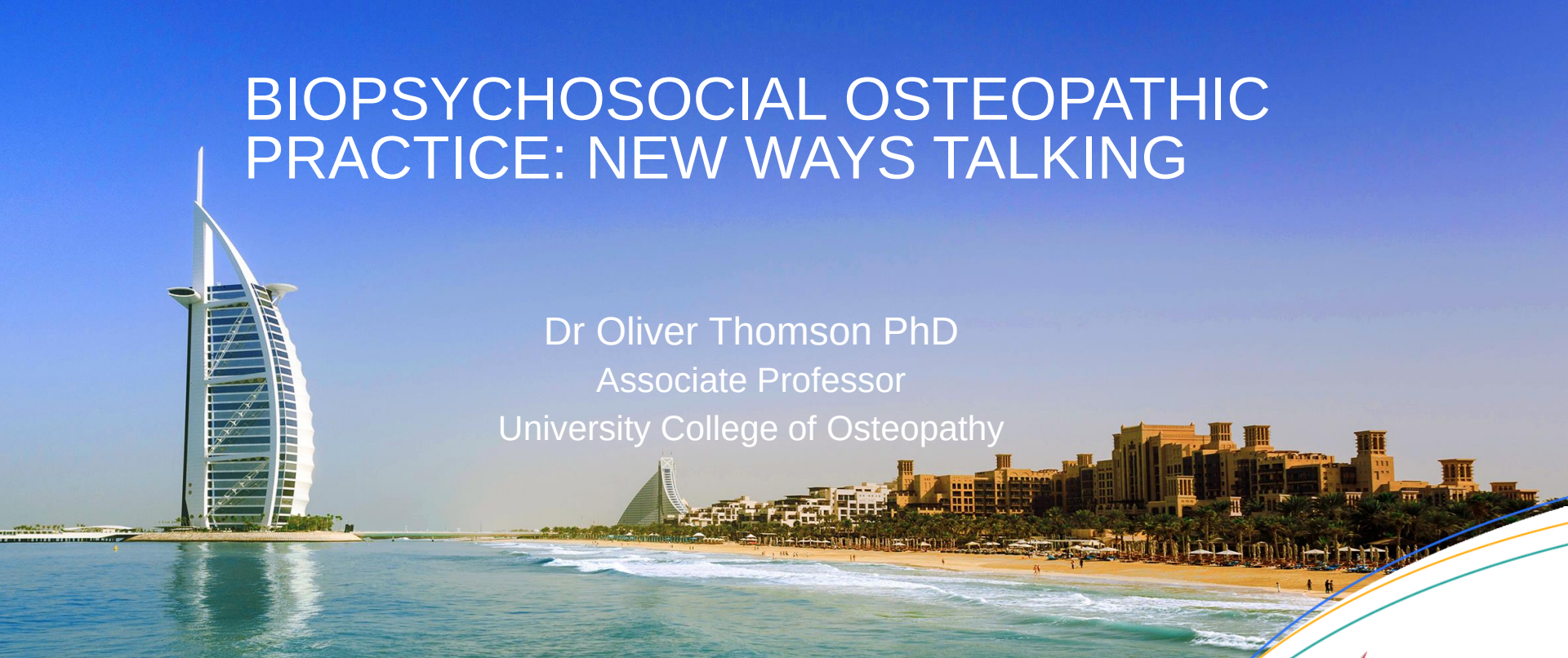
BIOPSYCHOSOCIAL OSTEOPATHIC PRACTICE: NEW WAYS TALKING



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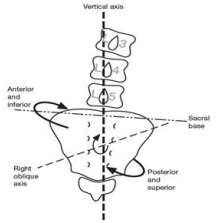
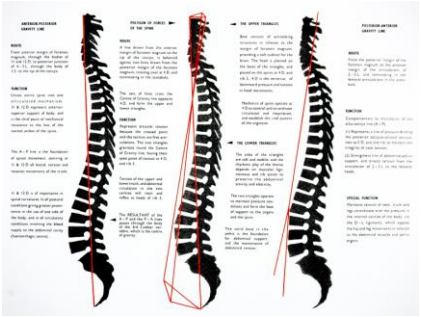
Emirates Osteopathic Conference

September 28–29, 2018, Dubai, United Arab Emirates

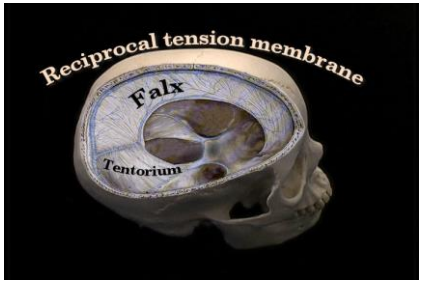
Osteopathic language



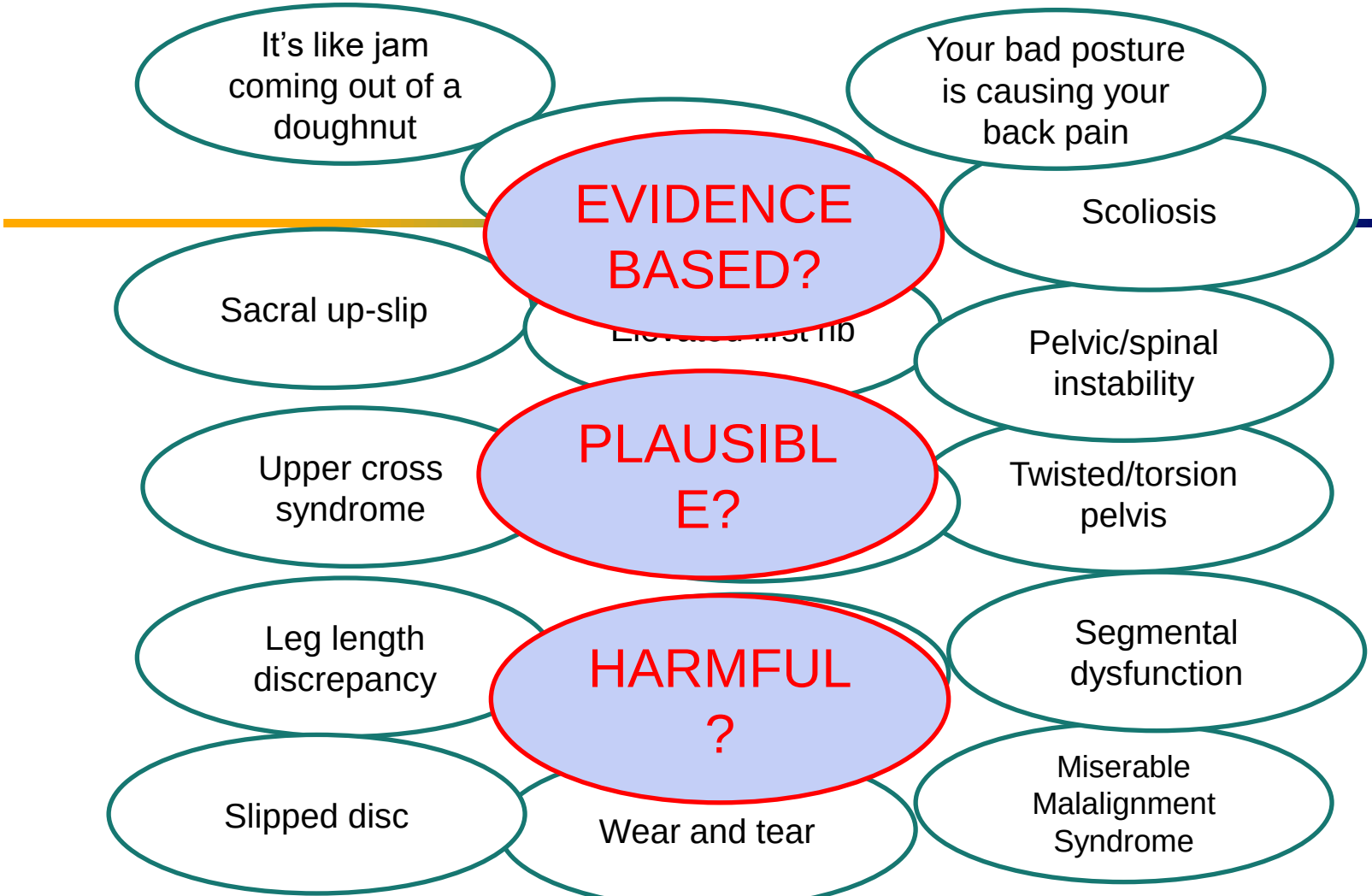
- Osteopathy has a rich ‘library’ of theories laden with anatomy, biomechanics and biomedical terminology.



- Risk of doing ‘more harm than good’ when using these ideas to shape how we communicate to patients the nature and meaning of their pain and disability?



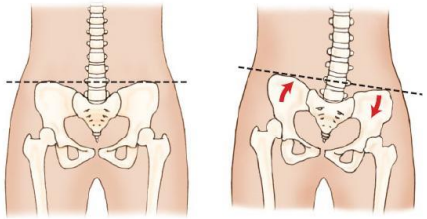
- Especially important in back pain (LBP)


It’s like jam coming out of a doughnut
Your bad posture is causing your back pain
EVIDENCE BASED?
Scoliosis
Sacral up-slip
Pelvic/spinal instability
PLAUSIBLE?
Upper cross syndrome
Twisted/torsion pelvis
Leg length discrepancy
Segmental dysfunction
HARMFUL?
Slipped disc
Wear and tear
Miserable Malalignment Syndrome

Why do words matter?

- People experiencing back pain may be more likely to ***pay attention*** to, or ***to retain***, information which they perceive to indicate the problem is serious or has a outcome poor.

- Diagnostic explanations by healthcare professionals ***influence*** patient coping and choice of treatment.



- Evidence that patients attend health professionals for a diagnosis and greater understanding of their LBP.

Sloan, T. J. and D. A. Walsh (2010). Explanatory and diagnostic labels and perceived prognosis in chronic low back pain. Spine 35(21): E1120-E1125.
Darlow, B., S. Dean, M. Perry, F. Mathieson, G. D. Baxter and A. Dowell (2015). Easy to Harm, Hard to Heal: Patient Views About the Back. Spine 40(11): 842-850.

Patients believe what *we* believe

- Growing evidence shows that MSK healthcare practitioners have a ***strong influence*** over attitudes and beliefs of patients with low back pain. Examples:

EJP
European Journal of Pain

REVIEW ARTICLE

The association between health care professional attitudes and beliefs and the attitudes and beliefs, clinical management, and outcomes of patients with low back pain: A systematic review

B. Darlow[1,2], B.M. Fullen[3], S. Dean[4], D.A. Hurley[3], G.D. Baxter[2], A. Dowell[1]

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The Enduring Impact of What Clinicians Say to People With Low Back Pain

Ben Darlow, MSportsPhysio[1]

ABSTRACT

Spine

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EPIDEMIOLOGY

Patients' and Physiotherapists' Views on Triggers for Low Back Pain

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Original Article

'Talking a different language': a qualitative study of chronic low back pain patients' interpretation of the language used by student osteopaths

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Caring Sciences

EMPIRICAL STUDIES

doi: 10.1111/scs.12043

'I am afraid to make the damage worse' – fear of engaging in physical activity among patients with neck or back pain – a gender perspective

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Example 1. Beliefs about back pain (1)

The Enduring Impact of What Clinicians Say to People With Low Back Pain

Ben Darlow, MSportsPhysio[1]

ABSTRACT

- Health care professionals have a considerable and **enduring influence** upon the **attitudes and beliefs** of people with low back pain.

- Provides and opportunity is used to **positively or negatively** influence attitudes and beliefs.

Darlow, B., A. Dowell, G. D. Baxter, F. Mathieson, M. Perry and S. Dean (2013). The Enduring Impact of What Clinicians Say to People With Low Back Pain. The Annals of Family Medicine 11(6): 527-534.

Example 2 Beliefs about back pain (2)

EJP
European Journal of Pain

REVIEW ARTICLE

The association between health care professional attitudes and beliefs and the attitudes and beliefs, clinical management, and outcomes of patients with low back pain: A systematic review

B. Darlow[1,2], B.M. Fullen[3], S. Dean[4], D.A. Hurley[3], G.D. Baxter[2], A. Dowell[1]

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4 Peninsula College of Medicine and Dentistry, Universities of Exeter and Plymouth, Exeter EX2 4SG, United Kingdom

- HCP beliefs about back pain are associated with patients' beliefs
- HCP attitudes and beliefs are associated with treatment and management approach:
  - HCPs with a biomedical orientation or elevated fear avoidance beliefs are more likely to advise patients to **limit work, physical activities** and **bed rest**.

Darlow, B., B. M. Fullen, S. Dean, D. A. Hurley, G. D. Baxter and A. Dowell (2012). The association between health care professional attitudes and beliefs and the attitudes and beliefs, clinical management, and outcomes of patients with low back pain: A systematic review. European Journal of Pain 16(1): 3-17.

The power of words

- Words/language give meaning to experiences
- Association between communication/ therapeutic relationship and health outcomes.
- Pain beliefs (e.g. about the nature of pain, meaning of pain, specific fears of hurting, harming or injuring the body and self-efficacy beliefs) are **strong predictors** of ongoing disability.
- Evidence suggests that patients experiencing LBP often **misinterpret** commonly used medical terms.

Street Jr, R. L., G. Makoul, N. K. Arora and R. M. Epstein (2009). How does communication heal? Pathways linking clinician–patient communication to health outcomes. Patient Education and Counseling **74**(3): 295-301.

Why do the words we use matter?

- Difference between describing physical sensations and labelling them as ‘pain’
- Once we notice discomfort, we tend to have cognitive judgements (e.g. bad)

  and emotional reactions (e.g. scary)
- Which lead to bodily reactions (e.g. tension, posture change, avoid moving)
- That aggravate/maintain the ‘pain’

How else can we talk to patients…

- In ways that acknowledge what they are feeling, but don’t reinforce fear-avoidance beliefs and behaviour...?

- And ways that help them develop more accurate body awareness and willingness to be active despite pain?

Think about your own language and provide examples of the following…

Harmful language	Healing/helpful language
Promote beliefs about structural damage/dysfunction	Promote a biopsychosocial approach
Promote fear, vulnerability and fragility	Promote resilience
Promote a negative future outlook	Promote positive outlook & normal activity/movement

Harmful language	Healing/helpful langauge
Promote beliefs about structural damage/dysfunction • Your back is *damaged* • You have *degeneration/arthritis/disc bulge/disc disease/a slipped disc* • The scan shows significant *damage* to the discs/joints	**Promote a biopsychosocial approach** • Your back is *sensitive*, not damaged • Sensitivity can be increased by awkward movements and postures, *inactivity, lack of sleep, stress, worry* • Your scan changes are *normal*, like grey hair
Promote fear, vulnerability and fragility • You have to be *careful* • Your back/core is *weak* and *unstable* • You should *avoid* bending/ lifting/running	**Promote resilience** • Your back is one of the *strongest structures* of the body • It's *very rare* to do permanent damage to your back • Movements will be painful at first but will get better as you get active
Promote a negative future outlook • Your back *wears out* as you get older • This will be here for the *rest of your life* • *Stop* if you feel any pain/Let pain guide you	**Promote positive outlook & normal activity/movement** • Relaxed *movement will help* your pain settle • Your back gets *stronger with movement* • Protecting your back and avoiding movement can

Lin, I. and P. O'Sullivan (2014). Acute low back pain: beyond physical therapies. Pain Management Today **1**(1)

Case example- John

- 56 year old man
- He has a 15 year history of low back pain.
- He's had several MRI scans in the past, the most recent shows 'degeneration of his back'.
- He's worried about the future, and thinks things will ge worse
- He's trying to rest his back, and doesn't lift or bend in order to protect it.
- He's been to a number of different therapist, and he's been told he has 'dysfunctions in his back', a 'twisted pelvis', and this is making his spine 'vulnerable'.
- He comes to see you…

Thinking about John…

- What language might **positively influence** John's situation?
- What language might **negatively influence** John's situation?
- And why..?

Suggestions

- Use the words ‘physical sensation’ or ‘feeling’ instead of ‘pain’
- Encourage patients to avoid describing sensations as ‘fine’, ‘OK’, ‘not painful’ etc.
- Encourage richer, more specific and creative ways to describe the nature, quality, shape, size etc. of sensations
- Work slowly and pause sometimes to explore what the patient is feeling in this moment to develop interoception
- Pause to explore what they are feeling/thinking/worrying about if they wince, frown, tense, stop moving suddenly…
- Be gentle and compassionate and ‘normalise’ automatic avoidant reactions as ‘what we all do’ to keep ourselves safe
- Add pain education and body mindfulness exercises to create opportunities to try different ways of responding

Thank you

- Questions?