

Airing Pain Programme 67: Biopsychosocial and spiritual?

The place of faith in pain relief, plus physiotherapy meets mental health, and educating doctors.

It's well established that pain needs to be understood and treated as a biopsychosocial problem, but what about the spiritual side of life? Professor of nursing and Anglican chaplain Michelle Briggs speak to Paul Evans about how some people in pain can find relief and meaning in the prayer and community engagement offered by their faith.

We've looked at the issue of pain education before – Emma Briggs gives an update on the struggle to increase pain training for doctors and improve its quality. Her interdisciplinary pain management course brings healthcare professionals together with a focus on empathy, working as a team and understanding the importance of drug and non-drug treatments.

Physiotherapy and mental health care might seem at opposite ends of the pain management spectrum, but physiotherapist Nathan Goss sets out why we have to see pain as a mind-body problem and argues that mental health difficulties are 'something we all experience'.

Paul Evans: Hello, I'm Paul Evans and welcome to **Airing Pain**, a programme brought to you by Pain Concern, the UK charity providing information and support for those of us living with pain and healthcare professionals. This edition has been funded by donations from residents at Falcon House, Edinburgh.

The biopsychosocial approach to managing chronic pain is well established. It acknowledges that thoughts, emotions, economics, environmental, cultural *and* biological factors all contribute to our wellbeing. But could the word 'spiritual' be added to that description?

'Towards culturally competent pain assessment' was a research project funded by the National Institute for Health Research. It explored the experience, expression and management of chronic pain across the five [most] common faith communities in the UK – Jewish, Hindu, Sikh, Muslim and Christian. Forty-four participants aged 65 and above were asked about their experiences of pain, their choices around self-management, their interactions with health professionals and whether or not faith had influenced the way they managed their pain.

Michelle Briggs was one of the research team. She's Professor of Nursing at Leeds Metropolitan University and she's an Anglican chaplain.

Michelle Briggs: We could not see any specific pattern of a Christian way of dealing with our faith or an Islamic way of dealing with the faith. What we found more interestingly is that the majority of people found faith as an incredibly positive resource to help them with their pains, so they talked about their [faith] providing solutions to help them live positively with their pain, in terms of prayer, in terms of community engagement, the support that they got from other members of their Faith community. They talked very positively about how their Faith had helped them cope and live with their pain and also not only cope and live with their pain but a way of understanding what their pain meant for them – their faith helped them have a sense of why we have pain in the world.

And that, as a pain community, what we saw was, certainly within the palliative medicine field – Dame Cecily Saunders was a pioneer in that area – and she talked about pain being a total pain experience, whereby we have physical pain, we have psychological, social and spiritual elements to our pain. And, that actually, that's one of the things we think – that we have pain because our bodies are broken, we have pain because the way we are thinking about pain might help, so our thoughts are broken or need fixing or we have pain because maybe our relationships break down or that there are issues around our relationships – and one of those relationships could be our relationship with God or within our faith.

And certainly within the palliative care field, one could argue that the pain management within that area is opened up because we are able to talk about all of those aspects, in a way that we don't necessarily talk, when we are talking about chronic pain management, where we focus sometimes predominantly on the broken bodies and maybe we talk about the psychology, but don't necessarily talk about the social factors that can help.

Evans: Are there any instances where our concept of God might get in the way of us managing our pain?

M Briggs: I think sometimes that might be – in the same [way] as anything can be a barrier to getting good pain relief: the way we work with our families; the way that we work with our health professionals; the way that we see God; the way that we're working with our faith community... sometimes that can be a difficulty and it's why within the research what we've come up with is a series of questions that, actually from a pain consultant point of view, or if you're going to a pain clinic, you may think about... one of the questions that we're asking is 'Does your religion influence how you understand your pain and it's cause?'

And of course there's the potential there for that influence to be a positive influence, because it helps me understand why I have my pain, but it could be that it's a negative influence, and that actually it's getting in the way of me accessing pain treatment or thinking about pain. Or, indeed, what we're asking is 'Can you tell me if aspects of your religion make your pain better or worse?'

One example that was given was somebody who felt that they would like to continue with their prayer, but the pain that they had made the prayer positions particularly difficult, so there was a real tension there. And one way their pain consultant helped them was to find a way to perform their prayers in a way that helped their pain. So that there were different ways to say the prayers and do the prayers, that combined their physiotherapy and their prayers.

So there are ways that when you ask those questions and you give people permission to talk about it, that we can find ways of improving people's pain management in combination with their faith community.

Evans: That's incredibly important, isn't it?

M Briggs: I believe so. I think sometimes we talk about being able to see all aspects of somebody's life and being able to work out how the pain can sometimes be in the driving seat of that person's life. They can be thinking about how the pain is stopping them doing things, and one area of their life can be their participation in their faith community, but it's an area of life we don't necessarily talk about. But there's a lot of evidence to suggest that prayer can help some people if it's an important part of their religious life or that other aspects of being able to participate in their faith can help their pain experience.

So being able to facilitate that as pain specialists, is an important area for some people. The important thing is that what we need to make sure when we're helping people tell their stories about how the pain is making a difference to their life, that we give people every opportunity to say the things that matter to them. For some people, in terms of our service user group, the older people that we spoke to in our research said 'Oh, I don't think it matters at all, I don't need to talk to my doctor about my religion – it's not positively helping me, it's not negatively getting in the way – it doesn't matter at all.' As is [the case with] lots of other things that we do around our pain – but when it does matter, it matters *a lot*. So I think that the important thing is that our assessments and when patients come and talk about pain, if it is an issue, that they are able, and they have permission be able to talk about it when it does matter.

Evans: Depending on your level of faith, whatever that faith maybe.

M Briggs: Yes, yep.

Evans: Pain is an all embracing thing – it's your life, it's biopsychosocial. If that is your life and your faith is your life, then everything is linked.

M Briggs: Absolutely, and it's part of any health professional's role to consider all aspects of somebody's health and think about these social, cultural and spiritual aspects, where they may provide solace or they may provide an area where there's work to be done in terms of improving somebody's pain management. So it's incumbent on people to be considering those. The real difficulty is how you consider those and how you sensitively and culturally ask questions, so that people feel safe and able to talk about their pain in that way.

Evans: That's right, if a pain doctor says to you, would you like to see a chaplain?

M Briggs: [laughs] Absolutely!

Evans: ...and says it the wrong way and...

M Briggs: And certainly our service users group said that that certainly shouldn't ever be the first question and that it should be a sense of 'What is your religion, if any? Do you have a religion? If you have one, does it influence how you understand your pain? Does it influence how you make decisions about your pain management?' And if people are saying 'yes' to those questions, then there are deeper questions to ask around 'Can you tell me particular aspects of your religion that are helping you and is there a way we can help you facilitate that?'

The example I gave about somebody struggling to participate in their prayers, and there was a way that that could be helped. Another example was a Sikh gentleman who found that part of his faith was to participate in the service and he wasn't able to, so there was a way found to allow him to continue to participate. There are ways that unless we have those conversations, we can't work out ways of helping.

But you're absolutely right, sometimes if you just leap in with 'Would you like to see a Chaplain?' the word 'Chaplain' might not even be understandable to most people, or the reason for seeing that person. Bearing in mind the group of people we are speaking to are people who are connected to the faith, they said 'Oh no, don't ask that question first, ask us why this is important to us and ask us whether this should be part of our pain management plan'.

Evans: So, biopsychosocial should be sociobiopsychosocial or maybe sociobiopsychospiritual?

M Briggs: Cecily Saunders would argue that a total pain model includes consideration of the biological, psychological, social and spiritual factors within that person's life. And, of course, for some people it will be a totally physical problem, for some people it will be a physical and psychological difficulty that they're working with and for other people the social and the spiritual factors will also be a part of that equation to getting to good pain relief.

Evans: That was Michelle Briggs, Professor of Nursing Care, Leeds Metropolitan University.

I'll just remind you of my usual words of caution, the small print if you like, that whilst we believe the information and opinions on **Airing Pain** are accurate and sound, based on the best judgements available, you should always consult *your* health professional on any matter relating to *your* health and wellbeing. He or she is the only person who knows you and your circumstances and therefore the appropriate action to take on your behalf.

Now, picking up on the points made by Michelle Briggs about the biopsychosocial and maybe spiritual factors affecting a patient's wellbeing, is the next generation of doctors and health professionals receiving the appropriate training to be able to take all of a patient's life factors into account?

Emma Briggs is a lecturer and Kings teaching fellow at King's College London. She's also chair of the British Pain Society Pain Education Special Interest Group. Back in 2011 the group published the results of a study looking at how much pain education students across the health disciplines were receiving. And it may surprise you to know that some vet schools were included in the study.

E Briggs: There was one University, one Veterinary School which did do a significant amount of pain teaching in their curriculum, which was higher than some of the schools that were teaching health disciplines for human healthcare. However, we only had two schools in the sample. It's difficult to make that conclusion universal. However, we do know that it makes up less than one per cent of the curriculum, pain education, when it is an increasing health concern. We have a third of our adult population who are experiencing long term persistent pain and just taking back pain alone, it's costing the economy 12 billion a year, estimated. It has a devastating effect on the individual lives of that many adults, yet we don't have it represented in the preparation of our healthcare professionals in that way. And it being an increasing healthcare concern, we need to see it in the curriculum; we need to see our healthcare professionals better prepared, so that they can manage pain for individuals, for their family and for public health.

Evans: So what sort of education are they getting?

E Briggs: What we know is that they're getting on average about twelve hours of education. We've recently conducted a study with the European Pain Federation (EFIC) and this looked at just medical undergraduates this time, whereas our previous study was a whole range of disciplines, but it compared the education across Europe and that was fascinating in itself. So we reckon they're getting on average twelve hours, which in those figures when the European standard is for medical students to have a curriculum which is 5,500 hours. So really, we're only getting 0.2 per cent of the curriculum.

But what is interesting is *how* they are being educated and it's largely by lectures, their knowledge is then tested through exams. So it's all about information and knowledge recall, which is great but by itself it's not going to help me as a clinician, learn how to communicate, learn how to have empathy with a patient, learn to problem solve, assess their pain and then make some clinical decisions about how am I going to treat this; how's the best pharmacological treatment; how's the best drug techniques that I need and is there any non drug techniques, some alternative therapies, that might help this individual? None of those techniques are going to help those skills and that competence that we need.

Evans: Are we on a par with other countries in Europe or the world even?

E Briggs: Unfortunately not, the UK figure is that sixty-eight per cent of universities in the UK have some sort of pain teaching, but that's usually spread out in other modules. So it might be in a module on pharmacology, it might be on the pain mechanisms and physiology, but they don't have dedicated pain management time.

Quite interestingly, in France, I suppose our closest comparison, eighty-four per cent of their medical schools actually had dedicated time, dedicated modules for pain teaching. That's because they have had a national plan around pain management since 1997 and in 2004, they made it compulsory that all medical schools should include pain within their teaching. All of them have pain teaching and eighty-four per cent of them have dedicated modules – so a block of teaching actually on pain itself. Germany are not far behind because they have worked with palliative care to get it on the curriculum and get it on the students final exams as well.

Evans: But, I suppose pain may not be a sexy subject for young undergraduate. It may not be an easy module to sell for the powers that be, in the universities and colleges. How do you make it sexy?

E Briggs: I think we've got to demonstrate the impact and continue to shout from the rooftops, the impact that it's having on individuals and their families. The increasing public health concern and, very sadly, I think, people respond much more to the economic aspect. And I think we've got increasing numbers in Europe. And I think there was a study that was conducted in Ireland, that said on average somebody in persistent pain can cost the economy 5,000, 6,000 euros, but that figure can actually go up to 30,000 euros, depending on the treatment somebody is having. So unfortunately sometimes the powers that be only respond to the economic arguments, but increasingly, there is this argument around social justice.

But actually, it's around saying that the health needs of the population need to be represented in how we are preparing our undergraduates. I was talking with some lecturers from South Africa and they were saying, actually, their local population... they increasingly need to teach around HIV and it's very difficult to get pain in there. Our population needs are different and pain *needs* to be up there as a priority

Evans: Emma Briggs.

Now Nathan Goss, is not a student, rather he's Senior Physiotherapist at the pain management programme at the Walton Centre in Liverpool. But when I spoke to him he was a relative newcomer to the world of pain, with just two years in this specialist field.

Nathan Goss: The area I worked in prior to pain was the mental health field. So I was a mental health physiotherapist – not the most usual field to be working in. There are plenty of physiotherapists working in the mental health field but we're not well known or understood really, what our roles were. And I was looking for an area in that I could combine my knowledge of physical health and mental health and the standard of mood problems and psychological difficulties really and pain brings those two fields together.

Evans: In what way?

Goss: Pain affects us not just physically, but emotionally and mentally as well. As a physiotherapist, I have always thought we are in one of those great positions, to be able to prescribe movement and exercise, which we recognise as being very important in the presence of any mental health problems or pain problems. Not a lot of people can actually do that I suppose, prescribe the exercise.

Evans: So, you were involved with people with mental health issues, depression, anxiety?

Goss: Absolutely, absolutely, the incidences of depression and anxiety are recognised as being much higher in the chronic pain population. Like I said, the role of exercise, the fear of movement that chronic pain brings is well recognised and it's a good role to be able to be able to understand both parties and actually help people get moving; because it's one thing being recommended movement but, actually, you need to have the recognised background knowledge to be able to do that, the reassurance... The method of delivering that advice, slots in very nicely with the area I'm moving into I suppose.

Evans: As a patient, if I were being referred to a physiotherapist, and the plus point of that particular physiotherapist was 'he's worked with mental health patients' – that would ring some alarms bells in me.

Goss: I think that's inevitable, we're assessing people with pain problems all the time. The mention of mental health, mood, depression, psychological difficulties creates that impression in a lot of people. And that's why we have to be good at understanding the impact of pain. And not just telling people, we have to learn from the patient, we have to understand their experience of pain.

And, actually, I think it's just about taking away the stigma really. I always describe mental health or psychological problems as something that we all experience. We're all on a sliding scale, it's not just something that gets to a certain tipping point and you've got something wrong with you. We're human beings, so we all have human psychology. We're on the sliding scale of mood – I wake up some days feeling not so great and find it more difficult to interact with others and maybe those interviews made me a little bit anxious as well beforehand. But these are human emotions and difficulties and we try to normalise that a little bit, I suppose, that's what we try to do, when I'm working with people with pain problems, rather than making them feel 'I've got a mental health problem'. Because I can understand that, if that's not delivered in the right way, it could be a bit of a shock.

Evans: But you're not a mind therapist, you're a body therapist.

Goss: You can't separate the two, really. Mental health work and working with the psychological side of things a little bit was the underrepresentation at university. We've just had a talk, suggesting university students get thirty seven and a half hours of pain education, which I'm not sure was the case when I was at University. I know we had a three hour lecture on mental health problems and I remember just thinking, that's not representative of where I want to be as a therapist. I need to be able to deal with both the mind and body [laughs] side of things. I think that's what therapy is about really, treating a physical difficulty or the other side, it's both together – they need to be integrated really.

Evans: What have you learned in your first two years of pain management?

Goss: I've learned that pain is a very complex thing. It's not something that is brilliantly understood in the context of other medical problems and in the field of the medical world – there's still lots and lots to learn and I've got a long, long way to go. But there are also some very simple, helpful messages that you can give to our group members, to help them move forward and lead a better quality of life. That's what I suppose keeps me interested and makes me enjoy my job, is the fact that there is scope for people to improve their quality of life. But certainly, there's a lot more to learn and lots of exciting future directions as well I think for pain management.

Evans: Nathan Goss, Senior Physiotherapist at the Pain Management Programme at the Walton Centre in Liverpool. Now when I got my first job in a completely unrelated field, I received three months of intensive lectures and cramming, before being let loose on the real thing. But I felt I'd learned *more* in the first week following that training period, than in the previous three months with my head buried in a textbook. Learning the theory is, of course, essential but experience of real life situations cannot be learnt in a book. So, going back to our undergraduates, how could the gap between lecture room and dealing with real patients be bridged? Emma Briggs again:

E Briggs: How we teach our undergraduates at Kings College London, is to make sure they get some lectures and they get a chance to rehearse those skills they need to work with patients. We have an undergraduate programme, something called an Interprofessional Pain Management Learning Unit and thirteen hundred students come together to learn about pain. And they're from all different disciplines, so they're from dentistry, medicine, nursing, midwifery, pharmacy and physiotherapy, and we give them some background information, some online learning to do and they meet a virtual patient with different painful conditions.

And they work through some of their communication issues, their empathy and then they need to demonstrate that to us in the classroom as well. So we then meet them in the classroom, they work in an interprofessional group, it's called, they work as a team because they need to collaborate as a team, as that's how they would work in practice when they qualify. So they collaborate to actually demonstrate the communication, the empathy, their understanding of the biopsychosocial, so they *really* understand the impact of that pain on the individual.

Then they come up with a plan which includes drug techniques and non drug techniques and we make sure that they understand the importance of working as a team. And in fact they do – the feedback that we have from that learning unit is... some of the direct quotes

from the students is 'I now understand the need to work together as a team and how the outcomes for the patient can be better as a direct result from that'.

Evans: These are virtual patients, do they meet real patients?

E Briggs: They do indeed, but at different stages of their career. They will have placements throughout – it's a core requirement of the course, that they have a certain number of hours. So in nursing for instance, half the course, fifty per cent has to be clinical time. Whether they have experience with some of the pain services varies according to the individual. We take in four hundred students, unfortunately, we couldn't get four hundred students time with clinical nurse specialists or specialist physios, but some of them do rotate in, if they have an interest in pain management. And they often do projects around pain management and special study units, which will focus on pain, so they do have opportunities.

Evans: Do they meet expert patients, people who come in and talk about how pain affects their life?

E Briggs: The expert patient in the classroom is a *really* powerful tool and yes they do. My experience with expert patients is, to give you one example, was of a patient who had to come and talk to a group and somebody says 'well we don't sometimes have time to do that assessment on pain management'. And they'd said this to me in the morning and I said 'let's have a think about that and what are the alternatives' and we worked round it. In the end I said 'What would the Nursing and Midwifery Council say about that? If you said "I haven't had time to do a pain assessment?"'

When the expert patient came in the afternoon and the student repeated the question – 'sometimes I don't have time to do a pain assessment' – the patient said to me 'You don't need a lot of time, but I need to know you are with me and that you're understanding me and that you're listening to me and that is enough for me. I realise that sometimes you don't have half an hour to do an extensive pain assessment but just be on my side and that means a lot to me.'

Evans: That's very powerful isn't it?

E Briggs: *Very, very powerful*, very powerful and they clearly weren't listening to me in the morning but when the patient came along, it was incredibly powerful.

Evans: You mention students who've been through this process of learning, do you have any feedback from people who haven't, who would have liked to have gone through it?

E Briggs: That's very interesting, with the study we've been doing, the European study, looking at medical students, we interviewed students in their final year or who're just qualified and we interviewed deans and lecturers and around managing pain itself.

Evans: So they had been released into the field and suddenly they feel cut adrift.

E Briggs: They do, absolutely.

Evans: I glibly said at the start 'How do you make pain a sexier subject?' Really, I would think that most people go into medicine because the patient is the focus of everything. Well that's how you make it sexy – it's working to help the patients, and an awful lot of us are in pain.

E Briggs: Absolutely, I agree with you totally Paul because in our Interprofessional Pain Unit, that exactly what we do and that's always keeping the patient at the centre. Making sure that the students work together and focus and collaborate and those are the skills that they need for the practice.

We were talking about the expert patient in the classroom, it's a really powerful learning tool is bringing people together, learning about people's stories and journeys and impact, because many of our students are going to be eighteen, nineteen – they may not have seen anybody with long term pain. They'll have their own pain experiences, but they may be short term and it's really important that we help them understand. And that's one of the other feedbacks that we've had from our learning unit – 'we never appreciated the range of painful conditions that people have had'. So it's important that people understand that there are different treatment plans for different painful conditions.

That's Emma Briggs, Chair of the British Pain Society Pain Education Special Interest Group.

Don't forget that you can download all the previous editions of *Airing Pain* or obtain CD copies direct from Pain Concern. If you'd like to put a question to Pain Concern's panel of experts or just make a comment about these programmes, then please do so via our blog, message board, email, Facebook, Twitter or pen and paper. All the contact details are at our website which is www.painconcern.org.uk.

Last words on undergraduate training to Emma Briggs:

E Briggs: We need to more adequately prepare them, we need to get their skills – it's not just about their knowledge. We need to develop their communication, empathy, problem solving, those prescribing skills, those patient education skills – helping patients with self-

management – it's a huge area missing in the curriculum at the moment. So we need to educate them better.

In my role as Chair of the Pain Education SIG [Special Interest Group] we're working on that and we are hopefully going to launch a document which will help universities with competencies and values that we feel are important to be into the curriculum. And we will also work with the individual disciplines that have a regulatory body like the General Medical Council, like the Nursing and Midwifery Council.

And we need to work with them because they set some of the standards around pain, and pain is in those standards but in very minimal form. So, just to give you an example, the 'Tomorrow's Doctors' document, it refers to being able to prescribe for common indications, such as pain and then it says, doctors should learn how to use local anaesthetics, *and that's it* – that's the whole of their recommendations around pain management and how we should be preparing our medical students. We need to work with them, in order to get some more standards around pain management, make sure it gets into the university curriculum, so that our healthcare professionals are better prepared to manage pain when they are qualified.

Contributors

- Michelle Briggs, Professor of Nursing, Leeds Metropolitan University
- Emma Briggs, Lecturer, Kings College London
- Nathan Goss, Senior Physiotherapist, Pain management programme at the Walton Centre in Liverpool

Contact

Pain Concern, Unit 1-3, 62-66 Newcraighall Road,
Edinburgh, EH15 3HS
Telephone: 0131 669 5951 Email: info@painconcern.org.uk

Helpline: 0300 123 0789
Open from 10am-4pm on weekdays.
Email: help@painconcern.org.uk

To make a suggestion for a topic to be covered in ***Airing Pain***, email suggestions@painconcern.org.uk

Follow us:
facebook.com/painconcern
twitter.com/PainConcern
youtube.com/painconcern