DELIVERING PAIN EDUCATION

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INTRODUCTION

The clinical landscape regarding the management of persistent pain has changed. No longer can we understand pain as purely a physical sensation, as for several years now it has been classified as a sensory and emotional experience[1]. Yet many clinicians continue to treat pain as an input with the premise that treating the tissues will elicit change. Unfortunately, this often provides only a short-term result for people living with pain, resulting in feeling better but not actually getting better. Therefore, a contemporary paradigm shift in the understanding of pain from biomedical to biopsychosocial thinking is required. However, this carries many personal and professional challenges for individuals and clinicians[2].

People who live with pain present to a variety of healthcare professionals looking for the 'off switch'. A removal of the pain by treating the pathology. This draws comparisons from the infectious disease model – ridding the body of the infecting agent. Something like the common cold or bacteria. Unfortunately, pain is inherently more complex than this, and it does not necessarily present as a causal link to the injury. Therefore, it is important to provide a shared understanding of pain that supports the practice of all health professionals that have exposure to those who live with pain.

THE PRACTICE-BASED EDUCATOR AND COLLABORATIVE LEARNING

Due to the enormity of the biopsychosocial model and the complexity of pain there is a need for advanced communication skills. This allows clinicians to identify when medical language and metaphors may be confusing or potentially threatening[3, 4], and to use language that encourages individuals to engage in a "safe" movement program and/or learn to live well with pain[5].

Barker et al[3] identify several aspects of the communication exchange process that creates difficulties between clinicians and patients, including:

- Understanding the clinician and medical literature
- The use of jargon and medical models rather than patient-centered lay models
- Patients and clinicians appearing to define terms differently
- Misunderstandings amongst healthcare professionals that can arise

Therefore, there is a need to shift from medical and scientific terminology to a more simplified language that is understood by the person living with pain. This enables an enhanced collaborative learning dialogue between the clinician and individual, therefore facilitating the opportunity to make sense of persistent pain[6].

This is vital when we consider the unhelpful role that healthcare professionals often play in both the instigation and perpetuation of downward spirals into disability, anxiety and pain within our local population. Complex terminology and language explaining anatomy and pathoanatomy is usually a main culprit for this, and studies have shown that this is not an effective method for reducing pain and disability. Conversely this may have the opposite effect, increasing fear and perpetuating pain [9, 10].

In order to bring about a meaningful change in the way that we think about and explain pain to our patients, we must first focus on the education of clinicians from all backgrounds. Dreeben[7] highlights that patient education forms a 'significant component of modern healthcare'. Yet, Bolton[8] argues that 'educational skills are merely assumed in both practice and research.'

PERSISTENT PAIN IN NEW ZEALAND

We know that persistent pain is a real problem, and many people can't access help for it. In NZ, one in six adults have ongoing pain[11].

There is compelling evidence to show that both people living with pain and clinicians display an outdated and unhelpful understanding of pain. Unfortunately, this knowledge gap is one of the driving forces behind the current epidemic growth of persistent pain in western societies. This is further compounded by the poor clinical outcomes that conventional, passive interventions so often provide[12].

Within New Zealand and other western societies, we routinely see patients who have repeatedly and unsuccessfully used healthcare resources in an attempt to 'fix' their pain. Current models of treatment based upon outdated biomedical evidence continue to be a driving force for the perpetuation of persistent pain states.

People living with long term pain are often unable to make sense of pain and withhold themselves from participating in familial and social pleasures. As a clinician, it is vital to adopt a collaborative and

integrated approach to provide a reduction in an individual's sense of suffering and to facilitate a reconnection with life's pleasures.

The application of massage therapy has been shown to provide short-term effects for acute, sub-acute and persistent back pain[14]. Yet massage is an incredibly personal, social and mindful experience for the person living with pain. Massage has been shown to reduce pain and anxiety in cancer patients[15], ease pain in knee osteoarthritis[16] and reduce low back pain[17]. Moreover, Massage Therapists require a competent knowledge of anatomy and physiology, pathoanatomy and disease processes[13]. With a solid grounding in the biopsychosocial (BPS) model, and in partnership with other clinicians, Massage Therapists are in a strong position to create a shift in focus for the individual that lives with persistent pain.

The combination of the San Diego pain summit experience, my interest in pain, rehabilitation and communication has sparked a new drive to reach out and collaborate with clinicians inspired to make a difference with sufferers.

CONCLUSION

Collaborative pain education provides a means for all clinicians to effectively meet the demands of the biopsychosocial model, and more importantly, the needs of people living with persistent pain. Furthermore, it provides a sense of uniformity for the patient that could otherwise be confused by multiple opinions and mixed messages regarding the origin and treatment of their pain. A simplified approach to pain education delivery will prevent individuals from becoming disengaged and provide them with an opportunity to make sense of pain, thus promoting a sense of hope and restoring an internal locus of control. Through understanding an individual's coping style and educating in a way that is non-threatening, clinicians would be better equipped to respond to and deliver the evolving demands of the biopsychosocial model and contemporary pain science.

Paul Lagerman will be at the Preconference and conference workshops in Wellington 18-20 August 2017.

He is an Auckland based Physiotherapist working in pain management at Active +. He is an advocate of practice-based education and collaborative learning and provides education courses and seminars in pain management for all clinical disciplines.

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