarding the client’s prognosis and normalize emotional responses to physical health issues (Cancelliere and Mohammed, 2019; Faulkner and Snell, 2023; Smith et al., 2020). For example, Smith et al. (2020) recommended that physiotherapists provide education and reassurance to people with post-intensive care syndrome:

Unique learning needs among people with [post-intensive care syndrome] and their family members include . . . reassurance as they address the fears related with the episode of critical illness and the sequelae of problems; [and] confirmation about their recovery in response to interventions . . . (Smith et al., 2020).

While reassurance and education by physiotherapists was generally recommended, Main et al. (2023) cautioned against providing overly optimistic reassurance and education, as it can create unrealistic client expectations that may lead to further distress (e.g. disappointment, anger, and frustration) which may impede recovery. However, some degree of optimism is needed as it appears to be associated with improved outcomes (Main et al., 2023). Consequently, Main et al. (2023) and Main et al. (2023) recommended physiotherapists offer education and reassurance that is guarded, yet cautiously optimistic, with a focus on intermediate client-centered goals as a path forward, rather than concentrating on the eventual outcome. Education and reassurance aimed at reducing health-related distress were not perceived as an isolated approach in physiotherapy care. Rather, education and reassurance were seen as fundamental components of management that complement or underpin other interventions aimed at reducing health-related distress. For example, Alappattu and Bishop (2011) recommended that physiotherapists provide education regarding psychological factors such as pain-related fear and anxiety as part of the provision of cognitive coping strategies. Similarly, George and Zeppieri (2009) described how education from physiotherapists can help decrease pain-related fear and support other interventions, such as graded exposure, which are also aimed at decreasing pain-related fear:

Patients receive education that decreases the fear and threat related with [low back pain]. Also, patients receive positive reinforcement for performing fearful activities and utilizing beneficial coping strategies. Therefore, it is impossible to separate the effects of the education and activity implementation components of the graded exposure treatment. In our opinion it is best to view graded exposure as a combined cognitive and behavioral treatment that encourages confrontation of fearful activities during rehabilitation of LBP (George and Zeppieri, 2009).

**Cognitive-behavioral approaches**

It was recommended in the included literature that cognitive-behavioral approaches aimed at reducing health-related fear, particularly pain-related fear and anxiety, be integrated into physiotherapy practice (Alappattu and Bishop, 2011; George and Zeppieri, 2009; Stearns et al., 2021; Varela and Melvin, 2023). Cognitive-behavioral approaches are characterized by an explicit focus on targeting maladaptive cognitions, emotions, and behaviors to improve clinical outcomes. Cognitive-behavioral approaches were generally described as a part of psychologically informed physiotherapy:

Cognitive-behavioral physical therapy is emerging in physical therapist practice and may be an effective intervention not only for psychological distress but for cognitive influences in older adults . . . Multiple interventions fall within the realm of cognitive-behavioral physical therapy, although a key component is that
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<td>General Health Questionnaire (GHQ-28)</td>
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<td>Beekman and Verhagen (2018)</td>
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<td>Patient Health Questionnaire Anxiety and Depression Scale (PHQ-ADS)</td>
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<td>Kroenke, Spitzer, and Williams (2003)</td>
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<td>Beck et al. (1996; BDI), Beck, Steer, and Brown (1996; BDI-II, and Beck, Guth, Steer, and Ball (1997; BDI-PC)</td>
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<td>Zung Self-Rating Depression Scale (ZSDS)</td>
<td>Measure of depression</td>
<td>Hunter and Murphy (2011)</td>
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<td>Geriatric Depression Scale (GDS)</td>
<td>Measure of depression among older adults</td>
<td>Yesavage et al. (1983)</td>
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<td>Edinburgh Postnatal Depression Scale (EPDS)</td>
<td>Screening tool for perinatal depression.</td>
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<td>Patient-Reported Outcome Measurement Information System Depression (PROMIS Depression)</td>
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<td>Pilkonis et al. (2011)</td>
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<td>Spitzer, Kroenke, Williams, and Löwe (2006)</td>
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<td>Measure of post-traumatic stress symptoms</td>
<td>Horowitz, Wilner, and Alvarez (1979; IES) and Motlagh (2010)</td>
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<td>Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)</td>
<td>Measure of post-traumatic stress disorder symptoms</td>
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<td>Patient-Reported Outcome Measurement Information System Anger (PROMIS Anger)</td>
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<td>Pilkonis et al. (2011)</td>
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<td>Injustice Experience Questionnaire (IEQ)</td>
<td>Measure of perceive injustice associated with injury.</td>
<td>Sullivan et al. (2008)</td>
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<td>Pain Catastrophizing Scale (PCS)</td>
<td>Measure of pain-related worrying (i.e. pain catastrophizing)</td>
<td>Sullivan, Bishop, and Pivik (1995) and Crombez et al. (2020)</td>
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<td>Fear-Avoidance Beliefs Questionnaire (FABQ)</td>
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<td>Waddell et al. (1993)</td>
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<td>Örebro Musculoskeletal Pain Questionnaire (OMPSQ or OMPSQ-SF)</td>
<td>Screening tool for early identification of yellow flags in with pain</td>
<td>Linton and Boersma (2003) and Linton, Nicholas, and MacDonald (2011)</td>
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<td>Tampa Scale for Kinesiophobia (TSK)</td>
<td>Measure of fear of movement-related pain in patients with musculoskeletal pain</td>
<td>Weermeijer, Meudlers, and Meudlers (2018)</td>
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<td>Sf(T) Back Screening Tool (SBST)</td>
<td>Screening to for physical and psychosocial factors (e.g. depression fear, anxiety, and catastrophizing) in people with low back pain</td>
<td>Traeger and McAuley (2013)</td>
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<td>Optimal Screening for Prediction of Referral and Outcome Yellow Flag (OSPRO-YF)</td>
<td>screening and assessment tool for pain-associated psychological distress</td>
<td>Lentz et al. (2016) and Butera, George, and Lentz (2020)</td>
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<td>Distress and Risk Assessment Method (DRAM)</td>
<td>Screening tool for psychological distress in people with pain</td>
<td>Main et al. (1992)</td>
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<td>Illness Perception Questionnaire (Brief IPQ and IPR-R)</td>
<td>Measure of cognitive and emotional representations of illness</td>
<td>Ng (2012) and Hill (2010)</td>
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<td>Fear of Pain Questionnaire (FPQ)</td>
<td>Measure of pain-related fear</td>
<td>McNeil and Rainwater (1998)</td>
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Table 5. (Continued).

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<td>Measure of fear of movement, depression, and pain catastrophizing based on the BDI-II, TSK, and PCS</td>
<td>Wideman and Sullivan (2012)</td>
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<td>Fear Of Daily Activities Questionnaire (FADQ)</td>
<td>Measure for fear of activities in people with low back pain</td>
<td>George, Valencia, Zeppieri, and Robinson (2009)</td>
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<td>Pain Anxiety Symptom Scale (PASS-20)</td>
<td>Measure of pain-related anxiety</td>
<td>Coons, Hadjistavropoulos, and Asmundson (2004)</td>
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<td>STarT MSK tool</td>
<td>Screening tool for physical and psychosocial factors (e.g., depression fear, anxiety, and catastrophizing) back, neck, knee, shoulder, or multisite pain</td>
<td>Dunn et al. (2021)</td>
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<td>Psychological Inflexibility in Pain Scale (PIPS)</td>
<td>Measure of pain avoidance and cognitive fusion with pain</td>
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</tr>
<tr>
<td>Cogniphobia Scale (C-scale)</td>
<td>Measure of fear and avoidance of cognitive exertion in headache sufferers</td>
<td>Seng and Klepper (2017)</td>
<td>1</td>
</tr>
<tr>
<td>Fear Avoidance Behavior after Traumatic Brain Injury Questionnaire (FAB-TBI)</td>
<td>Measure of fear avoidance behavior in adults after mild traumatic brain injury</td>
<td>Snell et al. (2020)</td>
<td>1</td>
</tr>
<tr>
<td>Work and Health Questionnaire (WHQ)</td>
<td>Screening tool for work-related factors and psychosocial variables in injured workers</td>
<td>Wideman and Sullivan (2012)</td>
<td>1</td>
</tr>
<tr>
<td>Back Disability Risk Questionnaire (BDRQ)</td>
<td>Screening tool for disability risk factors in people experiencing occupational low back pain.</td>
<td>Shaw, Pransky, Patterson, and Winters (2005)</td>
<td>1</td>
</tr>
<tr>
<td>Psychosocial Risk for Occupational Disability Instrument (PRODI)</td>
<td>Screening for psychosocial risk for disability in injured workers with low back pain</td>
<td>Schultz et al. (2005)</td>
<td>1</td>
</tr>
<tr>
<td>Plan of Action for a Case (PACE Tool)</td>
<td>Tool intended to connect risk identification with interventions in injured workers.</td>
<td>Iles, Sheehan, Munk, and Gosling (2020)</td>
<td>1</td>
</tr>
<tr>
<td>36-Item Short Form Survey (SF-36)</td>
<td>Measure of physical functioning, role limitations (physical), bodily pain, general health, vitality, social functioning, role limitations (emotional), mental health, and reported health transition</td>
<td>Ware, Snow, Kosinski, and Gandek (1993); and Ware (2000)</td>
<td>2</td>
</tr>
</tbody>
</table>

The PHQ-2 category includes the 2-item screening test for depression taken from the Primary Care Evaluation of Mental Disorders Procedure (2-item PRIME-MD), although the instruments vary slightly (Haggman, Maher, and Refshauge, 2004). The EPDS has also been used to screen for perinatal anxiety (Shrestha et al., 2016).

Symptoms of a patient’s condition (e.g. pain) are a central tenet of treatment (Simon and Hicks, 2018).

The recommended cognitive-behavioral approaches for use by physiotherapists are aimed at addressing maladaptive thoughts and behaviors which perpetuate pain, pain-related disability, and pain-related distress:

Psychologically informed physical therapy [interventions may include] . . . behavioral therapies (to modify behaviors), cognitive behavioral therapies (to address cognitions about pain), or acceptance-based therapies that encourage return to function despite pain (Hodges, 2019).

The recommended cognitive-behavioral approaches incorporate a diverse range of interventions and techniques that may be used by physiotherapists, such as graded exposure, graded activity, and acceptance and commitment-based approaches.

Treatment considerations for those who screen positive in the fear avoidance domain include graded exposure and cognitive behavioral strategies (Stearns et al., 2021).

Varela and Melvin (2023) suggested that physiotherapists consider functional behavioral interventions designed to facilitate problem solving skills, cognitive restructuring, and coping mechanisms reinforcing self-awareness, mastery and efficacy. The interdependent relationship between physical health issues such as pain and psychological distress means that while physiotherapists are not directly treating depression or other mental disorders (Varela and Melvin, 2023) these cognitive-behavioral interventions reduce health-related distress and allostatic load which are underlying transdiagnostic factors (Faulkner and Snell, 2023; Linton, Flink, and Vlaeyen, 2018; Rabey and Moloney, 2022).

Vandyken and Hilton (2017) recommended physiotherapists consider implementing cognitive functional therapy, cognitive behavioral therapy, and graded exposure to address pain-related fear. Cognitive functional therapy draws on components of cognitive behavioral approaches such as cognitive restructuring and graded exposure in vivo to reduce pain and movement-related fear (O’Sullivan et al., 2018). Several authors of included articles described
cognitive-behavioral approaches to the treatment by physiotherapists of pain-related fear, which have been informed by the Common-Sense model (Bunzli et al., 2017; Caneiro et al., 2022; Caneiro, Bunzli, and O’Sullivan, 2021). According to Bunzli et al. (2017) a Common-Sense Model informed approach to treating pain-related fear involves motivational, reflective, and validating communication techniques. It also incorporates exposure control, which involves gradually exposing the person to the tasks they fear, as an approach to challenging unhelpful cognitions (Caneiro et al., 2022). This was further described as follows:

Identified processes should be targeted in treatment, i.e., graduated exposure to address avoidance that is maintaining anxiety and low mood (Faulkner and Snell, 2023).

Behavioral exposure specifically targets pain-related fear and avoidance by gradually exposing the person to the tasks they fear or avoid while challenging unhelpful cognitions and disconfirming threat expectations (Caneiro et al., 2022).

However, as previously mentioned by Rabey and Moloney (2022), while management of some psychological factors may be within the scope of the physiotherapy profession, a particular management approach may not be within the scope of an individual physiotherapist. In the context of cognitive-behavioral interventions, Alappattu and Bishop (2011) recommended that physiotherapists consider using cognitive-behavioral interventions they are competent to use:

The presence of psychological variables may require cognitive behavioral interventions … Physical therapists trained in musculoskeletal dysfunction of the pelvic floor may include certain cognitive-behavioral interventions within their scope of practice (Alappattu and Bishop, 2011).

Mindfulness

Mindfulness was recommended by several authors as an approach to managing psychological distress that could be employed by physiotherapists (Billek-Sawhney, Wagner, and Braun, 2014; Donnelly, Brockwell, Rankin, and Moore, 2022; Simon and Hicks, 2018; Vandyken and Hilton, 2017). Rabey and Moloney (2022) suggested that mindfulness was particularly useful as it influences a broad range of allostatic load biomarkers which underpin distress. Consistent with the broad effects of mindfulness, the approach was recommended for physiotherapists managing a variety of different forms of distress, including depression, anxiety, stress, pain catastrophizing, and pain-related fear (Simon and Hicks, 2018; Vandyken and Hilton, 2017; Varela and Melvin, 2023).

Researchers have also shown antidepressant benefits for individuals engaged in yoga and mindfulness practices (Billek-Sawhney, Wagner, and Braun, 2014).

While the management of depression and anxiety with mindfulness was mentioned, the form of psychological distress primarily discussed in this context was pain-related distress. Bunzli et al. (2017) highlighted the potential benefits of mindfulness, stating that it can help regulate pain-related emotional responses. However, given the broad effects of mindfulness, Simon and Hicks (2018) noted that the focus of mindfulness is largely global, rather than specific to pain:

However, mindfulness-based stress reduction is unique to cognitive-behavioral therapy in that the focus is more global (i.e. not specific to pain) (Simon and Hicks, 2018).

Several authors suggested that mindfulness can be incorporated with movement, such as Tai Chi and yoga, as part of “mindful movement” (Billek-Sawhney, Wagner, and Braun, 2014; Simon and Hicks, 2018; Vandyken and Hilton, 2017).

Case-management including referral

While the included literature suggested that physiotherapists have a role in the direct management of psychological distress, particularly health-related distress, there was a general consensus that a multidisciplinary approach to management of psychological distress was preferred when the distress is persistent, or preexisting (Alappattu and Bishop, 2011; Caneiro, Bunzli, and O’Sullivan, 2021; Daley et al., 2021; Faulkner and Snell, 2023; Linton and Shaw, 2011; Simonds, Abraham, and Spitznagle, 2022; Searns et al., 2021; Sterling, 2009; Varela and Melvin, 2023; Vieira, Brown, and Raue, 2014; Watson, 1999):

Physiotherapists do not have the experience or training to manage [psychological distress] … not directly attributable to the pain condition … and need to refer on to specialist practitioners or develop a working relationship with mental health practitioners to facilitate joint management of these patients (Watson, 1999).

Physiotherapists must also collaborate and rely on specialists once a mental health concern is independently recognized (Varela and Melvin, 2023).
Consider referral/engagement in other services to address and manage preinjury mental health difficulties (Faulkner and Snell, 2023).

While persistent psychological distress, distress unrelated to the physical health issue, and preexisting psychological distress were suggested as indicators of a need for referral by physiotherapists, there was no consensus on the level of psychological distress necessitating referral. Delitto et al. (2012) highlighted this issue in their low back pain clinical practice guideline for physiotherapists:

The authors of these clinical guidelines acknowledge that this is a general description for a rather important process. However, there are no absolute guidelines for the levels of psychological symptoms that indicate referral (Delitto et al., 2012).

Some authors of included articles provided recommendations for physiotherapists based on scores from psychological questionnaires, while others provided general guidance on the timing of referral. As health-related distress was considered a common and normal response to physical health conditions, Sterling and Kenardy (2008) recommended referral to mental health care only if whiplash-related distress persisted beyond 3–4 weeks. Similarly, Daley et al. (2021) recommended referral when the client’s complaint is not improving and there are psychological factors involved:

For patients with multiple psychosocial risk factors who are not progressing or participating in treatment, referral to a psychologist may be beneficial. Discussion with stakeholders regarding psychologist referral is encouraged (Daley et al., 2021).

Main and Watson (1999) cautioned that the unnecessary referral of non-psychopathological distress could be harmful:

Patients presenting with painful conditions and related loss of function are very rarely psychiatrically ill, and inappropriate referral may simply magnify their distress (Main and Watson, 1999).

In determining the need for referral Wijma, van Wilgen CP, Meeus, and Nijs (2016) recommended that physiotherapists consider their own skills alongside those of their clients by asking themselves: “is this patient in the right place here with me, or should he/she be treated in a multidisciplinary setting or referred to another provider?”

Referral options generally included the client’s primary medical practitioner and psychologist. However, other professionals such as social workers, counselors, and spiritual care practitioners were also mentioned. For example, Alappattu and Bishop (2011) highlighted that pain-related distress among women with chronic pelvic pain can be associated with sexual dysfunction, and loss of partner intimacy. They proposed that a referral from the physiotherapist to a sex counselor or therapist should be considered for women who report sexual dysfunction or intimacy issues due to pelvic pain, indicating the necessity for an interdisciplinary approach to care:

The consequences of pain-related psychological variables in musculoskeletal pain include disuse and disability. In women with CPP, the sequelae likely include sexual dysfunction and loss of partner intimacy . . . [A] referral to a sex counselor or therapist is recommended [for these] women (Alappattu and Bishop, 2011).

Caneiro, Bunzli, and O’Sullivan (2021) emphasized the need for a multidisciplinary approach involving physiotherapists should operate within a shared framework, providing consistent messages to the individual, and thereby reducing care fragmentation and client anxiety.

Clinicians should refer patients for co-care in the presence of comorbid mental (e.g. emotional distress, depression, eating disorders) and physical health conditions (e.g. type 2 diabetes, heart disease, morbid obesity). We contend that multi-disciplinary care including psychologist, pain physician, medical doctor and physiotherapist needs to be integrated, so the team shares a common framework and delivers consistent messages that prevent care fragmentation and patient distress (Caneiro, Bunzli, and O’Sullivan, 2021).

As part of this process, Vieira, Brown, and Raue (2014) recommended that physiotherapists working with older adults approach the discussion of depression sensitively. Vieira, Brown, and Raue (2014) made this recommendation as clients may have concerns related to the stigmatization of mental illness and barriers such as financial barriers to accessing mental health care:

Patients often need a great deal of encouragement and support to follow through with appointments for mental issues that they may not feel are essential . . . A good approach to increase the acceptability of further evaluation is to use the language of the patient (e.g. “feeling low or down” instead of “depressed”) and discuss mental health referral in the context of other medical conditions [such as] . . . poststroke depression.

Of the authors who discussed management of clients experiencing suicidal thoughts and behaviors (Harrison, Thorp, and Ritzline, 2014; Simonds, Abraham, and Spitznagle, 2022; Stearns et al., 2021; Varela and Melvin, 2023), the recommended approach was generally an immediate referral to emergency care or another appropriate mental health service. For example:
If a patient verbalizes suicidal ideation, then immediate referral to an appropriate health care practitioner is warranted (Harrison, Thorp, and Ritzline, 2014).

Delito et al. (2012) and Billek-Sawhney, Wagner, and Braun (2014) recommended that physiotherapists refer any client with an intent and a plan for suicide for an immediate suicide risk assessment by mental health and medical professionals. Stearns et al. (2021) recommended physiotherapists proactively establish a referral network, including crisis line services, to ensure they are well prepared to support a client experiencing suicidal thoughts.

Discussion

This systematic mapping review of recommended approaches for physiotherapists to the identification, assessment, and management of clients experiencing psychological distress mapped recommendations from 40 secondary or tertiary scholarly articles. Most of the included articles were published in the past decade and were written by physiotherapists and psychologists. The majority of included articles focused on the identification, assessment and management of health-related distress, with a particular emphasis on pain-related distress. There was attention given to depression screening and referral, while other forms of psychological distress, such as generalized anxiety and post-traumatic stress disorder, were not discussed as frequently. Three recommended approaches to detecting and assessing psychological distress were identified: 1) brief depression screen; 2) integrated suicide/non-suicidal self-harm and depression screen; and 3) multidimensional screen and health-related distress assessment approach. As for the management of psychological distress, the main recommended approaches identified were: 1) education and reassurance; 2) cognitive-behavioral; 3) mindfulness; and 4) case management (including referral).

Given physiotherapists across all clinical areas of practice encounter clients experiencing psychological distress (Lucas and Parker, 2022; McGrath, Verdon, Parnell, and Pope, 2023) the identification, assessment and management of psychological distress should be of clinical and research interest to all physiotherapy sub-disciplines. According to the IOPTMH, mental health physiotherapists possess the “knowledge, skills and attitudes to assess [but not diagnose], support, treat and refer people with mental illnesses” (Probst et al., 2019, 2020). Although the subdiscipline of mental health physiotherapy is well positioned to provide leadership in this area, the subdiscipline is relatively new and small in comparison to other established physiotherapy research and practice areas such as musculoskeletal and pain physiotherapy (Heywood et al., 2022). The holistic approach commonly advocated by musculoskeletal and pain physiotherapy researchers incorporates mental health, although there tends to be a stronger emphasis on cognitive and behavioral factors, and when emotional factors are considered it is typically limited to pain-related distress (Daluiso-King and Hebron, 2020; Dillon et al., 2023). Consequently, the articles included in this systematic mapping review largely pertained to the assessment and management of pain-related distress and were typically authored by researchers with expertise in musculoskeletal pain assessment and management. Since the turn of the millennium, there has been considerable development in psychological screening, risk identification, pain-related distress assessment, and pain-related distress management relevant to musculoskeletal and pain physiotherapy settings (Alvarez et al., 2022; Lentz et al., 2016; Main et al., 2023; Stearns et al., 2021; Stewart, Kempenaar, and Lauchlan, 2011). There has also been considerable interest in the intersection of depression and chronic pain in the field of physiotherapy (Carballo-Costa, Quintela-Del-Río, Vivas-Costa, and Costas, 2023). These developments are evident in this review. In contrast, the few articles identified which provide recommendations for the identification, assessment, and management of generalized psychological distress, non-health-related distress, and psychopathology may be explained by the relative lack of development in mental health physiotherapy and psychologically informed physiotherapy in other research subdisciplines, such as neurological physiotherapy (Lucas and Parker, 2022).

The three recommended approaches to detecting and assessing psychological distress identified in this review suggest that screening for all forms of psychological distress is within the scope of physiotherapy practice. However, when all articles were considered together, only the assessment of health-related distress, particularly pain-related distress, was perceived to fall within the scope of the profession, with the formal assessment of non-health-related distress and psychopathology positioned outside of scope. This interpretation is consistent with the ‘Flags’ framework developed by the Decade of the Flags Working Group (Nicholas, Linton, Watson, and Main, 2011). According to the Decade of the Flags Working Group, ‘orange flags’ are psychiatric symptoms that meet criteria for psychopathology that requires referral to a specialist mental health professional for assessment and management. In comparison, ‘yellow flags’ are normal but unhelpful psychological reactions, such as distress not meeting criteria for
diagnosis of a mental disorder that may be addressed by suitably trained health professionals such as physiotherapists (Nicholas, Linton, Watson, and Main, 2011). However, given that many physiotherapists report a lack of confidence in assessing psychological factors, such as pain-related distress (Henning and Smith, 2022; Synnott et al., 2015) and that few have received training in psychological assessment (Driver, Lovell, and Oprescu, 2021; Simpson et al., 2021) currently the assessment of pain-related distress is best described as an advanced area of physiotherapy practice that is beyond the individual scope of most physiotherapists.

The four primary management approaches for psychological distress identified in this review: 1) education and reassurance; 2) cognitive-behavioral approaches; 3) mindfulness; and 4) case management including referral span the continuum of traditional (standard) physiotherapy practice and merge into that of psychologically informed physiotherapy. Although physiotherapists’ provision of education and case management is likely to be improved with training (Edgar and Connaughton, 2021; Synnott et al., 2016) the activities are considered to be within the remit of all physiotherapists by the Physiotherapy Board of Australia, Physiotherapy Board of New Zealand (2015). In contrast, management approaches such as cognitive-behavioral and mindfulness-based approaches are likely to require additional training beyond that provided in qualifying physiotherapy programs (Alvarez et al., 2022; Coronado et al., 2020; Tatta, 2022). The finding of the review that the direct treatment of psychopathology is generally viewed as beyond the scope of physiotherapy is incongruent with the position of the IOPTMH. According to the IOPTMH, interventions such as exercise, and cognitive and behavioral physiotherapy approaches, intended to directly reduce psychological symptoms, fall within the scope of specialist mental health physiotherapists working within a multidisciplinary team (Probst et al., 2020). Working within a multidisciplinary team allows physiotherapists to collaborate with other mental health professionals to ensure that their approach is safe and high-quality (Probst et al., 2020). In addition, the use of cognitive-behavioral approaches and mindfulness-based interventions in the management of pain-related distress lie within the scope of specialist pain physiotherapists (Alvarez et al., 2022; Coronado et al., 2020; Keefe, Main, and George, 2018; Tatta, Willgens, and Palombo, 2022). Safe and effective delivery of cognitive-behavioral approaches and mindfulness-based interventions by physiotherapists requires training, which may include competency assessment, supervision and feedback ( Alexanders and Douglas, 2016; Driver, Lovell, and Oprescu, 2021; Linton and Shaw, 2011; Simpson et al., 2021). Several studies of physiotherapist-delivered psychological interventions included supervision by psychologists as part of training (Alvarez et al., 2022). However, due to the emerging and evolving nature of this aspect of physiotherapy practice, there is no widely accepted standard for training, assessment and supervision (Coronado et al., 2020). Therefore, it is suggested that the management of pain-related distress is within the profession’s scope, but it is beyond the individual scope of many physiotherapists. This interpretation is consistent with the Low Back Pain Clinical Care Standard’s Quick Guide for Physiotherapists (Maher and O’Sullivan, 2023) which recommends non-specialist physiotherapists refer to specialist physiotherapists where clients are experiencing high levels of pain-related fear and distress, and to psychologists where clients are exhibiting high levels of anxiety, distress, depression, social stress, and unresolved trauma.

While not every included study explicitly referred to the revised flags framework (Nicholas, Linton, Watson, and Main, 2011) recommended approaches reviewed generally assumed that psychological distress can be divided into: yellow (i.e. subclinical and health-related distress); orange (i.e. symptoms of psychopathology); and red flags (i.e. severe depression and/or suicidality). However, differentiating normal distress from symptoms of psychopathology, as well as pain-related distress from depression, anxiety, and post-traumatic stress, is both conceptually and clinically challenging (Kirsh, 2010; Rusu, Santos, and Pincus, 2016; Stein and Nesse, 2015; Young, Lareau, and Pierre, 2014). Although a full discussion of the psychiatric nosology is beyond the scope of this review, there is strong evidence that psychological distress and psychopathological depression and anxiety lie on a continuum, with the boundaries between normal and abnormal being an artificial dichotomization (Ruscio, 2019). Furthermore, there is some debate regarding whether pain-related distress and depression/anxiety in the context of chronic pain are distinct constructs or just strongly related ones (Beesdo et al., 2009; Rusu, Santos, and Pincus, 2016). Consequently, it might be more appropriate to conceptualize yellow flags, orange flags, and red flags on a continuum.

Similar criticisms have been made by Stewart, Kempenaar, and Lauchlan (2011) who argued that the flags framework misses the complexity of the psychological and social world of the individual. Main and George (2011) acknowledged the importance of this criticism of the flags framework, but questioned whether such debate would advance clinical practice in
the “real” world. Although screening tools and awareness of common forms can assist with identification of psychopathology, Kirsh (2010) posited that they are not necessarily sufficient in differentiating normal distress from psychopathology among people experiencing persistent pain. To understand a person’s experience of distress requires an understanding of their context and the meaning of their distress (Johnstone and Dallos, 2014). However, most physiotherapists are not currently trained to obtain this. Physiotherapists, particularly physiotherapists assessing and managing pain-related distress, may benefit from mental health training to assist them to discern whether the psychological distress is generalized or specific to pain. This training is particularly important for physiotherapists, such as those working in rural areas, who may not be able to engage in timely co-care with mental health professionals due to significant workforce shortages (Cleary, Thomas, and Boyle, 2020). There are also concerns that universal depression and anxiety screening in primary care settings may lead to overdiagnosis and overtreatment (Thombs et al., 2023). Thombs et al. (2023) suggested that a more effective approach might be to provide people experiencing mental health concerns with timely access to caring health professionals with time to talk through their concerns, understand them as a person, and work with them to identify the best way forward. Mental health training may help physiotherapists discern when screening is warranted in their specific context. Beyond that, mental health training would equip them to support people experiencing psychological distress, making it possible to connect them with mental health services in a manner that is considerate, compassionate, and understanding.

**Limitations**

The reviewers’ clinical and research background may have influenced the articles included in the review. The two reviewers RLM and SS who screened, assessed, and extracted the papers practice clinically in the area of pain. Therefore, papers discussing the identification, assessment, and management of pain-related distress may have been more easily identifiable to the reviewers. Furthermore, although the approach to searching the literature was systematic, the heterogeneity of the article topics and article types may mean some eligible articles may not have been included. Additionally, while full-text review involved a double review approach, a single screen approach to screening the titles and abstracts of records was adopted due to the large number of records returned from the database search. Consequently, the risk of eligible articles being incorrectly excluded during title and abstract screening higher is than with a double screening approach (Waffenschmidt et al., 2019). Another limitation of this review was that it was not designed to evaluate the evidence which formed the basis of the identified recommended approaches. Therefore, physiotherapists should exercise caution when using the results of this review to inform their practice if they have not evaluated the individual included articles and the original research on which they are based. However, physiotherapists may find this review helpful as a directory of literature that describes approaches recommended for physiotherapy practice.

**Recommendations for physiotherapy research**

More research is needed to further inform the scope and role of physiotherapists in psychological assessment, including providing further clarity around the roles of physiotherapists in general, pain physiotherapists, mental health physiotherapists, and physiotherapists from other specialized areas in psychological assessment. Furthermore, given physiotherapists work in a range of clinical settings and with varying levels of isolation, ranging from sole primary contact physiotherapists working in remote areas to physiotherapists working in multidisciplinary teams alongside psychologists, further research is needed to understand the training required for physiotherapists in this area of practice to facilitate optimal client care. Future research should include evaluation of the evidence behind each of the approaches identified in the review, including investigations of client experiences of physiotherapist-initiated psychological assessment.

**Conclusion**

This systematic mapping review mapped approaches recommended for physiotherapists to identify, assess, and manage clients experiencing psychological distress and published in the scholarly literature. Current recommendations largely emphasize the role of physiotherapists in assessing and managing health-related distress, particularly pain-related distress. In regard to depression and suicide, physiotherapists were advised to screen for this using questionnaires such as the PHQ-9 and refer onwards to a mental health professional for further assessment. Management of psychological distress was largely focused on reducing health-related distress, with case management including co-care and referral recommended for generalized and non-health-related psychological distress. Given the inseparability of physical and mental health and the
high frequency of encounters with psychological distress in physiotherapy practice, physiotherapists may benefit from specific mental health training to assist them to understand the nature of the distress being experienced by their clients and to enable effective person-centered care.

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