

Topical Issues in Pain 2

Physiotherapy Pain Association Yearbook



Topical Issues in Pain 2

**Biopsychosocial assessment and management
Relationships and pain**

Editor

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Foreword

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Foreword

This is the second in the series of Topical Issues in Pain, the first volume met with resounding praise from reviewers and has proved to be very popular with physiotherapists and other professions. At the time of writing the first volume is being reprinted such is the demand. From the outset, the remit of this series was to bring together information with a sound evidence base and present it in a way that would make it possible for physiotherapists to incorporate that information into clinical practice. I hope that readers will find once again that we have gone some way towards achieving this aim in this volume.

There are four introductory essays from: Louis Gifford, George Peat of Keele University, Heather Muncey, past chair of the PPA, and Jennifer Klaber Moffett and colleagues.

Louis Gifford presents a biological argument against the use of unidisciplinary/single dimension/single modality reasoning and therapy models for pain management and treatment. We are asked to consider a more widespread multidirectional model for the repercussions of therapies and productive interactions with patients. For example, that in one direction all successful therapies and interactions with patients have at their heart an alteration in the expression of gene activity!

George Peat provides a thought-provoking essay which may prove to be uncomfortable reading for many. He asks the fundamental question: Has there been a real change? Evaluations of pain management programmes have often been criticised as only measuring change on their own terms. Perhaps I can explain this criticism through the following anecdote. In a conversation with a physiotherapist working in pain management I asked what she thought was a useful outcome measure. She told me that her programme found self-efficacy the best outcome measure as it was most responsive to change. Pain management programmes frequently identify changes in self-efficacy and fear avoidance beliefs as goals for the programme. We then assume, because we read it in some of the literature, that there is a close link between self-efficacy

and disability; that we need to change one before the other changes. Is this true or are we playing what George Peat has called the substitution game; measuring what we can change rather than what is important? The measurement of outcomes in chronic pain management is particularly difficult in a condition that fluctuates as chronic pain related disability does. We must be clear which changes are sustainable and whether they are cost effective if we are to justify our role in the management of patients with chronic pain. We all need a dose of constructive self-criticism and self-appraisal from time to time and I hope reading this chapter will prompt this in physiotherapy.

The title of Heather Muncey's chapter *The challenge of change in practice* might, on first sight, appear to be odd for inclusion in a book on pain. However, in the biopsychosocial section, Nick Kendall and I suggest that we need to develop a new approach to the assessment and management of patients with painful conditions. This approach, grounded very much in the biopsychosocial model, argues for an expansion of physiotherapy assessment to assess more explicitly the psychosocial factors involved in the development and maintenance of disability. This suggestion may not find favour with all physiotherapy practitioners. Although, in my opinion, there has been considerable change in the way in which physiotherapists approach pain problems, some therapists find it difficult to see the relevance of this approach and may be resistant to change. Heather Muncey's chapter will be of particular relevance to those therapists trying to introduce new ideas in conservative departments.

The fourth introductory essay reproduces a piece of work first published in the British Medical Journal and headed by research physiotherapist, Jennifer Klaber Moffett. This work provides some hard data for the long term effectiveness of a physiotherapy-led exercise programme for sub-acute and recurrent back pains that incorporates cognitive behavioural principles. The 'key messages' highlighted by the authors on page 64 are of great significance to physiotherapy and the work and aims of the Physiotherapy Pain Association.

The biopsychosocial section of the book also looks at the current evidence for the role of psychosocial factors in the transition from acute to chronic incapacity and response to treatment. This is a timely inclusion when there are increased pressures on physiotherapists to develop some form of psychosocial triage in order to enhance outcomes from the management of musculoskeletal pain. The biopsychosocial model demands that the patient is given a full biomedical assessment and the reliability and importance of this is presented by Lisa Roberts (Ch. 1). The role of attitudes to pain in the alteration of its perception is discussed by Jennifer Klaber Moffett (Ch. 5).

Nicholas Kendall and I take on the problem of reviewing the evidence for the use of psychosocial screening and assessment in musculoskeletal pain. Dr Kendall was responsible for the development of the psychosocial risk management strategy in New Zealand which coined the term *Yellow Flags*. The authors suggest a practical way forward for those (not only physiotherapists) involved in managing people with musculoskeletal pain. Although we both recommend the integration of an assessment of psychosocial factors into physiotherapy the reader is cautioned against developing this into

yet another poorly researched ‘fashion’, a phenomenon which is all too frequently observed in physiotherapy.

The section on relationships and pain gives a social focus to the suffering of the patient with chronic pain. Although physiotherapists are not trained specifically to intervene in this area it is important that they understand the social consequences of chronic pain and the way in which these are managed by psychologists and how they can be managed jointly. Issues relating to the relationship between patients and their pain and the potential of the physiotherapist/patient relationship are also addressed by Hazel O’Dowd (Ch. 6) and Toby Newton-John (Ch. 7). In the final chapters of this section Toby Newton-John, Suzanne Brook, Christina Papadopoulos, and Vicki Harding give very practical guides to helping chronic pain sufferers with sexual dysfunction, and women with back pain through pregnancy. Many women are worried about the potential adverse effects of pregnancy on their pain, and this practical approach will be invaluable to physiotherapists working in this field.

I would like to give my personal thanks to all the contributors to this volume. There is an old adage ‘If you want a job done well ask a busy man’, or in this case *person*. All the contributors are busy people because they are highly respected individuals who are in demand by their own profession and others. I am grateful that they have taken time to contribute to this volume in what is proving to be a very exciting and informative series. I look forward to the next one!

Paul Watson

Physiotherapy Pain Association Chairman 1999-

Preface

This volume is about changes in practice that will benefit patients and clinicians. It is also about our relationships with our patients, and their's with their pain and their families.

With changes in practice there is a necessary extension of traditional thinking into new territories and new skills to be taken on. We need to encourage those who are involved in the early treatment and management of pain to take on new information and new assessment and treatment approaches; the burden of responsibility for chronic pain prevention is with them. In particular, all the chapters in this book underline the recognition that musculoskeletal pain has biomedical and psychosocial components that must be managed within a biopsychosocial framework. There is plenty of practical guidance.

If clinicians better understand the development of chronic pain and disability and the processes that precipitate them, they can take an active and recognised role in prevention and the human and social costs of this major problem can be reduced. A major theme of this volume is that we need to think differently and, above all, that we need to understand and recognise what the traditional biomedical model means and where its values and weaknesses lie. The biomedical, or 'disease' model of pain is a single level construct which may be fine where a problem's cause can be established and which has a remedy available for it. The biomedical model assumes that an individual's complaints should result from a *specific* disease state represented by a focus of disordered biology, the diagnosis of which is confirmed by data from objective tests of physical damage and impairment. Intervention is directed specifically toward correcting the organic dysfunction or the pathology and if this doesn't work the patient, rather than our inadequate understanding, is frequently blamed. Thus, the traditional medical approach adopts a simple dichotomous view: symptoms are either somatogenic (real and potentially fixable) or psychogenic (not real and hence of little or no interest).

Although variations of this view still pervade, supporting evidence is lacking. If we really want to explain and understand pain, pain disability and pain response and prevent them from continuing to be major health care problems, we need to adopt a much more open minded multidimensional approach. We need new broader based models to help us understand chronic pain and incapacity and its development. This is what many in the vanguard of pain management and disability prevention are suggesting.

In the epilogue of his book *The Back Pain Revolution*, 1998, Gordon Waddell, a uniquely enlightened orthopaedic surgeon, lists the following important points about back pain:

- Human beings have had back pain throughout recorded history
- Back pain has not changed: it is no different, no more severe and no more common than it has always been
- What has changed is how we think about back pain and what we do about it
- We have turned a benign bodily symptom into one of the most common causes of chronic disability in Western society today
- But if we can create that epidemic, we can also reverse it.

Waddell's writing is pithy, smart, and makes intuitive sense. The messages are sound, evidence based, clear, and easy to follow. Like many others, he argues that the biomedical approach to back pain has not solved the problem and may even be adding to it via inappropriate intervention. He advocates passionately that we should all adopt a biopsychosocial framework. The following two messages taken from his book are pertinent here:

The biopsychosocial model is not a new philosophy. Rather, it is a method, or a set of tools, to apply that ancient philosophy (of caring for sick people) to our daily practice. It allows us to combine the role of healer with the more ancient role of counsellor, helping patients to cope with their problem. The patients' role must also change from passive recipient of treatment to more active sharing of responsibility for their own progress.

...It is no longer enough to know about anatomy and pathology. The biopsychosocial approach opens a whole new perspective on how people behave and cope with illness. It reveals the limitations of our treatment and of our professional skills. It exposes us to the difficulties and stress of dealing with emotions. We must accept that patients are not neat packages of mechanics or pathology, but suffering human beings. Professional life may be much simpler if we stick to physical treatment of mechanical problems, but health care demands that we treat human beings.' (p.442)

Waddell goes out of his way to acknowledge the physical nature of back pain, that it is usually initiated by a physical problem, and that over the last 10 years the balance of back pain research has 'perhaps swung too far towards the psychosocial issues, to the neglect of the physical'. He argues that we need more research into the physical basis of non specific low back pain with the focus primarily on physical dysfunction rather than on anatomic and structural lesions. This stance is praiseworthy; however, 10 years of research may need

as many years of integration into clinical reality. Perhaps in ten years' time books like this one, and the work of all the authors who have contributed to it, will receive a dash of recognition for initiating a practice change at a timely moment in our professional history?

Shifting therapist and patient thinking, from a largely unidimensional biomedical model based approach, to *incorporating* a multifaceted and multidimensional model, is the great philosophical and practical challenge confronting clinicians. Along with the first in the series, this volume rises to the challenge by providing the background information and practical pathways necessary for implementing changes in thinking and working practice.

Editing this volume of Topical Issues in Pain has been a pleasure; I am proud of what the authors have presented and I have been enlightened. I will be very surprised if you, the reader, do not get a great deal out of it too. Read, think, reflect and above all, integrate!

Louis Gifford, Falmouth
January 2000

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