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Developing a new approach to persistent pain management in osteopathic practice. Stage 1: A feasibility study for a group course

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ABSTRACT

Background: Persistent pain is a complex biopsychosocial problem which can be challenging to manage in clinical practice. This paper reports the first in a series of studies exploring ways to enhance care for patients with persistent pain using Acceptance and Commitment Therapy (ACT). In this study, six week 'Living Well with Persistent Pain' groups were co-facilitated by a clinical psychologist and an osteopath. **Method:** A mixed methods, repeated measures, observational design. Patients receiving osteopathic treatment were invited to 'opt-in' and attended screening interviews. Course content and structure were adapted from NHS pain services and open source ACT material. Data was collected from questionnaires at baseline, six weeks (end of course) and after three months, and semi-structured telephone interviews at three months.

Results: Fifteen patients completed a group course. Thematic Analysis of transcripts indicated that participants considered the course was helpful. Questionnaire data at three month follow-up showed small but sustained improvements in mean scores for activity and pain acceptance: CPAQ Activity change -1.02 (SD 0.90), 95%CI -1.78 to -0.27 ; CPAQ Total change -0.78 (SD 0.87), 95%CI -1.51 to -0.05 . **Conclusions:** Findings from this small feasibility study indicated that patient satisfaction with an ACT-based pain management group was high and questionnaires indicated improvements in activity and pain acceptance. However, individual responses varied widely and full data was obtained from only eight participants. Results were interpreted cautiously and used to inform the design of further studies exploring the process and effects of integrating ACT interventions directly with osteopathic care for individual patients.

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Introduction

Persistent musculoskeletal pain and pain-related disability involve increasing costs for healthcare services [1,2] and 45% of the estimated 7.8 million people with persistent pain in the UK are thought to have inadequate pain management [3]. These patients often have co-morbid health conditions and multiple pain sites [4,5], and better outcomes are reported from multidisciplinary care than from psychological or physical care alone [6,7]. Although many patients initially consult General Practitioners, first contact can also be with physical therapists, including osteopaths; a pattern that is likely to increase as the burden of musculoskeletal care increases in the aging population [8]. Pain disability results from

complex biopsychosocial interactions including central nervous system sensitisation, past experiences and reactions to pain [9]. Advances in understanding the psychological factors that influence the transition from acute pain to chronic disability [10] have informed best practice guidelines for pain management [11–13]. These programmes typically include group work in tertiary healthcare settings, with physical and psychological interventions delivered separately [6,14].

The widespread consensus that persistent pain is best understood as a biopsychosocial problem is not currently matched by agreement about how psychosocial aspects of musculoskeletal problems should be managed by physical therapists [15]. Current models of biopsychosocial care have been criticised as remaining grounded in a biomedical model [16,17], in which 'one-size-fits-all' guidelines fail to target patient sub-groups effectively [18]. Physical treatment is often prioritised [19,20], especially if practitioners lack the skills or confidence to work with psychosocial issues [21].

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Biopsychosocial models of osteopathy involve both risks and benefits. On one hand, osteopaths view the body as an integrated system [4] and focus on restoring physical function and agency in extended consultations that provide sufficient time to develop effective therapeutic relationships [22]. Non-specific treatment factors can promote well-being [23] and trusting relationships may increase patients' willingness to experience repeated exposure to discomfort, which can promote behaviour change [24,25]. Patients may welcome physical treatment but satisfaction ratings are frequently independent of changes in pain level or disability [26]. Conversely, physical therapy has been criticised for promoting passive coping strategies [27], as well-intentioned reassurance or over-protective messages about pain increase fear-avoidance behaviour [28,29], especially if ineffective physical treatment continues [30].

The search for more effective models of practice for patients with persistent pain prompted a systematic exploration of ways to integrate pain science, psychological pain management and clinical education at the University College of Osteopathy (UCO). This study explored the feasibility of creating an optional pain management course, based on the principles of Acceptance and Commitment Therapy (ACT), for patients already receiving osteopathic care. It formed a preliminary research stage in the Medical Research Council's guidelines for developing a complex behavioural intervention [31,32].

Background to the ACT approach

Psychosocial aspects of the biopsychosocial model of healthcare have been conceptualised using a range of psychological models. The most widely used and researched are Cognitive Behaviour Therapy (CBT) [23] and the more recent functional psychological approaches of '3rd wave' CBT, which include Acceptance and Commitment Therapy (ACT) [33]. ACT is a principles-based model of human functioning, with a coherent philosophical basis and an international values-based community committed to alleviating suffering and promoting well-being [34]. ACT is based on a form of philosophical holism called Function Contextualism, in which actions are interpreted as being inseparable from their context [33], which is consistent with osteopathic concepts of function and agency. It is also underpinned by a theory of cognition called Relational Frame Theory (RFT), which provides a way of understanding the limits of language-based problem solving processes [35].

The ACT model of normal psychological functioning and response to distress can be applied to all human situations [36]. The core processes are relevant to patients *and* practitioners, who need to be willing to explore challenges in their own lives using ACT principles and personal mindfulness practice before introducing this approach to patients. The ACT community is open source, with resources freely available to members at <https://contextualscience.org>, and principles-based interventions can be used effectively by practitioners with limited training in the theories underpinning this approach [37]. There are no formal accreditation processes and practitioners evaluate the success of their actions pragmatically in terms of 'workability' in achieving the intended aims.

Psychological flexibility is proposed as being central to well-being, and the core theoretical mechanism that mediates outcomes [33]. It is described as the capacity to act on values and what is possible in the present moment situation, rather than being constrained by habitual thoughts, feelings and impulses related to past experiences. Psychological flexibility is mediated by six, core

interconnected processes illustrated in the Hexaflex diagram (Fig. 1).

The six core processes are:

- *Acceptance* of uncomfortable experiences without trying to avoid or control them (e.g. willingness to move despite anticipated discomfort)
- *Defusion*, or the capacity to observe thoughts without reacting automatically (e.g. noticing the thought that 'hurt means harm' without reacting to it)
- *Present moment awareness* of what is going on inside and around you (e.g. of whole body sensations)
- A stable sense of *self as the context* of all experiences
- Clarity of personal *values* (e.g. What kind of person do I want to be? Who and what matters?)
- *Committed action* based on those values

ACT theories propose that habitual avoidance of unwanted experiences tends to be ineffective and risks creating a restricted life which is dominated by pain. Interventions aim to help patients recognise the effects of avoidant responses to pain and explore the impact of alternative choices, based on valued activities and roles that are personally fulfilling [37]. Randomised controlled trials have demonstrated effectiveness in managing persistent pain [38], with medium to large effect sizes for pain-related anxiety, distress, disability, physical performance, medical visits and work status [39–44], and smaller effects on pain intensity [43]. Improvements in physical and psychosocial disability, depression and anxiety may occur when mindfulness increases capacity for non-judgemental awareness and more flexible responses to pain [45,46], but further research into the underlying change processes and mechanisms is needed [23,47].

Study context and setting

The UCO clinic offers approximately 800 consultations a week, provided by student osteopaths under tutor supervision. Approximately 45% of these patients report chronic illnesses or disabilities [48], 44% have persistent pain, and the majority have multiple pain sites [49]. The clinic is located in an area of mixed inner city development and deprivation where patients often report socio-

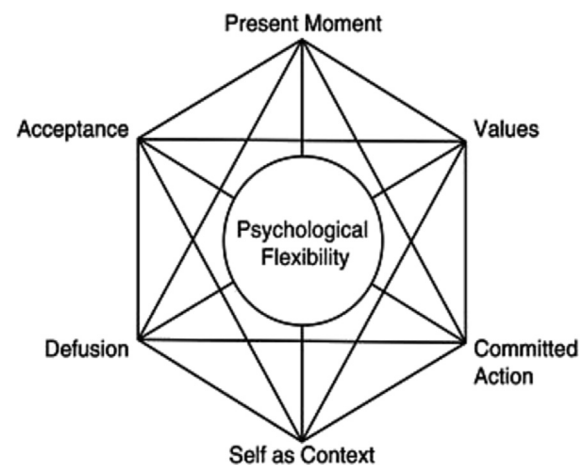


Fig. 1. The Hexaflex diagram [34].

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