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<tr>
<td>French et al. (2006)</td>
<td>To assess the effects of superficial heat and cold therapy for low back pain in adults</td>
<td>Level I Systematic review</td>
<td>Trials in which superficial heat or cold therapy was administered to ≥ 1 group within the trial. Trials in which cointerventions (e.g., exercise) were given were included only if the cointerventions were similar across comparison groups. Trials were excluded if they could not isolate the effects of heat or cold from the effects of the other therapies delivered.</td>
<td>2 trials found that heat wrap therapy significantly reduced pain after 5 days compared with oral placebo. 1 trial found that a heated blanket significantly decreased acute low back pain immediately after application. 1 trial found that adding exercise to heat wrap reduced pain after 7 days.</td>
<td>Many of the studies included in the review were of poor methodological quality.</td>
<td>This study provides weak evidence that occupational therapists can consider using superficial heat modalities as an adjunctive or preparatory intervention to prepare for or facilitate engagement in occupations.</td>
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<td>Guzman et al. (2001)</td>
<td>To assess the effect of multidisciplinary biopsychosocial rehabilitation on clinically relevant outcomes for participants with chronic low back pain</td>
<td>Level I Systematic literature review of RCTs</td>
<td>Evidence that intensive multidisciplinary biopsychosocial rehabilitation with functional restoration improved function compared with inpatient or outpatient nonmultidisciplinary rehabilitation is strong. Evidence that intensive multidisciplinary biopsychosocial rehabilitation with functional restoration reduced pain when compared with outpatient nonmultidisciplinary rehabilitation or usual care is moderate.</td>
<td>Evidence to evaluate the effects of cold for low back pain is insufficient, and evidence regarding differences between heat and cold for low back pain is conflicting.</td>
<td>The review focused on selected clinical outcomes, ignoring data on physical measurements and psychological scales. The studies examined selected participants with severe disabling low back pain treated in well-established multidisciplinary rehabilitation programs. The results might not apply to most clients seen in primary care.</td>
<td>Individuals with disabling back pain benefit from occupation-based interventions described by the study's authors as &quot;functional restoration&quot; with a biopsychosocial approach compared with nonmultidisciplinary rehabilitation or usual care (i.e., without a functional restoration approach).</td>
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<td>Henschke et al. (2005)</td>
<td>To determine whether behavioral therapy is more effective than other treatments for chronic low back pain and which type of behavioral treatment is most effective</td>
<td>Level I Systematic review of RCTs N = 21 trials for those with nonspecific low back pain ages &lt;18–&gt;65 Chronic low back pain was defined as back pain that persisted for &gt;12 wk; trials with participants with specific low back pain caused by pathological entities (e.g., infection, neoplasm, metastasis, osteoporosis, rheumatoid arthritis, fractures) were excluded.</td>
<td>Interventions Behavioral treatment was compared with placebo, no treatment, or waiting-list control. Different behavioral treatments were compared; behavioral treatments were compared with other kinds of treatment; and behavioral treatment in addition to other treatment (e.g., physiotherapy, back education, medical treatment) was compared with the other treatment alone. Behavioral treatment included respondent (e.g., progressive relaxation, electromyography biofeedback), operant, combined respondent cognitive, cognitive, and cognitive–behavioral therapies.</td>
<td>Outcome Measures • Overall improvement (self-reported or observed) • Back pain–specific functional status (Roland–Morris Disability Questionnaire, Oswestry</td>
<td>Evidence regarding vocational outcomes of intensive multidisciplinary biopsychosocial rehabilitation is contradictory. Combined respondent cognitive therapy or progressive relaxation therapy alone was more effective than no treatment for short-term pain relief, but whether this finding was also true for back-specific functional status is unknown. No significant differences were detected in comparisons among the various types of cognitive–behavioral therapies or in comparisons between behavioral treatment and exercises. Combined respondent cognitive therapy and progressive relaxation were more effective than no treatment for short-term pain reduction, although this finding was based on several studies of moderate or low quality.</td>
<td>The studies were of poor methodological quality; randomization, blinding of participants and outcome assessors, and tracking of co-interventions and compliance were absent in many studies. Many of the trials evaluated programs developed by the authors themselves, a possible source of bias. Statistical pooling of multiple outcome measures within the behavioral domain may have resulted in the lack of an effect in many of the comparisons. This review provides limited evidence that respondent cognitive therapy and progressive relaxation therapy may be effective for short-term chronic low back pain. Thus, psychosocial interventions for clients with chronic low back pain should accompany physical interventions and fit well within the scope of occupational therapy practice.</td>
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Heymans et al. (2004) To determine whether back schools were more effective than other treatments or no treatment for participants with nonspecific low back pain

**Level I**
Systematic review of RCTs in which 1 of the treatments consisted of a back school

\( N = 3,584 \) participants with nonspecific low back pain ages 18–70 (19 trials)

**Interventions**
Back school was defined as consisting of an educational and skills acquisition program including exercises given to groups of participants and supervised by a paramedical therapist or medical specialist.

The back school consisted of information on the anatomy of the back, biomechanics, optimal posture, ergonomics, and back exercises. Other treatments included exercise therapy, spinal manipulation, myofascial therapy, oral or written instruction, placebo, or waiting list.

**Outcome Measures**
- Return to work
- Pain
- Global measure of improvement
- Functional status (e.g., Roland–Morris Disability Questionnaire or Oswestry Disability Index)

No strong evidence was found for any particular type of back school treatment. Moderate evidence was found that back schools have better short- and intermediate-term effects on pain and functional status than other treatments for recurrent and chronic low back pain. Evidence that back schools in an occupational setting are more effective than other treatments, placebo, or waiting list status in terms of chronic low back pain, functional status, and return to work during short- and intermediate-term follow-up was moderate.

Hurwitz et al. (2005) To determine the effectiveness of recreational physical activity and back exercises on low back pain, related disability, and the psychological distress it causes

**Level I**
RCT

\( N = 610 \) participants; median age 50 yr

**Interventions**
- Group 1 received chiropractic care with physical modalities.
- Group 2 received chiropractic care without physical modalities.
- Group 3 received medical care with physical therapy.
- Group 4 received medical care without physical therapy.

Results suggest that participants experienced better outcomes not from specific back exercises, but rather from a focus on nonspecific physical activities to reduce pain and improve psychological health.

Specific back exercises may be counterproductive, and intervention should instead focus on meaningful activities as means and ends, take an effective and perhaps even

Physical activity such as walking or swimming has a more positive impact on decreasing pain for clients with chronic low back injury than back-strengthening exercises alone.

Occupational therapy programs, which focus on meaningful activities as means and ends, take an effective and perhaps even...
### Supplemental Table 1. Evidence for Occupational Therapy Interventions for Individuals With Work-Related Low Back Injuries and Illnesses (cont.)

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| Karjalainen et al. (2003) | To determine the effectiveness of multidisciplinary rehabilitation for subacute low back pain among working-age adults | Participants were enrolled in the study for 3 yr with an additional 18-mo follow-up period.  
**Outcome Measures**  
- Low back disability (Roland–Morris Disability Questionnaire)  
- Pain intensity (Numerical Pain Rating Scale)  
- Distress because of low back pain (Mental Health Index)  
- Metabolic Equivalent Task  
**Interventions**  
Inpatient or outpatient program was required to be multidisciplinary (i.e., physician’s consultation plus a psychological, social, or vocational intervention or a combination of these). Trials consisting solely of medical treatment and physical therapy were excluded. | Emphasize restoration of normal functioning. | Their exercise and physical activities. | Advantageous approach compared with traditional exercise or manual-based interventions. |

Participants in the intervention groups returned to work significantly sooner than those in other groups and experienced significant improvements in subjective disability and disorder-specific functional status. No effects could be attributed to the intervention in intensity of pain.  
Outcome Measures  
- Pain intensity  
- Global status  
- Disorder-specific functional status  
- Generic functional status or quality of life  
- Ability to work  
- Health care consumption and costs  
- Satisfaction with treatment  

The methodological quality of the 2 trials was low; defects included lack of blinding of participants, therapists, and observers and failure to report cointerventions.  
This study supports the philosophical underpinnings and client-centered approach of occupational therapy. A holistic or biopsychosocial approach to the rehabilitation of individuals with subacute work-related low back pain includes workplace visits and psychological, behavioral, and social interventions as part of a comprehensive rehabilitation plan.
The use of cognitive–behavioral assessments and interventions to facilitate a client's engagement or reengagement in occupations is well within the purview of occupational therapists. This study supports the holistic approach of occupational therapy to address a client's chronic pain related to his or her ability to perform work-related occupations.

Most of the examined trials were of low statistical power. In several of the examined trials, patients assigned to a waiting list in 1 trial may have continued to receive existing treatments (such as physical therapy or pharmacotherapy) that may be equivalent to the treatment control in another trial. The results indicate that active interventions of treatment controls also varied, from continuing previously ineffective psychological treatments to starting based on the principle of cognitive–behavioral therapy. Interventions producing significant changes for the domains of pain experience, cognitive coping and appraisal (positive coping measures), and reduced behavioral activity. Variations in the content and duration of interventions labeled as physical conditioning programs with management strategies that do not include a cognitive–behavioral approach reduced the number of sick days for a client with work-related back pain. Physical conditioning programs, including work conditioning, combined with a cognitive–behavioral approach, are effective in reducing the number of sick days for a client with work-related back pain. Thus, holistic, occupation-based, and cognitive–behavioral interventions should be considered for individuals with low back pain as part of an occupational intervention plan.
### Supplemental Table 1. Evidence for Occupational Therapy Interventions for Individuals With Work-Related Low Back Injuries and Illnesses (cont.)

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<td>Smith, McMurray, &amp; Disler. (2002)</td>
<td>To establish whether the guidelines in current use relating to intervention for acute low back pain are supported by more recently published scientifically rigorous research</td>
<td>Level I</td>
<td>Systematic review of RCTs, N = 18 trials with acute low back pain</td>
<td>Interventions included bed-rest, drug therapy, traction, spinal manipulation, exercise, back schools, work hardening, work conditioning, vocational intervention, and multidisciplinary pain programs including primarily psychological interventions.</td>
<td>Bedrest was found to not be an effective intervention for low back pain. Limited evidence was found to support traditional exercise-based therapy. The evidence did not support the use of traction and exercise or establish the efficacy of back schools. Work conditioning seems promising, but results are inconclusive.</td>
<td>The authors reported that the studies in this review were fraught with conflicting data and poor methodology. Also, the authors found inconsistency in definitions of acute low back pain, leading to inconclusive results and findings. Multidisciplinary programs that include a psychological component show a promising trend. Thus, reengaging in occupations (rather than bedrest) and addressing psychological sequelae (rather than solely physical impairments) of acute low back pain, which are within the scope of occupational therapy practice, have limited support.</td>
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<td>Staal et al. (2004)</td>
<td>To determine the effectiveness of a behavior-oriented graded activity program compared with usual care</td>
<td>Level I</td>
<td>Single-blind RCT, N = 134 participants absent from work because of low back pain randomly assigned to either graded activity or usual care</td>
<td>Interventions included 1 session 2 times/wk of graded activity, including physical exercise, application of operant conditioning, behavioral principles, and improved functioning and safe return to work even if pain persisted. The sessions continued until full return to work for a maximum of 3 mo. Group 2 received usual care, including the usual guidance and advice from the occupational physician and treatment from various caregivers.</td>
<td>The median number of days absent from work because of low back pain was 58 days in the graded activity group and 87 days in the usual care group, a statistically significant difference.</td>
<td>This study did not control for potential confounders such as compensation, legal issues, and workplace culture, possibly affecting the results. Simulated occupational activities that are meaningful to the client are important in rehabilitation and can significantly reduce the number of days absent from work.</td>
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Questionnaire
- Physical activity at baseline
- Pain intensity (Pain Numeric Rating Scale)

Note. RCTs = randomized controlled trials.

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