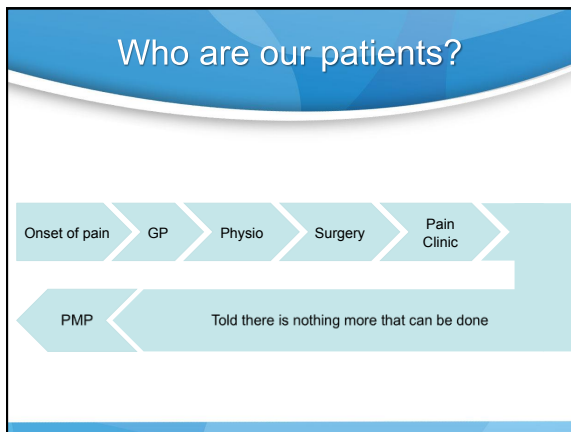


Lewisham Healthcare **NHS**  
NHS Trust

We know it works, but why? A qualitative study of patients' views of a pain management programme

**c a l m**  
centre for active lifestyle management

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### What are PMPs?

- Multi-professional approach
- Group of 9-14 people
- Reduce distress & disability

### What does it involve?

- What is chronic pain
- Medication
- Movement
- Goal setting and pacing
- Relaxation
- Distraction
- Stress management
- Problem solving
- Thoughts, feelings & actions
- Sleep
- Sexual relations
- Flare up planning
- Relatives Day

### Are they effective?

- Tackling depression reduces pain interference
- PMP ≥ TAU in pain clinic
- PMP ≥ "back book"



## Nicholas et al. (1991)

Physiotherapy programme	CBT-PMP	CBT-PMP with relaxation	Behavioural PMP	Behavioural PMP with relaxation	Attention control
Improved	Improved	Improved	Improved	Improved	Improved
■	↑	↑	↑	↑	■
	No difference		No difference		

## Are they effective?

- Nielsen & Jensen (2004)
  - Control of their pain
  - Belief that they are not disabled
  - Pain ≠ damage
  - Increasing physical activity
  - Seeking more social support
  - Pacing

## IPA

- Understanding the experiences that people go through
- Growing body of IPA research in chronic pain
- Understand the experiences of patients on a PMP

## Participants

- Seven self-selecting female participants.
- All had completed the 10 week PMP programme (CALM).
- Agreed to take part in a research interview after being informed about the research by the CALM team.

## Interview Process

- Semi-structured interview.
- Independent researcher (to encourage honest / valid responses).
- Audio recorded and later transcribed and analysed.

## Interview protocol

1. Can you explain your pain to me in your own words?
  - What does it feel like?
  - does it change in anyway?
2. Could you quickly tell me how your pain started?
  - How long have you had it?
  - Has it changed over time?
3. Could you tell me about past treatments you've had?
  - How did you find these?

## Interview protocol

- 4. How does your current treatment (i.e. PMP) compare to your past treatments?
- 5. Why do you think your pain persists?
  - Have you always held this belief?
  - What causes your pain?
- 6. How would you describe yourself as a person?
  - What would sum you up?
  - How do you think / feel about yourself?

## Interview protocol

- 7. Has attending the programme changed the way you think about yourself?
  - Do you see yourself differently?
  - In what ways are you a different person now?
- 8. Has attending the programme changed what you can do?
- 9. Why do you think that change has happened (if it has)?
- 10. What do you fear for the future?
  - What can you do to stop this from happening?
- 11. What do you hope for the future?
  - Could you achieve this despite your pain?

## Why does it work?

- What do you think?
- Any ideas on what our participants said?

## Superordinate themes

- 1 – Knowledge & Information provision.
- 2 – Group aspect / peer support.
  - 3 - Communication.
- 4 – Past vs. present self.

## 1 – Knowledge and Information Provision.

Participants valued the provision of information about pain management tools, and about the physiology of pain itself.

“With [the PMP] it was [...] more about giving you the knowledge, just making you more empowered.”

What our participants said:

“...and just the education in terms of understanding, like I said, the nerve system and how it works, and how it sends messages, and so just having that understanding is like, ‘oh, ok!’ so different nerve systems can be more sensitive, and it doesn’t mean that I’m weak.”



What our participants said:

“...at one point they [the PMP] admit, that they were not able to stop the pain but they still help us to work with it. And then, at least you know what is going on [...] it stops you feeling that it's your fault, or you're useless which is the impression that I was having before.”

## Knowledge in terms of tools:

“With the programme, it gave you the education on the nervous system, that your body does need to move. [...] Your brain is there, telling you, giving you all these warnings, and you are feeling the pain, it's very real. But, you need tools...”

What our participants said:

“I've learned how to you know, just to calm myself down if I am getting a bit anxious, to breathe, I've learned to breathe, and just calm myself down, and just think positive things instead of negative things.”

What our participants said:

“It's a combination of trying out the different tools and realising their benefits, realising that they work, and realising that if I pace myself I can get more done, rather than just thinking 'right let's just do it all' and suffer later.”

## Group aspect / peer support

- Feedback from participants suggests that this was one of the most important aspects of the PMP.
  - It was felt to reduce social isolation that often comes with the experience of chronic pain.
  - Provided support and validation.
  - Boosted social confidence.

What our participants said:

“But then it's reassuring to see that, you know, other people you know, go through it, and I know that [...] I'll be fine and I'll keep on going but it was nice to have other people know what you go through...”



What our participants said:

“And just hearing other peoples’ experiences also kind of helped to put things in perspective, so I think that made, that made a really good difference, just doing some of that small group work”



What our participants said:

“...the fact, that someone understands. You’re actually talking to persons who actually understands and can actually relate to what is going on, so it’s not just you, because it’s a class. And being able to express something how you’re feeling, and another individual could say ‘yes! That is exactly...’. So you realise it’s not in your mind, it’s more than that.”

## Communication

- In healthcare services:
- Multiple participants highlighted a lack of clear communication from healthcare professionals.
  - Lead to uncertainty, and feelings that pain was not ‘real’.
  - Felt unheard and disbelieved.

## Communication

- With friends and peers:
- Found it difficult to relate to others.
- Lack of understanding from friends and family about the experience of chronic pain and its effects.
  - Feelings of isolation and increased reluctance to socialise.

What our participants said:

I: So what did it feel like, not understanding what was going on?

P: You feel... you just feel as if you, as if you’re going crazy, as if like, maybe it’s all in your head and maybe it’s a psychological problem, and it’s not really a health problem, but it’s not, it really is a health problem!



What our participants said:


“I got fed up communicating with people. ‘How you feeling?’, well they don’t really want to know. I didn’t like to keep telling them.”

“I wasn’t communicating. I shut down. And no one was communicating with me, so ... communication had broken down, [...] no one was saying to me, ‘hey, how are you really? How you feeling’.”

Peers / socialising.

What our participants said:

“[...] but it was more... more about feeling ... that you're not, like useless just because you're in pain. Which a lot of the time is how you feel, and it's really, really hard to sort of, put it across to other people.”



Peers / socialising.

What our participants said:

“I mean really and truthfully, they diagnosed what I have but they don't really, like, go into depth and sit you down and say 'well this is why it's happening', and blah, blah.”

“I'm no longer kind of, depending on the doctors to kind of tell me what it is or, I'm not, I'm not ... that's just a by-product, and whatever they say I'm kind of confident that I can still, kind of manage through that, so I'm not kind of having that as such a big influence for me anymore.”

Healthcare services

“Whereas the hospital, the doctors, were saying 'you shouldn't be feeling like that'. In other words, they weren't acknowledging that I was in pain. [...] There was no talking, there was no real empathy. Whereas with the pain clinic, management, there's more empathy and understanding.”

### Past vs present self


- Participants noted a change in themselves, reflecting that they felt more confident and capable of managing their pain on completion of the programme.
- There was also mention of how self-concept was altered by the experience of chronic pain, often with a wish to return to who they had been prior to the onset of pain.

What our participants said:

“I feel good about myself. Whereas before, the pain, and the depression, and everything, it sort of really lowers you down, but coming here over the course of this six, eight weeks, I've really seen [...] an improvement in me.”

“...it [the PMP] was really good because it sort of, I think it gave me more inner strength in terms of being more ... confident about me.”

“So with the programme, it's really trying to help me to get back to who I am. I am seeing myself as a person aside from the pain”



## Relation to previous research:

- Nicholas et al. (1991) suggest that a group aspect may not be important for change, as discussion groups did not show as much improvement as behaviourally driven PMPs.
- Turner-Stokes et al. (2003) suggest that group is equally as effective as individual treatment.
- A meta-analysis by Morley et al. (in press) found that CBT was more effective than TAU, but only marginally.

- Our findings appear to contradict this, with the group aspect being identified by participants as one of the most important factors in the effectiveness of PMPs.
- Supported by Lamb et al. (2010) & Gatchel (2009) which demonstrated that group PMPs were more effective than other treatments on a number of measures.

- Group aspect helps address social deficits experienced by participants following the onset of their pain.
- Supportive and empathetic environment enabled participants to better understand and manage the problems caused by pain.

- This in turn seems to help participants return to their 'old selves' and regain an improved self-concept.
- At the same time participants reflected that they also felt more able to achieve their goals, now that they had tools to manage their pain more effectively.

Morley, Davis & Barton (2005); Sutherland & Morley (2007)

"I just want to go back to work, and to be able to wake up in the morning and if I want to go for a run I can, and if I want to cook dinner for my family I can and not be afraid that for the next three days I'm going to be in so much pain it's ridiculous, you know. I want to be able to live my life the way I used to."

"So I think I'm much more, yeah definitely much more focussed and recognise, that actually I can do it. It might take me a little bit longer but I can do it."

## Impact of PMPs

- PMPs effectively reduce distress and disability in participants (e.g. Flor et al., 1992; Williams et al., 2012).
- As previously noted, as a result of the PMP our participants felt more able to self advocate and express themselves clearly with peers and professionals.
- The provision of information and practical tips on managing pain also helped participants increase mobility and confidence in their ability to complete tasks and socialise with others, and reduced feelings of reliance on healthcare services.
- These factors help to explain findings which show a decreased use of healthcare services in participants following completion of a PMP (Clare et al., in press)



## Conclusions and discussion

Information about effective pain management can be provided through many means (self-help resources, individual CBT, computerised programmes etc), so why do PMPs receive such positive feedback from participants and why are they shown to be more effective?

-Participants in our sample highlighted that group processes in PMPs are more important than content alone, and that it was the ability to discuss issues related to pain, and receive feedback on them, that increased confidence in their abilities to manage pain.

## References

- Clare et al. (in press). Can a pain management approach reduce healthcare use? Stopping the revolving door. *British Journal of Pain*.
- Flor, Fydrich & Turk. (1992). Efficacy of multi-disciplinary pain treatment centers: a meta-analytic review. *Pain*, **49**(2), 221-230
- Gatchel et al. (2009). Preliminary findings of a randomized controlled trial of an interdisciplinary military pain program. *Mil Med*, **174**(3), 270-277.
- Lamb et al. (2010). Group cognitive behavioural treatment for low-back pain in primary care - a randomised controlled trial and cost-effectiveness analysis. *Lancet*, **375**, 916-923.
- Morley, Davies & Barton. (2005). Possible selves in chronic pain: self-enmeshment, adjustment and acceptance. *Pain*, **115**, 84-94
- Morley, Williams & Eccleston. (in press). Examining the evidence of psychological treatments for chronic pain: time for a paradigm shift? *Pain* (2013).
- Nicholas et al. (1991). Operant behavioural and cognitive-behavioural treatment for chronic low back pain. *Behav Res Ther*, **29**(3), 225-238.
- Nielsen & Jensen (2004). Relationship between changes in coping and treatment outcome in patients with Fibromyalgia Syndrome. *Pain*, **109**, 233-241.
- Perry et al. (2010). Comparison of a pain management program with usual care in a pain management center for people with spinal cord injury-related chronic pain. *Clin J Pain*, **26**(3), 206-216.

## References

- Sutherland & Morley. (2007). Self-pain enmeshment: future possible selves, sociotropy, autonomy and adjustment to chronic pain. *Pain*, **137**, 366-377.
- Teh et al. (2010). Effect of depression treatment on chronic pain outcomes. *Psychosom Med*, **72**(1), 61-67.
- Turner-Stokes et al. (2003). Outpatient cognitive behavioral pain management programs: a randomized comparison of a group-based multidisciplinary versus an individual therapy model. *Archives of Physical Medicine and Rehabilitation*, **84**(6), 781-788.
- Williams, Eccleston & Morley. (2012). Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database Syst Rev*, **11**