

The Shopping Basket Approach – history and introduction

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Foreword from Philippa Tindle

In the autumn 2015 edition of *In Touch*, Mick Thacker very ably described how Louis' Mature Organism Model was before its time, of its time and for the future. What a tribute – thank you Mick, and thanks must also go to Richmond and Hubert who acknowledged Louis' influence in their early careers and have written two papers reflecting their thoughts and current knowledge. While Georgie Oldfield, the final contributor to the edition, got the 'ah-ha' experience later and is finding answers in a different way.

For this Pain Solution themed edition, *In Touch* Editor, Paul Johnson suggested re-visiting Louis' 'Shopping Basket Approach' which was first published over three issues of *In Touch* (autumn 2001, spring 2002 and spring 2003) and reproduced (with permission) <http://giffordsachesandpains.com/download-material/the-shopping-basket-approach-articles/>

Louis analysed what he did in the clinic and attempted to make sense of what we, as physiotherapists, do really well – Rehabilitation. The Shopping Basket Approach is "for the clinician" and gives some order to the complex, and often difficult job we have of dealing with the patient in front of us.

The following is from the history and introduction to the chapter on the Shopping Basket Approach, and is taken from Louis Gifford *Aches and Pains: Book 3, Graded Exposure*.

Introduction

The Shopping Basket Approach has evolved from my own analysis of how I think and reason with a patient. In actual fact it was also a reaction to something which drives me mad: the very term 'Approach' – the Maitland, the McKenzie, the Kaltenborn, the muscle imbalance approach and so on. It's a term that drives clinical reasoning into a uni-dimensional place whereby the treatment that's given narrowly dictates the clinical reasoning, the assessment and the overall line of questioning. For example, why would someone with an 'ultrasound' approach want to know about psychosocial factors or how the problem has influenced the sufferer's function and activity levels, – or even want to try to understand the presentation in terms of biomedical features, – if all they're going to do in the end is stick an ultrasound machine on the spot where it hurts? Same for Maitland, McKenzie, muscle imbalance, all they require is the basic information needed to do the technique.

"Hi, Louis here, it's Monday, and you're lucky because Monday is ultrasound day, where's your pain love? Slip your things off, lie down here, show me the spot, bit of jelly, that'll be a bit cold, whoops, yes, right, off we go." 5 minutes later, – "see you on Friday, Friday is Laser day".

"Hi, Louis here, it's Monday..." and so on. (Tuesday is acupuncture day if you were wondering).



I also lectured in Switzerland in 'rehabilitation' centres where patients were booked in for three weeks and received a variety of 'treatments' daily, dictated only by a bell ringing every half an hour – all change!

The Shopping Basket is so named to try to mock this 'approach' thing a bit. Apologies, as that's not a very CBT way to start, by alienating the audience. I'm hoping the ultrasound and laser example set a lightish touch to the scene and we can now get up and running.

A last observation then: *one thing I realised a long time ago, is that how anyone reasons is hugely dictated by what they plan to do, – the more biased and limited in your skills/knowledge, the more blinkered and limited your reasoning is going to be!*

I hear that nowadays all these 'approaches' are integrating the biopsychosocial dimensions. Well, super, but to me they all are still stuck with the dominance of the physical treatment you are steering the whole thing towards. My suggestion is that you maybe think about becoming a Shopping Basket Approach therapist, if you like what I write and reason and, in just one compartment of it you'll find that it is possible to include a little joint wiggling and fiddling if you want to, but overall it is certainly very unusual for any given 'approach' to be a priority. There's one word that should dominate all physical therapist minds and that is **Rehabilitation**. It is such a

special word, and one that is unique to our profession; please, let us all never let it go,- it's got more evidence in its favour than any treatment approach or modality ever has, or ever will have.

I want to start by acknowledging a great friend, a great thinker and a huge contributor to the world of clinical reasoning. We all owe Mark Jones a huge thank you and a place high up there in the history of rational evidence based physiotherapy. Whether you know it or not Mark Jones' work will have influenced your clinical reasoning at some point. The easiest place to start is with his superb book: *Clinical Reasoning for Manual Therapists*– chapter 1 summarises it all and also read chapter 25 on Educational theory by Joy Higgs and chapter 26 by Darren Rivett and Mark– on 'Improving clinical reasoning in manual therapy'.

The book is full of case histories by the manual therapy 'gurus' of the world,– with Mark asking the Guru involved various 'reasoning' questions, and getting their responses as the case unfolds. Mark is beautiful in his diplomacy with them, I'd have lost my rag because a great many are not much better at reasoning than my ultrasound-on-Monday therapist. Read them, but it's thanks to Mark's questioning that there's a great deal to learn and ponder in there. I like it that he ends the book with the 'Improving clinical reasoning in manual therapy' chapter!

Mark started all this way back, just after the 1985 Manipulation course in Adelaide (he was on the course with myself and Dave Butler). He was doing some research based at the University. I remember he came up to Geoff Maitland's practice and videoed him assessing a patient. Afterwards the two of them went back through it and Mark asked him why he was asking the questions and what he was thinking and reasoning in his head with the information that he gleaned. Soon, Mark came up with his now famous 'Hypothesis Categories'.

They were:

- What is the 'source' of the symptoms and/or dysfunction?
- Are there any 'contributing' factors?
- What are the precautions and contraindications to physical examination and treatment?
- What is the prognosis?
- What treatment should be selected and what progression is likely?

For manual therapy, or any therapy geared towards a tissue based approach and a passive treatment approach to a pain problem, this was how it was. The answers to those questions were always described in terms of physical injury, tissue abnormality and movement and biomechanically altered function. Those were the questions we all needed to have in the back of our heads and needed to be able to provide answers to after listening and examining the patient.

Later, as Dave Butler and I started to introduce 'pain' and pain mechanisms, and a more 'top-down', self-management, multidimensional view of things, changes and additions to the hypothesis categories were required. These were committed to the literature in a combined author article:

Gifford LS, Butler DS. The integration of pain sciences into clinical practice. *Hand Therapy* 1997;10(2):86-95

The clinical reasoning hypothesis categories now became:

- Pathobiological mechanisms
- Dysfunction
- Sources
- Contributing factors
- Prognosis
- Precautions
- Management.

Pathobiological mechanisms had the following sub-divisions:

- Tissue mechanisms (i.e. what's going on in the tissues? For example, are they:– healing, healed, scar tissue, inflamed, etc.)
- Pain mechanisms (i.e. what pain mechanisms are operating or dominant:– nociception? peripheral neurogenic? Central? Affective emotional? Sympathetic? Motor (output), even immune?)

The **Dysfunction** category was expanded and defined in terms of the clinical 'expressions' of the pathobiological mechanisms. Hence:

- **General physical dysfunctions:**– what would now be termed 'disabilities' or 'activity capability/restrictions' or 'participation capability/restriction'. For example, the inability to walk for more than 5 minutes, inability to type or write or do house work, lift objects and perform work tasks.
- **Specific physical dysfunctions:**– or what I now call 'physical impairments'– they're the things that physical therapists find during their physical examinations,– like losses of range of movement, pain on certain movements and tests; weaknesses, neurological deficits,– and also all the little physical minutiae that many physical therapists seem to get obsessed about and go on courses, and pay lots of good money to learn about,– like muscle imbalance, neurodynamics, an accessory movement not being quite right, a facial-band restriction, a core stability abnormality and so forth.
- **Psychological/mental dysfunctions:** - this was an awful term but was an early recognition and germination of the importance of psycho-social factors being important.

So, pain mechanisms, or pathobiological mechanisms, and a broadening of the 'dysfunction' category were integrated into clinical reasoning and it was an honour for my work to be acknowledged and to co-author with Mark Jones and Ian Edwards the article:

Conceptual models for implementing biopsychosocial theory in clinical practice, published in the Journal, *Manual Therapy* in 2002

Further thanks to Mark Jones for being so inclusive of my thoughts in his and Darren Rivett's book *Clinical Reasoning for Manual Therapists*. Mark, as far as I know now, sees the hypothesis categories like this:

- *Activity capability/restriction* (abilities and difficulties an individual may have in executing activities) and *Participation capability/restriction* (abilities and problems an individual may have in involvement in life situations)
- *Patients perspectives on their experience*

- *Pathobiological mechanisms* (tissue healing and pain mechanisms)
- *Physical impairments and associated structure/tissue sources*
- *Contributing factors* to the development and maintenance of the problem
- *Precautions and contraindications* to physical examination and treatment
- *Management and treatment*
- *Prognosis.*

My view is that this is still quite heavily biased to a 'manual therapy' perspective. My way of doing things never quite sat comfortably with it, although these categories do offer a perfectly reasonable way to go about clinical thinking and reasoning.

So one day, sometime in about the year 2000, I sat down with a tad of irritable grumpiness about all the various 'approaches' and thought about how I think in the clinic. I came up with a series of simple compartments which I then put into an old fashioned, wicker shopping or gardening type basket. It had great clinical utility.

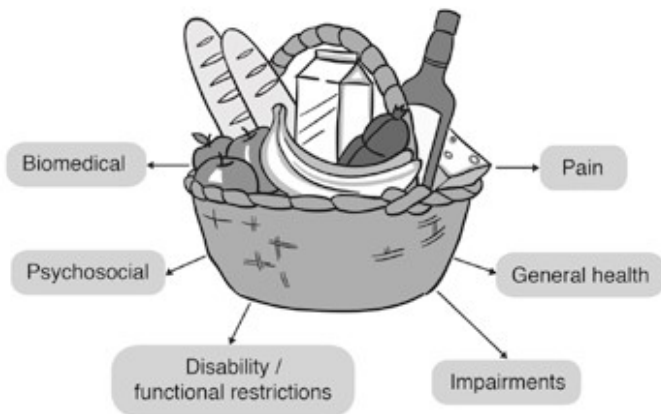


Figure 1: The Shopping Basket approach. All compartments interact

If you take a look at figure 1 you can see the basket and the various compartments. Nice and simple, like me. I like things nice and easy to use, – but all-encompassing too. The compartments are:

- Biomedical– which is all about 'think like a Dr' would, plus quite a bit more
- Psychosocial– think psychosocial predictors of outcome, or 'yellow flags'– that's the now famous ABCDEFW categorisation that every physiotherapist should be taught at undergraduate level
- Disability/functional restrictions– everything that the patient reports that they are having physical difficulties with in their life, it relates to home, work, social and fitness/hobby activities
- Physical impairments – that's the bit that most musculoskeletal physiotherapists are stuck in and feel very comfortable with
- General health and fitness– why this? Because it's so important and the evidence so clearly beneficial. I am not an expert here, but helping someone get fitter using a graded, paced and goal setting approach is fairly straightforward for anyone well trained with rehabilitation skills
- Pain! – the category that most clinicians start with. 'Where's your pain?' – I've stuck it last for the very reason that a Maitland training gets your 'needle stuck'* on asking about pain.

* The term 'needle stuck' refers to old vinyl records having a bit of dried up old jam in the grooves which causes a line of the track to just repeat on and on until you shove the needle on a bit. ... shows how old fashioned I am!

I'll never forget having a manipulation exam patient who didn't come in complaining of any pain! I was stymied, – gibbering, but luckily managed to eventually squeeze some pain out of him to fill in the time and impress the examiners. The following chapters deal with each compartment...

Afterword from Philippa

From there, Louis continued to detail his updated 'Shopping Basket Approach' in chapters that total 162 pages and are divided into:

- **The Biomedical compartment: part 1: part 2 serious pathology: part 3 pain mechanisms**
- **Psychosocial compartment: part 1 introduction and overview: part 2 the 'AB' of the 'ABCDEFW': part 3 the 'CDEFW' of the 'ABCDEFW': part 4 a bit more on 'emotion': part 5 Pink flags!**
- **The Disability and functional limitations/activity and movement restrictions compartment**
- **The Physical Impairment compartment: part 1 and part 2**
- **The General Health compartment**
- **The Pain compartment**

Owing to the space limitations of *In Touch* it isn't possible to reproduce each of these chapters in full, but I felt that it was appropriate, in this edition themed on "Pain Solution", to include the first few pages from the Pain compartment; extracted from Louis Gifford *Aches and Pains*, Chapter Graded Exposure 4.14 pp1144-1147.

The 'Pain' shopping basket compartment

This is a separate compartment because it is so important and usually the primary reason patients come to see us. As I said earlier, I've purposely put it last because it so easily goes first and then takes a stranglehold on therapist-reasoning, whose instinct is to focus on and try and relieve the pain and not see the many other issues that surround the patient and their situation. That usually means applying some form of therapy in the context of something found to be at fault during examination. Therapists usually waffle on about inflammation and stuck joints to suit whatever therapy they're doing. Yes, if you want a pain treatment to work, you have to invoke as much top-down as you reasonably can, if that's 'bullshit', so be it, so long as it doesn't create maladaptive constructs for the patient leading to maladaptive coping strategies– like becoming dependent on the treatment! As I will demonstrate in the patient sections that follow, I try to create a sound and logical context in which a pain treatment is applied.

Clinically, pain and the patients' description of their pain are often one of the first things that we listen to, record and get details of.

For the most part, like well-conditioned laboratory mice, we get our body charts out and dutifully fill them in. In my lectures I always used to note that the 'body-chart' represents only one dimension of the so-called 3 dimensions of pain. Let me remind you:

The three dimensions are:

- Sensory-discriminative
- Cognitive-evaluative
- Emotional-motivational.

Sensory-discriminative refers to the 'location of the pain,' the 'intensity,' the 'quality' and the 'behaviour' of pain over time. So on your body charts the location is obvious, but you also need descriptions of the type of pain and its behaviour– like 'constant deep ache,' or 'sharp only at end of range/often with movement'. Intensity of pain uses descriptors like 'nasty' or 'background' or 'nagging' and the use of simple 0-10 numerical rating scales. Getting aggravating and easing factors further fulfils the 'behaviour' compartment details.

It looks simple, but sadly is often hurried and given inadequate time. Please note, that the words the patient uses to describe their pain are important, and like it or not, express a degree of the emotional dimensions of their problem and situation. Think of words like 'ripping, knife-in, draining, stabbing' and you should be able to see what I mean.

I sometimes find myself saying to the patient after filling in a body chart: 'How would you sum all this pain up'– and I get some very interesting responses,

- "One minute my life was normal and then the lights went out."
- "I've been frightened to really tell anyone because it seems so unbelievable."
- "The god that came up with this was sick in the head."
- "If I could just get one hour's relief I could die happy."
- "I am overwhelmed and I cannot operate as a human being."

All these examples came from patients with pain of less than 6 weeks duration. My point is that pain just cannot be considered as isolated from the thinking, feeling human that is attached to it.

Spending time getting the details of pain from the patient is a giant step in the therapeutic encounter. You have to listen, you have to take your time, and you have to make sure that nothing is missed.

But sometimes there are exceptions, and as I will illustrate in the clinical examples section, this is usually with chronic maladaptive pain problems. In order to reason pain I find myself thinking about what I might be able to do to help, or whether I should be thinking that I should be trying to help with the pain. So, here is a list of all the possible ways I can think of, relevant to my practice, which may be able to help pain.

The pain-off list, a possible 'toolkit':

- Drugs
- Movement, activity, function, exercises, stretches, floppy movements etc.
- Various forms of rest
- Supports, crutches, collars, binders, tapes, compression

bandages and Tubigrip, orthotics and many other bits and pieces

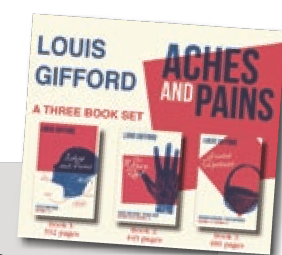
- Avoidance!
- Standard physiotherapy 'modalities', I'm happy with:
 - > Heat and cold
 - > TENS and other currents
 - > Ultrasound plus or minus currents at the same time
- Hands on – manual therapy, massage (in a multitude of contexts)
- Relaxation
- Reassurance, decreased concern, a better understanding– lessening the threat value
- Acceptance and adjustment
- Attention and focus changes
- Distraction
- Desensitising
- Fire-apart-Depart
- Novelty, excitement and fear
- Going away, holidays etc.– relates to novelty
- Socialising
- Hobbies
- Work
- Recreational drugs and alcohol, even some foods
- Anything that can 'trick' the pain off
- Achieving goals
- Working on well-being
- Family relationships, love and sex or no sex
- Resolving personal problems
- Improving confidence
- Feeling free
- Feeling in control
- Knowing about pain and its meaning
- Feeling physically fit
- Feeling mentally fit and well, 'balanced'
- Laughter and fun
- Music and entertainment

It could go on and on, but I think you'll agree that this list is a little different to what you might find in a standard textbook. The point is that I hope you can see, from what has gone before in this book, how all these things may help or influence pain.

This chapter concludes with reference and reproduction of an editorial Louis wrote for the PPA News called 'Tricking Pain' (Gifford LS. Editorial:Tricking Pain. PPA News 2007;23:3-8).

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Aches and Pains

Louis Gifford's *Aches and Pains* is available from CNS Press, Falmouth and can be ordered via www.giffordachesandpains.com/book-sales or by contacting info@achesandpainsonline.com