

# Communication and the

The things that you say can have more influence on a patient's journey than what you do. What follows is based on an APA Conference presentation by Specialist Musculoskeletal Physiotherapist Peter O'Sullivan.

In the beginning, my career developed around the practice of manual therapy. I think of the hours that I spent learning the technical skills of our trade, and in that process I think we intuitively develop relationship skills, but often we're not taught them. However, one of the things that has really struck me over the years of working with people with pain and disabling

pain is the critical role of communication and relationship building for bringing about behavioural change.

I reflect back and think about some of the most significant clinical changes that I've observed in patients. When I've gone back and asked them, 'What was it that underpinned that change?' it is simple things like, 'You believed

I could change.' 'You gave me the opportunity and confidence to change and have hope.' Simple things like this reflect relationship building and motivation to change.

The other thing that I get to see during clinical practice is the evolution of people who are caught up in disability and pain and the damage that can be done with the things that we say, the language we

use and the messages we give. It's not done consciously; it's often done because they reflect our own belief systems in terms of understanding the human body.

To highlight this, I want to use a patient's story, and it's quite a powerful story, of someone's pathway into pain and disability, and their pathway out.



## A patient's story: part 1

In February 2006, I had a busy day. While the kids were at school, I spent an hour or so using a hammer and chisel to hack the tiles off of our bathroom shower, mowed the lawn, went to a body combat course at the local gym. That afternoon, my lower back felt a little sore but I didn't think anything of it, until I sneezed that afternoon. With the sneeze something in my back went 'ouch' and I immediately felt the muscles in my back clench. Physio treatment saw me recover within about two or three weeks and not wanting this to ever happen again I sought another opinion from a sports medicine doctor. A CT scan was ordered and from that scan they determined that my right L5/S1 facet joint was arthritic and the likely cause. He suggested working with a physio to try and rotate my pelvis forward to try and take the pressure off the joint. It all sounded quite logical to me and I was very committed to working with a physiotherapist to reduce my lordosis to stop any further arthritic change or damage to that facet joint.

My mental state throughout this was positive and I was pretty much back to doing all of the things of normal activity. Then one day in February 2007 I was in a hurry and lifting a heavy box by bending down, twisting to the left and yanking the box upward to the right. I felt a click or heard

a click, I'm not sure which, and immediately my lower back was sore. I was running late for work so I hopped in the car and drove into work.

Over the course of the morning I went from being able to stand upright to being bent over and in quite a lot of pain. At this point I rang a local physiotherapist, another physiotherapist, and booked in to see him that day. I remember being quite calm about the whole incident, thinking that I would be back to good in no time.

The next day the physio saw me all bent over and managed to get me upright again. He said I'd probably damaged a disc given my symptoms and [told me] not to bend, just rest, take pain killers and see him again in three days. I saw the physiotherapist twice more for a week for treatment that involved gentle mobilisation and massage. Ten days later I was feeling not too bad and decided the bedroom curtains in my son's room needed a wash. I hopped up on the chair, lifted my arms over my head, grabbed the curtain rail and pushed up. A clunk or click happened somewhere in my lower back and it didn't feel right. I remember getting a bit upset and my husband calming me down. I could not get into my physio again, but I could get into another physio who came recommended. This physio saw me once a week for six weeks using acupuncture and traction.

# capacity to change



It was recommended to me that I didn't bend until I was healed, about six weeks. I was told, to use a sacroiliac belt to reduce the pressure on my disc. During the next six weeks, however, I was upright... did some gentle stretching and I was told to keep one foot off the ground resting on a foot stool, while doing ironing etc. Unfortunately, six weeks later I was not feeling any better. I couldn't stand for long, sit for long, or walk for long. Lying down was my only reprieve.

I was starting to get worried that I'd never get back to normal, especially after chatting with a lady who had apparently injured a disc at the same time as me and was feeling quite good. The physiotherapist said he'd done all that he could and referred me to another therapist.

Over the next two years I saw two more physiotherapists, a chiropractor, a sports medicine doctor and a pain specialist. I tried Panadol, Nurofen, Voltaren, Valium, stronger pain killers, to no avail. I even had a steroid injection in my right L5/S1 facet joint to rule out the source of pain. That was a very stressful procedure and it was followed by a major back spasm.

I was determined not to give up, that I wasn't always going to be like this; after all I was only in my late-30s. I've always been a reasonably active person, was actively involved in regular exercise—yoga, Pilates, aerobics,

riding my bike, walking with my children—and suddenly I wasn't doing any of that. And exercise had always been one of the ways that I coped with daily life.

The pain and the fear were relentless and it was eating at me. Some nights at the dinner table I might suddenly start crying. I started to have moments of anxiousness and then one night, while having an unusual midnight toilet visit, I had my first full-on panic attack and ended up lying on the bathroom floor.

It was then suggested to me that what I really needed was to see a psychiatrist. I knew I needed some help; I was quite happy to accept that I had anxiety, but not depression; after all, I was a strong mental person.

I started [treatment] with a psychiatrist, a lovely man, in January 2008, who recommended my mental treatment needed to be a combination of medication and cognitive behavioural therapy with a psychologist. At this point I was also seeing another physiotherapist, who recommended I work on my core muscles as a means to strengthen my back. Six months of working with a physio had not really brought any change to my physical state, but working with a psychologist had mentally made me stronger and no longer was I dissolving into tears all the time.

## Communication and the capacity to change

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That's the first half of a very powerful story. I'll get to the rest later.

I think what it highlights is that we see people develop disability not at one instant: this is a process of evolution. Layer upon layer of complexity creates this kind of situation. And I think that for this lady, there is a context. She's a highly stressed lady with a bunch of kids and she's running around doing a million things. She's not a great pacer. She's someone who will do everything at once and then suffer the consequences. She's had a whole series of negative encounters, which have been reinforced by negative information about her back, about the vulnerability of the spine, suggesting that this is not a robust structure. We wouldn't tell someone with a sprained ankle that they shouldn't dorsiflex it for six weeks, but these are the kind of messages that are given for a sprained back.

There's a strong biomedical focus in terms of her clinical encounters: she'd become highly fearful and avoidant, she was using

rest as a strategy of managing pain. She was dependent on a whole series of passive treatments. She had become massively hyper-vigilant. She had no internal locus of control. She became depressed and profoundly disabled, and really at the point of losing hope. These are the kinds of vicious cycles we see in people who develop disabling pain and I'm sure you would reflect on this in terms of other forms of disabling disorders.

So I suppose for clinicians, a question is, 'How good are we at communicating?' One of the things I've observed is that the failure in terms of management of some of our patients is not around technical skills, but in the quality of our communication. There's an interesting study published a while ago that indicated that doctors interrupted patients' opening statements after a mean time of 18 seconds. Only 23 per cent of patients completed their opening statements and out of 51 interrupted statements, only one was completed later. Patients who were allowed to finish without

interruptions usually only take 60 seconds and no longer than 150.

So the next question is: can we identify patients at risk? Clinicians make very inconsistent treatment decisions for patients with back pain using their clinical acumen alone. And we know that radiological imaging for back pain results can result in poorer health outcomes and poor prognosis. An arthritic facet joint or a black disk are not good predictors for future back pain and it is not a reason to be fearful and avoidant. It is not a reason to abnormally modify behaviours of movement and yet we often hear the stories of patients who have been told that by their doctor that their back is crumbling or by a physio to be careful to bend.

We know that negative beliefs about pain and fear of movement are predictive of disability. We know that a biomedical orientation leads to greater advice to limit work and physical activity. We know that our beliefs are reflected in the way we manage our patients. And the things that we say may not be what we intend, but the things that the

patient interprets may be quite different to what we intend.

There was a lovely qualitative study that was published recently that looked at asking patients what simple things meant. Chronic: a couple of steps from a wheelchair. Instability: liable to pop out and not a lot you can do. Wear and tear: something's rotting away. Neurological: death within six months.

This is language that we so commonly use and yet we don't consider the impact that that language can have on the people around us. I have been seriously confronted around this; I have published literature using words like 'instability', which I regret because I think the intention was different from what the message was translated to be.

And now, of course, empathy is a critical part of relationship building. It's been defined as the ability to see a patient's situation, perspective and feelings, and being able to communicate that understanding to a patient.

With that, I'd like to finish the patient's story.

### A patient's story: part 2

One day my physio rang me at home and asked me to see another physiotherapist who worked with complex pain disorders. And so began the process of reclaiming my life back. The choice of words might sound a bit melodramatic, but that's how I feel. When I came home from the consultation, I couldn't wait to tell my husband that I finally found a practitioner who understood the mental side of a person with chronic pain and showed empathy and understanding. My experience has shown me that many health practitioners don't really understand how much a patient's mental state plays in their rehabilitation. Or perhaps they do realise but they just don't have the skills and knowledge to integrate this area into their treatment.

The program that was setup for me started back at the very basics of movement, challenging me to move my body in a relaxed way and regaining muscle strength and to stop working on my core muscles completely. Just sitting in a chair and bending forward from the hips to touch the floor was a huge mental challenge. I would break out in a sweat and feel every muscle in my body tense I was waiting for the clench of agony in my back. It didn't come.

A home program was devised for me with the visits to surgery every six weeks or so, each visit containing more mental challenges as he made me

move my body by twisting, bending, lifting. I found each session rather draining. My anxiety kicked in, but I was determined to be pushed to my limits mentally and physically. Overtime I found myself looking at the way babies move and children, or just watching people on the street in front of me moving, trying to reinforce my perception that the spine is supposed to move, bend and twist and that it is perfectly normal and safe.

In October school holidays my husband I took our two children to Tasmania on a holiday that included lots of hiking. I remember standing on the top on Wineglass Bay lookout. Taking in the view I was very emotional and very pleased to be standing there. It had been 15 months since I started on the road back to normality. I admitted it took longer than I thought. But hey, I'm here now.

I'm currently in the process of reducing my anxiety medication and have dropped the dose without drama. I'm back to riding my bike on a regular basis, been attending aerobic classes once a week, but really, the best things were what people would term the simple things that had become challenges to me: browsing at the shops; hanging up washing on the line; easily picking up items off the floor; pushing a wonky shopping trolley at the shopping centre; and regaining the ease of movement in all things; and smiling again.

So I reflect on this story and I think, *What was it that underpinned this change?* These things come to mind: trust, relationships, empathy, listening, understanding, mindfulness, having a broad view of impairment and disability, pacing, relaxation, normalisation of movement, confidence, self efficacy, hope, developing an internal locus of control, setting goals and achieving them, developing meaning. These create a different vicious cycle, a positive cycle that gives people hope and meaning and the capacity for change.

So in terms of the clinical context, we can't lose sight of the context of the patient: the psychological and the biological. And this forms part of the therapeutic relationship. It fits with a patient-centred approach; the importance of all these different factors and understanding that the person we're dealing with is a human being.

The interesting thing from this sort of approach is it results in improved patient outcomes, greater patient satisfaction and greater therapist satisfaction, as well as a less chance of your likelihood of being sued.

So in terms of our clinical encounters, they reflect not just specific treatment effects, but the non-specific effects of the clinical encounter—the total combined treatment effect. We can't separate them and we can't underestimate the significance of these non-specific effects.

We know that patients value the quality of the communication with the therapist, more than they do the qualifications and the skills of the therapists. So I'll just finish with a quote: 'If you can't communicate, it doesn't matter what you know.'

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I have been  
seriously  
confronted  
around this;  
I have published  
literature using  
words like  
'instability',  
which I regret  
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