Airing Pain Programme 48: Nursing beyond drugs

How nurses can use relaxation therapy, massage, acupuncture and empathy to help people manage their pain

'Imagine how it feels like if you're in pain and people won't help you.' Like other healthcare professionals, nurses can sometimes struggle to understand the perspective of people living with pain. At a training day for student nurses devoted to chronic pain, Gareth Parsons impresses on his audience the importance of believing the patient and delivers some uncomfortable truths based on his research about the frustrations people with pain often have of healthcare professionals: 'you are the problem!'

Equipped with the training they receive, hopefully this group of nurses will instead be part of the solution. The first step is understanding that chronic pain is a condition in its own right – this way the nurses will be aware of the problems of treating chronic pain as if it were acute (for example, excessive use of opioids) and be able to help tackle anxiety and fear.

With a better sense of the nature of chronic pain, nurses will be less likely to 'throw drugs' at the problem, Owena Simpson says. She guides the student nurses in a session of relaxation therapy, while Maria Parry teaches the students basic massage techniques and recalls her own experiences of how a patient of hers was able to overcome insomnia thanks to massage therapy. Gareth Parsons finishes the session with an acupuncture lesson and explains why this treatment may be more effective for some patients than for others.

Paul Evans: Hello and welcome again to ***Airing Pain***, the programme brought to you by Pain Concern; a UK based charity working to help, support and inform people living with pain and healthcare professionals. This edition has been funded by an 'Awards For All' grant from the Big Lottery Fund in Wales.

Owena Simpson: As adult nurses we are very keen or go quite often first of all for medication rather than looking for alternative ways of managing people in pain and it's helping patients to recognise that there are other ways of managing chronic pain rather than going straight for the medication and all the side effects that that carries really.

Evans: In this edition of ***Airing Pain*** I've come to the University of South Wales to see how a group of student nurses are given an insight on how they might help people with chronic pain in their future careers. And this is a good time to join them because this is the very last lecture of their three year degree course in adult nursing. It's taken by senior lecturer Gareth Parsons, who, when he was a clinical nurse specialist in pain management developed nurse-lead chronic pain clinics in acupuncture, transcutaneous nerve stimulation (TNS) and relaxation therapy.

Gareth Parsons: Today is going to be a little bit different: we're going to expose you to some of the interventions that people in chronic pain might experience and these are all interventions that are delivered by nurses. So we've got massage, which is going to be done by Maria Parry.

Maria Parry: We had a patient who had actually broken his spine and he would come back and forth for respite every 6 weeks and he had extreme pain issues from spasms in his legs

and from cramp. He never had a good night's sleep, he was constantly moving and his pain issues meant that he could never get comfortable.

Parsons: Owena is going to be doing relaxation.

Simpson: It's peak time for assessments and stuff so there's just been one assignment handed in and now the dissertation is out there a bit, isn't it? So are you all feeling stressed? Or some of you maybe not. But there are underlying signs – that may be crying, headaches and colds all the time and just generally feeling on edge.

Parsons: If you look on this chart here, you'll see around the sides of the head there are lots of acupuncture points. The cranial nerves have got lots of little supplies to all the skin and the muscles around this area – very easy to stimulate pressure. So basically just rubbing the side of your head here – you probably do this, don't you? It's to give you food for thought on other ways you can help people in pain and it's also to make you think about pain in a different way to how you think about it at the moment. So with that in mind I have a question for you. Do you feel there's any difference between acute, chronic and palliative pain? What do you feel differentiates them? Length of time? Type of pain? Okay, so differences in intensity or recurrence – you know, whether it's there all the time. Severity? So you've captured some of the things I've said and also maybe come up with some of the myths which we're going to explore.

If you look at definitions of these different types of pains in the text books, this is what they say: acute pain – recent onset, it could be something that happens for an instant such as when you have a needle stick or you have an injection. Or it could be something that lasts for a few minutes or a few hours. Most people would say that acute pain is something that lasts less than 3 months. We often think that acute pain has a causal relationship, so you know what has caused the pain – it's immediate. That toothache is caused by your dental care, you may have an injury or you may have an underlying disease that is causing the pain. And it's possible to estimate the length of duration; we can think of it as having an end point. And you often see these things called pain trajectory, so they can actually map out what the classic acute pain would be for somebody who's had a hernia repair after surgery, or somebody who's in labour. People have actually mapped these out – what the characteristics of this pain are, how long it's going to last and you can see the differences between them.

If you look at palliative pain the length of it varies. We mustn't just think of palliative as being in the terminal phases. If you talk to Maria about palliative care, she'd say it's actually about when you change from active treatment to prolong life to treatment to evoke quality of life. It depends upon the nature of the disease, because most people think of palliative care as being about cancer but it can also be about other chronic diseases. And it usually, but not always, worsens, as it progresses. But there's a causal relationship due to the disease or due to treatments.

If we look at chronic pain, you've all picked up that chronic pain is something that has a long duration and the actual idea of chronic pain has been described in various ways. Most definitions would agree that it is something that has persisted for more than 6 months. Some would say more than 3 months, others would look at other criteria for it. This means that the pain has persisted beyond normal healing processes and what it might mean is there might not be an identifiable cause for the pain and the duration of the chronic pain is unlimited and there's no certainty of an end. It's very rare that chronic pain is cured. And I've looked after people who were born in pain and have lived 80 years in pain, as well as people who've acquired pain through something that's happened to them in their lives. Can you imagine what it will be like to be in pain for 80 years?

So I want you to think back last year about there being two main broad categories of pain. The first one is nociceptive pain. This is where your nervous system is essentially healthy and intact. The second one is neuropathic pain. This is pain where your nervous system is involved in some way in producing the pain or making a pain that exists worse. So there's something that has happened to the nervous system. Now these are quite clear-cut things to look at when you're looking at acute pain. But when you look at chronic pain what happens is the nervous system changes; there are physiological changes that go on in the nervous system that actually can make what starts off as a nociceptive, normal pain into having some of the characteristics of a neuropathic pain because of the nervous system is plastic, it changes and alters.

So because of this complexity, there's been this declaration that chronic pain is a major healthcare problem in its own right. This is the European Federation of the International Association for Study of Pain Chapter Declaration – that pain is a problem in its own right. This has been supported by the European Parliament and it's also been debated at the British Parliament. So if we think about why chronic pain is a problem in its own right – it's because the cause of pain may not be apparent. If you try and link chronic pain to a disease and there's no sign of the disease – what are you saying to the person with chronic pain? Your pain doesn't exist? And one of the problems we have with pain is we view pain through the lens of a bio-psychosocial model. However, in reality we pay lip service to it.

The reality is people in chronic pain have a lot of focus on the biology, some focus on the psychology and very little focus on the sociology. We do need to think about what's caused the chronic pain or what the aetiology is. More importantly I would like you to know what the patient's story is about the chronic pain – what their narrative is. We should listen to what they say and believe what they say and adjust our thinking so it's in tune with what they're thinking about their pain. And what we should aim to do is reduce the risk of developing chronic pain because once someone's got chronic pain, it's much harder to manage than if you can stop someone from getting entrenched in their chronic pain. So we need early appropriate assessment.

We need to believe the patient – remember the cause matters but it's not the only factor. It's not the most important factor either. More importantly we need clear communication – we need to explain things logically and in a way that people can understand instead of throwing jargon at them. We need to clarify misconceptions that people have because that's a way to tackle harmful pain behaviours. We need to tackle fears and anxieties. We should take a balanced holistic approach not just focused on the biological. And we should aim for good earlier appropriate pain relieving methods and that does not necessarily include drugs. Drugs with people in chronic pain can become part of the problem rather than the solution.

Hopefully I've given you some food for thought and challenged the way you think, a little bit, about chronic pain. And I hope you enjoy the experience of having some relaxation, a hand massage and me having my opportunity of revenge by putting some acupuncture needles in you. I know I'll enjoy that bit! Any questions?

Parry: I'm Maria Parry, a senior lecturer in palliative care. I'm a massage therapist and today we're teaching the third year students alternative ways of looking at chronic pain management. So, getting them to think about using other therapies in relation to chronic pain management by experiencing some of those therapies themselves.

[To students] Right, okay – are you all settled? When we think of pain we think of the pill box. I was lucky enough quite a few years ago as a staff nurse to be given the opportunity to train as a massage therapist and work within the Trust. They trained 6 of us at the time and I started to see that by using very simple massage on patients the benefits were phenomenal.

So what we're going to look at is a basic hand massage. I'm looking at using massage techniques and putting them into a very simple hand massage that, in essence, you can use some of the things that you pick up today on any patient without calling it a massage - you'll put cream on somebody's hand or feet (this transfers exactly to the feet and I'll talk about that as well). So you could use some of these techniques if you knew somebody had a chronic pain issue – you could refer them to somebody else or you could think, 'Well, I have 5 minutes to sit here and put some cream on and that may help.'

A lot of this is about the relaxation – we're not treating anybody here and if you look to the contraindications to massage they're as long as your arm. So you wouldn't massage anybody and a lot of people with chronic pain problems will probably have some of the contraindications. They might well have arthritis, they might have poor skin, they might have scars, they might have inflammation. So you have to put it into perspective. You have to look at the benefit versus the risk. But we are looking at something that is incredibly relaxing; I'm not looking at treating anyone with this.

So, basically, get as near as you can – hence the comfy clothes. I always say no short skirts today. I'm using a very basic grapeseed oil – it's one of the best carrier oils for massage. Sometimes when you go to see a massage therapist now a lot of them will use a mousse or almond oil which is very lovely and very expensive. Obviously think about allergies. You have to think about the kind of oil you're using. We've already highlighted some of the issues in clinical practice. If you're going to use oils to do this and use it as a therapist of course you have to think about consent, etc.

Right, okay – you need to have a partner each. So what I want you to do is roll your sleeves up, get a chair opposite, get your pillow and your towel.

Evans: So Becky, this is your last lecture in your 3 year nursing course. And this is the first time you've actually come across chronic pain?

Becky: Many years ago I worked as a pain specialist medical secretary and also worked in a physiotherapy practice, so maybe it's because I worked with physiotherapy at the same time. Maybe it's how this type of thing, I see the benefit because I've already seen the benefit in the past. I like to have a Thai massage sometimes so I see the benefit in that myself.

Evans: Ifan, You're having a massage by Becky. Were you surprised by anything in the lecture this morning about the difference between chronic pain and acute pain?

Ifan: I actually have done a placement at the Narberth, which is a palliative care environment so it's something that I have been used to.

Evans: I'm stopping the massage process – how is it going?

Ifan:: It's lovely. Really nice.

Parsons: This is somebody with complex regional pain syndrome type 1. This photograph was taken in June and it was a very hot June day. This is how he walked into the pain clinic. What do you see? We didn't ask him to take off his shirt by the way. He came in without a shirt on. If you saw this person walking down the street because this is the way he walks around the street – you'd think he's a mental health patient just by looking at him? Yeah? I mean he actually said to me, 'Gareth, people think that I'm a loony. But this is the only way that I can control my pain without using drugs.'

So what we're seeing is a series of different kind of pain behaviours. This is his original site of injury – his wrist. He fell over and fractured his wrist. He healed up lovely; the orthopaedic

surgeons were really happy with him and sent him away. After a week of his injury he was complaining about having this burning pain all the time but they just said it would settle down. Five years later he comes to us in the pain clinic in this state. He's got an expansion of his original pain area. In fact, the whole of his arm is in pain and in most of his torso he experiences pain. The reason why he's not wearing a shirt is just the feeling of clothes on his skin causes him pain. He has this altered sensation. He's also got something called cold allodynia, so cold causes him pain. Just on his hand around the site of his original injury. A breeze in the room going over him causes him pain.

The other thing he has is mechanical allodynia. When he came in this guy took his sling off because he kept his arm in a sling all the time. Which has caused him a problem with his shoulder; he actually has what we call in lay terms a frozen shoulder because he wears a sling all the time. Because every time he moves his wrist it causes him pain and that's why he is resting his wrist on his leg.

He's also got excessive counter stimulation – what he's doing on top of his arm is he's taking a cigarette and burning his skin because that relieves his pain. He was referred to a psychiatrist by the orthopaedic surgeons as somebody who self-harms. He came to us after being treated by the psychiatrist for suicide. He never had any suicidal thoughts but they treated him with anti-depressive drugs because he had been referred for his self-harming behaviour.

Also he's got a TubiGrip on him but it's not doing anything except telling other people that he's got a problem with his arm. So if you walk around with a sling on and a TubiGrip on your elbow you get sympathy from people – they're careful around you, they don't bump into you. He hasn't actually got an injury in his arm; his injury is in his wrist. But the Tubigrip is more prominent – so it's a pain display behaviour.

You've just said that you think he's a lunatic. So what does he think of you? This is from my research and it looks at patients' perceptions of healthcare professionals and basically for patients, you are the problem. Members of the general public are problematic as well but you're the real problem, because you're the ones they turn to for help and you don't help them. You actually make their situation worse. And the ways you do this is that you don't believe them. Or you're not interested in them. Or you treat them like an item to be processed. 'Come in, see us, do this, have this treatment, go away.' And they feel like they only get help if they demand it. But when they demand it they get labelled as angry and aggressive and that gets put in their notes. And then the next time they come in they have to make sure they make an appointment with someone else there to protect the doctor.

And their chronic pain is treated as if it's an acute pain because the main way that you deal with it is to throw drugs at it. And you throw drugs at it that work on a healthy nervous system. And if you don't believe me, this is from my research: this is prescriptions for chronic pain at a typical Welsh GP. The size of practice is about 12 000, which is about typical for a GP in this area. In my research I tried to recruit people that had chronic pain but the GP didn't actually keep chronic pain as a label in their computer system to identify them, so I had to find proxy ways of doing it. I thought, 'How many people in this practice have been prescribed an analgesic for at least 6 months?' That's one way of finding out if you've got chronic pain. If chronic pain lasts for 6 months let's look at the number of analgesia. Fifteen per cent of this practice are taking relatively strong to very strong opioids.

Now, have a look at those who are on drugs that are known to treat chronic pain, drugs like gabapentin or pregabalin – fairly commonly prescribed nowadays to people with chronic pain. Or being referred to a pain clinic, or to orthopaedics or rheumatology, or referred to a physiotherapist, or to the enhanced practitioner physiotherapist. Only 78 patients, only 0.63 percent. So 15 percent of patients should be having help; if they are on these strong analgesics they've had pain for more than 6 months. It needs to be looked at. In the UK the average time it takes to get to a pain clinic is 5 years. By then your pain is truly embedded in you. It's an unseen problem. Up to 11 percent of the people in the community have been estimated to have chronic pain – some surveys have put it higher. And very small numbers are referred to specialists for pain treatment. There's 7 Health Boards in Wales, 6 out of 7 of them have a pain clinic, 6 out of 7 have a pain management programme. There's not enough services out there, which results in delayed access and increased problems. And imagine what it's like if you've got pain and nobody's going to help you and you go to people to help you who can't help you because they don't know how to help you.

Simpson: My name is Owena Simpson and I am one of the senior lecturers for adult nursing and in this session we're going to do some relaxation therapy, looking at managing chronic pain. I've been qualified for 20 years and my background is cardiology and cardiac surgery and prior to coming to the university I was a heart failure specialist nurse.

Evans: As a Cardiology Nurse what can you teach nurses about chronic pain?

Simpson: As adult nurses we are very keen, or go quite often first of all for medication rather than looking for alternative ways of managing people in pain and it's about helping patients to recognise that there are other ways of managing chronic pain rather than just going straight for the medication and all the side effects that that carries, really.

Evans: And relaxation is important?

Simpson: Relaxation is very important and it's something we can all do with a bit of practice and something that people can do at home. They don't need expert people; they can buy different CDs and buy different other aids and find something that works for them.

Evans: And I do and it does.

Simpson: [Laughs] 'Well there we are. [To students] At the moment it's probably – maybe it's the right or wrong time – it's peak time for assessments and stuff so there's just been one assignment handed in and now the dissertation is out there a bit, isn't it. So are you all feeling stressed? Or some of you maybe not. But there are underlying signs that maybe you are? What sorts of things? Crying, headaches and colds all the time and just generally feeling on edge. Not being very nice to other people – so maybe you're quite snappy to people? Sleep? So that's your sign of stress. Other people will go to sleep, wake up early and others can't get to sleep. So we all manage things quite differently. Cold sores and stuff? That's one of mine. And is it healthy for us to be stressed then? No? Not at all, ever? Do we need to be a little bit stressed just to get up in the morning and to do things? So a little bit of stress is okay and that's healthy, but the problem is when it's sustained. Okay, now find a space on the floor and we'll have a practice of relaxation methods. Some of you will go to sleep and some of you won't. Are we ready?

Parsons: I'm going to show you this acupuncture needle. Don't get panicked, okay? This is one that you may use on a very large person around the bottom. These ones are stainless steel disposable needles. Use them once and throw them away – that's important with acupuncture. Don't reuse the needles. Most people's experience of having a needle is

having an injection, isn't it? If you look at the big needle that is being passed around – I don't know if it's got over to you yet, but two of those needles would fit inside the lumen, the hole of the green injection needle. They're designed to slide through tissue and not to cut tissue. What can be strange is finding the acupuncture sensation.

I learnt all this in the 90s and since the 90s we've had the development of fMRI (functional magnetic resonance imaging) scans and with fMRI scans we can actually demonstrate that something happens when you put an acupuncture needle into somebody. Where somebody's brain is activated with pain, the acupuncture stimulation produces a switching off of that pain activation. The surmise is that it's because your body's own endogenous opioid pathways are activated – these are the drugs in your body that are similar to morphine. When we give people morphine the same thing happens, but interestingly when you give somebody a placebo the same thing happens. We do know that a placebo does have a powerful effect in chronic pain. These are used in veterinary practice, for pigs and horses and cows. Now this is interesting as it seems to work – so do horses and pigs have the same placebo effect as a human being? My belief based on my audit data is that something is going on with nociceptive pain because in my experience those people that I gave acupuncture to who had typical, nociceptive type pains – headaches, joint pains, knee pains, lower back pains without surgery they had beneficial effects. Those people who had some type of neuropathic element, like post hepatic neuralgia or multiple sclerosis – I couldn't help them with their pain. So I think that there's something to do with the opiate pathways. So does anyone want to have a go? It has an achy effect doesn't it? It's weird isn't it?

Evans: Are these the nurses who are going to be sticking needles in me next?

Parsons: It's one thing to inflict pain onto someone else – but to have it yourself.

Parry: As you're swapping over I'll tell you a story about one of the benefits to a patient I had. I was a staff nurse at a community hospital not far from where I lived and I worked there for about 5 years and we used to have a lot of patients with chronic pain problems – there were a lot of patients that came back and forth for respite. We had a patient who actually had broken his spine and he used to come back and forth for respite every 6 weeks. He had extreme pain issues from spasms in his legs and from cramp. Consequently he used to buzz about 30 times a night – he never had a good night's sleep. He constantly was moving and his pain issues meant that he could never get comfortable. So when I did this course I went back and I said, 'How do you fancy if we try something new?' So when he came in I said, 'Right, let's get you sorted – we'll massage your legs and we'll see what happens.' So by the time we had finished – he would be laying in the bed like this and he was quite funny because he used to swear like a trooper and for some reason he used to call me Mo. Not sure why, but he would say, 'Mo – move me!' So I said, 'Let's see if you can manage to sleep' and do you know what? He did sleep! After 2 weeks of being admitted you saw a real difference in his sleep pattern.

The downside was that I only worked 5 days a week and some of those were day shifts. So when I was on days I used to go back at 9 pm as I only lived down the road, drag up my daughter, who was only about 1 at the time, put her in her child seat and leave her in the office, and go and do his legs. But I had a real ethical issue with this in the end because when he went home for 6 weeks we had real problems in finding somebody to go and do it. But we did find somebody in the end that could go and do it on an intermittent basis because the benefit was obvious. And you just wanted to say to people sometimes that there may not be a huge amount out there written and there might not be a huge amount of proper research evidence but the evidence is there and if you look at the benefit it can have for patients it is just phenomenal. He was a really good example of how it can work.

Evans: That's Maria Parry, senior lecturer in palliative care at the University of South Wales. Now, I'll just give you the usual words of caution – that whilst we believe that 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. All editions are available for download from Pain Concern's website and CD copies can be obtained direct from Pain Concern. All the contact details – should you wish to make a comment about these programmes via our blog, message board, email, Facebook, Twitter or even pen and paper – are at our website: which is *painconcern.org.uk*. The last words are from Maria Parry.

Parry: From a palliative perspective it's given me more thoughts of using non-drug-related therapies because of the link between hospice and therapies. They're widely used in hospice care and acknowledged in hospice care as being useful and I think that sometimes it's a little bit sad that we don't acknowledge these things. These other therapies can be *so* useful to patients. Obviously, in many palliative care centres they're free, so palliative patients will often be referred to a therapist who will give them a massage once a week. They don't have to go and pay for it once a week because I don't think sometimes that they think patients with chronic pain can access all these services and that is also something that we need to consider. It will be nice to see more people, which is why I think this day is so important – that they leave here and remember a lovely massage and 'Oh yes, it was to do with pain'. And if all they do is put those two things together, then I think we have done something that is useful in relation to patients with pain. Otherwise they will just go out and think, 'Let's give them some morphine or co-codamol' or whatever and it will not necessarily be beneficial to all patients.

Contributors

* Gareth Parsons, Senior Lecturer in Adult Nursing, University of Glamorgan

* Maria Parry, Senior Lecturer in Palliative Care, University of Glamorgan

* Owena Simpson, Senior Lecturer in Adult Nursing, University of Glamorgan

Contact

Pain Concern, Unit 1-3, 62-66 Newcraighall Road,

Fort Kinnaird, Edinburgh, EH15 3HS

Telephone: 0131 669 5951

Email: info@painconcern.org.uk

Helpline: 0300 123 0789

Open from 10am–4pm on weekdays.

Email: helpline@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