Incorporating knowledge about psychological aspects of pain within physiotherapy practice
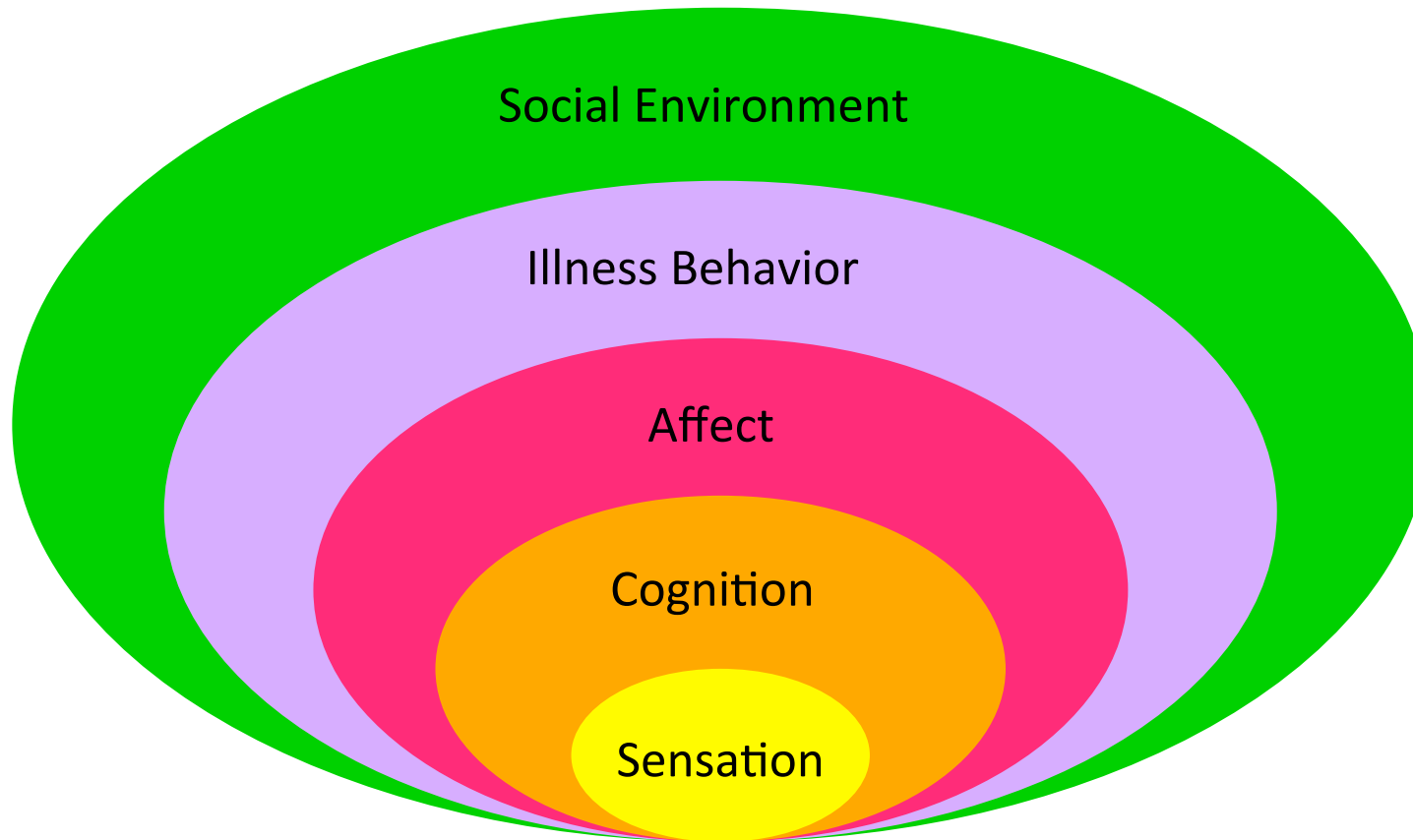
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Biopsychosocial model of pain and disability

Social Environment

Illness Behavior

Affect

Cognition

Sensation

Waddell et al, 1999

patient

practitioner

My goals

My beliefs

My expectations

My mood

My motivation

My mood

My beliefs

My goals

My motivation

My expectations

communication

empathy

trust

MY PAIN

HER PAIN

Why do practitioners' 'duck' the psychosocial?

- Overwhelming- can't deal with all the chaos at once.

- Feel under-skilled, untrained.

- 'Not my remit'

- Not acceptable to patients

- Don't buy the model

- Common myths

Get rid of the pain

and

all the other 'issues' will resolve themselves.

'Removing' the pain

Early stages

- Sometimes, reduced pain (with or without interventions) is a reinforcement to unhelpful behaviours and beliefs.

- Psychological 'risk' factors will continue to present a health risk- beyond back pain.

Later stages

- Unlikely at chronic stages

- Insufficient to impact on entrenched behaviours / cognitions / emotions

- So meaningful changes to overall health / function / healthcare utilization, cost are likely to be limited (as evident in trials).

Example: Taking into account patient's goals

- Who I might be in future dictates my choices today
- Lots of conflicting daily choices to make leading to different futures
- But people in pain
  - Have less choices
  - Find it tougher to make decisions
  - Might have unrealistic goals: Cure, sleep, energy…

Value-led goals

'walk 200 steps'

'walk (200 steps) to the park with your grandchildren'

I Can walk 200 steps despite my pain

I can be part of my grandchildren's lives

If I haven't trained to deliver psychological interventions,

I shouldn't be doing psychology

Possible structure

Screening and matching to individuals

Stepped care

- **Small teams (duos?)**
- **Frequent interaction**
- **Working from the same theory / philosophy**
- **With shared goals**
- **Linked training**
- **Linked supervision**

- **Pyramid structure of expertise**
- **Referral is key (timing, appropriate level)**

Keeping a sensible approach

- Developing skills to elicit patients concerns, identify psychological issues

- Developing a repertoire to address some of these needs within the consultation

- Developing a clear sense of skill limitation and need for referral

Example: dealing with depression / distress

- How to distinguish normal 'distress' and low mood from 'pervasive and major depression' is the key.
- It has implications for treatment:
  - Treating the mood of part of the pain problem
    - Yourself
    - In team
    - Through referral to PMP etc.
  - Treating the mood as a separate independent health problem.
    - Refer or advise consultation

Appropriate Distress

Loss

Justified anxiety about the future

Recognising problems

Change

Adjustment

"It just breaks my heart that I can't run anymore…"

"I honestly don't know how we're going to manage financially"

Acknowledge   Discuss   Problem solving

Unhelpful Distress

Magnification

Generalisation

Non-specific anger and resistance to help

"My whole life is destroyed and no-body seems to care"

"yes, BUT…"

Depression

Self-hate

Guilt

Shame

Extreme → Hopelessness

Helplessness

"It's all my fault, I always ruin everything…"

"I'm just so useless, there's no point trying…"

Refer to Clinical Psychologist or Psychiatrist

Gently explore suicidal / self-harm tendencies

As long as I know what's going on, it doesn't matter if my patients don't quite get it

because

I reassure patients and make sure they can trust me

Example 3: Miscommunication

Diagnostic uncertainty and recall bias in chronic low back pain

CrossMark

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ARTICLE INFO

ABSTRACT

Patients' beliefs about the origin of their pain and their cognitive processing of pain-related information have both been shown to be associated with poorer prognosis in low back pain (LBP), but the relationship between specific beliefs and specific cognitive processes is not known. The aim of this study was to examine the relationship between diagnostic uncertainty and recall bias in 2 groups of chronic LBP patients, those who were certain about their diagnosis and those who believed that their pain was due to an undiagnosed problem. Patients (N = 68) endorsed and subsequently recalled pain, illness, depression, and neutral stimuli. They also provided measures of pain, diagnostic status, mood, and disability. Both groups exhibited a recall bias for pain stimuli, but only the group with diagnostic uncertainty also displayed a recall bias for illness-related stimuli. This bias remained after controlling for depression and disability. Sensitivity analyses using grouping by diagnosis/explanation received supported these findings. Higher levels of depression and disability were found in the group with diagnostic uncertainty, but levels of pain intensity did not differ between the groups. Although the methodology does not provide information on causality, the results provide evidence for a relationship between diagnostic uncertainty and recall bias for negative health-related stimuli in chronic LBP patients.

1. Introduction

The identification of subgroups of individuals with low back pain (LBP) has been outlined as a priority, to modify interventions to match patients' obstacles to recovery [5]. Patients' beliefs and expectations about their pain have been shown to predict prognosis [13,15,17]. Among these beliefs, catastrophic thinking appears to be particularly important [24]. A related emerging area of research focuses on perceived diagnostic uncertainty, and the impact that such uncertainty could have on subsequent beliefs, behaviors, and outcomes. Precise causes and diagnostic labels

health services and prevent patients from directing their attention to other aspects of life.

Better understanding of the mechanisms underlying the relationship between beliefs and outcomes is needed. One method to study this is through quasi-experiments observing cognitive processes, such as attention and recall for specific types of stimuli. This method has the advantage of being relatively free of self-awareness and demand characteristics. There is evidence that patients with pain selectively recall pain and illness-related information in preference to other types of stimuli when compared with control groups [20]. In addition, despite early mixed evidence

Misunderstanding / misinterpreting common terminology

- Positive/negative findings
- Diet
- Signs of empathy as expressions of concern
- Idiopathic- Something very stupid

Patients might have psychological baggage which can get in the way of effective treatment, but

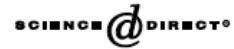I am an objective rational highly trained professional

Clinicians beliefs, and their association with behaviour

Persistent back pain – why do physical therapy clinicians continue treatment? A mixed methods study of chiropractors, osteopaths and physiotherapists

Tamar Pincus [a,*], Steven Vogel [b], Alan Breen [c], Nadine Foster [d], Martin Underwood [e]

Advising people with back pain to take time off work: A survey examining the role of private musculoskeletal practitioners in the UK

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Systematic review of clinicians' beliefs

√ **Seventeen studies from eight countries which investigated the attitudes and beliefs of** →

> general practitioners
> physiotherapists
> chiropractors
> rheumatologists
> orthopaedic surgeons
> other paramedical therapists

● **HCP beliefs about back pain are associated with the beliefs of their patients**

● **HCPs with a biomedical orientation or elevated fear avoidance beliefs are more likely to advise patients to limit work and physical activities, and are less likely to adhere to treatment guidelines**

What we know

Clinicians do not implement current guidelines

Their beliefs impact on their clinical decisions

What we need to know

How much does this effect patients' outcomes?

What are the training needs?

How best to fill these needs?

- **Mentioned in most guidelines, especially relevant at early stages**

- **Hard to do, in the context of uncertainty about aetiology, prognosis and even intervention.**

- **Extremely poorly researched**

Cognitive and affective reassurance and patient outcomes in primary care: A systematic review

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- **Prospective cohorts**
  - **Measured consultation behaviours**
  - **In relation to patient short term / follow up outcomes**
  - **Primary Care**
  - **Conditions associated with uncertainty**
    - LBP, fybromyalgia, IBS, CFS etc...

Coded in line with affective / cognitive reassurance hypothesis

Affective reassurance

- I can see that you've been suffering
- I am really listening
- I really understand
- I really care
- You can rely on me to help
- I know what I'm talking about
- It's going to be alright

Cognitive reassurance

- Here is an explanation which I think fits what you've described
- Here is what I propose we do
- Here is what I think might happen in the future
- Here is what you can do about it

Findings

Cognitive reassurance

- association with immediate outcomes – increased satisfaction, enablement and reduced concerns

- association with improvement of symptoms at follow up.

- association with lower health care utilisation.

Affective reassurance

- Immediate outcomes: Mixed:

- Higher satisfaction

- increased worry

- Follow up outcomes:

- 5 studies (high quality) affective reassurance associated with higher symptom burden/ less improvement

- Are we simply bad at doing affective reassurance?

- Are we providing it at the wrong time point?

- Could it have negative impact on patients?

In summary

ents are complex systems, in which
siological, psychological and social
cesses interact with behaviour

ractitioners are complex systems, in
hich physiological, psychological and
ocial processes interact with behaviour

The communication between the two is
carried out in a complex system…

Three messages to take home

- Check your patient value-led goals before advising them to do things, especially with behaviours they might not like.

- Ask about patients mood in relation to pain and pain-behaviour, and respond within your repertoire of skills.

- Clear explanations are probably the most reassuring intervention.

Or, to simplify, you can't duck psychology

Thank you!