Catastrophizing and Causal Beliefs in Whiplash

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In recent decades, whiplash has become the most common diagnosis following motor vehicle accidents.¹ In its acute phase whiplash is defined as myogenic neck complaints after a sprain of the neck.

Although the majority of patients show spontaneous recovery within the first few months after a traffic accident, in as many as 40% of cases these acute complaints lead to a chronic syndrome with neck pain and often cognitive complaints.²⁻⁴ This chronic syndrome is often referred to as late or postwhiplash syndrome, characterized by unexplained physical and cognitive symptoms. Although still subject to debate, a general consensus is building that postwhiplash syndrome should be regarded as a functional somatic syndrome in which cultural as well as psychological factors play a major role.⁵⁻⁶

Postwhiplash syndrome can lead to invalidating effects and long-term work disability.⁷⁻⁸ It is therefore of paramount importance to gain insight into the factors responsible for this chronic course.

Earlier work in the context of other chronic disorders characterized by unexplained physical complaints, such as chronic low back pain, provided evidence to suggest that pain catastrophizing and attributional bias are of crucial importance in the development of chronic complaints.⁹ In the Fear-Avoidance model for chronic musculoskeletal pain, the pathway from pain experience to fear, anxiety, and avoidance, leading ultimately to disuse and disability, is modulated by catastrophizing and threatening illness beliefs.¹⁰ Similar mechanisms may also apply to chronic neck complaints.¹¹⁻¹² Preliminary support for this comes from recent studies showing that fear of pain and the presence of relatively intense anxiety symptoms are related to poor prognosis of neck complaints following motor vehicle accidents.⁴⁻¹³

Pain catastrophizing refers to an exaggeratedly negative orientation towards actual or anticipated pain.¹⁴ Earlier research has found that the habitual tendency to make catastrophic interpretations of pain is associated with a heightened pain experience in various patient groups.¹⁵ Furthermore, catastrophizing has been associated with heightened disability in chronic pain, independent of the level of actual physical impairment.¹⁶⁻¹⁸

The first aim of the present study is to investigate whether pain catastrophizing is similarly involved in the development of chronic neck pain following motor vehicle accidents. In addition, this study investigated the role of “causal illness beliefs.”

Causal illness beliefs can be defined as the patient’s ideas about the origin or cause of the symptoms or illness experienced. It has been found in chronic fatigue syn-
Pain catastrophizing and causal beliefs–especially the attribution of neck complaints to whiplash–are thought to be caused or fuelled by culturally embedded beliefs regarding the course and severity of whiplash. Dysfunctional causal beliefs can be defined as the attribution of the cause of acute myogenic neck complaints to severe, neural or irreparable causes. At the chronic stage, somatic or organic beliefs in general can be considered dysfunctional.

Medical interpretation and explanation of myogenic neck pain after motor vehicle accidents by general practitioners or emergency room staff, commonly held knowledge and culturally defined ideas may give rise to dysfunctional illness beliefs regarding the cause of the neck complaints, which in turn may result in a chronic course.23

Furthermore, dysfunctional causal beliefs are thought to be caused or fuelled by culturally embedded beliefs regarding the course and severity of whiplash. It has been demonstrated that symptom expectations for whiplash differ between countries known to have different prevalence figures for chronic whiplash.24–29 Accordingly, it has been argued that these symptom expectations, and hence the attribution of complaints to whiplash, are responsible for more severe and prolonged complaints.23,27,28

Additionally, it is conceivable that pain catastrophizing leads to more dysfunctional causal beliefs. The tendency to attribute neck complaints to irreparable or severe causes in its turn may elicit catastrophic and dysfunctional causal beliefs could thus lead to a negative spiral, augmenting symptom severity and discharging into irrational expectations regarding the course of the symptoms and disability, fuelling a chronic course.10,30

In sum, this prospective study examined the predictive validity of catastrophizing and causal beliefs in the development of postwhiplash syndrome after motor vehicle accidents. More specifically, we tested the following predictions:

1. Pain catastrophizing and causal beliefs–especially the attribution of neck complaints to whiplash–are related to more severe whiplash complaints.
2. Pain catastrophizing and causal beliefs–especially the attribution of neck complaints to whiplash–hamper the recovery from acute whiplash complaints.

Materials and Methods

Study Design
We used a prospective longitudinal design. Participants were assessed at 1 (Q1), 6 (Q2), and 12 months (Q3) after their accidents.

Participants and Procedure
Traffic-accident victims who had initiated compensation claim procedures for personal injury with a Dutch insurance company were asked to participate in this study. In the Netherlands, the settlement of personal injury claims is based on liability insurance with the accident victims seeking compensation from the insurance company of the driver at fault.

During the intake period, 1252 questionnaires were dispatched. Questionnaires were not sent to victims known to be younger than 18 or older than 65. The number of initial questionnaires returned was 747 (59.7%). Nonresponse analysis revealed no significant difference in age (t test, P = 0.98) and gender (χ2, P = 0.20).

The initial selection from the returned questionnaires included only the responses of victims with neck complaints at Q1 who had been involved as drivers or passengers in a car accident (n = 156).

To rule out the potentially confounding influence of concurrent complaints and to obtain a homogeneous sample of participants with only soft tissue injuries, 16 victims were excluded because of a history of whiplash or other chronic pain, 1 or more fractures, or a loss of consciousness of longer than 1 minute. In the final sample therefore, 140 participants’ responses were eligible for further analysis.

Questionnaires and Outcome Variables
After a median time of 25 days (mean 26.44 days, SD = 9.32) after the accident, we sent each claimant a questionnaire (Q1) concerning the accident, the injuries they had sustained, and their complaints at that time.

Consistent with our previous studies on postwhiplash syndrome, participants suffering from neck pain, loss of consciousness of no longer than 1 minute and no self-reported previous neck complaints were included as postwhiplash syndrome patients.3,4,13

Disability was measured using the Neck Disability Index (NDI). The NDI consists of 10 items with a 6-point scale, addressing functional activities (personal care, lifting, reading, work, driving, sleeping, and recreational activities), pain intensity, concentration, and headache.31 The NDI has been shown to be valid, reliable, and sensitive to change in a population of patients suffering from neck pain and showed a high internal consistency.31

Pain catastrophizing was measured using the Pain Catastrophizing Scale (PCS).14,32 The PCS is a 13-item self-report measure asking participants to reflect on past painful experiences and to indicate the degree to which they experience thoughts or feelings during pain on a 5-point scale, ranging from 0 (not at all) to 4 (always). Previous research showed that the PCS has adequate psychometric properties, with good temporal stability (Pearson’s r2 = 0.92) and adequate internal consistency.33

To assess the participants’ causal beliefs of post-traumatic neck complaints we used the Causal Beliefs Questionnaire Whiplash (CBQ-W), which was developed for this study. This CBQ-W was developed by defining 4 dimensions of causations, based on clinical experience and known causes of cervical
symptoms—a muscle or ligament injury, a vertebral injury, a neural or cerebral injury and psychological factors. Four questions were formulated for each dimension covering different injury severities (Table 1). Finally, 2 questions were added (items 4 and 8) to test specific beliefs—i.e., that the cause of symptoms is “whiplash” and something is irreparably damaged—not specifically related to 1 of the 4 dimensions.

The questionnaire starts with “My complaints are caused by” or perhaps after followed by 18 possible causes as listed in Table 1. Participants were asked to indicate on a 4-point scale (absolutely not, probably not, probably yes or absolutely yes) whether the particular origin is likely to be correct.

Furthermore, all patients completed a standardized self-administered questionnaire.

The presence (yes/no) and severity (NDI score) of postwhiplash syndrome at Q1, Q2, and Q3 were defined as general outcome variables.

## Data Reduction

### Causal Beliefs Questionnaire Whiplash.

By means of exploratory factor analysis (principal component analysis with VARIMAX rotation), the factor structure of the CBQ-W was investigated. On the basis of their eigenvalues and through the inspection of the scree plot, 5 factors were found (Table 1).

Factor 1 contains items referring to an expected psychological origin of the complaints (CBQ-W Psychological). Factor 2 contains items referring to an expected severe injury as the cause of the complaints (CBQ-W Severe Injury). Factor 3 (CBQ-W Vertebral) contains items referring to an expected vertebral origin of the complaints, with the exception of “something broken in my neck” (item 9), which loads on factor 2. Factor 4 (CBQ-W Muscular) contains items regarding the expected muscular origin of the complaints, with the exception of “there is a muscle tear” (item 11) which was included in factor 2 because of its higher factor loading. Due to the unsatisfactory reliability of factor 5, it was not used in the further analysis. Instead item 4 (“My complaints are caused by whiplash”) was included as a possible predictive variable in the analysis (CBQ-W Whiplash) for its specific attributional value.

All in all, the factor structure obtained has face validity and reflected 4 theoretically meaningful dimensions that came close to our a priori dimensions. We have therefore used the mean value of the obtained factor scales in the subsequent analyses.

## Results

Table 2 provides an overview of the basic characteristics of the participants at Q1, Q2, and Q3.

<table>
<thead>
<tr>
<th>Components</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eigenvalues</td>
<td>4.825</td>
<td>2.353</td>
<td>1.796</td>
<td>1.381</td>
<td>1.151</td>
</tr>
<tr>
<td>Reliability (Cronbach’s alpha)</td>
<td>0.838†</td>
<td>0.778*</td>
<td>0.830*</td>
<td>0.671‡</td>
<td>0.490*</td>
</tr>
</tbody>
</table>

My complaints are caused by
- 5. Me being emotionally upset 0.872
- 18. Me being afraid of something 0.825
- 13. Me being shocked by the accident 0.808
- 7. Me being under psychological pressure 0.892
- 9. Something being broken in my neck — 0.787
- 10. Damage to my spinal cord — 0.689
- 15. Brain injury — 0.586
- 17. My nerves not working properly — 0.568
- 11. A muscle tear — 0.537
- 8. Something being irreparably damaged — 0.446
- 12. My vertebrae not lining up — — 0.856
- 6. Something to do with my vertebrae — — 0.832
- 16. My vertebrae being shifted — — 0.827
- 3. Spraining of my neck muscles or ligaments — — — 0.770
- 1. Something to do with my muscles or ligaments — — — 0.757
- 14. Bruising of my muscles or ligaments — — — 0.748
- 4. Whiplash — — — — 0.775
- 2. Nerve injury — — — — 0.792

Only factor loadings >0.4 printed.

*n = 137; †n = 138; ‡n = 139. | Q1 | Q2 | Q3
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Postwhiplash syndrome, no. (%)</strong></td>
<td>140 (100)</td>
<td>81 (66.4)</td>
</tr>
<tr>
<td><strong>Gender, female (%)</strong></td>
<td>95 (67.9)</td>
<td>56 (69.1)</td>
</tr>
<tr>
<td><strong>Age, mean (SD)</strong></td>
<td>36.4 (12.0)</td>
<td>35.6 (12.3)</td>
</tr>
<tr>
<td><strong>NDI score, mean (SD)</strong></td>
<td>16.7 (8.9)</td>
<td>16.7 (8.3)</td>
</tr>
<tr>
<td><strong>Severity of paresthesia, mean (SD)</strong></td>
<td>2.6 (2.4)</td>
<td>3.2 (2.6)</td>
</tr>
<tr>
<td><strong>Radiating pain in arms, mean (SD)</strong></td>
<td>3.3 (2.6)</td>
<td>3.3 (2.7)</td>
</tr>
<tr>
<td><strong>PCS Total, mean (SD)</strong></td>
<td>12.94 (11.3)</td>
<td>13.78 (10.97)</td>
</tr>
<tr>
<td><strong>CBQ-W Psychological, mean (SD)</strong></td>
<td>1.69 (0.82)</td>
<td>1.74 (0.80)</td>
</tr>
<tr>
<td><strong>Severe injury, mean (SD)</strong></td>
<td>1.45 (0.40)</td>
<td>1.55 (0.42)</td>
</tr>
<tr>
<td><strong>Vertebral, mean (SD)</strong></td>
<td>1.91 (0.74)</td>
<td>2.13 (0.86)</td>
</tr>
<tr>
<td><strong>Muscular, mean (SD)</strong></td>
<td>2.97 (0.69)</td>
<td>2.73 (0.82)</td>
</tr>
<tr>
<td><strong>Whiplash, mean (SD)</strong></td>
<td>2.45 (0.86)</td>
<td>2.86 (1.07)</td>
</tr>
</tbody>
</table>
Of 140 participants in the final sample, 18 did not return the second and third questionnaires, and 12 did not return the third questionnaire. Analysis indicated no significant differences with respect to scores during the first assessment between those who did and those who did not return the questionnaires.

**Relationship Between the CBQ-W, PCS, and Neck Disability Scores**

To explore the relationship between the PCS, the CBQ-W factors and the concurrent NDI scores, Spearman correlation coefficients were calculated (Table 3).

In line with predictions, the correlational analysis shows that on all 3 occasions pain catastrophizing is associated with a higher concurrent NDI score.

Similarly, the CBQ-W factors are also correlated with a higher concurrent NDI score at Q1, Q2, and Q3.

To explore the independent contribution of pain catastrophizing and the various types of causal beliefs we carried out a multiple linear regression analysis using the NDI score as the dependent variables at Q1, Q2, and Q3, respectively, and the concurrent PCS score, CBQ-W factors, age and gender as predictor variables.

Table 4 shows the results after backward stepwise elimination while retaining age and gender. Pain catastrophizing scores show an independent relationship with the concurrent NDI score on all 3 occasions.

All CBQ-W factors, with the exception of CBQ-W Severe Injury and CBQ-W Psychological, are independently related to the NDI score at Q1. The CBQ-W Whiplash also contributes independently to the concurrent NDI score at Q2 and Q3. Analysis at Q3 also reveals that CBQ-W Severe Injury is significantly related to the concurrent NDI score.

Age and gender provide no significant contributions to any of the models.

**The Prognostic Value of Causal Beliefs and Pain Catastrophizing for the Persistence of Postwhiplash Syndrome**

Table 5 shows the results of 2 multiple logistic regression models after stepwise backward modeling, while retaining age and gender, using the persistence of postwhiplash syndrome at Q2 (model 1) and Q3 (model 2) as dependent variables, and the variables from Q1 as predictor variables.

The NDI score at Q1 shows a significant relationship with the persistence of postwhiplash syndrome at Q2 and Q3. Most importantly for the present context, the results indicate that the CBQ-W Psychological and CBQ-W Whiplash factors at Q1 have independent predictive value for the presence of postwhiplash syndrome at Q2 and Q3, over and above the NDI score at Q1.

With regard to the presence of postwhiplash syndrome at Q2, CBQ-W Vertebral also shows a significant contribution, whereas the PCS score was found to be statistically significant, yet with an odds ratio of <1, which indicates a negative contribution. However, univariate logistic regression analysis reveals a small positive relationship between the PCS score at Q1 and the persistence of post-whiplash syndrome at Q2 (odds ratio = 1.044, 95% CI = 1.001–1.088, \( P = 0.042 \)) and Q3 (odds ratio = 1.061, 95% CI = 1.017–1.108, \( P = 0.006 \)).

**Discussion**

The major results of the present study can be summarized as follows:

i. The severity of neck disability at 1, 6, and 12 months follow-up is associated with concurrent pain catastrophizing.

ii. The severity of early complaints is related to the persistence of whiplash at 6 and 12 months follow-up.

iii. Attributing initial neck complaints to whiplash was found to be related to more severe concurrent disability and to have prognostic value for the persistence of whiplash at 6 and 12 months follow-up, over and above the initial complaint severity.

Consistent with research into chronic pain, pain catastrophizing was found to be related to concurrent neck disability. Because of the correlational design of the present findings it is not possible to determine whether more severe disability leads to more pain catastrophizing or vice versa. However, since early pain catastrophizing was not found to have independent prognostic value for whiplash complaints at 12 months follow-up, the present pattern of findings provides no convincing support for the idea that pain catastrophizing plays an important role in the generation and persistence of whiplash complaints.
In line with previous research, more severe initial complaints were related to the persistence of whiplash at both 6 and 12 months follow-up.3,4,34

Most importantly for the present context, the results show that attributing neck complaints to whiplash has a predictive value over and above the intensity of initial complaints. Therefore, independent of the severity of initial complaints, attributing the perceived complaints to whiplash seems to have a detrimental influence on the prognosis. Although earlier studies have argued that symptom expectation, obligatory after attributing complaints to the medico-cultural entity “whiplash” could be responsible for the development of chronic whiplash complaints, the present study is the first to actually show a negative prognostic effect of attributing complaints to whiplash.24–26,35

Table 4. Multiple Linear Regression Model

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficients (β)</th>
<th>Standard Error</th>
<th>95.0% CI</th>
<th>Standard Coefficients (B)</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent variable: neck disability index at Q1, independent variables from Q1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.05</td>
<td>0.05</td>
<td>−0.05 to 0.14</td>
<td>0.06</td>
<td>0.898</td>
<td>0.371</td>
</tr>
<tr>
<td>Gender</td>
<td>1.37</td>
<td>1.37</td>
<td>−1.19 to 3.93</td>
<td>0.07</td>
<td>1.061</td>
<td>0.291</td>
</tr>
<tr>
<td>CBQ-W psychological</td>
<td>1.58</td>
<td>0.93</td>
<td>−0.26 to 3.43</td>
<td>0.15</td>
<td>1.701</td>
<td>0.091</td>
</tr>
<tr>
<td>CBQ-W muscular</td>
<td>2.33</td>
<td>0.82</td>
<td>0.71 to 3.95</td>
<td>0.19</td>
<td>2.845</td>
<td>0.005</td>
</tr>
<tr>
<td>CBQ-W whiplash</td>
<td>1.92</td>
<td>0.68</td>
<td>0.57 to 3.27</td>
<td>0.19</td>
<td>2.813</td>
<td>0.006</td>
</tr>
<tr>
<td>PCS</td>
<td>0.29</td>
<td>0.07</td>
<td>0.15 to 0.42</td>
<td>0.37</td>
<td>4.160</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Constant</td>
<td>−4.42</td>
<td>3.60</td>
<td>−15.57 to 7.73</td>
<td>2.340</td>
<td>0.021</td>
<td></td>
</tr>
</tbody>
</table>

Dependent variable: neck disability index at Q2, independent variables from Q2 | | | | | | |
| Age | 0.09 | 0.06 | −0.02 to 0.20 | 0.13 | 1.633 | 0.107 |
| Gender | 0.29 | 1.48 | 2.67 to 3.24 | 0.02 | 0.192 | 0.848 |
| CBQ-W muscular | 1.61 | 0.86 | −0.10 to 3.32 | 0.16 | 1.872 | 0.065 |
| CBQ-W whiplash | 3.00 | 0.82 | −1.69 to 4.31 | 0.38 | 4.558 | <0.001 |
| PCS | 0.34 | 0.07 | 0.21 to 0.47 | 0.45 | 5.216 | <0.001 |
| Constant | −4.44 | 3.32 | −11.05 to 2.27 | 2.340 | 0.021 |

Dependent variable: neck disability index at Q3, independent variables from Q3 | | | | | | |
| Age | 0.05 | 0.06 | −0.06 to 0.17 | 0.09 | 0.924 | 0.359 |
| Gender | −1.74 | 1.87 | −5.49 to 2.01 | −10 | −0.928 | 0.358 |
| CBQ-W severe injury | 5.09 | 2.01 | 1.06 to 9.12 | 0.30 | 2.531 | 0.014 |
| CBQ-W whiplash | 2.39 | 0.73 | 0.92 to 3.86 | 0.33 | 3.260 | 0.002 |
| PCS | 0.19 | 0.09 | 0.01 to 0.36 | 0.26 | 2.159 | 0.035 |
| Constant | −0.85 | 3.83 | −8.53 to 6.83 | 2.340 | 0.021 |

Table 5. Multiple Logistic Regression Model

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient (B)</th>
<th>Standard Error</th>
<th>Wald X²</th>
<th>P</th>
<th>Odds Ratio</th>
<th>95.0% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent variable: postwhiplash syndrome at Q2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>−0.03</td>
<td>0.02</td>
<td>1.53</td>
<td>0.216</td>
<td>0.974</td>
<td>0.933</td>
</tr>
<tr>
<td>Gender</td>
<td>0.58</td>
<td>0.57</td>
<td>1.03</td>
<td>0.310</td>
<td>1.792</td>
<td>0.582</td>
</tr>
<tr>
<td>Neck disability index</td>
<td>0.18</td>
<td>0.05</td>
<td>12.54</td>
<td>&lt;0.001</td>
<td>1.197</td>
<td>1.084</td>
</tr>
<tr>
<td>CBQ-W psychological</td>
<td>1.47</td>
<td>0.52</td>
<td>7.93</td>
<td>&lt;0.001</td>
<td>4.335</td>
<td>1.562</td>
</tr>
<tr>
<td>CBQ-W vertebral</td>
<td>1.30</td>
<td>0.47</td>
<td>7.70</td>
<td>&lt;0.001</td>
<td>3.686</td>
<td>1.467</td>
</tr>
<tr>
<td>CBQ-W whiplash</td>
<td>1.23</td>
<td>0.36</td>
<td>10.34</td>
<td>&lt;0.001</td>
<td>3.430</td>
<td>1.618</td>
</tr>
<tr>
<td>PCS</td>
<td>−0.12</td>
<td>0.04</td>
<td>8.24</td>
<td>&lt;0.001</td>
<td>0.898</td>
<td>0.814</td>
</tr>
<tr>
<td>Constant</td>
<td>−7.29</td>
<td>1.84</td>
<td>15.61</td>
<td>&lt;0.001</td>
<td>0.001</td>
<td></td>
</tr>
</tbody>
</table>

Dependent variable: postwhiplash syndrome at Q3 | | | | | | |
| Age | 0.01 | 0.02 | 0.09 | 0.765 | 1.006 | 0.966 | 1.048 |
| Gender | 0.53 | 0.58 | 0.83 | 0.362 | 1.695 | 0.544 | 5.276 |
| Neck disability index | 0.15 | 0.04 | 10.86 | 0.001 | 1.156 | 1.061 | 1.260 |
| CBQ-W psychological | 0.98 | 0.46 | 4.63 | 0.031 | 2.670 | 1.091 | 6.534 |
| CBQ-W vertebral | 0.84 | 0.44 | 3.70 | 0.055 | 2.307 | 0.984 | 5.411 |
| CBQ-W whiplash | 0.98 | 0.35 | 7.64 | 0.006 | 2.657 | 1.329 | 5.314 |
| PCS | −0.06 | 0.04 | 7.64 | 0.097 | 0.942 | 0.878 | 1.011 |
| Constant | −7.19 | 1.78 | 16.34 | <0.001 | 0.001 |

Dependent variable: Neck Disability Index at Q1, Q2, and Q3. Explanatory variables from Q1, Q2, and Q3, respectively. After backward stepwise elimination, while retaining age and gender. Model 1 (Q1): R² = 0.48. Model 2 (Q2): R² = 0.55. Model 3 (Q3): R² = 0.55.


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The finding that attributing early complaints to whiplash is an important factor with regard to concurrent disability and prognosis not only supports theories regarding the potential influence of cultural embedded causal beliefs, but also has important implications for management and treatment. The present findings suggest modifying symptom expectations regarding whiplash and altering the causal attribution of initial myogenic neck complaints as 2 possible therapeutic strategies.

Altering symptom expectation is a cultural process that should be employed at the population level, typically requiring educational campaigns and professional guidelines. Although this could lead to a broad and definitive strategy at the population level, it is to be expected that this will be a slow process taking several years. Altering causal beliefs is an individual process that can readily be employed by developing a cognitive behavioral intervention aiming at modifying these specific causal convictions.

The present findings also indicate that attributing initial complaints to psychological factors has additional prognostic value regarding the persistence of disability after 1 year. This finding is consistent with previous research showing that early anxiety-related distress was related to delayed recovery from postwhiplash syndrome. Cognitive behavioral interventions may also be helpful to reduce the influence of this type of dysfunctional convictions.

Finally, it was found that attributing early complaints to vertebral causes is related to persistent complaints at 6 months and with borderline significance at 12 months follow-up. This seems especially important since physiotherapy and/or manual therapies concentrating on alleged vertebral causes are quite common in acute whiplash. In light of the fact that, by definition, no vertebral abnormalities are found in common whiplash, our results suggest that a therapy implicitly suggesting a vertebral cause could have adverse effects by fuelling dysfunctional beliefs.

Some comments are in order with respect to this study’s limitations. All findings regarding the CBQ-W should be interpreted with care since the connotations regarding whiplash are highly culturally dependent. It could well be that this same questionnaire in a different population, especially with different cultural beliefs regarding neck complaints after motor vehicle accidents, would lead to different results. It would therefore be beneficial to investigate expectations and beliefs regarding whiplash in relation to causal beliefs in different populations.

In addition, the present sample consisted of participants who had initiated compensation claim procedures. However, the threshold for starting such procedures is low in the Netherlands, there seems to be no strong reason to suspect that this introduced a bias toward patients whose complaints were more serious. Nevertheless, some studies have found that compensation is a critical factor to consider when studying postwhiplash syndrome. Therefore, the personal injury claimant context should be taken into account when interpreting our findings. Furthermore, since the exact nature and expectations of compensation may vary greatly from country to country, we advise caution when extrapolating results from one population to another.

To conclude, the present results indicate that causal beliefs have important prognostic value for the course of postwhiplash symptoms. Moreover, the pattern of findings supports the view that an early conviction that neck complaints are caused by the medico-cultural entity “whiplash” has a detrimental influence on the course of symptoms and may contribute to delayed recovery.

### Key Points
- The role of pain catastrophizing and causal beliefs in whiplash.
- Attributing initial neck complaints to whiplash was found to predict the persistence of disability, over and above the severity of the initial complaints.
- Pain catastrophizing is predominantly related to concurrent disability.
- Causal beliefs may play a major role in the perceived disability and course of neck complaints after motor vehicle accidents.

### References


