There have been a number of exciting developments at our Centre over the past year. We have recently completed a 5-year longitudinal project examining risk factors for problematic recovery following Total Knee Arthroplasty (TKA). Our initial analyses of these data suggest that psychological factors such as catastrophic thinking and negative expectancies lead to poor surgical outcomes. Analyses also indicated that for individuals who were depressed prior to TKA, only approximately 50% of these individuals recover from depression following successful surgery. In other words, in spite of reductions in pain, many individuals remain depressed after TKA.

We have also completed a series of studies examining the relation between the display of pain behaviour and outcomes of occupational rehabilitation. Research in this area has been consistent in showing that the display of pain behaviour predicts poor rehabilitation outcomes. Our work has attempted to uncover why pain behaviour would be associated with poor rehabilitation outcomes. Finally, we have been conducting more research on perceptions of injustice following motor vehicles accidents. Our previous research has shown that perceptions of injustice are associated with long-term disability following whiplash injury. Intuitively, one might have expected that whiplash victims would view the driver of the other vehicle as the perpetrator of their current distress and suffering. Surprisingly, one recent study has shown that the insurance representative is viewed as the primary target of injustice perceptions as often as the driver of the other vehicle. More details about this research are contained in this newsletter.

Our Newsletter has taken on a new format, where one section will focus on research findings and another on practice issues. We welcome submissions from PGAP providers of interesting case studies, or discussions of challenging practice issues.

MICHAEL JL SULLIVAN, PhD

The Negative Impact of Pain Behaviour

Clinicians have long had an intuitive sense that patients who present with high levels of pain behaviour are more difficult to treat. Pain behaviour refers to the movement alterations that occur during the experience of pain. Pain behaviours might include communicative behaviours such as grimacing and vocalizations, or they might include protective behaviours such as slow, halting movements, holding and rubbing. Consistent with clinical reflections, numerous research investigations have revealed that the display of pain behaviour is a prognostic indicator for poor recovery outcomes. A question that has remained unanswered is; why should pain behavior predict poor recovery outcomes?

Over the past few years, we have conducted a number of studies examining the processes by which pain

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Message from the Scientific Director:
behaviour might impact negatively on recovery outcomes. At one time it was assumed that pain experience was the primary determinant of pain behaviour. In other words, individuals with the most severe pain were the ones most likely to display pain behaviour. Albeit intuitive, research did not support the notion that pain severity was the primary cause of pain behaviour. Across a number of studies, research findings suggested that pain severity rarely accounted for more than 10% of the variance in pain behavior. While many individuals with severe pain exhibit pain behaviour, almost as many exhibit no pain behaviour.

Our research has shown that some individuals are more likely than others to display pain behaviour. In one study, we showed that chronic pain patients with high levels of catastrophizing were more likely to exhibit pain behaviour than individuals with low levels of catastrophizing (Thibault et al., 2008). In another study, we showed that whiplash patients with high perceived injustice displayed more pain behaviour than whiplash patients with low perceived injustice (Sullivan et al., 2010).

Our research also showed that pain behaviour appeared to serve a communication function. In one study, we exposed healthy individuals to an experimental pain stimulus; cold water immersion. In response to immersing one arm in ice water, most individuals report increasing pain intensity over time. While pain intensity rises over one minute of water immersion, pain behaviour actually decreases. Pain behaviour is most apparent immediately following immersion, but then decreases over time, even though participants report that their pain intensity is increasing. This pattern is more consistent with a view of pain behavior as a communication than as a reflection of pain experience (Sullivan et al., 2004). In the latter study, we also showed that high catastrophizers displayed more pain behaviour when someone was present in the room with them than when they were alone. Again, this finding is most consistent with the view that pain behaviour serves a communication function.

Most recently we have been interested in the inferences that observers make upon seeing someone display pain behaviour. A very interesting study was conducted by a PhD student at our Centre, Marc-Olivier Martel. He showed participants video segments of chronic pain patients engaged in a simulated occupational lifting task. The chronic pain patients in the video segments varied in the amount of pain behaviour they displayed. However, all were experiencing the same degree of pain. He then asked observers to rate the chronic pain patients in terms of how likeable they were, how dependable they were and how ready they were to return to work. The results of the study showed that chronic pain patients who display pain behaviour are viewed as less likeable, less dependable and less likely to return to work (Martel et al., 2012).

These findings shed some light on the processes by which pain behaviour might prolong the period of disability following injury. Patients’ pain behaviour during a medical evaluation might lead the clinician to infer that the individual is not ready to return to work. The clinician’s judgment that a patient is not ready to return to work may result in a recommendation for continued sick leave. Similarly, if an employer considers the individual who displays pain behaviour as less likeable and less dependable, he/she may be less likely to agree to hire the individual. Here the employer’s judgments may directly or indirectly contribute to prolonged work absence.

Dr. Martel also conducted another study examining the degree to which pain behaviours were automatically elicited or whether they were consciously initiated. He filmed pain patients while they lifted a series of weighted canisters; in one condition patients were asked to report their level of pain as they lifted the canisters; in another condition, patients were asked to estimate the weight of the canisters. Overall, the findings revealed that pain behaviours were less frequent when patients were estimating the weight of canisters than when they were rating their pain. Since weight estimation is a more cognitively demanding task than rating one’s pain, it is possible that the weight estimation task compromised the resources required to intentionally initiate pain behaviours. In other words, if pain behaviours were automatically elicited, the cognitive demands of a task would have had no effect on their expression (Martel et al., in press). This is the first study to strongly suggest that, at least some pain behaviours, are intentionally initiated.

Marc-Olivier Martel recently graduated with his PhD from McGill University and is currently completing a post-doctoral fellowship at Harvard University.
What Contributes to the Injured Person’s Sense of Injustice?

A few years ago, we developed the Injustice Experiences Questionnaire (IEQ). Our intent was to develop a scale that would assess the degree to which individuals experienced their losses and suffering consequent to injury in terms of injustice perceptions. Our initial studies confirmed our clinical impressions; individuals with high perceived injustice experienced more pain, more emotional distress and more disability (Sullivan et al., 2008). Our subsequent studies went on to document the various ways in which perceptions of injustice impacted negatively on recovery. Whiplash patients with high perceptions of injustice were less likely to benefit from rehabilitation interventions, were less likely to return to work, and were more likely to experience post-traumatic stress symptoms (Sullivan et al., 2009). On the basis of studies highlighting the deleterious effects of perceived injustice, we suggested that it was necessary to address perceptions of injustice in rehabilitation interventions designed to promote successful recovery following musculoskeletal injury.

In order to develop effective treatment techniques to reduce perceptions of injustice, it was first necessary to better understand the factors that contributed to perceptions of injustice following injury. A central feature of perceived injustice is the attribution of blame for one’s loss or suffering. As a first step in increasing our understanding of the determinants of perceived injustice, we decided to launch a study examining the targets of individuals’ injustice perceptions; in other words, who did whiplash victims consider to be to blame for their loss and suffering?

A study currently being conducted by a doctoral student at our Centre, Whitney Scott, was designed to examine who whiplash victims blame for their loss and suffering. In this study, clients with whiplash injuries who are enrolled in a rehabilitation program are interviewed about their injustice experiences. The interview proceeds by highlighting an item from the IEQ that the participant endorsed strongly. For example, for the item ‘I am suffering because of someone else’s negligence’, the interviewer would ask the participant, “Who were you thinking of when you responded to this item?”. The participant’s answers to the interview questions essentially reveal the targets of their perceptions of injustice.

Although the study is not yet completed, some interesting findings are emerging. Initially, we had assumed that since all participants had been injured in a rear-end collision, the driver of the other vehicle would be the likely target of injustice perceptions. Indeed, the driver of the other vehicle was frequently mentioned as the target of the participants’ injustice perceptions. Surprisingly, the insurance representative was mentioned as frequently as the driver of the other vehicle as the target of injustice perceptions.

Obviously, the insurance representative was not responsible for the accident. However, the insurance representative is the gateway to access to services, resources and compensation. Many participants indicated that they felt they were not given access to needed services or resources and as such felt that the insurance company was to blame for their ongoing suffering. Others mentioned that they felt they had been treated disrespectfully, or that the claims adjusters had not treated their case fairly.

Revenge motives frequently arise in the context of perceived injustice. In other words, when wronged, individuals seek retribution for their losses or suffering. The target of injustice perceptions, will also likely be the target of revenge motives. So how does a whiplash victim take revenge on the insurance company?
The only real avenue for revenge is to increase the ‘costs’ incurred by the insurer, and the most effective way to do this is to remain disabled. As long as the disability persists, there will be treatment costs, resources costs, and indemnity costs.

It is not necessary to assume that clients intentionally augment their disability in order to take revenge on the insurer. But the presence of revenge motives means that the client will be more invested in proving his or her disability than in focusing on recovery goals. The more the client is invested in proving his or her disability, the slower the recovery process will be.

For the whiplash victim, one fact that cannot be changed is that the accident occurred. In this manner, one might suggest that ascriptions of blame to the driver of the other vehicle are unavoidable. However, that the insurer should become the target of injustice perceptions is completely avoidable. For example, if a disrespectful interaction with a case manager gives rise to perceptions of injustice, it follows that a respectful interaction would not have contributed to perceptions of injustice. To the degree that insurance representatives can use an interaction style that minimizes the probability of the emergence of injustice perceptions, claim costs and associated duration of disability could be reduced substantially.

We are currently working with several injury insurers in Canada and the US, with the goal of developing techniques that will minimize the probability that the insurer will be seen as the target of the client’s injustice perceptions. Although there have been no clinical trials conducted yet on methods of reducing injury-related injustice perceptions, it is likely that research will reveal that this is a domain where prevention will be more effective than treatment.

The Psychology of Recovery from Joint Replacement Surgery

Arthritis is the leading cause of disability in North America. Patients with severe symptomatic OA of the knee may be considered candidates for knee replacement surgery (Total Knee Arthroplasty; TKA). TKA involves the replacement of diseased knee joints with prosthetic joints. Although TKA yields significant benefit for many individuals with OA, research suggests that 15% to 30% of patients will follow a problematic course of recovery characterized by prolonged and intense pain, mobility restriction, disability, and reduced quality of life.

A number of modifiable psychosocial variables have recently been identified as risk factors for poor surgical outcomes following TKA. In one study, we followed a cohort of approximately 200 individuals for one year after TKA. Analyses revealed that individuals with high scores on a measure of catastrophizing experienced more severe pain and disability following surgery than individuals with low catastrophizing scores. We also showed that catastrophizing leads individuals to ‘expect’ more negative surgical outcomes, and individuals with the most negative outcome expectancies, actually go on to have the worst recovery outcomes.

Increasingly researchers have called for greater attention to the development of interventions that specifically target pain-related psychosocial risk-factors in patients scheduled for TKA. It has been suggested that reducing psychosocial risk factors might lead to more positive post-surgical outcomes.

We have recently initiated a study with the objective of developing and testing an intervention targeting pain related psychosocial risk factors in individuals scheduled for TKA. The intervention we are developing will be based to some extent on PGAP. As in PGAP, one of the objectives will be to promote positive outcome expectancies for successful recovery following TKA. Two weeks after surgery, participants will be invited to enroll in a 10-week life-role reintegration program designed to assist them in resuming many of the activities that were discontinued due to their OA symptoms. As with PGAP, the primary objective is not to reduce post-surgical pain but rather to reduce post-surgical disability and increase quality of life. The results of this trial should be available in approximately two years.
Case Study - PGAP™ for a Client with Chronic Low Back Pain

Tanya was a 44 year old nurse who had sustained an injury to her lower back while at work. She was referred to an occupational rehabilitation program which she attended for 4 weeks. Tanya returned to work 6 weeks following her injury and worked for 2 months when her physician recommended that, due to her ongoing symptoms, she should discontinue her employment. When she was referred to our centre (Kootenay Health Services), she had been off work for 13 months.

Our initial assessment indicated that Tanya might be a suitable candidate for PGAP. She obtained scores in the risk range on all screening measures (Catastrophizing, 6/10; Perceived Injustice; Self-Reported Limitations, 8/10; Fear of Symptom Exacerbation, 6/10). Tanya also scored in the moderate severity range on measures of pain and depression.

Tanya’s Week 1 activity log revealed a very sedentary lifestyle. She would get up in the morning to get her son ready for school but spent much of the rest of the day resting, watching television or surfing the internet. In Week 3, Tanya agreed to the following activity goals: getting the house organized, going for walks with her husband, playing catch with her son, going to watch her son’s hockey games, and re-connecting with friends.

Tanya was able to start getting up earlier in the morning and would take a 15-minute walk when her son left for school. She made steady but slow progress toward her activity goals in the first few weeks of the program. At one point, she confessed that she felt overwhelmed by the thought of doing more each week. Mid-treatment assessment revealed reductions in self-reported limitations and fear of symptom exacerbation. However, no change was observed on catastrophizing or perceived injustice.

In Week 5, the Thought Reaction Record was introduced. Tanya described a stressful situation where she had met with a co-worker who shared how stressful work had been and could not imagine how Tanya would be able to meet those demands if she returned to work. Tanya reported that she felt stressed and was not confident that she could return to work. She reacted to these feelings by becoming tearful and watching television for the rest of the day. In a discussion of how she might have handled the situation differently, Tanya indicated that she could have reviewed the progress she had made toward her goals as a way of increasing her self-confidence.

In Week 7, Tanya completed the Discontinued Activities Form for work-related activities. Her responses about feared work activities formed the basis of a discussion with the insurer and her employer about the development of a graduated return to work plan. Tanya reflected that she felt like she played a central role in the development of the return to work plan and was more confident that she would succeed. In this discussion, it became clear that Tanya felt she had not been included in this first return to work plan of a year earlier. She indicated that many of the activities that had been included in the initial return to work plan were beyond her tolerance limits, but that no one seemed interested. It was clear that she experienced that situation with a sense of injustice. She recounted the following “Last year, I was pushed back to work too soon. I couldn’t keep up with the plan but no one seemed to care”. Her sense of injustice might have contributed to some degree to her decision to discontinue her employment and the subsequent extended period of disability.

In Week 8, the graduated return to work plan was initiated. Although Tanya was concerned that pain flare ups might interfere with her ability to perform her occupational activities, she was able to stick to the return to work plan, and within two weeks had resumed all her pre-injury activities.

In Week 9, the final assessment was conducted, the results of which are shown on the following page:
At the time of the final assessment, all scores on psychosocial measures were below the risk range (i.e., 5/10). The largest reductions were observed on catastrophizing (-5 points), fear of symptom exacerbation (-5 points) and self-reported limitations (-4 points). On these measures, a reduction of 2 points or more is considered clinically meaningful.

Tanya also showed important reductions in her symptoms of pain and depression. Her initial scores on pain and depression were in the moderate severity range; at treatment termination, her scores on both measures were below clinical threshold.

Both in terms of her verbal reports (e.g., lack of confidence in the ability to perform activities, concerns that activity would lead to pain flare ups, concerns that she would not be able to meet her occupational demands) and scores on the screening measures, it was clear that psychosocial factors were contributing to Tanya’s distress and disability. The successes that Tanya was able to experience from successful activity planning, and the ensuing sense of achievement seemed to contribute to her motivation to keep striving toward her goals.

Tanya appeared to benefit tremendously from PGAP’s client-centered approach. Tanya was able to experience a high sense of control as a result of being the one who chose activity goals, and the one to set the pace of activity involvement. It was necessary however to continue to emphasize the importance of progressively increasing activity involvement, otherwise, Tanya’s fears might have led to an excessively slow pace of activity involvement.

The gains that Tanya made went beyond reducing psychosocial risk factors. Tanya also showed important reductions in her symptoms of physical and emotional distress. She also shared that her confidence in her ability to achieve her goals had increased dramatically through the program. At one year follow-up, Tanya was still working full-time.

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Case Study - PGAP™ with a Client with Fibromyalgia and MDD

Rachel was a 49-year-old warehouse worker who had a long history of physical injuries including 2 car accidents, and two workplace accidents. She also had a 10-year history of fibromyalgia and emotionally taxing life events including recent deaths of close family members. She had been working at the warehouse through the majority of these life-events. She indicated that her most recent time off work occurred after a workplace incident when she had a conflict with a co-worker and her supervisor. She went off of work due to emotional distress for 5 months and then she was asked to return to work. Just at that time, another family member passed away and she found herself vomiting and feeling dizzy and her supervisor and family doctor told her not to come back to work yet. She stated that she had seen a psychiatrist for an assessment, but was not being followed actively by any medical rehabilitation specialists aside from her family doctor. At the time of the referral to the Centre for Rehabilitation and Health, she had been off work for 8 months.

Our initial assessment indicated that Rachel might be a suitable candidate for PGAP. She obtained scores in the risk range on 3/4 screening measures (Catastrophizing, 8/10; Self-Reported Limitations, 9/10; Fear of Symptom Exacerbation, 6/10). Rachel also scored in the severe range on measures of pain, depressive symptoms and fatigue.

Rachel’s Week 1 activity log revealed a very sedentary lifestyle. She would get up at irregular times between 10AM and 1PM and let the dog out, then spent the rest of the day resting, watching television or surfing the internet. In Week 3, Rachel agreed to the following activity goals: getting the house organized (including doing laundry), having regular showers, going for longer walks, re-connecting with friends, and waking at a regular time to take medication and prepare for return to work where she would have to wake up at that time.

Rachel was having difficulties getting up at her desired time, but she was getting out of bed earlier in the morning. She began walking longer distances. She went to restaurants, attended neighbourhood events, and visited parks with her family. Steady but slow progress was made toward her activity goals in the first few weeks of the program. There were a few challenges along the way. She had some sessions where she would become tearful, thinking about her pain and isolation. She benefitted from emotional support, and re-framing using the thought reaction record. Mid-treatment assessment revealed reductions in fear of symptom exacerbation and catastrophizing. However, no change was observed on self-reported limitations. She was better at getting out of bed and getting ready for the day when she had an appointment with another person to motivate her. I thought that she might be more successful at getting up in the morning if she had her work to go to. She indicated that she was willing to begin a graduated return to work program.

In Week 5, the Thought Reaction Record was introduced. Rachel described distress related to painful feelings and sadness about her relationship with her father. Using the thought reaction record, she decided to focus her energies on her rehabilitation, and to set her attention to the positive strengths she possessed. Her desire to return to her job, and the many positive aspects of working assisted her to feel motivated to use her strength and positive attitude to move her life forward.

In Week 7, Rachel had a return to work meeting and agreed to a graduated plan to help ease her back to work. Her concerns with dealing with a co-worker with whom she had a conflict had been resolved by HR, and the co-worker was no longer working in the same vicinity as Rachel. Rachel had also made the decision to focus her energies on her own rehabilitation rather than on the conflict. She was provided with encouragement and modified duties to build up her strength as she returned to work. Although Rachel was concerned that pain flare ups might interfere with her ability to perform her occupational activities, she was able to stick to the return to work plan, and resumed all her pre-injury activities.
In Week 9, the final assessment was conducted, the results of which are shown below:

At the time of the final assessment, all scores on psychosocial measures were just at or below the risk range. The largest reductions were observed on self-reported limitations (-4 points), fear of symptom exacerbation (-3 points) and fear of activity (-2 points).

Rachel also showed important reductions in her symptoms of pain and depression. Her initial scores on pain and depression were in the severe range; at treatment termination, her scores on both measures were reduced to mild.

By making observations about Rachel’s strengths, and her behaviour patterns, I supported her with her motivation to return to work. It was essential to listen to Rachel and validate her feelings, while continuing to emphasize the importance of progressively increasing activity involvement. By listening and validating, I developed rapport and an alliance with Rachel. She was able to work with her return-to-work team on coming up with solutions to rehabilitation obstacles. Rachel also showed important reductions in her symptoms of physical and emotional distress.

At the end of the Program, Rachel stated that she had never participated in a program like PGAP before, and she was grateful for the support, and ready to continue with her life.

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Information Updates

An Information Session for Insurer Representatives:

The University Centre for Research on Pain and Disability will host a free Progressive Goal Attainment Program (PGAP™) information session for insurer representatives on November 29, 2012 from 10am to 12:00 at the Four Points by Sheraton Toronto Airport Hotel at 6257 Airport Road, Mississauga, Ontario.

This session will briefly summarize current research on psychosocial risk factors for delayed recovery. The presentation will also describe the use of the PGAP as a cost effective intervention suitable for clients who present with a psychosocial risk profile. In this presentation, the applicability of PGAP to different client populations (e.g., medical conditions, mental health conditions) will be addressed.

Registration is required as seating is limited. Expression of interest is required using your insurer affiliated email address: info@pdp-pgap.com
Veterans Affairs representatives are included in this invitation. VAC email address is required to request a space.

PGAP™ Workshops Scheduled for 2012 - 2013

Our 2-day PGAP workshops will be scheduled in Toronto, Ontario on November 30 & December 01, 2012 and on March 22 & 23, 2013. Dr. Sullivan is on sabbatical September 2012 through September 2013 and additional workshops are unlikely to be scheduled. The language of instruction for these workshops is English. Unfortunately, simultaneous translation is not available.

Information and registration forms are available to download on our website: http://www.pdp-pgap.com/pgap/en/workshops.html

Please note confirmation of receipt of registration forms will only be sent out after our return from vacation – after September 5.

OFFICE VACATION DATES

The University Centre for Research on Pain and Disability will be closed from August 20 – September 4 inclusive. Telephone calls, faxed messages, emails and orders for materials will not be monitored during this time. Please feel free to leave messages that will be responded to after September 4.
Selected activities and publications since our last Newsletter

Published Refereed Papers


Accepted/ In Press Refereed Papers


Martel, M-O., Wideman, T., Sullivan, M.J.L. Pain patients who display pain behavior are perceived as less likable, less dependable and less likely to return to work. Pain, in press.

Scott, W., Sullivan, M.J.L. Perceived injustice moderates the relationship between pain and depression among individuals with persistent musculoskeletal pain. Pain Research and Management, in press.

Wideman, T.H., Main, C.J., Lewis, M., Sullivan, M.J.L., Hill, J.C. Comparing the responsiveness of a brief, multidimensional risk screening tool for back pain to its unidimensional reference standards: The whole is greater than the sum of its parts. Pain, in press.


**In Press Book Chapters**


**Published Book Chapters**


**Scientific and Invited Plenary Presentations:**


Sullivan, M.J.L. Perceived injustice as a determinant of the persistence of physical and emotional problems following musculoskeletal injury. International Association for the Study of Pain 14th World Congress on Pain, Milan, Italy. August 2012.

Niederstrasser, N.G., Stanish, W., Dunbar, M., Tanzer, M., Sullivan, M.J.L. Dimensions of catastrophic thinking that mediates the relation between fear and disability following total knee arthroplasty. International Association for the Study of Pain 14th World Congress on Pain, Milan, Italy. August 2012.

Wideman, T.H., Hill, J.C. Keele, Main, C.J., Lewis, M., Sullivan, M.J.L. Comparing the responsiveness of a brief, multidimensional risk screening tool for back pain to its unidimensional reference standards: the whole is greater than the sum of its parts. International Association for the Study of Pain 14th World Congress on Pain, Milan, Italy. August 2012.


Scott, W., Wideman, T., Sullivan, M.J.L. The relative clinical utility of percent change and absolute post-treatment scores on pain catastrophizing as indicators of meaningful change during the course of a multidisciplinary rehabilitation program for individuals with whiplash injuries. Annual Scientific Meeting of the Canadian Pain Society in Whistler, BC. May 2012.

Sullivan, M.J.L. Mental Health Consequences of Injury: Who is at risk and what can be done about it. Workers and Employers Services, WorkSafeBC. (InterOrganizational Training Committee). Richmond, BC. May 2012.


Colloquia and Invited Clinical Presentations

Psychosocial interventions for the prevention of occupational-related disability. LifeTEAM. Dallas, Texas, May 2012.


Targeting psychosocial risk factors to promote return to work. McGill Science Café. Montréal, QC, April 2012.

Les symptômes dépressifs ralentissent-ils le rythme de rétablissement après une blessure musculosquelettique? Salon réadaptation et gestion d’invalidité. Laval, QC, April 2012.


Psychosocial interventions for the prevention of occupational-related disability. LifeTEAM. Los Angeles, California, February 2012.


Targeting psychosocial factors to promote occupational integration. Liberty Mutual’s Regional Medical Directors Meeting. Hopkinton, MA, July 2011.

Le rôle de la perception d’injustice dans la réadaptation des personnes ayant des lésions musculo-squelettiques. SAAQ. Quebec City, QC, June 2011.

TRAINING WORKSHOPS (Knowledge Exchange)


- Gaspe, Quebec, December 01, 2011
- Gaspe, Quebec, November 30, 2011

The Progressive Goal Attainment Program (PGAP): Training Workshop

- Richmond, British Columbia, June 15-16, 2012
- Dallas, Texas, June 01-02, 2012
- Houston, Texas, April 01-02, 2012
- Toronto, Ontario, March 30-31, 2012
- Los Angeles, California, February 23-24, 2012
- New Haven, Connecticut, November 17-18, 2011
- Winnipeg, Manitoba, November 4-5, 2011