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The course of whiplash
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Can kinesiophobia predict the duration of neck symptoms in acute whiplash?

J. Buitenhuis, J. Jaspers, V. Fidler

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Abstract

Objectives: In low back pain, clinical studies suggest that kinesiophobia (fear of movement/reinjury) is important in the etiology of chronic symptoms. In this prospective cohort study, the predictive role of kinesiophobia in the development of late whiplash syndrome is examined.

Methods: Victims of car collisions with neck symptoms who initiated compensation claim procedures with a Dutch insurance company were sent a questionnaire containing symptom-related questions and the Tampa Scale of Kinesiophobia (TSK-DV). Follow-up questionnaires were administered, respectively 6 and 12 months after the collision. Survival analysis was used to study the relationship between the duration of neck symptoms and explanatory variables.

Results: Of the 889 dispatched questionnaires, 590 (66%) were returned and 367 used for analysis. The estimated percentage of subjects with neck symptoms persisting one year after the collision was 47% (SE 2.7%). In a regression model without symptom-related variables, kinesiophobia was found to be related to a longer duration of neck symptoms (P=0.001). However, when symptom-related information was entered into the model, the effect of kinesiophobia did not reach statistical significance (P=0.089).

Discussion: Although a higher score on the TSK-DV was found to be associated with a longer duration of neck symptoms, information on early kinesiophobia was not found to improve the ability to predict the duration of neck symptoms after motor vehicle collisions.
Can kinesiophobia predict the duration of neck symptoms in acute whiplash?

Introduction

Few medical subjects give rise to as much discussion and controversy as whiplash. Although the term ‘whiplash’ is widely used, it is not so much a diagnosis as a description of an injury process. The chronic syndrome, with long-lasting symptoms and without evidence of structural or somatic trauma, is often referred to as late or post-whiplash syndrome.

In the last decades, many studies on chronic neck symptoms after motor vehicle collisions have been published in search of discriminating etiological factors. Studies on somatic theories and mechanical aspects of the trauma are still being published, but recently more articles have focused on psychological, cultural and social factors as an explanation for the various characteristics of this syndrome.

Although still subject to debate, a general consensus is building that post-whiplash syndrome should be regarded as a functional somatic syndrome with etiological factors known to be involved in similar syndromes.

A recent systematic review of prognostic factors stated that high initial pain intensity, restricted cervical range of motion, high number of symptoms, previous psychological problems, and nervousness are considered risk factors for delayed recovery, although the available evidence is not very strong. Therefore additional research on possible etiological and predicting variables, including behavioral and cognitive aspects, is needed.

One such potential factor is kinesiophobia. Kinesiophobia is a specific pain-related fear in which a patient has an excessive, irrational, and debilitating fear of physical movement and activity resulting from a feeling of vulnerability to painful injury or reinjury. Fear of movement leads to inactivity and is a good predictor for disability in the case of chronic low back pain. Pain-related fear plays a central role in the fear-avoidance model. This model offers a framework for conceptualizing the process of developing chronic low back pain.

In low back pain, clinical studies suggest that an excessively negative orientation toward pain “catastrophizing” and fear of movement/(re)injury are important in the etiology of chronic symptoms. In the fear-avoidance model, catastrophizing leads to pain-related fear, leading to avoidance behavior including avoidance of movement and physical activity. In low back pain, fear-avoidance beliefs are identified as risk factors for chronic low back symptoms, suggesting these factors are causal.

Furthermore, chronic low back pain patients who retrospectively reported a sudden traumatic pain onset exhibited higher kinesiophobia than patients who reported that the pain symptoms started gradually.

Since, in the case of whiplash, it is known that an early active treatment is preferable,
a passive attitude induced by fear of movement can also play a role in the development of post-whiplash syndrome.\textsuperscript{21,22,23} For treatment it is of course of great importance to know if fear is the main factor leading to inactivity.

Therefore, because of the apparent role of kinesiophobia in the transition from acute to chronic low back pain, it is conceivable that it could play a role in recovery from acute neck pain as well.

Recent research in this context appears to support this idea.\textsuperscript{24,25} Nederhand et al. recently concluded that a test for fear of movement can be used to help predict the outcome of traumatic neck pain.\textsuperscript{25}

In this 1-year prospective study we investigate the predictive value of early kinesiophobia on the duration of neck symptoms after motor vehicle collisions.

\textbf{Materials and Methods}

\textbf{Participants}

Over a 10-month period, we invited all car collision victims with neck symptoms who had initiated compensation claim procedures with a Dutch insurance company to participate in the study. We excluded claimants younger than 18 or older than 65 years of age, and victims with structural injuries, loss of consciousness or with a history of chronic pain.

In the Netherlands, the settlement of personal injury claims is based on liability insurance, where accident victims seek compensation from the insurer of the driver at fault. The letter of invitation made it clear that the study was independent of the compensation procedure.

\textbf{Questionnaires}

We sent the claimants a questionnaire (Q1) concerning the collision and their symptoms at that time. Table 1 provides an overview of the items on the questionnaire. We also asked the claimants to fill in the Tampa Scale of kinesiophobia (TSK).\textsuperscript{17}

The TSK is a 17-item 4-point questionnaire that measures the fear of (re)injury due to movement. The Dutch version of the TSK (TSK-DV) has good reliability and validity.\textsuperscript{18,26,27}

Six (Q2) and twelve (Q3) months after the collision, we monitored the course of the symptoms by means of two identical questionnaires, which contained a subset of questions of the first questionnaire (Q1). When the neck symptoms had ceased the victims were asked how long the neck symptoms had lasted. From this data the duration of neck symptoms was calculated.
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**Statistical analysis**

We used Cox model regression to study the relationship between duration of neck symptoms and explanatory variables. We analyzed both the total duration of symptoms starting from the collision and the duration of symptoms after filling out the first questionnaire (Q1). The former analysis involved all eligible subjects and explanatory variables known at the time of the collision, the latter analysis included only subjects with symptoms at the time of filling out Q1. In this analysis we examined the role of the TSK-DV score and of the symptom-related information, while correcting for possible confounding variables. The delay in filling out Q1 (the time between the collision and Q1) and the period in which the accident took place were also included in the analysis.

Note that in Cox regression analysis the effect of an explanatory variable on the duration of symptoms is expressed as a hazard ratio (HR). A HR less than 1 corresponds to a situation where a higher value for the explanatory variable results in a longer duration, a HR above 1 corresponds to a shorter duration. HR is one when there is no relation.

To investigate the effect of non-response, we compared the time-to-claim closure of respondents and partial respondents. Time-to-claim closure is the time between the collision and the moment the claim compensation procedure ends, and is used

---

**Table 1**

Overview of variables analyzed in relation to the duration of neck symptoms.

<table>
<thead>
<tr>
<th>Variable</th>
<th>values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>years</td>
</tr>
<tr>
<td>Gender</td>
<td>male, female</td>
</tr>
<tr>
<td>Head restraints</td>
<td>no/yes</td>
</tr>
<tr>
<td>Collision anticipated</td>
<td>no/yes</td>
</tr>
<tr>
<td>Seat in car during collision</td>
<td>5 possible seats</td>
</tr>
<tr>
<td>Site of collision</td>
<td>8 sectors</td>
</tr>
<tr>
<td>Seatbelt use</td>
<td>no/yes</td>
</tr>
<tr>
<td>Neck pain intensity</td>
<td>1 (no pain) – 10 (severe pain)</td>
</tr>
<tr>
<td>Headache intensity</td>
<td>1 (no pain) – 10 (severe pain)</td>
</tr>
<tr>
<td>Neck stiffness</td>
<td>1 (no stiffness) – 10 (severe stiffness)</td>
</tr>
<tr>
<td>Severity of restriction of neck movements</td>
<td>1 (no restrictions) – 10 (severe restrictions)</td>
</tr>
<tr>
<td>Radiating pain in arms</td>
<td>1 (no) – 10 (severe pain)</td>
</tr>
<tr>
<td>Severity of paresthesia in the arms</td>
<td>1 (no) – 10 (severe paresthesia)</td>
</tr>
<tr>
<td>Concentration symptoms</td>
<td>1 (no) to 10 (severe symptoms)</td>
</tr>
<tr>
<td>Difficulty reading</td>
<td>1 (no) to 10 (severe symptoms)</td>
</tr>
<tr>
<td>Difficulty attending to a conversation</td>
<td>1 (no) to 10 (severe symptoms)</td>
</tr>
<tr>
<td>Dizziness</td>
<td>1 (no) to 10 (severe dizziness)</td>
</tr>
<tr>
<td>Use of medication since collision</td>
<td>no/yes</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>no/yes</td>
</tr>
<tr>
<td>Daily duration of pain</td>
<td>1 (always) to 5 (less than 3 hours)</td>
</tr>
<tr>
<td>Onset of neck symptoms</td>
<td>hours after collision</td>
</tr>
<tr>
<td>Tampa Scale of Kinesiophobia</td>
<td>17 - 68</td>
</tr>
</tbody>
</table>
in automobile insurance studies.\textsuperscript{29} We used 5\% as the nominal level of statistical significance.

The TSK-DV score and the initial symptoms (questionnaire 1) were recorded at the same time. To answer the question whether the TSK-DV score can be predicted from these symptoms, we carried out multiple linear regression with gender, age and symptom variables as the independent variables.

Computations were carried out using the statistical package SPSS 11.

\textbf{Results}

\textbf{Participants and response}

During the intake period we dispatched 889 questionnaires. The median time of dispatch was 19 days after the collision (P25=13 days, P75=28 days). The number of questionnaires returned was 590 (66\%). Among those returned, the median time for return was 32 days after the collision (P10=18 days, P90=65 days). Forty-seven per cent of questionnaires were returned within 30 days, 67\% within 40 days. Most collisions took place on Fridays (19\%); 12\% and 10\% of the collisions took place on Saturdays and Sundays.

We studied the total duration of symptoms in a group of 367 eligible subjects. Table 2 summarizes the reasons for exclusion of 223 of the 590 questionnaires received. Compared to the group with insufficient information (n=88), the eligible group (n=367) was on average 3 years younger (t-test, p=0.044), had a similar gender composition (chi-square test, p=0.78) and a similar time-to-claim closure distribution (Cox regression, p=0.74).

\begin{table}[h]
\caption{Overview of included and excluded subjects}
\begin{tabular}{lrr}
\hline
Questionnaires sent & 889 & 100\% \\
returned & 590 & 66\% \\
\hline
excluded & & \\
Too young/too old & 20 & \\
No collision/no neck symptoms & 101 & \\
Insufficient data & 88 & \\
Already suffered chronic pain or Whiplash & 11 & \\
Various & 3 & \\
\hline
Total excluded & 223 & \\
Eligible & 367 & \\
\hline
\end{tabular}
\end{table}
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Table 3. Basic characteristics of the eligible group (n=367 unless stated otherwise) and of the study group with symptoms on the first questionnaire (n=211).

<table>
<thead>
<tr>
<th></th>
<th>Eligible group</th>
<th>Study group with symptoms on the first questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Mean (SD)</td>
<td>36 (12)</td>
<td>38 (12)</td>
</tr>
<tr>
<td>Gender Male (%)</td>
<td>156 (42%)</td>
<td>88 (42%)</td>
</tr>
<tr>
<td>Car seat Driver</td>
<td>285 (78%) (n=365)</td>
<td>160 (76%)</td>
</tr>
<tr>
<td>where was the car hit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rear center</td>
<td>269 (81%) (n=332)</td>
<td>156 (74%)</td>
</tr>
<tr>
<td>Use of seatbelts Yes</td>
<td>340 (93%)</td>
<td>196 (93%)</td>
</tr>
<tr>
<td>Head restraints Yes</td>
<td>354 (97%)</td>
<td>200 (95%)</td>
</tr>
<tr>
<td>Collision anticipated Yes</td>
<td>112 (31%) (n=365)</td>
<td>68 (32%)</td>
</tr>
<tr>
<td>Day of the week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunday to Saturday</td>
<td>10,11,15,16,17,19,12 (%)</td>
<td>10,11,11,18,20,21,10 (%)</td>
</tr>
<tr>
<td>Delay (collision to Q1, days)</td>
<td>median (P25,P75)</td>
<td>31 (22, 43)</td>
</tr>
</tbody>
</table>

Figure 1. Kaplan-Meier curve of duration of neck symptoms in eligible group (n=367). Vertical strokes mark censored observations.
Table 3 presents the basic characteristics of the eligible group. During the follow-up, 51% of this group became free of neck symptoms. Figure 1 shows the Kaplan-Meier curve. The estimated percentage of subjects with neck symptoms persisting one year after the collision was 47% (SE 2.7%). The median of the duration of symptoms was 180 days.

In the eligible group (n=367), the first questionnaire was returned after a median delay of 32 days after the collision (P10=18 days, P90=67 days). Of the eligible group, 211 subjects could be included for further analyses of duration of neck symptoms after filling out the first questionnaire. From the respondents we excluded 86 subjects who were already symptom-free, 44 who were symptom-free at the time of filling out the first questionnaire according to the second questionnaire but not according to the first questionnaire (thus providing inconsistent information), and 26 subjects who did not

**Table 4.** Symptom-related characteristics at first questionnaire (n=211).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensity of neck pain (n=210)</td>
<td>6.0 (2.1)</td>
</tr>
<tr>
<td>Daily duration of pain (n=208)</td>
<td>2.3 (1.4)</td>
</tr>
<tr>
<td>Hours after collision until onset of neck symptoms, hours (n=209)</td>
<td>0 (0, 3)</td>
</tr>
<tr>
<td>Headache intensity (n=211)</td>
<td>5.0 (2.7)</td>
</tr>
<tr>
<td>Neck stiffness (n=211):</td>
<td>6.2 (2.6)</td>
</tr>
<tr>
<td>Severity of restriction of neck movements (n=211)</td>
<td>5.0 (2.3)</td>
</tr>
<tr>
<td>Extent of neck pain (n=209)</td>
<td>3.5 (2.8)</td>
</tr>
<tr>
<td>Severity of paresthesia in the arms (n=210)</td>
<td>3.0 (2.7)</td>
</tr>
<tr>
<td>Use of medication since collision (n=211)</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>120 (60%)</td>
</tr>
<tr>
<td>Concentration symptoms (n=211)</td>
<td>4.5 (2.9)</td>
</tr>
<tr>
<td>Difficulty reading (n=211)</td>
<td>4.0 (2.8)</td>
</tr>
<tr>
<td>Dizziness (n=210)</td>
<td>3.8 (2.9)</td>
</tr>
<tr>
<td>Sleep disturbance (n=211)</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>116 (55%)</td>
</tr>
<tr>
<td>Tampa Scale of kinesiophobia score (n=211):</td>
<td></td>
</tr>
<tr>
<td>mean (SD)</td>
<td>40.5 (8.6)</td>
</tr>
<tr>
<td>median (P25,P75)</td>
<td>41 (34, 47)</td>
</tr>
</tbody>
</table>
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return the second questionnaire. Table 3 summarizes the basic characteristics of the study group, and Table 4 presents the symptom-related information.

**Duration of neck symptoms**

Table 5 summarizes the results of Cox regression analyses. Three models are presented. All of them include gender, age, delay, and a variable indicating whether the collision occurred during the first three months of the study. These potential ‘basic’ confounders appeared to be related to the outcome at some stage of the analyses, although not all of them are significant in the final models.

Model 1 results from including all variables except the questions concerning the nature of the symptoms. In addition to the basic variables, the model includes the TSK-DV score and the presence of head restraints. According to this model, a score 10 points higher on the TSK-DV corresponds to reducing by about a factor of 2 the instantaneous probability of becoming symptom free. The presence of head restraints was found to be associated with a longer (!) duration of neck symptoms. Kaplan-Meier curves in Figure 2 illustrate the effect of the TSK-DV.

Table 5: Results of Cox regression

<table>
<thead>
<tr>
<th>Variable</th>
<th>model 1</th>
<th>model 2</th>
<th>model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HR</td>
<td>P-value</td>
<td>95%-CI</td>
</tr>
<tr>
<td>Gender (M:F)</td>
<td>1.77</td>
<td>0.034</td>
<td>1.04 - 3.02</td>
</tr>
<tr>
<td>Age (10 years)</td>
<td>0.78</td>
<td>0.025</td>
<td>0.63 - 0.97</td>
</tr>
<tr>
<td>Study period</td>
<td>0.28</td>
<td>0.038</td>
<td>0.09 - 0.93</td>
</tr>
<tr>
<td>Delay (days)</td>
<td>0.98</td>
<td>0.025</td>
<td>0.96 - 1.00</td>
</tr>
<tr>
<td>Head restraints (N:Y)</td>
<td>3.06</td>
<td>0.021</td>
<td>1.18 - 7.9</td>
</tr>
<tr>
<td>TSK-DV (10 points)</td>
<td>0.47</td>
<td>0.001</td>
<td>0.33 - 0.65</td>
</tr>
<tr>
<td>Restricted movements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiating pain in arms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>2.27</td>
<td>0.007</td>
<td>1.25 - 4.1</td>
</tr>
</tbody>
</table>

HR = Hazard Ratio, CI = Confidence Interval, Study period: first 3 months of the study compared to the rest
Model 2 results from considering all variables except the TSK-DV score. We found three variables describing symptoms to be related to the outcome. Neck stiffness, radiating pain in arms, and difficulty falling asleep were associated with longer duration of neck symptoms. Model 3 results from considering all variables together. The results are similar to those in Models 1 and 2; however, the effect of the TSK-DV score is smaller and no longer significant.

The models presented include three questions describing symptoms from the first questionnaire. Because the symptom-related questions are correlated, on interchanging some of these variables with other symptom-related questions we obtained similar results. The overall picture is that when we enter symptom-related information into the model, the effect of the TSK-DV score does not reach statistical significance.

In the linear regression analysis the TSK-DV score was found to decrease with age (p=0.054), to be higher for males (p=0.032) and to increase with neck pain, concentration problems and sleep disturbance (all P<0.001); the adjusted r-square was 0.38. Cronbach's
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alpha for the TSK score was 0.76 (n=211), similar to the value reported for other populations.26

Discussion

Our study shows that a relation exists between the score on the TSK-DV and the duration of neck symptoms. However, when subjective symptom variables are added to the model, the TSK-DV score is no longer significantly related to the duration of neck symptoms. This loss of significance is due to correlation between specific symptoms and the TSK-DV score.

The relation found between the duration of neck symptoms and gender and age has also been reported in other studies.30,31

In accordance with earlier research on kinesiophobia in low back pain, which showed a modest but significant relation between pain intensity and the TSK-DV score, we found the TSK-DV scores to be significantly related to the intensity of neck pain.20,26 This is consistent with the understanding that a relation exists between anxiety and pain.19 Furthermore, we found that men score significantly higher on the TSK-DV, which is also reported in other studies.26 Studies on post-whiplash syndrome, on the other hand, found that whiplash-injury related neck symptoms last longer in women.20,30,32,33 We also found concentration problems and difficulties in falling asleep to be significantly related to the TSK-DV score. This suggests that an interaction exists between kinesiophobia, or pain-related fear, and the frequently reported cognitive symptoms.19

Our results do not seem to be consistent with the study by Nederhand et al.25 There are several items that should be considered when comparing the results.

First, there is a major difference in the targeted population. In the study by Nederhand et al., the participating patients were recruited after visiting a hospital emergency room. From as yet unpublished data in a study using a different sample from the same population, we estimate that only 50% of our targeted population visited a hospital after the collision. Recruiting from patients that visited a hospital after the collision could select a group exhibiting more symptoms and more fear.

Second, the primary outcome variable used is very different. Nederhand et al. used the score on the Neck Disability Index (NDI) after 6 months as primary outcome variable. In our study the duration of neck symptoms is the primary outcome variable.

When the results of the study by Nederhand at al. are considered carefully, the differences are perhaps smaller than at first appear. We could not reject the nullhypothesis of no effect of TSK adjusted for confounders. However, as Nederhand et al. based their
conclusions on an unadjusted analysis, adjustment of the results could remove the TSK effect in their data as well.

Because the TSK-DV score, when corrected for early subjective symptom reports, does not significantly relate to the duration of neck symptoms, it does not seem suitable as an instrument for predicting the duration of neck symptoms after motor vehicle collisions. However, the fact that the TSK-DV score is significantly related to the duration of neck symptoms when the early subjective symptom information is not considered leaves room for further discussion. Studies on chronic pain have shown that pain-related fear can lead to overprediction of pain, pain vigilance and concomitant muscular activity, and therefore to possible higher scores on pain-related questions.8,19,34-36

We cannot explain the negative effects of head restraints on the duration of neck symptoms, as shown in model 1. Although some studies describe no significant relation between head restraints and the outcome of whiplash, the obvious surmise is that head restraints help to prevent acute neck distortion.37,38 We feel that the negative relation found is an indication of the very limited value of mechanical factors on the development of post-whiplash syndrome.39

We would like to emphasize that this is one of the first studies using the Tampa Scale of Kinesiophobia for patients with neck pain. Furthermore, our study focuses on the duration of neck symptoms, and not disability or other more behavioral parameters. Other studies on the value of kinesiophobia in whiplash used the Neck Disability Index (NDI), and although limited to a six-month follow-up, found no relation between the NDI and the TSK.24,25 To achieve an adequate response we did not include a specific neck pain disability questionnaire.40 Although the validity of some of these questionnaires has recently been questioned, we feel that conclusions on the validity of the fear-avoidance model in neck pain after motor vehicle collisions should be considered carefully.41

A further limitation of our study is the fact that since it is a mail-out survey there was no control of the conditions under which questionnaires were completed.

Though the study group consisted of subjects who had initiated compensation claim procedures, we do not think that this induced a bias towards more serious symptoms.15,42 In the Netherlands, starting such a procedure has a very low threshold. The damage report form used for claiming the car damage, and usually filled out within a few days of the collision, contains a section for the names of victims and their symptoms. We invited all claimants directly from these forms, including victims who did not seek medical help at the time, or did not visit an emergency room at all. Furthermore, although the insurer
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and victim can be seen as opposing parties, most claims in the Netherlands, even large
ones where serious injuries are involved, are settled out of court. None of the participating
subjects were in actual litigation.

Although a recent study, using a Functional Capacity Evaluation (FCE) as primary
outcome, has found no relation between kinesiophobia and the results on the FCE, future
research on the role of kinesiophobia in neck pain after motor vehicle collision should
use a disability outcome.\textsuperscript{43} Since the Tampa Scale of Kinesiophobia was constructed for
back pain, it should perhaps be adjusted when used for neck pain. Future research should
examine which fears are specific to patients with traumatic neck pain. Furthermore,
research on pain catastrophizing and its relation with neck pain after motor vehicle
collisions should be conducted.

To sum up, a higher score on the Tampa Scale of Kinesiophobia was found to be
associated with a longer duration of neck symptoms, but this relationship ceased to
be significant after correction for early subjective symptoms. With knowledge of early
symptoms at hand, the information on early kinesiophobia does not improve our ability
to predict the duration of neck symptoms after motor vehicle collisions.
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